# MISSISSIPPI DEPARTMENT OF PUBLIC HEALTH

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## BACKGROUND

An estimated 10,254 individuals were living with HIV disease in Mississippi in 2012, with many HIV cases in rural areas of the state. Mississippi has a large African American population, ranking second in the U.S. for the proportion (38%) of the state population that is African American (US Census, 2010). African Americans in Mississippi are disproportionately affected by HIV, accounting for 78% of all new cases in 2010, with an HIV incidence rate nearly eight times that of whites. Social-structural factors that can negatively affect access to and participation in HIV-related services by persons in Mississippi, particularly African Americans, include poverty, HIV stigma, homophobia, generally limited availability of quality health care, and lack of health insurance coverage.

To address the effects of some of these factors, the Mississippi State Department of Health (MSDH) is focusing its CAPUS activities primarily in Public Health Districts III, IV, V and VI. District III includes the Delta-Hills region, which has the state's largest concentration of African Americans. It is one of the state's most impoverished areas and had the third highest number of new HIV cases in 2012. District IV includes Lowndes County, which had an HIV case rate of 261.0 per 100,000 population in 2011. District V includes the metropolitan Jackson area which has the state's highest population density and the highest number of new HIV cases in 2012. District VI is described as entirely rural and lacking in primary health care services.

## USE SURVEILLANCE DATA AND DATA SYSTEMS TO IMPROVE CARE AND PREVENTION

MSDH reports surveillance data to the CDC, but because of limited capacity for data management and analysis, does not use this information for program planning, implementation, or monitoring of HIV care and prevention services. CAPUS will support MSDH efforts to make needed improvements by assessing and integrating its surveillance and other data systems that include CAREWare, Patient Reporting Investigation Surveillance Manager (PRISM), ApolloLIMS laboratory information management database, and eHARS. This integration will provide MSDH with a more complete picture of HIV in the state, allow it to locate individuals for follow-up, identify clients for reengagement, and conduct continuum of care analyses to monitor clinical outcomes.

Two priority populations have been identified for improving linkage to, retention and re-engagement in HIV care: 1) persons newly diagnosed with HIV without documented care within 45 days of diagnosis; and 2) African American men who have sex with men (MSM) who were engaged in care, but have no documented CD4 or VL data during the past 12 months. The STD/HIV Epidemiology staff will develop queries to identify

these populations. Monthly line listings will be generated for all newly reported cases, those diagnosed in the past 60 to 90 days, and for all living cases with no record of CD4 or VL in the past 12 months. Field records generated from the line listings will be provided to Disease Intervention Specialists (DIS) and Social Workers for follow-up and case management.

## INCREASE HIV TESTING, LINKAGE TO, RETENTION IN, AND RE-ENGAGEMENT WITH CARE, TREATMENT, AND PREVENTION

Access to HIV testing in Districts III and IV is extremely limited. Additionally, stigma, homophobia, and fear of discrimination and isolation fuel negative perceptions of HIV testing among African Americans, which contribute to their reluctance to seek HIV testing in traditional settings. To increase testing among African Americans, particularly MSM, MSDH will fund one community-based organization (CBO) in Districts III and IV to provide free rapid HIV testing in non-traditional settings, including barbershops, health fairs, bars, homeless shelters, substance abuse treatment centers, and faith-based organizations. The CBOs will be required to attain a minimum positivity rate of 2% each year and to work with DIS in these districts to ensure that all clients receive confirmatory testing, partner services, and referral to an HIV case manager.

MSDH will also pilot a client-centered comprehensive case management approach in collaboration with Ryan White providers and CBOs in Districts III and IV. This approach emphasizes client strengths and self-reported needs to promote retention in care and medication adherence. Case managers will follow each client through linkage to care and other services, and will monitor retention and adherence. MSDH will also expand its work force to reach more clients. Currently, MSDH case management is conducted through funding by Ryan White Part B. However, many individuals in priority areas are not eligible for Ryan White services. MSDH will hire 3 additional case managers, expanding its capacity to reach clients who do not qualify for Ryan White services or who do not receive case management through Medicaid or private insurance.

## ENHANCE PATIENT NAVIGATION

The MSDH does not have a patient navigation program for persons living with HIV and AIDS (PLWHA), and no other organizations in the state provide navigation services. District III has the highest poverty rate in the state and the third largest proportion of the population that is living with HIV. This district has no navigation services; however, it does have several HIV testing sites, two Ryan White Part C grantee programs that provide HIV Early Intervention Services, and at least one community-based AIDS organization that serves HIV-positive African American MSM. The high prevalence of HIV infection among African Americans in District III and the regional availability of HIV care and service organizations provide an opportunity for MSDH to pilot a patient navigation activity in this area. MSDH will work with an academic institution and a rural CBO to develop a program to train PLWHA in District III to become peer navigators. Competency standards for patient navigation will be guided by the national CLAS standards developed by the HHS Office of Minority Health. MSDH policies will enable the navigators to work closely with HIV case managers and other service providers to improve outcomes across the continuum of care. The peer navigators will assist clients with accessing HIV

case management and transportation to medical care and other services. Peer navigators will also assist with the completion of applications for needed services, such as housing, food, social security, and Veteran services. Based on the outcomes of this pilot effort, MSDH may expand navigation services to other districts.

## ADDRESS SOCIAL AND STRUCTURAL FACTORS DIRECTLY AFFECTING HIV TESTING, LINKAGE TO, RETENTION IN, AND RE-ENGAGEMENT WITH CARE, TREATMENT, AND PREVENTION

MSDH and its partner organizations have identified two interrelated structural factors that create significant barriers to access to and participation in care by PLWHA, particularly in rural areas. These factors are (1) a lack of medical providers capable of providing HIV care, and (2) a lack of access to transportation to reach HIV care providers. To increase the number of qualified providers, MSDH will recruit, train, and mentor rural physicians in Districts IV and VI, where there are currently no health care providers who can serve PLWH. The training will be implemented in collaboration with the Mississippi Chapter of the Delta Region AIDS Education and Training Center (DRAETC) and the Division of Infectious Disease at the University of Mississippi Health Center. Using DRAETC's educational materials and cultural competency and stigma-reduction workshops, the training activities will enable rural health providers who do not currently provide HIV care services to understand the basics of HIV patient care and treatment and mitigate cultural myths surrounding HIV stigma in the rural south. The newly trained providers will be paired with skilled HIV physician mentors who will provide ongoing technical assistance and support with providing care and treatment to HIV-positive patients.

To address the limited availability of transportation, MSDH will identify and assess existing transportation resources. Using GIS analysis, MSDH will identify gaps by mapping identified transportation resources and matching them with the location of current HIV cases and their proximity to health care providers. MSDH will contract with transportation providers or an integrated medical services/transportation company to transport HIV-positive individuals to care providers in areas of need. This activity will increase access to care by persons with HIV, thereby promoting linkage to, retention, and re-engagement in HIV care.

Currently, there is very limited marketing of HIV testing to the African American community in the state. Fear and negative perceptions about HIV testing continue to be barriers to African Americans being tested for HIV. To enhance the impact of the CAPUS project and other HIV prevention activities throughout the state, MSDH will implement a social marketing campaign for District V that may be expanded to other public health districts. The campaign will increase public awareness about HIV and promote HIV testing and HIV medical care. MSDH will work with a local marketing firm to develop the "Be Positive, You're Negative" campaign, which will include the KNOWIT text messaging service number for locating testing sites. MSDH will contract with JATRAN, the transit system in Jackson, Mississippi (District V), to display the advertisement as a full-color wrap-around on buses. The bus route selected for this activity serves African American neighborhoods and includes a stop at Jackson Medical Mall, the location of MSDH's Crossroads (STD/HIV) Clinic. MSDH will also place an LED billboard near to two Jackson-area rapid HIV testing programs operated by the University of Mississippi Medical Center and the Open Arms Health Care Center. In addition, Jackson State University (JSU) will display the campaign ad on the jumbotron at JSU's stadium during football games.

## FUND COMMUNITY-BASED ORGANIZATIONS USING A MINIMUM 25% OF TOTAL AWARD

Over the course of the 3 year funding period, MSDH will allocate a minimum of 25% of its CAPUS budget to community-based organizations. CBOs will implement rapid HIV testing and the client-centered, comprehensive case management pilot in Districts III and IV, as well as train and support peer navigators in District III.