

Improving the Response to HIV/AIDS in Arkansas

A new research report produced by the State Healthcare Access Research Project (SHARP) examines successes and challenges in accessing healthcare for people living with HIV/AIDS in Arkansas, and proposes opportunities for improving access. The Health Law and Policy Clinic of Harvard Law School and the Treatment Access Expansion Project reviewed Arkansas health policy, met with stakeholders including Arkansans living with HIV/AIDS, and invited comments from state officials. **The full report is available online at www.taepusa.org.**

SUMMARY OF RECOMMENDATIONS:

1. State Revenue and Spending Issues – While Arkansas is a fiscally responsible state, its tax and appropriations policies hurt Arkansans living with HIV/AIDS. Arkansas provides no state funding for HIV care, other than the state Medicaid match. Tax policies disproportionately burden low-income families, and state law makes it easier to increase regressive sales taxes than income taxes. The following changes would help improve access to care:

Dedicate revenue for health programs – Committing funds for treatment of HIV and other chronic conditions that disproportionately affect low-income Arkansans would not only improve individual and public health, but would ultimately save money by prolonging productivity and avoiding higher-cost medical interventions.

Reverse the decline in corporate taxation – Corporate taxes have fallen from 31% of general revenue to 6% in the past three decades. Even a small increase in corporate taxes could have a big impact.

2. Medicaid – While Arkansas does better than the national average in providing Medicaid for children, it has one of the lowest income eligibility standards in the country for adults (17% of federal poverty level). Restrictive Medicaid eligibility helps drive people to expensive emergency rooms for care, resulting in a “hidden health tax” of \$1500/year on every insured Arkansan. HIV-related coverage could be significantly improved by adopting the following reforms:

Support the federal Early Treatment for HIV Act (ETHA) – ETHA would give states the option to cover low-income, predisabled people living with HIV, and would provide enhanced Federal matching funds for states.

Develop targeted case management and a Home- and Community-Based Services (HCBS) program for HIV – Arkansas offers targeted case management for some groups and has a waiver to provide HCBS under Medicaid. Arkansas should consider expanding these programs to include people living with HIV/AIDS.

Roll back AIDS Drug Assistance Program (ADAP) restrictions – New restrictions prohibit Medicaid enrollees from receiving ADAP, jeopardizing access to life-saving medications for many low-income Arkansans living with HIV/AIDS. State funding for ADAP could enable a reversal of these limits.

Increase Medicaid provider reimbursement rates – Low reimbursement rates have greatly reduced Medicaid patients’ access to qualified healthcare providers and specialists. Rate increases should focus on specific services, including HIV testing and counseling, primary care, dental care, and specialist care.

Expand ARHealthNetworks – Expanding this program to more employers and part-time workers, as well as improving the benefit package, could help improve coverage and offset deficiencies in Medicaid.

3. Arkansas Department of Health (ADH)-related Issues – The HIV/STD/Hepatitis C section at ADH has recently taken significant steps to improve quality, performance, oversight, and accountability. There are some additional changes that could further enhance the section’s effectiveness:

Consider creating a Consumer Office – ADH should consider creating an internal Consumer Office to supplement the Consumer Advisory Board and ensure that the perspective and experience of a person living with HIV/AIDS are incorporated into daily operations and decisions.

Engage in dialogue with field-based providers – ADH should continue to seek input from service providers and should plan longer site visits to better understand the unique needs in different regions of Arkansas.

Improve coordination between surveillance and client services programs and move some HIV/STD surveillance functions under the section chief – Following the lead of 77% of states, Arkansas should consider moving the day-to-day collection, monitoring, and movement of surveillance data under the HIV/STD/Hepatitis C section chief, while leaving data analysis with the technical experts in epidemiology and surveillance.

4. **HIV-related Stigma** – Stigma remains a major barrier to access to healthcare, with negative implications for accessing prevention, testing, and care. Stigma impacts both individual and public health. Opportunities to address stigma include:

Educate the public and healthcare providers – There needs to be more public education about how HIV is and is not transmitted, as well as information for providers about the damaging effects of stigma. Wherever possible, people living with HIV/AIDS should be part of educational messages, to personalize the issue.

Create an antistigma media campaign using social media – Using models from other states, Arkansas should create an antistigma campaign that incorporates new social media, as well as traditional media.

Seek help from supportive clergy – Advocates should seek guidance from supportive clergy on effective ways to reach out to other clergy, and incorporate faith-based, factual messages about HIV/AIDS.

Routinize HIV testing and require insurance coverage – Making opt-out HIV testing routine can help “normalize” HIV and reduce stigma associated with HIV testing. Arkansas should consider requiring health benefit plans to cover one annual HIV test for people ages 13 to 64, in line with federal recommendations.

5. **Provider Shortages and Capacity** – Most of Arkansas’ counties are at least partially medically underserved, and 50% of uninsured adults (including many people living with HIV/AIDS) have no usual source of medical care. Specialist care is in even shorter supply. There are several ways to improve access to HIV/AIDS care:

Greater integration of HIV/AIDS into existing systems of care – HIV care should be more incorporated into Arkansas’ care systems, such as the community health centers and the Area Health Education Centers.

Create “one-stop shops” – Locating both medical and social services in one place helps ensure better coordination of care and relieves transportation burdens.

Use mobile health vans – A mobile health van is a potential way to bring basic medical and dental screening and care to Arkansans, particularly in rural areas.

Explore federal programs, other states’ efforts, and other sources of providers – Arkansas could use the federal National Health Service Corps, investigate other rural states’ medical provider recruitment efforts, and consider attracting providers from outside the U.S.

Consider designating Advanced Practice Nurses (APNs) as primary care providers (PCPs) – Allowing APNs to be reimbursed at comparable rates to physicians for providing the same service would expand the pool of PCPs and financially help clinics that use APNs.

Use telemedicine and Continuing Medical Education (CME) to improve capacity – Through telemedicine, HIV specialists can share their knowledge with other medical providers. Arkansas should consider requiring 1 hour of CME training biannually to improve physician knowledge about HIV symptoms and care.

6. **AIDS Drug Assistance Program (ADAP)** – Funding shortfalls and increased enrollment have led ADH to drastically cut income eligibility for ADAP and initiate a waitlist for the program. The following changes could help ensure that people do not lose access to life-saving medications:

Support emergency federal funding for ADAP – The economic downturn has significantly increased demand on ADAPs. An additional \$126 million in federal funding for FY2010, distributed to states eligible for ADAP supplemental grants (including Arkansas) would help meet current program needs.

Explore using the Comprehensive Health Insurance Pool (CHIP) – Arkansas could explore whether using ADAP funds to purchase insurance through CHIP would be cost-effective and amend state law as needed to accomplish this.

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, state and federal government officials, academics, 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 two main goals: (1) remove existing barriers to effective care and treatment and (2) build state-based advocacy capacity to address the care and treatment needs of people living with HIV/AIDS. The project is conducted with support from Bristol-Myers Squibb. For more information visit **SHARP online at www.taepusa.org**.

Prepared by the Health Law and Policy Clinic of Harvard Law School and the Treatment Access Expansion Project.
Funded by Bristol-Myers Squibb, with no editorial review or discretion.



Health Law and Policy Clinic of
Harvard Law School



Bristol-Myers Squibb



SHARP

State Healthcare Access Research Project

A WithInSight Initiative

Arkansas State Report

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

Prepared by: Matthew Siegler, Amy Rosenberg, and Robert Greenwald

PREPARED BY HEALTH LAW AND POLICY CLINIC OF HARVARD LAW SCHOOL
AND THE TREATMENT ACCESS EXPANSION PROJECT

withinsight

A collaboration between the HIV community and Bristol-Myers Squibb



Arkansas HIV/AIDS Minority Task Force

February 2010

On behalf of the Arkansas HIV/AIDS Minority Task Force, we endorse the findings and recommendations of the Arkansas State Healthcare Access Research Project (SHARP) report. The HIV/AIDS Minority Task Force was integrally involved in developing and reviewing this report, and we believe that the report provides a fair and accurate picture of challenges and opportunities related to healthcare access for Arkansans living with HIV/AIDS.

The Arkansas HIV/AIDS Minority Task Force was created by Act 842 of 2007 and charged with making recommendations to address the growing HIV/AIDS epidemic and its disparate impact on Arkansas's minority communities. After providing a report to the General Assembly in November 2008, the Task Force has continued to pursue its mission by exploring ways to prevent new HIV infections in minority communities and improve access to care and services for HIV-positive individuals. This report details the Task Force's activities throughout 2009 (see Part III).

One way the HIV/AIDS Minority Task Force fulfilled its mandate in 2009 was by participating in the development of the SHARP report. Task Force members provided their perspectives and expertise to the SHARP process, which sought input from a wide range of stakeholders across the state, including Arkansans living with HIV/AIDS, community-based social services providers, healthcare providers, government officials, academic researchers, and other advocates.

The SHARP report identifies key successes, challenges, and opportunities for improving healthcare access in Arkansas. The HIV/AIDS Minority Task Force supports using the report's recommendations as a framework for future efforts to enhance access to care and services. We ask state government leaders to work with us to more effectively educate the public, prevent new HIV infections, and provide cost-effective care and services. Together we can make meaningful progress to slow the spread of the epidemic and meet the needs of Arkansans living with HIV/AIDS.

Rick Collins
Future Builders, Inc.
Cochair, Arkansas HIV/AIDS Minority Task Force

Michelle R. Smith, PhD, MPH
Jefferson Comprehensive Care System, Inc.
Cochair, Arkansas HIV/AIDS Minority Task Force

Arkansas Minority Health Commission
Arkansas HIV/AIDS Prevention Coalition

February 2010

This letter is submitted to demonstrate the Arkansas Minority Health Commission's (AMHC) and Arkansas HIV/AIDS Prevention Coalition's endorsement of the 2010 SHARP Arkansas State Report in its entirety.

Established as a state agency through the enactment of Act 912 of 1991, the Arkansas Minority Health Commission's charge is to study issues relating to the delivery and access of health services to Arkansas's underserved communities, identify gaps in health delivery systems, and make recommendations to relevant agencies and the General Assembly for improving health delivery and inform as to whether services are adequate and available. In addition, Initiated Act I of 2001 mandates the AMHC to increase awareness of disorders disproportionately critical to minorities, such as HIV/AIDS.

The AMHC and the Arkansas HIV/AIDS Prevention Coalition strongly believe that if implemented, these recommendations will inevitably improve the health status of not only minority Arkansans disproportionately affected by HIV/AIDS, but the state's overall goal of improving the health of all Arkansans who are living with and impacted by this disease.

Idonia L. Trotter, JD, MPS
Executive Director
Arkansas Minority Health Commission

Patricia Minor, RN
Chair
Arkansas HIV/AIDS Prevention Coalition

Arkansas HIV/AIDS Consumer Advisory Board

February 2010

As members of the Arkansas HIV/AIDS Consumer Advisory Board, we write in support of the recommendations contained in the Arkansas State Healthcare Access Research Project (SHARP) report. We believe that implementing these recommendations would improve access to care and services for Arkansans living with HIV/AIDS.

The HIV/AIDS Consumer Advisory Board (CAB) comprises members from across Arkansas who are living with HIV/AIDS. We provide advice and consumers' perspectives to the Arkansas Department of Health (ADH) and facilitate communication between ADH and HIV-positive Arkansans. A majority of CAB members participated in the development of the SHARP report by sharing their knowledge, experiences, and opinions and reviewing drafts of the report. We believe that the report accurately conveys some of the major challenges faced by Arkansans living with HIV/AIDS in obtaining healthcare and services.

This is a critical time for those of us living with HIV/AIDS in Arkansas. Income eligibility for the AIDS Drug Assistance Program and for HIV care and services has been cut drastically in the past year, as resources are inadequate to keep up with growing need. People are losing access to life-saving medications, which will have serious consequences for both individual and public health.

The SHARP report offers some suggestions for how to improve the situation in Arkansas. We encourage state government officials, in both the General Assembly and the Executive Branch, to consider its recommendations and to take action to ensure that Arkansans living with HIV/AIDS have the care and services they need to live full and productive lives.

Sincerely,

Arkansas Consumer Advisory Board Membership

contents

| | |
|--|-----------|
| 3. Issues Related to the Arkansas Department of Health HIV/STD/Hepatitis C Section | 52 |
| <i>Successes</i> | 52 |
| <i>Challenges</i> | 53 |
| <i>Communication and collaboration with the community</i> | 54 |
| <i>Surveillance</i> | 55 |
| <i>Bureaucratic state contract rules</i> | 56 |
| <i>Opportunities</i> | 56 |
| <i>Consider creating a Consumer Office within Arkansas Department of Health</i> | 56 |
| <i>Continue to seek input from the field—and go there</i> | 56 |
| <i>Improve communication and consider moving some surveillance functions under the jurisdiction of the HIV/STD/Hepatitis C section chief</i> | 57 |
| <i>Examine state public health structure and funding allocation</i> | 57 |
| <i>Centralize functions and streamline paperwork</i> | 57 |
| <i>Revise cumbersome state contracting rules</i> | 57 |
| 4. HIV-related Stigma | 58 |
| <i>Successes</i> | 58 |
| <i>Challenges</i> | 58 |
| <i>Stigma in rural Arkansas</i> | 59 |
| <i>Stigma among faith communities</i> | 60 |
| <i>Opportunities</i> | 60 |
| <i>Education for the public and healthcare providers</i> | 60 |
| <i>Create an antistigma campaign using social media</i> | 60 |
| <i>Seek help from supportive clergy and tailor messages</i> | 61 |
| <i>Routinize voluntary HIV screening and require insurance coverage</i> | 61 |
| 5. Provider Shortages and Capacity | 62 |
| <i>Successes</i> | 62 |
| <i>Challenges</i> | 63 |
| <i>Opportunities</i> | 64 |
| <i>Greater integration of HIV care into existing systems of care</i> | 64 |
| <i>Create “one-stop shops”</i> | 65 |
| <i>Take the show on the road</i> | 65 |

contents

| | |
|--|----|
| <i>Use federal programs to help recruit providers and explore other sources of providers</i> | 66 |
| <i>Consider designating advanced practice nurses as primary care providers</i> | 66 |
| <i>Use telemedicine to improve provider capacity</i> | 67 |
| <i>Use the continuing medical education requirement to improve provider capacity</i> | 67 |
| 6. AIDS Drug Assistance Program | 67 |
| <i>Challenges</i> | 67 |
| <i>Opportunities</i> | 68 |
| <i>Support emergency federal funding for ADAP</i> | 68 |
| <i>Explore using the Comprehensive Health Insurance Pool and amend state law as needed</i> | 68 |
| 7. Other Healthcare Access Challenges | 69 |
| <i>Mental health and substance abuse treatment services</i> | 69 |
| <i>Housing</i> | 69 |
| <i>Transportation</i> | 70 |
| <i>Corrections-related issues</i> | 70 |
| <i>Dental care access</i> | 70 |
| <i>Culturally and linguistically competent services</i> | 71 |
| <i>Lack of comprehensive, science-based health education</i> | 71 |
| APPENDIX A: Arkansas HIV/AIDS Case Prevalence and Rates by County, 2007 | 73 |
| APPENDIX B: Map of Arkansas Counties | 76 |
| APPENDIX C: 2009 Federal Poverty Guidelines | 77 |
| NOTES AND REFERENCES | 78 |

special acknowledgment

SHARP staff would like to give special recognition to our community partner, the Arkansas HIV/AIDS Minority Task Force. Task Force members played a critical and instrumental role in developing this report, and we truly appreciate their help.

The members of the Arkansas HIV/AIDS Minority Task Force volunteer their time, knowledge, and experience to better the lives of people living with HIV/AIDS statewide. We thank them for their dedication and look forward to future collaboration toward the goal of improving access to healthcare for Arkansans living with HIV/AIDS.

Members of the 2009 Arkansas HIV/AIDS Minority Task Force:

- Rick Collins (Cochair)
- Dr. Michelle Smith (Cochair)
- Johnny Adams
- Rueben Arana
- Carol Davis
- Chinetta Davis
- Reverend Sharen Lightsey
- Sylvana Niciteretse
- Dr. Barbara Perry
- Lupita Roy-Rasheed
- Vickie Gibbs-Scott
- Dr. Katherine Stewart
- Jena Thomason
- Dr. Wallace "Al" Thomas
- Idonia Trotter
- Suzann Wilson
- Sue Worsham

acknowledgments

We gratefully acknowledge the contributions of the following individuals, who shared their knowledge, experience, perspectives, and opinions with us in the development of this report.

- Adell Adams, Pine Bluff focus group
- Representative Fred Allen, Little Rock
- Krissten Bagwell, White River Rural Health Center
- Patty Barker, Arkansas Public Policy Panel
- Debbie Biazio, Northeast Arkansas Regional AIDS Network
- Jay Burk, Ft. Smith Fights AIDS
- Anthony Callaway, Pine Bluff focus group
- Dr. Michael Cannon, Arkansas AIDS Foundation
- Bob Coffey, Volunteer Advocate and ADH Consumer Advisory Board
- Rick Collins, Future Builders, Inc.
- Consandra Crawford, Pine Bluff focus group
- Carol Davis, Arkansas Department of Health
- Chinetta Davis, Jefferson Comprehensive Care System, Inc.
- Larnell Davis, Jefferson Comprehensive Care System, Inc.
- Kevin Dedner, Arkansas Department of Health
- Ann Dixon, ADH Consumer Advisory Board
- Sharon Donovan, Arkansas Department of Health
- Cheris Dunivan, White River Rural Health Center
- Senator Joyce Elliott, Little Rock
- Asher Gaddy, Pine Bluff focus group
- Liz Gates, Arkansas Department of Health
- Rayne Gordon, Arkansas Department of Health

acknowledgments

- Kathy Grisham, Community Clinic
- Laura Hanen, National Alliance of State and Territorial AIDS Directors
- Sharon Hewitt, Pine Bluff focus group
- Mark Hollis, ADH Consumer Advisory Board
- Carl Jackson, Black Community Developers, Inc.
- Tiyanika Keller, Arkansas Department of Health
- Diedra J. Levi, Brothas & Sistas (Living With, Affected By)
- Reverend Sharen Lightsey, Jubilee Christian Center
- Thomas Markham, Northwest Arkansas Positive Links Support Network
- Ann Mattingly, Bristol-Myers Squibb
- Kellye McCartney, Arkansas Department of Health
- Tiffany McFadden-Kidd, Arkansas Minority Health Commission
- Patricia Minor, Arkansas Minority Health Commission
- Mark Morehead, Arkansas Department of Health
- Donald Morris, Pine Bluff focus group
- Dr. Creshelle Nash, Arkansas Minority Health Commission
- Kim Newsom, Arkansas Department of Health
- Sylvana Niciteretse, Jefferson Comprehensive Care System, Inc.
- Patrick Packer, Southern AIDS Coalition
- Murray Penner, National Alliance of State and Territorial AIDS Directors
- Lupita Roy-Rasheed, Philander Smith College
- Randy Russell, Healthcare Responses
- Leandra Sanders, Jefferson Comprehensive Care System, Inc.
- Vickie Gibbs-Scott, Arkansas Department of Health
- Representative/Dr. Gene Shelby, Hot Springs

acknowledgments

- Joyce Sims, Pine Bluff focus group
- Dr. Angela Smith, Jefferson Comprehensive Care System, Inc.
- Dr. Michelle Smith, Jefferson Comprehensive Care System, Inc.
- Dr. Nate Smith, Arkansas Department of Health
- Dr. Katharine Stewart, University of Arkansas for Medical Sciences, College of Public Health
- Dr. Al Thomas, Arkansas BlueCross BlueShield
- Steve Thomas, ADH Consumer Advisory Board
- Cherry Whitehead-Thompson, East Arkansas Family Health Center
- Siobhan Traylor, Arkansas Minority Health Commission
- Idonia Trotter, Arkansas Minority Health Commission
- Representative Linda Tyler, Conway
- Melanie Varnado, Pine Bluff focus group
- Kenneth Waller, Alliance on Community Health
- Representative Kathy Webb, Little Rock
- Rodney Wheeler, Jefferson Comprehensive Care System, Inc.
- Vernon Wilsman, ADH Consumer Advisory Board
- Patricia Wright, University of Arkansas for Medical Sciences, College of Public Health
- Sue Worsham, South Arkansas Fights AIDS
- Donna Yutzy, Bridewell Associates
- Sue Gershon, Patrick Tierney, and Mark Bekheit of Harvard Law School, for research and writing assistance
- Elise Procaccio, Laurie Novoryta, and Beth Burnside of Discovery Chicago, for help with logistics
- And especially, all of the Arkansas residents living with HIV/AIDS who met with us and shared their experiences regarding healthcare access

part I: introduction

For HIV/AIDS in Arkansas, this is a time of serious challenge, but also one of opportunity. The Arkansas Department of Health (ADH) HIV/STD/Hepatitis C Section is charged by Arkansas law with the responsibility for protecting public health and controlling these diseases. New leadership in the ADH HIV Section has brought a commitment to fiscal discipline and oversight, heightened accountability, established better communication with stakeholders, and achieved greater collaboration with other agencies. ADH is dedicated to improving prevention efforts and assuring access to quality care for Arkansans living with HIV/AIDS. The Arkansas Minority Health Commission, mandated by state law to study and address minority health disparities, is also concentrating its work on HIV/AIDS. Increased emphasis and improved collaboration among key stakeholders is helping bring new energy to focus on HIV/AIDS prevention and care in the state.

This energy will be much needed to take on the growing and urgent challenge of HIV/AIDS in Arkansas. The South in general is at the epicenter of the current HIV 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,
- the largest percentages of persons with HIV who are not in care, and
- the fewest resources
- a disproportionate impact in minority communities

Arkansas has one of the highest rates in the country of people living with HIV/AIDS who are not receiving regular medical care—at nearly 70%, this is twice the national average and higher than surrounding states. Arkansas also receives the least amount of federal HIV/AIDS funding of any southern state. Other than the state match for those Arkansans living with AIDS who receive Medicaid, Arkansas does not contribute any state funds for HIV care programs, although through the commitment of the Board of Commissioners of the Arkansas Minority Health Commission, some state funds have been directed to HIV prevention and education initiatives. The combination of limited resources and increasing need has forced ADH to make recent painful eligibility cuts in access to services and lifesaving medications.

Arkansas is a relatively poor state with a large rural population, characteristics shared by many Arkansans living with HIV/AIDS. While poverty is not listed specifically as a healthcare access challenge in this report, poverty underlies virtually all of the other challenges

part I: introduction

discussed, and is a major barrier to both HIV prevention and care. As one Delta-area provider put it, “when you have no roof over your head, no food, and hungry children to worry about, HIV is not necessarily your biggest priority.”

Arkansas is also a state with regional demographic and economic differences that can create unique prevention, care, and service needs. Northwest Arkansas, for example, is more affluent and has a larger white population than the rest of the state, but also has sizeable Marshallese and Hispanic populations, who need culturally and linguistically appropriate interventions. The Delta region, which has a larger African American population, currently suffers high levels of poverty and unemployment, and may have more in common with other Deep South Delta states than it does with northwest Arkansas. Differences between more urban and rural areas also may demand different approaches to education, prevention, and care.

Despite the many challenges, Arkansas is in a better position than many other southern states to deal with HIV/AIDS. Arkansas’s HIV and AIDS total case numbers are lower than other southern states, presenting Arkansas with the important opportunity to take action and seize control of the situation before it gets worse. Numerous research studies (as well as common sense) suggest that preventing HIV and providing early access to treatment are cost effective. Prevention and early treatment preserve productivity, prolong health, and help avoid more costly interventions, such as hospitalization and emergency room visits.

In numerous instances, Arkansas has shown that it is willing to invest in programs and support efforts to improve health. In the 2009 legislative session, for example, lawmakers passed a bill requiring health benefit plans to cover an annual prostate cancer screening for men over age 40. We realize that the current economic climate makes it much more difficult to find funds for new initiatives. But Arkansans are practical people who understand that it makes sense (both fiscally and compassionately) to invest in public health now to save more money and lives in the future. Now is the time for state law and policy makers to demonstrate leadership on HIV/AIDS.

While this report views healthcare access challenges through the lens of access to care for people living with HIV/AIDS, it is important to note that most of the challenges discussed apply equally to much wider constituencies. People living with HIV/AIDS in Arkansas 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.

part II: profile of arkansas

OVERVIEW OF THE HIV/AIDS EPIDEMIC IN ARKANSAS

Epidemiological information^{*}

Number of AIDS and HIV cases

As of December 3, 2009, 5,710 Arkansans were estimated to be living with HIV or AIDS (2,978 with HIV and 2,732 with AIDS).¹ The 2007 annual rate of reported AIDS cases was 6.9 per 100,000 in Arkansas, compared with 12.4 nationally.²

In 2007, the most recent year with full data available, Arkansas reported 346 new cases of HIV and 195 new cases of AIDS. As of June 30, 2009, the cumulative total of HIV/AIDS cases is 7,640, 60% (4,609) of which meet the AIDS case definition.³ A total of 1,996 of those diagnosed with AIDS have died. The rate of deaths per 100,000 in Arkansas is 2.0 among whites, 10.8 among African Americans, and 2.5 among Latinos—significantly above the national target of reducing AIDS deaths to 0.7 per 100,000.⁴

Demographics

The incidence of HIV/AIDS is not evenly distributed among different racial, ethnic, or gender groups. Although African Americans make up only 15.5% of the population of Arkansas, they account for 39% of cumulative AIDS cases and 42% of cumulative HIV cases as of June 2009.⁵ In spite of the fact that African Americans are a minority, there were more new reported cases of AIDS among African Americans than among whites in 5 of the past 10 years, and more reported cases of HIV among African Americans than among whites in 7 of the past 10 years.

Whites, who make up 78.6% of the population of Arkansas, account for 58% of AIDS cases and 54% of HIV cases. Hispanics make up 5.3% of the population and account for 3% of cumulative AIDS cases and 2% of cumulative HIV cases.⁶

In 2008, males made up 78% of new AIDS cases and 80% of new HIV cases. Males account for 82% of cumulative AIDS cases and 79% of cumulative HIV cases.

The most common age at diagnosis for **HIV** is between 30 and 39, accounting for approximately 37% of HIV cases, followed by ages 20 to 29, which make up 28% of HIV cases. Twenty-one percent of cases were diagnosed in people ages 40 to 49, and 6% were diagnosed in those between 50 and 59. Only 5% of cases of HIV have been reported among those under the age of 20, and only about 2% of cases have been reported among those over the age of 59.

* Data included in this report were current as of December 2009.

part II: profile of arkansas

The most common age at diagnosis of **AIDS** is between 30 and 39, an age group that accounts for more than 41% of AIDS diagnoses. Twenty-one percent of AIDS diagnoses were in individuals between the ages of 20 and 29, while 25% were in individuals between the ages of 40 and 49. Approximately 11% of AIDS cases were identified in individuals over the age of 49. Fewer than 2% of AIDS cases were identified in individuals under the age of 20.⁷

Arkansas has 221 HIV-positive inmates in state or federal prisons—that is approximately 1% of the prison population in Arkansas.⁸

Reported exposure categories

The largest exposure category for cumulative cases in Arkansas is men who have sex with men, at 50% of the cumulative total of HIV cases and 54% of cumulative AIDS cases, followed by heterosexual (22% of HIV and 19% of AIDS cases) and injection drug use (13% of both HIV and AIDS cases).⁹

Geographic distribution

No one region in Arkansas is the major driver of the HIV/AIDS epidemic. Certain counties consistently rank highest in HIV/AIDS cases, but they are spread from Ouachita and Union counties in the southwest region of the state, to Pulaski County in central Arkansas, to Carroll County in the northwest, Monroe County in the southeast, and Crittenden and St. Francis counties in the Delta.¹⁰ The 10 counties with the highest **HIV** rates (in alphabetical order) are: Calhoun, Carroll, Crittenden, Jefferson, Monroe, Ouachita, Phillips, Pulaski, Scott, and Union. The 10 counties with the highest **AIDS** rates (in alphabetical order) are: Benton, Crittenden, Monroe, Nevada, Ouachita, Poinsett, Pulaski, St. Francis, Scott, and Union.¹¹

Unmet need

Arkansas has perhaps the highest rate of “unmet need” for HIV treatment of any state in the nation. The Arkansas Department of Health (ADH) determined that 65.6% of confirmed HIV and AIDS patients as of December 2006 were “out of care” over the course of the next year (although ADH reports a more recent figure as close to 70%). The department defined “in-care” as “anyone who received CD4 count, viral load count, or treatment” and defined “out of care” as anyone who had not received the aforementioned services.¹² Arkansas’s rate is significantly higher than many neighboring southern states, as shown in the following chart:

part II: profile of arkansas

| State | Percentage of Unmet Need (People aware of HIV+ status, but not receiving care) ¹³ |
|-----------------|--|
| Arkansas | 65.6% |
| Alabama* | 65%* |
| Mississippi | 50% |
| Oklahoma | 48% |
| Tennessee | 47% |
| Louisiana | 43% |
| Texas | 32% |

*Alabama does not require all laboratories to report CD4 and viral load tests, which raises questions about the accuracy of the unmet need number. Furthermore, for newly diagnosed HIV cases, Alabama reports about 64% of individuals are in care (with 36% not in care).

Arkansas ranks poorly in other measures of access to care. People living with HIV in Arkansas are substantially more likely to receive a concurrent AIDS diagnosis (32%), progress to AIDS within 12 months (46%), or die within 12 months of a diagnosis (5%). Because it typically takes 10 years for HIV disease to progress to AIDS, these statistics indicate that many Arkansans are being diagnosed and entering care in extremely late stages of their illness. As the following chart demonstrates, Arkansas is nearly double the national average in some categories and significantly higher than other states in the region.¹⁴

| State | Newly reported HIV who also had an AIDS diagnosis within CY 2007 | Newly reported HIV who progress to AIDS within 12 months of diagnosis | Newly reported HIV who die within 12 months of diagnosis |
|----------|---|--|---|
| Alabama | 29% | 31% | 2.7% |
| Florida | 12% | 22% | 2% |
| Georgia | 37% | 24% | 4.1% |
| Missouri | 15% | 18% | 4% |
| Average | 23.5% | 23% | 3.4% |
| Arkansas | 32% | 46% | 5% |

part II: profile of arkansas

Funding

Arkansas received slightly over \$12.7M in federal HIV/AIDS funding in fiscal year (FY) 2008. This is the lowest total level of federal funding of any southern state. Arkansas's federal funding broke down as follows: \$9.6M in Ryan White funding, \$1.9M in Centers for Disease Control and Prevention (CDC) HIV/AIDS funding (of which \$1.4M was for HIV prevention efforts), \$400,000 in Substance Abuse and Mental Health Services Administration funds for substance abuse treatment, and \$766,000 in Housing Opportunities for Persons with AIDS (HOPWA) funding.¹⁵

STATE ECONOMIC PROFILE

Arkansas's 2007 gross domestic product (GDP) was \$95.116B. This amounts to about 0.7% of the total United States GDP, a figure which has held steady since 1997. The per capita GDP for 2007 was \$27,810. This is the third lowest per capita GDP in the nation, higher than only Mississippi and West Virginia. Arkansas's GDP, measured in chained 2000 dollars, has grown steadily between 1997 and 2008, for a total increase of 26.8%. This growth was slower than the national GDP growth of 33%.

Eighty-six percent of Arkansas's GDP comes from private industry, including 18% from manufacturing (10% manufacturing of durable goods, 8% manufacturing of nondurable goods). Wholesale trade, retail trade, real estate, rental, and leasing, and healthcare and social assistance each contribute more than 5% to the GDP. Fourteen percent of Arkansas's GDP comes from the public sector.¹⁶ The state's principal industries are manufacturing, agriculture, forestry, business services, and tourism.¹⁷ Fifty-six percent of Arkansas's private businesses have fewer than 10 employees, 76% have fewer than 100 employees, and 24% had more than 100 employees. Five Fortune 500 companies have headquarters in Arkansas and serve as major employers to the state, including Wal-Mart Stores (Bentonville), Tyson Foods (Springdale), Murphy Oil (El Dorado), Alltel (Little Rock), and Dillard's (Little Rock).¹⁸

Arkansas is a predominantly rural state with an extremely productive agricultural sector. In 2008, agriculture accounted for \$3.3B of Arkansas's GDP and 3.1% of Arkansas's workforce was employed in the agricultural sector.¹⁹ There are nearly 50,000 farms in Arkansas, covering 13,700,000 acres of land—40% of the state's acreage. Arkansas ranks 13th in the nation in the total value of agricultural products sold, 2nd in the nation in poultry production, and devotes more acres to rice production than any state in the nation.²⁰

part II: profile of arkansas

Between 2006 and 2008, the median household income in Arkansas was \$40,507—the third lowest median household income in the country, ranking above only Louisiana and Mississippi.²¹ Arkansas's unemployment rate, however, is lower than the national average, at 7.1% as of September 2009, compared with 9.8% for the country as a whole.²²

The personal income tax rate in Arkansas ranges from 1% to 7%. All individuals earning more than \$10,000 per year and families earning more than \$17,500 per year must pay state income taxes. All incomes over \$31,000 per year pay the highest individual rate. The corporate tax rate ranges from 1% to 6.5%. The sales tax rate is 6%. The tax rate on food items was recently lowered to 3%. Arkansas has a sin tax on both tobacco and alcohol but both are lower than most states around the country.²³ Arkansas did raise its tobacco tax by 56 cents (from 59 cents to \$1.15 per pack) in the 2009 legislative session, with the proceeds intended to support health-related initiatives.²⁴ This brings Arkansas closer to, but still less than, the national average tobacco tax of \$1.19 per pack.²⁵

STATE DEMOGRAPHIC PROFILE

According to the US Census Bureau's estimates, the total population of Arkansas was 2,830,047 as of 2008. The median age is 37.1—very close to the national median of 36.7. Fourteen percent of the population was 65 or older, somewhat higher than the national average of 12.6%. A total of 24.7% of the population was under the age of 18, compared with 24.5% of the population nationally.

A total of 78.6% of the population of Arkansas is white and 15.5% is black. In addition, Arkansas's population includes Native Americans (0.7%), Asians (1.1%), Native Hawaiians and other Pacific Islanders (0.1%), people of 2 or more races (1.8%), and people of other races (2.3%). Five percent of the population of Arkansas is Hispanic or Latino. Arkansas has a higher percentage of white and black residents than the national averages of 74.3% and 12.3% respectively, and a lower percentage of most other groups (15.1% Hispanic, 0.8% Native American, 4.4% Asian, and 2.2% 2 or more races).²⁶

Arkansas is a heavily rural state. Though a majority of the population of Arkansas, about 60%, lives in urban areas, this number is still substantially lower than the national average of 83%. Rural Arkansas is substantially poorer than urban areas of Arkansas, with a poverty rate of 20%, as opposed to 16% in urban areas. The 2008 unemployment rate is 6% in rural Arkansas and 4.5% in urban Arkansas. Rural per-capita income in 2007 is \$25,650 and rural earnings per job are \$31,376. In comparison, per-capita income in urban areas is \$33,258, and earnings per job are \$40,899.²⁷

part II: profile of arkansas

Arkansas residents in rural areas have had less formal education on average than those in urban areas—as of 2000, 29% of rural residents 25 and older had not completed high school, compared with 21% in urban areas. Only 12% of rural residents completed college, while 20% of those in urban areas did.

HIV and AIDS cases are concentrated in urban areas. While 60% of the population lives in a county classified as metropolitan, 73% of HIV cases and 72% of AIDS cases were reported in those counties.²⁸ Nevertheless, Arkansas's rate of rural HIV and AIDS cases (27% and 28%, respectively) is significantly above the averages for the nation (7% in 2006) and the South as a region (10% in 2006).

OVERVIEW OF STATE GOVERNMENT STRUCTURE AND POLITICAL ENVIRONMENT

Arkansas is a fiscally and socially conservative state with a Democratic General Assembly, a Democratic governor, and a Democratic Congressional delegation. The state legislature has 100 representatives and 35 senators. Democrats dominate both houses of the legislature—71-38-1 in the House and 28-7 in the Senate—with Republicans having small footholds in the northwest and northeast of the state.²⁹ Democratic Governor Mike Beebe was elected in 2006 with 55% of the vote, replacing Republican Mike Huckabee.³⁰ In the 2008 election President Obama received only 39% of the vote, his sixth lowest total for any state in the nation.³¹ Senators Lincoln and Pryor are widely regarded as two of the most conservative Democrats in the US Senate. Both have been reelected by healthy margins even as the state voted for Senator McCain in 2008 and President Bush in 2000 and 2004. Three Democrats and one Republican represent Arkansas in the House of Representatives. In general, Arkansas Democrats are more aligned with typically Republican policies than their national counterparts, allowing them to maintain their traditional dominance in what is otherwise a very conservative state.

Structurally, the Arkansas state government has some important characteristics that shape the nature of state representation and state health policy. The state legislature has a large number of representatives per capita. Each of the 100 House members represents approximately 20,000 constituents—compared to approximately 460,000 constituents per California legislator. The legislature typically meets from January to March each year, but in 2010 will begin a new system with distinct fiscal sessions and

part II: profile of arkansas

regular sessions in alternating years. Legislators are also term limited, placing significant pressures on elected officials to be immediately responsive to active voters but also posing challenges to legislators hoping to develop institutional memory and deep expertise.

The distribution of powers between the major state agencies also affects the development and administration of state and federal health programs in Arkansas. The major public health programs are split between the Department of Human Services (DHS) and the Arkansas Department of Health (ADH). The Department of Human Services controls the Medicaid program as well as substance abuse and mental health services, while ADH is responsible for general public health programs and HIV-specific programs like Ryan White and the AIDS Drug Assistance Program (ADAP). Despite the potential inefficiencies of this division of labor, a past attempt to combine the departments is widely regarded as a failure. The number of overlapping positions, confused lines of authority, and poor administration are often cited as the reasons the departments were eventually split apart. Additionally, while more than three-fourths of US states place their state AIDS director in charge of HIV surveillance, Arkansas does not.³²

Arkansas is a fiscally conservative state with unique appropriations and revenue systems. Arkansas's tax structure relies more heavily on regressive forms of taxation than most other states, and requires a three-fourths supermajority for income tax increases. Sales taxes require only a majority vote.³³

The state constitution bars any state borrowing without a vote of the people and mandates that no monies arising from a tax levied for one purpose can be used for any other purpose. These 2 basic mandates, combined with the state's Revenue Stabilization Law, create a system where the state always has a balanced budget and has considerable flexibility in cutting costs. Most revenue is not earmarked for a specific use but is distributed into priority-based categories by the legislature. These categories allow the state to separate out monies that urgently need to be spent from wish-list items that can more easily be cut if revenue falls. After funds are separated by category, they are then appropriated to individual programs through more than 1,300 appropriations bills. After money is appropriated, the legislature reviews and must give its approval to all agency contracts worth more than \$25,000.³⁴

part II: profile of arkansas

GENERAL HEALTH

Health insurance coverage

Arkansas residents are slightly less likely to be insured than American residents on average, and those who have insurance are more likely to receive it through public programs. One exception to this is insurance coverage of children, where Arkansas does better than the national average.

Approximately 82% of Arkansas residents have health insurance, slightly lower than the national average of 85%. Of the insured population, 46% receive health insurance through an employer, compared to 52% nationally. A total of 4.4% have private insurance through the individual market (similar to the national average), 16.5% have Medicaid (compared with 14% nationally), 14% have Medicare (compared with 12% nationally), and 2% have other public insurance.³⁵ Insurance rates vary throughout the state, with 15% of residents in central Arkansas lacking coverage but markedly lower insurance rates in surrounding public health areas: 23% lack coverage in the southeastern public health region, 21% in the southwest, 20% in the northeast, and 18% in the northwest.³⁶ Health insurance rates also vary by race. In 2008, 27.4% of African Americans and 15.5% of whites in Arkansas lacked any kind of healthcare coverage (Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention & Health Promotion, Behavioral Risk Factor Surveillance System, Health Care Access/Coverage, Arkansas-2008).

Among the nonelderly, rates of insurance are somewhat lower. Eighty percent of nonelderly Arkansas residents are insured, compared with 83% nationwide. Fifty-two percent receive health insurance through an employer, compared with 60% nationwide; 18% receive Medicaid, compared with 15% nationally; 5% have private individual health insurance, the same as the national rate; and nearly 5% receive other public insurance, compared with under 3% nationwide.

The Arkansas Center for Health Improvement cites even higher rates of uninsurance among Arkansas's nonelderly. For adults aged 19 to 64 years, 25% do not have coverage, and for those 19 to 44 years, 30% are estimated to be uninsured.³⁷

A unique feature of Arkansas's healthcare system is the significant state effort to offer coverage for children. Ninety-two percent of Arkansas's children are insured—a higher rate than that of children nationwide (89%). Forty-two percent of children receive health

*Not including ARKids First, the state's children's health insurance program

part II: profile of arkansas

insurance through an employer-sponsored plan (compared with 54% nationwide), 45% have Medicaid* (compared with only 30% nationally), and just under 4% have private insurance (roughly the same as the national level). Approximately 78% of poor children receive Medicaid in Arkansas, compared with 64% nationally.³⁸

Health insurance costs

Arkansans pay the second highest premium share of any state in the country. From 2000 to 2007, the average health premium for a family in Arkansas increased more than 5 times the rate of wage growth.³⁹ Wages increased by 11.6%—an average of \$2,364—while premiums increased by 65.8%—an average of \$4,179.⁴⁰ In 1997, employer-based family health insurance cost an average of \$4,539; the cost of similar coverage in 2006 had risen to \$9,928.⁴¹ By 2016, at current increase rates, the cost of similar insurance is projected to be \$21,715, which would consume 48.4% of projected Arkansan family income.⁴² Across the nation, the average premium share for an employee is 25%. In Arkansas, employees pay an average 32% of the cost of their coverage. About 27% of middle-income Arkansas families spend more than 10% of their income on healthcare.

A significant portion of these costs is a result of uncompensated care for the uninsured. According to the Arkansas Center for Health Improvement, Arkansans pay a “hidden health tax of roughly \$1,500 per year on premiums as a direct result of subsidizing the costs of the uninsured.”⁴³

Death rates and causes

In 2006, Arkansas had 992.6 deaths per 100,000 residents, compared with 810.4 nationwide. The overall age-adjusted death rate among blacks (1118.5 per 100,000) was substantially higher than that among whites (862.7 per 100,000) (Source: Centers for Disease Control and Prevention, National Center for Health Statistics, Compressed Mortality File 1999-2006, accessed at <http://wonder.cdc.gov/cmfi-icd10.html>, Mar 11, 2010). Within all but one age bracket, non-white death rates exceeded white death rates.

White and Non-white Death Rates per 100,000, by Age

| Age Range | White | Non-white |
|-----------|--------|-----------|
| 1-4 | 34.0 | 73.0 |
| 5-14 | 22.4 | 14.6 |
| 15-24 | 114.9 | 132.8 |
| 25-44 | 194.9 | 295.7 |
| 45-64 | 776.3 | 1075.4 |
| 65+ | 4932.3 | 5543.6 |

part II: profile of arkansas

By far the leading causes of death in Arkansas were heart diseases and cancer, at 264.1 and 219.7 per 100,000 respectively.⁴⁴

Most Common Causes of Death in Arkansas

| | | |
|----|-----------------------------------|-------|
| 1 | Heart diseases | 26.6% |
| 2 | Cancer | 22.1% |
| 3 | Cerebrovascular | 6.8% |
| 4 | Chronic lower respiratory disease | 5.4% |
| 5 | Accidents | 5.1% |
| 6 | Diabetes | 3.0% |
| 7 | Alzheimer's | 2.8% |
| 8 | Influenza/Pneumonia | 2.8% |
| 9 | Nephritis/Nephrosis | 2.2% |
| 10 | Septicemia | 1.8% |

Causes of death varied by race. Homicides were the 6th most common cause of death among non-white residents, and HIV/AIDS was the 14th most common cause of death among non-white residents. Neither cause of death ranked in the top 15 for white residents. Heart diseases and cancer were more common causes of death for whites than for non-whites. Arkansas death rates were higher than national death rates in each of the top 10 causes of death. In 2005, the infant mortality rate was 806 per 100,000, compared with 687 per 100,000 nationally.

Health status and behaviors

Arkansas ranks 44th in the nation in the prevalence of smoking among adults. Twenty-three percent of Arkansas adults smoke, compared with 18% of the population nationwide.

Arkansas residents report slightly less physical activity than Americans nationwide, with 46% participating in moderate or vigorous physical activities, compared with 49% nationally.

part II: profile of arkansas

Arkansas has somewhat higher rates of overweight and obese adults than the national average. Approximately 65% of Arkansas residents are overweight (including those who are obese), compared with 63% of United States adults. More men than women are overweight (73% and 53%, respectively). About 29.5% of Arkansas residents are obese, compared with about 26.6% nationally. Arkansas is tied for the seventh highest obesity rates in the nation.

Thirty-three percent of Arkansas adults report that they have poor mental health: roughly in line with the national average.⁴⁵

The rate of chlamydia cases is lower than the national rate, at 354 per 100,000, compared with 370 per 100,000. The rate of gonorrhea in Arkansas is higher than the national rate, at 148 cases per 100,000, compared with 119 per 100,000. The rate of syphilis is comparable with the national rate, at 13 per 100,000 and 14 per 100,000 respectively.⁴⁶

A recent report on health system performance across the nation ranked Arkansas 48th out of the 50 states and the District of Columbia, ahead of only Louisiana, Oklahoma, and Mississippi. The report assessed states' performance on healthcare in terms of access, quality, costs, and health outcomes. One positive note is that more than half of Arkansas's performance indicators improved by 5% or more from 2007 to 2009, and the state improved from its 49th place 2007 ranking.⁴⁷

Healthcare facilities and providers

As of Summer 2009, Arkansas has 103 licensed hospitals. Arkansas has 95 hospitals that are members of the Arkansas Hospital Association (AHA). Of those, 22 are urban general hospitals, 21 are rural community hospitals, and 28 are critical access hospitals. Critical access hospitals are acute care facilities created under the Medicare Rural Hospital Flexibility Program, which provide outpatient, emergency, and limited inpatient services. The remaining AHA-member hospitals are classified as specialty (7), psychiatric (7), long-term care (5), rehabilitation (3), and veterans (2) facilities. These AHA-member hospitals are distributed across the state.⁴⁸

Arkansas's first Congressional district, which covers the northeastern portion of the state and includes Arkansas, Baxter, and Jackson counties, has 22 AHA-member hospitals. Arkansas's second Congressional district, which covers the center of the state and includes Pulaski, Faulkner, and Conway counties, has 29 AHA-member hospitals. Arkansas's third Congressional district, which covers the northwestern corner of the state and includes Washington, Johnson, and Pope counties, has 21 AHA-member

part II: profile of arkansas

hospitals. Arkansas's fourth Congressional district, which extends across the southern half of the state and includes Montgomery, Union, and Jefferson counties, has 26 AHA-member hospitals.⁴⁹

The remaining 8 hospitals in Arkansas are non-AHA members and are classified as critical access (1), rehabilitation (3), and long-term acute healthcare (4) facilities.⁵⁰ There are also 75 rural health clinics in Arkansas.⁵¹

Fifty-nine of Arkansas's 75 counties are classified as medically underserved areas by the Arkansas Department of Health (ADH) under US Department of Health's federal guidelines. Fourteen more counties are classified as partially medically underserved areas. The Arkansas Department of Health classified only Boone and Grant counties as having adequate access to medical services.⁵² As to mental health treatment, 46% of Arkansas's population was classified as living in a mental health professional shortage area as of September 2008. This compares to 18% of the United States population.⁵³

As indicators of access to care, in 2008, 16% of Arkansans experienced a time when they could not see a doctor because of cost, 17% did not have a personal doctor, and 37% did not have a routine checkup.⁵⁴

There are 8,225 medical doctors,⁵⁵ 30,935 registered nurses, and 762 nurse practitioners licensed to practice in Arkansas.⁵⁶ In 2004, ADH reported that 72% of all physicians (55% of primary care and 79% of secondary care providers) were located in Arkansas's population centers — Little Rock, Rogers/Bentonville, Fayetteville/Springdale, Fort Smith, Hot Springs, Jonesboro, and Pine Bluff.⁵⁷ The Office of Rural Health and Primary Care designated 30 counties and parts of at least 15 other counties as suffering from a primary care health professionals shortage. All or part of 17 counties have a ratio of 1 or fewer physicians to 5,000 persons. All or part of 13 other counties have a ratio of 1 physician to 4,000-4,999 persons.⁵⁸

HIV testing

There are 104 HIV/AIDS testing locations in Arkansas. These include county health departments and county health units (county health units represent parts of larger counties), as well as AIDS service organizations and other community organizations.

In 2007, 44% of Arkansans reported ever having an HIV test.⁵⁹ In 2001, 43% reported ever having had an HIV test, compared with 46% of the national population. In the same 2001 study, 29% reported having received an HIV test in the preceding 12 months. The national figure was 28%.⁶⁰

part II: profile of arkansas

Arkansas law provides for voluntary, confidential HIV testing.⁶¹ Arkansas has had name-based reporting requirements for HIV since July of 1989.⁶² Arkansas does not require informed consent for HIV testing when, in a physician's judgment, the test is medically indicated and the subject of the test has otherwise provided consent for medical treatment.⁶³ Counseling is not required to be provided with HIV test results, except in the cases of healthcare worker occupational exposure, sexual offense victims, and first responder (police, fire fighters, emergency medical technicians) exposure through assault and battery.⁶⁴ Arkansas has a policy of opt-out HIV testing of pregnant women, meaning that healthcare providers are required to test pregnant women as early as possible in their pregnancies or at the time of delivery unless they refuse testing.⁶⁵

Substance abuse and mental health facilities

The Division of Behavioral Health Services in the Arkansas Department of Human Services contracts with 15 community mental health centers (CMHCs). Each CMHC is required to provide diagnostic evaluation, treatment planning, individual therapy, group therapy, medication management, case management, crisis services, vocational, housing and educational support, transportation, and rehabilitative and day treatment services. Community mental health centers have service sites in 69 of the 75 counties in all of the state's 15 "catchment" areas. The CMHCs provide services from 135 service sites throughout the state of Arkansas.⁶⁶

Each of Arkansas's 15 "catchment" areas also has a licensed substance abuse treatment center. Licensed treatment centers that accept publicly funded clients have 2,075 treatment slots, 970 of which are funded by the state. A total of 16,061 people received treatment at licensed facilities in 2006, and 5,800 people were placed on a waiting list. Only 814 (14%) of those on the waiting list received services.⁶⁷

The state's Office of Alcohol and Drug Abuse Prevention is responsible for funding of alcohol and drug prevention and treatment services, providing court ordered treatment, licensing of alcohol and drug treatment programs, the State Methadone Authority, administering the drug and alcohol safety educational programs, and providing training to the field of substance abuse. The office distributes federal and state grants to local organizations (27 in 2007), funds 13 prevention resource centers, licenses 49 treatment programs, approves opioid treatment programs, and oversees court ordered treatment. Additionally the office funds 13 regional alcohol and drug detoxification centers, 14 residential/outpatient centers, 5 secure treatment beds, 8 outpatient programs, 7 special women's services programs, 3 residential adolescent treatment programs, 1 methadone program, and 14 drug and alcohol safety education programs.

part II: profile of arkansas

In state FY07, more than 69,000 persons received mental health services and more than 16,000 received substance abuse prevention and treatment services through the Bureau for Homeless and Housing Shelters.⁶⁸

HEALTH PROGRAMS SERVING HIV-POSITIVE INDIVIDUALS

Medicaid

Medicaid is Arkansas's plan for medical assistance under Title XIX of the Social Security Act. Arkansas Medicaid is run by the Arkansas Department of Human Services (ADHS), and serves 750,000 individual beneficiaries annually through more than 24,000 providers. The program provides both mandatory and some optional services, including domiciliary care services, prescription drugs, and rehabilitative hospital services, as well as a number of services available only to those under age 21.

Total Medicaid spending for Arkansas was \$3,693,500,000 in 2008. Acute care made up 70% of total spending, long-term care made up 20%, and prescription drugs made up 10%. The state funds approximately 27% of program-related costs and the federal government pays for 73%—the second highest federal medical assistance percentage (FMAP) in the nation, surpassed only by Mississippi. Administrative costs are generally split evenly between the state and federal governments.⁶⁹

About 26% of Arkansas residents were enrolled in Medicaid as of 2009, including 16% of the state's elderly, 12% of adults, and 63% of children.⁷⁰ In 2006, 14.9% of enrollees were disabled, which is generally in line with the national average. Among nondisabled enrollees, 56% were children, 20% were adults, and 8.6% were elderly. Arkansas Medicaid covers 5% more children than the national average but 5% fewer adults and 2% fewer elderly.⁷¹

Individuals are certified as eligible for Medicaid by ADHS staff at the state's county human services offices or district Social Security offices. Arkansas limits Medicaid eligibility based on income.⁷² There is no asset test for children or expanded Medicaid for parents, but there is an asset test (\$1,000 for a family of 3) for preexpansion Medicaid for parents.⁷³

Income limits on eligibility for working parents are far stricter in Arkansas than nationally—at \$3,060, Arkansas's limit represents just 17% of the federal poverty level (FPL). In comparison, the national eligibility average is \$11,928, or 68% of the FPL.⁷⁴

part II: profile of arkansas

In contrast, income limits on eligibility for pregnant women, infants, and children are more generous than the national average: \$35,200 (200% of the FPL), compared with \$23,408 (133% of the FPL) nationally. While in Arkansas the enrollment threshold for children ages 6-19 is the same as that for infants, pregnant women, and other children, nationally the threshold for older children is lower—\$17,600 (100% of the FPL) on average.⁷⁵

Three percent of the population of Arkansas, 95,802 people, receives Supplemental Security Income (SSI), which is close to the national average of 2%. To qualify for SSI an individual must be over 65, blind or disabled, and have very low income. A disabled person, according to Social Security, is unable to perform any significant gainful activity, for a period of 12 months or has a condition that results in death.⁷⁶

Benefits for adults are limited in several ways. As with all Medicaid programs, care provided must be medically necessary. Medicaid covers a maximum of 12 hospital outpatient visits and 12 office visits (not counting 1 basic family planning visit and 3 periodic family planning visits). Adult beneficiaries (except for nursing facility beneficiaries) are limited to 3 pharmaceutical prescriptions, including refills, per month. Extensions may be granted for a maximum of 6 prescriptions per month for beneficiaries at risk of institutionalization. Inpatient hospital days are limited to 23 per state fiscal year, except for early periodic screening, diagnosis, and treatment beneficiaries and certain organ transplant patients.⁷⁷ In 2009, Arkansas Medicaid added an adult dental benefit.

Arkansas requires some cost sharing by beneficiaries. Some beneficiaries must pay the first 10% of the first day of hospital stays, and some must pay 50 cents to \$3 of each prescription. Beneficiaries in the working disabled aid category are required to pay 25% of the charges for the first day of inpatient hospital service, and have a higher copayment on some additional services.⁷⁸

Arkansas has a medically needy category called “Medicaid spend-down,” which enrolled 14,300 in 2003, the most recent year for which data are available. The program is open to individuals who “spend down” (ie, spend money on medical care such that their remaining income is reduced) to an income level of \$108 (15% of the FPL) and have \$2,000 or less in resources, and to couples who spend down to an income level of \$217 (22% of the FPL) and have resources of \$3,000 or less.

Arkansas does not have any 1115 or Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA) programs specifically designed for people with HIV.⁷⁹

part II: profile of arkansas

Arkansas does have an 1115 HIFA waiver for a program called ARHealthNetworks, which began in 2006 as a program designed to allow employers who had not previously provided health insurance to their employees to provide a "safety net" benefit package through a public-private partnership. The program covers low-income workers (at or below 200% FPL) at businesses with fewer than 500 employees that have not had a health plan for more than 1 year. The plan bars denial of coverage for preexisting conditions, sets a maximum annual benefit of \$100,000, and covers 7 inpatient days per year, 2 major outpatient services per year, 6 physician office visits per year, and 2 prescriptions per month. Drugs are subject to copay of \$5 generic, \$15 brand formulary, and \$30 brand nonformulary. The plan subsidizes premiums from \$25 to \$250 depending on income. Its enrollment has grown from just over 2,000 when it began 3 years ago to nearly 8,000.⁸⁰

Arkansas also has waivers to cover nonemergency transportation services, children in families up to 200% FPL, and family planning services for women ages 14 to 44 between 133% and 400% of FPL.⁸¹

Arkansas also offers home- and community-based services (HCBS) under 3 programs—the mandatory home health benefit, the optional personal care services benefit, and optional 1915(C) HCBS waivers for people with mental retardation/developmental disabilities (MR/DD), elderly people, people with physical disabilities, and elderly people with physical disabilities.

As of 2005, Arkansas had 34,371 participants in HCBS programs, including 6,788 home health participants, 12,131 participants in 1915(c) HCBS waiver programs, and 15,542 recipients of personal care services. Arkansas spends \$13,140,257 on home health expenditures, \$61,133,807 on personal care service expenditures, and \$125,829 on HCBS waiver expenditures.

The largest category of beneficiaries of the waiver program is the aged (7,420 participants), followed by those with MR/DD (3,342), physically disabled individuals (1,273), and those who are aged and disabled (56). Expenditures per participant ranged from \$22,367 for MR/DD participants to \$11,632 for physically disabled recipients, \$7,534 for aged/disabled recipients, and \$4,711 for aged recipients.

As of 2006, there were 714 individuals on waiting lists for the HCBS waiver program, all of whom fell into the MR/DD category. Unlike some states, Arkansas's waiver program does not have a category for those living with HIV/AIDS.⁸²

part II: profile of arkansas

Medicare

Arkansas has 505,634 residents (18% of the state population) enrolled in Medicare. Approximately 78% are eligible based on age, and 22% are eligible due to disability. Arkansas's Medicare program spends \$6,529 per enrollee—most of which goes to hospital care (\$3,951) and physician and clinical services (\$1,587).

A total of 101,319 individuals, 22% of those Medicare enrollees, are "dual eligibles"—eligible for both Medicare and Medicaid. In 2005, the state of Arkansas paid \$45M in Medicare premiums for dual eligibles, \$53M for Medicare-covered acute care services, \$24M for other acute care, \$48M for prescription drugs, and \$171M for long-term care—a total expenditure of \$342M.⁸³

State Children's Health Insurance Program

ARKids First-A is the Arkansas Medicaid program for children. ARKids First-B is for people whose income is above the threshold for regular Medicaid, but who still do not have health insurance for their children. For ARKids-A the income limit for a family of 3 is \$24,352.20 for children under age 6 and \$18,309.96 for children age 6 and over. For families with children under 6, the income limit increases by approximately \$5,000 for each additional child, and for families with children age 6 and over, the limit increases by approximately \$3,000. For ARKids-B the income limit for a family of 3 is \$36,619.92 regardless of the age of the children, and the income limit increases by approximately \$7,500 with each additional child. ARKids-A does not require cost sharing. ARKids-B does require cost sharing (copayments and coinsurance) but caps cost sharing at 5% of the family's annual pretax income. Both programs provide a variety of medically necessary services, such as emergency room services, physician services, and prescription drugs, as well as preventative care such as immunizations.⁸⁴ Together, the programs have helped Arkansas cut the rate of uninsured children from 21% in 1997 to 9% in 2009.⁸⁵

AIDS Drug Assistance Program

The AIDS Drug Assistance Program (ADAP) provides certain HIV-related medications to some people with HIV/AIDS who do not have or have only limited coverage under Medicaid, Medicare, or private insurance. Medications are covered only if they are included under the ADAP formulary, and the medications must be dispensed through Healthcare Pharmacy, the Arkansas ADAP-approved pharmacy.

In FY08, Arkansas's ADAP budget was \$4,245,310, all of which was federal funding allocated under a Ryan White Part B ADAP earmark. Arkansas contributed no state dollars in FY08 to its ADAP.

part II: profile of arkansas

The AIDS Drug Assistance Program in Arkansas had 393 clients (72% of whom were uninsured) and filled 1,294 prescriptions in June 2008, the most recent date for which information is available. During the same period, ADAP spent \$729,460 on total drug purchases.

Arkansas's ADAP covers 51 HIV/AIDS medications, including all approved NRTIs (11), NNRTIs (3), 9 of 10 approved protease inhibitors, the 1 approved fusion inhibitor, the 1 approved multiclass combination product, and 15 of the 29 Public Health Service recommended "A1" opportunistic infections prophylaxis drugs. Arkansas's ADAP does not cover any CCR5 antagonists or integrase inhibitors, but it covers 11 other medications.⁸⁶

Because of inadequate resources and steeply increasing need, financial eligibility for ADAP was cut twice in 2009, first from 500% FPL to 200% FPL in May 2009, then to 150% FPL in November 2009.⁸⁷ After not having had a waitlist for ADAP since 2006, Arkansas reinstated a waitlist in Fall 2009. Active and careful management of ADAP by ADH allowed the income eligibility level to return to 200% FPL in early 2010, and allowed the individuals on the waitlist to be enrolled in the program. As of April 1, 2010, there was no one on the ADAP waitlist.

Ryan White Program

In FY08 Arkansas received \$9,644,768 in funding under the Ryan White Program—\$7,900,830 under Part B, \$1,130,027 under Part C, and \$613,911 under Part D.⁸⁸

The Arkansas Department of Health (ADH) is the Part B grantee. Part C Early Intervention funds go to Jefferson Comprehensive Care System, Inc. (JCCSI) (\$541,341), East Arkansas Family Health Center (\$299,384), and White River Rural Health Center (\$289,302). Jefferson Comprehensive Care System, Inc. also has a \$24,740 Part C Development and Planning grant. Part D grantees receive dedicated funding to provide services for women, infants, children, and families. In Arkansas the 2 recipients are JCCSI (\$341,402) and White River Rural Health Center (\$228,080).

ADH has used a ConsortiaCARE model to administer its Part B funding throughout the state. This model will be changing in 2010 to a service access center system that will incorporate medical case management and create more points of access to care around the state. More information about the new service delivery system can be found in the Request for Applications (RFA) issued by ADH in October 2009.⁸⁹ Under the new service delivery system, Jefferson Comprehensive Care System, Inc. (JCCSI) and White River Rural Health Center are the agencies contracted to provide Ryan White-funded services throughout the state.

part II: profile of arkansas

The Arkansas Department of Health also contracts directly for physician, oral health, and pharmacy services and has 94 local health units in all of Arkansas's 75 counties. The department also has 22 public health investigators who provide diagnostic, partner notification/referral, and treatment services to individuals with STDs.⁹⁰ As of November 2009, ADH lists 17 Ryan White Part B providers for physician services, 16 oral health providers, and 2 specialty physician services providers.⁹¹

Because of limited resources and increasing demand, ADH cut the financial eligibility level for Ryan White services from 500% FPL to 200% FPL in 2009.

OTHER PROGRAMS SERVING PEOPLE WITH HIV/AIDS

Housing Opportunities for Persons with AIDS

The Housing Opportunities for Persons with AIDS (HOPWA) program provides accessible housing and support services statewide for low-income individuals with HIV through tenant-based rental assistance and short-term rent, mortgage, and utility assistance. Service areas for the HOPWA program are divided according to the 4 US Congressional districts for Arkansas. The state does not provide services in Crittenden County, which relies on neighboring Memphis, Tennessee, for its HOPWA funding.⁹³

The HIV Services Section of the Arkansas Department of Health (ADH) administers the HOPWA program. Under subgrant agreements with ADH, the Northeast Arkansas Regional AIDS Network, the Arkansas AIDS Foundation, and White River Rural Health administer short-term rental assistance, long-term housing assistance, and utility assistance.⁹⁴

In FY08, Arkansas received \$766,000 in federal HOPWA funding. The state does not contribute any funds towards the program.⁹⁵

Centers for Disease Control and Prevention

The Centers for Disease Control and Prevention (CDC) makes annual grants to states, localities, and community-based organizations for HIV prevention, surveillance, and capacity building. In FY08, Arkansas received \$1,972,199 from the CDC. A total of \$1,487,501 went for HIV prevention and \$206,099 for community-based organizations and capacity building assistance. Arkansas also received \$1,106,106 for general STD prevention in FY08.

*ADH numbers the districts 1, 2, 3, and 5 because the original 6 districts were combined into 4.

part II: profile of arkansas

OTHER HIV-RELATED PROGRAMS, LAWS, AND POLICIES

The HIV Prevention Program provides education and training on HIV transmission, ways to avoid infection, federal regulations regarding HIV in the workplace, and education on federally required counseling. The AIDS/STD Surveillance Program conducts surveillance and research to characterize and track infections in Arkansas.⁹⁶ However, as discussed previously, where three-fourths of US state AIDS directors have authority over their surveillance program, Arkansas's state AIDS director does not.

Under Act 614 of 1989, exposing another individual to HIV without providing notice is a Class-A felony in Arkansas. Failure to inform a medical provider of HIV status is a Class-A misdemeanor under Act 413 of 1989. Arkansas also has an HIV Shield Law, relieving healthcare providers of the obligation to provide informed consent before an HIV test if they have been exposed to a patient's bodily fluids.⁹⁷ Two other key HIV policies in Arkansas are the lack of a sterile needle exchange program and a requirement that if sex education is provided abstinence must be stressed.⁹⁸

ARKANSAS INSTITUTIONAL EFFORTS TO IMPROVE CARE

Arkansas Minority Health Commission

Established through the enactment of Act 912 of 1991, the Arkansas Minority Health Commission (AMHC) is charged to study issues relating to the delivery and access of health services; identify gaps in health delivery systems; make recommendations to relevant agencies and the General Assembly for improving health delivery and study and make recommendations as to whether services are adequate and available. In 2001, the Arkansas General Assembly passed Initiated Act 1, which charges the AMHC with creating greater awareness of disorders that disproportionately impact minority groups (African American, Asian, Hispanic, Native American) in Arkansas. AMHC works to increase awareness, provide screenings or access to screenings, and develop intervention strategies and pilot projects to address minority health disparities. As a result of a strategic planning process which identified a dearth of prevention outreach, education, and awareness related to HIV/AIDS among Arkansas's minority population, the AMHC Board of Commissioners voted in early 2008 to aggressively focus on HIV/AIDS to build capacity within minority communities and form networks of grassroots community coalitions to combat the disease statewide.

part II: profile of arkansas

HIV/AIDS Minority Task Force

In 2007 the Arkansas state legislature passed a bill (H.B. 2615) creating an HIV/AIDS Minority Task Force to examine the HIV/AIDS pandemic and its specific effects on minority communities, and make recommendations for HIV/AIDS prevention and treatment. In January 2008, Governor Mike Beebe appointed 17 people from across the state of Arkansas, all actively involved in the fight against the spread of HIV/AIDS, to serve on the Task Force.⁹⁹ In November 2008, the Task Force published a report making such recommendations. Part III of this report contains an update on Task Force activities since 2008.

Healthy People 2010

As part of the Healthy People 2010 program, a national health initiative launched by the US Department of Health and Human Services, the Arkansas Department of Health has set a goal to reduce deaths from HIV infection to 0.7 deaths per 100,000 population from the current rate of 3.3 deaths per 100,000.

HIV/AIDS hotline

Arkansas has a hotline to provide basic HIV/AIDS information and to give referrals to various AIDS services in the state. The Arkansas AIDS Hotline is (800) 232-4636.


Other publicly financed health insurance programs

In 1995, the Arkansas General Assembly created the Arkansas Comprehensive Health Insurance Pool (CHIP). The program was designed to provide an alternative coverage platform for high-risk Arkansas residents that are "deemed uninsurable by the private marketplace." CHIP is an individual, comprehensive major medical policy with premiums set by statute. CHIP currently provides coverage for about 3,000 Arkansans who would otherwise not have health insurance coverage.¹⁰⁰

Health Connections

The Health Connections branch of the ADH Center for Health Advancement provides educational materials and 24-hour telephone support, primarily for low-income individuals in need of assistance. The materials and telephone support are "developed and monitored for cultural appropriateness" and are available in both English and Spanish. The program contracts with the state's Medicaid program to assist Medicaid and ARKids recipients, working "to ensure that each program participant has a medical home, obtains age-appropriate immunizations, receives helpful health promotion information, and develops the skills necessary to interact effectively with the healthcare system."¹⁰¹

part II: profile of arkansas



Provider retention efforts

Given Arkansas's significant shortage of medical providers, the state government has taken 2 important steps to maintain or expand the ranks of medical providers. The Retired Physician Immunity Act of 1995 (Act 844) grants retired physicians immunity from civil suit if they continue to work in the community. In 1997, the Volunteer Licensed Health Care Professional Immunity Act (Act 276) exempts other nonretired healthcare professionals from civil damages if they provide free services.¹⁰²

part III: the arkansas HIV/AIDS minority Task Force—2009 Update

With the leadership of State Representative Willie Hardy and the support of Governor Mike Beebe, the Arkansas HIV/AIDS Minority Task Force was created by Act 842 of 2007. In January 2008, Governor Beebe appointed 17 people from across the state to serve on the Task Force. The Task Force was charged with making recommendations about how to address the growing HIV/AIDS epidemic and its disparate impact on Arkansas's minority communities. Following a series of meetings and after seeking input from concerned Arkansans in all regions of the state, the Task Force produced a report detailing its recommendations in November 2008. Focusing on Arkansas's minority communities, the report put forth suggestions for:

- reducing the risk of HIV/AIDS,
- exchanging information and ideas,
- assessing prevention and treatment needs,
- identifying existing resources,
- encouraging HIV testing,
- ensuring access to treatment and services,
- reducing high-risk behaviors,
- creating targeted risk reduction and education programs
- developing education programs for the public, and
- creating a statewide prevention campaign.

A link to the report is available at: <http://www.arminorityhealth.com/subcommittees.html#1>.

Since the publication of the 2008 report, the HIV/AIDS Minority Task Force has continued to pursue its mandate through regular meetings and working in close collaboration with the Arkansas Minority Health Commission (AMHC) and the Arkansas Department of Health (ADH). Throughout 2009, Task Force members have explored ways to further the goals of preventing new HIV infections in minority communities and improving access to care and services for HIV-positive individuals. The Task Force regularly invites guest speakers to present on topics that help inform its work, such as the Arkansas legislative process, HIV/AIDS-related legislation in other states, and initiatives in the South to combat HIV/AIDS. Guest participants have included staff from the Arkansas Public Policy Panel, the Southern AIDS Coalition, and Harvard Law School's Health Law and Policy Clinic. The Task Force has used the expertise of its members, along with outside resources, to further develop and refine ideas for addressing HIV/AIDS in Arkansas's minority communities.

part III: the arkansas HIV/AIDS minority Task Force—2009 Update

In 2009, the Task Force has examined recommendations for improving HIV prevention, education, and access to care and determined that some recommendations would require new revenue to implement, while some could be implemented through partnerships and possible funding from AMHC. The recommendations are listed below.

The Arkansas HIV/AIDS Minority Task Force has identified the following recommendations as requiring **new monies** for effective/successful implementation:

- Fund community-/faith-based organizations via a “Request for Proposal” to provide HIV/AIDS prevention services across the state of Arkansas.
- Provide additional funding for HIV/AIDS testing and prevention services at designated locations throughout minority communities across Arkansas such as historically black colleges and universities, Hispanic-led community-based organizations, and organizations targeting African Americans and women.
- Develop a culturally and linguistically appropriate statewide HIV/AIDS prevention campaign directed toward group members who are at risk of HIV infection using various media. This campaign may consist of billboards, pamphlets, and brochures designed for minority populations.
- Increase free and confidential testing at the community level throughout the state in nontraditional environments, events, and venues to encourage minority group members who are at risk of HIV infection to seek testing. Nontraditional settings will include but are not limited to social events, family, and community gatherings.
- Patients with a proven diagnosis of HIV/AIDS who cannot afford private insurance and are Medicaid eligible should be given special consideration for rapid admittance into the Medicaid program, eliminating inordinately long wait times that presently exist for some HIV/AIDS patients.
- Patients with HIV/AIDS who are enrolled in the Medicaid program should be given special consideration to have copays for their anti-HIV drugs waived if possible.

part III: the arkansas HIV/AIDS minority Task Force—2009 Update

- For patients with HIV/AIDS who are not eligible for or cannot afford private insurance and are ineligible for Medicaid, consideration should be made to make the Comprehensive Health Insurance Pool (CHIP) program more accessible by lowering premiums for this group of patients.
- For patients with HIV/AIDS who are covered by the CHIP program, increased financial aid to help with patients procuring anti-HIV drugs should be considered.
- For patients with HIV/AIDS who are not covered by private insurance, Medicaid, Medicare, CHIP, or Ryan White, and cannot access the ADAP program for drugs, consideration should be given for creation of a fund to help this category of patients at least get some help with obtaining anti HIV-drugs.
- Increase counseling and testing at the community level as an effective approach in reducing the risk of infection. When accompanied by consequence-based counseling, this method helps clients identify their own risk as they continue to engage in risky behaviors.
- Provide funding so that areas of high HIV prevalence and/or incidence may implement the *Respect Model* at testing sites. The Centers for Disease Control and Prevention (CDC) proved that the *Respect Model* is effective in reducing HIV infection and risky behaviors. Fund community-/faith-based organizations via a Request for Proposal to provide HIV/AIDS prevention services across the state of Arkansas that will help reduce or eliminate high-risk behaviors in minority group members who test negative for HIV/AIDS but continue to practice high-risk behaviors.
- Encourage culturally sensitive statewide HIV/AIDS prevention programs for 3 high-risk groups: youth ages 13-24, Marshallese residing in northwest Arkansas, and individuals transitioning from incarceration back into society. The Marshallese is a newly identified population drawn to the United States by economic opportunity and good education for their children. The Task Force recommends partnering with trusted healthcare professionals to provide HIV/AIDS prevention services to this group since this is the best way to disseminate information. Offer community-level HIV/AIDS prevention and intervention programs with prevention messages that enhance and reinforce responsibility and decision making.

part III: the arkansas HIV/AIDS minority Task Force—2009 Update

The Arkansas HIV/AIDS Minority Task Force has identified the following recommendations as those that can be implemented through **partnerships** and **funds possibly provided by the AMHC**:

- Build/strengthen coalitions among community-/faith-based organizations, state agencies, and other entities focusing on HIV/AIDS awareness and prevention.
- Expand the newly established Arkansas HIV/AIDS Prevention Coalition throughout counties in Arkansas.
- The Arkansas HIV/AIDS Minority Task Force proposes that a comprehensive and accessible method for exchanging ideas and information among community-/faith-based organizations, governmental, and state entities include activities such as data collection, dissemination of information, monitoring, and evaluation. The plan will include a directory of HIV/AIDS prevention services. This information will be compiled in a database of HIV/AIDS prevention services and made available to agencies and organizations providing HIV/AIDS prevention services and other interested individuals. A hard copy of this directory will be made available and not limited to the following entities: state correctional facilities, state agencies, hospitals, Department of Human Services (DHS) offices, workforce centers, county libraries, and black churches throughout the state of Arkansas. A Web page with various links to entities such as the AMHC, ADH, University of Arkansas for Medical Sciences (UAMS), CDC, and statewide community-/faith-based organizations that provide HIV/AIDS prevention services will include national, regional, state, and local announcements of events and activities of scheduled conferences, forums, seminars, and workshops focusing on HIV/AIDS prevention service activities.
- The Arkansas HIV/AIDS Minority Task Force recommends assessing the needs of prevention and treatment programs within minority communities and identifying existing resources that are available within minority communities. The HIV/AIDS Prevention Services Directory will serve as the primary tool and will be updated when necessary.
- The task force recommends that all newly diagnosed individuals with HIV/AIDS and all those existing infected patients who desire this service be afforded the opportunity to attend at least 1 HIV/AIDS training

part III: the arkansas HIV/AIDS minority Task Force—2009 Update

course/workshop that will provide information concerning all available services, both treatment and otherwise, within their respective communities. This service can possibly be made available through Ryan White or jointly in collaboration with UAMS, ADH, and AMHC.

- The Task Force strongly recommends that all eligible patients be assured accessibility to these workshops. For this to become a reality, it will be necessary for this service to be made available in at least 1 location in each of the 4 Congressional districts in Arkansas. It is recommended that these training courses/workshops be set up and organized as soon as funds are available. This service as well as transportation to training course/workshops can possibly be made available through Ryan White or jointly in collaboration with UAMS, ADH, and AMHC.
- The Arkansas Department of Corrections (ADC) has an HIV prevention program that includes monthly education sessions, testing, services, and care for those found to be infected, referrals to the Ryan White Consortia, and penalties for nonadherence to treatment plans upon release. While there are programs provided during incarceration, the Task Force recommends that similar programs be implemented at the community level to continue this prevention service.
- Conduct public forums in each of the 4 Congressional districts that will engage a wide range of community leaders to discuss and design education programs for the public. These public forums will be communicated to the public using the following: flyers, public service announcements (English and Spanish), "save the date" cards, information to school systems to encourage parents in communities, information to area chambers of commerce, and the governor's office media sources.

One notable success of the Task Force is the close working relationship that has developed among the Task Force, ADH, and AMHC. The AMHC has prioritized HIV/AIDS as its primary focus area for the next several years. In July 2009, AMHC announced the 7 recipients of a total of \$340,419 in grants to help in the fight against HIV/AIDS in minority communities in Arkansas.¹⁰³ The grant recipients focus on different at-risk populations within Arkansas. The grant recipients, amounts of awards, and brief program descriptions are as follows.

part III: the arkansas HIV/AIDS minority Task Force—2009 Update

Alliance on Community Health, Inc. – \$50,000: Through its Southern Arkansas AIDS Project, gender relevant and culturally sensitive social skills training will be conducted to reduce high-risk behavior by heterosexual women. In addition, a community mobilization program will be implemented to reduce unintended pregnancy and HIV.

Arkansas Human Development Corporation – \$50,000: The goal of this program is to educate the Hispanic population to increase HIV/AIDS awareness and screening in an effort to reduce the spread of the disease.

Black Community Developers, Inc. – \$50,000: HIV prevention education messages are provided to youth and young adults ages 12 to 25 through Play Safe, a program that utilizes visual and performing arts, written words, group presentations, and workshop seminars to enhance awareness. A link to job readiness and life skills will be included in this program.

Brothas & Sistas, Inc. – \$50,000: Founded in the early 1990s to provide prevention education and testing for HIV/AIDS, this organization initially targeted the African American gay and lesbian population. Plans are to distribute literature, implement incentive programs, and provide testing to the lesbian, gay, bisexual, and transgender population. Social networks will also be used to disseminate and gather information.

Future Builders, Inc. – \$40,419: Reduce risky behaviors associated with the transmission of HIV/AIDS of 600 African American homeless individuals in Pulaski County through a program called It's Your Choice. Services will be delivered at the River City Ministry in North Little Rock, a Day Resource Center for the homeless.

Jefferson Comprehensive Care System, Inc. – \$50,000: Through its program called SISTAHS, 48 college students from Philander Smith College, Arkansas Baptist College, and the University of Arkansas at Pine Bluff will be randomly selected to participate in a class. Sessions are gender-specific, culturally relevant, and include behavioral skills practice, group discussions, lectures, role-playing, prevention video viewing, and take-home exercises.

Tri County Rural Health Network, Inc. – \$50,000: Community-wide health information summits that focus on HIV/AIDS education will be held for residents of Lee, Monroe, Phillips, and St. Francis counties. The summits will be creatively implemented as a fun day. Residents will receive a listing/directory of HIV/AIDS resources available in Arkansas or within a 100-mile radius.