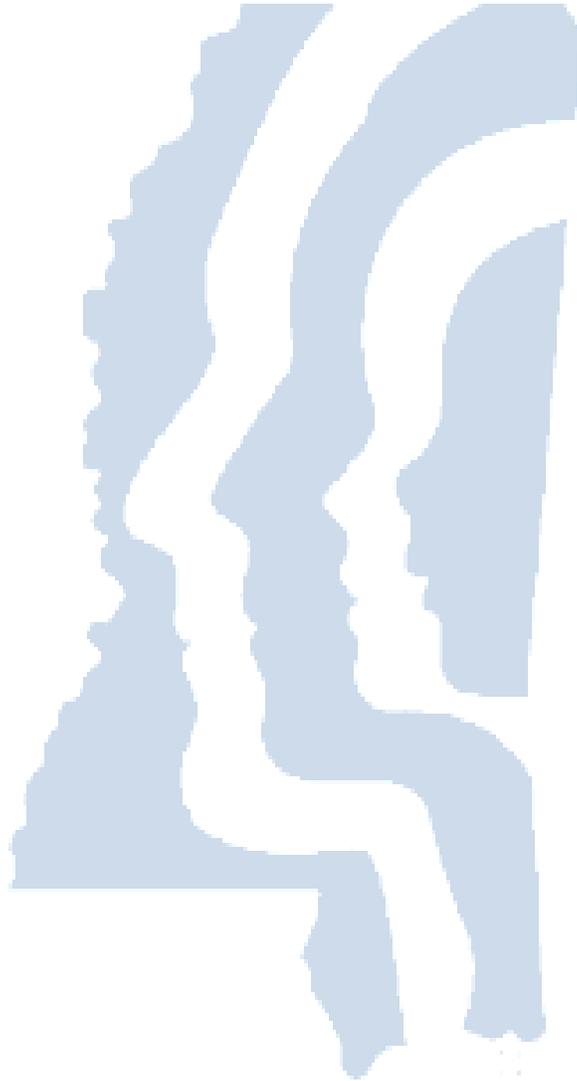


Mississippi State Department of Health
STD/HIV OFFICE



2012-2015

Jurisdictional Plan

(Amended July 2015)

Table of Contents

| | |
|---|----|
| <u>Section I.....Brief Overview of Mississippi’s Epidemiological Data</u> | 5 |
| <u>Section II.HIV Prevention Program: Existing Resources, Program Gaps, and Description of Unmet Needs</u> | |
| <u>Section III. Jurisdictional Determination and New Priorities</u> | 53 |
| <u>Section IV. Jurisdictional Planning Methods and Proposed Activities and Strategies</u> | 54 |
| <u>Section V. Detailed Workplan</u> | 68 |
| <u>Appendices</u> | 76 |

Section I. Brief Overview of Mississippi's Epidemiological Data

This section provides a brief overview of existing epidemiological data, quantitative and qualitative needs data, and emerging trends affecting the prevention of Human Immunodeficiency Virus (HIV) infection in Mississippi. This section also provides a description of the existing HIV prevention resources and services in the state.

Description of Local HIV/AIDS Epidemic

Mississippi is one of the most rural states in the United States and its population arguably the poorest. It is bordered to the north by Tennessee, Alabama to the east, Arkansas and Louisiana to the west, and Louisiana and the Gulf of Mexico to the south. According to the 2010 Census, Mississippi has a population of 2,967,297 people, with a racial distribution of 59% white, 37% black, 3% Hispanic, and 2% other. Mississippi ranks second in the nation (after the District of Columbia) for the highest proportion of African Americans. Based on the U.S. Census Bureau 2011 American Community Surveys, Mississippi ranks first in the nation for the most people living in poverty (22.6% of the total population) and the lowest median household income (\$36,919) for the 50 states and the District of Columbia. Mississippi also ranked first in the 2009 American Community Survey.

Mississippi's 82 counties are divided into nine public health districts (Appendix A) and there are HIV cases in every county. Acquired Immunodeficiency Syndrome (AIDS) has been reportable in Mississippi since 1983 and cases of Human Immunodeficiency Virus (HIV) since 1988. Table 1 on the following page shows the case rates for people living with HIV in Mississippi by public health district in 2010. The high proportions of African Americans with HIV/AIDS who reside in rural areas, the socioeconomic consequences of the high poverty rate, low health literacy, and stigma pose significant challenges for effective HIV care and services delivery.

Table 1: Distribution of HIV Infection by Public Health District, Mississippi-2013

| <i>Public Health District</i> | <i>2013 Population Estimate</i> | <i>Case Rates for People Living with HIV as of 12/31/12</i> |
|--------------------------------------|--|--|
| <i>District I</i> | 322,373 | 17.7 |
| <i>District II</i> | 365,397 | 11.2 |
| <i>District III</i> | 211,212 | 24.1 |
| <i>District IV</i> | 245,601 | 11.0 |
| <i>District V</i> | 640,418 | 30.8 |
| <i>District VI</i> | 242,912 | 14.4 |
| <i>District VII</i> | 172,718 | 16.8 |
| <i>District VIII</i> | 308,460 | 18.5 |
| <i>District IX</i> | 475,835 | 13.0 |
| <i>Statewide</i> | 2,984,926 | 18.6 |

Summary of 2013 HIV Epidemiological Profile

According to the 2011 National HIV Surveillance Report, Mississippi had the 7th highest rate of HIV infection in the United States. The state’s capitol city, Jackson, had the third highest rate of HIV diagnoses and the eighth highest AIDS diagnosis by metropolitan statistical area (MSA) in 2011. Over the past two decades, the number of persons living with HIV in Mississippi has increased each consecutive year. As of December 31, 2013, there were an estimated 10,473 Mississippians living with the HIV. 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. A peak in the number of deaths was observed in 1994, but the mortality rate has stayed fairly stable during the past ten years. Since 2001, there has been a gradual increase in the number of individuals living with HIV.

HIV Infection by Geographical Location

Appendix C provides a distribution of HIV disease cases by county that were reported in 2013. There was at least one report of HIV disease from each county in Mississippi, and over half of all cases occurred in six counties. These include Hinds (27%), Rankin (6%), Harrison (5%), DeSoto (5%), Forrest (5%), and Lauderdale (4%) counties. These counties have population sizes greater than 100,000, with the exception of Forrest and Lauderdale Counties. Most new HIV disease cases were identified in the West Central Public Health District V, which includes the metropolitan Jackson area, where 47% of all persons with HIV disease in Mississippi reside presently. In 2013, the prevalence of HIV (number of living cases) in District V was 623.2 cases per 100,000 persons. The Delta-Hills Public Health District III had the second highest case rate at 476.8 per 100,000 persons, followed by the Southeast Public Health District VIII, with a prevalence of 306.0 cases per 100,000 persons (Table 1 on page six and Appendix D).

HIV Infection by Ethnicity/Race, Gender, and Age

Mississippi's African American population is profoundly and disproportionately affected by HIV. African Americans comprise only 38% of the State's total population, but accounted for about 75% of all new cases in 2012 and had an incidence rate nearly seven times that of Caucasians. In African American men, there was a gradual decrease in reported cases until 2005, when cases started to increase. From 2007-2012, there was a 13.8% increase in cases (from 283 to 322 cases). In 2012, African American men had rates nearly nine times higher than Caucasian men (63.2 vs. 7.4). African American men represented 59% of cases reported in 2012 and were the only group to experience an increase in cases over the ten-year period (2002-2012).

Males have consistently higher rates of HIV infection than females. Trends show that men are nearly four times as likely to be infected with HIV. In 2012, males represented 78% of all reported cases and among those living with HIV in Mississippi; African American men had the highest prevalence rates. African American men had rates 4.5 times higher than Caucasians males. Among females, African Americans had the highest rates of living cases. Their rates were 8.7 times higher than Caucasian women.

Since 2007, the proportion of cases of HIV among women in Mississippi has steadily declined. In 2012, 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 prenatal case management activities. Among females, African Americans have the highest burden of disease, representing 75% of cases in 2012. Since 2008, cases have decreased 35% (from 184 to 119 cases). In 2012, African American females had rates nearly seven times higher than white females (17.9 vs. 2.7). Over the past decade, rates among whites have remained stable.

HIV Disease Cases Reported by Age Group, Mississippi, 2001-2010

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. From 2001-2006, 30-44 year olds reported the highest number of cases, representing 33% of cases in 2006. Since then, there has been a shift in the distribution of cases to 15-29 year olds. This age group saw a 47% increase from 2006-2012. Cases among other age groups have remained stable. In 2012, 15-29 year olds represented 44% of cases, 30-44 year olds represented 29% of cases, and 45-59 year olds represented 21% of cases.

HIV Infection by Risk Factors

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. 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. Since 2008, there has only been a slight dip in the proportion of cases reported that have no risk identified (from 53.6% to 30%). From 2003-2012, those who reported as MSM increased from 40% to 51%. Transmission from heterosexual sex has remained fairly stable.

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.

Late Diagnosis of HIV Infection in Mississippi

From 2001 thru 2010, there were 5,028 cases of HIV disease. Thirty-six percent (1,808) developed AIDS within 1 year of initial HIV diagnosis. In 2001, 38% were late diagnoses of HIV infection. There was a peak observed in 2004 (43%) and then declines until 2009. Although the number of overall cases declined from 2009-2010, the proportion of Late diagnoses increased (from 28% to 36%). The mean age of individuals who were late diagnoses was 39

years and 33.5% of cases were 45 years or older. There were more cases reported in males (74.6%) and African Americans accounted for 74.7% of all diagnoses. Men who have sex with men (MSM) was the highest mode of HIV exposure reported (34.1%). 64.7% were non-residents of the Jackson metropolitan area and individuals who lived in urban areas at the time of diagnosis represented 50.7% of cases. 88.3% were diagnosed at non-MSDH clinics.

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. African Americans with HIV disease have the highest number of deaths each year, accounting for nearly 80% of deaths annually. When considering race and sex, African American men with HIV disease have the highest number of deaths, followed by African American females, white males, and white females. White females with HIV disease reported 15 or fewer deaths each year. 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 3).

Table 3: Deaths among Persons with HIV Disease in Mississippi, 2010

| | Number | Percent |
|-----------------------------|---------------|----------------|
| Age at time of death | | |
| 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% |
| Sex | | |

| | | |
|----------------|-----|-------|
| Male | 101 | 73.2% |
| Female | 37 | 26.8% |
| Race | | |
| AA | 109 | 79.0% |
| White | 22 | 15.9% |
| Other | 7 | 5.1% |
| PH Dist | | |
| 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% |

Section II. HIV Prevention Program: Existing Resources, Program Gaps, and Description of Unmet Needs

Existing Resources

Evidence-based Behavioral Interventions (DEBIs)

Currently, MSDH STD/HIV Office Policy Branch funds six organizations to provide five (4) Diffusion of Effective Behavioral Interventions (DEBIs) to targeted populations in areas with highest incidence of HIV infection. Three of the five subgrantees are also contracted to provide waived rapid in non-clinical setting to targeted high risk populations. Subgrant agreements also require the funded organization to provide HIV risk reduction education and condom distribution to individuals at highest risk for HIV acquisition and transmission through community and street outreach. Subgrantees are monitored and evaluated to ensure fidelity of interventions and outreach to the specified target populations. STD/HIV Office Policy Branch staff and Expanded Testing Coordinator conduct announced and unannounced site-visits. Findings are provided to the subgrantee in the form of a letter highlighting areas of best practices and areas needing corrective action. Programmatic reporting forms have been updated to align with CDC-required data variables. Additionally, Prevention Service Council (PSC) meetings are held to exchange information, to discuss accomplishments, barriers, current trends within the target areas, and to provide updates regarding strategy changes. Subgrantees provide

reports on intervention activities, testing events, community outreach, and condom distribution to the Mississippi HIV Planning Group (MSHPG) on a quarterly basis. Table 4 lists the subgrantee organizations, the funded interventions, and the high morbidity target populations. Figure 1 show the funded subgrantees and the geographical distribution of disease.

Table 4: CY2013 Funded DEBIs

| <i>CY 2013 Funded Subgrantee Organizations</i> | | | |
|--|--|---|--|
| <i>Subgrantee</i> | <i>Intervention</i> | <i>Target Population</i> | <i>Public Health District</i> |
| <i>AIDS Service Coalition</i> | <i>RESPECT; Rapid HIV Testing in non-clinical settings Condom Distribution;</i> | <i>Individuals at high-risk; Newly-identified PLWHA</i> | <i>PHD VIII Forrest & Jones Counties</i> |
| <i>Building Bridges, Inc.</i> | <i>3MV; RESPECT; Rapid HIV Testing in non-clinical settings; Condom Distribution</i> | <i>African American Males; Individuals at high-risk</i> | <i>PHD V Claiborne, Hinds, Madison & Rankin Counties</i> |
| <i>Grace House</i> | <i>CLEAR; Condom Distribution</i> | <i>PLWHA & Individuals at high-risk</i> | <i>PHD V Hinds County</i> |
| <i>Southern Health Commission</i> | <i>VOICES/VOCES; Condom Distribution; ARTAS</i> | <i>African-American Males</i> | <i>PHD III Sunflower & Washington Counties</i> |
| <i>Southeast Mississippi Rural Health Initiative, Inc.</i> | <i>CLEAR; Rapid HIV Testing in non-clinical settings; Condom Distribution; ARTAS</i> | <i>PLWHA; Individuals at high-risk</i> | <i>PHD VIII Forrest County</i> |
| <i>South Mississippi AIDS Task Force January 1, 2014 – June 30, 2014</i> | <i>RESPECT; Rapid HIV Testing in non-clinical settings Condom Distribution</i> | <i>Individuals at high-risk; Newly-identified PLWHA</i> | <i>District IX Harrison County</i> |

Brief overview of Current DEBI's

CLEAR

CLEAR is an intense individualized client-centered program for ages 16 and older living with HIV/AIDS or at high-risk for HIV disease. **CLEAR** is delivered one-on-one using cognitive behavioral techniques to change behavior. The intervention provides clients with the skills necessary to be able to make healthy choices for their lives.

Many Men Many Voices (3MV)

3MV is a seven-session, group-level HIV and STD prevention intervention for black gay men. This intervention addresses factors that influence the behavior of black men who have sex with men (MSM), including cultural, social, and religious norms; interactions between HIV and other sexually transmitted diseases. 3MV is designed to be delivered by two culturally competent facilitators in groups of up to 12 clients.

RESPECT

RESPECT is an individual-level, client-focused HIV prevention intervention consisting of two brief interactive counseling sessions in conjunction with conventional HIV testing. It has been modified for implementation with waived rapid testing. The intervention is scripted and provides teachable moments to emphasize a client's risk for HIV acquisition or transmission.

VOICES/VOCES

Video Opportunities for Innovative Condom Education and Safer Sex (VOICES/VOCES) was designed to help clients develop the skills needed to practice safer sex and negotiate condom use. A group-level, single session video based intervention. During the session, a variety of topics, including substance abuse, domestic violence, or the latest drug therapies for HIV may be discussed. These are important topics; however, they should stay focused on condom use and negotiation.

ARTAS

Anti-Retroviral Treatment and Access to Services

ARTAS is an individual-level, multi-session, time-limited intervention with the goal of linking recently diagnosed persons with HIV to medical care soon after receiving their positive test result. ARTAS is based on the Strengths-based Case Management (SBCM) model, which is rooted in Social Cognitive Theory (particularly self-efficacy) and Humanistic Psychology. SBCM is a model that encourages the client to identify and use personal strengths; create goals for himself/herself; and establish an effective, working relationship with the Linkage Coordinator (LC).

Education and Trainings

The Education Branch is responsible for providing education and training throughout the state. This branch works diligently to address the National HIV/AIDS Strategy priorities for HIV Prevention: *1) Intensify HIV prevention in the communities where HIV is most heavily concentrated; 2) Expand targeted use of effective combinations of evidence-based HIV prevention approaches; 3) Educate all Americans about the threat of HIV and how to prevent it.*

The overarching goal of Education Branch is to increase knowledge and awareness, and reduce stigma about STDs including HIV/AIDS throughout the state. This branch offers a proactive training calendar of courses utilizing the guiding principles of CDC's curriculum. Mandated CDC courses are strategically aligned with the Mississippi epidemiological profile and courses are held in various locations statewide. The Education Branch extends training courses to health department staff, community planning group members, healthcare professionals, and other interested community stakeholders. The Education Branch works collaboratively with the Mississippi STD Prevention Training Center (MSPTC) and Mississippi AIDS Education Training Center (AETC) to promote education and training for healthcare professionals within Mississippi.

The Education Branch staff conducts presentations in prioritized communities to increase awareness, promote testing, and develop partnerships for educating communities at risk. Educational trainings offered by the Education Branch include the following:

- *STD/HIV Instructor Course*
- *Fundamentals of HIV Prevention*
- *Fundamentals of HIV Prevention: Addressing Issues of Youth*
- *Fundamentals of Waived Rapid Testing*
- *ARTAS*

The STD/HIV Office Education Branch developed testing leaflets to foster awareness of HIV testing locations throughout the state. The three testing leaflets identify diverse testing locations for traditional and rapid testing for the northern, central and southern parts of the state. Testing leaflets are disseminated to all testing partners to distribute during community events, health fairs, and community/street outreach. Additionally, the Education Branch staff work with CBOs, ASOs, and other HIV providers to coordinate Capacity Building Assistance or Technical Assistance by submission of request through the Capacity Building Assistance Request Information System (CRIS) system. The Education Branch staff continuously work with the MSDH Office of Communication to develop educational materials and update website information to improve access to STD/HIV information.

Social marketing plans were in progress to publicize education and testing for HIV/AIDS through the local transportation system. Mississippi is primarily a rural state. Our HHS CAPUS cooperative agreement provided funding for this promotional activity, but our human resources (staff) were funded by PS12-1201. The Jackson Metro area is urban and sustains the city's only public transportation system, JATRAM. The propose plan included advertisement through the JATRAM public transportation system. This approach was classically now as a moving billboard. The advertisement will cover the exterior means of transportation. This transportation route covers a highly visible area of those individuals most at-risk for HIV/AIDS and other STDs. The targeted route also includes the Jackson Medical Mall where the MSDH STD/Office Crossroads Clinic is located that offers testing and treatment for HIV/AIDS and STDs.

The MSDH STD/HIV Office Expanded Testing program contracts and collaborates with clinical and non-clinical sites to provide routine opt-out testing in areas of high HIV morbidity. Table 5 provides the organizations that have sub-grant agreements to provide routine opt-out HIV testing.

Table 5: MSDH STD/HIV Office Expanded HIV Testing Sites (Clinical/Non-Clinical)

| Testing Organizations | Settings | Public Health District and target counties |
|---|--|--|
| <i>Jackson Hinds, Comprehensive Health Center 3502 West Northside Drive Jackson, MS 39213 (seven sites)</i> | <i>Community Health Clinic</i> | <i>District V Hinds</i> |
| <i>G.A. Carmichael 1668 W Peace St, Canton, MS 39046</i> | <i>Community Health Clinic - Clinical</i> | <i>District V Hinds</i> |
| <i>Central Mississippi Health Services 1134 Winter Street Jackson, MS 39204</i> | <i>Community Health Center – Clinical</i> | <i>District V Hinds</i> |
| <i>Southeast MS Rural Health Initiative, Inc. P.O. Box 1729 Hattiesburg, MS 39403</i> | <i>Community Health Center – Clinical and Non-clinical</i> | <i>District VII Forrest</i> |
| <i>Coastal Family Health Center 715-A Division Street Biloxi, MS 39530</i> | <i>Community Health Center – Clinical</i> | <i>District IX Harrison</i> |
| <i>University of Mississippi (Ole Miss) 225 V.B. Harrison Health Center University, MS 38677</i> | <i>University-Clinical</i> | <i>District II Lafayette</i> |
| <i>Mississippi State University</i> | <i>University-</i> | <i>District IV</i> |

| | | |
|---|---|----------------------------------|
| <i>360 Hardy Road Mississippi State, MS 39762</i> | <i>Clinical</i> | <i>Oktibbeha</i> |
| <i>Alcorn State University/ Felix H. Dunn Health Center 1000 ASU Drive 779 Alcorn State University 39096</i> | <i>HBCU University – Clinical</i> | <i>District V Claiborne</i> |
| <i>The University of Southern Mississippi USM Student Health Center 118 College Drive,#5116 Hattiesburg, MS 39406</i> | <i>University – Clinical</i> | <i>District VIII Forrest</i> |
| <i>Jackson State University JSU Student Health Center 1400 Lynch Street Jackson , MS 39217</i> | <i>HBCU University – Clinical</i> | <i>District V Hinds</i> |
| <i>AIDS Services Coalition 121 College Street Hattiesburg, MS 39401</i> | <i>CBO - Non Clinical</i> | <i>District 8 Forrest</i> |
| <i>Building Bridges Incorporated 2147 Henry HILL Drive, Suite 206Jackson, MS 3204</i> | <i>CBO – Non Clinical</i> | <i>District 5 Hinds</i> |
| <i>Grace House P.O. Box 68924 Jackson, MS 39286</i> | <i>CBO –Non Clinical</i> | <i>District 5 Hinds</i> |
| <i>South Mississippi AIDS Task Force 2736 Fernwood Road Biloxi, MS 39535</i> | <i>CBO – Non Clinical</i> | <i>District 5 Hinds</i> |

All rapid HIV test sites have individualized protocols which provide guidance for linkage to care. All newly diagnosed HIV positive persons must receive HIV prevention education, post-test counseling, and partner services by the public health district DIS. Currently, there are thirty-

seven DIS in the public health districts. Each district has at least two DIS with the exception of District V having eight DIS and District IV having zero. The DIS position is funded in each district based on population and morbidity in each district. The DIS refers all newly diagnosed HIV positive clients to district HIV case managers to assist positive HIV individuals with access to medical care and other needed resources.

Condom Distribution

The MSDH STD/HIV Office condom distribution within the community continues and remains critical component of HIV prevention efforts. The Office and County Health Departments distribute Lifestyle male latex condoms and female condoms (FC2) to individuals at high risk for acquisition and transmission of HIV disease. Currently, the six funded CBOs distribute condoms to persons living with HIV and individuals at high-risk for acquisition of HIV disease. *In CY 2014, MSDH STD/HIV Office increased funded CBOs distribution of condoms to 97,000. Additionally, MSDH collaborates to distribute condoms with community partners including STD/HIV educators, CBOs, AIDS Service Organizations (ASOs), Historically Black Colleges and Universities (HBCU), local barbershops, clinics, hotels, LGBT bars, store owners, correctional facilities and businesses in high HIV prevalence areas. In CY 2013, MSDH has distributed 1,405, 900 condoms through its community partners. Four hundred thirty thousand (430,000) condoms were paid for through PS12-1201 funding. CY 2012 condoms distributed by MSDH STD/HIV Office and Reproductive Health totaled 3,075,200. In CY 2011, approximately 4,439,000 (4,439 cases x 1,000 per case) male latex and 60,400 (604 bags x 100 per bag) female condoms were disseminated from the MSDH Central Supply warehouse. Of this number, approximately 3,439,000 male condoms were purchased as a contraceptive and protection against other STDs including HIV using Title X Family Planning grant funds. About 1,000,000 condoms were purchased using funds from the HIV Prevention Cooperative Agreement Award with CDC. As a new activity, the STD/HIV Office collaborated with MSDH Field Services to modify the MSDH Patient Clinic Encounter Form to document the distribution of condoms to HIV positive and high-risk individuals during clinic visits. The MSDH STD/HIV Office developed a condom distribution awareness program titled “Get it On: Protect Yourself.” The program continued to be implemented at MSDH public health Category B expanded testing sites and Category A CBOs. MSDH and CBOs continue to build community partnerships to*

develop distribution sites of condoms in areas of HIV morbidity. MSDH continues to provide condom distribution bags as part of its condom distribution program.

MSDH Policy Branch will work to increase condom distribution in areas of high HIV morbidity by working with funded CBOs, traditional and nontraditional community partners. Areas will be identified by epidemiological data MSDH will increase condom distribution as outlined in the Comprehensive Prevention Plan. MSDH STD/HIV will increase its purchase of condoms to reach goals of increased distribution. MSDH will add condom distribution sites to the STD/HIV Resource Registry and develop an online application and reporting requirement guide on the STD/HIV website. The MSDH STD/HIV Office will collaborate with LGBT Bars to provide condoms directly especially establishments in areas of high morbidity.

Partner Services

Presently, the MSDH employs 38 Disease Intervention Specialists (DIS) who work in the nine Public Health Districts and provide partner services and notifications for infectious diseases. DIS are required to provide follow-up on all newly reported HIV infected individuals who have been identified by the MSDH STD/HIV Office Surveillance Branch. DIS provides partner services to suspects and associates of HIV infected individuals. Part of the responsibilities of the DIS is to work with each subgrantee that performs HIV/STD testing and assure the provision of partner services to individuals identified as HIV positive. MSDH strives to assure that a consistent methodology is in place across all testing venues for partner counseling and referral services (PCRS).

Description of Current Continuum of Care

Mississippi Continuum of Care Cascade

The MSDH 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 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. All Class I diseases should be reported by telephone within 24 hours of first knowledge or suspicion. 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 confirmatory HIV testing and Serologic Testing Algorithm for Recent Seroconversion (STARHS) by the Mississippi Public Health Laboratory.

The MSDH uses Ryan White Part B Program funds to operate two MSDH clinics for HIV-infected individuals. The clinics are Crossroads Clinics Central (CCC), which serves the metropolitan Jackson area, and Crossroads Clinics 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 and the clinic is called Crossroads Clinics North (CCN). 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 CCC is located in an inner-city shopping mall located at the Jackson Medical Mall. Tenants of this multi-use complex include social/human service agencies, state and city government offices, university classrooms and retail shops. Since April 2012, Ryan White Part B funds a full-time dental clinic at Crossroads Clinic Central that provides comprehensive dental care to HIV positive eligible patients.

The UMMC Adult Infectious Diseases Clinic and a branch of Jackson-Hinds Comprehensive Health Care Center, a Federally Qualified Health Care Center that serves the metropolitan Jackson area, are located in the Jackson Medical Mall. 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) utilizes a centralized pharmacy approach by which HIV medications prescribed by health providers are dispensed from the MSDH pharmacy in Jackson to a local health department clinic nearest to 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 500 cells. 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.

Presently, eleven HIV case managers are funded by Ryan White Part B for the nine Public Health Districts to 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 located at the Jackson Medical Mall, is a Ryan White Part C funded program. The clinic provides services that contribute to the HIV Continuum of Care as follow:

- **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 advocates 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 that serves residents of the Mississippi Gulf Coast region. Services contributing to the Continuum of Care for HIV-infected individuals include:

- 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 pre-natal 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. 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. 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, and Perry, Pike, Stone, Walthall, and Wayne counties. Eligible individuals from other neighboring counties may also be seen.

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 are 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 the 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) may 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 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 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 relocated the Community-Based Dental Partnership program to a different location in the Jackson Medical Mall. The Crossroads Clinic Central re-established a Dental Clinic in 2012 using Part B funds in order to provide dental care to individuals who are not eligible to receive Medicaid benefits and do not have dental insurance.

Prevention of Mother to Child Transmission

Preventing HIV infection during pregnancy period is critical. Diagnosing and treating HIV infections in women of child bearing age is one way that Mississippi is preventing perinatal HIV transmission. Presently, the UMMC Department of Pediatrics is the state's only Ryan White Part D funded organization in Mississippi.

The MSDH local health departments work closely with the UMMC Pediatric Infectious Disease (UMMC Ped) Department. Mississippi has low prenatal infections due to being actively aggressive and involved in getting HIV positive 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 Pediatric staff also follows up with local health departments in the county where the patient resides.

HIV Testing Schedule for Infants Born to Mothers Infected with HIV

HIV infection can be reasonably excluded in children under 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 one to two months, and again at four to six months using virologic HIV test. Virologic tests detect HIV antibodies in the blood. Table 6 provides the periodicity

schedule for HIV testing of infants at UMMC Ped. UMMC Peds tests infants earlier and more frequently.

Table 6: 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 |

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 Expanded Testing Initiative (ETI). CDC provides funding to offer free HIV Rapid Testing in various clinical and nonclinical settings. As of December 31, 2011, the Expanded Testing program in Mississippi had 15 participating sites that offer rapid HIV test, free of charge to all their patients/clients. These sites include local emergency rooms, community health centers, mental health community centers, and homeless clinics.

Rapid HIV testing is performed at the point-of-care-site using blood 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. In the future, MSDH will branch out to correctional institutions, college health centers, and community based organizations.

Program Gaps

State Medicaid Program Limitations

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 to HIV positive individuals and access to dental service is a challenge. Many HIV positive individuals access to trauma care and emergency treatment, essentially, tooth extraction are limited. Medicaid does not cover physical or occupational therapy, psychologist services, dentures, speech therapy, prosthetic or orthotic devices, or hearing aids for HIV positive individuals.

Gaps in Health Care Workforce

Out of the state's 82 counties, 77 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 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. With only one dentist for every 2,469 people, Mississippi has the nation's worst dentist to population ratio and few dentists (less than 36%) actively participate in the state's Medicaid Dental Program.

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, recovery support services (formerly known as aftercare/outreach 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.

Gaps in HIV Testing

In rural area and some locations of the metropolitan area, the lack of public transportation is a barrier for access to HIV testing and treatment. Many rural communities lack facilities that offer HIV testing, although rapid HIV testing could easily be implemented. African American are heavily concentrated in the predominately rural Mississippi Delta Region. Many minorities do not have jobs that provide health insurance or are underinsured. Although free and confidential HIV testing is available at all county health department clinics in the 82 counties, fear of local recognition and stigma are primary factors that prevent individuals from undergoing HIV testing in rural communities.

Gaps in Access to Care

In the 1990's, the Mississippi Ryan White Part C Grantees formed a Rural Area Network (RAN) to provide an integrated service delivery system for HIV patients who would normally have difficulty connecting to care providers. Their target population includes patients living in rural areas or areas where there were no physicians willing to manage HIV/AIDS patients. However, the network revealed many coverage gaps statewide and there is a need to increase the number of primary care clinics willing and able to provide care. Also rural clinics, hospitals, and health centers that participate in National Health Service Corp and other access programs unfortunately have a turnover in staff that creates instability for their HIV patients. For the Hispanic and Asian

populations, there is a growing need for linguistic translation services. Some HIV positive patients do not know the name of their case manager nor have kept an on-going relationship with their case manager and not engaged in primary care.

Many primary care physicians may lack the knowledge to provide effective HIV treatment and care. There is also a limited number of nutritionists and dieticians with the proficiency to tackle nutrition related issues and provide patient education on nutrition for those living with HIV. Newly diagnosed patients oftentimes experience depression and have no reliable access to mental health services or lack financial coverage. Only a handful of peer-driven support groups for HIV positive individuals have been identified presently.

Incarcerated populations also need transitional case management to prepare for 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. Many patients will not contact the clinic for an appointment until they are out of medication or have become ill. People also re-offend or violate parole or work release and be re-incarcerated before they make their first appointment. 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.

Description of Unmet HIV Prevention Services

This section includes the results of the qualitative research portion of the Community Needs Assessment conducted by the MSDH and the Mississippi HIV Planning Group (MSHPG) for HIV Prevention.

Methods

In June 2013, Mississippi State University implemented 2 focus groups in collaboration with MSDH and a community based organization (CBO) in Mississippi. A question guide was

developed around understanding barriers and facilitators to testing and care. Also, questions were developed to understand knowledge of services, important services as well as best ways to communicate about testing to this group. The CBO assisted with recruiting African American gay men aged 18-29. Youth under the age of 18 were not recruited for this focus group due to the need to obtain parent consent and a risk for breaking confidentiality. Consent forms were filled out by participants. The process was approved by the Institutional Review Boards of Mississippi State University and Mississippi Department of Health.

In 2009, two focus groups and three key informant interviews were conducted in Washington County: one group was African American males only and the other was African American females only. During the same time period, a focus group was conducted in Hinds County. In 2011, two focus groups with diverse ethnicity were conducted in Hinds County.

Findings

Participants suggested that the promotion of testing was not sufficiently prominent in schools and there was a need for sex education to start as early as possible so that young people have information before they are sexually active. They suggest increased promotion of testing in youth-centered areas such as schools and clubs; also they would like to see more gay-friendly, youth friendly services, including testing, general health care, housing, psychiatric/counseling. Youth would like to be able to talk confidentially with doctors and expect that their privacy would be upheld professionally. The cost of health care, insurance, and HIV drug prescriptions was a big concern.

There were references to several organizations that provide HIV/AIDS services including: A Brave New Day, Crossroads Clinics, G. A. Carmichael Clinic, Grace House, My Brother's Keeper, Inc., Sororities/Fraternities and Family Medical Centers. The respondents strongly suggested the establishment of peer support group services for people living with HIV disease.

The risk behavior 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. The focus groups recommended immediate attention to HIV/AIDS/STDs related issues such as testing availability and education. Also, awareness on drug and alcohol addiction, mental health issues and suicide should be promoted.

Participants believed churches were actually part of the problem because they foster stigma and exclusion of HIV positive persons in the communities. There was a consensus among focus group members that churches should play a more active role in prevention and treatment of HIV/AIDS/STDs. Additionally, barriers to prevention and treatment listed by focus group included the lack of education about prevention and/or care; lack of public transportation/cost of travel to services; and stigma and fear of retribution from families and friends of HIV positive persons. Some focus group members expressed distrust for the ability of public health officials to maintain confidentiality and expressed concern regarding the inclusion of people who are not “People Living With HIV/AIDS” in primary peer activities such as support groups.

Cultural differences, beliefs, and practices were seen as barriers by numerous respondents especially in the African American communities. Inadequate service providers, stigma attached to homosexuality, lack of acceptance and lack of empowerment of women were reflected in the findings.

Respondents believed there are too few financial resources available for prevention and treatment of HIV disease. Certain respondents believed duplication of services in certain areas should be re-established in other areas of need.

The need for increased education especially for the younger generation is critical to raising awareness, increasing safe sex practices and reducing fear and stigma of HIV disease. In addition, focus groups suggested that public health agencies should invest more time in communication and collaboration activities with community organizations and PLWHA.

The overall findings of the focus groups supports the need for increased HIV/AIDS related services, education and awareness, testing sites, maintaining confidentiality, and communication and collaborations with partners and community.

Perceived 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.
- Communication and integration between multiple 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.
- Lack of assistance for HIV-positive individuals to qualify for health insurance programs.
 - Medicare eligibility determination
 - Medicaid eligibility determination
- Lack of 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.
- Difficulty locating former prisoners

- Oftentimes, staff at correctional facilities cannot locate former prisoners to provide follow-up test/results after 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, 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
- Barriers to getting tested
 - Being afraid of the results is the number one reason for not getting tested (20%). Other barriers were: 'Not at risk' (15%), and 'Assume I do not have HIV'. Men were more likely to answer afraid of results than women.
- Information Delivery
 - The most popular resources for information were the health department, family doctor and the internet. Presentations and workshops was another resource that was popular. The internet was chosen most frequently by participants ages 18-39 while presentations/workshops were preferred by folks 40 years and older.

Identified Areas of Need in HIV Prevention

- Develop programs to increase 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.
- Develop media campaigns that raise the awareness and the urgency of the matter with facts intended to reduce stigma, grounded in culturally sensitive messages.
- Form effective partnerships with faith-based institutions.
- Focus on youth, including jailed and incarcerated youth and their sexual partners.
- Provide mental health relief for HIV+ persons through support groups.
- Use mobile testing centers and organized testing outreach events to promote free testing.
- Use examples of prevention and testing programs that have worked in similar communities in southern states that are culturally sensitive. (e.g., Saved Sista Project).

- Address the HIV continuum of care holistically by collaborating with drug and alcohol addiction treatment centers.

Description of Unmet HIV Care and Treatment Services

The following needs determination methods were used to develop the 2012 HIV Statewide Coordinated Statement of Need: 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 and Tennessee.

2012 Ryan White Part B Needs Assessment

The following sections provide the detailed needs assessment methods and findings that contributed to the 2012 Statewide Coordinated Statement of Need and HIV Care and Treatment Comprehensive Plan. 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.

Focus Groups

Eight focus group sessions were conducted at the First Annual Mississippi Statewide AIDS Conference in Jackson. Each session consisted of six to ten participants in each session. Qualitative data were analyzed and important categories and themes were recorded.

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
- 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

Self-Administered Survey

Self-assessment surveys were distributed at the Annual 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 various topics, including demographics, frequency of receiving care, and access to care. Participants were also asked to rank the top five needed core services and supporting services.

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.

Other Needs include:

- 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

2010 Mississippi Medical Monitoring Project (MMP) Needs Determination

Unmet need for services by HIV infected individuals during a 12 month period was determined using Health Resources Service Administration (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.

Demographics

The majority of participants were Black, non-Hispanic males (46.5%) and Black, non-Hispanic females (33.9%). White, non-Hispanics made up 15.7% of those interviewed. Thirty-six percent of those interviewed were age 45-54 years, 29.6% were 35-44 years, 22.2% were 18-34 years, and 12.6% 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 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%), followed by public benefits (39.0%), transportation (13.0%), case management (11.9%) and meal/food services (11.6%). 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 or denied.

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

| 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%) |
|--------------------|------------|

Please refer to Appendix T for additional information on the 2010 MMP data.

Memphis TGA Ryan White Part A Unmet Needs Determination

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.

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. Tables 8 and 9 summarize 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

The Uninsured

Table 9

| 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% |

2012 Mississippi Coordinated Statement of Need for HIV Care and Services

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. Mississippi's Medicaid Dental Program does not provide routine preventive or restorative care to adults with HIV/AIDS.

Increase Availability of Medical Providers

There are a limited number of doctors are available in rural communities. There is a periodic turnover of health providers enrolled in National Health Service Corp Programs.

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 are 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.

Table 10 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.

| Characteristics | No. of persons diagnosed with HIV infection through 12/31/2009 and living with HIV on 12/31/2010 (overall population) ^f | No. of persons who have ≥ 1 care visit ^d between 01/01/2010 through 12/31/2010 | No. of persons who have ≥ 2 care visits between 01/01/2010 through 12/31/2010, at least 3 months apart ^e | % of persons who have ≥ 2 care visits between 01/01/2010 through 12/31/2010, at least 3 months apart among the overall population | % of persons who have ≥ 2 care visits between 01/01/2010 through 12/31/2010, at least 3 months apart among persons who have ≥ 1 care visit between 01/01/2010 through 12/31/2010 |
|-----------------|--|--|--|--|--|
|-----------------|--|--|--|--|--|

Sex

| | | | | | |
|--------|------|------|------|-------|-------|
| Male | 5464 | 1720 | 1062 | 19.44 | 61.74 |
| Female | 2662 | 816 | 450 | 16.9 | 55.15 |

Age on 12/31/2009

| | | | | | |
|-----------|------|------|-----|-------|-------|
| 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 |
| ≥ 65 | 202 | 55 | 36 | 17.82 | 65.45 |

Race/ethnicity

| | | | | | |
|------------------------|------|------|------|-------|-------|
| 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 ^a | 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 ^b | 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 |
| Total | 8126 | 2536 | 1512 | 18.61 | 59.62 |

^aMultiple race, American Indian/Alaska Native, Asian, Native Hawaiian/Other Pacific Islander, and unknown race.

^bHeterosexual contact with person known to have, or to be at high risk for, HIV infection.

^cPersons who have at least one CD4 or viral load test are considered as receiving HIV care.

^dCD4 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.

^eTwo care visits should be 3 months apart.

^fThe 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.

Section III. Jurisdictional Determination and New Priorities

Priority Jurisdictions Determination

Previous prioritizations of target populations were selected by the Mississippi HIV Planning Group (MSHPG) based on epidemiological data reported from the MSDH STD/HIV Office as a requirement of the Centers for Disease Control (CDC) and Prevention HIV Prevention Cooperative Agreement. The prioritized populations and geographical locations for 2012 as defined by epidemiological data as listed in Table 11.

Table 11: 2012 MSCPG Prioritized Populations and Counties by Public Health District

| 2012 Prioritized Target Populations | 2012 Prioritized Target Counties | Population Affected | Public Health Districts |
|--|--|--|--------------------------------|
| Persons living with HIV/AIDS (PLWHA) | Hinds, Harrison, Rankin, Forrest, Jackson | 4,458 or 45% | V, VIII & IX |
| African American Males (ages 13-64) | Hinds, Rankin, Washington, Harrison, Forrest, Lee | 162 or 28% | II, III, V, VIII & IX |
| African American MSM (ages 13-29) | Hinds, Washington, Forrest, Harrison, Lee, Rankin, Jones, DeSoto | 84 or 15% | II, III, V, VIII & IX |
| African American Females (ages 13-44) | Hinds, Coahoma, Pike, Lauderdale, DeSoto | 42 or 7% | I, V, VI & VII |
| Caucasian MSM | Forrest, Rankin | 40 or 7% | V & VIII |
| Hispanics | Statewide | 16 or 3% | All 9 PHDs |
| Incarcerated Populations | Rankin, Sunflower | Data not captured in the HIV reporting system. | III & V |
| Substance Users | Statewide | Data not captured in the HIV reporting system. | All 9 PHDs |

The suggested priorities based on feedback from community members are to:

- Develop programs to increase 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.
- Develop media campaigns that raise the awareness and the urgency of the matter with facts intended to reduce stigma, grounded in culturally sensitive messages.
- Form effective partnerships with faith-based institutions.
- Focus on youth, including jailed and incarcerated youth and their sexual partners.
- Provide mental health relief for HIV+ persons through support groups.
- Use mobile testing centers and organized testing outreach events to promote free testing.
- Use examples of prevention and testing programs that have worked in similar communities in southern states that are culturally sensitive. (e.g., SAVED SISTA, SISTER Project/Sister Informing Sister About Topic & AIDS).
- Address the HIV continuum of care holistically by collaborating with drug and alcohol addiction treatment centers.

Section IV. Jurisdictional Planning Methods and Proposed Activities and Strategies

Mississippi HIV Planning Group

The Mississippi HIV Planning Group (MSHPG) for HIV Prevention was established to assist the Mississippi State Department of Health (MSDH) in its HIV prevention process. MSHPG members consist of representatives from state and local agencies, non-governmental organizations, and individuals at risk for or affected by HIV. The MSHPG for HIV Prevention must be reflective of the HIV/AIDS epidemic. Membership requires representation from each of the nine Public Health Districts. MSHPG may have up to twenty-five (25) members, which include a Community Co-Chair and Mississippi State Department of Health Co-Chair. Confidential nomination forms are submitted to the Membership Selection Committee for review. HIV prevention planning is an ongoing process where MSHPG and MSDH work in partnership with key stakeholders to strengthen prevention activities. Enhance access to HIV prevention, care, and treatment services for populations at highest risk for HIV acquisition and transmission.

Objectives of HIV Prevention Community Planning:

- Identify and implement recruitment and retention strategies for MSHPG membership and a diverse group of stakeholders to ensure a comprehensive engagement process
- Develop a coordinated, collaborative, and seamless approach to increase access to HIV prevention, care and treatment services for individuals disproportionately affected by HIV in Mississippi
- Develop methods to elicit and ensure community and stakeholder input in the development and implementation of the jurisdictional plan

Currently, MSHPG convenes planning group meeting on the second Friday of each month. HIV Prevention Community Planning will continue to identify and implement recruitment and retention strategies for MSHPG membership and a diverse group of stakeholders to ensure a comprehensive engagement process; coordinated, collaborative, and seamless approach to increase access to HIV prevention, care and treatment services for individuals disproportionately affected by HIV in Mississippi are implemented.

The MSHPG grew its membership in 2011 and 2012 to achieve parity, inclusion and representation (PIR). In CY 2013 MSHPG membership declined. Currently, membership is at sixteen; however, MSDH and MSHPG are presently seeking nominations for membership representative of the epidemic. Most MSHPG members are directly involved in HIV prevention or care and treatment. The MSHPG and other invited key stakeholders provided valuable input for the development of this HIV Jurisdictional Plan. Although personal interests among MSHPG members and key stakeholders can be diverse, all play a key role in the planning, development, and implementation of High Impact Prevention (HIP) strategies. This is particularly valuable and necessary in order to address the HIV epidemic in minority populations.

Stakeholder Engagement Process

MSHPG members agreed on a timeline for the 2012 Jurisdictional Plan process which MSDH staff strived to comply with as feasible. MSHPG members and key stakeholders were invited to

participate in at least three stakeholder engagement listening sessions during the development of this plan. Participants represented different geographical areas of the state. Needs assessment and focus group findings were used to develop five questions (tool is located in Appendix U) for stakeholder discussion. Invited participants also received the National HIV/AIDS Strategy (NHAS), NHAS Implementation Plan, CDC's High Impact HIV Prevention, Mississippi 2012 Ryan White Plan, and the HIV Prevention Gap Analysis prior to the listening sessions. Feedback and suggestions from MSHPG members and stakeholders were considered in the development of the jurisdictional plan. The stakeholders' engagement sessions provided the following strategies:

- Expand testing through outreach to the targeted communities to reach more at risk individuals;*
- Improve information sharing and dissemination. For example, add NPIN and other CDC Portal links to the MSDH Website; Develop electronic news letters or use social media tools to disseminate information;*
- Work in partnership with Public School Districts to increase HIV Education and Testing for students;*
- Develop permanent housing programs; develop partnerships with housing advocacy groups;*
- Create statewide HIV/AIDS coalitions with possible regional chapters;*
- Expand Medical and non-medical case management services, especially in rural communities;*
- Reduce stigma through media/marketing campaigns;*
- Increase use of transportation services for appointments;*
- Develop peer navigator programs for people newly identified with HIV infection;*
- Provide transitional case management for incarcerated populations;*
- Obtain a mental health nurse practitioner to prescribe medications for depression, etc.;*
- Seek Ryan White support to pay for public mental health services; and*
- Support alcohol and drug addictions programs for HIV clients.*

Suggested Community-Based Prevention Strategies:

- *Increase visibility for condom distribution and improve distribution to those with infection or at risk individuals by partnering with hotels, barbershops, salons. Also provide lube in condom distribution kits;*
- *Provide more female condoms in condom distribution outreach;*
- *Evaluate capacity of CBOs that receive CDC funding to provide DEBIs;*
- Increase the number of Train the Trainer (TOT) opportunities to train CBO staff in Mississippi;
- Invite a member of Mississippi STD/HIV Training Prevention Center (MSTPC) to join the MSHPG; and
- Develop educational information materials for transgender populations.

Suggested Strategies to Enhance Linkage to Care (Comprehensive Prevention Through Positives):

- Increase communication, collaboration, and coordination across CBOs for testing of high risk communities; Develop census tract mapping of CBOs to navigate their community through organized community outreach;
- Implement ARTAS Training for CBOs and MSDH staff;
- Provide guidance for capacity building to support grassroots programs in rural communities; Identify CBOs that may serve as mentors to the new CBOs. Implement peer educator programs to serve the northwestern part of the state and help to develop new start-up organizations;
- MSDH needs to partner with and engage non HIV/AIDS association/organizations- For example, the Mississippi Center for Non-Profits can assist with the dissemination of information and provide capacity building education for CBOs.
- Increase availability of peer support groups; Increase and strengthen controls to ensure confidentiality of those who attends support groups; Support groups should be kept “under the radar” to prevent disclosure of status; and
- Improve health insurance coverage and implement the components of the Affordable Care Act that will benefit those living with HIV infection in the state.

MSHPG in CY 2013 scheduled time on monthly agenda to engage stakeholders regarding unmet needs as well as HIV prevention activities occurring within their respective PHD. Topics were introduced from stakeholders and shared during HIV planning process. Bylaws were revised to include a stakeholder nomination and selection process. MSDH and MSHPG members established an advisor group of funded CBOs, ASOs, Health Providers, DIS, and other key stakeholders to meet and plan HIV testing, prevention, education and awareness, within PHD IX. MSHPG members participated in the advisory group would provide a summary of activities and input based on stakeholders suggestions, strategic planning, and interaction with individual with high risk of HIV transmission and accusation. MSHPG along with MSDH modified the needs assessments which implemented in at risk communities and restructured focus group questions to align with High Impact Prevention (HIP). MSDH subgrantee conducted two focus groups with young African American MSM populations within PHD V to insure input from the unrepresented populations.

MSDH and MSHPG held Brown Bag Luncheon in collaborations with Black AIDS Institute to discuss strategies for reducing stigma, and development of safe places to for PLWHA to disclose their HIV status. Participants included CBOs, ASOs, PLWHA, Medical Providers, STD/HIV Surveillance Director, Epidemiologist, HIV Social Worker, Care and Service Provider, Department of Mental Health, and a HIV Community Advocate. Due to the success, MSDH will host a number of Brown Bag Lunch discussions to engage additional stakeholders, which will provide input during the Jurisdictional Plan development and update. CY 2014, stakeholder engagements and Jurisdictional Plan development will be outlined during the MSHPG Strategic Planning meeting in November 2013.

MSDH considers the HIV Jurisdictional Plan to be a “living” document that will need re-assessment and re-appraisal at least annually. For CY 2014 and 2015, the MSDH may modify and revise the jurisdictional plan based on emerging epidemiological trends and developments in scientific evidence with input and guidance from the Planning Councils.

Behavioral Activities and Strategies

In CY 2013, MSDH will solicit support from organizations with the ability to provide the evidenced-based interventions emphasized by CDC to address priority jurisdictions. Additionally, Project START, a non-emphasized CDC DEBI, may be used as an effective behavioral intervention to address the need for linkage of HIV positive ex-offender populations to HIV care and services. Table 12 provides the prioritized populations and Diffusion of Effective Behavioral Intervention (DEBI) which were suggested in CY 2012.

Table 12: CY 2012 Prioritized Populations and Diffusion of Effective Behavioral Intervention (DEBI)

| Prioritization Population | Evidence Based Interventions |
|--|---|
| Persons Living with HIV/AIDS | CLEAR Healthy Relationship Partners for Health WILLOW (Women only) RESPECT |
| African American Men (13-64) | D-Up Mpowerment VOICES/VOCES Community Promise Nia RESPECT |
| African American MSM (13-64, especially 13-29) | D-Up Many Men Many Voices (3MV) Mpowerment Personalized Cognitive Counseling (PCC) Community Promise RESPECT |
| African American Females | The Future is Ours Sister-to-Sister VOICES/VOCES RAPP Community Promise RESPECT |
| Caucasian MSM (13-64) | Popular Opinion Leader (POL) Personalized Cognitive Counseling (PCC) Community Promise Mpowerment RESPECT |
| Correctional Facilities and Detention Centers | Project START RESPECT |
| Hispanics | VOICES/VOCES RESPECT |
| Substance Abusers | SAFES |

| | |
|--|------------------------------|
| | Community Promise RESPECT |
|--|------------------------------|

In CY 2014, MSDH STD/HIV Office will improve the use of individual-level behavioral interventions by contracting with organizations that provide risk reduction interventions models for HIV positive persons and HIV negative individuals at high risk for acquisition of HIV. MSDH will implement interventions emphasized by CDC and proven to have the highest impact in the reduction of HIV incidents.

Linkage to care during the transition from incarceration to society continues to be a major problem within the state. The MSDH will issue a Request For Proposal (RFP) to solicit CBOs and implement a DEBI intervention for HIV positive ex-offenders leaving prison. MSDH and CBOs will work with Mississippi Department of Corrections (MDOC) to implement the intervention to assure the HIV Continuum of Care.

MSDH will disperse funds to plan, develop and implement the expansion of support group programs for minorities in urban and rural communities. The goal is to have an active support group that meets at least monthly in all nine public health districts, with multiple support groups available in communities with the highest incidence.

Education and Training

The STD/HIV Office will use GIS mapping for epidemiological data to identify at risk communities and populations for communication and marketing campaigns. Proposed media campaigns will be tailored to include targeted messages and techniques as appropriate for different cultural, linguistic, and geographical communities. Presently, the STD/HIV Office is planning to market HIV testing using the local public transportation system in the metropolitan Jackson area. The MSDH plans to advertise using buses operated by the Jackson Transit System (JATRAN), the only public transit system in Jackson Metro area. This approach is classically known as a moving billboard and the advertisement will cover the exterior means of the vehicles. Transportation routes will be chosen that reach the highest proportion of individuals at-risk for HIV/AIDS and other STDs based on GIS data. The targeted routes may also include the location of the Jackson Medical Mall where the MSDH Crossroads Clinic is located that offers testing

and treatment for reportable STDs. The statewide media campaign will also target the at-risk populations in other geographical areas as identified in Section III. MSDH will obtain guidance on evaluation methods from the Mississippi State University Social Science Research Center staff. Methods will be considered to identify relevant information about the impact of our tailored marketing strategies to increase the use of HIV testing services.

The STD/HIV Office has also implemented a new electronic resource registration guide website located at <http://msdh.ms.gov/msdhsite/static/14,0,150,570.html> in lieu of a paper-based resource guide. The resource registry will serve as a practical tool to allow providers and community-based organizations to register their contact information and the type, availability, and location of HIV services offered. The web-based electronic resource guide (registry) will enhance the accuracy and timeliness of information that is available for HIV prevention and linkage to care services.

Expanded HIV Testing

In CY 2014, the HIV Testing Program will obtain new strategic partners to provide HIV testing in healthcare and non-healthcare settings using CLIA-waived HIV rapid tests to targeted jurisdictions. The Expanded HIV Testing Coordinator will seek partnerships with organizations to perform testing at non-traditional venues. All sites will be selected in accordance with HIV incidence and prevalence as defined by the epidemiological data. MSDH will sustain routine opt-out CLIA-waived HIV rapid testing at productive healthcare settings (e.g., emergency departments, community health centers, and substance abuse treatments centers) based on incidence data. Additionally, the program will continue its partnerships with Historically Black Universities and Colleges (HBUC) and the Mississippi Department of Mental Health (DMH) to reach populations seeking Alcohol and Drug Services. MOUs are under development with several Alcohol and Drug Treatment Centers to provide HIV testing to clients who seek services.

In CY 2014, MSDH will foster collaborations between agencies and CBOs to plan targeted HIV testing opportunities at non-healthcare events such as:

National Black HIV/AIDS Awareness Day

National Women and Girls HIV/AIDS Awareness Day

National Native HIV/AIDS Awareness Day

National Asian & Pacific Islander HIV/AIDS Awareness Day

World Hepatitis Day

National Caribbean American HIV/AIDS Awareness Day

National HIV Testing Day

National Gay Men's HIV/AIDS Awareness Day

National Latino AIDS Awareness Day

World AIDS Day

Condom Distribution

The MSDH STD/HIV and Family Planning Programs share the financial cost for purchasing male and female condoms for distribution in the nine Public Health Districts. County health departments already distribute Lifestyle latex male and female condoms (FC2) to the general population as barrier contraceptives and a protection method against STDs. MSDH is developing protocols to distribute condoms to targeted populations through the use of a condom campaign titled “Get it On: Protect Yourself!” Condom distribution for the “Get it On: Protect Yourself!” campaign will include a bag that contains 20 male condoms or 10 female condoms that will be offered to all individuals accessing services or requesting condoms in targeted communities. MSDH is also developing protocols for individual distribution of condoms to clinic patients. MSDH Patient Encounter Forms have been modified to capture targeted risk factor information (HIV positive, HIV negative or unknown, or general distribution).

The campaign will assist efforts to develop strategic collaborations to improve condom distribution through community partners, such as STD/HIV educators, CBOs, ASOs, Historically Black Colleges and Universities (HBCU), local barbershops, clinics, hotels, LGBT bars, store owners, and businesses within high HIV prevalence areas. New partnerships will require written MOUs for risk factor data collection as part of condom distribution in areas with high HIV morbidity. Priority locations will be identified using GIS epidemiological data mapping at the census-tract level.

All CBOs funded to conduct DEBIs or HIV rapid testing will also be required to distribute condoms and capture risk data as part of their community outreach activities. Specific targeted communities for condom dissemination will be described in the agreements. Subgrantees will be allowed to purchase different brands of male condoms to improve compliance; however all condoms must meet CDC specifications for effective performance, and subgrantees must adhere to state procurement rules. Organizations that perform HIV testing in healthcare settings should also provide condoms to clients. All organizations will be asked to register as a condom distribution service in the MSDH online HIV services registry at http://msdh.ms.gov/msdhsite/_static/14,0,150,570.html.

During CY 2013, MSDH plans to increase the use of male and female condoms through targeted distribution (4,439,000 male and 60,400 female in 2011) by about 100,000 males and 5,000 females. Additional male condoms will be distributed to 5,000 individuals (5,000 x 20 condoms per individual = 100,000) and female condoms to 500 individuals (500 x 10 condoms per individual = 5000) through the Public Health Districts for communities with highest incidence and prevalence of HIV infection. MSDH will monitor and evaluate distribution and increase goals as needed based on existing epidemiological data.

During CY 2014, MSDH will increase the condom distribution by an additional 100,000 condoms. To be distributed through by Public Health District with highest prevalence of HIV disease. PHD will be selected based on the epidemiological data.

Comprehensive Prevention for Positives

A key strategy for HIV positive individuals is to engage them in the HIV Continuum of Care. MSDH will collaborate with state and local government agencies; community-based organizations; Ryan White funded health clinics; patient advocacy organizations; public schools; correctional facilities and detention centers; private health providers; and health insurance companies to increase access to services available to HIV positive Mississippians and encourage inter-agency and inter-organizational communication and collaboration.

MSDH proposes to provide HIV care and treatment education and training for health providers at rural and Federally Qualified Health Centers (e.g., Community Health Centers) to improve the

knowledge and skills to perform CLIA-waived HIV Rapid Testing and Early Intervention Services. MSDH also proposed to collaborate with the Mississippi State Medical Association and Mississippi Hospital Association to promote education and training opportunities for new and existing healthcare workers. The jurisdictional plan includes the need to implement new policies regarding CD4+ T-lymphocyte count and HIV viral load reporting and the implementation of Electronic Laboratory Reporting (ELR) in Mississippi. The proportion of PLWHAs who are actively engaged in medical care will serve as a measure of progress. Collaborative partners include the Mississippi HIV Planning Council (MSHPG), Care and Services Planning Council, MSDH, state and local agencies, and new partnerships such as the Mississippi Rural Health Association and the Mississippi Primary Health Care Association.

Key strategies to improve comprehensive prevention through positives:

- *Improve Case-Manager Encounters with Clients* - Improve the relationship between the HIV case-manager and the patient through the use of standardized case management tools and standards of care and the development of an education and training curriculum designed for medical and non-medical case management professionals. Responsible parties will include the Delta Region AIDS Training Center, MSDH, Mississippi Department of Mental Health (MDMH), and the Mississippi Social Workers Association.
- *Improve Access to Transportation Services* - Use GIS mapping technologies and develop a variety of different travel reimbursement methods based on mileage caps (less than 50 miles; 51-100 miles). Gas purchase and public bus cards may be distributed to patients that meet the eligibility criteria based on finances and GIS data. Prepare a Funding Opportunity Announcement (FOA) to obtain transportation contracts for driver services and monitor use of these services through HIV Case Managers. Responsible parties will include MSDH and Ryan White Program Funded Organizations and CBOs.
- *Limited Support Groups Available* - Increase the number of active support groups in high impact jurisdictions by developing an individualized peer-to-peer health counselor program with points of contact through an HIV medical provider or HIV case manager. A centralized approach for dedicated support group development and organizational training will be implemented through a Funding Opportunity Announcement for organizations with the competency and expertise to develop peer health counselor

training and the ability to coordinate the development of rural support group program through local organizations that undergo training. The MSDH Delta Heart Study presently uses Community Health Workers to assist chronic disease management which may serve as a model for the HIV peer health counselor program. Responsible parties for support group and peer health counselor development will include MSDH, the Department of Mental Health, and eligible CBOs.

- *Depression among those who were recently unaware and newly diagnosed patients* – MSDH will implement mental health assessments as part of the initial medical case management visit as a proposed strategy to address this issue. Case managers will be responsible for informing clients of referral sites for mental health services.
- *Stigma* – Improve efforts to engage PLWHA to make referrals for others in their social networks to get tested for HIV by implementing a peer health counselor program and social marketing through various HIV/AIDS service providers and faith-based organizations. Responsible parties include MSDH, CBO's, and all other HIV service providers, their organizations, and individual staff members.
- *Confidentiality* - A proposed strategy to increase trust and prevent the inappropriate release of information is to provide education and training for the public and health care providers on HIV confidentiality and data security. More education and training for health providers on LBGT health issues is also necessary. Responsible parties include MSDH staff, CBO's, and all other HIV service providers.

Policy Initiatives

Beginning August 2012, the Mississippi State Board of Health will require CD4 count and viral load to be reported according to rules and regulations governing reportable diseases in Mississippi. The reportable condition will assist with medical adherence, disease management, viral load suppression, and linkage for HIV positive individuals to appropriate care and treatment and interventions ultimately reducing transmission of HIV infection. Reported CD4 count and viral load data will be used to monitor the HIV Continuum of Care, including linkage and re-engagement to care. HRSA-sponsored CAREWare data systems will also be used to monitor case management and treatment activities for individuals that receive Ryan White funded services.

MSDH has also change the AIDS Drug Assistance Program (ADAP) policy to increase eligibility of HIV positive individuals from a CD4 count of 350 to 500. The policy change will allow more HIV positive individuals to receive ADAP much earlier and potentially result in viral load suppression and improved CD4 counts.

MSDH will also continue its work with the Mississippi Department of Education and public school districts to address the need for evidence-based reproductive health education for adolescents. Education and awareness regarding HIV disease prevention, transmission risks, and consequences is low among youth. A proposed strategy is to encourage district and school administrators to educate the youth in public schools on topics related to sexual health and HIV prevention.

CY 2013 MSDH explored additional policy changes that will assist with HIV prevention education, testing, and linkage, retention, and reengagement in care. In April CY 2013, MSDH began accepting Multispot HIV-1 and HIV-2 testing as a confirmatory report test. MSDH is now changing its own HIV testing algorithm for use at all public health clinics. The HIV-1 western blot will no longer be used as a primary confirmatory test. Confirmatory testing for HIV-1 and HIV-2 will be performed using the HIV 1-2 antibody differentiation assay by EIA (Multispot). The MSDH Public Health Lab test report will display HIV-1 and HIV-2 antibody screening test results on the final lab report. If the results of the HIV 1-2 antibody differentiation assay are inconclusive, a qualitative HIV-1 Nucleic Acid Amplification Test (PCR) will be performed. This test will help detect acute HIV infection. All results of the tests performed will be represented on the lab report. The MSDH Public Health Lab will incorporate all test results to provide an HIV Testing Summary that will be located at the top of the report form. The HIV Testing Summary will present possible scenarios for both HIV-1 and HIV-2. Nursing services, clinical management, and/or consultation and referral will depend upon the results of all the tests performed by the PHL and scenarios presented in the summary. Some HIV-1 and HIV-2 results will require consultation. MSDH will implement the new testing algorithm in October 2013.

A key objective in 2014 will be to increase the number of HIV testing sites to reach high-impact populations. MSDH is collaborating with the state Department of Mental Health to implement HIV testing at mental health clinics. These sites have great potential to offer expanded risk counseling, such as substance abuse counseling. We will also work with the Mississippi Primary Health Care Association to expand the number of FQHCs that participate in our programs. Meetings have been held and some clinics have already completed training. FQHCs also have potential to perform HIV primary care which benefits our continuum of care.

The STD/HIV Program is working to improve its information technology infrastructure in order to develop local analysis of the HIV treatment cascade. Local analysis will require the ability to combine and analyze data that is presently stored in different databases. The HIV treatment database for Ryan White Part-funded clinicians (CAREWare) is being moved to MSDH from its current location. The existing STD reporting database STD*MIS will be the new Patient Reporting Investigating Surveillance Manager (PRISM). PRISM will allow electronic data entry at the local level which will result in real-time electronic follow-up of STD/HIV cases. This system will improve the quality and timeliness of our surveillance, which presently relies on manual data exchange and paper lab records submitted to the central office. PRISM also has a component that will allow clients to receive coded (confidential) text messages with test results and can communicate the need to seek follow-up at the clinic. Services for clients and their partners can be improved at the MSDH STD clinics to ensure linkage to treatment or care when new STD/HIV infections are identified. Also, STD clients can be prioritized for follow-up to ensure these clients do not leave the clinics without appropriate follow-up.

MSDH will explore additional policy changes that will assist with HIV prevention, education, testing and linkage, retention and reengagement in care. Current policy leading to structural barriers will be reviewed to determine changes that will increase HIV continuum of care.

Section V. Detailed Workplan

| Problem/Needs Statements | Proposed Goals | Related Objectives | Key Actions Steps | Responsible Parties/Outcome Variables | Relevant Timelines |
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| P1. Lack of HIV Testing Sites in Minority Communities. | G1. Build capacity for clinical and non-clinical testing sites increase the availability of access to testing. | By April 30, 2014, increase by 40% the number of HIV-expanded testing sites. By April 30, 2015, increase by 50% the number of HIV-expanded testing sites. By December 31, 2015, increase by 55% the number of HIV-expanded testing sites. | 1. Educate clinical and non-clinical organizations on the need for rapid testing. 2. Obtain MOU between agency and MSDH to conduct testing. 3. Provide Fundamental of Prevention Counseling and Fundamentals of Waived Rapid Testing Training. 4. Orient facilities to MSDH Testing Protocol. 5. Ensure CLIA Waiver is obtained for sites to conduct waived rapid testing. 6. Supply test kits to participating sites. 7. Monitor through site-visits, programmatic reports, reports to MSCPG. 8. Evaluation Web reports and monitoring. | MSDH Surveillance Branch and Expanding Testing Coordinator /Increased number of sites. Increased number of HIV infection identified. | 1/31/13-4/30/14 5/1//14-4/30/15 5/1/15 12/31/15 |
| P2. Need for waived rapid testing within Substance Treatment Facilities. | G2. Increase expanded testing efforts at Alcohol and Drug treatment Centers for minority and high risk populations. | By April 30, 2014, increase by 30% the number of Substance Abuse Treatment Centers that provide HIV-rapid testing. By April 30, 2015, increase by 40% the number of Substance Abuse Treatment Centers that provide HIV-rapid testing. By December 31, 2015, increase by 50% the number of Substance Abuse Treatment Centers that provide HIV-rapid testing. | 1. Educate substance abuse treatment centers on the need for rapid testing. 2. Obtain MOU between agency and MSDH to conduct testing. 3. Provide Fundamental of Prevention Counseling and Fundamentals of Waived Rapid Testing training. 4. Orient facilities to MSDH Testing Protocol. 5. Ensure CLIA Waiver is obtained for sites to conduct waived rapid testing. 6. Supply test kits to participating sites. 7. Monitor through site-visits, programmatic reports, reports to MSCPG. 8. Evaluation Web reports and monitoring. | MSDH Surveillance Branch and Expanding Testing Coordinator / Increased number of sites. Increased number of HIV infection identified. | 10/31/13-4/30/14 5/1//13-4/30/14 5/1/14 4/30/15 |
| P3. Need for DEBI intervention for PLWHA. | G3. Expand the number of CBOs that provide interventions to PLWHA. | By January 1, 2014, increase CBOs that provide interventions to PLWHA by 10%. By February 1, 2013, contract with CBO to provide Project START or an intervention to connect ex-offenders with services post incarceration by 5%. | 1. October 31, 2013. release RFP to solicit proposal for targeted interventions to populations designated priority in 2012 2. Request CBA training on interventions addressing prioritized population 3. Issue an agreement to CBO with capacity to work with targeted population and potential to have highest impact 4. Work with Education Branch to coordinate training for funded CBOs 5. Monitor and evaluate implementation and impact 6. Monitor reported HIV incidence cases to determine risk 7. Evaluate for continued funding | MSDH and Community Based Organizations/ Increased number of PLWHA intervention sites. Decrease in annual numbers of HIV infection. Behavioral intervention post assessments for | 10/15/12-12/31/15 |

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| | | <p>By January 1, 2014, increase CBOs that provide interventions to PLWHA by 15%.</p> <p>By January 1, 2015, increase CBOs that provide interventions to PLWHA by 15%.</p> | | <p>behavior modification lowering risk of transmission.</p> <p>Number of Street and Community outreach numbers and evaluations.</p> <p>Condom distribution and condom demonstration reports and data entry into PEMS and Evaluation Web.</p> | |
| P4. Need for DEBI intervention targeting African American MSM | G4. Provide interventions to target AA MSM between the ages of 13-29 in PHD V | <p>By December 30, 2013, decrease the number of new HIV infections within the AA MSM population in PHD V by 2%.</p> <p>By June 30 2015, decrease new infections in AAMSM population by 5%.</p> | <ol style="list-style-type: none"> 1. Release RFP to solicit proposal for targeted interventions addressing AA MSM in targeted area 2. Issue an agreement to CBO with capacity to work with population and potential to have highest impact 3. Request CBA Training for PCC and other interventions targeting AA MSM populations 4. Monitor and evaluate implementation and impact through site visit, data reporting, Programmatic reports 5 Monitor reported HIV incidence cases to determine risk | <p>MSDH and Community Based Organizations</p> <p>Number of sites providing appropriate intervention to target population.</p> <p>Decrease in annual numbers of HIV infection in the targeted population and area.</p> <p>Behavioral intervention post assessments for behavior modification lowering risk of transmission.</p> <p>Programmatic Reports site-visits and sub grantee agreement requirement.</p> | <p>10/15/12-12/30/13</p> <p>10/15/12-12/31/15</p> |
| P5. Need for DEBI intervention targeting high risk negative populations | G5. Provide interventions to target AA and other population prioritized for 2012 | <p>By December 30, 2013, decrease the number of new HIV infections within the population considered high-risk for acquisition of infection by 2%.</p> <p>By June 30 2015, decrease new HIV infections by 5%.</p> | <ol style="list-style-type: none"> 1. Release RFP to solicit proposal for targeted interventions addressing high risk populations in targeted area 2. Issue an agreement to CBO with capacity to work with population and potential to have highest impact 3. Request CBA Training for PCC and other interventions targeting AA MSM populations 4. Monitor and evaluate implementation and impact through site-visits, programmatic reports, reports to HIV Planning Group 5 Monitor reported HIV incidence cases to | <p>MSDH and Community Based Organizations/</p> <p>Number of sites providing appropriate intervention to target population.</p> <p>Decrease in annual numbers of HIV infection in the targeted population</p> | <p>10/15/12-12/31/13</p> <p>10/15/12-12/31/15</p> |

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| | | | determine risk | and area. Behavioral intervention post assessments for behavior modification lowering risk of transmission. Programmatic Reports site-visits and sub grantee agreement requirement. | |
| P6. Need for targeted condom distribution in areas highly impacted with HIV where individuals are at greatest risk for acquisition and transmission of HIV Infection | G6. To increase condom distribution and accessibility in HIV Highly impacted areas thereby decrease new infections of HIV | <p>By January 30, 2014, contract with CBOs and other agencies to increase condom distribution in highest HIV impacted areas by 25%.</p> <p>By June 1, 2014, Establish additional MOU with Clinics and FQHC to distribute condoms in high impacted areas.</p> <p>By October 30, 2013, Condom Distribution information to be developed for MSDH Website to provide application and eligibility requirements for distribution program.</p> <p>By January 2015- December 31, 2015, maintain 1,500,000 Condom Distribution in highest impacted areas.</p> | <ol style="list-style-type: none"> 1. Through RFP process issued in fall of 2014 identify CBOs and other agencies servicing or willing to provide condom distribution services to areas of high HIV morbidity. 2. Provide training on distribution and data collection requirements 3. Create an online tool for providers to become involved in condom distribution in high prevalent areas. 4. Develop MOU for distribution and reporting requirements 5. Distribute condoms through county health departments monitoring of distribution through PIMS system. 6. Continue to work with DIS to provide condoms on suspect follow-up, re-engagement visits, partner service, and testing events 7. Conduct focus groups in areas where distribution is needed to determine culturally and appropriate sites for distribution that would have the greatest impact. 8. Continue to use mobile clinic for distribution in areas where targeting testing occurs. | <p>MSDH STD/HIV Policy Branch will work with CBOS and community partners; MSDH mobile clinic</p> <p>Number of sites providing appropriate intervention to target population.</p> <p>Decrease in annual numbers of HIV infection in the targeted population and area.</p> <p>Behavioral intervention post assessments for behavior modification lowering risk of transmission.</p> <p>Programmatic Reports site-visits and sub grantee agreement requirement.</p> | <p>9/10/13-101/31/14</p> <p>01/01/14-12/31/15</p> |

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| <p>P7. Not enough doctors in rural communities; inconsistency in availability of physicians; many communities have only one physician and that they don't stay there for long period of time.</p> | <p>G7. Increase the number of health providers with the competency to provide adult and pediatric HIV primary care in rural jurisdictions.</p> | <p>By June 30, 2014 increase by 3% the number of HIV-infected individuals that reside in rural settings who had two or more medical visits in an HIV care setting.</p> <p>By December 2014, increase by 5% the number of HIV-infected individuals that reside in rural settings who had two or more medical visits in an HIV care setting.</p> <p>By December 2015, 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.</p> | <p>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.</p> | <p>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.</p> <p>Number of physicians completing education for HIV testing and related services</p> <p>Number of providers offering HIV related services and linkage to appropriate referrals</p> <p>Monitor number of new providers and number visits per provider by PLWHA</p> <p>Review CD4+ cell count data reported through ELR. 10</p> | <p>9/30/12-6/30/13 07/01/13 – 12/31/15.</p> |
| <p>P8. Need for Education and awareness</p> | <p>G8. Increase education and awareness throughout the Hinds County/Jackson Metro area.</p> | <p>By December 31, 2013, implement and maintain evaluation social media marketing campaign.</p> | <p>Collaborate with Office of Communications to develop a social marketing campaign through GIS Mapping: Broadcast – television, radio, and internet banner ads Print – newspapers and magazines HIV/AIDS Hotline – Facebook and Twitter Outdoor – Billboards, Bus shelter displays, taxis, vinyl wrap JATLAN buses, HBCUs (sporting events), airports billboards/signage, banners, restroom stalls, etc.</p> | <p>Education Branch Office of Communications STD/HIV Office Epidemiologist</p> | <p>10/13-12/14</p> |
| <p>P9. Need for Education and awareness</p> | <p>G9. Continue to foster awareness, educational and training opportunities</p> | <p>By December 31, 2013 collaborate with various entities to support HIV/AIDS awareness events for targeted communities</p> | <p>1) Collaborate with My Brother's Keeper, Inc. to plan and coordinate Jackson Black Pride Event 2) Partner with PTN and AETC to provide educational trainings and updates for HIV/AIDS care and treatment 3) Provide HIV trainings using the CRIS system through CDC. 4) Work with other CBOs and partnerships to increase awareness and knowledge about STDs.</p> | <p>Education Branch AETC</p> | <p>09/13-12/13</p> |

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| <p>P10. Many HIV-infected individuals do not have a medical case-manager 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.</p> | <p>G10. Increase the use of medical case management services by eligible HIV-infected individuals.</p> | <p>By December 31, 2013, increase by 15% the number of HIV-infected individuals who receive a medical case management work plan.</p> | <p>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 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.</p> | <p>Delta Region AIDS ETC and MSDH; Schools of Social Work; Mississippi Primary Health Care Association.</p> | <p>10/10/12-12/31/13</p> |
| <p>P11. Lack of or limited availability and access to non-medical case management that would address issues related to housing, transportation, and other non-medical related services and resources.</p> | <p>G11. Increase the use of non-medical case management services by eligible HIV-infected individuals.</p> | <p>By June 30, 2014, increase by 10% the number of community-based organizations that provide non-medical case management (e.g., housing assistance, food banks, etc.)</p> | <p>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.</p> | <p>MSDH and Community Based Organizations</p> | <p>10/10/12-6/30/14</p> |
| <p>P12. Limited transportation services, especially for long distance medical related visits.</p> | <p>G12. Provide transportation services for all eligible HIV-infected clients.</p> | <p>By June 30, 2014, increase by 20% the proportion of HIV-infected clients who receive transportation assistance for core services.</p> | <p>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.)</p> | <p>MSDH, Part C and D grantees, Community-based organizations of interest. Form Ad hoc committee to develop plan - include UMMC Part D case manager.</p> | <p>10/1/12-6/30/13</p> |
| <p>P13. Only a handful of peer-driven support groups, and limited funds to support them.</p> | <p>G13. Increase the number of active support groups available in high-impact jurisdictions.</p> | <p>By June 30, 2014, increase by 15% the number of HIV-infected clients who participate in HIV support groups in targeted</p> | <p>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)</p> | <p>Department of Mental Health; CBOs; Meeting with Preventive Health Program to learn more about Delta project. ?</p> | <p>10/1/14-6/30/15</p> |

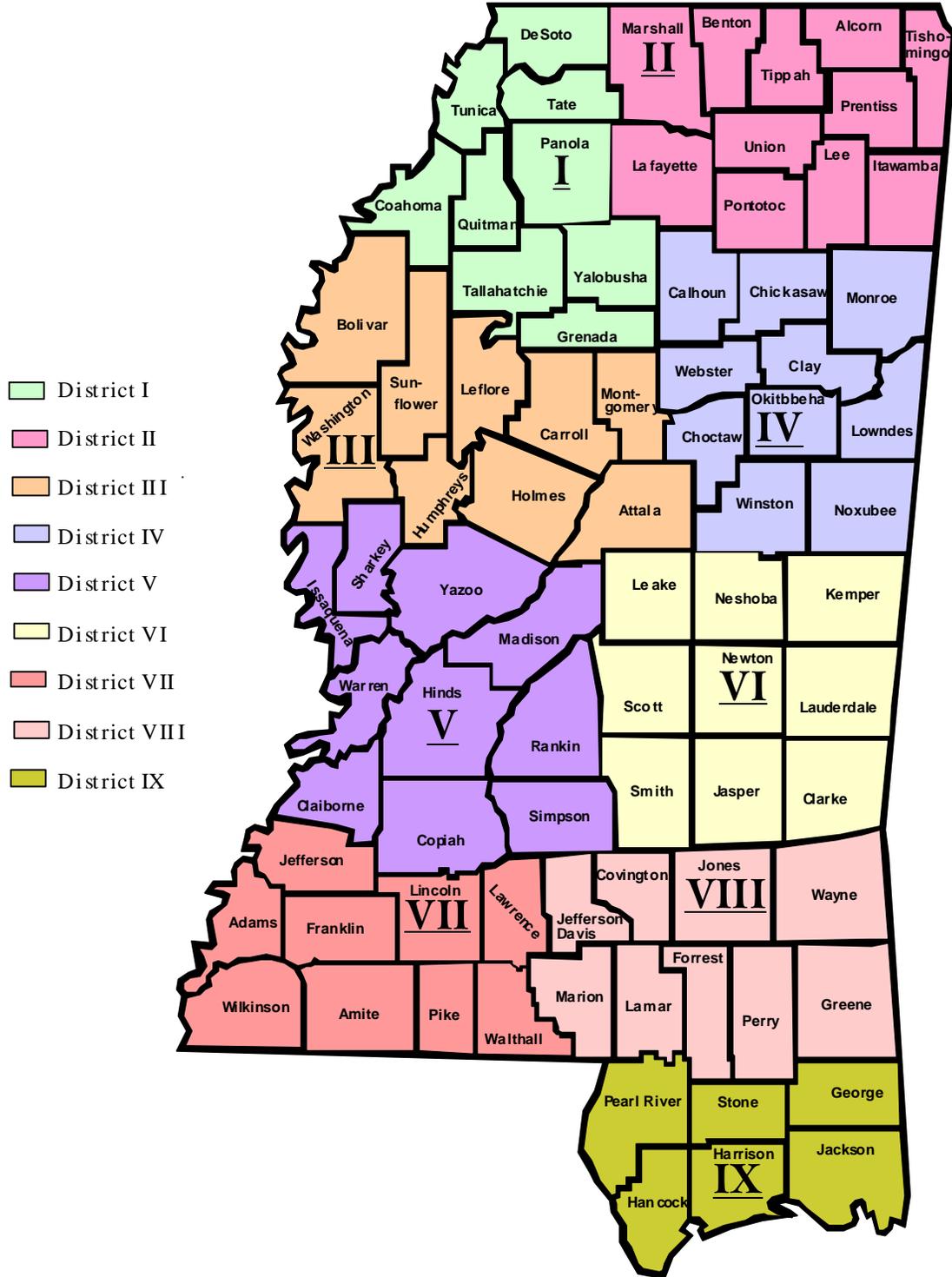
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| | | jurisdictions. | to understand how they form partnerships with local ASO and other resources to develop a peer support group in the coastal area. (This action will take place in the next 6 months) | Clinical psychologist ?; Coastal Family- Cindy Bruce | |
| P14. Limited access or availability of reliable long-term housing; current program offers support to limited number of months rather than for a year. | G14. Enhance support for housing assistance while improving efforts to help clients become self-sufficient. | TBD | Enhance collaboration with health providers; Promote and monitor HIV medication adherence to improve health. Recruit members of COC and PTEH; Use SMATF services which offers 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 | 12/31/13-12/31/14 |
| P15. Lack of or limited access and availability to emergency housing arrangements. | G15. Develop alternate models to increase housing support options in state. | By June 30, 2014, provide linkage to Capacity building training for CBOs in the state. | 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. | 10/1/13-6/30/14 |
| P16. Newly diagnosed patients oftentimes experience depression and they have no reliable access to mental health services. These individuals also may be unaware of HIV-related services available. | G16. Increase access to mental health services. | By December 31, 2014, 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) | 10/30/13-12/31/14 |
| P17. Primary care physicians lack knowledge regarding effective HIV treatment and care and there are not enough infectious disease physicians. | G17. 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 | 10/30/12-12/30/13 |
| P18. Because of stigma, people are less likely to get tested for HIV at their local health department. | G18. Implement peer navigator system and maintain afterhours | TBD | TBD (Request Technical Assistance) | TBD | |
| P19. Because of stigma, people are less likely to get tested for HIV at their local health department. | G19. Maintain afterhours testing and treatment at all Crossroads facilities | TBD | TBD (Request Technical Assistance) | TBD | |

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| P20. HIV medications are very expensive; 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) | G20. Improve the delivery of HIV medications to clients. | TBD | TBD | TBD | |
| P21. Lack of resources and services in rural communities (including transportation services, alcohol and drug rehab services, and support services); many CBOs provide similar resources and are not spaced out - duplication of effort occurs. | G21. Improve coordination of HIV services for clients statewide. | See objectives for improvement of case management system (P11 and P12) | See key actions for improvement of case management system (P11 and P12). | MSDH and collaborative partners | |
| P22. Confidentiality is a major personal barrier to receiving appropriate care and treatment services. | G22 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 information is protected presently. | MSDH and collaborative partners | 12/31/13-12/31/14 |
| P23. Rural residents are unaware of their risks for contracting the disease and about what's available for them to access in neighboring communities. | G23. 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 transportation vehicles, and implement use of radio/TV ads. | MSDH | |
| P24. Education and awareness regarding HIV disease prevention, transmission risks, and consequences is low among youth, and rural communities. | G24. Increase public knowledge and awareness about HIV infection and transmission. | TBD | Use assistance from social workers and DIS workers to refer clients to local rural HIV service providers | GAFHC, Part C Programs | |

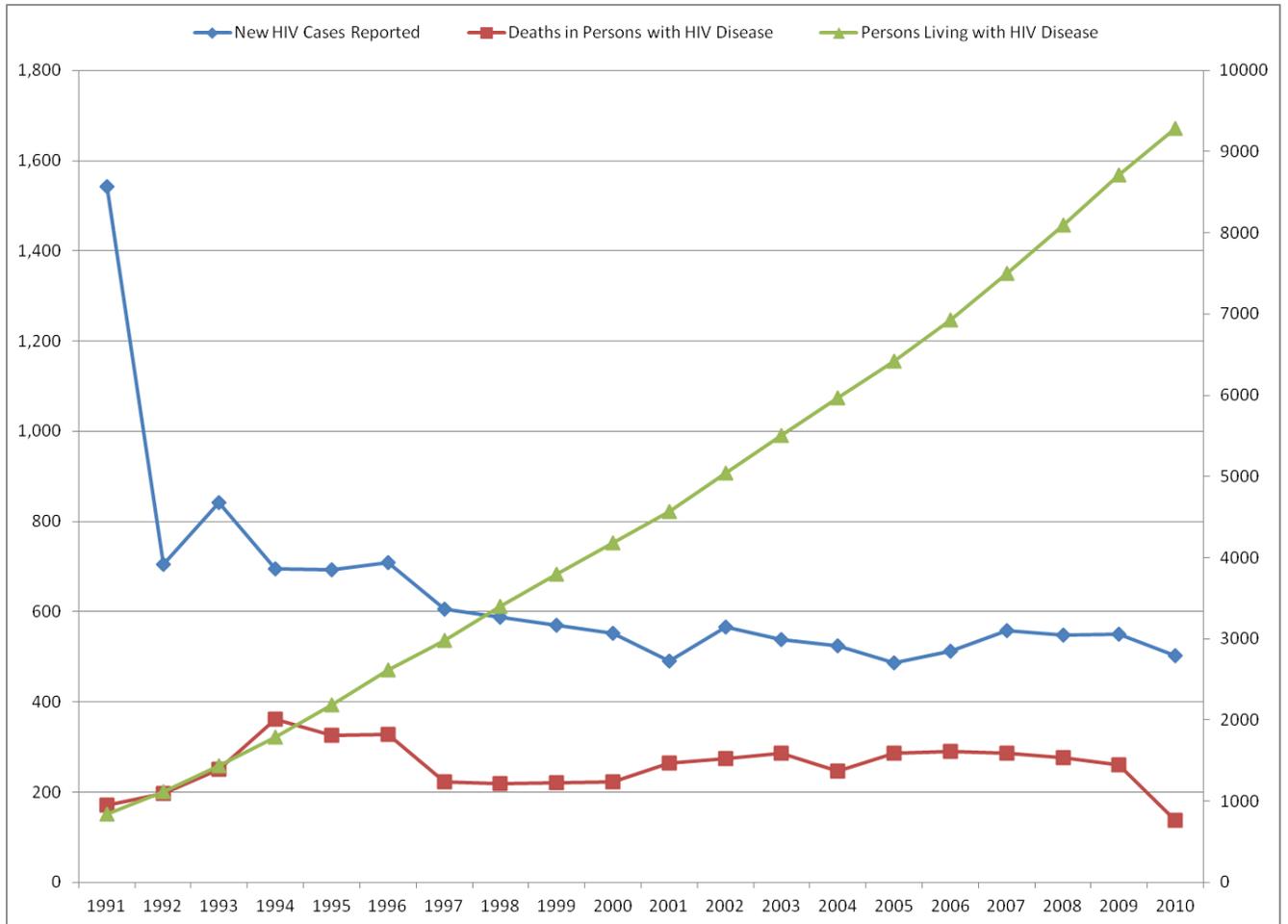
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| <p>P25. Locating former prisoners who may be HIV positive becomes difficult after they are released from prison.</p> | <p>G25. Reinstate case management services for incarcerated HIV clients on discharge from jail/prison.</p> | <p>By December 31, 2013, increase by 10% the number of released prisoners who receive an HIV case management care plan.</p> | <p>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 juvenile detention centers.</p> | | <p>10/30/12-12/31/14</p> |
| <p>P26. Language barriers frequently prevent special populations such as the Hispanic population from seeking and receiving adequate care.</p> | <p>G26. Assure that all clinical HIV care sites have access to language interpreters.</p> | <p>TBD</p> | <p>TBD</p> | <p>Work with Office of Health Disparities.</p> | |

Appendix A:

Mississippi State Department of Health Public Health Districts

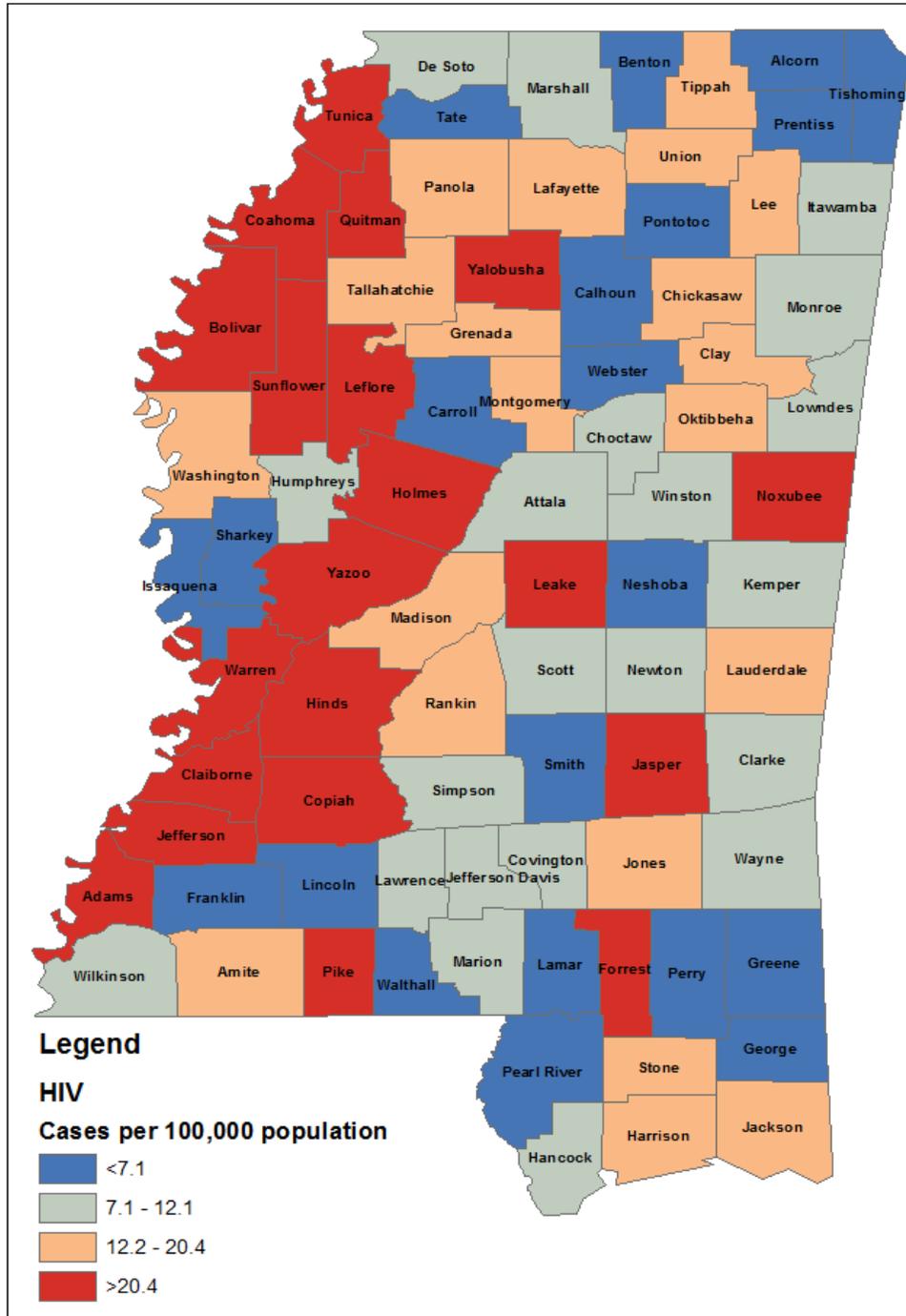


Appendix B: Number of Cases Reported, Deaths, and Persons Living with HIV Disease, Mississippi, 1991-2010



Appendix C: HIV Disease Reported by County, Mississippi, 2013

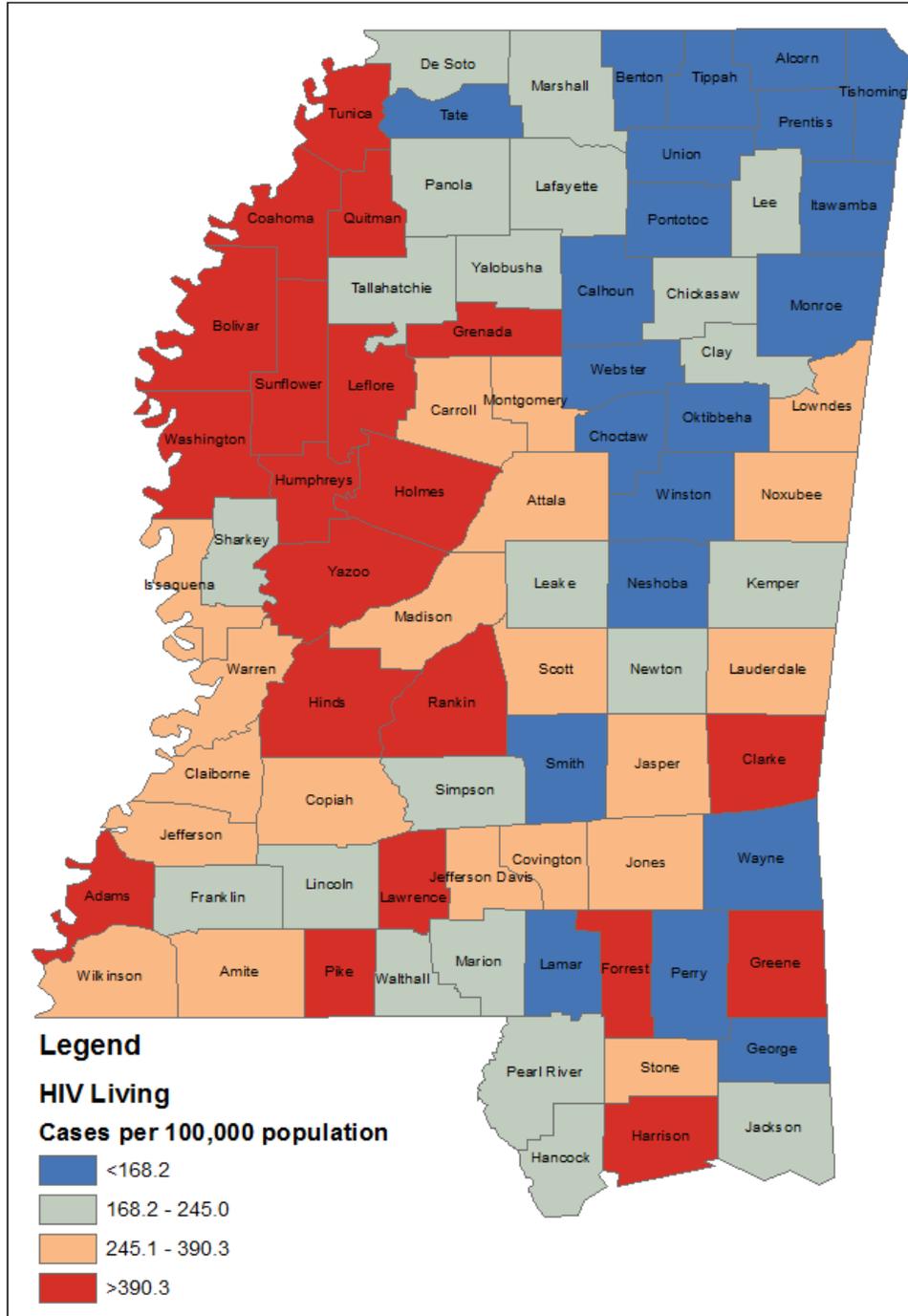
HIV Cases Reported in Mississippi by County, 2013 (per 100,000 population)



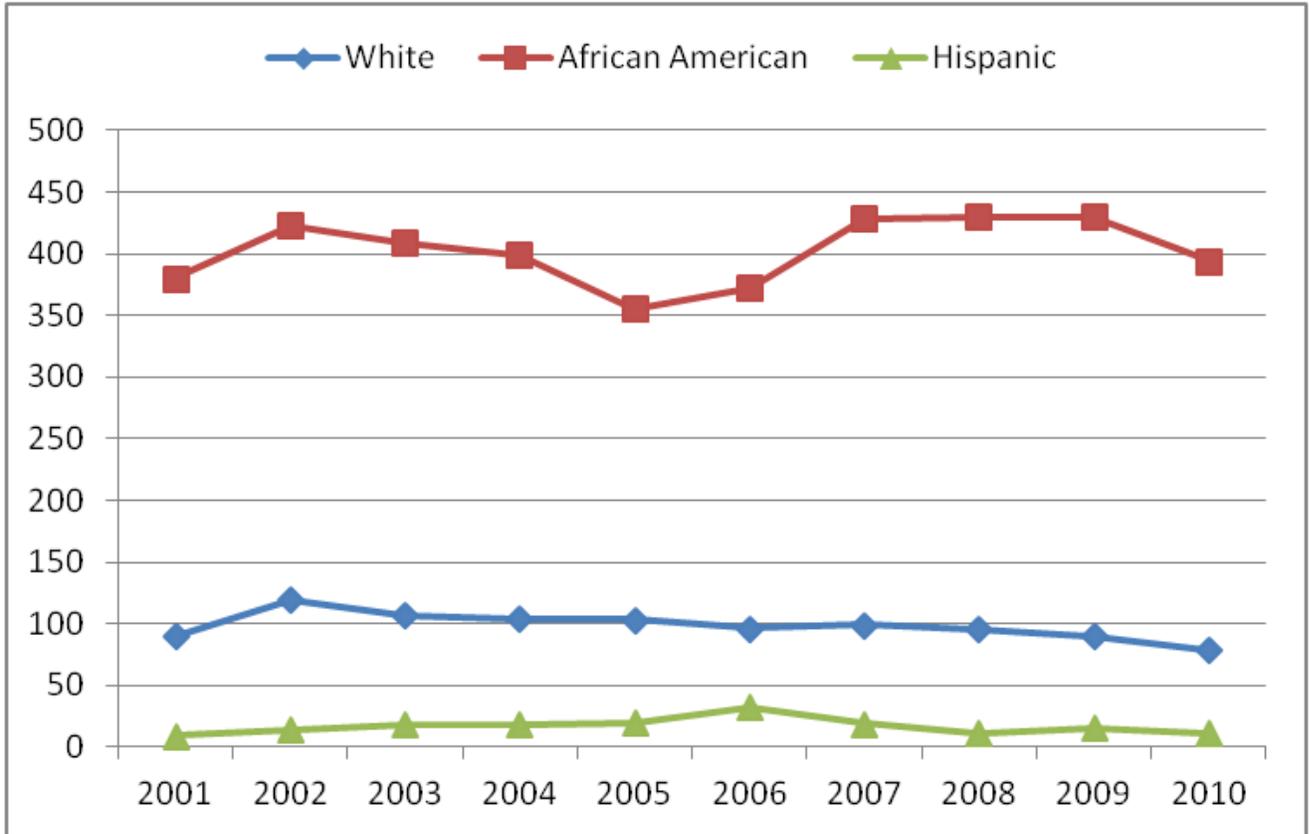
Appendix D: Mississippians Living with HIV Disease by County, Mississippi, 2010

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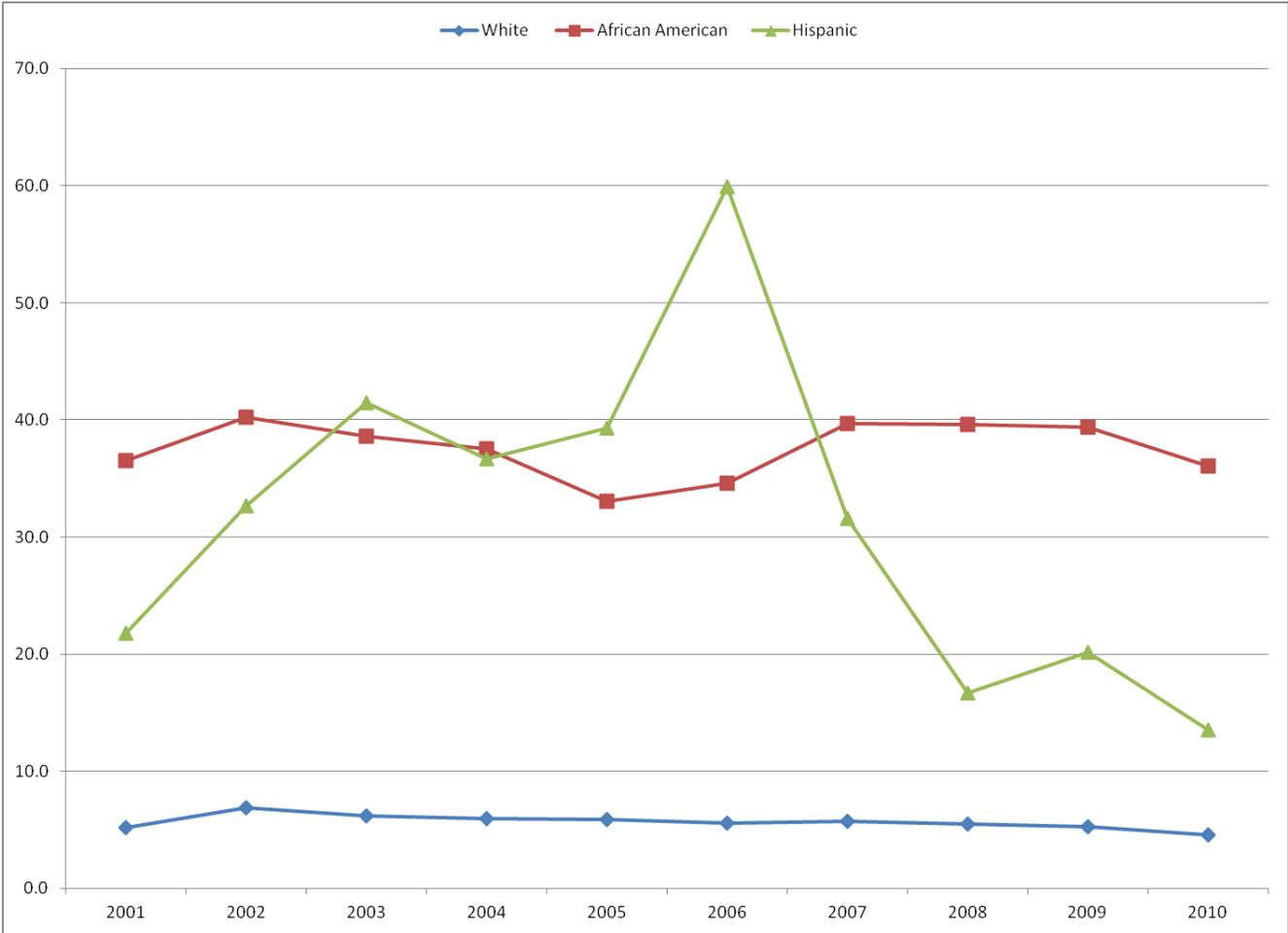
Mississippians Living with HIV Disease by County (cases per 100,000 population) as of December 31, 2013



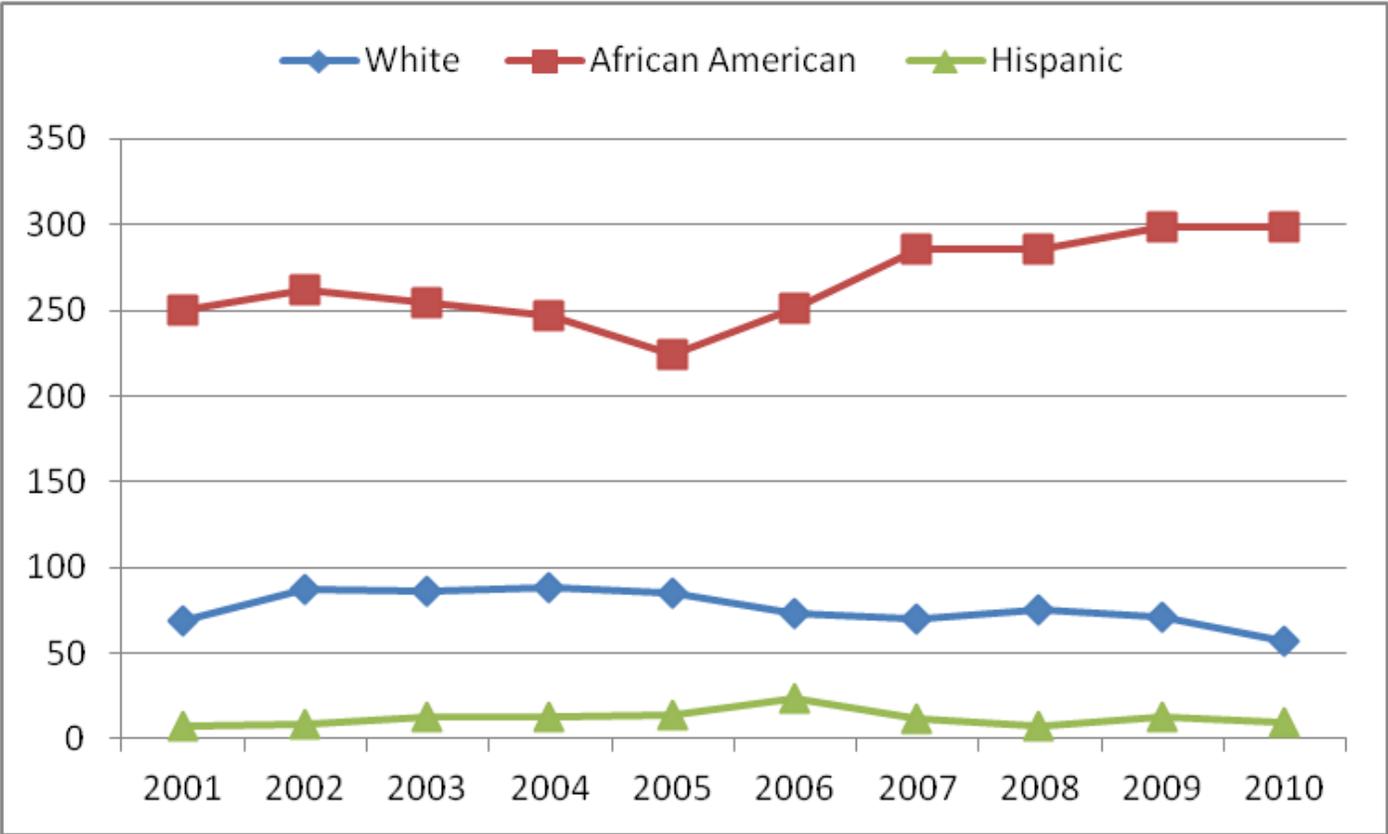
Appendix E: HIV Disease Reported by Race/Ethnicity, Mississippi, 2001-2010



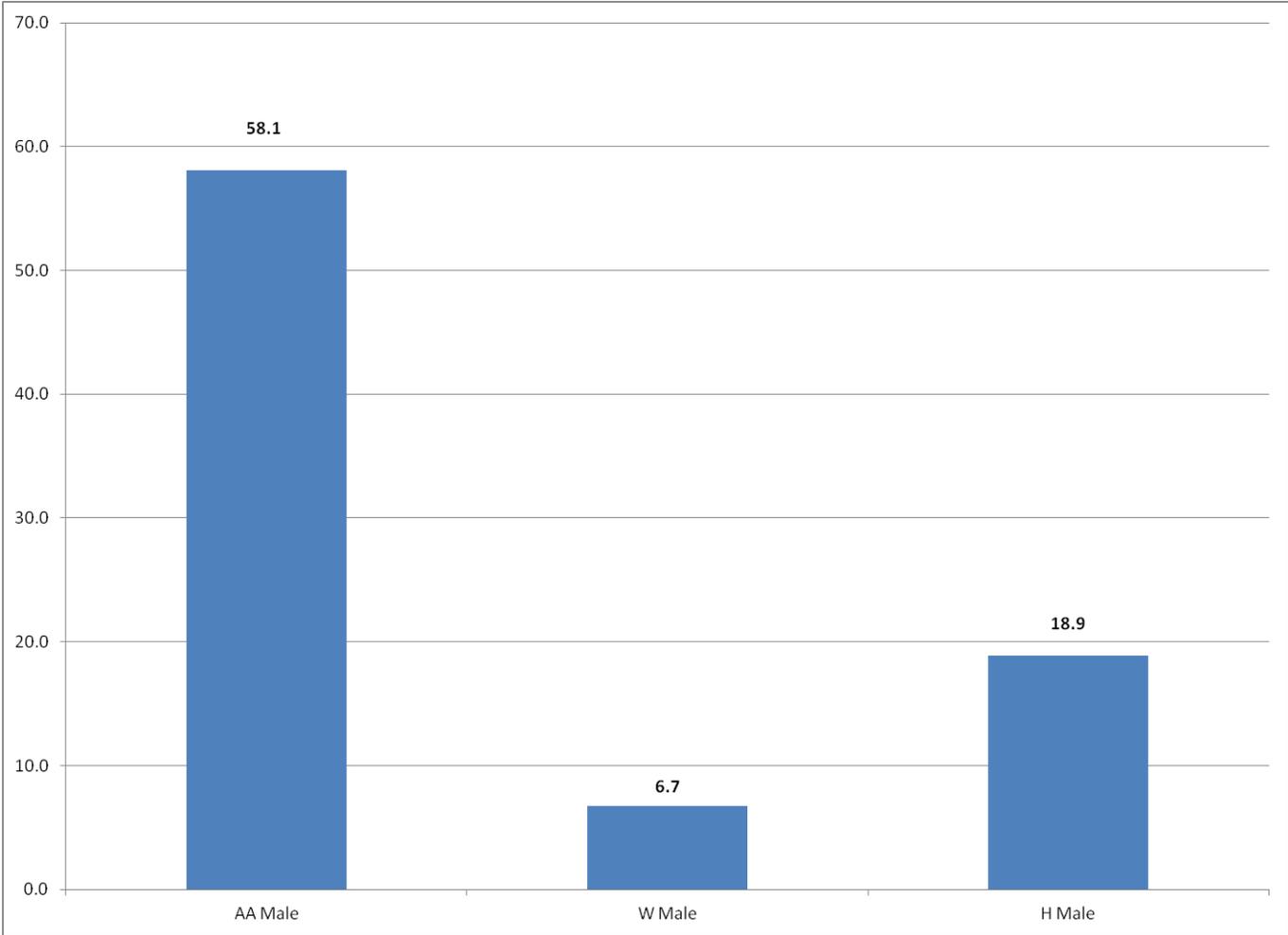
Appendix F: HIV Disease Rates Reported by Race/Ethnicity, Mississippi, 2001-2010



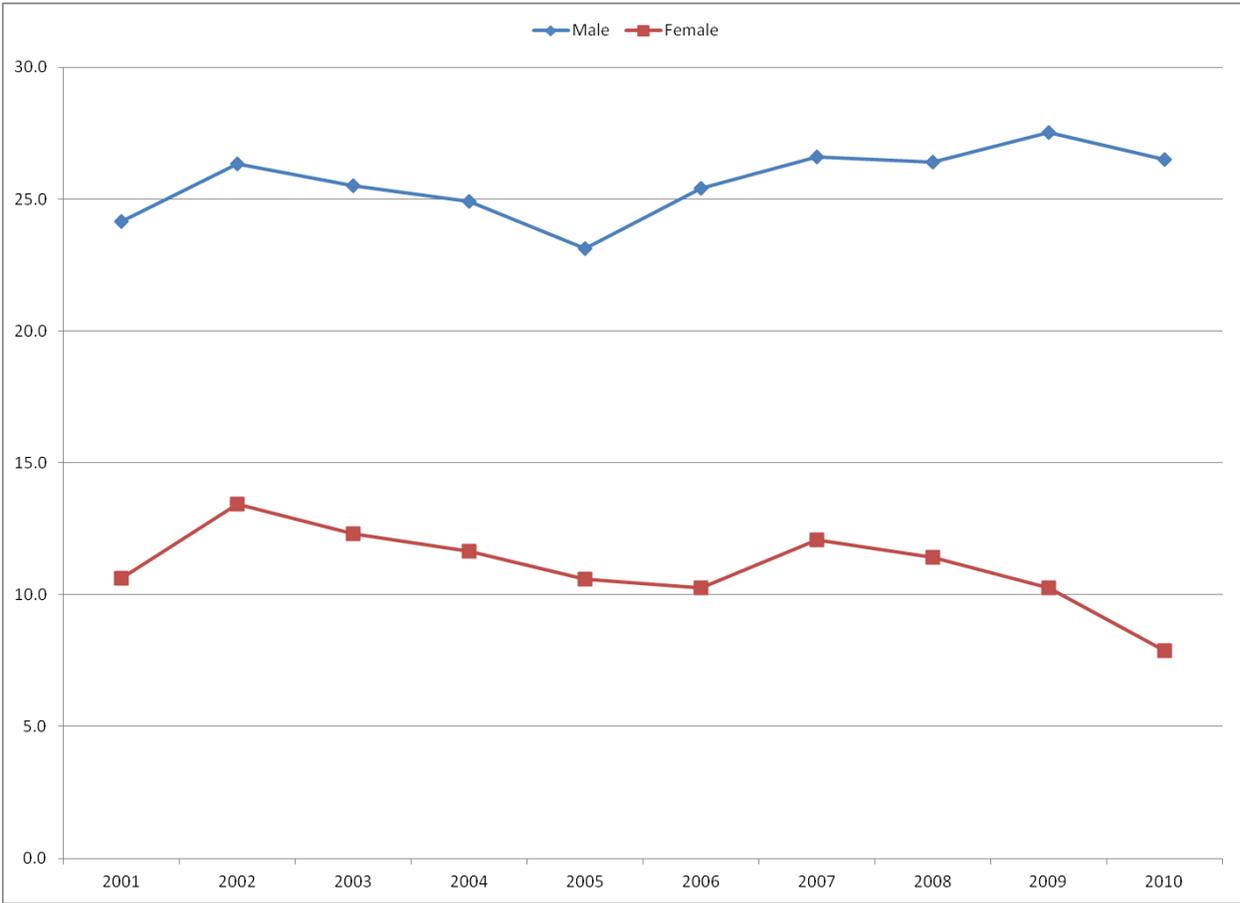
Appendix G: HIV Disease Cases Reported among Males by Race/Ethnicity, Mississippi, 2010



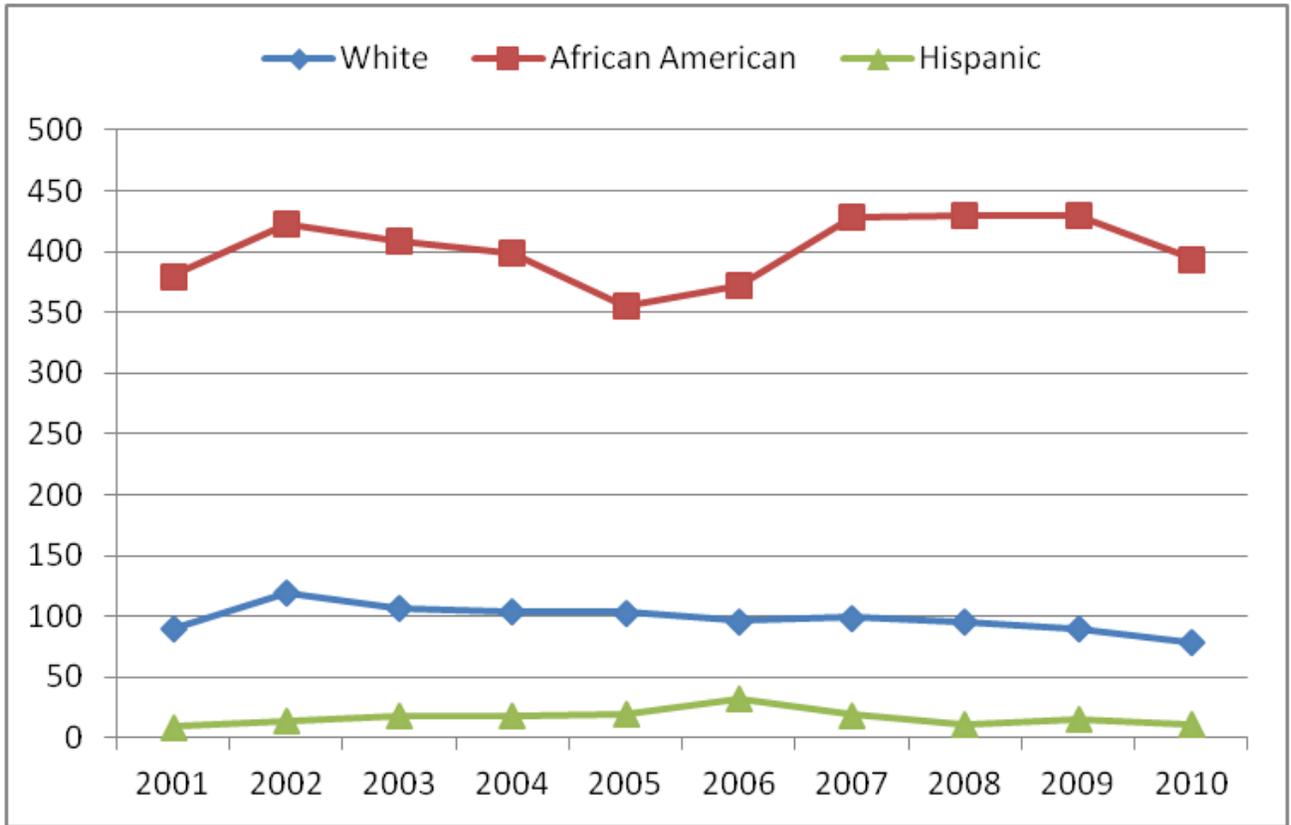
Appendix H: HIV Disease Rates among Males by Race/Ethnicity, Mississippi, 2010



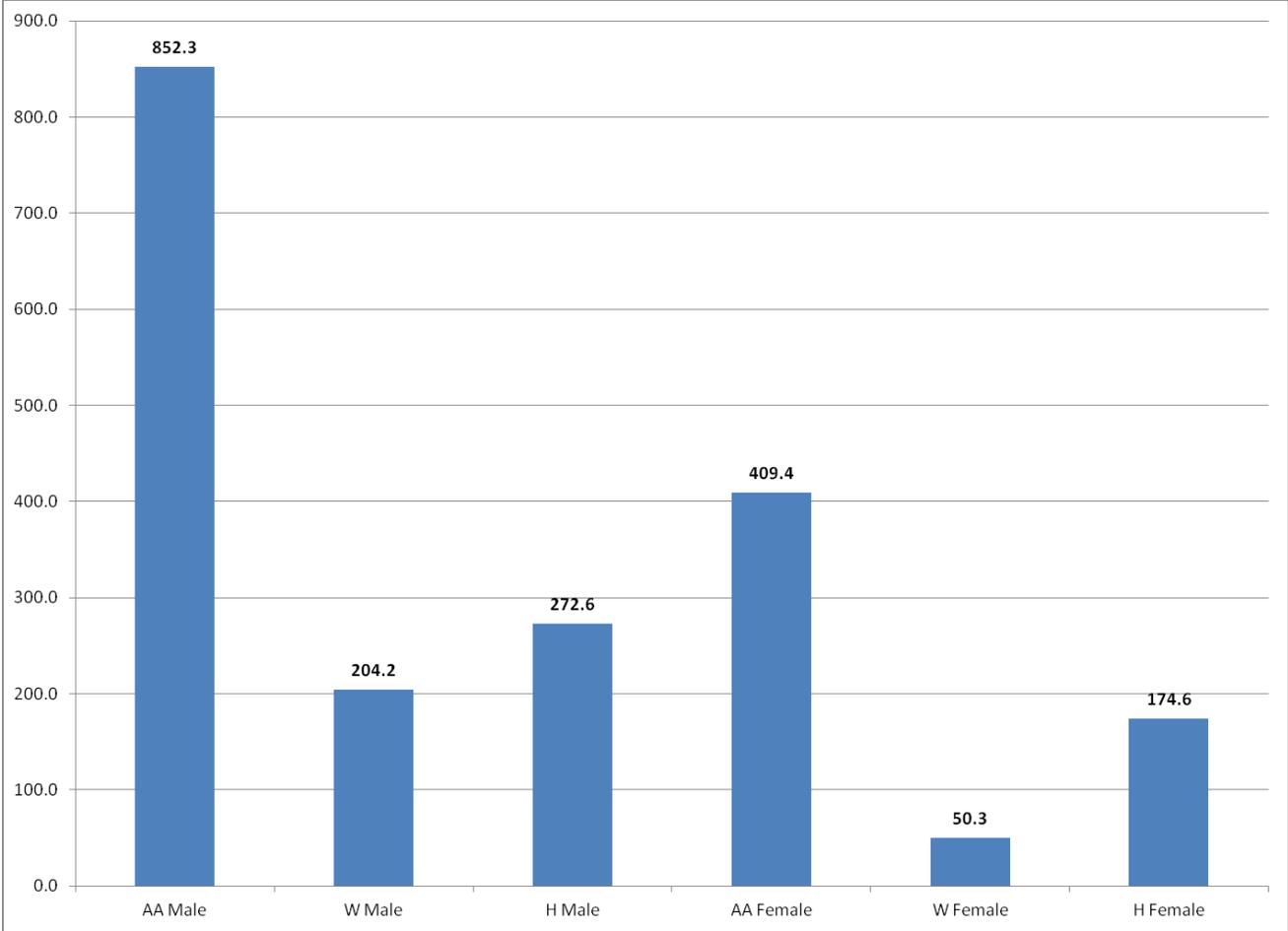
Appendix I: HIV Disease Rates Reported by Gender, Mississippi, 2001-2010



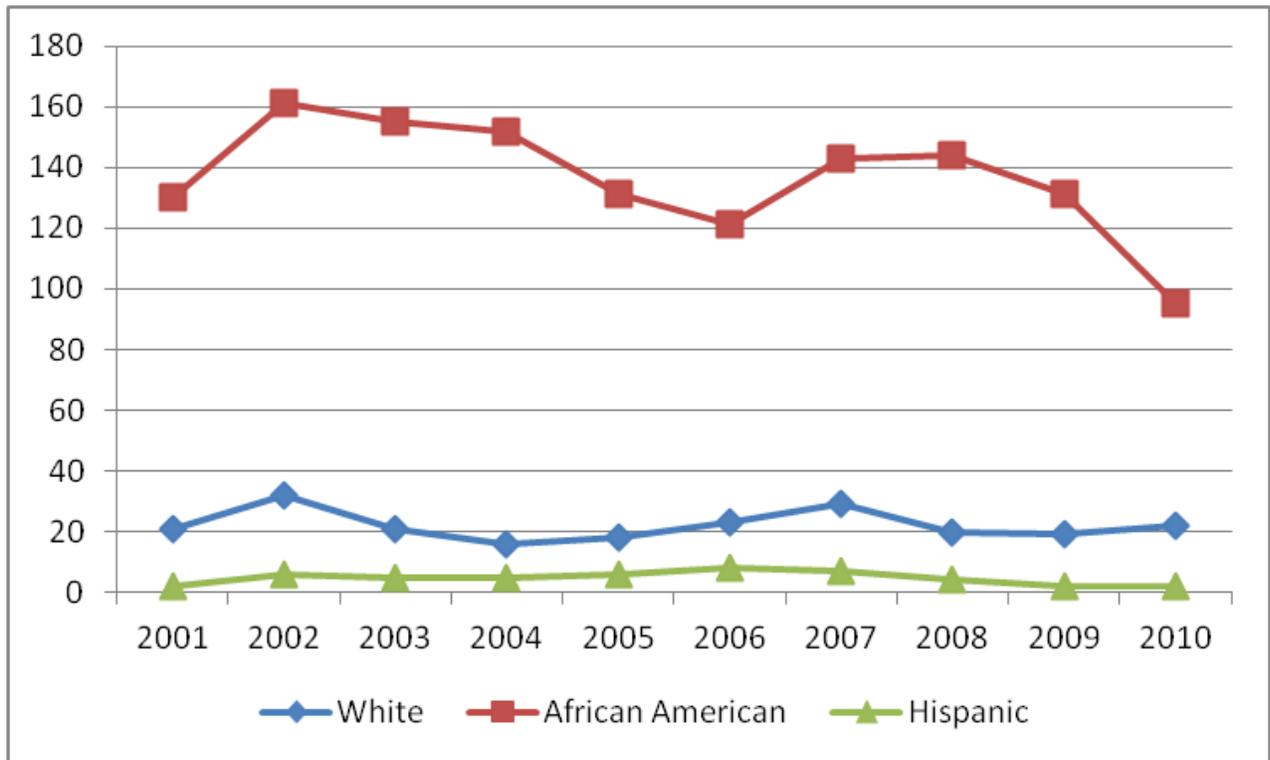
Appendix J: HIV Disease Cases Reported by Race/Ethnicity, Mississippi, 2001-2010



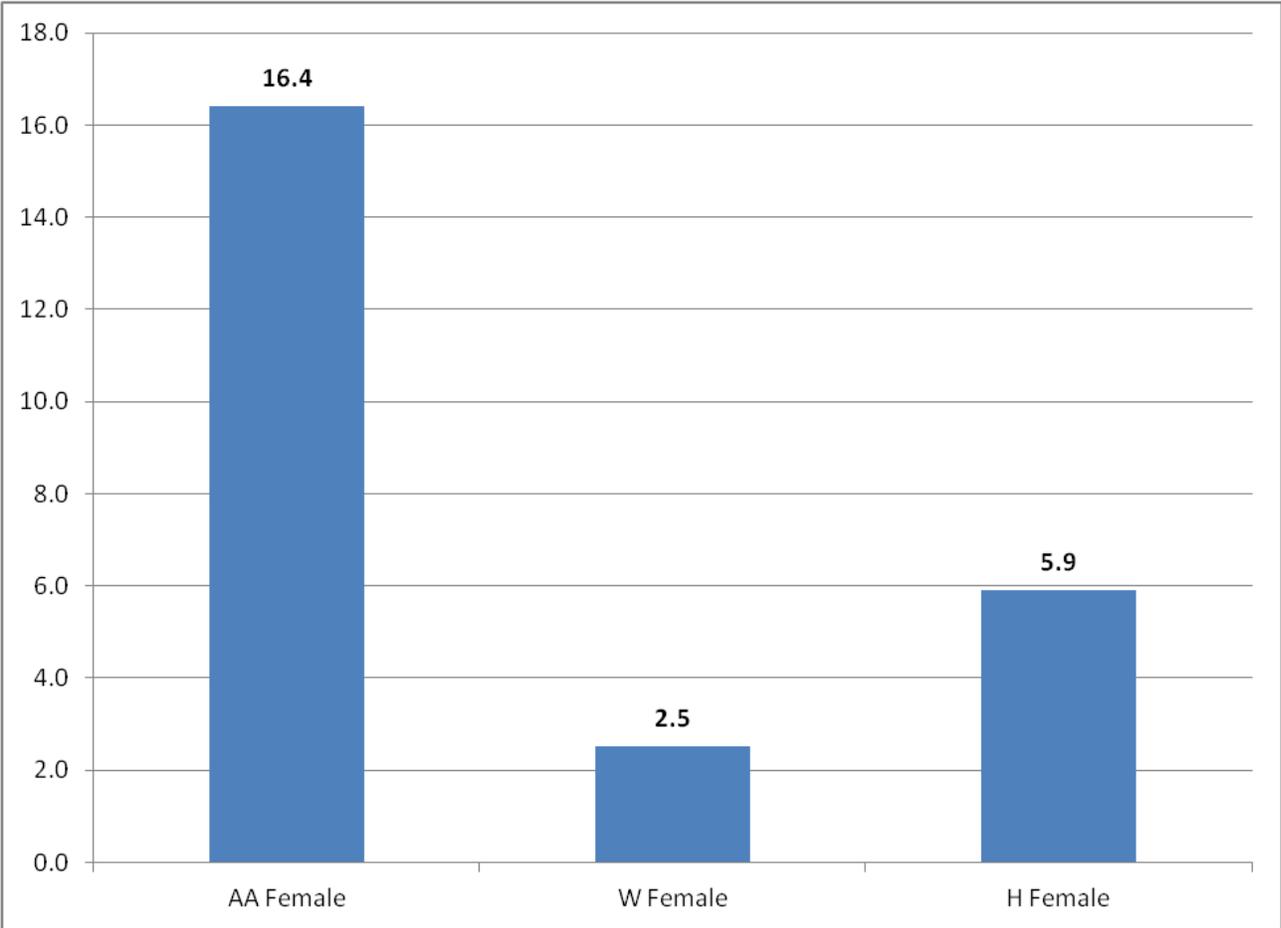
Appendix K: Mississippians Living with HIV Disease, Rates by Gender and Race, Mississippi, 2010



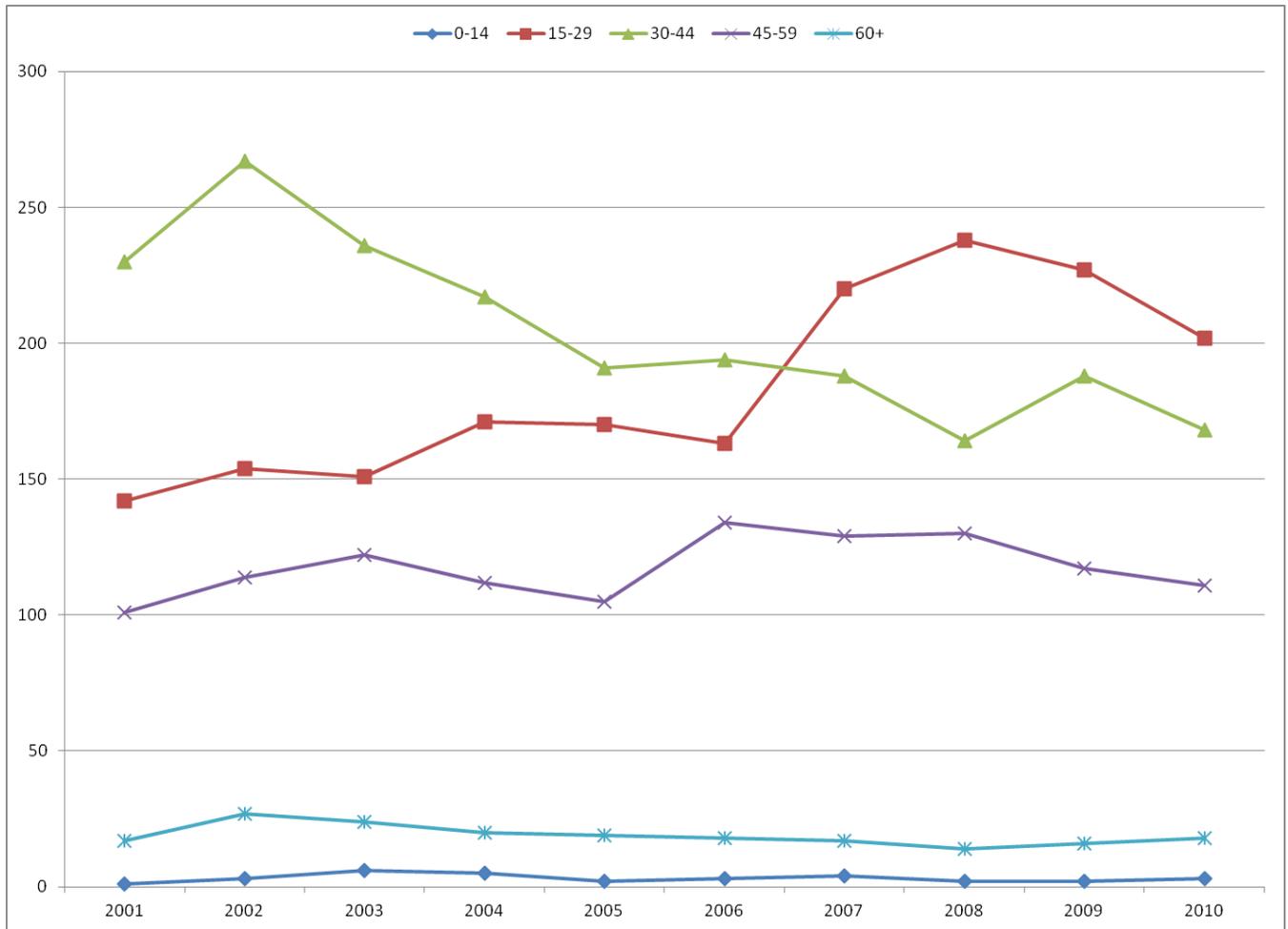
Appendix L: HIV Disease Reported among Females, by Race/Ethnicity, Mississippi, 2001-2010



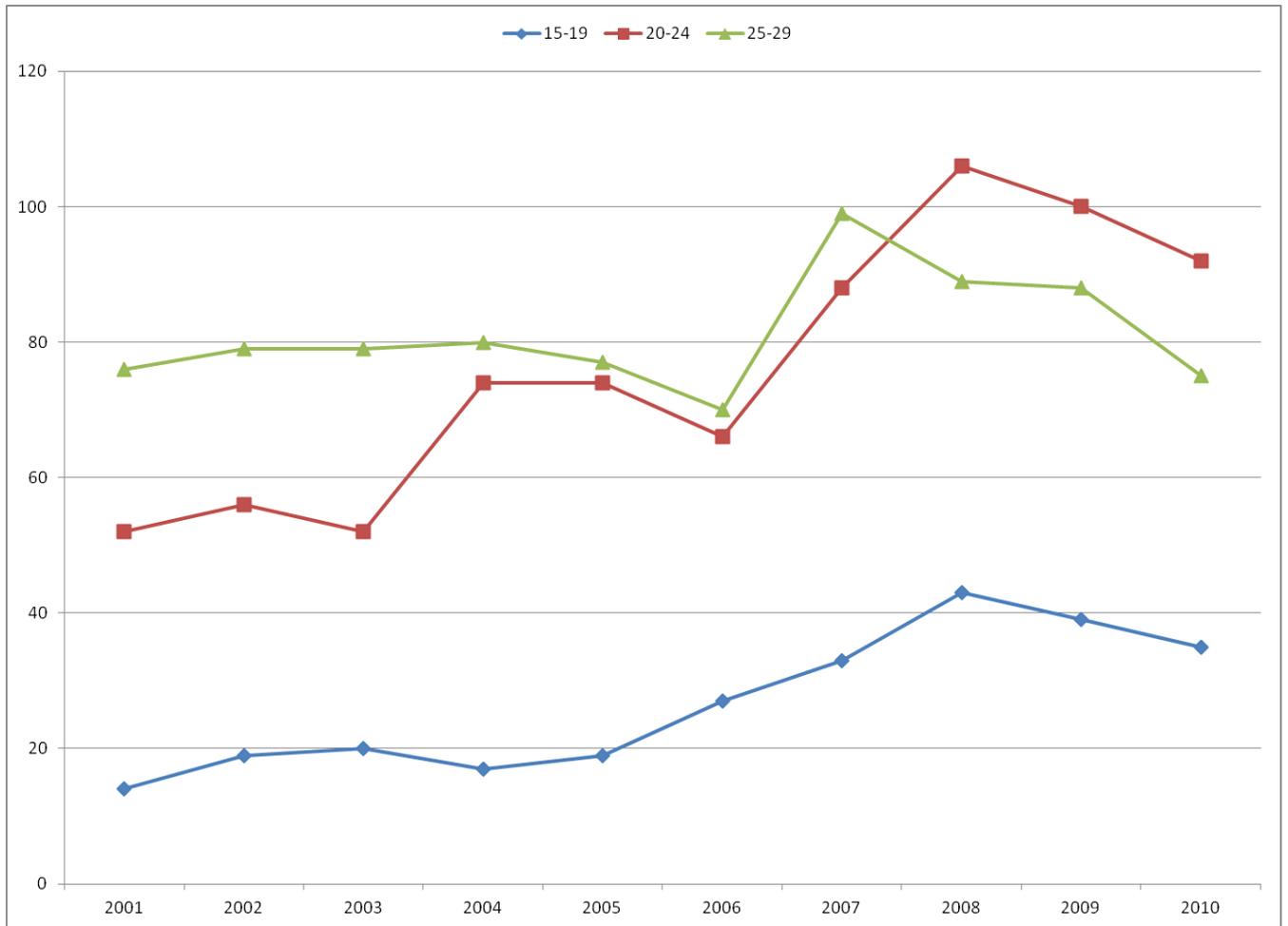
Appendix M: HIV Disease Rates among Females by Race/Ethnicity, Mississippi, 2010



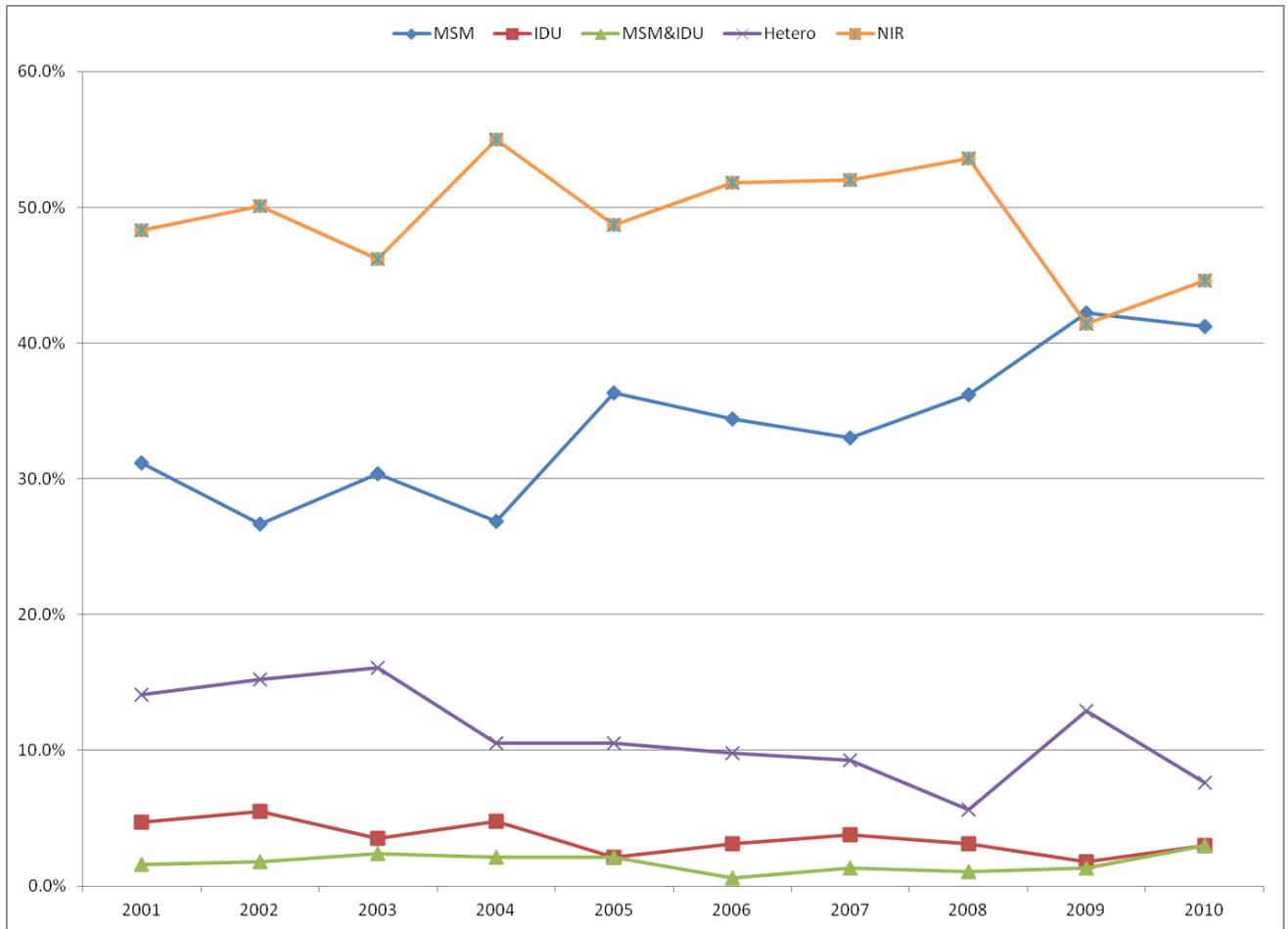
Appendix N: HIV Disease Reported by Age Group, Mississippi, 2001-2010



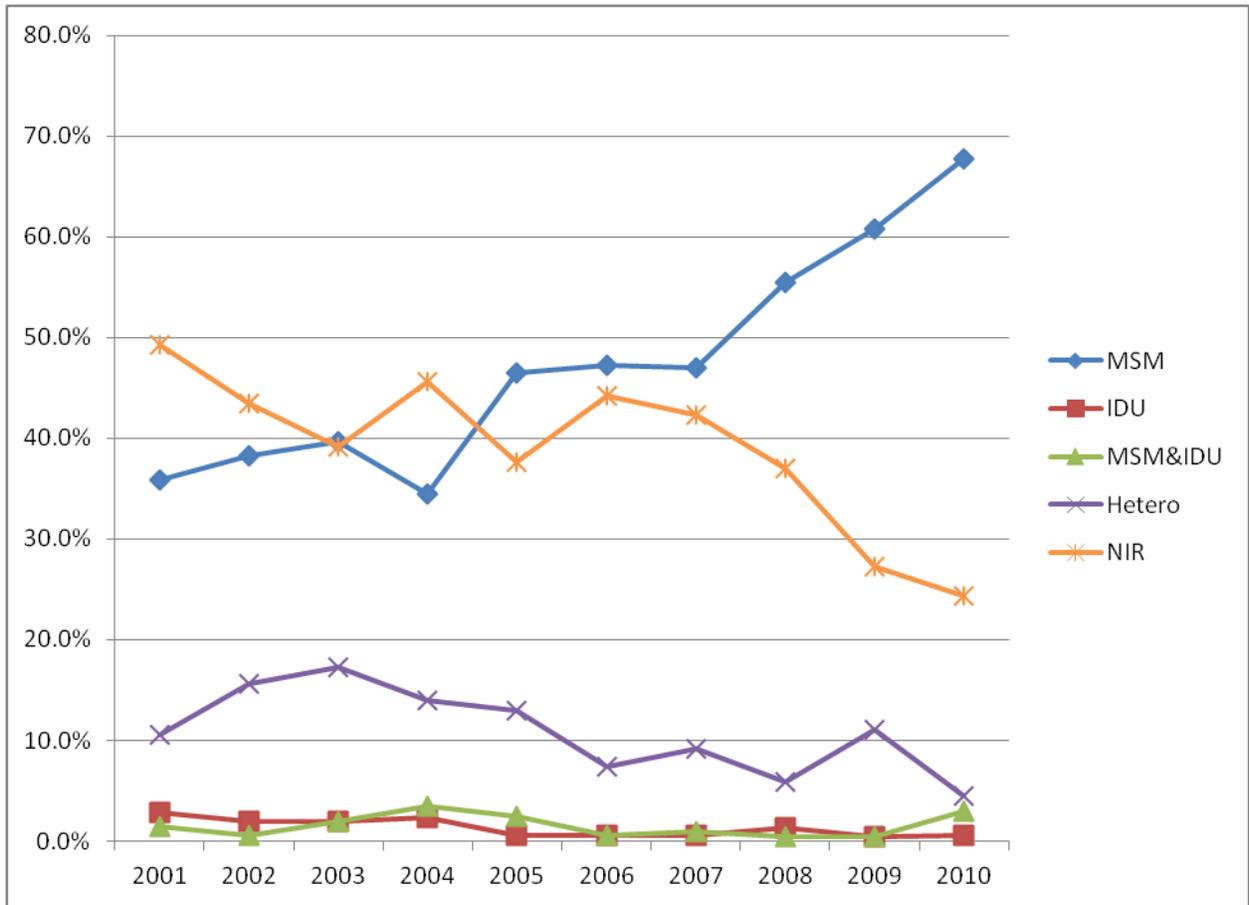
Appendix O: HIV Disease Reported Among 15-29 Year Olds, Mississippi, 2001-2010



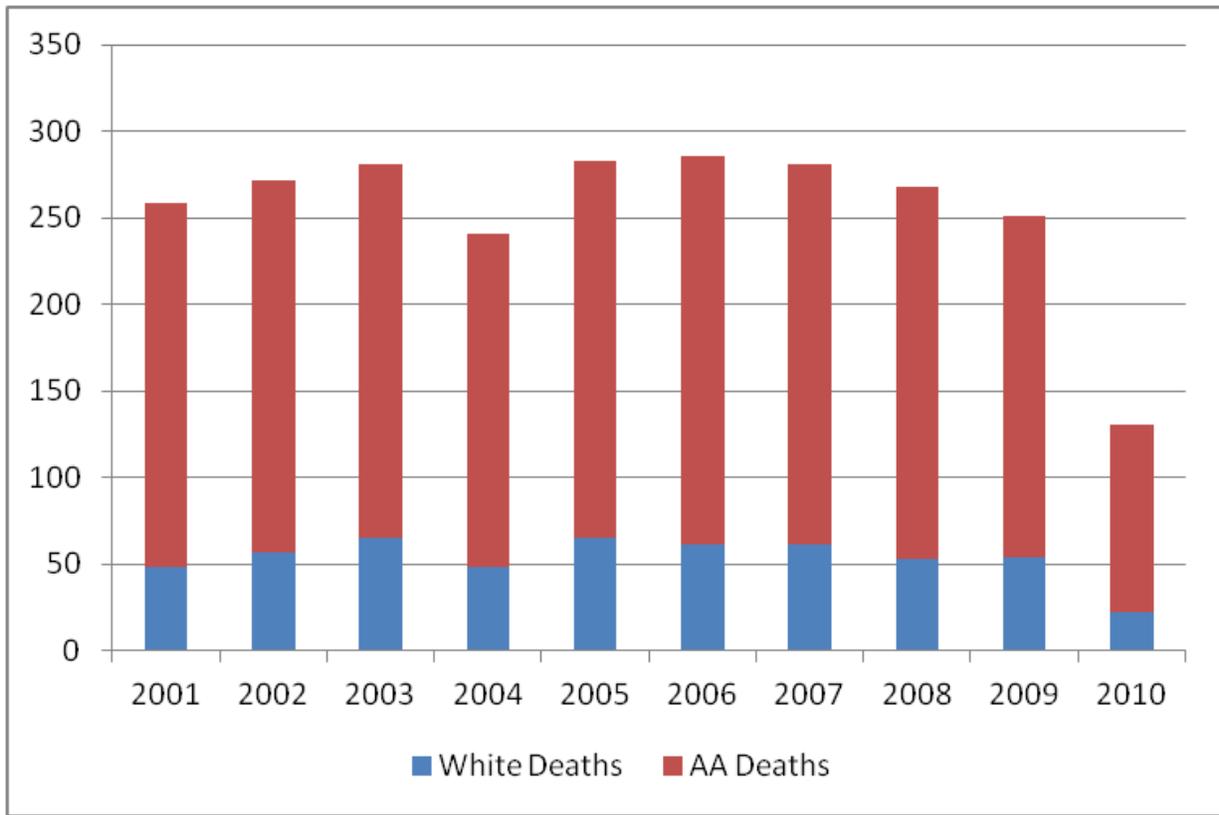
Appendix P: Distribution of Risk Factors among Reported Cases, Mississippi, 2001-2010



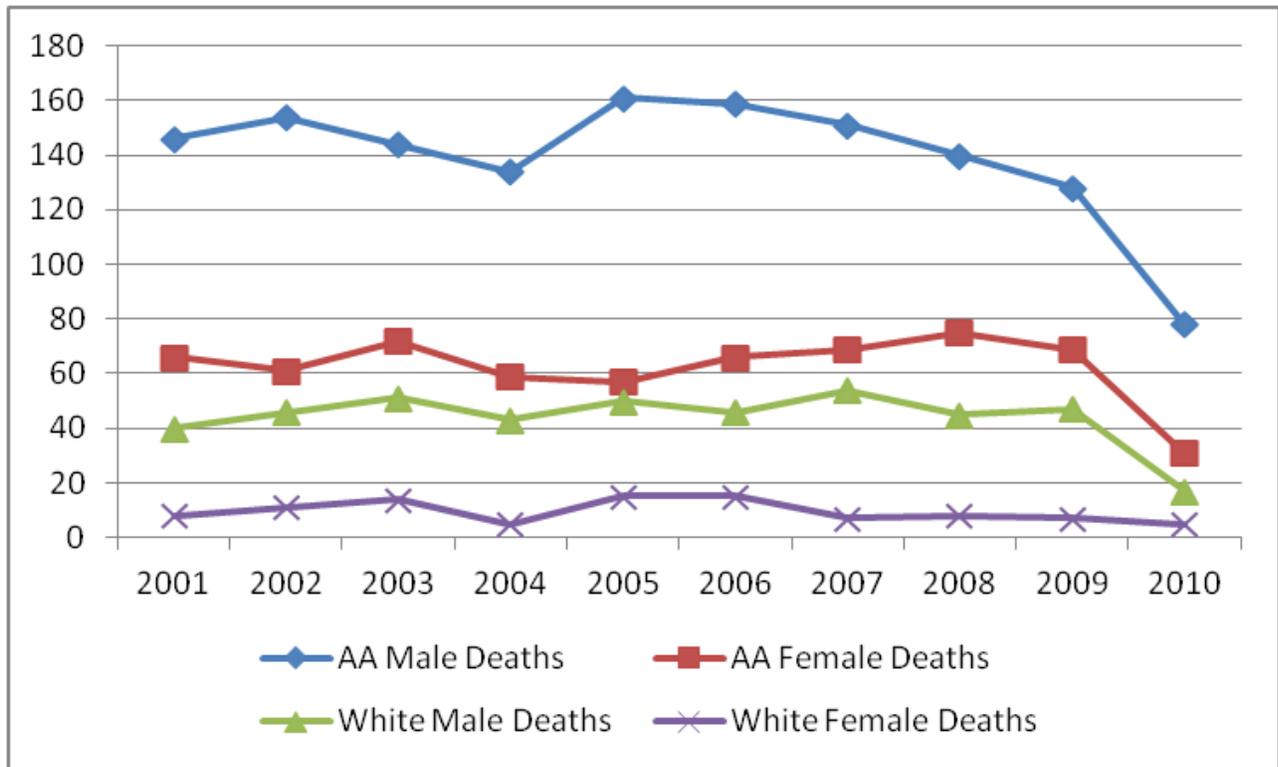
Appendix Q: Distribution of Risk Factors among 15-29 Year Olds, Mississippi, 2001-2010



Appendix R: Deaths among Persons Living with HIV Disease, Mississippi, 2001-2010



Appendix S: Deaths among Persons with HIV Disease, by Race and Gender, Mississippi, 2001-2010



Appendix T: Insert MMP 2010 Fact Sheet



Mississippi 2010 MMP Fact Sheet

What is the Medical Monitoring Project (MMP)?

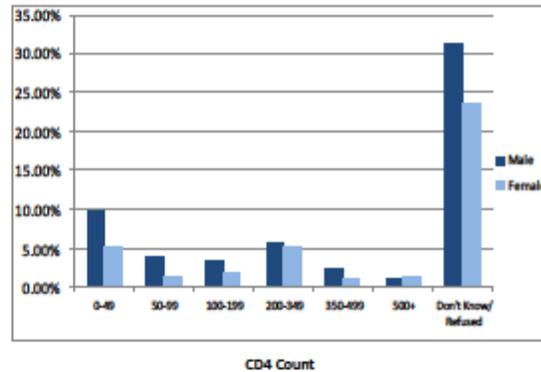
- MMP is a surveillance study implemented by the MS State Department of Health (MSDH) and the Centers for Disease Control and Prevention (CDC) to obtain information about patients with HIV/AIDS receiving on-going medical care and the types of services they needed and received. This information will help 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 2010 cycle.

| Patient Demographic Information | | | |
|---|---------------|----------------|----------------|
| Race/Ethnicity at the Time of Interview by Sex* | | | |
| | Male n=134 | Female n=93 | Total n=227 |
| 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% |

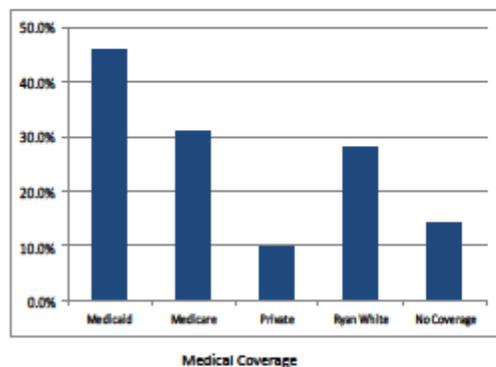
Time between HIV Diagnosis and Entry into HIV Care (Among Participants Diagnosed in the Past 5 Years)

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

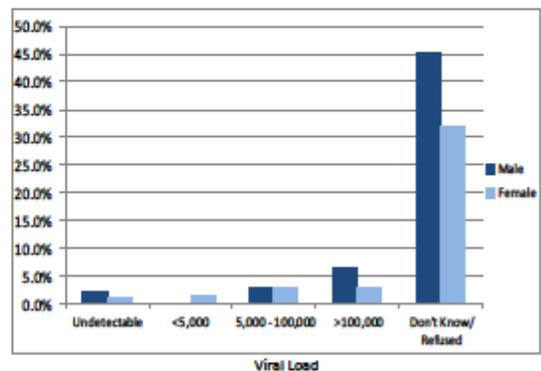
Lowest CD4 Ever by Gender (Self-Reported)



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.

Appendix U: MSDH Jurisdictional HIV Prevention Plan Timeline

- June 29 - Distribute key documents to all MSCPG members and send proposed engagement questions to invited external participants.
- July 10 – Hold strategic planning meeting with invited external participants (finalize timeline and questions)
- July 13 – Obtain input through MSCPG meeting/Prevention Service Council meetings (agenda items for jurisdictional plan) and (Possible new stakeholder’s input after these meetings end)
- July 20 – 1st Stakeholders Conference Call - pose standardized questions to participants
- Aug. 3 – First draft due for review
- Aug. 10 – 2nd Stakeholders meeting
- Aug. 24 – Final draft due
- Aug. 30 – Deadline for any last minute feedback on final draft
- Sept. 4 – Begin routing for agency approval
- Sept. 14 – Deadline for agency approval & distribution to MSCPG for Letter of Concurrence Consideration
- Sept. 21 – Deadline to receive MSCPG Letter for CDC
- Sept. 28 – Deadline to submit to CDC

Engagement Questions

1. Based on CDC Priorities for High-Impact Prevention Report and the National HIV/AIDS Strategy, what key strategies or recommendations are you most in favor of (list up to three), and what strategies or recommendation are you least supportive of (provide at least one)?
2. Please review the Combined 2012 Ryan White HIV Comprehensive Plan and Statewide Coordinated Statement of Need provided. Please describe up to three activities described in the plan that are shared with jurisdictional prevention issues or concerns?
3. Based on the 2012 HIV Prevention Needs Assessment Final Report, other provided documents, and your own experiences, please complete the matrix below:

| Identified Needs | Recommendations to | Key Responsible Parties | Proposed Evaluation |
|------------------|--------------------|-------------------------|---------------------|
|------------------|--------------------|-------------------------|---------------------|

| | Address Issue | | Measure(s) |
|--|----------------------|--|-------------------|
| Tailored culturally-appropriate information and dissemination strategies | | | |
| Increase/Improve linkage, retention, and reengagement for HIV treatment | | | |
| Increase access to mental health services | | | |
| Improve HIV prevention for at-risk youth | | | |
| Reduce stigma | | | |
| Increase/improve targeted HIV testing activities for high-risk populations | | | |
| Add other issues: | | | |
| | | | |

4. What HIV Prevention strategies are not occurring in Mississippi that should be considered?
5. Suggestions to improve access to and use of housing assistance programs?