2018 Early Identification of Individuals with HIV/AIDS Workgroup Meeting

Welcome, Anika Kaleewoun

Agenda Overview with Emil Angelica

Introductions

Context & Overview/EIIHA /Jonathan

Early identification of individuals with HIV/AIDS refers to people with HIV infection who have not yet been diagnosed, they are not active in care or services. In 2009, with the reauthorization of the Ryan White legislation, there was a new emphasis on reducing the population who don't know their HIV status. Our focus is in reaching those who do not know their status and re-engaging those who know their status but are not engaged in care. For Part A, which are the grant funds that come to Hennepin County, a big part of our application, is about demonstrating how we identify people living with HIV and linking them to care as soon as possible. A third of our application score is based on the narratives anda data that we can present on our efforts and outcomes to identify those undiagnosed, testing high risk populations, getting them linked to care, and engaging them in service to support a lifetime of retention in care. This group formed in 2009 to get all the stakeholders in the room, with about 80 people meeting at the Urban League and informed all the strategies that we initially embarked on to find people who were undiagnosed and get them into testing services, linking those who tested positive to care, and for those not testing positive get them into prevention services. This initial meeting informed the Minnesota Planning Council's EIIHA plan. This workgroup came out of that workgroup and has been meeting at least annually, to network all those involved in these efforts, to talk about our successes and challenges, and continue to update our strategies

We know early intervention services and targeted testing that is meant to find new HIV diagnoses will also find people who are out of care. So EIIHA covers both testing and linking people found positive to care and linking people testing negative to prevention services.

Ryan White funding efforts are represented here, does not include state's MDH and CDC funding.

The four required components of early intervention services are HIV testing and counseling, referrals, linkage or re-linkage to care, and health education/risk reduction.

555/Hilary, health educator for the PreP program

Hilary from Clinic 555, downtown St. Paul, Ramsey County public health building. Started receiving funding from MDH to start a PrEP in July, 2016 program, been going almost two years and have started about 82 people on PrEP. Funded to target both high risk heterosexual and high risk homosexuals individuals. Since July 2016, they've started 69 male, 12 female, and one tranwoman candidate on PrEP. This program received 3 grants in July 2016, we have about 50 people on the prep program right now. The PreP program has 69 male candidates, 12 female candidates, 1 transwomen client. Majority of PrEP clients are in their 20's. There is a pretty even split of PrEP clients who have no insurance, who are on private insurance, and those on public insurance. About 32 people over the past 2 years have

discontinued PrEP, a majority who are just lost to follow-up. HIV testing is part of the PrEP protocol if they test positive when enrolling into PrEP program they are referred to HIV medical care.

Clinic 555 is doing community outreach and partnership. Title X grant that funds family planning services, they do a lot of outreach. Also have an MDH HIV testing grant, awarded 3 grants, one grant for black women, one for black MSM, and one for IDU. And a grant for EIS as well. Do a lot of education and outreach. Do testing and education at Ramsey County correctional facilities, but there is a problem linking people found positive to care. Go to transitional living, shelters, support groups, community events, treatment centers and detox to do testing and education within Ramsey County.

There are many initiatives as far as community outreach & contracts with West African task force there is testing in education for: corrections, colleges/support groups//8 treatment centers/shelters, community events & festivals….and making sure that they receive testing and health care particularly in the correctional facilities. The focus on engaging African born women an organization based out of Brooklyn Ctr on HIV education & testing working with them and receiving education & referrals.. There is outreach and grants/title 10 grant is a federal grant, family planning services we were also awarded three other grants, MN Dept. of health 1 for Black women 1 for MSM and one other for we have resources & other referrals from , Red door. MN Aids project & Lavender magazine. (Ongoing intervention need be put in place for the African Immigrant services in terms of creating community trust & integration and a stand point of abundance. Also focusing on African-born women, contracted with African Immigrant Services to plan HIV testing and education in conjunction with West African taskforce. Also receive referrals from Red Door, JustUs Health, and Lavender Magazine.

Clinic 555, Alejandro Aguilera, EIS Program

Seeking to build relationships for better community coordination and collaboration in order to be able to talk about HIV and move past stigma and historical distrust.

Red Door/Javier

PrEP was approved for use in 2012, at the same time MDH was preparing for the next round of grants. The idea with the prevention with positives was to work with positives and their negative partners this is how we got into the grants. In 2013 Red Door started working with PrEP. Javier provided an overview of funding, grants, and staffing to start and sustain the PrEP program. Red Door's grant has always been focused on men who have sex with men. Javier went over the numbers of clients served for the PrEP program from 2015-2017. PrEP enrollment started right away without even advertising. PrEP has brought people to Red Door that wouldn't have otherwise come. Not all PrEP clients take their pill every day but don't have numbers to verify. PrEP has done a lot to reduce stigma of HIV. PrEP clients need to return every 3 months to get prescription and for full STD testing. Generally, before PrEP maybe people would come in once a year for testing, PrEP now increases number of times of testing to 4 times a year or more! Do see condom use going down and may potentially seeing more risky behavior, not sure linkage to PrEP without more data. May also be seeing more infections due to more testing not that there is an absolute increase in infections.

SUB-SAHARAN AFRICAN YOUTH & FAMIY SERVICES IN MN/Fikru Ethicha

SAYFSM provides, HIV prevention, education, testing, counseling, condom distribution, PrEP education and referral. The presentation is about successes and challenges on serving the African communities.

Successes:

- Provide culturally competent HIV education since 2002
- Conduct community and faith leader HIV/AIDS forum biannually
- Work with churches and mosques
- Collaborate with community centers
- Formed an East African women HIV team
- Distribution of condoms
- PrEP education

Challenges:

- Less community services to serve African community
- Target population always want incentive, not self motivated
- Most of work needs to be tracked by numbers tested, cannot focus on what needs to happen before testing – awareness
- Stigma and past negative experiences
- Belief that once people come to the USA with HIV they become cured, no longer have HIV, only had in Africa
- Youth don't fear HIV infection
- Africans go to hospital when sick, not for prevention
- Other priorities than HIV in community outreach
- Funding, awareness and testing should not be seperate

Future priorities:

- Collaborate
- Improve community awareness and openness to being tested
- Increase discussion of HIV at community level

Q & A

- Are women coming seeking PrEP as them may not be able to control condom usage? It is easier for women to take a pill and yes SAYFSM will refer them to PrEP programs.
- Are there specific African born populations that are harder to reach? I focus on East African cause that's who I know. There are people that only stay at home and go to church. But I cannot generalize. The populations up in prevelance are Ethiopia, Somalia, Nigeria, so looking to partner with other agencies to reach community on the ground.

LGBTQ Directory

- Formed from the MN Transgender Health Coalition and Rainbow Health Initiative found here: http://mnlgbtqdirectory.org/. Now housed at JustUs Health.

HIV TESTING in MN/Jared Shenk

- Will cover prevention, estimate of undiagnosed HIV infections in MN, HIV testing data, and HIV incidence in 2017.
- Target populations for prevention gay and bisexual men, African Americans, Latinx, IDU, and transgender communities.
- Estimate of undiagnosed HIV infections, CDC model, standardized across the US, can only run by state.

- Current unaware estimate is 1100, always a lag of two years.
- HIV testing data in Minnesota comes out of EvaluationWeb, system administered by CDC.
    - Country of birth is incomplete, cannot track if positives are reported to MDH, self-reported by clients, and entered by provider staff, tests are counted by unique test not by unique person as system is de-identified.
- Testing data from 2013-2017.
    - 15,654 HIV test administered in 2017, with a positivity rate of 0.44. Average positivity rate was 0.45 from 2013-17.
    - Testing by current gender, positivity rate for transgender 1.43.
    - Testing by race/ethnicity, highest positivity rates are in Black community at 0.53 and Hispanic community at 0.58.
    - Testing by age group, highest positivity rate was in 65 and over at 0.88 (but only 907 tests conducted) and unknown age at 0.68.
    - Testing by risk, about 54% was conducted with folks identifying as heterosexual, 32% with homosexual, and 6% IDU. Highest positivity rates were MSM/IDU at 3.21.
    - By geography, new diagnoses 292 in metro, 30 in greater MN.
    - Disparities are any population with a positivity rate above the average 0.45. The highest 3 are MSM/IDU, Transgender, and MSM.
    - Closer look at MSM and race/ethnicity (highest pos. rate is Black MSM at 2.77), MSM and age (highest pos. rate is MSM 13-24 at 1.33)
    - Zipcodes of new MSM positives: 55404, 55403, 55407, 55408, 55411, 55406, 55412. Zipcodes of MSM of color: 55411, 55407, 55404, 55408.
- HIV surveillance in Minnesota
    - Incidence rate of new infections 5.3 per 100,000
    - 2017 had 284 new HIV cases reported, slight reduction from years before. Deaths of PLWH has gone down since 1996 when HAART was introduced, and PLWH in Minnesota continues to rise.
    - By geography, HIV diagnoses in MN by residency at diagnosis.
    - By race and ethnicity, Black African born population has rate of 55.6 per 100,000, Black non-African born have rate of 46.6, average rate for Minnesota is 5.3
    - By gender identity and risk, rate for MSM is 150.
    - By age by assigned sex at birth, clusters to ages 20-24
    - Births to HIV infected birthing parents and number of perinatal acquired HIV infections. On average 60 births per year to people living with HIV and generally 1 or less perinatal HIV infection. Generally this is from a woman who had no pre-natal care or just moved to Minnesota.
    - HIV diagnosis among foreign-born person in MN, largest percent are from Africa.
    - Time of progression to AIDS

Focus Group Worksheet – Responses presented in themes

A portion of the May 22, 2018 EIIHA meeting was to hear from participants on their ideas of barriers affecting people living with HIV and at risk of HIV and strategies that would be successful in addressing the barriers. Participant comments below are grouped by number of times the idea was mentioned.

1. What are the biggest barriers for people **living with** HIV to accessing preventative and care services?
   - Stigma (5)
   - Meeting basic needs (4) (such as food, transportation, and housing)
   - Having easy access to services (2) especially for consumers in Greater MN (2)
   - Cost of health insurance and cost of services (3)
   - Addressing Mental and chemical health needs (2)
   - Lack of culturally competent providers – race/ethnicity, LGB**T**Q, etc. (2)
   - Lack of trust in systems
   - Start and stop projects (frequent changes in strategies)
   - Lack of information and awareness

2. What are the biggest barriers for people **at risk** of HIV to accessing preventative and care services?
   - Awareness, education, and availability services that are culturally specific (5)
   - Stigma (3)
   - Getting services to the rural consumer (2)
   - Cost and Insurance access (2)
   - Social co-factors: transportation and other basic needs
   - Lack of continuity in HIV prevention services

3. If you had $100,000 to allocate to getting people **living with** HIV tested and into care what would you spend it on?
   - Provide education and build awareness (4)
   - Outreach/build relationships with communities of color (3)
   - Provide home based testing kits
   - Women in rural Minnesota
   - Incentives to reward retention in care and viral suppression
   - Sustainable basic needs support (including mental health)
   - Establish a community led care group in charge of funding for activities

4. If you had $100,000 to allocate to getting people **at risk** of HIV tested and on PrEP (and into care) where would you invest it?
   - PrEP campaign to educate communities of color (3)
   - Concerted effort in stigma resources
   - Insurance especially for immigrants who may not necessarily access public funding
   - Women in rural Minnesota
   - Support of testing in the community (shelters, coffee shops, etc)
   - Funding for culturally specific OUTREACH ONLY services
   - Provide home testing kits
   - Sustainable basic needs support (including mental health)

- Micro savings organization led by the community – access to the organization is contingent on being tested (would need a board that makes decisions and oversees loan applications)

5. If you had to choose, which two ideas from questions 3 and 4 above would you want to implement first?
   - Build relationships in communities of color to provide education and reduce stigma (different populations need different tactics to engage and be effective) (2)
   - Mental health services
   - Provide home testing kits – this will encourage those who may not want to test in public
   - Provide services for women in rural Minnesota
   - Education on HIV