Mississippi State Report

An Analysis of the Successes, Challenges, and Opportunities for Improving Healthcare Access

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Access to high-quality, comprehensive healthcare is critical for people living with HIV and AIDS. Advocating effectively for improved healthcare access requires understanding the underlying legal and policy landscape of a state, the state’s fiscal and cultural environment, and existing barriers to healthcare access.

The State Healthcare Access Research Project (SHARP) is researching and analyzing this information and examining states’ capacities to meet the care and treatment needs of people living with HIV and AIDS. Working together with community partners, the project is identifying past successes, current challenges, and future opportunities to improve access to care and services for people living with HIV/AIDS. SHARP has three main goals: (1) improve access to care and treatment, (2) build advocacy capacity in SHARP partner states and communities, and (3) share information and effective strategies among partners in the SHARP states. SHARP is currently active in seven states, plus Los Angeles County, California: Alabama, Arkansas, Illinois, Louisiana, Mississippi, North Carolina, and South Carolina. The project will take on additional states or regions in 2011.

Collaboration with community partners is integral to the SHARP process. We have met or spoken with people living with HIV/AIDS, healthcare providers, community-based AIDS services providers, state and federal government officials, representatives of faith-based organizations, academic researchers, and other stakeholders as we conducted our in-state research for this report. These community partners have shared their opinions and insights about the successes and challenges faced by people living with HIV and AIDS as they seek care. They have also shared their perspectives on the political, cultural, and fiscal factors unique to Mississippi.
Our goal is for each state’s SHARP report to be informative and useful. It is our hope and intention that the reports will become a framework for future efforts to expand healthcare access—tools that can be used as part of a broader strategy to bring healthcare to more people living with HIV/AIDS. It is important to note that the reports reflect a snapshot of a state at a moment in time—with national health reform recently passed in Congress and states responding to ongoing economic difficulties, the landscape of healthcare access is changing almost every day. Some of the opportunities discussed in this report may need to be revised accordingly.

SHARP is being conducted by the Health Law and Policy Clinic of Harvard Law School and the Treatment Access Expansion Project (TAEP), with support from Bristol-Myers Squibb. The Health Law Clinic has provided legal services to low- and moderate-income people living with HIV/AIDS for 20 years, and actively participates in HIV healthcare access advocacy efforts. The Treatment Access Expansion Project is a national organization focused exclusively on HIV healthcare access advocacy. The mission of both organizations is to help bring quality, comprehensive healthcare to more people living with HIV and AIDS.

We extend our deepest thanks to everyone, especially the many Mississippi residents living with HIV/AIDS, who contributed to this project by sharing their experiences, knowledge, expertise, perspectives, and opinions regarding access to healthcare and support services.

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From Greenville to Gulfport, from Tupelo to Natchez, HIV/AIDS now touches every county in Mississippi. The challenges faced by people living with HIV/AIDS in accessing healthcare and services mirror those faced by Mississippians generally, including healthcare provider shortages, inadequate transportation options, limited health literacy, and insufficient safe, affordable housing. For people living with HIV/AIDS, these challenges are magnified by the significant social stigma and discrimination associated with HIV disease.

The South in general is at the epicenter of the current HIV/AIDS epidemic in the United States, with

- the highest rates of new infections,
- the most AIDS deaths,
- the greatest number of people living with HIV/AIDS, and
- the fewest resources.

Lack of resources is a constant issue. One striking example is the Adult Special Care Clinic at the University of Mississippi Medical Center, which serves more than 1,800 patients and has only 3 case managers. Mississippi receives the second-lowest amount of federal HIV/AIDS funding of any state in the South (ahead of only Arkansas). The state itself has not historically prioritized investment in public health, a fact reflected in Mississippians’ high rates of STDs, obesity, diabetes, and other health issues. Mississippi’s tax structure features relatively high sales taxes (including a 7% sales tax on food and groceries) and relatively low income and corporate taxes, which disproportionately burden lower-income families. In Mississippi, a person earning $10,001, a person earning $1 million, and a corporation would each be taxed at the same rate.

Mississippi, like other southern states, is relatively poor and rural—characteristics shared by many people living with HIV/AIDS in the state, and that complicate the provision of healthcare and services. While poverty is not listed specifically as a healthcare access challenge in this report, poverty underlies virtually all of the other challenges discussed, and is a major barrier to both HIV prevention and care. Individual poverty is compounded by the limited assistance available through public programs. For example, Mississippi Medicaid covers only five prescriptions a month, forcing many people living with HIV to choose between getting their HIV medications, medications for other conditions like diabetes and hypertension, and food.
Despite the many challenges, there are also reasons to be optimistic that access to care and services for people living with HIV/AIDS in Mississippi can be improved. Mississippians are generous people—one national organization ranked Mississippi first or second in the nation for per capita charitable giving from 1995-2004. This generosity can be applied in the context of HIV/AIDS, where investment in prevention and early access to care can save both money and lives later on. Mississippi also has a dedicated group of community members, care and services providers, and government officials who are committed to working toward change.

As noted, while this report views healthcare access challenges through the lens of access to care for people living with HIV/AIDS, it is important to recognize that most of the challenges discussed apply equally to much wider constituencies. People living with HIV/AIDS in Mississippi and the providers who work with them would do well to partner with other communities in broad-based coalitions to advocate for improvements in prevention services and healthcare access.

**OVERVIEW OF HIV/AIDS**

**Epidemiological information**

**Number of HIV and AIDS cases**

As of December 31, 2009, there were 12,989 cumulative HIV/AIDS cases in Mississippi, including 9,214 living cases and 4,658 cumulative deaths. There were 610 newly reported cases of HIV disease in 2009 and 21 deaths. The statewide rate of living HIV cases as of December 31, 2009, was 313.5 per 100,000 population; for new 2009 cases, the rate was 20.8 per 100,000 population.

**Unmet need**

Unmet need refers to the percentage of people who are aware of their HIV-positive status but who have not accessed medical care in the previous 12 months (based on tracking CD4 and viral load testing). In Mississippi, at least 50% of known HIV cases are not in care.

The following sections outline details of HIV/AIDS epidemiology in Mississippi, with information about cases newly reported in 2009 (incident cases), living cases as of December 31, 2009 (prevalent cases), and cumulative HIV/AIDS cases from September 1, 1983-December 31, 2009.

**Demographics**

**Race/ethnicity**

African Americans are significantly disproportionately impacted in incident HIV cases. In 2009, of the 610 newly reported cases, 77% (470) were African American, 18% (111) were white, 3% (18) were Hispanic, and 2% (11) were listed as other. The incident case rate for African Americans (43 per 100,000 population) indicates that they were nearly 7 times more likely than whites (6.2) and 1.5 times more likely than Hispanics (27.4) to have a case of HIV reported in 2009. The greatest disparity occurred between African American and white women, with African American women more than 8.5 times as likely to have a newly reported HIV case in 2009.

Among the 9,214 individuals living with HIV disease at the end of 2009, 73% (6,687) were African American, 18% (1,111) were white, 3% (111) were Hispanic, and 2% (18) were listed as other. The prevalence rate for African Americans (43 per 100,000 population) indicates that they were nearly 7 times more likely than whites (6.2) and 1.5 times more likely than Hispanics (27.4) to have a case of HIV reported in 2009. The greatest disparity occurred between African American and white women, with African American women more than 8.5 times as likely to have a newly reported HIV case in 2009.

Among the 9,214 individuals living with HIV disease at the end of 2009, 73% (6,687) were African American, 24% (2,210) were white, and 2% (18) were Hispanic. Other categories are: American Indian/Alaska Native (0.2%/15 cases), Asian (0.2%/15 cases), Other (0.7%/62 cases), and Unknown (0.4%/40 cases). As with the incident case rates, rates for living HIV cases reveal large racial and ethnic disparities. African American men have a prevalence rate of 841 per 100,000 population, making them more than 4 times likelier than white men (202.9) and 2.5 times likelier than Hispanics (336.5) to be living with HIV disease.
Of cumulative cases, African Americans comprised 72% (9,393 cases), whites 25% (3,263), and Hispanics 1.5% (197). American Indians/Alaska Natives, Asians, Other, and Unknown each accounted for less than 1% of cases.

**Gender**
Men accounted for 73% (445 individuals) of new 2009 cases, with women making up 27% (165). Among living HIV/AIDS cases as of December 31, 2009, 68.5% (6,316) were in men, with 31.5% (2,898) in women. Of the 12,989 cumulative HIV/AIDS cases, men make up 71%, with women comprising 29%.

**Age**
For cases newly reported in 2009, the most common age of diagnosis was 25-44 years (317 cases, or 52%), followed by 13-24 years and 45-64 years (both categories with 144 cases, or 24%). A bright spot is that Mississippi had no reported cases of HIV in infants (0-1 year) in 2009, an indication that efforts to prevent perinatal (mother-to-infant) transmission are succeeding.

Among persons living with HIV/AIDS as of December 31, 2009, 62.6% (5,770) were aged 25-44, 19.3% (1,778) were 13-24, and 16.6% were 45-64. There were only 68 people (0.7%) aged 65 or over reported living with HIV/AIDS.

Among Mississippi’s cumulative 12,989 HIV/AIDS cases since September 1, 1983, 25-44-year-olds also represented the age group with the greatest number of cases (8,237, or 63.4%), followed by 45-64-year-olds (2,401/18.5%), 13-24-year-olds (2,026/15.6%), and 65-plus (237/1.8%). The fact that the 45-64-year-old age group, which ranked second overall for cumulative cases, has been surpassed by the 13-24-year-old category for both new and currently living cases suggests that the HIV epidemic in Mississippi is getting younger.

**Reported exposure categories**
In HIV/AIDS cases reported in 2009 in men, male-to-male sex (MSM) was the most frequently reported exposure category (238 cases, or 53.4% of new male cases), for both African American and white men. MSM was followed by "no risk identified" (NRI) (164, or 36.9%), heterosexual sex (29, or 6.5%), MSM and injection drug use (IDU) (8, or 1.8%), IDU (5, or 1.1%), and pediatric (1, or 0.2%). For Hispanic men, the primary reported exposure category was NRI (9, or 60% of new Hispanic male cases) followed by MSM (3, 20% of new Hispanic male cases). For women of all races and ethnicities, the primary exposure category was NRI (121, or 73.3% of new female cases), followed by heterosexual sex (41, or 24.8%) and IDU (3, or 1.8%). Overall out of the 610 cases, NRI was the most reported exposure category for HIV infection (285 cases, or 46.7%), with MSM second (238 cases, or 39.0%).

Among the 9,214 living cases of HIV disease as of December 31, 2009, NRI was the most commonly reported exposure category (3,375 or 36.6%), followed by MSM (3,170/34.4%), heterosexual sex (1,576/17%), and IDU (691/7%). For African Americans and Hispanics, NRI was the most reported category; for whites, it was MSM.

Among cumulative cases since 1983, MSM was identified as the exposure category for 4,499 cases (34.6%), followed by NRI (4,432/34.1%), heterosexual sex (2,337/18%), and IDU (932/7%). As with living cases, African Americans and Hispanics most commonly reported NRI as an exposure, while whites most commonly reported MSM.

**Geographic distribution**
Mississippi differs from most other states in that a large proportion of HIV/AIDS cases are from rural areas (areas with fewer than 50,000 people). According to the Centers for Disease Control and Prevention (CDC), in 2006, approximately 45% of AIDS cases first reported in Mississippi occurred among residents of rural areas (164 of 364 cases). This is a significantly higher percentage than for the United States as a whole, where 7% of 2006 AIDS cases were rural and also a much higher rate than the South as a region, where rural cases accounted for 10% of 2006 AIDS cases. A high proportion of rural HIV/AIDS cases poses extra challenges for effective care and services delivery.

There are HIV cases in every county in Mississippi. However, there is significant geographic variation. Public Health District (PHDI) V, which encompasses Jackson, had by far the most cases reported in 2009 (218). District IX, the coastal region including Gulfport, was second with 76. In a similar range were Districts I, in northwest Mississippi bordering the Memphis metropolitan area (62 cases); III, the Delta/Hills region of west Mississippi (67 cases); and VIII, the southeast region (63 cases). PHDs I, II, V, VIII, and IX also had the highest incident case rates. Less affected districts included II, northeast Mississippi (27 cases); IV, east Mississippi (33 cases); VI, east central Mississippi (36 cases); and VII, southwest Mississippi (28 cases). Missippi’s PHDs are shown in Appendix A.
The 10 counties with the highest incident HIV case rates per 100,000 population in 2009 are listed below. The statewide rate was 20.8 per 100,000 population.

1. Carroll (86.8)
2. Clarke (63.3)
3. Coahoma (58.7)
4. Tunica (57.4)
5. Hinds (54.9)
6. Benton (49.3)
7. Claiborne (46.1)
8. Attala (45.8)
9. Sunflower (45.6)
10. Washington (36.3)

The 10 counties with the highest incident HIV case numbers in 2009 were:

1. Hinds (136)
2. Harrison (39)
3. De Soto (35)
4. Rankin (29)
5. Forrest (23)
6. Jackson (23)
7. Washington (20)
8. Coahoma (16)
9. Jones (16)
10. Madison (15)

For living cases of HIV disease as of December 31, 2009, the PHDs with the highest case rates were V (562.1 per 100,000 population), III (415.8), IX (277.9), VIII (264.3), and VII (264.1). PHDs with the highest numbers of living cases were V (3,552 cases), IX (1,237), III (957), VIII (797), and I (751).
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National Comparison
Because national statistics take longer to compile than state statistics, the latest comparative numbers available by the time of publication are through 2008. According to the CDC, the national AIDS case rate in 2008 was 12.3 cases per 100,000 population, as compared to 12.6 in Mississippi, ranking Mississippi ninth among states.12

Mississippians are more likely to be infected with AIDS13 through heterosexual contact and less likely to be infected through injection drug use than the national average. Mississippi has nearly half the average proportion of new cases attributed to IDU—12.8% compared to the national average of 25.8%. Mississippi’s cases are more likely to stem from heterosexual contact, with 31% reported cases attributed to heterosexual contact, compared to 18.0% nationally. The rate of MSM infection in Mississippi is similar to the national average (46.8% and 47.3%, respectively).14

In Mississippi, a lower percentage of 2008 AIDS cases occurred in whites than the national average, with 14.9% of AIDS cases in Mississippi occurring in whites, as opposed to 27.8% of cases nationally. Conversely, a higher percentage of Mississippi AIDS cases occurred in African Americans (80.3%) than nationally (48.3%). Hispanic residents of Mississippi (2.1% of cases) were much less likely than Hispanics nationally (20.7%) to be diagnosed with AIDS in 2008.15 Females in Mississippi were more likely than average to be diagnosed with AIDS in 2008, as 33.7% of cases in Mississippi were female, compared to 25.9% nationally.16

Funding
In fiscal year 2009 (FY09), Mississippi received $27.1 million in federal funding for HIV/AIDS prevention, education, care, and services. Among Southern states (including Alabama, Arkansas, Florida, Georgia, Louisiana, Mississippi, North Carolina, and South Carolina), Mississippi received the second least amount of funding, ranking ahead of only Arkansas ($12.8 million). In addition, Mississippi contributed $750,000 from the state General Fund for HIVAIDS programs. Most of Mississippi’s HIVAIDS funding is administered by the Mississippi State Department of Health (MSDH) STD/HIV Office (see the following budget chart).

FY09 Total Federal HIV/AIDS Funding to Mississippi

<table>
<thead>
<tr>
<th>Source</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ryan White Program Funding</td>
<td>$ 18,993,056</td>
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<tr>
<td>CDC* HIV/AIDS</td>
<td>$ 5,770,497</td>
</tr>
<tr>
<td>HOPWA**</td>
<td>$ 1,739,542</td>
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<tr>
<td>SAMHSA*** HIV/AIDS Funding</td>
<td>$ 676,454</td>
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<tr>
<td>OMH**** HIV/AIDS Funding</td>
<td>$ 0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$ 27,179,549</td>
</tr>
</tbody>
</table>

*Centers for Disease Control and Prevention
**Housing Opportunities for People with AIDS
***Substance Abuse and Mental Health Services Administration
****Office of Minority Health

Source: Kaiser Family Foundation, statehealthfacts.org

2010 MSDH STD/HIV Office Funding – Projected/Estimated

<table>
<thead>
<tr>
<th>Source</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title II Part B (Ryan White)</td>
<td>$ 14,305,464</td>
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<tr>
<td>Comprehensive STD Prevention Systems Projects</td>
<td>$ 1,401,526</td>
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<tr>
<td>HIV/AIDS Prevention</td>
<td>$ 2,113,284</td>
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<tr>
<td>Medical Monitoring Project</td>
<td>$ 295,856</td>
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<tr>
<td>HIV/AIDS Surveillance</td>
<td>$ 475,386</td>
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<tr>
<td>HOPWA (City of Jackson)</td>
<td>$ 856,000</td>
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<tr>
<td>HOPWA (Mississippi)</td>
<td>$ 749,000</td>
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<tr>
<td>State General</td>
<td>$ 750,000</td>
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<tr>
<td>Rapid HIV Testing PS 07768</td>
<td>$ 690,000</td>
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<tr>
<td>Adult Viral Hepatitis</td>
<td>$ 65,057</td>
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<tr>
<td>Hepatitis C (Donation)</td>
<td>$ 65,000</td>
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<tr>
<td><strong>Total</strong></td>
<td>$ 21,766,573</td>
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</tbody>
</table>

Source: MSDH, STD/HIV Office
part II: profile of Mississippi

STATE ECONOMIC PROFILE

Mississippi is one of the poorest states in the nation. Although the state’s gross domestic product (GDP) was $95.9 billion in 2009, ranking it 35th in the nation, on all measures of individual income Mississippi ranks the lowest of any state. The per capita real GDP in 2009 was $22,634 (adjusted for inflation).16 This was the lowest per capita GDP in the country, falling 29% below the national average of approximately $42,000.18 The average annual growth rate of Mississippi’s GDP—4.17%—is lower than the average annual growth rate of the national GDP, which was 4.30% for the 1999-2009 period.22 Mississippi’s GDP contributed 0.68% of the total United States GDP in 2009, a decrease of 0.2% since 1997, but a slight (0.1%) increase over 2008.21

Median household income in Mississippi was $36,646 in 2009, representing a decrease of 2.9% from the 2008 level of $37,749. The national median household income in 2009 was $50,221. Mississippi’s median household income in the three-year period from 2007 through 2009 was $36,650, ranking it lower than every other state.23 However, Mississippi is also among the states with the lowest cost of living.24

The percentage of people living below poverty level in Mississippi is the highest in the nation, particularly in the state’s rural areas.25 Statewide, 20.8% of Mississippians lived below the poverty level in 2008, compared to 13.2% nationwide.26 In rural areas, the rate was 24%, with the economically depressed counties of the Delta region suffering from significantly higher poverty rates, ranging from 30%-50%.27

Similar to the nation as a whole, Mississippi’s unemployment rate rose significantly during the economic recession in 2009 and early 2010. The rate stood at 6% in January 2008, growing to 8.2% in January 2009, 11% in January 2010, and a high of 11.6% in March 2010. Since then, unemployment in the state has begun to decrease, with the August 2010 rate at 10% and the September 2010 rate at 9.8%.28 The rate in Mississippi has been consistently higher than the national unemployment rate, which was 9.6% in August and September 2010.29

As a percentage of 2009 GDP, Mississippi’s largest industries are government (18.5%), real estate and rental and leasing (9.2%), nondurable goods manufacturing (9%), durable goods manufacturing (8%), and retail trade (8%). Real estate and government contributed the most to the growth in Mississippi’s GDP, whereas durable goods manufacturing and construction declined.31

Although government and real estate/rental and leasing account for the greatest contributions to Mississippi’s GDP by industry, the state itself presents agriculture as its top industry. Approximately 29% of the state’s workforce is employed in agricultural jobs, contributing $6.3 billion to the state economy. Mississippi contains approximately 42,000 farms covering 11 million acres—or 38% of the state—with the average farm size at 273 acres. Mississippi’s top agricultural crops include poultry and eggs, forestry, soybeans, corn, rice, and catfish.32

As of 2009, Mississippi’s ten largest employers were Northrop Grumman Shipbuilding, University of Mississippi Medical Center, Mississippi Band of Choctaw Indians, Sanderson Farms, North Mississippi Health Services, Harrah’s Entertainment, Nissan North America, Forrest General Hospital, Baptist Health Systems, and Beau Rivage Resort and Casino.33

Mississippi has three state income tax rates—3%, 4%, and 5%—with income brackets ranging from $5,000 to $10,000. These rates and brackets are the same for personal and corporate income. The state sales tax rate is 7%, with an additional 1% added for food and soda sold from vending machines. The 7% tax rate applies to food and groceries, with the exceptions of food purchased with the Supplemental Nutrition Assistance Program (SNAP, formally known as food stamps), produce sold by the farmer who grew it, and food purchased at certified farmers’ markets. This rate is slightly higher than the national average of 5.85%.35

Mississippi’s cigarette tax was increased in 2009 to $0.68 per pack. This was a $0.50 increase from the previous tax rate. The mean cigarette tax in all states was $1.34 in 2009. In 2009, Mississippi generated nearly $68 million in revenue from the tobacco tax (and over $100 million in tobacco settlement revenue in 2010). Mississippi’s gasoline tax is relatively low at $0.188 per gallon, ranking it 43rd in the nation.37

Although Mississippi’s conservative political culture has led the state to reject federal money in the past, including $56 million in stimulus funds for unemployment benefits in 2009, as of 2006, Mississippi was receiving $2.02 of federal spending for every $1.00 of federal taxes paid. This ranked the state second in the nation (behind New Mexico) for the greatest return of federal funds.38
STATE DEMOGRAPHIC PROFILE

Mississippi had a population of 2,951,996 in 2009, which represents a 9.1% increase since 2000. The population tends to be young, with a median age of 35.3, vs the national average of 36.7. The birthrate is higher than the national average; in 2007, Mississippi’s rate was 15.9 per 1,000 population, compared to 14.3 nationally.

According to 2009 US Census numbers, Mississippi is 60.5% white, compared to the national average of 79.6%, and 37.2% African American, vs the national average of 12.9%. While Mississippi has a comparatively high African American population, Hispanics/Latinos are underrepresented at 2.5% of the population, compared to 15.8% nationwide. Mississippi also has small Asian (0.9% vs 4.6% nationally) and American Indian/Alaska Natives (0.5% vs 1% nationally) populations. Mississippi also has around half the national average of people who identify as two or more races, 0.9% vs 1.7% nationwide.

Residents of Mississippi are less likely than in other states to have been born outside of the United States, as only 1.4% of Mississippi residents are foreign-born, compared to 11.1% nationally. In 2009, the overwhelming majority (98%) of Mississippi’s residents were citizens.

Mississippi is less densely populated than the average state. In 2000, there were 60.6 persons per square mile, while the national average was 79.6. Mississippi residents who live in more urban areas are more educated, less likely to be impoverished, more likely to be employed, and were less likely to have lost jobs from 2006 to 2009 than residents of rural areas. Urban residents have higher levels of education, at every level of education, than rural residents; for instance, in 2000, 31.7% of rural residents had not completed high school, compared to 21.0% of urban residents, and only 23.8% of rural dwellers completed some college, while 30.4% of urban residents did. The disparity in education likely helps to explain the difference in unemployment and economic figures. In 2008, the poverty rate in rural areas was 24.0%, which was significantly higher than the urban rate of 16.7%. In 2009, the rural unemployment rate was 11.1%, while the urban rate was 7.8%.

OVERVIEW OF STATE GOVERNMENT STRUCTURE AND POLITICAL ENVIRONMENT

Mississippi is a socially conservative state, where cultural norms related to race and religion have historically dominated the political landscape. This social and political background has an impact in the context of HIV prevention and care because it can lead to the existence of stigma around the disease, for instance, with respect to modes of transmission, including homosexual or nonmarital sexual activity. Mississippi is also fiscally conservative, with the state’s leaders at times declining federal funding for social services. For example, while Governor Barbour accepted some American Recovery and Reinvestment Act (ARRA) funds, in 2009 he rejected $56 million for unemployment benefits. However, federal Medicaid funding has at times been a large source of revenue for the state. Mississippi’s Executive Branch consists of a number of elected officials, including the governor, lieutenant governor, secretary of state, attorney general, state auditor, state treasurer, commissioner of agriculture, commissioner of insurance, three public service commissioners, and three transportation commissioners. The current governor is Haley Barbour, a Republican in his second four-year term of office. Governor Barbour is term-limited, so a new governor will be elected during the next election cycle. Mississippi holds its state officer elections in the years preceding presidential election years, so the next election for governor will take place in 2011. Governor Barbour is only the second Republican governor of Mississippi since the nineteenth century.

Although Mississippi governors have historically been Democrats, the state has voted for a Republican for US president in nine of the last ten elections, and the last time it voted for a Democratic candidate was in 1976, when Jimmy Carter—a southern Democrat—was elected. However, federal Medicaid funding also has at times been a large source of revenue for the state. Mississippi holds its state officer elections in the years preceding presidential election years, so the next election for governor will take place in 2011. Governor Barbour is only the second Republican governor of Mississippi since the nineteenth century.

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Other state agencies that have responsibility for implementing programs and policies related to HIV prevention and care include the Department of Education, the Department of Corrections, the Department of Mental Health, the Department of Human Services, and the Medicaid Division. The latter two agencies—Medicaid and Human Services—are executive agencies, with directors who are appointed by the governor, adding a political influence over the direction of the agencies.\textsuperscript{62} The governor has less institutional power than the legislature in Mississippi, but because the legislative session is short and the legislature does not have many staff members, the administrative agencies effectively are responsible for shaping the direction of state policy.\textsuperscript{63}

The Mississippi legislature is composed of a House of Representatives and a Senate.\textsuperscript{64} There are 52 state senators and 122 state representatives.\textsuperscript{65} Mississippi has single-member legislative districts, which means that each district elects only one representative for each house of the state legislature. State legislators are elected to four-year terms and may be reelected.\textsuperscript{66} The lieutenant governor serves as president of the Senate, and the House of Representatives elects its own speaker.\textsuperscript{67} The legislature convenes on the Tuesday after the first Monday in January each year, and the legislative session lasts for 90 days, except for every fourth year, when the session is 125 days.\textsuperscript{68} Most state legislators are not professional politicians—many have “day jobs”\textsuperscript{69} in other fields when the legislature is not in session.

As of October 2010, Democrats controlled the Mississippi legislature, with a 27-25 majority in the Senate and a 72-50 majority in the House.\textsuperscript{70} Approximately half of the Democrats in the Senate and the majority of Democrats in the House are African American.\textsuperscript{71} This is a change from most of the state’s history. Traditionally, Democrats in Mississippi—and throughout the South—were white, and racial tensions heavily influenced Mississippi politics throughout the twentieth century.\textsuperscript{72} As the national Republican Party grew more conservative, white conservative politicians in Mississippi migrated to that party, and legislative redistricting helped African American politicians gain state legislative seats as members of the Democratic party.\textsuperscript{73}

Recent legislative issues that have led to passionate debates in Mississippi include education funding, Medicaid funding, and tax increases, particularly the tobacco tax increase.\textsuperscript{74} When political issues are put to the public to decide, Mississippians tend to vote on the conservative end of the spectrum. In 2001, voters overwhelmingly decided to make Mississippi’s long-time state flag—bearing the Confederate battle flag—the official state flag after a legal challenge to its status led the state supreme court to hold that it had not previously been legally adopted.\textsuperscript{75} In 2004, Mississippi voted to amend the state constitution to ban same-sex marriage and the recognition of same-sex marriages performed in other states.\textsuperscript{76}

PART III: Mississippi’s political climate

Mississippi’s congressional delegation is representative of the political trends at the state level. Both of the state’s US senators, Thad Cochran and Roger Wicker, are members of the Republican party. Until 2010, there were three Democrats among its four representatives in the House, although two of them were affiliated with the conservative-leaning group of “Blue Dog Democrats.” In the 2010 election, those two Democrats were replaced by Republicans, changing the balance of seats in the state so that now only one congressional district and no senate seats in Mississippi are held by Democrats. Mississippi has only one majority-minority legislative district, represented by the state’s only African American congressperson, Bennie Thompson.

GENERAL HEALTH

Infant mortality and life expectancy

Mississippi has a higher infant mortality rate than the national average. The infant mortality rate in the state was 10.6 (per 1,000 live births), compared to the national average of 6.8, from 2004-2006. The highest rates of infant mortality occur in African American infants, both in Mississippi (15.4 per 1,000 live births) and nationally (13.5). In comparison, white infants have a rate of 6.8 in Mississippi and 5.7 nationally, while Hispanic infants have a rate of 5.7 in the state and 5.5 nationally.\textsuperscript{77} The life expectancy at birth in Mississippi is 73.9, compared to 78.0 nationally.\textsuperscript{78}

Health status and behaviors

The life expectancy and infant mortality rates mentioned are indicators that Mississippians are less healthy than average Americans. A national study released in December 2010 ranked Mississippi as the least healthy state for the ninth year in a row based on health determinants including infant mortality, premature deaths, percentage of children in poverty, and preventable hospitalizations.\textsuperscript{79}

Obesity is a significant public health problem in the state of Mississippi. A total of 67.8% of adults were obese or overweight in 2009, compared to 60.8% nationally.\textsuperscript{80} Like other health issues in Mississippi, obesity and overweight figures vary by racial and ethnic group. African American and Hispanic Mississippians have higher rates of morbidity than white residents, figures that mirror national trends; 73.2% of African American Mississippi residents, 70.1% of Hispanics, and 64.9% of white Mississippians were overweight or obese in 2009. Nationally, the figures were 66.4%, 63.2%, and 60.2%, respectively.\textsuperscript{81}

In 2009, 11.6% of Mississippi’s population had been diagnosed with diabetes, compared to 8.3% nationally.\textsuperscript{82} The prevalence of diagnosed diabetes (per 100 adults) was 9.7% in Mississippi compared to 5.5% nationally in 2005.\textsuperscript{83} A total of 22.7% of Mississippians smoke, while the national average is 18.7%.\textsuperscript{84}
A separate but equally serious public health problem is the rate of infectious disease, particularly sexually transmitted diseases (STDs), in Mississippi. In 2008, Mississippi ranked first among states in chlamydia (728.1 per 100,000 persons, compared to 401.3 nationally) and first in gonorrheal infections (256.8 per 100,000 persons, compared to 111.6 nationally). In addition, Mississippi also ranked eighth for syphilis infections. Such rates are inherently problematic and suggest high rates of unprotected sexual contact that has serious implications for controlling the spread of HIV.

Death rates and causes
Mississippi also has a higher death rate than average. In 2007, Mississippi’s death rate was 943 per 100,000, compared to 760.2 nationally. The statistics also show uneven mortality rates among races. In 2006, white Mississippians had a lower death rate than their African American counterparts (902.8 vs 1,121.5), while the rates in both populations were higher than the national averages (764.8 for whites and 982.2 for African Americans).

Males have a higher death rate than females, both in the United States and in Mississippi. The 2006 rate per 100,000 people was 793.9 for females and 1,187.4 for males in Mississippi (compared to 658.1 for females and 926.0 for males nationally).

10 Leading Causes of Death in Mississippi (per 100,000 population)

<table>
<thead>
<tr>
<th>Cause</th>
<th>Total</th>
<th>White</th>
<th>Non-White</th>
<th>Rate Total</th>
<th>White</th>
<th>Non-White</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Heart Diseases</td>
<td>7,487</td>
<td>5,098</td>
<td>2,389</td>
<td>253.6</td>
<td>285.7</td>
<td>204.6</td>
</tr>
<tr>
<td>2. Malignant Neoplasms</td>
<td>6,093</td>
<td>4,132</td>
<td>1,961</td>
<td>206.4</td>
<td>231.5</td>
<td>168.0</td>
</tr>
<tr>
<td>3. Accidents</td>
<td>1,635</td>
<td>1,152</td>
<td>483</td>
<td>55.4</td>
<td>64.6</td>
<td>41.4</td>
</tr>
<tr>
<td>4. Emphysema/Chronic Lower Respiratory Diseases</td>
<td>1,553</td>
<td>1,300</td>
<td>253</td>
<td>52.6</td>
<td>72.8</td>
<td>21.7</td>
</tr>
<tr>
<td>5. Cerebrovascular Disease</td>
<td>1,422</td>
<td>927</td>
<td>495</td>
<td>48.2</td>
<td>51.9</td>
<td>42.4</td>
</tr>
<tr>
<td>6. Diabetes Mellitus</td>
<td>897</td>
<td>434</td>
<td>463</td>
<td>30.4</td>
<td>24.3</td>
<td>39.7</td>
</tr>
<tr>
<td>7. Alzheimer’s Disease</td>
<td>696</td>
<td>737</td>
<td>159</td>
<td>30.4</td>
<td>41.3</td>
<td>13.6</td>
</tr>
<tr>
<td>8. Nephritis, Nephrotic Syndrome, and Nephrosis</td>
<td>698</td>
<td>367</td>
<td>331</td>
<td>23.6</td>
<td>20.6</td>
<td>28.4</td>
</tr>
<tr>
<td>9. Influenza and Pneumonia</td>
<td>578</td>
<td>401</td>
<td>177</td>
<td>19.6</td>
<td>22.5</td>
<td>15.2</td>
</tr>
<tr>
<td>10. Septicemia</td>
<td>537</td>
<td>333</td>
<td>204</td>
<td>18.2</td>
<td>18.7</td>
<td>17.5</td>
</tr>
</tbody>
</table>

Minority populations are more likely to be uninsured, with 22% of African Americans and 48.5% of Hispanics uninsured, compared to 17% of whites.

In Mississippi, fewer private sector employers offer health insurance to their employees than the national average (48.7% vs 55%). The coverage offered is generally more expensive for employees than the national average, with employers contributing a lower share of the cost. For example, in 2009 the average employee cost for a family premium in Mississippi was $3,907 (vs $3,474 nationally), while employers paid $8,683 (vs $9,533).

In 2009, 19.6% of Mississippians reported that they could not see a doctor because of the cost, compared to 14.9% nationally. This ranks Mississippi second in the US (behind Texas).

Uncompensated care
Uncompensated care places a high burden on Mississippi’s hospitals. For example, from FY08-FY09, North Mississippi Health Services, which includes six hospitals and affiliated clinics, saw uncompensated care increase from $56.6 million to $70.8 million. Bad debt and uncompensated care totaled $400,000 a day (twice the national average cost). Baptist Memorial Hospitals in New Albany, Oxford, and Booneville had around 17% uncompensated care (totaling approximately $86 million) in 2009, which included charity care, unreimbursable Medicaid services, and bad debt.
HEALTH SERVICES CAPACITY

Primary care
Mississippi has 9 public health districts, and each of the state’s 82 counties has a local health department office that provides a number of services, including free HIV testing.108 Out of the state’s 82 counties, 77 counties or parts of counties were designated as health professional shortage areas (HPSAs) in 2010.109 Mississippi’s rate of residents living in primary care shortage areas was almost three times the national average (31.9% vs 11.8%).109

There are approximately 5,606 “active licensed physicians” in Mississippi, 2,216 of whom are primary care physicians.110 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.111

Mississippi had 37,105 active registered nurses (RNs) and 2,222 nurse practitioners (NPs) as of June 2009.112 Mississippi began licensing physician assistants (PAs) in 2000, under the State Board of Medical Licensure, which also regulates the licensing of physicians.113 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.114

There are approximately 1,503 licensed dentists in Mississippi. Similar to the distribution of physicians throughout the state, most dentists are concentrated in the Jackson and Gulf Coast metropolitan areas; 74 counties or parts of counties are considered dental HPSAs, and 14 counties have just one or no dentists at all.115

There are 164 Medicare-certified Rural Health Clinics in Mississippi as of June 2010.116 The state also has 98 community hospitals, which amounts to 4.5 hospital beds for every 1,000 people.117 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.118

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.119 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.120 Over 20% of the state’s total population, as well as over 20% of the uninsured population, live in these 26 counties.121 In places like the Delta region, the lack of primary care providers leads people to seek such care in hospital emergency rooms.122 It has been estimated that Mississippi spends over $250 million annually on avoidable emergency room care.123

Mental health and substance use facilities
The Mississippi Department of Mental Health (DMH) directly operates six psychiatric facilities and other facilities that provide inpatient mental health and substance use treatment.124

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.125 Many CMHCs provide both inpatient and outpatient care, although they have a higher capacity for outpatient services.126 Services can include prevention services, employee assistance programs, counseling, outreach/aftercare services, primary residential services (including detoxification services), transitional housing services, vocational counseling, and emergency services.127 Sixty-nine “community-based ‘satellite centers’” affiliated with the CMHCs are located throughout the state.128 Thirteen of the 15 mental health regions are designated as HPSAs for mental health services.129

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.130

Because of the shortage of providers and the fact that the CMHCs are the only facilities in the state that offer a sliding scale fee arrangement for individuals without insurance or who are unable to pay full rates, the wait to be admitted for treatment can be from 30-60 days, with longer waits for access to inpatient facilities or for treatment outside of an individual’s home region.131 This situation has been made worse by state budget cuts to mental health services.132 In 2008, Mississippians were more than twice as likely as other Americans to live in a mental health professional shortage area (40.2% vs 18.7%).133
An Analysis of the Successes, Challenges, and Opportunities for Improving Healthcare Access

PROGRAMS SERVING PEOPLE LIVING WITH HIV/AIDS

There are a variety of ways that people living with HIV/AIDS in Mississippi can receive care and services, including the Ryan White Program, the AIDS Drug Assistance Program (ADAP), Housing Opportunities for People with AIDS (HOPWA), Medicaid, the Children’s Health Insurance Program (CHIP), Medicare, and Substance Abuse and Mental Health Services Administration (SAMHSA)-funded programs.

Ryan White Program

The Ryan White Program is the country’s largest federally funded program specifically for people living with HIV/AIDS. It provides care and services to people without other sources of coverage or ability to pay.

Part A of Ryan White provides “emergency assistance to Eligible Metropolitan Areas and Transitional Grant Areas that are most severely affected by the HIV/AIDS epidemic.” Mississippi does not receive Part A funding, with the exception of four counties in north Mississippi that receive services through Memphis’ Transitional Grant Area funding—Tunica, Tate, DeSoto, and Marshall. Eligible people in these areas still receive ADAP funding through Mississippi.

Part B provides a base grant for a state, the ADAP award, ADAP supplemental grants, and grants to states for emerging communities (EC), communities reporting between 500 and 999 cumulative reported AIDS cases over the most recent five years. In FY09, Mississippi received $14,305,464 in Part B funds. This included approximately $7.6 million for ADAP and $285,111 in EC funding. Part B funding goes to the Mississippi State Department of Health (MSDH) in Jackson.

Part C funds outpatient primary care for HIV-positive individuals. This funding goes directly to clinical sites, rather than through the state health department. Mississippi received $3,219,681 in Part C funding in FY09. Appendix B contains a map showing the Part C grantees.

Part D provides family-centered outpatient and ambulatory care for women, infants, children, and youth with HIV. In FY09, Mississippi received $1,035,223 in Part D funding. Providers funded by Part D include the University of Mississippi Medical Center, the Mississippi Circle of Care in Jackson, and Southeast Mississippi Rural Health Initiative in Hattiesburg.

Part F funds a variety of different programs. In FY09, Mississippi received $284,032 for Community-based Dental Partnership programs and $148,656 in Special Projects of National Significance (SPNS) funding. Mississippi is part of the Delta Region AIDS Education and Training Center (AETC), which also includes Arkansas and Louisiana. Part F funding goes to Louisiana State University, with Mississippi’s AETC funded as a subgrantee.

AIDS Drug Assistance Program

Eligibility, Utilization, Formulary, and Administration

ADAP helps provide antiretroviral medications and certain other drugs to low-income, HIV-positive individuals. To be financially eligible for Mississippi ADAP, an individual must have household income less than 400% of the federal poverty level, and meet certain medical requirements. People enrolled in Medicaid, Medicare, or private insurance that covers HIV medications are not eligible for ADAP. ADAP 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.
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In July 2010, there were 1,048 clients enrolled in ADAP and 788 clients who filled prescriptions. From January 1, 2010 to July 31, 2010, there were 450 completed applications or reapplications to ADAP, with 91 pending, and 31 Medicare Part D gap clients enrolled.111 As of October 2010, Mississippi ADAP had no waiting lists or other cost-containment measures, although the state is currently considering cost-containment measures for FY12.112 The ADAP formulary includes 54 medications (both antiretroviral and general formulary drugs).113

Mississippi ADAP operates through a central pharmacy run by MSDH—all prescriptions are filled by the central pharmacy, and medications are then sent to a county health department office of the client’s choosing, where they need to be picked up. ADAP recently adopted measures to streamline prescription processing by initiating direct provider-to-pharmacy management of all prescriptions, except for when the client is a new enrollee or re-enrollee to the program.114 This should result in a more efficient process, and means that the central ADAP administrative office can focus on processing applications and re-enrollments, rather than acting as a middleman between providers and the pharmacy. The pharmacy is also hoping to implement electronic prescribing soon.115

Client Demographics

In 2007, ADAP served 1,151 clients in Mississippi, including 331 new clients.116 Sixty-nine percent were male and 31% were female.117 The majority (61%) were between 25 and 44, with 33% between 45 and 64.118 Mississippi ADAP clients are 77% African American and 23% white.119

Funding

In FY08, the total ADAP budget was $7,585,816. The vast majority (96%) of FY08 ADAP funding came from Part B earmarks (compared to 51% nationally) with Part B base funds (contributed by the state from Part B money) and drug rebates also contributing 1% and 3%, respectively. The FY09 ADAP earmark was $7,610,703. In FY11, the state General Fund will contribute $700,000 toward ADAP.120

ADAP as TrOOP

While Mississippi ADAP covers people in the Medicare Part D coverage gap (the donut hole), this coverage historically has not counted toward an individual’s true out-of-pocket (TrOOP) expenditures, thus preventing the individual from ever reaching the other side of the coverage gap. As of January 2011, as part of federal health reform, ADAP will count as TrOOP. This will enable Medicare Part D ADAP clients to reach the other side of the donut hole, where so-called “catastrophic coverage” begins and the federal government pays the majority of prescription costs.121

Housing Opportunities for Persons with AIDS

The United States Department of Housing and Urban Development (HUD) operates the HOPWA program, which grants funds to states, local governments, and nonprofit organizations so that they may provide housing assistance and related services to people with HIV and AIDS.122 Low-income individuals who are at or below 80% of the median income in their area and who are diagnosed with HIV/AIDS are eligible to receive HOPWA assistance for themselves and their families.123 In addition to housing-related services such as rental assistance, HOPWA grantees may provide support services such as case management, substance use and mental health treatment, and job training.124 Ninety percent of HOPWA funding is provided through HUD’s Formula Program, and 10% is allocated through the Competitive Program.125 Formula Program funding is based on Centers for Disease Control and Prevention (CDC) statistics about cumulative AIDS cases and incidence in a particular state or metropolitan area (this does not count HIV cases).126 To qualify for HOPWA funding, metropolitan areas must have a population greater than 500,000 and at least 1,500 cumulative AIDS cases. The largest city in the metropolitan area administers the funds.127

In Mississippi’s case, only the Jackson metropolitan area—which includes the five counties of Copiah, Hinds, Madison, Rankin, and Simpson—qualifies for city-based funding, and the City of Jackson serves as the grantee for this region.128 The state itself may receive funding for areas outside the qualifying metropolitan areas if there are 1,500 cumulative AIDS cases in other regions of the state.129 The state of Mississippi thus receives funding independent of the Jackson funding. However, both the Jackson and state HOPWA grants are administered by the MSDH. MSDH serves as the subgrantee for the City of Jackson grant, and the city’s funds may only be used to provide assistance for people in the five-county metropolitan area.130

HOPWA Competitive Program funding is provided for two kinds of programs: SPNS and new long-term projects. SPNS are innovative programs that can serve as models for other states and organizations, and long-term project grants are to provide housing and services in areas of the country that do not qualify for Formula Grants.131

In 2010, Mississippi received a total of $1,918,992 in HOPWA funds from the Formula Grant program. The state did not receive any Competitive Grant funds; $948,759 of the 10% Competitive Grant dollars was to the state, and the City of Jackson received $970,233.132 The last time Mississippi received Competitive Program dollars was in 2008 when Grace House, a transitional housing facility based in Jackson, received $1,267,393 for a three-year SPNS grant to increase the number of beds at the facility and develop a long-term housing
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HOPWA funds can generally be used for three main kinds of housing assistance—community residency, short-term, and tenant-based. Community residences provide on-site housing facilities for eligible tenants. Short-term rent, mortgage, and utility (STRMU) payments are considered emergency assistance to prevent homelessness. As such, recipients must currently have housing and may only receive STRMU payments for 21 of every 52 weeks, but they do not necessarily need to contribute to rent or mortgage costs. Finally, Tenant-based Rental Assistance (TBRA) programs provide rent subsidies to help people remain in permanent housing. Under TBRA programs, tenants must pay 30% of their income toward housing.

Additionally, owners of qualified residential facilities can apply for grants for capital improvements or construction and renovation of housing for those with HIV and AIDS. Short-term supported housing funds are available to facilities that temporarily house otherwise homeless persons living with HIV and AIDS and provide resources for finding more permanent housing. Eligibility of facilities is capped based on capacity (no more than 50 individuals or families at once), duration of stay (no more than 60 days in a 6-month period), and the provision of required housing search services.

States may decide which of these programs to fund with their HOPWA grants, so the available options differ between states. The primary form of funding in Mississippi is STRMU assistance. This means that individuals with HIV/AIDS must currently have housing to qualify for HOPWA assistance, and they may only receive that assistance for up to 21 weeks per year. Additionally, Mississippi requires HOPWA recipients to provide information about their sources of income, to be sure that they have the capacity to continue in their housing after the HOPWA assistance ends. There is not a requirement that individuals be employed, but if they are unemployed and do not have income from government benefits programs (such as Supplemental Security Income [SSI] or Social Security Disability Insurance [SSDI]), they must submit a letter of support from someone who has agreed to support them along with proof of that person’s financial capacity.

In addition to the short-term assistance, Mississippi also provides a limited amount of longer-term TBRA funding to individuals who have a letter from a physician stating that they are unable to work or to perform day-to-day functions. These individuals are then eligible for 12 months of HOPWA assistance, after which they are ineligible for further assistance for a period of 12 months. Under Mississippi’s TBRA program, as required by HUD’s national guidelines, recipients must contribute 30% of their income to housing costs. Most of the Mississippians who receive TBRA assistance have SSDI as their primary source of income, so they must use those benefits to meet the HOPWA contribution requirement. Only a very small number of the total HOPWA recipients—approximately 6 or 7 people—have been TBRA recipients in the last few years, the majority of whom lived in the Jackson grant area. This is the only long-term housing option available in Mississippi—the state does not provide permanent supportive housing.

Some of the state’s HOPWA funding under these programs has helped assist individuals living in one of the three transitional housing facilities in the state. Grace House in Jackson and 1-2-1 Haven House in Hattiesburg have received HOPWA funds from the state to cover rent for eligible recipients in their community residences. Augusta House in Biloxi was built with HOPWA funds. MSHD employs social workers for each of the nine public health districts to help residents apply for HOPWA assistance (and provide other HIV/AIDS-related services). Most districts have one social worker, but there are three in District V (which includes the Jackson metropolitan area), although one of these positions was vacant at the time of the writing of this report. The social workers submit the applications to MSHD, which determines the client’s eligibility and makes assistance payments directly to a landlord or mortgage company. In FY10, the state program served 478 people; numbers of individuals served through the City of Jackson program were still being calculated at the time of the writing of this report.

Medicaid

Mississippi Medicaid is Mississippi’s medical assistance program under Title XIX of the Social Security Act. It is jointly funded by the federal government and state government, and administered by the Mississippi Division of Medicaid. Medicaid covered 23% of the state’s population in 2009; 15% of white Mississippians and 37% of African Americans received coverage through the program, including 24% of females and 22% of males in Mississippi.

Funding/Enhanced FMAP

Mississippi has consistently had the highest federal medical assistance percentage (FMAP) in the nation. FMAP is the federal matching percentage for Medicaid spending, which takes into account states’ per capita income compared to the national average. This means that the federal government pays a higher share of Medicaid costs in poorer states than in wealthier states. For example, in 2010, Mississippi provided 15% of every dollar, while the federal government provided nearly 85%.
In 2009 and 2010, the American Recovery and Reinvestment Act (ARRA) instituted a temporary FMAP increase nationally through the end of 2010.\textsuperscript{184} ARRA funds were intended to compensate for the extra people eligible for Medicaid because of the recession.\textsuperscript{183} On August 10, legislation was signed extending the enhanced FMAP rate for six months into 2011, providing states with $161 billion through a phased-down enhanced match—3.2% beginning the first calendar quarter of FY11, then dropping to 1.2% in the second calendar quarter.\textsuperscript{184} In order for a state to receive the enhanced FMAP, the chief executive officer of the state must certify, no later than 45 days after enactment, that the state will request and use such additional federal funds.\textsuperscript{186}

According to an April 2010 report from the National Conference of State Legislatures, the Mississippi legislature passed its FY11 budget without assuming that the enhanced FMAP would be extended beyond December 31, 2010, but also passed House Bill 1059.\textsuperscript{184} HB 1059 directs the State Fiscal Officer to transfer up to $187 million of enhanced FMAP-generated savings to the budget contingency fund if the ARRA FMAP is extended.\textsuperscript{187} Mississippi Congressman Bennie Thompson has asked the Centers for Medicare and Medicaid Services to investigate this plan, as the federal legislation extending the ARRA FMAP (Public Law 111-226) specifically prohibits using the FMAP dollars for a rainy day fund.\textsuperscript{188}

| Mississippi Medicaid FMAP Rates, 2007-2010 |
|-----------------|-----------------|
| **Year (FY)**  | **FMAP Rate**   |
| 2007            | 75.89%          |
| 2008            | 76.29%          |
| 2009            | 84.24%          |
| 2010            | 84.86%          |

The average Medicaid payment per enrollee in was $4,080, compared to $5,163 nationally, in FY07. In addition, Mississippi Medicaid spending represented 6.6% of the state’s General Fund (revenue from “broad-based state taxes,” essentially the main fund for state operations), as opposed to the national average of 16.3%. The total Medicaid spending (which, unlike the General Fund amount, includes both “other state funds which are used to comprise the state share of Medicaid matching funds and federal funds”) was 22.4%, higher than the national average of 20.7%.\textsuperscript{184}

Eligibility

Mississippi has more stringent Medicaid eligibility criteria than other states. To be eligible, children (or their families) must be under 200% of the poverty level, compared to the national average of 235%. In addition, working parents must be under 44% of the poverty level, compared to 64% nationally, and pregnant women must be under 185%, as opposed to 133% nationally.\textsuperscript{185} In addition, there is no medically needy program,\textsuperscript{185} which means that beneficiaries cannot spend down “excess” income to be eligible for Medicaid.

Other than the income requirements, to qualify for Medicaid, a person must be a citizen or lawful permanent alien, a Mississippi resident, and meet disability and/or age, resources, and other eligibility requirements.\textsuperscript{186} There is an asset limit of $4,000 per single person and $6,000 per couple.\textsuperscript{184}

Potential Medicaid and CHIP beneficiaries have to apply in person at the Medicaid Regional Office or outstation site in the area and complete a face-to-face interview (including verification) for Medicaid enrollment and re-enrollment annually. In 2009, 48 states had eliminated the initial face-to-face interviews for Medicaid and CHIP enrollment;\textsuperscript{186} as of 2010, New York also eliminated the requirement.\textsuperscript{184} Thus, Mississippi is now the only state that continues to require a face-to-face meeting for Medicaid and CHIP enrollment. In addition, Mississippi is the only state that requires a face-to-face interview for Medicaid or CHIP renewal.\textsuperscript{187} Both requirements, particularly the renewal provision, place a significant burden on beneficiaries and likely discourage enrollment and re-enrollment.

Benefits/Programs

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.\textsuperscript{186}

For prescription drugs, beneficiaries are limited to five prescriptions a month, including two branded prescriptions.\textsuperscript{189} 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.\textsuperscript{189}

Many key Medicaid services are limited. Dental services, an access challenge for many HIV-positive individuals, are limited to trauma care and emergency treatment, essentially, tooth extraction. Medical and surgical dental services are subject to the same restrictions. Medicaid does not cover physical or occupational therapy, psychologist services, dentures, speech therapy, prosthetic or orthotic devices, or hearing aids.\textsuperscript{190}
**Medicaid and Mental Health**

Medicaid also offers some mental health programs in various treatment facilities, both inpatient and outpatient. Many are limited, though, and are only available to children (such as inpatient acute psychiatric care) or under very specific circumstances. Others require a specific diagnosis or prior authorization to be covered. Overall, access to mental health for Medicaid beneficiaries is limited. Some programs are available to both children and adults, including services in community mental health centers or a state hospital’s Community Services Division. Federally Qualified Health Centers and Rural Health Clinics also provide services to children and adults, based on visits (one medical and one mental health), all of which count against the service limits for adults. Acute psychiatric services are available to children and adults as part of hospital general psychiatric units, with prior authorization. In addition, adults may receive 12 visits for psychiatry services with a physician or nurse practitioner, which do not count against the medical visits. Finally, outpatient departments of general hospitals may provide mental health services, but acute freestanding psychiatric facilities are not covered for adults.

Mississippi Medicaid provides inpatient detoxification for chemical dependency, but this is limited to detoxification and does not cover alcohol and drug treatment. With a primary mental health diagnosis, beneficiaries may receive care under the rules for psychiatric units.

**State Children’s Health Insurance Program**

CHIP provides healthcare for uninsured children, generally those whose families make too much money to qualify for Medicaid. The income eligibility level for enrolling a child in CHIP in Mississippi was 200% of the federal poverty level ($36,620 for a family of three) in December 2009. In addition, income disregards for earnings, monthly childcare expenses, and child support received are factored into enrollment calculations, although child support paid is not.

CHIP has no premiums or deductibles, although it requires small copayments for some services to higher-income families. Like Medicaid, signing up requires in-person interviews for initial enrollment and annual re-enrollment. There are no exclusions for pre-existing conditions. CHIP covers preventive care, prescriptions, dental and mental health, hospital care (inpatient and outpatient), clinic visits, lab services, eyeglasses, and hearing aids.

**Medicare**

Medicare is a federally funded program that provides health coverage to people over age 65 who are eligible for Social Security, and to disabled people under 65 who are eligible for SSDI benefits. Medicare covered 13% of Mississippi’s population in 2009, compared to 12% of the population nationally. Medicare spending per enrollee in 2006 was $7,855 in Mississippi and $8,304 nationally. An estimated 100,000 people with HIV are on Medicare nationwide, which represents about 20% of HIV-positive people receiving care.

**Medicare and Mental Health**

Medicare Part A covers hospital inpatient mental health care, either in general hospitals or psychiatric hospitals. Inpatient care in a psychiatric hospital is limited to 190 days over a person’s lifetime.

Medicare Part B also helps cover costs for inpatient care

Medicare Part B covers outpatient services (both in hospital outpatient departments and other facilities, such as clinics). Services covered if they are a part of treatment include individual and group psychotherapy (with qualified providers), family counseling, psychiatric evaluation, medication management, occupational therapy, and testing to evaluate whether beneficiaries’ needs are met.

Medicare Part D prescription drug plans vary in their coverage. However, they are required to cover all or most antidepressant, anticonvulsant, and antipsychotic medications. Part D has a low-income subsidy for beneficiaries that meet certain income and asset guidelines. In Mississippi, 0.2% of Medicare beneficiaries are partial dual eligibles, meaning that they receive some assistance from Medicaid, while 2.1% of beneficiaries are full dual eligibles, which means that they qualify for full Medicaid benefits.

**Substance Abuse and Mental Health Services Administration**

Mississippi received $676,454 in SAMHSA HIV/AIDS funding in FY09. Of that funding, $254,320 was for prevention and $422,134 for substance abuse treatment.
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OTHER HIV-RELATED LAWS, REGULATIONS, AND POLICIES

Criminal transmission laws
Mississippi has criminal laws against transmission of HIV, as well as other laws that could result in criminal prosecution of people suspected of having HIV. For example, it is a felony to knowingly expose another person to HIV. Additionally, anyone suspected of having an STD is subject to examination and investigation by a representative of the state Board of Health, and refusing to comply may be punishable as a misdemeanor.

Corrections policies
As of May 2010, the Mississippi Department of Corrections (MDOC) is no longer housing male HIV-positive prisoners in a segregated unit at the state penitentiary in Parchman. Instead, those inmates will be housed with the general prison population. Female HIV-positive prisoners have not been housed in segregated units, and some HIV-positive male prisoners have been housed in nonsegregated, low-security facilities. Opponents of the segregation had expressed concerns about the policy of grouping nonviolent and violent offenders together in the unit; however, MDOC noted that the unit allowed prisoners to access specialized medical care. As of March 2010, there were 258 HIV-positive inmates in MDOC facilities, and 152 inmates from the Parchman facility were to be affected by the policy change (with the others unaffected because they were already housed in nonsegregated units).

Mississippi law requires correctional facilities to test inmates for HIV and other communicable diseases, but leaves the specific procedures up to the determination of the MDOC. MDOC tests prisoners upon their entrance to correctional facilities, with the Mississippi State Department of Health (MSDH) having processed entry HIV antibody tests since 1989. MDOC may also test inmates under other circumstances while they are incarcerated, but as of November 2010, does not test upon release from prison. Additionally, there is no specific plan for testing all inmates before they are transferred to another facility. Bill has been introduced in the state legislature to require testing of prisoners upon release, but they have not passed out of committee.

Sex education
Mississippi has the highest rate of teen births in the nation, with 71.9 births per 1,000 girls ages 15-19 in 2007 (up 5% from the 2006 rate), compared to 42.5 nationally. In 2005, Mississippi ranked fifth in the nation for teen pregnancy rates, with 85 cases per 1,000 girls ages 15-19. The national teen pregnancy rate in 2005 was 70 cases per 1,000. As of 2008, Mississippi also had the highest rates in the nation of certain STDs, including chlamydia and gonorrhea.

According to Mississippi law, schools are not required to teach sex education at all; however, if schools choose to teach sex education, state law requires that abstinence be the standard for this instruction. The Mississippi code explicitly identifies certain areas of instruction that constitute abstinence education. Instruction on contraceptives is permissible, "but only if such discussion includes a factual presentation of the risks (failure rates, diseases not protected against) of those contraceptives." Sex education instructors may not demonstrate how contraceptives are used, and school nurses may not dispense contraception to students.

Although the Mississippi code provides that any sex education program in schools "shall include instruction in abstinence education," it also allows (somewhat incongruously) for local school boards to implement by majority vote sex education programs that do not teach abstinence. Abstinence programs, and sex education programs in general, do not need to include all of the components of abstinence instruction listed in the code, but schools may not teach material that contradicts what is listed. As comprehensive sex education advocates have noted, "If these conflicting regulations make it difficult to ascertain what information may or may not be included in a sex education program." Mississippi law also includes an "opt-out" provision that requires parents to be informed in writing at least one week in advance whenever topics related to human sexuality are to be presented in schools and gives them the right to excuse their children from such instruction.

Mississippi schools are required to teach health education to all students, and the guidelines for doing so, along with suggested content, are contained in the 2006 Mississippi Comprehensive Health Framework (“Framework”) compiled by the state Department of Education. The Framework does not require students to learn about STDs, HIV, or pregnancy prevention, although for grades 8 through 12 these areas are included within the suggested curriculum. Additionally, the T.E.A.C.H. Mississippi Manual—a compilation of teaching strategies and resources for implementing the Framework—includes materials on HIV and STD transmission and prevention for grades 6 through 12. According to a Centers for Disease Control and Prevention (CDC) survey of school districts, a majority of Mississippi schools taught at least one topic related to HIV, STDs, or pregnancy prevention to grades 6 through 12, and several schools taught more than one. Topics included abstinence, transmission and prevention of STDs/HIV, and the risk of alcohol and drugs, among others. However, some school districts provide no sex education at all.

Some state legislators have tried to address the problem of sex education in public schools by introducing comprehensive sex education legislation. In the 2010 legislative session, a bill was introduced that would have required public schools to implement either an abstinence-only or abstinence-plus sex education curriculum, amending the state law that allows for—but does not currently mandate—sex education. This bill passed in the House, but it died in committee in the
The county health departments are the primary locations for HIV testing in the state. However, in some more populated areas, HIV testing is also performed at other healthcare facilities and AIDS service organizations, although not all of these facilities offer free testing. In addition to the county health departments, there are around 20 other organizations or medical centers that provide HIV testing, with most clustered in areas like Jackson, Biloxi, and Hattiesburg, and some located in the Delta region and eastern Mississippi. Additionally, residential facilities operated by the Department of Mental Health (DMH) and regional mental health centers are now able to perform rapid HIV testing or link any new intake patients to places where they can get tested. They do not have the capacity to confirm the tests at these sites, but will transport patients to a place where the test can be confirmed. The availability of HIV testing is now offered as part of DMH’s standard intake procedures. Patients in residential facilities who choose to be tested off-site are provided transportation by DMH.

Other policies
Mississippi is 1 of 17 states that do not provide state or local funding specifically designated for HIV prevention services; all of the state’s HIV prevention efforts are federally funded by the CDC’s Division of HIV/AIDS Prevention.

Mississippi has not operated a media or public education/outreach campaign focused on HIV prevention for many years. However, the Mississippi Department of Human Services has used federal abstinence-only-until-marriage grant money to fund an extensive media campaign promoting abstinence as a means to prevent teen pregnancy. Finally, there are no needle/syringe exchange programs in Mississippi. Such programs are neither expressly permitted nor prohibited by state law. Nevertheless, the state Uniform Controlled Substances Law appears to indicate that they are not legal, as it prohibits the transfer of drug paraphernalia—including hypodermic needles and syringes—if the transferor should reasonably know that the item is intended for illicit drug use. However, the prescription of syringes by licensed physicians is itself arguably legal in Mississippi if it is for a legitimate medical purpose—presumably including disease prevention—although it is a closer question whether the dispensation of syringes by pharmacists is legal. The transfer of syringes by anyone who is not a licensed physician or pharmacist acting under a valid prescription is almost certainly illegal under the statute.

One reason that there has not been discussion of expressly legalizing needle/syringe exchange programs in Mississippi is because injection drug use is not a significant mode of transmission in the state—the drugs of choice tend to be those that are ingested or smoked.
HIV/AIDS IN THE TRIBAL POPULATION

In the country as a whole, the Native American population has the third highest rates of HIV/AIDS (after African Americans and Hispanics), when adjusted for population size. In Mississippi, both the Native American population and the number of HIV/AIDS cases within this population is small. The Mississippi Band of Choctaw Indians is the only federally recognized tribe within the state. There are approximately 9,600 registered members of the tribe, and there are currently 7 HIV-positive persons in the tribal community.

In terms of risk factors for this population, it appears that HIV is, on the whole, being contracted outside of the tribe and brought back in by people who have lived outside the reservation for some period of time. The risk from intravenous drug use is low, as it is among Mississippians generally. Although there is a high rate of alcohol abuse within the tribe and there is an increase in substance use, injected drugs are not the drugs of choice for this population.

Most of the Choctaw members receive their healthcare through the Choctaw Health Department, which is part of the Indian Health Service (IHS), an agency of the US Department of Health and Human Services. The Choctaw Health Department provides a "one-stop-shop" for many different kinds of medical and behavioral healthcare for registered tribal members, as well as people with tribal affiliation from outside of Mississippi. The Health Department is funded through IHS as well as by the Mississippi Band of Choctaw Indians. The Mississippi State Department of Health (MSDH) maintains a connection with the tribal community through a liaison from its STD/HIV Office, although MSDH plays a limited role in providing services. Its primary role is to be sure that people are connected to care if they need it and to collect the surveillance and epidemiological information it needs.

IHS does not provide dedicated funding for HIV/AIDS services; however, HIV/AIDS programs are included within the projects that may be implemented with funding from other IHS budget areas covering medical services. In addressing the HIV/AIDS epidemic, IHS must be sensitive to the varying cultural beliefs and practices among tribal populations. The agency’s protocols for HIV/AIDS treatment are thus flexible to allow for tribal groups to create a program that serves their particular communities’ values and needs.

Native American communities and health centers are also eligible to receive Ryan White and AIDS Drug Assistance Program (ADAP) funding for their HIV/AIDS services; however, the Choctaw Health Department is not currently funded by those programs.

The Choctaw Health Department reports health data both to IHS and to MSDH, according to Mississippi state law. Although the follow-up procedures for tribal members testing positive for HIV may be different than for the nontribal community in the rest of the state, the case reporting requirement is the same, so MSDH collects surveillance data from the tribal community.

Tribal members generally choose to receive their healthcare at the Choctaw Health Department. However, they are eligible to receive care at MSDH facilities if they choose to go outside of the tribal community for privacy or other reasons. In this case, they are provided with the same treatment options as other MSDH patients. HIV testing is available at the Choctaw Health Department. The Health Department recently changed its testing policies, and it no longer requires pretest counseling. Since this change was implemented, the Health Department has seen an increase in the number of patients requesting HIV tests. If an individual tests positive, he or she is referred to the Behavioral Health Department, where they will learn about the importance of changing risky behaviors and complying with the medication regimen.

Two of the most significant barriers to HIV/AIDS prevention and treatment in the Native American community are stigma and fear of lack of confidentiality within the small communities. Because of the small size of the Choctaw community, this is a particularly salient issue. People are reluctant to be public about being tested because of immediate social stigma that attaches to that act. The Choctaw Health Department is sensitive to this issue and works to keep patient information as confidential as possible. Additionally, the Health Department implements education and outreach programs to inform the community about HIV/AIDS and to reduce the stigma associated with the disease. The Health Department holds health fairs, does outreach within other community organizations, and visits persons in the tribal detention facility, covering topics such as sexual education and explaining what resources are available to community members. The Department does outreach to people of all ages, including children as young as 5 and 6 years old, to dispel myths about the disease.
HEALTH LITERACY, EDUCATION, AND STIGMA

Background
Health literacy is defined in the US Department of Health and Human Services’ (HHS) Healthy People 2010 report as “(t)he degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.” Health literacy includes a wide range of skills that allow people to find, understand, assess, and use health information to make informed choices, reduce health risks, and improve quality of life. Health literacy depends not only on the abilities of the patient to understand and use information, but also on the skills of care and services providers to communicate information in a way that is accessible.

A 2010 report from HHS notes that nearly nine out of ten adults have difficulty using everyday health information and that limited health literacy is associated with worse health outcomes and higher costs. Populations most likely to experience limited health literacy include minority racial and ethnic groups, people with less than a high school education or GED, individuals with income at or below the federal poverty level, people with disabilities or other health issues, and people who are not literate in English.

Challenges
The compromised health status of many Mississipians, including many living with HIV/AIDS, reflects limited health literacy. Health literacy in Mississippi is intricately interwoven with issues of poverty, classism, racism, homophobia, lack of educational opportunity, social conservatism, religious views, and stigma. Health literacy also reflects overall literacy, with one survey estimating that 16% of Mississippi adults lack basic literacy skills. Limited health literacy has serious consequences for both individual and public health, as well as economic consequences. One study estimated the national cost of low health literacy to be $106-$236 billion annually, and potentially much higher when future costs were considered.

In the context of HIV/AIDS in Mississippi, limited health literacy means that there is widespread misinformation among the general public around even basic facts about HIV transmission. It means that families often do not have the knowledge to teach their children how to reduce their risk of contracting STDs or HIV—information that many Mississippi youth are not receiving in school. For people living with HIV/AIDS, limited health literacy means that they may not access care and treatment effectively—or at all.

As noted above, health literacy is bound up with a number of other factors. Two that are particularly relevant in the context of HIV/AIDS are inadequate education and stigma. In a sort of vicious circle, limited health literacy both results from and helps create inadequate education and HIV-related stigma.

Education—school-based
As previously discussed, Mississippi has no statewide requirement for comprehensive, evidence-based sex education in public schools—in fact, the state has no requirement for sex education at all. If school districts choose to teach sex education, state law requires that it include abstinence instruction. But confusingly, state law also allows the 152 local and regional school districts to have sex education that teaches something other than abstinence, as long as it doesn’t contradict the components of abstinence listed in state law. Community partners note that this framework leaves individual school districts unclear about what they are allowed to do.

While Mississippi does have a state requirement for health education, the Comprehensive Health Framework does not require (only suggests) instruction in STDs, HIV, or pregnancy prevention. A Centers for Disease Control and Prevention (CDC) survey found that the two topics related to STDs, HIV, and pregnancy prevention that were taught most in grades six through eight in Mississippi were the benefits of abstinence and how STDs and HIV are transmitted. The least taught topics were how to access reliable information and services about STDs and HIV and compassion for people living with HIV. For grades 9 through 12, the least taught topics were skills-based (communication/negotiation, decision-making, goal setting) and condom-related (efficacy, importance of proper use, how to obtain). The high teen pregnancy rate and rates of STDs clearly demonstrate that Mississippi youth are not following the teachings of abstinence-only education. The CDC Youth Risk Behavior Surveillance found that 61% of Mississippi high school students reported having sex at least once (compared to 46% nationally), with 13.4% having had sex for the first time before age 13 (vs 5.9% nationally). Mississippi ranks first in the country in both of these categories. Young people in Mississippi are not getting the information and materials they need to make informed choices and take responsibility for their own health. As one advocate notes, “These girls don’t understand how they got pregnant, let alone how they got an STD.” Another advocate who has worked with young men who have sex with men (MSM) found the level of misinformation about HIV among them to be “off the charts.”

Social and economic determinants
Limitations in education and resources are particularly relevant in the context of HIV/AIDS, as they are tied to social and economic determinants. Social conservatism, religious views, and stigma are perhaps the most publicized, but are not the only factors. Health literacy also reflects overall literacy, with one survey estimating that 16% of Mississippi adults lack basic literacy skills. Limited health literacy has serious consequences for both individual and public health, as well as economic consequences. One study estimated the national cost of low health literacy to be $106-$236 billion annually, and potentially much higher when future costs were considered.

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Community partners observe that in Mississippi’s socially, culturally, and religiously conservative environment, sex and health education is seen as a responsibility belonging to the family, rather than the schools, and that parents often believe that talking to their children about sex will make the children think that the parents condone them being sexually active. Even if they were willing to talk to their children about sex and health issues, many parents themselves never received adequate health education and do not have the knowledge to convey, perpetuating a cycle of limited health literacy.

Education—general public
In addition to the inadequate education in public schools, people living with HIV/AIDS and community-based providers report widespread lack of knowledge and awareness about HIV/AIDS among the general public. Stories abound of people being given paper plates to eat from and being told to wash their clothes separately when it was known that they were HIV positive. One consumer participant from the Delta shared that her mother took her children and would not let her have physical contact with them, because the mother believed that HIV could be transmitted simply by touching. These stories reveal a striking lack of health literacy about HIV in terms of how the disease can and cannot be transmitted. A misperception persists that AIDS is a disease affecting only gay men—one health educator noted that it is a challenge to get people to accept that “it’s not who I am, it’s what I do.”

According to community partners, there is also a lack of awareness of the treatment options and prognosis after an HIV-positive diagnosis, with many people not understanding the difference between HIV and AIDS and believing that being diagnosed with HIV means that death is imminent. In fact, HIV can often now be managed as a chronic illness, especially when diagnosed and treated early. This limited health literacy can lead people to avoid HIV testing to learn their status if they think that nothing can be done.

Education—people living with HIV/AIDS
It is not a coincidence that HIV and AIDS disproportionately impact populations identified as being more likely to experience limited health literacy, including minorities and people living in poverty. The same limited health literacy that can lead to a lack of awareness of risk for HIV can also compromise access to care for people who know that they are HIV positive. Studies by both the Agency for Healthcare Research and Quality (AHRQ) and the Institute of Medicine (IOM) have found that limited health literacy is associated with poorer management of chronic conditions, including HIV/AIDS. 148

With HIV disease, early medical intervention and treatment generally can preserve health and delay the progression to AIDS. But partly due to low health literacy, some people diagnosed with HIV may not understand the importance of early and consistent access to medical care. On one hand, someone diagnosed with HIV may feel fine and not see the need to engage with care because they do not understand the disease processes occurring inside their bodies. On the other, one infectious disease doctor observes that many patients believe that HIV still equals an acute disease with imminent death, and due to their lack of knowledge, do not understand that treatment exists that can often allow HIV to be managed effectively as a chronic illness. People living with HIV/AIDS in Mississippi note that widely available information and education about chronic disease management, presented in a format that is culturally competent and literacy-level accessible, does not exist in the state.

HIV-related stigma
Stigma was the challenge to accessing care and services most cited by SHARP participants around the state. HIV-related stigma is a multifaceted, nuanced phenomenon, deeply connected to other forms of prejudice and discrimination, including racism, homophobia, and classism. Low health literacy is one of the factors perpetuating stigma and discrimination against people living with HIV/AIDS, as lack of knowledge leads to fear and incorrect assumptions about both HIV disease and people living with it. At the same time, stigma connected to HIV/AIDS drives people away from information and services that could improve health literacy.

HIV/AIDS stigma in Mississippi—as in other states—is partly due to the association of HIV with behaviors often considered shameful, such as MSM, promiscuity, and injection drug use. In Mississippi, community partners note that the deep prejudice against homosexuality is particularly problematic, especially as HIV/AIDS is still widely perceived as a “gay disease.” Mississippi has been referred to as the “buckle of the Bible belt,” and the socially and culturally conservative climate, along with some churches’ condemnation of homosexuality, fuel HIV-related stigma. Among many examples, HIV service providers in north Mississippi told of one of their clients who, seeking compassion and support, disclosed to his pastor that he was living with HIV. The pastor told him to leave—that he was no longer welcome in the church and that he was damned. Stigma also ties in to Mississippi’s complex history of race and class relations, as HIV/AIDS disproportionately impacts African American and low-income communities. Some health providers and educators note that African Americans may mistrust public and private healthcare systems. African Americans, particularly MSMs, also may experience discrimination from within their own communities, such as from churches, which may preach that HIV is punishment for a “bad lifestyle,” rather than a health issue.
HIV-related stigma exists across the state, but can be particularly a problem in more rural areas of the state, where the “smallness” of rural communities and the fear of others “knowing their business” make people living with HIV/AIDS reluctant to seek care anywhere near where they live. SHARP participants around the state cite numerous examples of people traveling long distances for care to avoid going to the local clinic or county health department office because their cousin’s wife’s sister (or someone else they know) works there, and they fear, often rightfully, that their confidentiality will not be protected. As one community partner notes, “Forget six degrees of separation—in Mississippi, it’s more like two. Everybody knows everybody.”

Limited health literacy also affects the families and social networks of people living with HIV, which can worsen stigma because of not understanding how the virus is and is not transmitted (eg, that you cannot get HIV by sharing a drinking glass or utensils with an HIV-positive person). Stigma experienced in family and social settings, as well as the amplly supported belief that the public harbors widespread fear and negativity toward people living with HIV/AIDS, may lead to greater secrecy and social withdrawal on the part of those living with the virus. In this way, stigma affects people’s health-related decisions, including delaying HIV testing, putting off needed care, and not disclosing HIV status to sexual or drug-using partners or medical providers.

Stigma, like low health literacy, impacts both individual and public health. People who do not know they have HIV are more likely to transmit the virus, as are people who are not in care and have higher levels of the virus in their bodies. People who are late to enter care are often more ill. This can also lead to economic consequences in the form of lost productivity and the need for higher-cost medical interventions. Stigma also undermines public education about HIV by discouraging people living with the virus from disclosing their status and participating in education, outreach, and advocacy efforts.

**Successes**

There are efforts to improve health literacy, raise awareness and educate about HIV, and address stigma taking place around Mississippi. A few examples include: The Southern AIDS Commission, based in Greenville in the Mississippi Delta, has run social marketing campaigns featuring billboards and television and radio public service announcements to raise awareness about STDs and to promote HIV testing. Building Bridges, based in Jackson, works with young women to teach them how to make informed choices and protect their health. My Brother’s Keeper, also based in Jackson, is one of the pilot sites for the Black Treatment Advocates Network, a national initiative seeking to build a network of Black HIV/AIDS treatment advocates who can help improve health knowledge and links to care. Some African American sororities have incorporated HIV/AIDS prevention education into their activities, and some churches and faith-based organizations include HIV as part of health ministries and health fairs. For example, the New Jerusalem Church in Jackson incorporates practical HIV prevention education and information into its health ministry, and surveyed more than 5,000 church members to see whether they would seek HIV testing if it were available at church. Because a majority of members indicated that they would be willing to test at church, New Jerusalem is exploring bringing rapid HIV testing into the church setting. The state Department of Health and the Office of Healthy Schools in the Department of Education both report being invited by some schools to present information about HIV/AIDS to students.

**Opportunities**

Advocate for comprehensive sex and health education in public schools

Comprehensive, evidence-based, developmentaly appropriate sex and health education would improve students’ health literacy by giving them the knowledge and tools they need to make informed decisions and take personal responsibility for their health. One of the goals of the HHS’ National Action Plan to Improve Health Literacy is to “incorporate accurate, standards-based, and developmentally appropriate health and science information and curricula” from early childhood through the university level; the report notes that lack of consistent health curricula across grades K through 12 may reduce student health literacy. Education raising health literacy would also help combat HIV-related stigma, which in turn would help reduce barriers to people living with HIV/AIDS accessing care. SHARP participants note that the current Mississippi law on sex education is confusing for many school districts, and that in the absence of a mandate from the state, many local school districts provide minimal instruction. While a bill to allow “abstinence plus” education passed the House in the last state legislative session, it died in the Senate. Advocates and others should continue to pursue a change in state law to require (or at least permit) comprehensive sex and health education, including education on HIV/AIDS.

Create an antistigma campaign using social media

In 2009, the Western North Carolina AIDS Project (WNCAPI) launched a media campaign to combat stigma in largely rural western North Carolina. Entitled “You need to know,” the campaign is designed to raise awareness about how HIV/AIDS affects everyone in the community, not just people living with the illness, and to show support for people living with HIV/AIDS. The campaign features television public service announcements, as well as an online petition with a goal of collecting 5,000 signatures, and makes use of social media sites as well as more traditional media like posters, bumper stickers, and billboards. The
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campaign is privately supported by the Cable Positive Foundation, with a local production company and cable channels also donating time and talent. WNCAP’s campaign could be a model for a similar campaign in Mississippi, and antistigma efforts in other southern states can also be explored. Incorporating social media such as Twitter, Facebook, and MySpace into an antistigma campaign may also be an effective way to reach younger audiences. Any social marketing campaign should be developed with input from its local target audience, to ensure that messages will be effective in reaching people.

The recently launched Greater Than AIDS campaign is a partnership of the Kaiser Family Foundation, the Black AIDS Institute, and corporate partners including Clear Channel Communication and Essence magazine to respond to the severe and disproportionate impact of HIV/AIDS among black Americans and to confront stigma. The multiphase campaign has a toolkit of free materials available that can be downloaded and printed or posted.

Support and expand the “Health House” model and ensure inclusion of HIV/AIDS

The Mississippi Health House Network is a model that uses trained and certified Community Health Workers (CHWs) as the foundation of health networks in rural or urban disadvantaged areas. The health house coordinates care with the second and third levels of the healthcare network (community health centers, clinics and hospitals, respectively) to maximize healthcare efficiency and effectiveness. CHWs, who come from the communities in which they work, conduct health assessments and screenings, make referrals, and educate about health issues, including HIV. The Health House Network is being launched in Jackson and communities in the Delta, with plans to expand as funding permits. Dr. Aaron Shirley, Mississippi medical pioneer and creator of the Jackson Medical Mall, is spearheading the project. The Health House Network presents an important opportunity to include education and counseling about HIV, resource referrals, and potentially rapid HIV testing in a community setting.

Seek help from supportive clergy and tailor messages

While many churches remain silent or are actively stigmatizing about HIV/AIDS, there are some churches, both African American and white, that have been supportive of people living with HIV/AIDS and that have shown a willingness to include HIV prevention and services into their ministries. Guidance should be sought from leaders of these churches about the most effective ways to reach out to other clergy and the messages that might resonate with them about the need for both HIV prevention education and compassion for people living with HIV/AIDS. As with any culturally competent efforts, initiatives with faith communities (both clergy and congregants) need to both understand where people are coming from and meet them where they are. One potential framework and source of information is the HIV/AIDS Manual for Faith Communities and accompanying curriculum, developed by Vivian Berryhill of the National Coalition of Pastors’ Spouses, based in Memphis, in conjunction with the HHS.

Advocates should urge supportive pastors to participate in testing campaigns by encouraging their congregations to get tested, volunteering at testing events, and getting tested themselves. National HIV Testing Day and World AIDS Day present annual opportunities for faith leaders to get involved. Similarly, supportive faith leaders can attend community events, such as health fairs, along with AIDS service organizations and health providers. By simply being present at these events, faith leaders can show their support for and decrease stigma about individuals living with HIV/AIDS.

Support federal funding for faith-based initiatives

At the federal level, Representative Charles Rangel (D-NY) introduced The National Black Clergy for the Elimination of HIV/AIDS Act of 2009 (HR 1964), a bill that would authorize $50 million in grants each year from 2010 to 2014 for public health agencies and faith-based organizations to conduct prevention and testing activities as well as outreach efforts. The legislation currently has 48 cosponsors, including both Democrats and Republicans. Senator Kirsten Gillibrand (D-NY) introduced the bill (S.3011) in the Senate in 2010. No Mississippi representatives or senators are cosponsors of the bills. Advocates should contact their representatives to make sure they are aware of this legislation, and urge them to sign on to the bills as cosponsors.

Routinize voluntary HIV screening

In 2006, the CDC announced new recommendations for HIV testing, recommending that voluntary, opt-out HIV screening be part of routine medical care for everyone aged 13 to 64. The recommendations were designed to increase early HIV diagnosis among the estimated 250,000 Americans who do not know that they are HIV positive, and to bring people into care earlier, when they can best benefit from new treatments. Increasing the number of people aware of their HIV status is a key element in prevention and care efforts. Earlier knowledge of HIV status benefits both individual and public health, and also has economic benefits in the form of lower-cost medical interventions and prolonged productivity. Routine, voluntary, opt-out (ie, giving people the right to decline to be tested) screening can also be a way to destigmatize HIV. Making HIV screening a regular part of medical care, like cholesterol tests or blood pressure screening, can help “normalize” HIV and make it less intimidating. If everyone were tested for HIV, the stigma, blame, and shame currently often associated with HIV testing could be markedly reduced.
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STRUCTURE AND SYSTEMS ISSUES—STATE GOVERNMENT AND COMMUNITY-BASED PROVIDERS

Challenges

GOVERNMENT STRUCTURE AND SYSTEMS

“Siloization”
There are many different state government agencies in Mississippi with programs involving HIV/AIDS issues and that work with people living with HIV/AIDS, including the Departments of Health, Mental Health, Human Services, Education, and Corrections, and the Division of Medicaid. Both government officials and community-based providers note that there is not necessarily adequate communication, coordination, and collaboration among these agencies. For example, while the Departments of Health and Corrections have worked together on medical care for HIV-positive inmates and issues of HIV and STD prevention, the Mississippi Department of Corrections (MDOC) did not coordinate with the Mississippi State Department of Health (MSDH) around recent policy changes involving prisoners living with HIV/AIDS.290

There appear to be very few, if any, official mechanisms for sharing information and coordinating policies and programs. The “silo” effect, where each agency operates independently, can result in inconsistent policies across state government that may further complicate access to care and services for people living with HIV/AIDS. However, SHARP participants report that some communication between agencies happens informally, and upon her appointment as State Health Officer, Dr. Currier has been proactive in reaching out to other agencies to identify areas of common interest.

MSDH-related issues
One of the issues raised by participants at the September 2010 Jackson Town Hall meeting was the attitudes and tactics of some MSDH Disease Intervention Specialists (DIS). The role of DIS includes notifying people of positive HIV test results, counseling about risk reduction behaviors, inquiring about sexual or drug-using partners who may be at risk, helping link individuals into care, and making referrals for services. SHARP participants in various regions of the state mentioned incidents of DIS being disrespectful, harassing, and sometimes threatening toward clients, as well as violating client confidentiality, such as by contacting clients’ employers. A DIS encounter can and should be a key point of support, counseling, and active linkage to care for people newly diagnosed with HIV, but the approach of some DIS workers has alienated people from future contact with the Department of Health and from other systems of care. To their credit, MSDH officials have acknowledged problems within the DIS program and the need to revise DIS training and the department HIV Interview Record used by DIS, in which, among other things, HIV-positive individuals must sign a form acknowledging that the “necessity of not causing pregnancy or becoming pregnant” has been explained to them.

SHARP participants voiced that, historically, there have been issues of inadequate communication and lack of transparency between MSDH, community-based providers, and people living with HIV/AIDS. Community members express frustration at what they view as a lack of collaborative process and a “top down” approach on the part of MSDH. Conversely, the perspective from the MSDH side has been that the community expects the Department to do everything and has not demonstrated a long-term commitment to advocacy. The reality most likely lies somewhere in between, and trying to determine which position has more validity is not necessarily helpful in moving forward in a more collaborative way or conducive to finding creative solutions to difficult challenges.

COMMUNITY STRUCTURE AND SYSTEMS

AIDS services organizations/community-based organizations
With the exception of the Hattiesburg area (see “Successes” below), similar “silo” issues to those in state government also exist among AIDS service organizations (ASOs), community-based organizations (CBOs), and community-based healthcare providers. SHARP participants report a fragmented community structure and comment that cooperation and collaboration among ASOs, CBOs, and other providers is limited. This is probably due, at least in part, to competition for very limited resources. Compounding the issue is the fact that Mississippi has very few ASOs—some parts of the state, like northeast Mississippi, have no ASOs. There are very few “one-stop” ASOs that provide prevention education and testing, as well as supportive services like case management. There has also not been a consistent, statewide HIV/AIDS grassroots advocacy network, again probably at least partly due to a lack of resources. There is a shared statewide computer network/database for clinical care, but due to resource constraints, this network is currently available only to clinical care providers, not ASOs.

Integration of HIV/AIDS into other care systems
As is true in many states, HIV/AIDS care and services are not always integrated into other care systems and settings in Mississippi. In particular, SHARP participants comment that some community health centers are not “pulling their weight” when it comes to accepting and treating individuals living with HIV/AIDS. This is probably related to several factors, including the insurance status of many people living with HIV/AIDS, the perception that specialized training is necessary to provide HIV/AIDS care, and HIV-related stigma.
In light of federal health reform, HIV/AIDS care will need to be integrated into other healthcare systems. Lessons learned from the care and services systems created through the Ryan White Program over the past 20 years (such as the “medical home” concept) can help inform best practices for HIV care. Any new resources for healthcare are more likely to be associated with health reform implementation, such as the $11 billion allocated for community health centers over the next five years. While there will still certainly be a need for Ryan White programs after implementation of health reform, an HIV-specific care system is unlikely to be sustainable in the long term.

**Successes**

*“A Call for Change” town hall community discussion*

In September 2010, three CBOs (A Brave New Day, AIDS Action in Mississippi, and Mississippi in Action) organized a town hall discussion in Jackson between the HIV/AIDS community and the MSDH. The catalyst for the meeting was the desire of the HIV/AIDS community to express concerns related to MSDH policies and practices and to weigh in on the criteria used in the search for a new director of MSDH’s STD/HIV Office.

Top health department officials, including State Health Officer Dr. Mary Currier, State Epidemiologist Dr. Paul Byers, Director of the Office of Communicable Diseases Joy Sennett, and District VII and VIII Health Officer Dr. Thomas Dobbs attended, as did state representatives Stephen Holland and John Hines, Sr. People living with HIV/AIDS and other advocates from around the state had an opportunity to voice their concerns directly.

As important as any specific message from the meeting is the fact that it occurred—that the highest-ranking public health official in Mississippi and other senior staff came out to listen to members of the HIV/AIDS community. Dr. Currier has acknowledged that there are issues within the MSDH that need to be addressed (some of which are discussed in the following section), and has made a commitment to continue the conversation, ensuring that the Jackson meeting will not be a one-off event. Representative Holland, who chairs the Public Health and Human Services Committee, also pledged to convene a forum at the Mississippi state legislature to raise awareness about HIV/AIDS issues when the next legislative session begins; Representative Hines will help plan this event.

This willingness to have open, public communication between government officials and community members bodes well for future efforts to improve access to care for people living with HIV/AIDS.

**Opportunities**

*Continue community-government dialogue*

As mentioned previously, State Health Officer Mary Currier has committed to continuing the conversation begun at the September 2010 meeting in Jackson. Community advocates should take Dr. Currier up on this offer. MSDH has indicated its willingness to examine and change problematic practices and policies, and should work with the community in doing this. Both MSDH and the community can take steps to create a more collaborative relationship going forward with clearer communication and a more transparent process.

*Consider creating a consumer advisory board and/or a consumer office within MSDH*

While MSDH has advisory bodies for prevention, care, and services required as conditions of federal funding that include people living with HIV/AIDS, there is not a statewide consumer advisory board (CAB). Statewide CABs exist in other states [Arkansas recently established one] to advise health departments and involve people living with HIV/AIDS in decisions about the systems of care that directly affect them. MSDH should consider creating a CAB. MSDH could also explore the possibility of creating a consumer office, staffed by a person living with HIV/AIDS, within the STD/HIV Office, as some other states have done. The primary advantage of an internal consumer office is that the perspective and experience of a person living with HIV/AIDS and representing consumers would be incorporated into the day-to-day operations and decisions of the office. The consumer office manager could be the liaison between the STD/HIV Office and Mississippi consumers, helping to achieve better communication and greater transparency, and to promote better understanding of MSDH policy and program decisions among consumers. Having a consumer as part of MSDH staff could also engender more trust and support of the Health Department on the part of consumers.
Explore creating an interagency working group on HIV/AIDS

To address the “silosiation” issue among different state government agencies, Mississippi could explore creating an interagency working group on HIV/AIDS, involving all the agencies that work with HIV/AIDS clients and issues, and including the governor’s office, key state legislators, and community representatives. This could help create more coordinated policies and programs and use resources more efficiently. Community partners note that similar models have been used for other health issues, such as the Teen Pregnancy Prevention Task Force.

Establish a cooperative network of community-based providers

To address the “silosiation” issue among ASOs, CBOs, and other providers, Mississippi can look next door to Alabama for an example of a cooperative network. The AIDS Service Organization Network of Alabama (ASONA) includes the executive directors of ASOs, CBOs, and healthcare facilities from around the state. ASONA members meet regularly to update each other on organizations’ activities, and to coordinate around funding, policy, and advocacy issues. ASONA was a key part of the advocacy coalition that secured $5 million in state funding for Alabama’s AIDS Drug Assistance Program in 2010. ASONA members have divided up responsibility for different regions of the state to ensure that an individual living with HIV/AIDS anywhere in Alabama can be linked with care and services. While this may be difficult to do in Mississippi because of the limited number of ASOs, creating some sort of more coordinated network could help use resources efficiently and enable more clients to access care and services.

Work to integrate HIV/AIDS into other systems of care

As noted, stand-alone models of HIV care may not be sustainable in the long term, particularly given health reform implementation. HIV/AIDS care and services will need to be integrated into other care settings, including community health centers. Some Ryan White providers in Mississippi are already Federally Qualified Health Centers (FQHCs); others could explore becoming FQHCs. Integrating HIV/AIDS care and services into other care systems can also have the added benefit of helping to reduce HIV-related stigma.

TRANSPORTATION

Challenges

Transportation was universally mentioned by community partners as one of the main obstacles to accessing care. Transportation is a challenge in both rural and more urban areas. Public transportation is virtually nonexistent in rural areas, and is limited even in more urban areas. Where public transportation exists (usually bus routes), service often is infrequent, or is set up in such a way that it is not efficient to get from place to place. One community partner notes that even though her agency is on a bus line, because of bus schedules and routes, it can take clients 2 hours to get to the clinic—a trip that would take 20 minutes by car. Clients may not be able to afford bus fare, and resource-strapped AIDS service organizations may not have funding consistently to assist with transportation costs.

In poor, rural areas, many residents do not have cars. Even if households have a vehicle, family members may have to share access to it, and may not be able to afford gas, maintenance, or insurance costs. Cars may be unreliable over long distances, such as highway travel; because of the rural nature of Mississippi, the nearest provider might be far away. A 2006 poll conducted in 11 Delta counties found that 25% of respondents traveled 16 miles to more than 30 miles to reach primary healthcare providers. To access specialized care, more than 44% traveled over 30 miles, and approximately 15% reported not accessing specialized care at all. This problem is magnified for people living with HIV, as Ryan White providers are geographically spread out around the state (see map in Appendix B), and service areas necessarily span wide distances. Some patients travel up to 50 miles to receive care at the Jackson-based University of Mississippi Medical Center, which provides transportation to patients living within this distance. Some travel even further—one north Mississippi provider would take clients three hours each way to Jackson to receive dental care.

Stigma worsens already serious problems with transportation. Consumers and providers around the state observe that because of stigma and confidentiality concerns, people living with HIV, particularly in rural areas, are often reluctant to go to healthcare facilities in their own communities. One Gulf Coast-area consumer notes that his friends receive care in New Orleans or Mobile to avoid being seen at a local clinic. Community partners recount many incidents of disclosure of HIV status (usually from front office staff), indicating that these are realistic fears. Even if people are willing to use a clinic in their area, many HIV-positive individuals have not disclosed their status to their families or friends, so they are often uncomfortable asking for a ride to the clinic, even if they have family or friends with access to private vehicles.
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The federal Ryan White Program requires that at least 75% of Part B funds be spent on “core medical services,” with a maximum of 25% available for support services. Under Ryan White Part B, transportation is considered a core medical service, meaning that any transportation expenses must come out of the 25% of funds allowed for support services. Ryan White–funded transportation services have been narrowly defined to mean transportation solely to and from HIV-related medical services, provided directly or through a voucher to the client. This interpretation limits options potentially available to clients. Ryan White policy precludes direct cash payments to clients, and transportation for purposes other than medical-related services is not allowed, although the program does allow organizations to use funds to purchase or lease vehicles for client transportation.

In Mississippi, a proposal to use Ryan White Part B funds to purchase vehicles was rejected due to concerns about excessive driver expense and high maintenance and insurance expenses. Community partners in north Mississippi note that with Ryan White transportation, clients must come up with the money to get to their appointments first—they cannot get reimbursed for gas until they prove that they have attended their appointment.

Mississippi Medicaid does provide some transportation, known as the Non-Emergency Medical Transportation Program, and managed by LogistiCare Solutions, LLC. Beneficiaries have to call 72 hours in advance to ensure that they receive rides. Consumers and providers alike report that Medicaid transportation can be inconvenient and not user-friendly for clients—one provider calls it “terrible”—and that it can take most of a day to get to and from a short medical appointment.

The lack of access to reliable and affordable transportation seriously compromises the ability of Mississippians living with HIV to access care. Particularly when transportation difficulties collide with other issues—fear of confidentiality breaches, denial about diagnosis or the seriousness of the problem, and stigma—patients often simply do not show up for appointments.

Successes

Clinic-based transportation assistance

Several clinics around the state have tried to make gas cards or gas vouchers available to patients to help defray the cost of getting to their appointments. For example, the Crossroads Clinic in Jackson has experimented with $5 gas cards, providing people with small amounts of money to help offset the cost of getting to their appointments.

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Jackson Medical Mall

Both service providers and consumers lamented the lack of “one-stop shops” in Mississippi—places where people living with HIV/AIDS could get all the medical and social services they needed in one place, without needing to travel around to multiple sites. An excellent one-stop shop model, though not necessarily specific to HIV, is the Jackson Medical Mall (JMM). The Jackson Medical Mall is a great example of coordinating access to care by putting various health services providers, pharmacies, and access to health information in one centralized location that is easily accessible to patients. Created from an abandoned mall in Jackson, Mississippi, JMM is a mix of healthcare providers, social/human service agencies, state and city government offices, university classroom and conference space, retail shops, and restaurants.

Southeast Mississippi Rural Health Initiative in Hattiesburg also provides gas vouchers for patients to cover the cost of transportation to the clinic. Coastal Family Health Center in Biloxi also provides assistance with gas vouchers and bus passes. For patients whose primary difficulty with obtaining transportation is gas money, this should help increase the rate of appointment retention. However, this assumes that people have access to vehicles, which may not be the case. In addition, people might be hesitant to ask to borrow one from family or friends because it would mean disclosing information about their health.

Aaron E. Henry Community Health Services Centers, which is based in Clarkdale, realized that transportation was an issue for its patients, so it purchased its own fleet of buses and vans in order to help provide transportation. Their transportation system is called “Delta Area Rural Transportation System” (DARTS) and vehicles are used both to bring patients to appointments and also to provide transportation for work commutes and community events. Providing transportation for a fee for these other purposes helps offset the cost of providing free transportation to patients visiting the clinic. DARTS is part of a larger regional network of transportation providers, called Delta Rides. This is a network of nonprofit organizations within the Delta region that provides public transportation, both door-to-door services that require advanced reservations and regular fixed routes. While underfunded and not optimal for regular transportation services, Delta Rides might serve as a useful template to expand upon for more comprehensive public transportation. Any such system would need to have oversight provisions in place to ensure that the needs of medical transportation clients were prioritized equally with other riders’ needs.
The University Medical Center Adult Special Care Clinic and the Crossroads Clinic are both housed at JMM. By allowing people to access many services in one centralized location, JMM eases transportation barriers. This approach is efficient because entire families can consolidate healthcare needs in one facility and make appointments accordingly. An additional benefit for people living with HIV/AIDS is that, because JMM houses so many different providers, requesting a ride there does not imply anything about HIV status.

Opportunities

Explore agency vehicle purchase, volunteer driver networks, or certification as transportation provider

One possibility to expand transportation options is for community-based organizations to organize transportation themselves. For example, they might seek grant funding to purchase a van or other vehicle and provide the transportation themselves (similar to the Aaron E. Henry clinic’s model). Using a network of volunteer drivers to take people to appointments is another possibility. Finally, AIDS service organizations could also explore the process for becoming certified as Medicaid transportation providers. While these options all raise questions of liability and insurance, such issues are not necessarily insurmountable.

Investigate coordination with other transportation resources

Advocates and providers could investigate coordinating with other transportation systems and resources. One example is Mississippi’s Division of Aging and Adult Services, which has nearly 300 vehicles to drive seniors to various destinations (including medical appointments). In this service, transportation is provided by local civic and community groups and Area Agencies on Aging, in coordination with programs funded by the Mississippi Department of Transportation. In some locations, the Area Agency on Aging provides transportation to individuals besides seniors (e.g., as part of the Delta Rides network). Alternatively, there might be ways to use other vans or buses in the community. Local schools, Head Start programs, and churches have vehicles that are not in use during the day. The strength of this approach is that it works with the infrastructure already present in a community.

Advocate at the federal level for Ryan White change

Transportation arguably should be considered a core medical service under Ryan White, particularly in rural areas. If clients have a medical provider and appointment, but no way to get there, the net effect is the same as if they had no provider. The idea of categorizing transportation as a core service was raised during the last Ryan White reauthorization process in 2009, but ultimately was not included. Advocates should work with others in rural states to seek this change in future Ryan White reauthorizations.

Bike or car sharing

Bike or car sharing might be feasible options, particularly in the Jackson or Gulfport/Biloxi areas. Bike-sharing programs exist at the University of Mississippi in Oxford and at Mississippi State in Starkville. One model for a car-sharing program is Zipcar, which serves other southern cities such as Tuscaloosa, Alabama, and Greenville, North Carolina. This service is less expensive than car rental or ownership, but still poses barriers due to cost and the need for Internet access and a credit or debit card to access the program.

Mobile health units

Mobile health vans might serve as a way to bring healthcare to people in their communities. The Mississippi State Department of Health (MSDH STD/HIV Office) successfully used a Centers for Disease Control and Prevention (CDC)-funded Mobile Medical Clinic and has worked to persuade officials at the Health Resources Services Administration that such an approach is an effective way to bring care to people living with HIV in low-access areas. Coastal Family Health Center in Biloxi and other coastal locations use mobile health units to bring prenatal care and pediatric primary and mental healthcare to patients. Because of stigma, it would be important that any such mobile program encompass more than just HIV-related care. While a clinic on wheels may not lend itself to more complex treatment, a mobile van could provide, at a minimum, health screenings and basic examinations and could potentially deliver medications.

HOUSING

Background

Safe, affordable housing is an integral component of coordinated care for people living with HIV/AIDS. The Mississippi Development Authority (MDA) has noted that housing is the largest unmet need for the HIV/AIDS population in the state. Accessing safe, affordable, and stable housing is a concern for many Mississippians, but it is particularly acute for people living with HIV/AIDS for a number of reasons. The stigma associated with the disease may lead landlords to consider them to be unattractive tenants. The inability to secure and maintain steady employment can lead to loss of income to pay for housing. Mental illness and substance use are often present as comorbidities in people living with HIV/AIDS, leading to further stigma and an inability to maintain
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stable housing. The confluence of risky behaviors, including drug use, that can lead to HIV infection may also lead to arrest or incarceration of a substantial number of infected individuals. Criminal records may disqualify these persons from employment or housing assistance programs once they are released from prison, thus making it even more difficult for them to access the care they need, or putting uninfected individuals at greater risk of infection. Addressing the housing problem is thus critical both for persons already living with HIV/AIDS and for preventing further transmission. Stable housing makes it easier and more efficient to connect people with care and other supportive services. People who are housed are more likely to keep their clinic appointments and adhere to their medication regimen, in part simply because many HIV medications require refrigeration and patients with a fixed address can be more easily contacted by case managers. Homelessness itself increases the risk of HIV transmission and progression of the disease. Studies have suggested that for each person stably housed for 24 months, 14 to 29 new HIV infections can be prevented, and that the death rate among homeless people with HIV is 5 times greater than for HIV-positive people who are housed.

The Housing Opportunities for Persons with AIDS (HOPWA) program, operated by the US Department of Housing and Urban Development (HUD), is the only federal funding program that is specifically dedicated to the HIV/AIDS population and the only HIV/AIDS-dedicated housing assistance program in Mississippi. However, HUD provides many other types of funding for different housing programs throughout the state, including Community Development Block Grants, Emergency Shelter Grants, Home Investment Partnership grants, Supportive Housing Program grants, and stimulus-funded Homelessness Prevention and Rapid Re-Housing (HPRP) grants. As detailed in the following paragraphs, funds from some of these other programs have been granted to AIDS service organizations (ASOs) in Mississippi to support their housing programs. Finally, Ryan White funds may be used to provide housing support to HIV/AIDS clients, but because housing (like transportation) is not considered a core medical service, it is limited to the 25% funding restriction for support services, as opposed to the 75% of funding required to go to core medical services.

In order to be eligible for many of the HUD funding programs, organizations must participate in a continuum of care, which is a network created to engage in coordinated planning efforts to assess and address the housing and homelessness needs of certain regions and communities. Mississippi has three continuas of care for homelessness. The Partners to End Homelessness Continuum of Care covers the 5 counties in the Jackson metropolitan area; the Open Doors Continuum covers 6 counties in the Gulf Coast region; and the Mississippi United to End Homelessness Continuum—also known as the Balance of State Continuum of Care—covers the remaining 71 counties. Two kinds of planning are required by HUD. At the state level, the MDA works with the continua of care to create a five-year Consolidated Plan that identifies housing needs and develops a strategic plan for meeting the state’s objectives in the nonentitlement areas of the state (areas that do not receive community development block grant funding). Each entitlement area—Jackson, Gulfport, Biloxi, Hattiesburg, and Pascagoula—drafts its own consolidated plan. A continuum of care plan is also drafted by the community groups within each continuum to guide the delivery of services to the homeless population.

Successes

Although Mississippi generally lacks transitional and permanent housing facilities for people with HIV/AIDS, the three transitional housing programs that do exist represent important successes for the communities they serve. As members of the continua of care for each of their regions, the programs help to build awareness among the broader homelessness prevention community of the challenges faced by people living with HIV/AIDS. 1-2-1 Haven House, which is affiliated with the AIDS Services Coalition in Hattiesburg, provides transitional housing and integrated services for up to ten residents, including on-site mental health counseling and case management. It receives HOPWA funding through its eligible residents, but requires all residents to remain active in the community by working or volunteering. Haven House is a member of the Mississippi United to End Homelessness/Balance of State Continuum of Care, and it accepts residents from throughout the area covered by that network. Besides the HOPWA rent assistance payments, Haven House is funded by a transitional housing grant from the HUD Supportive Housing Program, and outside private and public funders, including the City of Hattiesburg.

Augusta House is a transitional housing program in Biloxi operated by the South Mississippi AIDS Task Force (SMATF). It was built with HOPWA funds in 2003 and can house up to 12 residents. Because of its affiliation with SMATF, Augusta House is also able to provide supportive services to its residents, such as case management and counseling. SMATF has three (soon four) units of scattered site permanent housing funded through the HUD Supportive Housing Program. It is one of only two organizations providing permanent housing for people living with HIV/AIDS in the state. Besides HUD, Augusta House is supported by the City of Biloxi and private donors. It is a member of the Open Doors Continuum of Care.
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The other organization providing permanent housing services is Grace House in Jackson, which was the first transitional housing facility in the state and the first to provide permanent housing opportunities. Like the other facilities, Grace House also provides residents with case management and helps them access supportive services. The organization operates a total of five houses, two of which are for permanent housing. It has transitional housing beds for up to 12 men and 6 women, and 3 permanent housing beds at scattered sites.

Grace House is a member of the Partners to End Homelessness Continuum of Care, through which it was given HPRP stimulus funds to help people with HIV/AIDS and other disabilities with rental and utility assistance. In 2008, it was awarded a HOPWA Competitive Program grant of nearly $1.3 million that included funds for rehabilitation of housing facilities, operational funds for the transitional housing programs, and money to support a Tenant-based Rental Assistance (TBRA) program. HOPWA funding does not support the permanent housing program, but Grace House is currently applying for HUD Supportive Housing Program funding for the program. Grace House supports approximately 20 TBRA recipients and 12 HPRP recipients.

Another success in the housing arena is that providing housing for persons with HIV/AIDS is one of the six primary objectives outlined in the state Consolidated Plan prepared by the MDA. The MDA ranks the housing needs of this population as a “high priority,” meaning that MDA will dedicate funding to address it within the five-year period of the Plan (2010-2015). The Plan recognizes that there is a need to increase the housing options available to the HIV/AIDS population, including more long-term assistance for HOPWA recipients and more scattered site housing (housing that is provided in multiple locations, rather than in one HIV/AIDS-dedicated structure).

Challenges

The Consolidated Plan and transitional housing opportunities are so important in Mississippi because of the general lack of housing resources and the broader challenges faced by the HIV/AIDS population in accessing affordable, stable housing. Because of the 25% restriction on funding of supportive services through Ryan White and the inconsistent availability of rental and utility assistance from ASOs, HIV housing must be paid for mostly with HOPWA funds, which are inadequate to meet need. Additionally, there is not enough stock of accessible and affordable housing dedicated to HIV/AIDS patients. There is no other dedicated HIV/AIDS housing besides the three transitional housing programs.

Although those facilities provide essential services to the HIV/AIDS community, they are insufficient on their own to meet the need, and there is a 24-month limit on residence in transitional housing under the Supportive Housing Program.

HOPWA is also insufficient as a funding source in some cases because it does not provide housing placement services or rental assistance to persons who are homeless. Individuals must already have secured housing to be eligible for Mississippi State Department of Health (MSDH) HOPWA assistance. However, homelessness is a reality for some Mississippians living with HIV/AIDS. In January 2009, more than 2,800 persons were estimated to be homeless in Mississippi, including 301 families with children and 876 people considered to be chronically homeless. In the state as a whole, the 2009 point-in-time count indicated that there were a total of 89 HIV-positive homeless persons—69 people in shelters and 20 unsheltered, with the majority in the Jackson area. This count likely under-represents the actual numbers because of the nature of a point-in-time count, which includes only the number of homeless individuals who are counted on one particular night. The 2010 point-in-time count conducted by Jackson-based Partners to End Homelessness surveyed people in shelters in Hinds, Rankin, and Warren counties and found that 26 people said that they had received HIV/AIDS services, 1 person reported needing services, and 8 people reported having been derided services.

For the nonhomeless population with HIV/AIDS, maintaining affordable housing can be a significant challenge. As of 2009, 44% of households in Mississippi spent 30% or more of their income on housing costs, which is classified as a “cost burden.” Experiencing a cost burden is one factor that leads a household to be counted as having an “unmet need.” Other factors include overcrowding and inadequate facilities like kitchens or bathrooms.

According to the MDA’s Consolidated Plan, there were 3,567 households with unmet need in the HIV/AIDS population.

Community partners note that the need is most likely much higher, and estimates are that at least half the people living with HIV/AIDS will need housing assistance at some point. MSDH currently does not have a formula for determining unmet HOPWA need, so it is unclear what that number might be. However, it is working with one of HUD’s approved technical assistance agencies, Alabama-based Collaborative Solutions, to establish the proper formula. HUD misinterpreted the information provided by the state, so its report that Mississippi has 0% unmet need is inaccurate, according to MSDH.

The number of households facing a cost burden is likely in part a result of increasing rental costs, particularly in metropolitan areas like Jackson and the Gulf Coast. The median monthly rent in Jackson in 2005 was $649, and in 2009 it was $715. In Gulfport, the 2005 median monthly rent was $634, which rose to $668 in 2009. In Mississippi as a whole, the median monthly rent was $538 in 2005 and $644 in 2009. For Hinds County, the 2009 rate was $725, and in the Delta region it ranged from $500-$600. MSDH determines HOPWA short-term rental, mortgage, and utility assistance payments according to the HUD calculation
of fair market rent by apartment size and county. In Hinds County in 2009, for example, a tenant living in a one-bedroom apartment would have received a maximum of $676 per month. In Harrison County, the amount would have been $722, and in Tallahatchie, a Delta county, it would have been $406. All of these assistance amounts are below the median monthly rental cost in each area. HOPWA recipients must pay any balance of the monthly rental cost above the HUD fair market rent value. The HUD fair market rental rates—and thus the HOPWA assistance rates—have risen only slightly in 2010.

In addition to paying the balance of their monthly rental costs, HOPWA tenants may only receive rental assistance for 21 weeks each year, so they are also responsible for paying for housing for the remaining 31 weeks. Short-term assistance is the only HOPWA funding available to the majority of the HIV/AIDS population in Mississippi. According to the MDA Consolidated Plan, in order to be eligible for longer-term assistance, tenants must be hospice eligible, which means that they have been diagnosed by a physician as having six months or less to live. This abrupt end to housing assistance after 21 weeks can cause hardships for individuals who are unable to work due to their health or who have histories of incarceration, mental illness, or substance use, because of the additional barriers they face to finding housing. The time-limited funding can lead to instability in housing, which, as noted, can have an adverse effect on the health of the individuals involved as well as negative public health consequences.

Additionally, Mississippi landlords have expressed the concern that they must turn away HOPWA recipients who cannot afford to sign a full-year lease, making it more difficult for recipients to find suitable housing. Even landlords who are sympathetic to the needs of persons with HIV/AIDS have indicated that they are financially unable to commit to tenants with only a short-term guarantee of rental assistance. Community members note that some landlords are not so sympathetic, relating stories of people getting kicked out of housing if the landlord finds out about their HIV status, and that some landlords think that the HOPWA program—which pays landlords directly instead of having the tenant pay—is a "scam," so they are skeptical about accepting HOPWA tenants.

These landlords’ responses to HOPWA tenants are also indicative of the broader problem of stigma, which is often cited as a barrier to persons with HIV/AIDS being able to access resources within their communities. Because of the stigma associated with HIV/AIDS, individuals may have trouble finding housing at all. In addition to landlords refusing to rent to persons with HIV/AIDS, community members have reported that some inpatient rehabilitation centers are not willing to take in this population.

Stigma can also lead to difficulty in finding employment to provide the income to pay for housing. Furthermore, the HOPWA assistance rates—have risen only slightly in 2010. advocating for more resources for housing

For people living with HIV/AIDS, housing truly is healthcare. There need to be more resources available to help people living with HIV/AIDS pay for rent and utilities. More housing case management could help ensure that people are stably and appropriately housed, as well as linked into other services and care. Advocates should also focus on increasing HOPWA funding for longer-term housing assistance and housing placement services. HUD regulations allow HOPWA grants to be used for both of these purposes.

Expand and act on the knowledge and strategies that already exist at the administrative level

The MSDH acknowledges in the Mississippi Statewide Coordinated Statement of Need (SCSN) that there is a need for improving the housing situation of the HIV/AIDS population. In particular, the SCSN notes the importance of long-term assistance and stable housing arrangements to patients’ maintenance of treatment. The MDA has similarly recognized the importance of providing more housing options and longer-term assistance. However, these documents lack specific strategies for translating these acknowledged needs into a plan for action.

The recognition of the importance of housing in treating and preventing HIV/AIDS that is reflected in the MDA Consolidated Plan and the Plan’s inclusion of HIV/AIDS issues in its broader discussion of housing needs are both critical and important steps forward. However, the five-year Consolidated Plan lacks specific objectives, and the one-year 2010-2011 plan only outlines the goals for the number of people to be served by the HOPWA program. The relevant administrative agencies should use these two planning processes to broaden their approach to HIV/AIDS housing by expanding the reach of their programs and working to address HIV/AIDS needs in a more holistic and integrated way, including thinking about problems such as housing placement, job retention, and antistigma outreach, as well as expanding the availability of long-term assistance. Agencies should define and implement specific, attainable steps to meet the objectives outlined in their plans and to address the needs they have acknowledged.
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Increase publicity and awareness of the programs that are available
The 2009 Housing and Community Development Survey queried 413 stakeholders throughout Mississippi. Although a significant number of respondents indicated that the HIV/AIDS population was a high-need group in the context of housing, a similar number responded that it was a medium-need group, 17 replied that there was low-need, and 11 respondents indicated that there was no need. Additionally, a substantial number of respondents indicated that there were either no HIV/AIDS services in their area or that they did not know if there were. Advocates and administrative agencies should publicize HOPWA more broadly to care and services providers and people living with HIV/AIDS throughout the state. Making information about applying for the program and the eligibility criteria more easily accessible online will help people know that they have the option of receiving housing assistance and will lead to more accurate estimations of unmet need. Publicity and outreach should also focus on increasing awareness among providers of the housing-related needs of people living with HIV/AIDS and other non-HIV-dedicated housing programs.

Advocate at the federal level to change the HOPWA funding formula
Federal HOPWA funding is currently distributed through a formula based on the number of cumulative AIDS cases (cases since the beginning of the epidemic) in a jurisdiction, rather than on the number of people living with HIV and AIDS. This means that states with the fastest growing numbers of new cases (primarily in the South) receive disproportionately fewer resources to meet expanding need, since the epidemic in the South is more recent and there are fewer cumulative cases. Advocates should work for a change in HOPWA’s funding formula.

Investigate other states’ efforts
Alabama is a southern state that has been particularly effective at securing funding for housing and maximizing its housing resources. Mississippi could explore the approaches used in Alabama and in other states for ideas about how to increase the supply of housing for its residents living with HIV/AIDS.

HEALTH PROFESSIONAL SHORTAGES AND SERVICE SHORTAGES

Challenges

Providers
Mississippi has a patchwork safety net system, which includes community health centers, Rural Health Clinics, Federally Qualified Health Centers (FQHCs), and county health departments. There are approximately 157 Medicare-certified Rural Health Clinics as well as 21 FQHCs operating 178 service delivery sites around the state. In addition, the Mississippi State Department of Health (MSDH) divides the state into 9 Public Health Districts, with between 6 and 11 counties covered by each district. There is at least 1 MSDH office in each of Mississippi’s 82 counties.

This patchwork system has not been enough to ensure access to healthcare providers. Similar to other poor, rural states, Mississippians experience a lack of access to primary care providers, particularly outside of the Jackson metropolitan area. In 2008, 31.9% of Mississippians were living in primary care “health professional shortage areas” (HPSAs) as compared to only 11.8% of Americans generally. Seventy-seven out of the 82 counties in Mississippi are HPSAs in whole or in part. According to a 2007 report from the National Association of Health Centers and the Robert Graham Center, 45.2% of Mississippians are “medically disenfranchised” (defined as lacking adequate access to a primary care physician due to a local shortage of physicians), as compared to 19.4% individuals nationally. Mississippi is one of eight states in which over 40% of the population is “medically disenfranchised.” The lack of public transportation options in all but a few parts of the state further complicate the issue, as many Mississippians find it difficult to travel outside of their immediate area to access medical services, particularly if they do not have access to a vehicle. This is a challenge for primary care, but is even more pronounced in the case of specialized care, as many counties do not contain specialists in all fields, so travel is inevitably required to receive specialized care.

For people living with HIV/AIDS, it is incredibly difficult to find an infectious disease doctor—or even any medical professional—able to provide HIV/AIDS services and treatment. Health clinics funded under Ryan White Part C are only located in Districts I, III, V, VII and IX, so service areas are “spotty” and people in many parts of the state have to travel great distances to receive care or services. As of 2009, the Mississippi State Board of Medical Licensure reported only 29 infectious disease doctors operating in the state. Nineteen of these doctors practice in Hinds County (Jackson), and the other 10 are...
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Sprinkled throughout the remaining parts of the state, as further illustration, of the 9,214 individuals known to be living with HIV/AIDS in Mississippi, more than 1,800 receive care at the Adult Special Care Clinic at the University of Mississippi Medical Center (UMC) in Jackson. In addition, community members comment that some health facilities will turn patients away from care if the patient cannot afford the copay needed for treatment, even if that facility gets Ryan White funding to provide care to those with HIV/AIDS who cannot get care elsewhere, and that some “cherry-pick” patients, refusing to accept patients who are not covered by Medicaid. The lack of trained HIV/AIDS and infectious disease specialists in Mississippi is compounded by the fact that Mississippi has only one medical school, UMC, operating in the state, and has trouble attracting doctors from other places to work in Mississippi. One health center notes that they have been trying to attract an infectious disease doctor to join their clinic for more than two years. They have interviewed candidates, but once the candidates come to visit they are not interested in the position and it is challenging to sell doctors on the idea of moving to Mississippi, particularly to rural areas.

In addition to the lack of access to primary HIV/AIDS care through an infectious disease doctor or other health professional trained to treat HIV/AIDS, many local consumers and advocates in Mississippi report instances where health providers refused to treat patients for other health problems once they learned that the patient was HIV positive. This is a particular problem in a state like Mississippi, which is starting out with health provider shortages in all areas of medical practice. This means that if patients even get to see a relevant specialist, they may be turned away from care due to their status. According to community members, this response could stem from either the provider’s genuine fear that HIV disease is so complicated that he or she is incompetent to provide care or from the provider’s bias or aversion to the client based on the patient’s status. Aside from HIV status, community members note that some individuals were unable to receive care because some providers will not accept Medicaid as a form of payment, due to the fact that Medicaid reimbursements in Mississippi are so low. All of these factors combine to make it challenging for Mississippians living with HIV/AIDS.

In addition to the lack of access to primary HIV/AIDS care, Mississippi also suffers from a general lack of resources available to individuals living with HIV/AIDS. In addition to the shortages in the number of healthcare providers, Mississippi also suffers from a general lack of resources available to individuals living with HIV/AIDS. Funding for HIV/AIDS services in Mississippi is generally an unhealthy state, and in the panoply of health problems facing the state, HIV/AIDS is not one of the top priorities and does not receive much attention in the state government. This is shortsighted, as the HIV/AIDS epidemic has been consistently growing in Mississippi, and providing care and treatment for HIV-positive individuals is essential to keep their viral load down so that they are less likely to spread the disease to others, and less likely to need more expensive medical interventions. The state has undergone constant budget cuts over the past several years, and the state government is unwilling to raise taxes to offset some of the expenses. Thus, Medicaid, among other agencies, has had to cut its budget consistently over the past few years and is very limited in the amount of services it can provide.

This is further compounded by the fact that Mississippi has very few AIDS services organizations (ASOs) operating around the state. The few ASOs that do exist in the state are generally underfunded and are not able to provide the full array of services that ASOs in other places often provide. The ASOs that do exist around the state are struggling to provide their clients with the linked services that make up the essential continuum of care for patients, including housing support, case management, treatment adherence counseling, emotional support, and advocacy. Additionally, there is a general lack of legal services in Mississippi and there are no legal services organizations focusing their efforts on the HIV/AIDS population.
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Successes

Numbers of nonphysician health professionals
Despite the overall lack of access to health care, Mississippi has a higher rate of registered nurses for 100,000 members of its population than the United States as a whole (950 in Mississippi vs 842 nationally). In addition, Mississippi has a higher rate of nurse practitioners per 100,000 as well, at 76 in Mississippi vs 51 nationally. According to a 2007 report by the Center for Health Professions at University of California, nurse practitioners in Mississippi are allowed more responsibility than nurse practitioners in other states. In Mississippi, nurse practitioners are allowed to practice without physician involvement, as long as a written protocol is approved by the Board of Nursing showing that they are working in “collaboration” with a physician whose practice is compatible with that of the nurse practitioner. In addition, nurse practitioners have authority to diagnose and refer patients as well as write prescriptions for some controlled substances (with additional board approval).

Though there are many registered nurses and nurse practitioners operating throughout the state, there are very few physician assistants—Mississippi had only 3 physician assistants per 100,000 population in 2008 (vs 24 per 100,000 nationally) and as of 2010 had a total of only 76 physician assistants operating in the state.

Delta Region AIDS Education and Training Center
The Mississippi AIDS Education and Training Center (AETC), which is part of the Delta Region AETC that covers Louisiana, Mississippi, and Arkansas, has had a lot of success connecting Ryan White providers from around the state with experienced HIV/AIDS doctors at the UMC in Jackson. In the past year, the AETC has also expanded to provide training for any health professionals in the state who are interested in learning about caring for individuals with HIV/AIDS. They have also added a training program track that includes a one-day “HIV 101,” a two-day training course for those already working with HIV-positive patients, and “Advanced Clinics,” where providers from around the state can come work for a few days with specialist HIV/AIDS health providers at UMC. These programs are all eligible for continuing education credit. In addition to providing programs in Jackson, the AETC is also providing training at different hospitals and health centers around the state, and is open to requests to provide such trainings. Overall, through the AETC’s new initiatives, thousands of doctors, nurses, and social workers around the state have been invited to trainings, allowing these providers to incorporate quality care for HIV/AIDS patients into their practices.

Crossroads Clinics

The three Crossroads Clinics in Mississippi have been cited as successes by the consumers and providers affiliated with them. These clinics were created by MSDH as multidisciplinary HIV care sites. Crossroads Jackson was opened first, inside the Jackson Medical Mall. MSDH recently opened Crossroads North in Greenville and Crossroads South in McComb to help increase access to care in these underserved areas. Patients have had positive feedback about their experiences at the Crossroads Clinics, and these clinics show a real commitment on the part of the MSDH to provide care for individuals with HIV/AIDS throughout the state.

Mississippi programs to nurture and promote rural area physicians
Noting the lack of medical providers in many rural areas of the state, the Mississippi State University has operated a Rural Medical Scholars Program for more than ten years. Through this program, high school rising seniors from rural areas in the state are invited to spend five weeks in the summer at Mississippi State University learning about careers as family practice physicians. Participants come from all over the state, as each community college in the state selects and sponsors two candidates from its district. In 2007, the Mississippi legislature created a more advanced program at UMC called the Mississippi Rural Physicians Scholarship Program (MRPSP). MRPSP works with students in four phases (undergraduate, medical or osteopathic school, residency, and initial practice support) to train, mentor, and encourage individuals who want to practice in rural areas in the fields of family medicine, obstetrics and gynecology, pediatrics, medical pediatrics, or general internal medicine. At the medical school phase, students in the program are awarded scholarships to support their education. These programs are doing great work to help engage individuals from rural areas in primary care health professions.

Training programs such as the Rural Medical Scholars Program and Rural Physicians Scholarship Program are complemented by loan repayment programs for health providers that work in rural areas after graduating from medical school. Mississippi runs the State Family Medicine Education Loan to help pay off one year of tuition for medical school at UMC for each year that the eligible participant spends practicing family medicine, internal medicine, pediatrics, or obstetrics/gynecology in a geographic shortage area of the state (outside of the Jackson area). Providing incentives such as loan repayment are an effective way of incentivizing health providers to settle in rural and medically needy areas.
Opportunities

Funding for workforce expansion (including new community health centers) under Patient Protection and Affordable Care Act

The Department of Health and Human Services (HHS) has set aside $250 million from the Affordable Care Act’s Prevention and Public Health Fund in 2010 alone for investing in the development of an expanded primary care workforce, with a focus on underserved and particularly vulnerable populations. This funding is targeted for various initiatives that would be of use in Mississippi, including supporting physician assistant training in primary care, encouraging students to pursue full-time nursing careers, establishing new nurse practitioner-led clinics, and encouraging states to plan for and address health professional workforce needs, among others. MSDH, UMC, and individual hospitals and clinics should consider how they can take advantage of this significant new funding source to expand and strengthen Mississippi’s healthcare workforce and address provider shortages and geographic disparities in access to care.

Strategic planning for the future of Ryan White programs

With implementation of healthcare reform, thousands of individuals who previously received care and treatment through Ryan White programs will now access healthcare through Medicaid and new state insurance exchanges. It is clear that despite the tremendous possibilities of healthcare reform for individuals living with HIV and AIDS, major gaps in affordability and access to essential care, treatment, and services will remain. Even after full implementation of healthcare reform, Ryan White programs will be necessary to fill these gaps.

Ryan White programs offer an important blueprint for the expansion of comprehensive health and support services for people with chronic illnesses. In many ways, Ryan White programs serve as a best practices model for comprehensive and holistic provision of care and treatment. As major healthcare reform provisions go into effect, however, the role of Ryan White will undoubtedly change. Advocacy around integration of Ryan White providers into Medicaid and state exchange provider networks, for instance, will be crucial to ensure seamless access to care for the thousands of people newly eligible for Medicaid and private insurance coverage. Integration of Ryan White programs and models of care into Medicaid and private insurance models is also important to ensure a smooth healthcare reform transition for those currently receiving care.

One obvious opportunity for integration is for Ryan White clinics to pursue certification as FQHCs. The healthcare reform law includes billions of dollars in funding and grants for community health centers, including $11 billion in funding for the operation, expansion, and construction of health centers throughout the nation over the next five years. In light of this significant funding opportunity, advocates should encourage health centers to apply for grants to expand services for people living with HIV and AIDS, and clinics (including Ryan White clinics) that are not in compliance with federal rules regarding qualified health centers should consider bringing themselves into compliance to be eligible for federal grants.

Educating health professionals and HIV/AIDS sensitivity

In addition to the lack of primary HIV/AIDS care through an infectious disease doctor or other health professional trained to treat the patient’s HIV/AIDS, many local consumers and advocates in Mississippi note that other health specialists often refuse to treat patients for other health problems once they learn that the patient is HIV positive. The AETC is addressing this issue by increasing its outreach and training to all health providers, not just those at Ryan White-funded clinics; however, additional HIV/AIDS education for all healthcare providers can help eliminate the reluctance to treat those with HIV/AIDS and thus will help to address the problem of healthcare provider shortage that is facing many Mississippians living with the disease. Since a large majority of the doctors practicing in the state are educated at UMC (which is the only medical school in the state), some of this additional education could be provided to new doctors as part of their medical education. This training could coordinate seamlessly with the training already being provided through the AETC to health professionals already practicing in the state.

Increase funding and capacity-building for ASOs

ASOs are a crucial piece of the continuum of care for HIV/AIDS patients. In many other states, ASOs provide all of the nonmedical services needed by consumers, including adherence counseling, emotional support, advocacy, legal support, and connection to other social services. Since there is a lack of medical providers in the state, ASOs should be able to fill the gap and keep patients connected to care. ASOs can also help to advocate for changes to the system if they see that many HIV/AIDS patients are falling through the cracks in the same places or if there are systemic problems with the provision of care in an area. Since individual patients only know their own experience, they are unable to see and identify these systemic problems, and ASOs would be able to fill that role. Mississippi should encourage the growth of ASOs in the state and should help find ways to support these organizations and also keep them connected with each other. In addition, moving forward, ASOs need to find ways to partner with other health-related organizations to ensure access to care and advocate for their patients, who often share some of the same barriers to care no matter what disease they are suffering from.
Mental Health and Substance Abuse

Challenges

Access

The Mississippi Department of Mental Health (MDMH) was established in 1974, and is charged with addressing the service needs associated with mental illness, mental retardation, developmental disabilities, and substance abuse and dependence.389 Mississippi operates a number of psychiatric facilities through MDMH, including five state-run psychiatric facilities (North MS State Hospital in Tupelo, South MS State Hospital in Purvis, East MS State Hospital in Meridian, MS State Hospital in Whitfield, and Central MS Residential Center in Newton); five regional facilities (Boswell Regional Center in Magee, Hudspeht Regional Center in Whitfield, North MS Regional Center in Oxford, South MS Regional Center in Long Beach, and Ellisville State School in Ellisville); and two specialized facilities (Specialized Treatment Facility in Gulfport and Mississippi Adolescent Center in Brookhaven).390

In order to be admitted to a MDMH-operated psychiatric facility, an individual must complete an affidavit at Chancery Court. He or she must also undergo a pre-evaluation at a mental health center; if such a screening implies that a commitment is necessary, the next step is to be examined by either a physician and a licensed psychologist, or two physicians. Based on the recommendation of these experts and any other evidence presented, a judge will then decide if hospital treatment should follow and whether it should occur at an inpatient or outpatient facility.391 According to one social worker, once the court determines that residential treatment is needed, the patient will then have to go home and wait (sometimes several weeks) for a bed in one of the residential treatment facilities to become available.

In addition to inpatient psychiatric facilities, there are also 15 regional community mental health centers (CMHCs) operating throughout the state of Mississippi, which offer comprehensive services to children and adults.392 Each mental health center is certified by the MDMH and funded through an amalgamation of federal, state, and local dollars. Most of the funding for the regional CMHCs comes from the Substance Abuse and Mental Health Services Administration (SAMHSA).393 Individual CMHCs are administered by regional commissions whose membership is representative of each county in the area covered by the center.394 Thus, while each center must meet the same licensure requirements by the MDMH, the facilities are unique in the programming they offer to the individuals served. Since these regional centers are operated independently under the control of regional commissions, they offer varying services from region to region, but generally provide a range of outpatient services, some inpatient services, and some substance abuse services.395

Finally, MDMH operates seven mental health crisis stabilization units located throughout the state, though in July 2010 it began a process of transferring ownership and operational control of these units to CMHCs around the state.396

The system of MDMH-operated inpatient psychiatric facilities and CMHCs has left many people in need of mental health and substance abuse services without treatment. In 2008, 40.2% of Mississipians were living in mental health “health professional shortage areas” (HPSAs) as compared to 18.7% of Americans generally.397 Thirteen of the 15 mental health regions in the state are designated as HPSAs for mental health services.398 Numerous consumers, providers, and advocates from around the state report serious gaps in HIV-positive individuals’ access to mental health and substance abuse services. Many parts of the state, particularly outside the Jackson area, are unable to attract mental health professionals to work in their region. In addition, for residential or inpatient services, there generally are not enough beds, which leads to long wait times for residential mental health or substance abuse treatment.

Community members note that there are generally waiting periods for both inpatient and outpatient mental health treatment. They note that the waits for outpatient care were generally only a few weeks, as opposed to the wait for residential treatment, which can be several months.399 However, at one community meeting, one consumer reported being unable to get an appointment with a mental health professional for six months, despite the fact that he was covered by private insurance.400 In some cases, due to the long wait times, patients express an interest in obtaining mental health services outside of their region of the state. Though patients are allowed to access mental health facilities outside of their catchment area, they can be penalized financially for doing so (fees are imposed by the treating facility, and are not set by MDMH).401 Finally, we heard that in some cases when patients went to the regional mental health centers they had to see a different mental health professional on every visit, which was disruptive to their treatment.

Like so many services in Mississippi, access to care depends on where the patient is located. In the Jackson area, there is reportedly enough access to mental health services, so patients in need of care can get appointments; however, access to substance abuse treatment remains a problem even in the Jackson area. The lack of access is a particular problem for individuals with HIV/AIDS, who often have comorbidities with substance abuse or mental health problems. Lack of treatment for these issues further complicates patients’ ability to remain in care and adhere to complicated treatment regimens.402 According to the Mississippi Statewide Coordinated Statement of Need and Comprehensive Plan, one of the
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**Successes, Challenges, and Opportunities**

Some clinics report that they have been able to set up agreements with regional CMHCs or MDMH facilities to provide care for patients, usually via vouchers paid by the clinic. For example, Southeast Mississippi Rural Health Initiative (SEMRHII) in Hattiesburg provides some on-site mental health counseling; however, they cannot prescribe medications or deal with serious mental health issues. SEMRHII also has an agreement to send patients to facilities through Pine Belt Mental Healthcare Resources for free, but it does not have such agreements with other facilities in the state.

Provision of limited mental health services through Ryan White clinics, however, has not been enough to address the unmet need, leaving many individuals with HIV/AIDs cut off from mental health care when they need them the most. Currently no Ryan White Part B funds are used for mental health services for individuals living with HIV. According to the Mississippi State Department of Health (MSDH), the state recognizes that mental health is a growing area of need in the HIV population, and state health officials are working to negotiate contractual relationships so that they can make referrals for Ryan White patients to mental health facilities for services.

In addition, SAMHSA provides some funding to Mississippi earmarked for treating HIV/AIDS patients requiring substance abuse treatment; however, the funding is limited and does not provide for any comprehensive service across the state. Overall, there is no general system in place to ensure access to mental healthcare for those with HIV/AIDS. Access to substance abuse treatment is even more challenging for those without insurance, and providers report that this is one of the top barriers facing their HIV-positive patients.

**Lack of Coordination**

There is a lack of coordination and communication among mental health, substance abuse, and HIV/AIDS programs, despite the fact that these programs are often serving the same clients and that people living with HIV/AIDS are often multiply diagnosed with mental health and/or substance use issues. The mental health system in Mississippi is operated under the MDMH, which is a separate agency from the MSDH. The two agencies do not appear to coordinate their work, which increases the “siloization” effect mentioned elsewhere in this report. In addition to having separate agencies, both operate with decentralized systems around the state. The MSDH has 9 public health districts, whereas the MDMH operates through 15 mental health regional centers. MSDH is more centralized in its operations, and it offers similar services in its district offices around the state. MDMH is more decentralized, and services tend to vary from region to region as the regional mental health centers can apply for their own federal or private grants to offer different services and programs. The public health districts and mental health regions do not overlap in their boundaries, and they do not share any office space or collaborate in any organized way throughout the state, although they do occasionally

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**Funding/Cost**

The mental health system in Mississippi suffers not only from a lack of providers, especially in rural areas, but also from a lack of support from the state government. MDMH and regional CMHCs recently underwent budget cuts and more cuts are expected. This year, Mississippi’s mental health budget has been reduced by 7% from its FY10 level and 22% from FY09 level, for a total reduction in budget of about $9 million. In addition, this year the Mississippi Department of Human Services decided to keep funds for its own work that it usually gives to the MDMH as an annual block grant. The block grant to MDMH is usually distributed through subgrants to other mental health services in the community, thus, the lost block grant led to cuts in case management, substance abuse, work activity, and children’s services in facilities around the state. These cuts have resulted in the loss of 200 beds at the state mental health hospital, and several crisis mental health centers around the state were closed, among other service cuts.

In addition to the severe lack of funding that has led some facilities to halt services or shut their doors altogether, another formidable barrier to accessing mental health care and substance abuse treatment is the limited Medicaid coverage for these services. In Mississippi, Medicaid does cover outpatient and inpatient mental health services for children under age 21; however, for adult patients it only covers mental health treatment for limited care, and only offers inpatient services in restricted situations for adults with very specific diagnoses. Even coverage for outpatient mental health treatment for those on Medicaid is very limited. Furthermore, Medicaid only covers inpatient detoxification for chemical dependency, and does not cover any alcohol or drug treatment. One commentator notes that Medicaid can only cover services provided through the regional CMHCs, and not at the state MDMH facilities.

Many uninsured people living with HIV have access to primary care providers at Ryan White clinics and have access to HIV medications through the AIDS Drug Assistance Program (ADAP), but because they do not meet the stringent Medicaid categorical eligibility rules, they are unable to access even the limited care provided via Medicaid. Thus, the only way these patients can see a mental health provider is if mental health services are integrated into the care provided at the Ryan White clinic. Ryan White clinics also provide wrap-around services to fill service gaps for HIV-positive patients on Medicaid. Some Ryan White clinics around the state have been able to use their Part C funds to provide access to limited mental health counseling.

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**Part III: Successes, Challenges, and Opportunities**

Top challenges facing individuals in Mississippi who have HIV/AIDS are access to mental health and substance abuse treatment, due to both financial and organizational limitations in Ryan White and state funding.

**Funding/Cost**

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**Part III: Successes, Challenges, and Opportunities**

State Report | MISSISSIPPI

An Analysis of the Successes, Challenges, and Opportunities for Improving Healthcare Access
Part III: Successes, Challenges, and Opportunities

Mississippi

Part III: Successes, Challenges, and Opportunities

The fact that there are two separate systems for care means that there are few “one-stop-shops” for treatment where patients can obtain primary care, mental health services, and substance abuse treatment. Of course, private psychiatrists, psychologists, and therapists may choose to see patients at community health centers or hospitals, but there is no organized system of linking care through the state agencies and their public offices.

Substance Abuse

Consumers and providers throughout the state note the dire need for more access to substance abuse treatment facilities. The lack of access to substance abuse treatment is even more striking than that of access to mental health services. While there are some state-run facilities that provide substance abuse treatment and there are some beds available for residential substance abuse treatment through each of the regional CMHCs, the need often exceeds the capacity. For example, in some of the regions, fewer than 20 beds are available for residential treatment, and the region covers a catchment area of several counties. In addition, commentators say that most of the residential programs are only for 45 days, and there are few longer-term programs available. In addition, as noted, Medicaid will not cover alcohol or substance abuse treatment, which further limits the services available to individuals.

Many consumers and providers around the state point out that it is incredibly difficult to get individuals into substance abuse treatment. They note that sometimes a patient will decide to get treatment for addiction, but then they have to wait several weeks or months to actually get into a program, at which time the patient may no longer be in a state of mind to begin treatment. Community partners report that most residential programs are not available to individuals who do not have private insurance. One commentator notes that it is easier to find beds in residential substance abuse treatment facilities for men than for women, since more beds are available for men in the facilities around the state.

Successes

Health centers with integrated care services that offer some mental health treatment

In some clinics around the state, efforts are being made to colocate multiple services so that patients can more easily access services such as mental health counseling. This is especially true when Ryan White providers are also full service clinics or Federally Qualified Health Centers, since patients can easily access their other care needs. One example of such success is SEMRHI, which started out as an FQHC and then applied for and became a Ryan White provider. SEMRHI provides a range of services and, as noted, has been able to offer basic mental health counseling on-site as well as making referrals for free care to the PineBelt Mental Healthcare Resources. SEMRHI has an active community advisory board and also provides gas vouchers to help pay for transportation of patients to the clinic. SEMRHI is also well integrated into the continuum of care in the Hattiesburg area and shares excellent relationships with the local AIDS service organization (ASO) and community-based organizations, referring patients among each other.

Similarly, Coastal Family Health Center, with locations in several towns along the Gulf Coast, also provides a full range of services including dental, optical, case management, mental health counseling, and substance abuse counseling. In the ASO context, the AIDS Services Coalition in Hattiesburg found mental health to be such a barrier that it made funds available to provide mental health counseling to its clients on-site at 1-2-1 Haven House, allowing clients another outlet to access much-needed mental health treatment.

New program linking mental health patients with HIV testing

As part of a new program, all patients doing a new intake with an inpatient or residential mental health center are offered the opportunity for an HIV rapid test. The testing can be done on-site in many locations; however, the test results cannot be confirmed on site. If the patient has to go off-site for testing or confirmation of test results, residential treatment patients are provided with transportation to a location where they can get a rapid HIV test. This program was piloted in the Delta in mental health regions 1, 5, and 6, and has now been expanded around the state. This is a great step in the direction of coordinating treatment and care, especially since comorbidities often exist between mental health/substance abuse problems and HIV/AIDS.

Opportunities

Increasing the rural healthcare workforce

As mentioned earlier, there are several programs already in place in Mississippi intended to increase the number of physicians and health professionals in underserved rural areas in the state. Some of these programs work to bring individuals from rural areas into health professions in the hope that they will return to those rural areas to work, and other programs implement loan forgiveness to incentivize work in rural areas after graduation from a medical degree program. These programs in Mississippi are currently focused on primary medical care fields; however, mental health is an area of such need that the state might consider including it as a field of medicine that would be covered under such programs.

Telemedicine

If regional CMHCs are unable to attract more mental health providers to their clinics, they may have to turn to telemedicine, a process by which medical consultations can be done via videoconference. This technology is particularly relevant in the case of mental health treatment, as patients can do counseling sessions via teleconference with mental health providers who are in a remote location. Setting up these systems and contracting with physicians in another location can be costly, but there is the potential for increased provision of service, particularly in the area of mental health.
Ryan White funding for mental health services

As mentioned, the STD/HIV Office at MSDH is aware of the need for increased mental health services to individuals with HIV/AIDS, and they are working on contracting with mental health facilities to make services available. This is an opportunity to look at the gap in the system for both mental health and substance abuse needs and perhaps direct some Ryan White Part B funding in the state to increase access to these services for HIV-positive individuals who are both uninsured or on Medicaid, since Medicaid does not provide comprehensive mental health treatment. In addition, in July 2010, President Obama announced the National HIV/AIDS Strategy (NHAS), which calls on federal agencies to facilitate better coordination of healthcare, mental health, substance abuse, and support services for people living with HIV and AIDS.\(^{1,10}\)

The NHAS presents an important opportunity to ensure coordination of funding streams between Ryan White programs and SAMHSA to ensure that people living with HIV and AIDS have access to comprehensive mental health and substance abuse treatment and services.

**EMPOWERMENT OF PEOPLE LIVING WITH HIV/AIDS**

**Successes**

In November 2009, the federal Office of National AIDS Policy (ONAP) hosted a town hall meeting in Jackson to gather community input for the development of the first-ever National HIV/AIDS Strategy; in September 2010, as described in the “Structure and Systems” section, HIV/AIDS community members came together for a discussion with top Mississippi State Department of Health (MSDH) officials and key legislators. At both of these events, Mississippi consumers stood up, identified themselves as people living with HIV/AIDS, and spoke directly about their concerns to officials with the power to change policies that affect them. Long-time community providers and MSDH staff note that these meetings are a first for Mississippi, in that so many people were willing to attend a public forum and identify themselves as living with HIV/AIDS. Mississippi also has some funding for advocacy work, in the form of a National AIDS Fund grant to the Jackson-based organization, A Brave New Day, to develop the Mississippi Peer Advocates Council (MPAC), a statewide network of HIV survivors focusing on state-based advocacy.

**Challenges**

**Consumer/provider relationships**

The relationship between consumers and HIV/AIDS care and services providers in Mississippi is complex and has not necessarily reflected a partnership model. Consumer/provider relationships tie in to issues of classism, racism, homophobia, cultural competence,
part III: successes, challenges, and opportunities

of employment or transportation, or mental health issues, seeking care for HIV may not be their highest priority. Several community-based providers commented that HIV was not their clients’ biggest problem.

Enforcing rights
Throughout Mississippi, community partners recounted many incidents of HIV-related discrimination and breaches of confidentiality, occurring at health department county offices, medical care facilities, and workplaces, among other sites. For the most part, consumers experiencing this discrimination did not file complaints, either out of fear of retribution from the provider, out of a belief that filing a complaint would not lead to any action or consequences, or because they did not want to further disclose their HIV status. There is a dearth of free legal services in Mississippi generally, and people living with HIV, like many other Mississippians, often have no realistic way of enforcing their legal rights.

Opportunities
Work with MSHD to create consumer resource packets for all regions of the state
Advocates should work with the MSHD to create region-specific resource packets that can be given to people upon a positive HIV test result. Packets could include information about programs and services (including Ryan White, AIDS Drug Assistance Program, Housing Opportunities for Persons with AIDS), healthcare and social services providers in the area, mental health and alcohol and drug treatment resources, self-care tips, patient rights (see the following), and other relevant information.

Educate about chronic disease management and self-advocacy skills
Consumers in Arkansas have recently organized and conducted several community workshops using “Making Sure Your HIV Care Is the Best It Can Be,” a training curriculum available from the Institute of Healthcare Improvement. The workshop is designed to build skills consumers need to actively participate in their HIV care and to advocate for themselves with providers. Consumer advocates could investigate whether this curriculum could be effective for use in Mississippi. Advocates should also look at consumer-focused education and training for other diseases, such as diabetes, that help consumers take “ownership” of their care and treatment.

Explore using health coaches/peer mentors
The Health Education and Literacy Program in St. Louis, Missouri, uses lay health coaches to reach uninsured and underinsured residents and empower them to take control of their health, communicate with providers, and become more confident in navigating the healthcare delivery system. Despite barriers to healthcare among this population, including transportation access, financial obstacles, and lack of trust in the healthcare system, health coaches had a positive effect on patients’ care. Among chronic disease patients, 27% were able to discuss their self-management plan after working with a health coach (up from 1% before). In Alabama, trained peer mentors (themselves living with HIV) provide information and support and help newly diagnosed individuals navigate care and services systems. These models may also be effective in Mississippi to educate consumers and to help reduce the sense of isolation that can accompany an HIV-positive diagnosis.

Create a patient bill of rights and educate consumers about it
Representatives from MSHD and the community have been working on a patient bill of rights to enumerate the rights that patients are entitled to as recipients of healthcare services. MSHD and community members should take the steps necessary to finalize this project, and ensure that consumers are aware of and understand their rights in healthcare settings.

Work to reduce confidentiality violations
More training is needed for health facility staff, including front office staff (and including health department county offices) on what confidentiality means, the importance of maintaining patient confidentiality, and the potential consequences of violating confidentiality. According to community partners, clinical facility front office staff may have heard of HIPAA (the federal Health Insurance Portability and Accountability Act), but do not necessarily understand its requirements. The AIDS Education and Training Center could help to provide such trainings. There also need to be real consequences for breaches of confidentiality and better mechanisms for consumers to file grievances when confidentiality is violated. An independent ombudsperson’s office might be one approach. Advocates could work with Mississippi legal services offices, community-based organizations such as the American Civil Liberties Union, and bar associations on strategies to make legal representation more available to people with discrimination or HIPAA violation claims. An approach used in some other states is for AIDS service organizations to develop a panel of attorneys who are willing to take referrals pro bono.

Incorporate findings from the Medical Monitoring Project into policy and program development
The Medical Monitoring Project (MMP) is a national supplemental surveillance system, coordinated by the Centers for Disease Control and Prevention, that examines clinical and behavioral trends among people receiving care for HIV infection with the idea that understanding these trends can help improve services for people living with HIV/AIDS. Mississippi’s MMP has interviewed hundreds of consumers, collecting data on behavior and service utilization. While analysis of MMP data is not yet complete, the project findings should help inform policy and program development to ensure that consumer perspectives are incorporated into program design.
appendix A: Mississippi Public Health Districts Map

Source: Mississippi State Department of Health

Mississippi Public Health Districts Map

appendix B: Mississippi Statewide HIV Community Service Delivery Network 2009-2010 Map

Source: Delta Region AIDS Education and Training Center
### appendix C:
Living Cases/Rates of HIV Disease by County
2005-2009

Source: Mississippi State Department of Health

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**appendix C:**
Living Cases/Rates of HIV Disease by County
2005-2009
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**Statewide Total**: 8,330, 8,540, 8,806, 9,055, 9,214, 285.2, 293.4, 301.7, 308.1, 313.5

### Appendix D: 2010 Federal Poverty Guidelines

#### 2009/2010 Federal Poverty Guidelines

The 2009 Poverty Guidelines for the 48 Contiguous States and the District of Columbia

<table>
<thead>
<tr>
<th>Persons in Family</th>
<th>Poverty Guideline (100% FPL)</th>
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<tr>
<td>1</td>
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<td>8</td>
<td>$37,010</td>
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For families with more than 8 persons, add $3,740 for each additional person.

The Mississippi legislature is composed of two chambers—a House of Representatives and a Senate. There are 52 state senators and 122 state representatives. The legislature convenes in January and in most years the legislative session lasts for 90 days (every fourth year the session lasts 125 days).

Only state legislators may formally propose new laws or changes to laws during a legislative session. A proposal for a new law is called a bill, and bills may be introduced by legislators in either the House or the Senate. Bills can be sponsored by an individual legislator or by a group of legislators in the same house. The more co-sponsors a bill has, the more attention and credibility the issue will receive.

The Mississippi Legislative Process Guide
Prepared by the Harvard Law School Health Law & Policy Clinic
October 2010

Types of bills:

- General legislation (proposing new substantive laws or changing existing laws)
- Constitutional amendments
- Appropriations bills (allocating money to be spent)
- Revenue bills (discussing money to be collected through taxes or borrowing)

2011 Legislative Session Important Dates

- January 4, 2011
  First day of the session
- January 12, 2011
  Deadline for legislators to request drafting* of general bills and constitutional amendments
- January 17, 2011
  Deadline for introducing general bills and constitutional amendments
- February 23, 2011
  Deadline for introducing appropriations and revenue bills
- February 1, 2011
  Deadline for committee action on bills in house of origin
- April 2, 2011
  Session adjourns

* All bills must be formally drafted prior to being introduced. Legislators may request drafting and pre-file a bill prior to the start of the session.

Tips for Successful Advocacy

1. Prepare—Plan what you are going to say before meeting with your legislator.
2. Be brief—Focus on one or two key points.
3. Be polite—Show confidence but don’t be confrontational.
4. Know the facts—Bring data or testimony from community members.
5. Be clear—Let your legislator know what action you would like him or her to take.

What This Means for Advocates

- Find a legislator to sponsor a bill on the issue you want addressed. (Even better, find more than one legislator.)
- Your sponsor doesn’t need to be a member of the committee that will review the bill, but that will help.
- When a bill is being reviewed by a committee or debated by the full house, contact your representatives to encourage them to vote for the bill (or against a bill that will hurt your cause).
- Broaden your coalition—the more voices you have from around the state, the more representatives will have an interest in your concerns.
- Your bill must pass both the House and the Senate to become a law.

How a Bill Becomes a Law

1. A bill is introduced in the House or the Senate by a legislator or group of legislators.
2. The bill is referred to one or more committees in the original chamber by the Speaker of the House or the President of the Senate. The committee reviews the bill, makes changes, and decides whether to report the bill to the full House or the full Senate.
3. If the committee takes no action on the bill, then it is said to have “died” in committee. If the committee reports the bill, then it is debated on the floor by all of the members of that chamber. Remember, a bill must pass all of the committees to which it is referred.
4. If the full House or Senate votes to pass the bill following the debate, it is sent to the other chamber, where it follows the same process of committee review, floor debate, and vote. A bill that has passed the House can die at any point in the Senate (and vice versa), ending the legislative process for that particular bill.
5. If the bill passes both houses in an identical form, it is sent to the Governor. Often, the second chamber made changes to the bill. If the bill passes the second house in a different form than the original bill, then the first house must accept or reject the changes. If it accepts the changes, the bill is sent to the Governor.
6. If the original house rejects the changes, a conference committee of members of both houses is formed. The conference committee drafts a compromise bill, which is voted on by both the House and Senate. If both houses pass the conference bill, it is sent to the Governor.
7. After the Governor receives the bill, he may sign it, veto it, or do nothing. If he signs the bill, it becomes a law. If he vetoes the bill, then it does not become a law, but the legislature may override the veto by a 2/3 vote of both houses, turning the bill into a law. If the Governor does nothing, after 5 days the bill becomes a law unless the legislature has adjourned. In that case, the Governor has 15 days to veto the bill and must return it to the legislature within 3 days of the beginning of the next session. If these deadlines pass, the bill becomes a law.
notes and references


3 Id.

4 Id.


7 Percentages may not add to 100% due to rounding.


13 The statistics referred to in this section specifically refer to diagnoses of AIDS, not HIV.


31 Id.


notes and references


46 Information obtained from: United States Census Bureau, State and County Quickfacts, http://quickfacts.census.gov/qfd/states/28000.html. This is a 2010 figure.


50 Information obtained from: United States Census Bureau, State and County Quickfacts, http://quickfacts.census.gov/qfd/states/28000.html. This is a 2000 figure.

51 Information obtained from: United States Census Bureau, State and County Quickfacts, http://quickfacts.census.gov/qfd/states/28000.html. This is a 2000 figure.


53 See KRAKE & SHAFFER, MISSISSIPPI GOVERNMENT AND POLITICS: MODERNIZERS VERSUS TRADITIONALISTS (1992), at 19 (“I’/poverful pressures for social conformity exist within Mississippi societ y.”)


60 Mississippi State Board of Health, MISS. STATE DEP OF HEALTH, http://mdsh.ms.gov/msdhstat risks/STATS/19/0,124, html (last visited Nov. 6, 2010).

61 Miss. State Dep’t of Health STD/HIV Director job description.


64 MISS. CONST. OF 1890 Art. IV § 33.

65 MISS. CONST. OF 1890 Art. XIII § 254.

66 MISS. CONST. OF 1890 Art. IV § 36. The state constitution also provides that the legislature may extend the session by 30 days with a 2/3 vote of each house, with an unlimited number of extensions.

67 Mississippi Senate Roster, MISS. STATE LEGISLATURE (Aug. 11, 2010), http://billstatus.is.state.ms.us/members/s_ roster.pdf; Mississippi House Roster, MISS. STATE LEGISLATURE (May 12, 2010), http://billstatus.is.state.ms.us/members/h_roster.pdf.

68 MISS. CONST. OF 1890 Art. IV § 36. The state constitution also provides that the legislature may extend the session by 30 days with a 2/3 vote of each house, with an unlimited number of extensions.

69 Mississippi Senate Roster, MISS. STATE LEGISLATURE (Aug. 11, 2010), http://billstatus.is.state.ms.us/members/s_ roster.pdf; Mississippi House Roster, MISS. STATE LEGISLATURE (May 12, 2010), http://billstatus.is.state.ms.us/members/h_roster.pdf.

70 MISS. CONST. OF 1890 Art. IV § 129.

71 Miss. Supe., supra note 17, at 5.


74 Id. at 280.

75 MISS. CONST. OF 1890 Art. XIV § 263A.

76 Miss. State Dep’t of Health STD/HIV Director job description.

77 MISS. CONST. OF 1890 Art. IV § 36. The state constitution also provides that the legislature may extend the session by 30 days with a 2/3 vote of each house, with an unlimited number of extensions.

78 MISS. CONST. OF 1890 Art. IV § 36. The state constitution also provides that the legislature may extend the session by 30 days with a 2/3 vote of each house, with an unlimited number of extensions.


80 MISS. CONST. OF 1890 Art. IV § 36. The state constitution also provides that the legislature may extend the session by 30 days with a 2/3 vote of each house, with an unlimited number of extensions.

81 MISS. CONST. OF 1890 Art. IV § 36. The state constitution also provides that the legislature may extend the session by 30 days with a 2/3 vote of each house, with an unlimited number of extensions.


83 Miss. State Dep’t of Health STD/HIV Director job description.

84 MISS. CONST. OF 1890 Art. XIV § 263A.


87 Id. at 280.

88 MISS. CONST. OF 1890 Art. XIV § 263A.


91 Id. at 280.

92 MISS. CONST. OF 1890 Art. XIV § 263A.


95 Id. at 280.

96 MISS. CONST. OF 1890 Art. XIV § 263A.


99 Id. at 280.

100 MISS. CONST. OF 1890 Art. XIV § 263A.


103 Id. at 280.


85 Information obtained from: Center for Disease Control, National Center for HIVAIDS, Viral Hepatitis, STD, and TB Prevention, Mississippi 2010 profile, at http://www.cdc.gov/chrp/stateprofiles/pdf/Mississippi_profile.pdf.


91 These figures pertain to PPACA (the federal health reform legislation). From now until 2014, rates of coverage will rise. While this will likely cause other problems such as provider shortages, it will increase coverage rates substantially in Mississippi.


102 Miss. State Dep’t of Health, FY 2011 Mississippi State Health Plan, 4-5 (2010), available at http://www.statehths.com/mdhstatl/statistsrcs/3923.pdf. According to the U.S. Department of Health and Human Services, a Health Professional Shortage Area (HPSA) can be a geographic area, a specific population group, or a facility such as a correctional institute or a public/non-profit medical facility. For a geographic area to be designated as an HPSA, the area must have an estimated patient-to-doctor ratio of at least 3,000 people for every 1,000 doctors. This ratio is further increased to 3,000 and 3,500 people per primary care doctor, the area must have “unusually high needs for primary care services or insufficient capacity of existing primary care providers.” Additionally, it must be shown that primary care physicians in neighboring areas are “overutilized, excessively distant (more than 30 minutes away), inaccessible,” Health Res. & Servs. Admin., Primary Medical Care HPSA Designation Overview, U.S. DEPT OF HEALTH & HUMAN SERVS, http://bhpr.hrsa.gov/primarycare/hpsadesignation.jsp (last visited Nov. 6, 2010), Health Res. & Servs. Admin., Guidelines for Primary Medical Care/Dental HPSA Designation, U.S. DEPT OF HEALTH & HUMAN SERVS., http://bhpr.hrsa.gov/shortage/hpsadqdc.jsp (last visited Nov. 6, 2010).


105 Notes and references...

106 Notes and references...

107 Notes and references...

108 Notes and references...

109 Notes and references...

110 Notes and references...

111 Notes and references...

112 Notes and references...

113 Notes and references...
notes and references


112 Id. at 15, 27.

113 Id. at 17.

114 Interview with representative of Mississippi Department of Mental Health.


117 Community Mental Health/Mental Retardation Centers, MISS. DEP’T OF MENTAL HEALTH, http://www.dhms.state.ms.us/community_care.htm (last visited Nov. 6, 2010).

118 Information from Mississippi Department of Mental Health and Tonya Tate, National Alliance on Mental Illness.

119 Information obtained from Mississippi Department of Mental Health, “Substance Abuse Services,” at http://www.dhms.state.ms.us/substance_abuse.htm.


122 Mississippi Department of Mental Health, Bureau of Alcohol and Drug Abuse, FY 2011 State Plan, 20-22 (2010), available at http://www.dhms.state.ms.us/pdf/2011/2010%20Annual%20Plan.pdf. In addition, the Mississippi Department of Mental Health, there are also three “community-based primary residential substance abuse programs for adolescents.” Id. at 21. The State Department of Health has indicated that there are a total of 386 residential and transitional programs in Mississippi. See Miss. State Dep’t of Health, FY 2011 Mississippi State Health Plan, 10 (2010), available at http://www.healthymis.com/msdhsite/_static/resources/3923.pdf.


124 Information from Mississippi Department of Mental Health and Tonya Tate, National Alliance on Mental Illness.


127 Information obtained from U.S. Department of Health and Human Services, Health Resources and Services Administration, About the Ryan White HIV/AIDS Program, at http://abih.sabina.gov/about.html.


130 Information obtained from the TARGET Center [HHS, HRSA, HIV/AIDS Bureau &the Danya Institute, Inc.], Ryan White Community: Mississippi, at http://careacttarget.org/Community/state.asp?abbr=MS.


132 Information obtained from the TARGET Center [HHS, HRSA, HIV/AIDS Bureau & the Danya Institute, Inc.], Mississippi White Community: Mississippi, at http://careacttarget.org/Community/state.asp?abbr=MS.


136 Information obtained from the TARGET Center [HHS, HRSA, HIV/AIDS Bureau &the Danya Institute, Inc.], Ryan White Community: Mississippi, at http://careacttarget.org/Community/state.asp?abbr=MS.


138 Information obtained from the TARGET Center [HHS, HRSA, HIV/AIDS Bureau &the Danya Institute, Inc.], Ryan White Community: Mississippi, at http://careacttarget.org/Community/state.asp?abbr=MS.


140 ADAP Patient Eligibility Sheet, Mississippi State Department of Health, December 2009. Treatment naïve patients must have a CD4+ count below 350 or a viral load above 100,000.
141 Information from Eva Thomas, ADAP Director, presented at the Ryan White Care and Services Planning Council meeting, August 6, 2010.

142 National Alliance of State & Territorial AIDS Directors, The ADAP Watch, October 2010. Available at: http://www.nastad.org/docs/Public/InFocus/2010104_ADAP%20Watch%20update%20-%26%204.10.pdf.


144 Information from Eva Thomas, ADAP Director, presented at the Ryan White Care and Services Planning Council meeting, August 6, 2010.

145 Id.


157 Id.


160 Information from Valencia Evans, MSDH and Vanessa Henderson, City of Jackson.


169 Id.

170 Information from Valencia Evans, Mississippi State Department of Health.

171 Information from Valencia Evans, Mississippi State Department of Health.

172 Information from Valencia Evans, Mississippi State Department of Health.

173 Information from Valencia Evans, Mississippi State Department of Health; Statewide Coordinated Statement of Need, p. 83-84.

174 Statewide Coordinated Statement of Need, p. 83-84.

175 Information from David Peyton, Mississippi State Department of Health.


181 Information from Valencia Evans, Mississippi State Department of Health.


183 Information from Valencia Evans, Mississippi State Department of Health.

notes and references

185 Id.
207 MISS. CODE ANN. 31-21-14(c) (2010).
208 MISS. CODE ANN. 41-23-29 (2010).
notes and references

220 Chris Joyner, MOOC no longer will segregate inmates with HIV, THE CLARION-LEDGER (Jackson, MS), Mar. 18, 2010, at A. 16.


225 The national teen birth rate rose 1% in 2007 and has risen 5% since 2005, which marked the first year since 1991 that the rate increased. Id. at 4, 9.


227 2009 Sexually Transmitted Disease Surveillance: Table 2: Chlamydia, CTES. FOR DISEASE CONTROL & PREVENTION (Nov. 16, 2009), http://www.cdc.gov/std/stats08/tables/2.htm; 2008 Sexually Transmitted Disease Surveillance: Table 2: Gonorrhea, CTES. FOR DISEASE CONTROL & PREVENTION (Nov. 16, 2009), http://www.cdc.gov/std/stats08/tables/2.htm.


239 SIECUS and Planned Parenthood received survey responses from 37 school districts about their sex education programs. Four of those districts indicated that they do not provide sex education at all. SIECUS REPORT at 5. The Jackson Press reported in January 2010 that a Department of Education survey indicated that 91 of 121 public school districts in Mississippi did not have a sex education policy or did not know if one was in place. Lacey McLainBlitch, Compromise Sex-Ed Bill Moves Ahead, JACKSON FREE PRESS, Jan. 21, 2010, available at http://www.jacksonfreepress.com/index.php?option=com_content&task=view&id=21110.

240 SIECUS and Planned Parenthood define comprehensive sex education as including “age-appropriate, medically accurate information on a broad set of topics related to sexuality including human development, relationships, decision making, abstinence, contraception, and disease prevention.” SIECUS REPORT, at 4.

241 Miss. H.B. 837 (2010), available at http://billstatus.ls.state.ms.us/documents/2010/pdf/HB0800-0899/HB0837PS.pdf. The bill defined abstinence-plus education as incorporating the elements of abstinence-only programs, but providing additional instruction in other areas approved by the local school board, which could include the transmission and prevention of STDs and the use of contraceptives. Additional bills that would have implemented some form of comprehensive sex education were introduced in 2010 in both houses, but they never passed out of committee. See Miss. H.B. 140 (2010), 147, S.B. 2680 (2010).


245 MISS. CODE ANN. § 41-23-3 (2010).


249 Id. at § 113.03.


251 Electronic mail correspondence from Craig Thompson, former MSDH STD/HIV Office Director, November 15, 2010.

252 [NASTAD REPORT, supra note 7932.pdf [hereinafter NASTAD REPORT].


254 Information from phone call with representative of Mississippi Department of Mental Health.


256 Id. at 42; SIECUS REPORT, at 15.

257 NASTAD REPORT, supra note 95, at 45.

258 MISS. CODE ANN. § 41-21-139(1), 41-21-105(1)(c) (2010).

notes and references

261 Information from David Peyton, MSDH; Miss. State Dep’t of Health, State of Mississippi 2009 Ryan White HIV/AIDS Statewide Coordinated Statement of Need and Comprehensive Plan, 33-34, 41.


264 Information from the Choctaw Health Department.

265 Id.  


268 Id. at 4.


272 Id.


274 Id.


276 Id.

277 Id. at 84, 86.


279 Id.


281 Interview with Melissa White, New Jerusalem Church, Jackson, Mississippi.


284 Id. at http://www.greaterthan.org/take-action/ (accessed November 5, 2010).


notes and references

286 Id.


288 Id. and cosponsor list available at http://thomas.loc.gov/cgi-bin/thesaurus (accessed November 5, 2010).


290 SHARP Community Partners meeting, September 2010.


292 Id. at 14.


294 Interviews with community partners, October 2010.


297 Electronic mail correspondence from Craig Thompson, former MSDH STVHIV Office Director, November 15, 2010.


300 Information obtained from Mississippi Department of Human Services, Division of Aging and Adult Services, “Services Overview,” at http://www.mdhs.state.ms.us/aas_info.html.


302 For the occasional driving plan, drivers pay a one-time $25 application fee and $50 a year; cars start at $8 an hour during the week (gas included). Information obtained from Zipcar, “Occasional Driving Plan,” at http://www.zipcar.com/tucson/availability/learn-more/plan-key-opd.

303 Electronic mail correspondence from Craig Thompson, former MSDH STVHIV Office Director, November 15, 2010.


308 Id. at 6.


336 U.S. Census Bureau, 2009 American Community Survey, Table GCT2515.


340 SHARP Community Partners meeting, Jackson, Mississippi, October 27, 2010.


348 Comment from landlord at Jackson town hall meeting 9/21/10.

349 SHARP Community Partners meeting, Jackson, Mississippi, October 29, 2010.

350 SHARP Community Partners meeting, Jackson, Mississippi, October 27, 2010.


An Analysis of the Successes, Challenges, and Opportunities for Improving Healthcare Access

notes and references

408 Id.
412 Mississippi Division of Medicaid, Get Connected with your Mental Health Services, http://www.medicaid.ms.gov/MentalHealthServicesDetails.aspx.
413 Representative from Mississippi Department of Mental Health, October 27, 2010.
414 Representative from Mississippi State Department of Health, November 4, 2010.
415 Representative from Mississippi State Department of Health, November 4, 2010.
416 Representative from Mississippi Department of Mental Health, October 27, 2010.
417 Representative from Mississippi Department of Mental Health, October 27, 2010. During the pilot program, no individuals came up as positive, and it was later discovered that the testing kits had expired so the test results were not accurate. In response to this flaw, more training has been provided to mental health centers conducting these trainings in the hope that these errors will not occur in the future. However, the Department of Mental Health was unable to contact the patients who had been tested during the pilot to let them know to come in for re-testing.
419 Mississippi State Department of Health, Statewide Coordinated Statement of Need, 2010.
420 Interview with Dr. Deborah Konkle-Parker, University of Mississippi Medical Center, October 11, 2010.
421 Id.
424 Id.
425 Id.
About SHARP – A national project of the Health Law and Policy Clinic of Harvard Law School and the Treatment Access Expansion Project, the State Healthcare Access Research Project (SHARP) develops state-level research reports by conducting a series of focus groups and one-on-one interviews with people living with HIV/AIDS, community-based AIDS services providers, healthcare providers, faith leaders, state and federal government officials, and other researchers and advocates. The insights gained from these meetings are supplemented with independent research. SHARP is designed to examine states’ capacities to meet the healthcare needs of people living with HIV/AIDS and has three main goals: (1) improve access to healthcare, treatment, and services; (2) support coalition development and self-sustained, grassroots advocacy capacity; and (3) share information and effective strategies within and among states. This project is conducted in collaboration with and funded by Bristol-Myers Squibb’s WithInSight Initiative. The content of this summary does not necessarily reflect the views or opinions of Bristol-Myers Squibb. Visit SHARP online at www.taepusa.org or www.withinsightinitiative.org.