Minnesota Council for HIV/AIDS Care and Prevention

MINNESOTA

HENNEPIN COUNTY
MINNESOTA

Integrated HIV Prevention and Care Plan

Minnesota and Minneapolis–St. Paul Transitional Grant Area
2022–2026

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Acronyms

ADAP: AIDS Drug Assistance Program

AIDS: Acquired Immunodeficiency Syndrome

BIPOC: Black, Indigenous, and People of Color

CDC: Centers for Disease Control and Prevention

CBO: Community-Based Organization

DHS: Minnesota Department of Human Services

EHE: Ending the HIV Epidemic in the U.S. national strategy

EIS: Early Intervention Services

HCPH: Hennepin County Public Health

HIV: Human Immunodeficiency Virus

HOPWA: Housing Opportunities for People with AIDS

HRSA: Health Resources and Services Administration

IDU: Injection Drug Users

MDH: Minnesota Department of Health

MCHACP: Minnesota Council for HIV/AIDS Care and Prevention

MSM: Men who have Sex with Men

MSM/IDU: Men who have Sex with Men and Inject Drugs

NA or NA2020: Needs Assessment survey of PWH, conducted every five years

NHAS: National HIV/AIDS Strategy

PEP: Post-exposure Prophylaxis

PrEP: Pre-exposure Prophylaxis

PWH: People with HIV

PWID: People who Inject Drugs

RWHAP: Ryan White HIV/AIDS Program

STD: Sexually Transmitted Disease

TGA: Transitional Grant Area

U=U: Undetectable = Untransmittable

Section I: Executive Summary

Multiple agencies in Minnesota partner together to lead the response to HIV. The Minnesota Department of Health (MDH) is responsible for CDC-funded HIV prevention efforts, while the Minnesota Department of Human Services (DHS) is responsible for Ryan White Part B and statewide Ryan White services, and Hennepin County Public Health is responsible for Ryan White Part A and Ryan White services in the Transitional Grant Area (TGA). The work of these agencies is guided by the Minnesota Council for HIV/AIDS Care and Prevention (MCHACP or "the Council"). The Council is Minnesota's integrated HIV community planning body and meets the requirements for planning for MDH, DHS, and Hennepin County Public Health.

The *2022–2026 Integrated HIV Care and Prevention Plan for Minnesota and the Minneapolis–St. Paul Transitional Grant Area* ('Integrated Plan' or 'the plan') is a collaborative effort between MCHACP, MDH, DHS, Hennepin County Public Health, and many additional partners who are involved in or impacted by HIV prevention and care in our jurisdiction.

This plan describes both the continuing and evolving needs of people affected by the HIV epidemic throughout the state and also serves to outline our plan to diagnose and treat people with HIV, prevent new HIV infections, and respond to existing and potential HIV outbreaks and other emerging needs.

At the end of calendar year 2021, there were an estimated 9,696 people with HIV/AIDS (PWH) in Minnesota, 56 percent of whom had HIV (non-AIDS diagnosis). Minnesota has averaged about 300 new HIV diagnoses each year for at least ten years, not including the expected decline in the number of new HIV diagnoses in 2020 due to COVID-19's impacts on testing and services. The majority of PWH in Minnesota live in the Twin Cities metropolitan area and surrounding counties, but nearly one in five PWH live outside of the Twin Cities metropolitan area. The most common known mode of exposure among PWH in Minnesota is male-to-male sexual contact, although the number of diagnoses with an "unknown" mode of exposure has been growing for the last several years.

While HIV can infect anyone, there are significant disparities in the rates of HIV transmission and prevalence in Black/African American, Black/African-born, Hispanic, and American Indian communities in Minnesota. Persistent racial and ethnic disparities linked to social determinants of health like poverty, unequal access to health care, lack of access to education, stigma, racism, and homophobia exacerbate the unequal HIV care and prevention outcomes we see in our state.

Minnesota is a leader in health care innovation and access and has achieved consistently high rates of ensuring that PWH are diagnosed and that people who are diagnosed are linked to care quickly. However, rates of retention in HIV care have remained in the low to mid-seventies for several years, and rates of viral suppression have remained around 65 percent.

Six years ago, Minnesota developed and submitted its first Integrated HIV Care and Prevention Plan for 2017–2021. MCHACP, MDH, DHS, and Hennepin County have annually monitored and reported on progress toward reaching that plan's goals. The community has helped identify new strategies for reaching the goals over the last five years and many of those strategies have been implemented.

Since development of the first Integrated HIV Care and Prevention Plan in 2017, the State of Minnesota created, launched, and updated Minnesota's HIV Strategy: A Comprehensive Plan to END HIV/AIDS (also known as END HIV MN). As the Part A grant recipient, and home to the county with the highest number of HIV diagnoses and prevalence, Hennepin County launched its own county-based strategy in 2017 called Positively Hennepin. Since their launch, both END HIV MN and Positively Hennepin have used a community-based, participatory approach to assess and update these plans, ensuring they are meeting the current and emerging needs of PWH and people at risk for HIV infection in our state and TGA.

Additionally, an HIV outbreak was declared in Hennepin and Ramsey Counties in 2020, and in 2021, an HIV outbreak was declared in the Duluth region, an area in northern Minnesota adjacent to Lake Superior. Cases dated back to 2018 and 2019, respectively. The State of Minnesota uses the Minnesota Cluster and Outbreak Detection and Response (CODR) plan to separately track, report, and implement strategies to intervene in these outbreaks and mitigate risks.

The community engagement efforts that resulted in the creation of, and updates to, END HIV MN, Positively Hennepin, and the CODR were instrumental in informing the Integrated Plan. The three plans are provided in the appendix.

This new Integrated HIV Care and Prevention Plan for 2022–2026 brings these jurisdictional plans into alignment with the current needs and priorities of Minnesota and the Minneapolis–St. Paul TGA under the pillars of the national Ending the HIV Epidemic (EHE) Initiative.[1]

The goals, objectives, and strategies of the 2022–2026 Integrated Plan, while closely aligned with the goals of END HIV MN, Positively Hennepin, and Minnesota's outbreak response, are new. The implementation and monitoring of the Integrated Plan's strategies will rely on coordinated efforts from MDH, DHS, Hennepin County, and the Council, as an all-hands-on-deck approach is required to achieve this plan's ambitious goals.

[1] Minnesota does not currently receive EHE funding.

Section II: Community Engagement & Planning Process

Jurisdictional planning process

In planning for development and submission of the Integrated Plan, a Sponsor Team formed, which included representatives from each government agency responsible for submission of the plan, as well as the MCHACP Coordinator. The Sponsor Team identified staff members who would make up the Integrated Plan Steering Committee ("Steering Committee") to lead the development of, and be responsible for the successful delivery of, the plan. The MCHACP Co-Chairs agreed to serve as Council representatives on the Steering Committee.

Members of the Steering Committee included:

- the Co-Chairs of MCHACP,
- the MCHACP Coordinator,
- the Hennepin County Ryan White Program Coordinator (RWHAP Part A),
- the manager and two staff from the DHS HIV/AIDS Supports section (RWHAP Part B), and
- the Prevention Unit manager and a staff member from the MDH STD/HIV & TB section (CDC Prevention Program).

The Steering Committee established a project charter, working agreements, a meeting schedule, and used an online project management website to manage the work and communication in one place. The Steering Committee met twice a month from April through October 2022 to lead development of the plan. Meeting facilitation and general project management support was provided by an internal State of Minnesota management consultant. Between meetings, Steering Committee members gathered data, input, and other support from additional RWHAP Part A, Part B, and CDC Prevention Program staff, as needed.

Steering Committee members took advantage of resources available from the Integrated HIV/AIDS Planning Technical Assistance Center (IHAP-TAC), like the online course *An Introduction to Integrated Prevention and Care Planning*, webinars related to integrated plan development, and peer-to-peer learning sessions. As the Steering Committee developed a work plan with key dates for deadlines, it also strategized how to structure Section V: 2022–2026 Goals and Objectives and develop SMARTIE[2] goals. The Steering Committee reached consensus to structure the 2022–2026 Goals and Objectives based on the four pillars identified in the EHE initiative. Steering Committee members presented this option to MCHACP and its committees where it received support for continuing with this structure.

[2] SMARTIE stands for Specific, Measurable, Attainable, Relevant, Timely, plus focusing on Inclusion and Equity.

Next, the Steering Committee moved into the needs assessment and the situational analysis, which then informed development of the goals and objectives, and then the implementation and monitoring plan. This section and the executive summary were written last.

The planning process project manager attended monthly MCHACP meetings to provide updates on planning progress and present draft sections for input and feedback from Council members and other stakeholders who regularly attend the meetings. The draft priorities for the Needs Assessment section of the plan were provided to Council members by email and members completed an online form to select the priorities that should be included in the Integrated Plan. Additional meetings were held for input on the priorities, goals, and objectives of the plan with the Needs Assessment & Evaluation Committee, Disparities Elimination Committee, and Planning & Allocations Committee. The Council's Community Voices Committee specifically reviewed and provided feedback on the plan's goals and objectives.

As MCHACP members and stakeholders provided feedback into the sections of the plan, revised drafts were emailed to MCHACP and community members with contact information for the project manager and MCHACP coordinator so members could provide additional input.

The Steering Committee incorporated all of the input received into this final version of the plan.

The final plan was presented to the Council, RWHAP Part A program leadership, RWHAP Part B program leadership, and CDC Prevention Program leadership for review and feedback prior to solicitation of the letter of concurrence.

Engagement of PWH and others impacted by the plan

Council membership and representation

MCHACP serves as the single integrated HIV care and prevention community planning body for Minnesota and the MSP-TGA. The council includes broad representation from affected communities and those who have an interest in, or are impacted by, HIV prevention and care programs in the state and TGA. The Council currently includes 22 members, 12 of whom (55 percent) have HIV, and the overall membership reflects the local HIV epidemic in terms of race, ethnicity, gender identity, mode of exposure, and geographic location. MCHACP committees also include participation from PWH, with each of the six standing committees exceeding the requirement that at least 33 percent of members are PWH who are not aligned with an agency receiving Ryan White funding.

MCHACP's Membership and Training Committee tracks Council membership. Any vacancies in representation or reflectiveness are regularly recruited for and filled. It is a requirement that the Council co-chairs and the committees reflect the diversity of the Council, and that at least one community co-chair be a PWH who is not aligned with any agency receiving Ryan White funds. MCHACP includes representation from legislatively mandated categories including local public health, health care providers, community-based organizations, social services providers, non-elected community leaders, mental health and substance abuse treatment providers, and RWHAP Part B, C, and D recipients.

In addition to Council membership, MCHACP offers a community membership option for people who work in the field of HIV, are living with HIV, or are affected by HIV to participate in the work of the Council at the committee level. All Council and committee meetings are open to the public and notification of meetings, meeting materials, and past minutes are distributed to a listserv of interested stakeholders, posted to the Council's public Facebook page, and available on the Council's website, www.mnhivcouncil.org.

Additional engagement efforts

In addition to including key stakeholders who participate on MCHACP and its committees, this plan was greatly influenced by the results of the most recent five-year survey of consumers, the 2020 HIV/AIDS Comprehensive Needs Assessment. The survey was administered through online, paper, and phone modes. The paper mode was available in English and Spanish and promotion materials were created in seven different languages, including languages spoken by people born in Africa. The demographics of respondents were tracked during data collection to ensure the demographics of respondents closely matched HIV surveillance data in Minnesota. The 2020 HIV/AIDS Comprehensive Needs Assessment asked questions related to six broad areas:

- Sociodemographic, geographic, and epidemiological characteristics.
- Social determinants of health.
- Injection drug use.
- HIV care continuum outcomes.
- Barriers to HIV medical care and medication adherence.
- Need and accessibility of Ryan White HIV/AIDS Program (RWHAP) fundable services.

The survey is a collaborative effort of the Council, Hennepin County Public Health, and DHS. It will be repeated in 2025.

Additionally, two recent efforts to update jurisdictional plans, both of which included engagement of PWH and others impacted by HIV prevention and care services, informed the Integrated Plan. One such effort was to update Positively Hennepin, which is Hennepin County's strategy to end the HIV epidemic. In 2021, a crosswalk assessing progress-to-date was presented to a committee of key stakeholders to provide input on how to continue moving the plan forward. Small-group feedback sessions were conducted with service providers, clinicians, community leaders, community-based organizations, clients, and advocates. As part of that plan update, 16 diverse consumers living with HIV took part in listening sessions and 96 individuals participated in a survey.

The other effort that gathered input from PWH and others impacted by HIV care and prevention services was an update to END HIV MN, Minnesota's comprehensive statewide strategy to end new HIV infections and improve health outcomes for PWH in Minnesota. Every two years, DHS and MDH collaborate to assess the impact of END HIV MN and to reprioritize the tactics, as needed. That process included gathering input in 2021 from MCHACP's Disparities Elimination Committee and from 78 people who participated in a meeting or took a survey, including[3]:

[3] These categories are not mutually exclusive. The total of the percentages is more than 100%.

- 26% who identified as a PWH, taking PrEP, or as an advocate or ally;
- 38% who identified as an HIV educator, PrEP navigator, or similar;
- 29% who identified as a government partner, including state and local public health;
- 26% who identified as a Ryan White provider; and
- 10% who identified as a doctor, nurse, PA, NP, pharmacist, or similar.

An addendum to END HIV MN (Appendix A) was reviewed and approved by the END HIV MN Advisory Board, which includes the perspectives of consumers, providers, and other partners.

Priorities

As noted in Section III, the following priorities emerged from the community engagement and planning process:

- **Racial disparities** persist across PrEP access and adherence, new HIV diagnoses and prevalence, and across the Care Continuum.
- There are **two outbreaks** in Minnesota, which are primarily impacting people who inject drugs and who are unhoused.
- **Young people** are disproportionately impacted, with higher rates of new diagnoses and lower rates of viral suppression.
- **Transgender people** face increased barriers and stigma, with diagnoses increasing among transgender people while the 2020 Needs Assessment survey found they are most likely to report challenges with accessing housing, paying bills, buying food, accessing medical services, and adhering to medical treatment.
- **Linkage and retention** rates must increase, along with viral suppression, in order to effectively decrease the number of new diagnoses.
- State funding for **PrEP delivery** has decreased and fewer providers are being funded by MDH. Minnesota does not have a good picture of statewide data on PrEP prescription or use because only part of the system is state funded.
- People's **basic needs** must be met before they can focus on their health. On the 2020 Needs Assessment survey, high percentages of PWH reported challenges with affording housing, running out of food, and paying medical bills.
- **Ryan White service levels** are not increasing among people who are eligible. Most PWH who took the 2020 Needs Assessment survey have incomes that would qualify them.
- Minnesota has yet to make progress with **systematic routine, opt-out testing** across the healthcare system. In 2020, 31% of Minnesotans reported ever being tested for HIV.
- The 2020 Needs Assessment survey shows that **mental and chemical health** issues contribute to PWH missing HIV care and/or not taking their medication as prescribed.
- Reliance on special revenue generated through the 340B rebate program represents a **risk for long-term service stability**.

- **Lack of coordination** between components of the HIV care and prevention system leads to duplication of services and disconnect between partner organizations.
- **Lack of connection** between the HIV sector and other major sectors (e.g., housing, behavioral health, aging) creates barriers to referring PWH and who are at risk of infection to support services that are not funded with HIV-specific funding sources.
- **Lack of continuity of care for PWH who are incarcerated** leads to some PWH not being automatically enrolled for ADAP or receiving the care they need.

Section III: Contributing Data Sets & Assessments

Data sharing and use

This plan is informed by several data sources, which are described briefly here.

HIV/AIDS statistics

The data in the epidemiologic snapshot come from the Minnesota Department of Health Infectious Disease Epidemiology, Prevention and Control (MDH IDEPC) Division's annual HIV/AIDS Statistics reports.[4] IDEPC releases HIV/AIDS statistics publicly on an annual basis and has provided regular updates via its website on the recent outbreaks in Minnesota.

Although the publicly available data covered most of the prevalence, diagnosis, and care continuum data disaggregated in multiple ways, the Integrated Planning Steering Committee made an additional data request to IDEPC for new MSM HIV/AIDS diagnoses to also be disaggregated by race/ethnicity to include as part of the needs assessment (Figure 20 and Figure 21), and requested data from IDEPC and Hennepin County to disaggregate prevalence and new HIV diagnoses in the TGA.

2020 HIV/AIDS Comprehensive Needs Assessment

Through a collaboration between MCHACP, Hennepin County Public Health, and DHS, the *2020 HIV/AIDS Comprehensive Needs Assessment* (NA2020)[5] collected over 800 responses from PWH in Minnesota on a wide variety of issues, including barriers to medical care and service needs. Several presentations, reports, and full data books summarizing and disaggregating the survey results are available publicly. Respondents were at least 18 years old, living with HIV/AIDS, and residing in the Part A or B jurisdiction at the time of survey completion. Respondents were offered a $25 gift card to Target or Walmart as a "thank you" for their contribution.

[4] https://www.health.state.mn.us/diseases/hiv/stats/index.html

[5] https://www.mnhivcouncil.org/needs-assessment--evaluation.html

Housing data

Housing data reviewed as part of the planning effort included a presentation from November 2021 provided to MCHACP from the Minnesota Ryan White HIV/AIDS Program,[6] as well as a report on housing availability from the Minnesota HIV Housing Coalition.[7]

Recent engagement efforts for other plans

Two jurisdictional plans related to HIV care and prevention were updated during the Integrated Plan planning process, and both included engagement opportunities for PWH and others invested in or impacted by these plans. The input collected from these efforts was used as a data source for the development of the Integrated Plan. One engagement effort, which included virtual meetings and a survey conducted in late 2021, was to reprioritize the tactics of the legislatively mandated, statewide plan to end HIV in Minnesota, END HIV MN. The other engagement effort, which included listening sessions for PWH conducted in June and July 2021, supported an update to Hennepin County's strategy to end the HIV epidemic, Positively Hennepin.

Epidemiologic snapshot

Limitations of interpreting 2020 data given the impact of the COVID-19 pandemic on HIV diagnoses

As noted in the CDC *HIV Surveillance Report, 2020*, the COVID-19 pandemic led to disruptions in HIV testing and access to clinical services throughout 2020, impacting HIV diagnoses in 2020. Given these disruptions, data for 2020 should be interpreted with caution. Since the COVID-19 pandemic is ongoing, more time and data are needed to accurately assess COVID-19's impact on HIV in the United States. Assessments of trends in HIV diagnoses that include the year 2020 are discouraged.

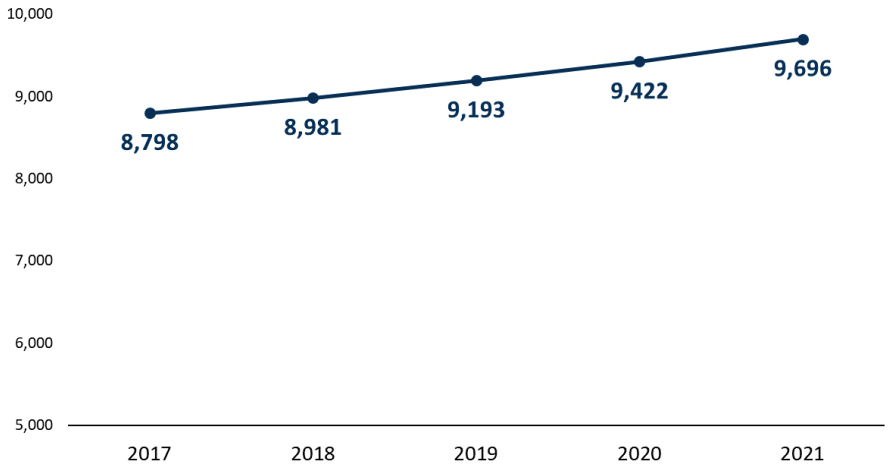
Like national data, there was a steep decline in HIV diagnoses in Minnesota from 2019 to 2020 and then an increase from 2020 to 2021. The 2020 decrease is predominantly attributed to declines in testing as described above, and likely represents HIV being underdiagnosed, rather than a "true" reduction in the number of people newly infected in Minnesota.

[6] Peterson, A. D. "Ryan White HIV/AIDS Program, housing, and the HIV outbreak update for the Minnesota Council for HIV/AIDS Care and Prevention." November 9, 2021.
[7] Lieberman, K. "Housing Availability Assessment Report." July 2019.

Prevalence of HIV/AIDS in Minnesota and the TGA

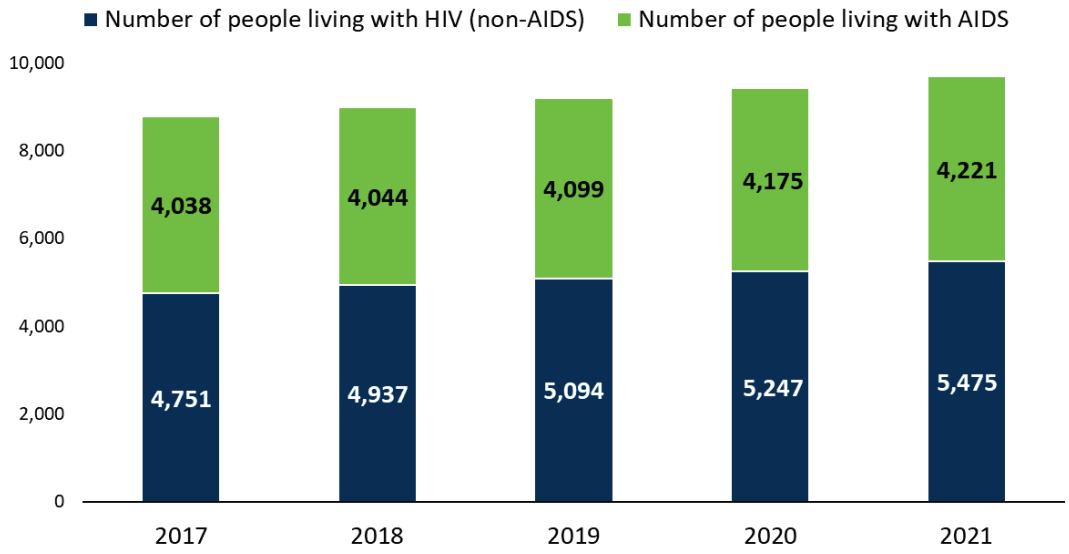
As of December 31, 2021, there were estimated to be 9,696 people alive and living with HIV/AIDS in Minnesota[8] (Figure 1).

Figure 1. Total number of people living with HIV/AIDS in Minnesota by year



Among people living with HIV/AIDS in Minnesota, a little over half are living with HIV (non-AIDS) (56 percent in 2021) (Figure 2).

Figure 2. Number of people living with HIV (non-AIDS) and people living with AIDS in Minnesota by year

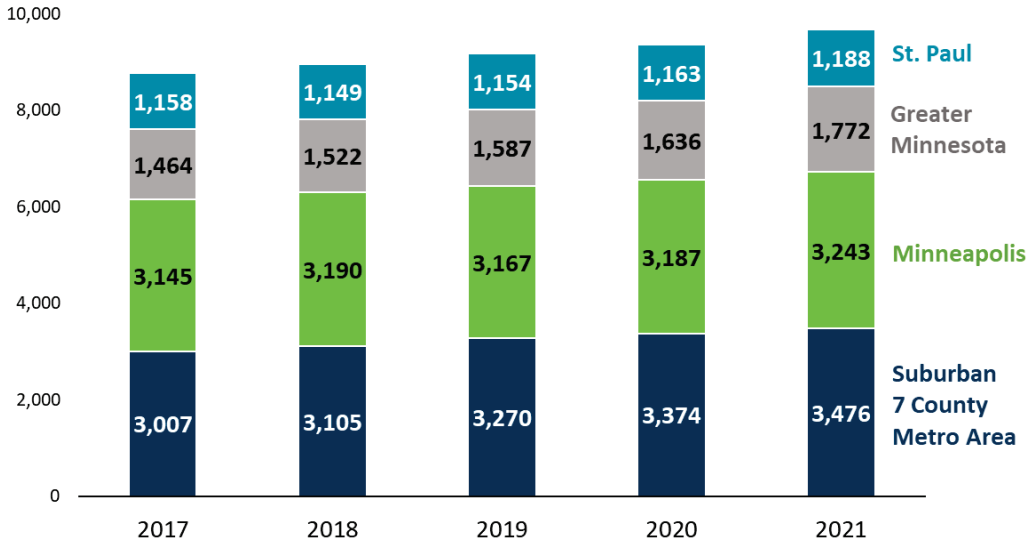


[8] This number includes persons with Minnesota reported as their current state of residence, regardless of residence at time of diagnosis. It also includes state prisoners and refugees arriving through the HIV+ Refugee Resettlement Program, as well as HIV+ refugees/immigrants arriving through other programs.

Prevalence by geographic area

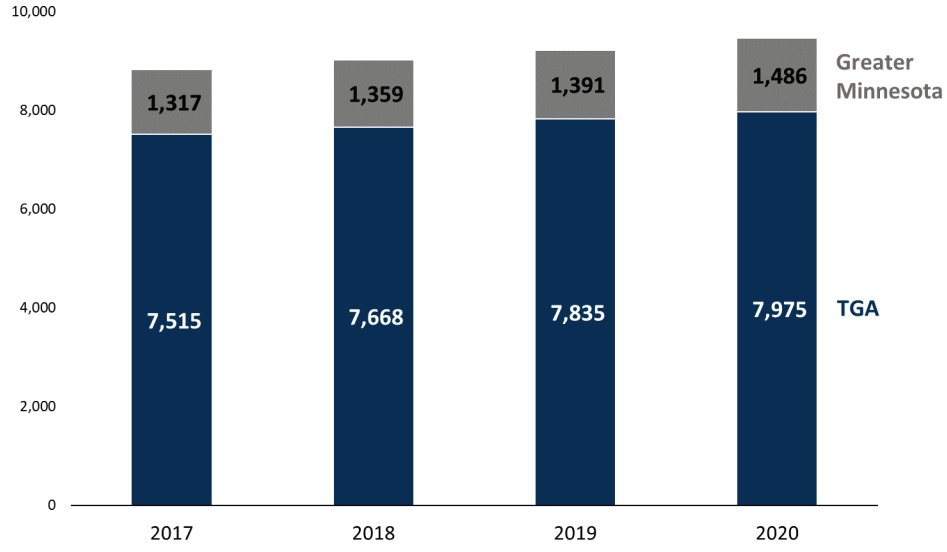
As of 2021 within Minnesota, the number of people living with HIV/AIDS in Minnesota is largest in the suburban seven-county Twin Cities metropolitan area (not including the cities of Minneapolis and St. Paul), followed by the City of Minneapolis, Greater Minnesota, and then the City of St. Paul (Figure 3).

Figure 3. Number of people living with HIV/AIDS in Minnesota by year and geographic area



When including the additional counties of Minnesota and two counties in Wisconsin, the TGA has about 200 to 300 more people living with HIV/AIDS (Figure 4). Data for 2021 for the TGA was not yet available for this report. For this graph, the TGA includes 11 Minnesota counties (Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington, and Wright) and two Wisconsin counties (Pierce and St. Croix).

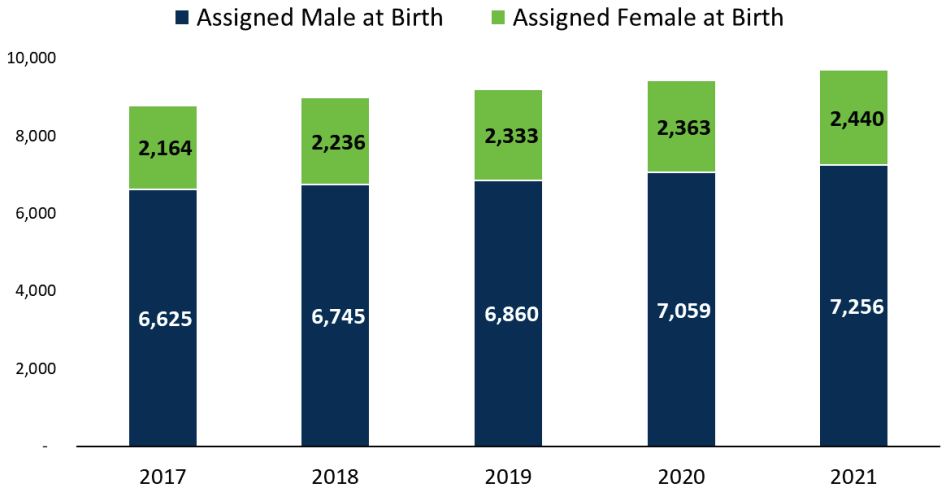
Figure 4. Number of people living with HIV/AIDS in Minnesota and the TGA by year and geographic area



Prevalence by sex assigned at birth

The majority of people living with HIV/AIDS in Minnesota were assigned the sex of male at birth (Figure 5). For at least the past five years, about 75 percent of people living with HIV/AIDS in Minnesota were assigned male at birth and about 25 percent were assigned female at birth.

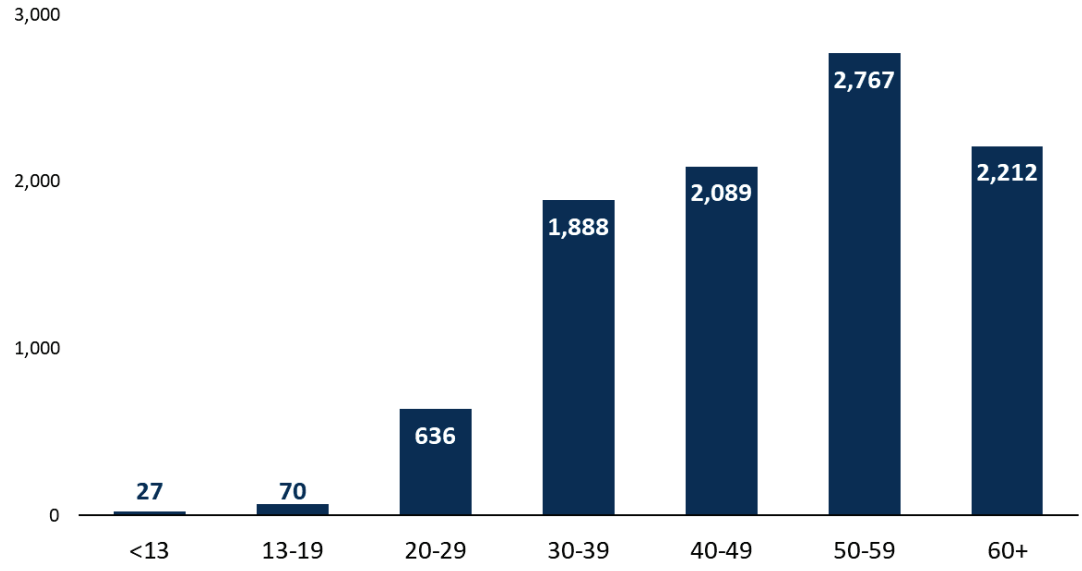
Figure 5. Number of people living with HIV/AIDS by sex assigned at birth and year



Prevalence by age

The age group with the largest number of people living with HIV/AIDS in 2021 was the group aged 50 years old to 59 years old (Figure 6). That age group has also had the largest number of people living with HIV/AIDS for at least the last five years.

Figure 6. Number of people living with HIV/AIDS in 2021 by age group



The age group that has grown the most over the last five years is the group aged 60 years of age and older (Table 1). From 2017 to 2021, the number of people living with HIV/AIDS in this group increased by almost 60 percent. The group that has decreased by the largest percentage is the group aged less than 13 years of age, with a decrease from 2017 to 2021 of almost 50 percent. However, this group is the smallest.

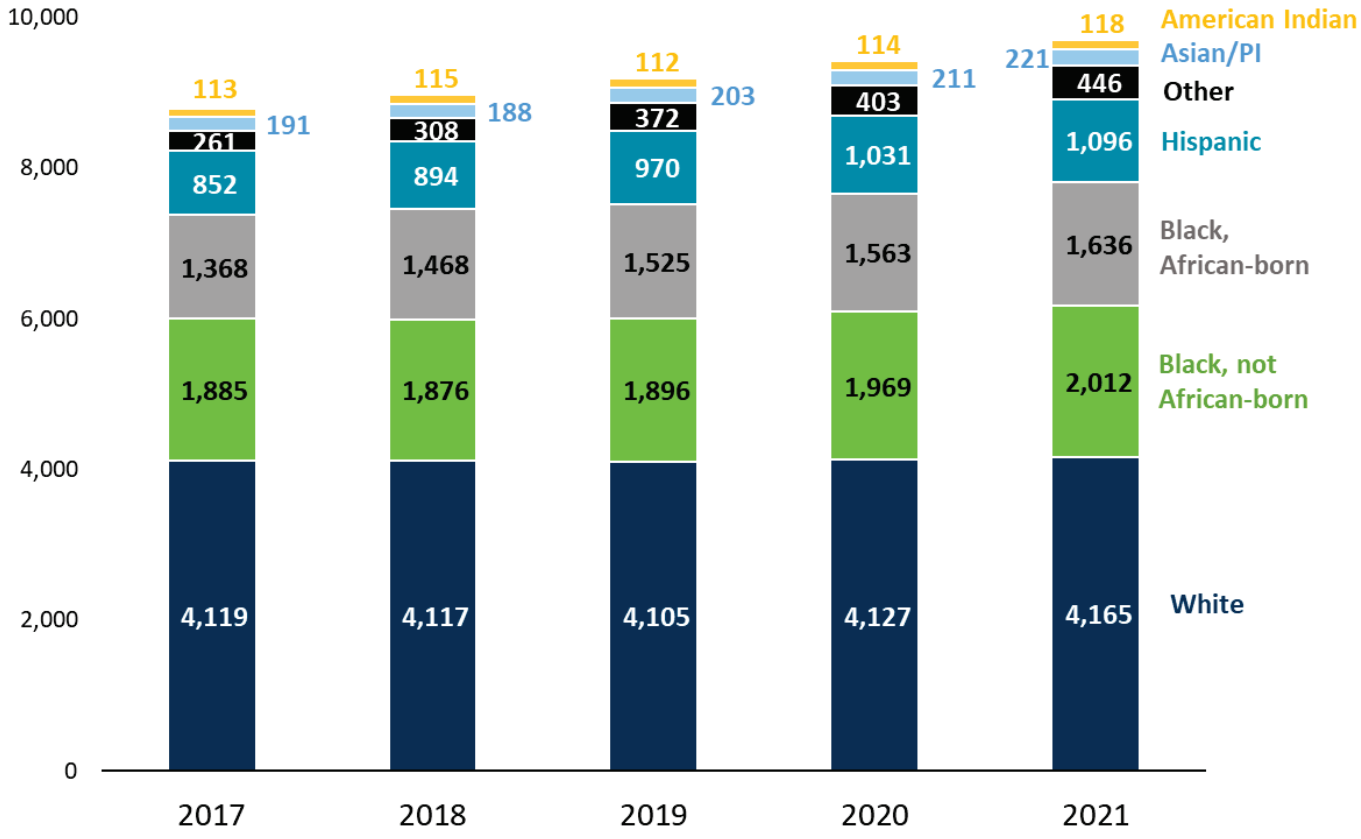
Table 1. Number of people living with HIV/AIDS by age group and year, including percentage change from 2017 to 2021

Year	Younger than 13 years of age	13–19 years of age	20–29 years of age	30–39 years of age	40–49 years of age	50–59 years of age	60 years of age and older
2017	52	70	727	1,701	2,108	2,727	1,397
2018	48	65	726	1,737	2,109	2,720	1,569
2019	42	64	690	1,783	2,045	2,773	1,789
2020	38	62	659	1,819	2,068	2,781	1,988
2021	27	70	636	1,888	2,089	2,767	2,212
Percentage change from 2017 to 2021	**-48%**	**0%**	**-13%**	**11%**	**-1%**	**1%**	**58%**

Prevalence by race/ethnicity[9]

It's important to note that race is not considered a biological reason for disparities related to HIV/AIDS experienced by people of color. Race is a social construct, and while there are health disparities between racial and ethnic groups, these are driven by underlying factors relating to structural racism, as well as historical traumas and current systematic impacts of those traumas.

Figure 7. Number of people living with HIV/AIDS in Minnesota by race/ethnicity and year



The majority of people living with HIV/AIDS in Minnesota are White (Figure 7); however, when compared with the total population of Minnesota, White people have one of the lowest rates[10] of people living with HIV/AIDS (Table 2). All other race/ethnicity groups have rates per 100,000 that are higher than the rate for White people.

[9] "Black, African-born" refers to Black people who reported an African country of birth; "Black, not African-born" refers to all other black people. People who identify as "Hispanic" can be of any race, so all other categories are non-Hispanic. "Other" refers to multiracial people or people with unknown or missing race.

[10] 2010 United States Census Data used for rate calculations, except where otherwise specified.

The rate of prevalence of HIV/AIDS per 100,000 people, when compared with the rate for White people, is:

- 14.5 times higher for Black, not African-born people;
- almost 14 times higher for Black, African-born people;
- four times higher for Hispanic people;
- twice as high for American Indians; and
- similar to the rate for Asian people and Pacific Islanders (PI).

Table 2. Number of people and rates (per 100,000 people) of people living with HIV/AIDS in Minnesota in 2021 by race/ethnicity

Race/Ethnicity	Number of cases	Percentage of total	Rate per 100,000
White, non-Hispanic	4,165	43%	94
Black, not African-born	2,013	21%	1,367
Black, African-born	1,636	17%	1,302[11]
Hispanic	1,096	11%	438
Asian/Pacific Islander (PI)	221	2%	102
American Indian	118	1%	212
Other	446	5%	N/A

Prevalence by location of birth

One particular population of interest in Minnesota that sets us apart from other states is our larger foreign-born HIV-positive population. Between 1990 and 2021, the number of foreign-born people living with HIV/AIDS in Minnesota increased substantially, especially among African-born populations.

In 1990, 50 foreign-born people were reported to be living with HIV/AIDS in Minnesota, and by 2007 this number had increased to 1,126 people. In 2021, the total number of foreign-born people living with HIV/AIDS in Minnesota was 2,553, a 5 percent increase from 2020. This trend illustrates the growing diversity of the HIV-positive population in Minnesota.

Table 3. Countries of birth among foreign-born people living with HIV/AIDS in Minnesota in 2021

Country of birth	Number of cases	Percent of total among foreign-born people
Ethiopia	362	14%
Mexico	322	12%
Liberia	299	11%
Kenya	211	8%
Somalia	169	6%
Cameroon	140	5%
Nigeria	72	3%
Sudan	71	3%
Guatemala	44	2%

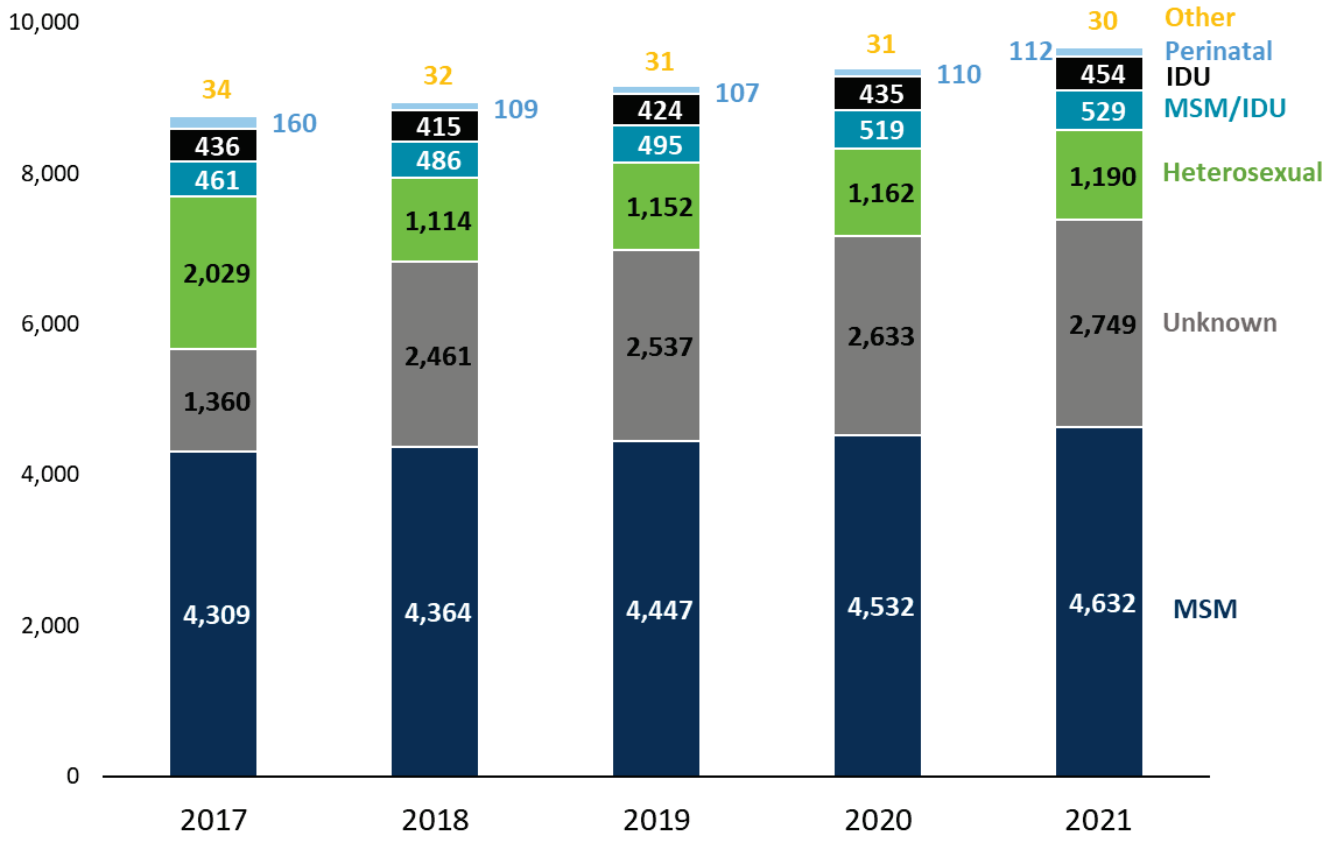
[11] Estimate of 145,078 Source: 2019 American Community Survey.

Country of birth	Number of cases	Percent of total among foreign-born people
Uganda	40	2%
Other[12]	872	34%

Prevalence by mode of exposure[13]

The most common known mode of exposure among people living with HIV/AIDS in Minnesota is men who have sex with men (MSM) (Figure 8). The proportion of prevalence of HIV/AIDS in the state by mode of exposure has declined by the largest percent for heterosexual exposure (decline of 71 percent from 2017 to 2021), while the category of unknown/unreported mode of exposure has increased the most (increase of 51 percent from 2017 to 2021).

Figure 8. Number of people living with HIV/AIDS in Minnesota by mode of exposure and year



[12] Includes over 100 additional countries.

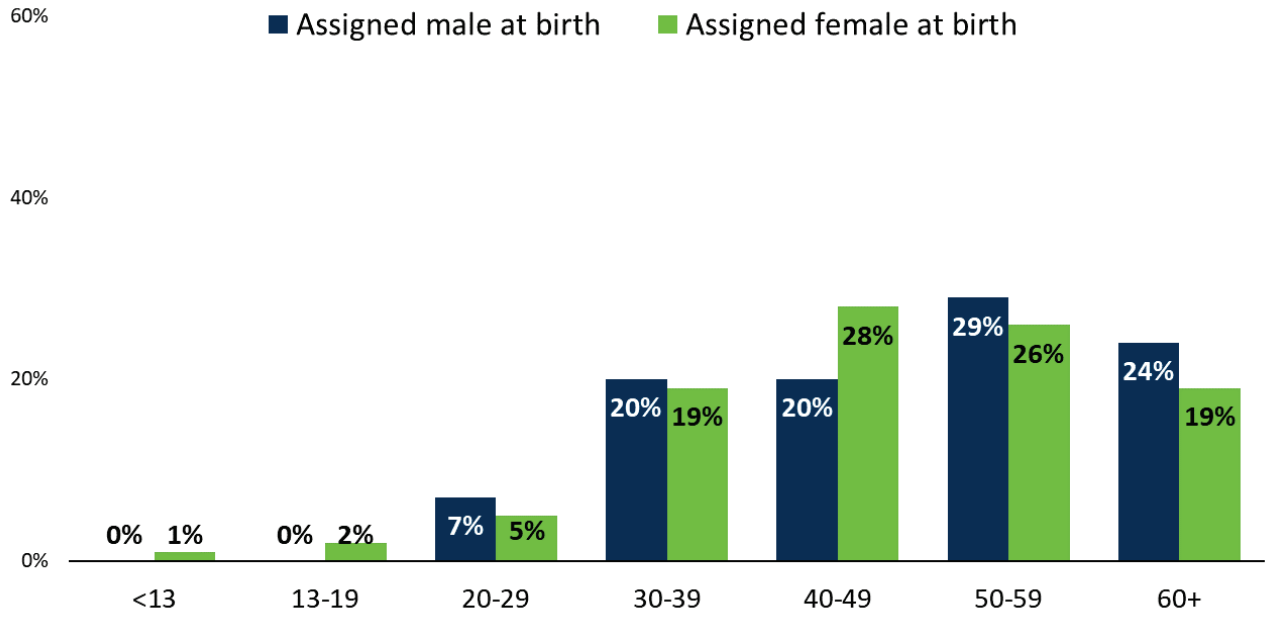
[13] MSM = Men who have sex with men. IDU = Injecting drug use. Heterosexual = For males: heterosexual contact with a female known to be HIV+, an injecting drug user, or a hemophiliac/blood product or organ transplant recipient. For females: heterosexual contact with a male known to be HIV+, bisexual, an injecting drug user, or a hemophiliac/blood product or organ transplant recipient. Perinatal = Mother to child HIV transmission. Other = Hemophilia patient/blood product or organ transplant recipient. Unknown risk = Unreported or unknown risk.

Prevalence by intersectional identities

Race/ethnicity and sex assigned at birth

In 2021, among people living with HIV/AIDS who were assigned the sex of male at birth, the majority (50 percent) were White, while the largest percentage of people living with HIV/AIDS who were assigned the sex of female at birth were Black, African-born people (40 percent) (Figure 9).

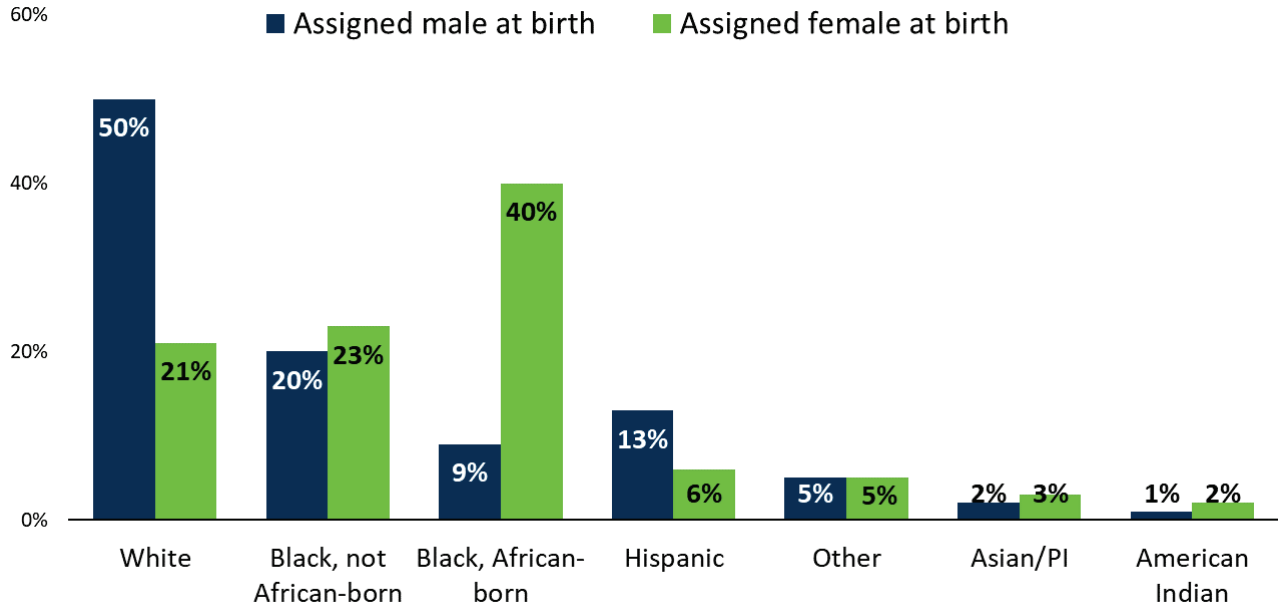
Figure 9. Percent of people living with HIV/AIDS in Minnesota in 2021 in each race/ethnicity category among people assigned male at birth and people assigned female at birth



Age and sex assigned at birth

In 2021, among people living with HIV/AIDS in Minnesota who were assigned the sex of female at birth, the group aged 40 years old to 49 years old is the largest (20 percent). Among those assigned the sex of male at birth, the largest group is aged 50 years old to 59 years old (Figure 10).

Figure 10. Percent of people living with HIV/AIDS in Minnesota in 2021 in each race/ethnicity group among people assigned male at birth and people assigned female at birth



Country of birth and sex assigned at birth

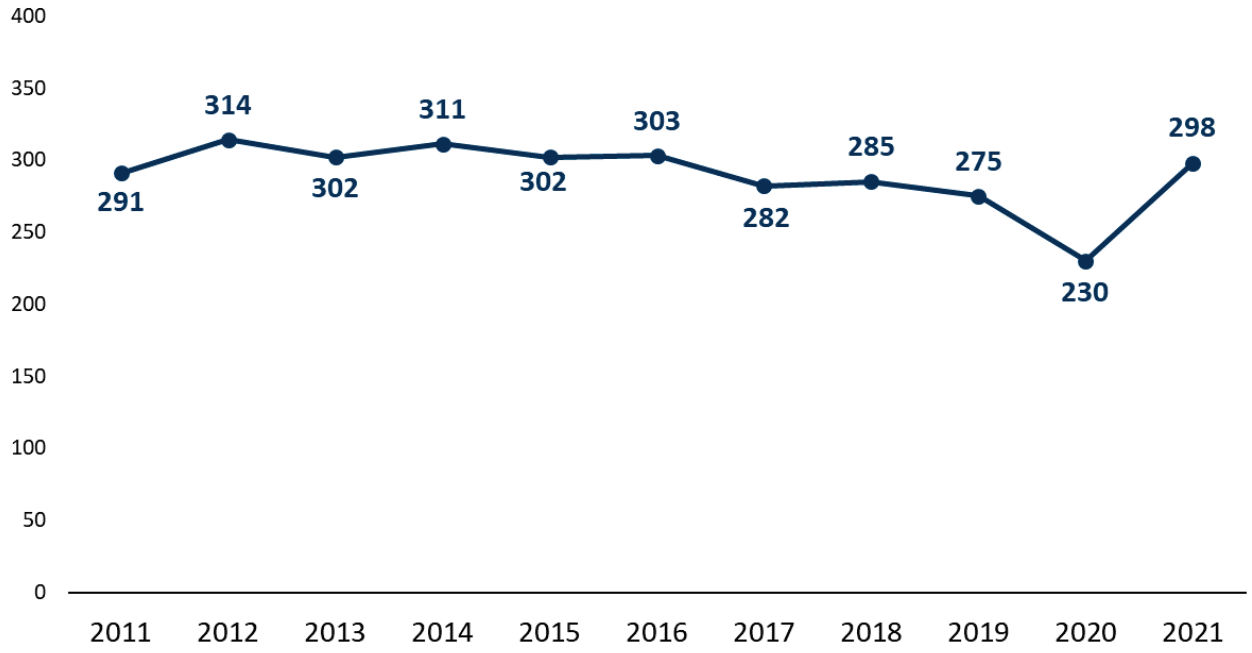
In 2021, among African-born people living with HIV/AIDS in Minnesota, the majority (59 percent) were assigned the sex of female at birth, while among US-born people living with HIV/AIDS, the majority were assigned male at birth (82 percent).

In 2021, among both Latin America/Caribbean-born and US-born people living with HIV/AIDS in Minnesota, the majority were assigned the sex of male at birth (84 percent and 82 percent, respectively).

Trends in new HIV diagnoses

In 2021 there were 298 newly diagnosed cases, compared with 230 cases in 2020 (Figure 11). The year 2020 was an outlier, however, with a 16 percent decrease in HIV diagnoses from the previous year, likely attributable to the same factors driving the national decrease in diagnoses in 2020 due to the impact of COVID-19 pandemic.

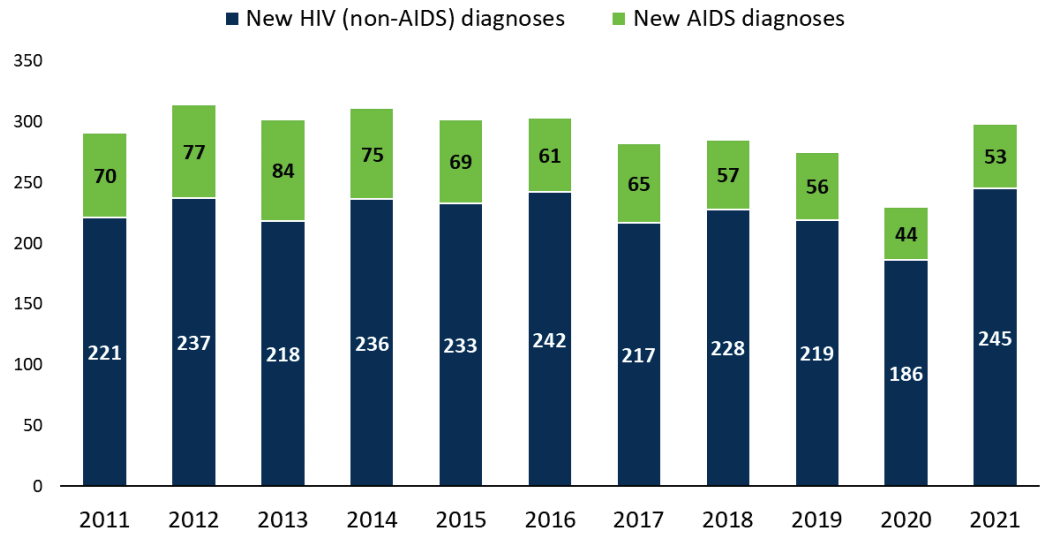
Figure 11. Number of new HIV disease diagnoses (including AIDS at first diagnosis) by year



Two-hundred ninety-eight diagnoses in 2021, while a 30 percent increase over 2020, is an 8 percent increase from 2019, and is average compared with the number of diagnoses per year in the prior decade, excluding 2020. More time and data will be required to determine whether the increase from 2019 to 2021 is a true increase in HIV infection rates or if part of the increase is due to a rebound in diagnoses after disruptions in 2020.

Despite the increase from 2020 to 2021, the number of new AIDS diagnoses each year has generally declined over the years from 84 in 2013 to 53 in 2021 (Figure 12).

Figure 12. Number of new HIV (non-AIDS) and new AIDS diagnoses by year



New diagnoses by geographic area

The largest number of new HIV diagnoses in the last five years have been in the suburban seven-county metropolitan Twin Cities area, excluding Minneapolis and St. Paul, followed by the City of Minneapolis, Greater Minnesota, and the City of St. Paul (Figure 13).

Figure 13. Number of new HIV diagnoses by area of the state and year

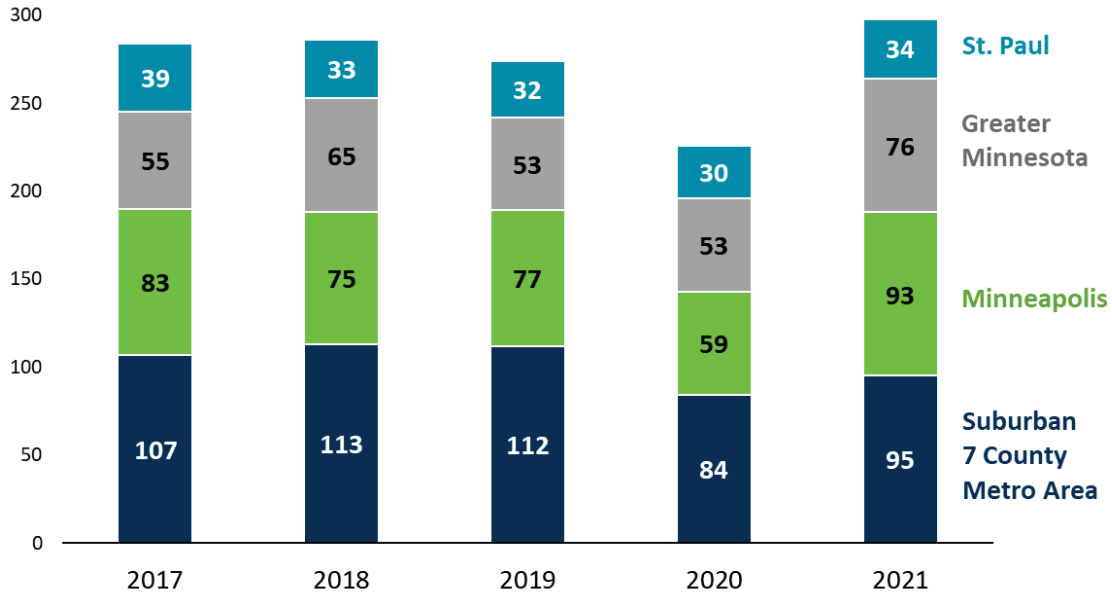
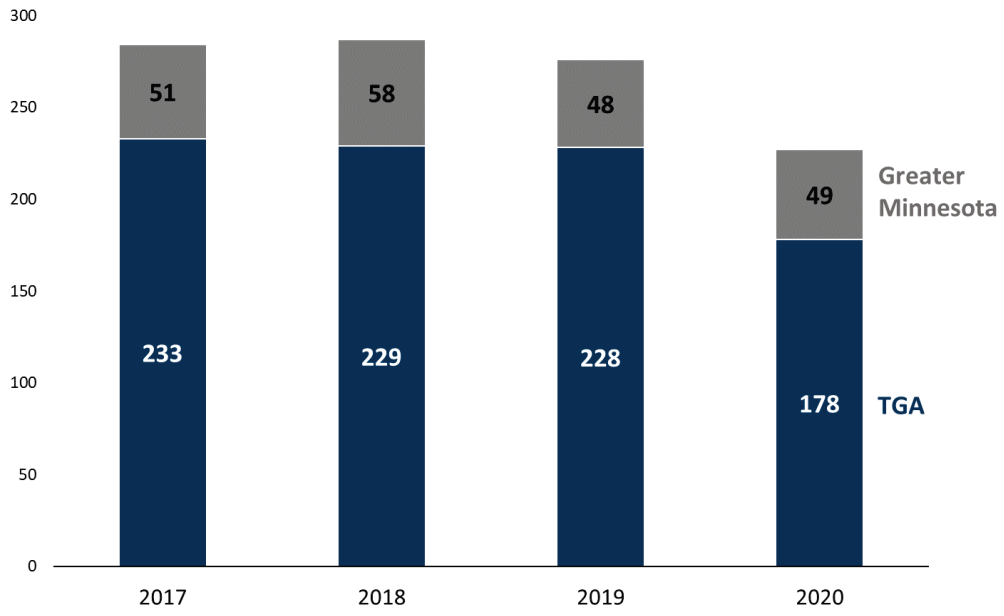


Figure 14 shows the number of new HIV diagnoses in the TGA compared to Greater Minnesota from 2017 to 2020. Data for 2021 for the TGA was not yet available for this report. Again, the TGA includes 11 Minnesota counties (Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington, and Wright) and two Wisconsin counties (Pierce and St. Croix).

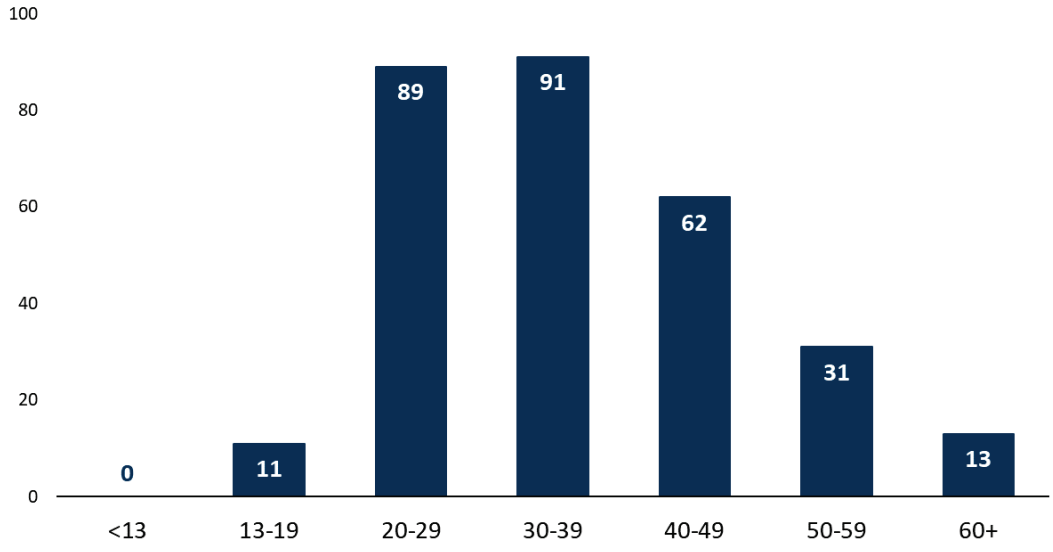
Figure 14. Number of new HIV diagnoses in Minnesota and the TGA by geographic area and year



New diagnoses by age

The age group with the most new HIV diagnoses in 2021 was the group aged 30-years-old to 39-years-old, with 91 new diagnoses, followed by the group aged 20-years-old to 29-years-old (Figure 15).

Figure 15. Number of new HIV diagnoses in 2021 by age group



Since 2019 there have been no new HIV diagnoses among people younger than 13 years of age (Table 4). The largest percentage increase from 2017 to 2021 is among the group aged 30-years-old to 39-years-old (32 percent), while the largest decrease is among people aged 60-year-old and older (38 percent).

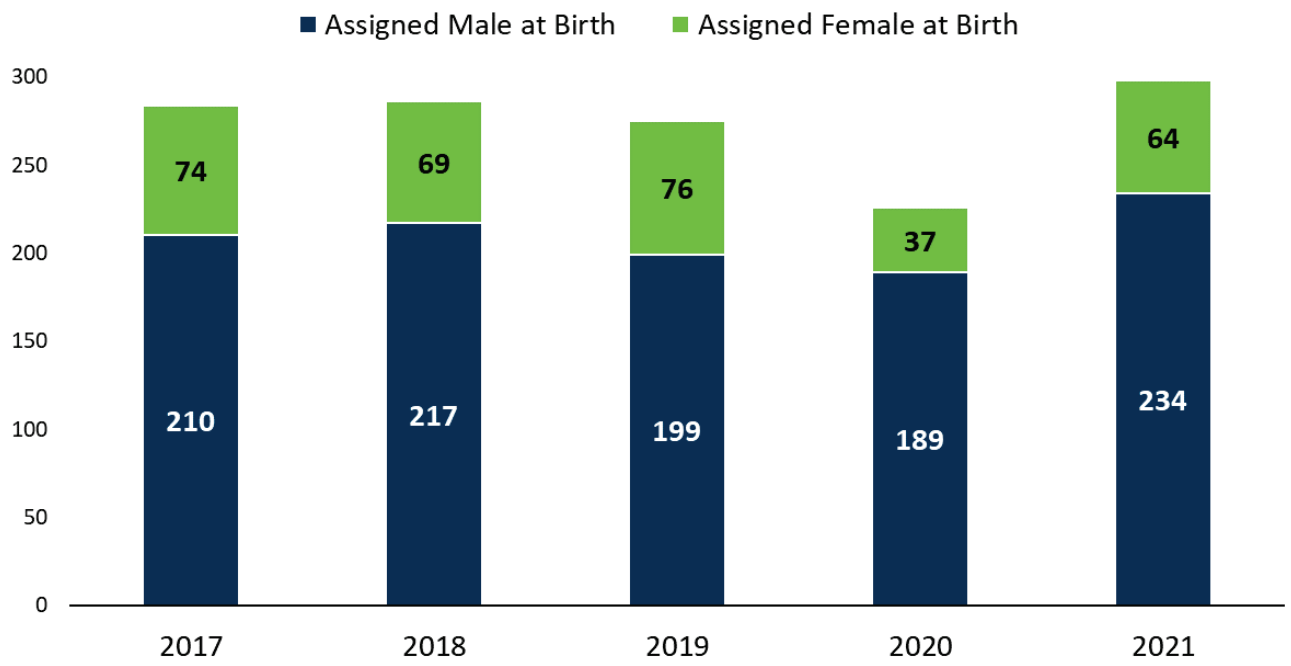
Table 4. Number of new HIV diagnoses by age group and year, including percentage change from 2017 to 2021

Year	Younger than 13 years of age	13-19 years of age	20-29 years of age	30-39 years of age	40-49 years of age	50-59 years of age	60 years of age and older
2017	1	8	100	62	54	41	18
2018	1	8	94	92	57	25	9
2019	0	9	102	82	33	39	10
2020	0	10	78	66	42	21	9
2021	0	11	89	91	62	31	13
Percentage change from 2017 to 2021	**n/a**	**27%**	**-12%**	**32%**	**13%**	**-32%**	**-38%**

New diagnoses by sex at birth

The majority of new diagnoses of HIV for at least the last five years are among people who were assigned the sex of male at birth (Figure 16).

Figure 16. Number of new HIV diagnoses by sex assigned at birth and year



New diagnoses by race/ethnicity

Among new HIV diagnoses for almost all of the last five years, the relative majority have been White people (Figure 17). However, Black, not African-born people had the highest rate of new HIV diagnosis in 2021 per 100,000 people, followed by Black, African-born people (Table 5. Number of people and rates (per 100,000 people) of new HIV diagnoses in Minnesota in 2021 by race/ethnicity).

Figure 17. Number of new HIV diagnoses by race/ethnicity and year

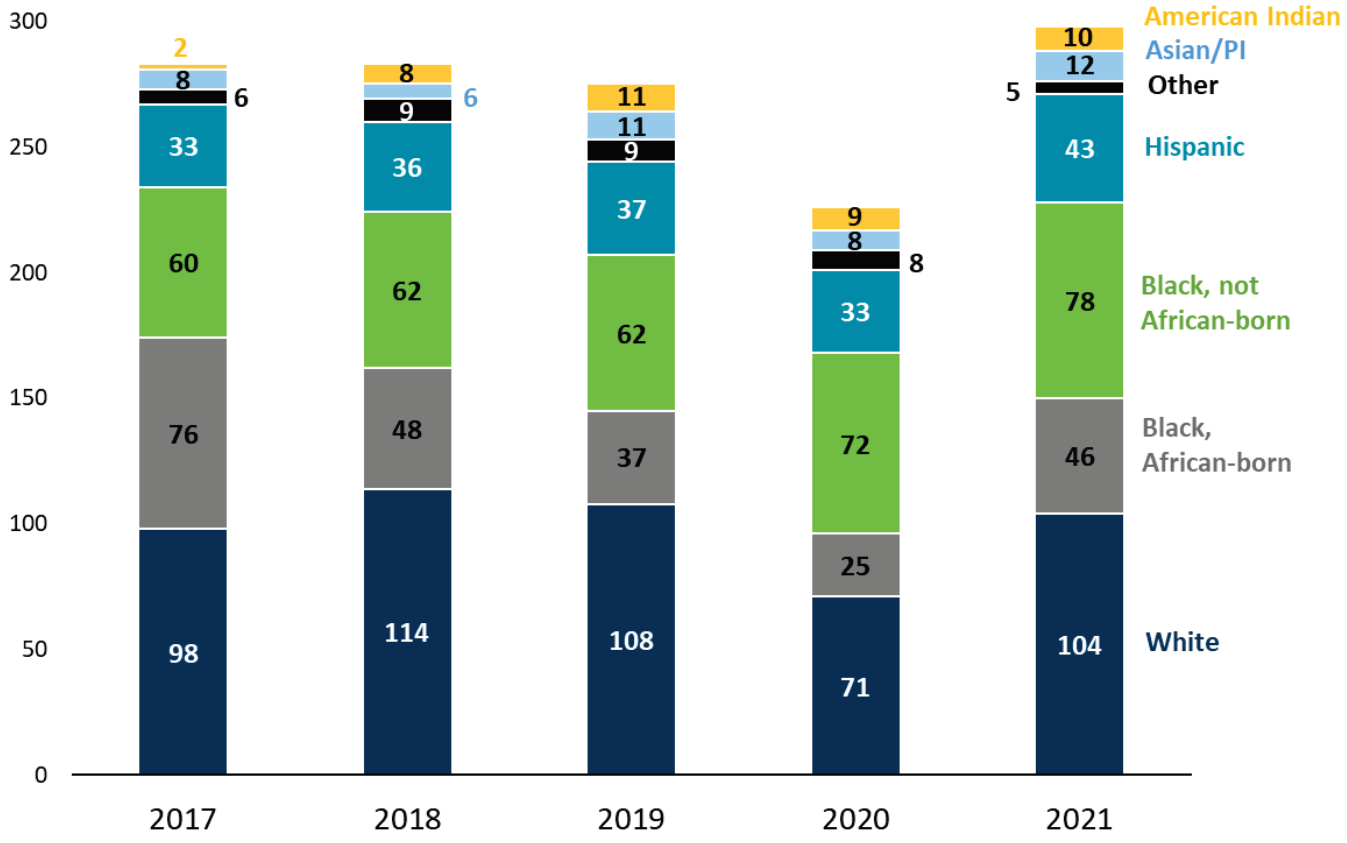
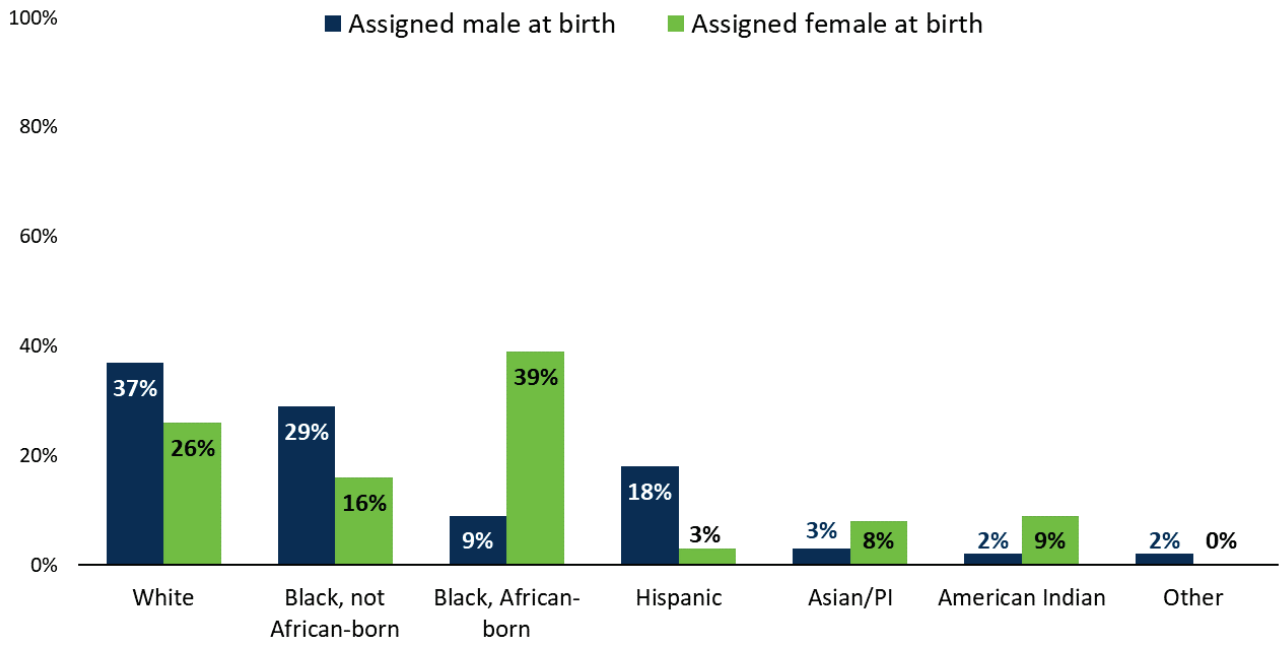


Table 5. Number of people and rates (per 100,000 people) of new HIV diagnoses in Minnesota in 2021 by race/ethnicity

Race/Ethnicity	Number of new cases	Percentage of total	Rate per 100,000
White, non-Hispanic	104	35%	2
Black, not African-born	78	26%	54
Black, African-born	46	15%	37
Hispanic	43	14%	17
Asian/Pacific Islander (PI)	12	4%	6
American Indian	10	3%	18
Other	5	2%	5

The largest percentage of new HIV diagnosis among people assigned the sex of male at birth were identified as White (37 percent) in 2021, while the largest percentage among people assigned female at birth was Black, African-born (39 percent) (Figure 18).

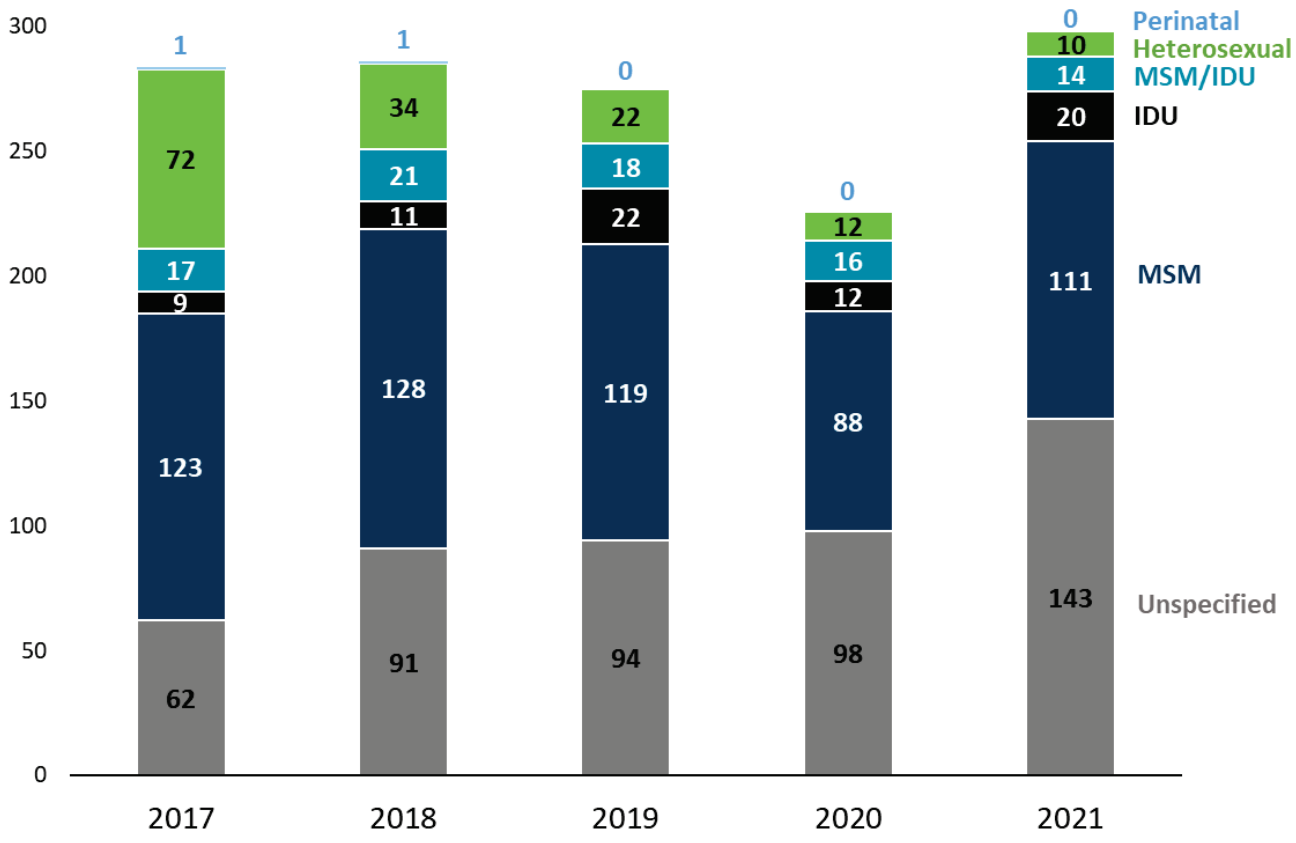
Figure 18. Percent of new HIV diagnoses in Minnesota in 2021 in each race/ethnicity category among people assigned male at birth and people assigned female at birth



New diagnoses by mode of exposure

For many years, MSM was the most reported mode of exposure among new HIV diagnoses; however, in 2021, the number of unspecified new diagnoses surpassed MSM, with 143 new diagnoses in 2021 with an unspecified mode of exposure (Figure 19). The number of new cases among injection drug users (IDU) has also increased (other than in 2020), with this being a factor in the state's outbreaks, which are described more in the next section. There have been no new perinatal HIV cases in Minnesota since 2018.

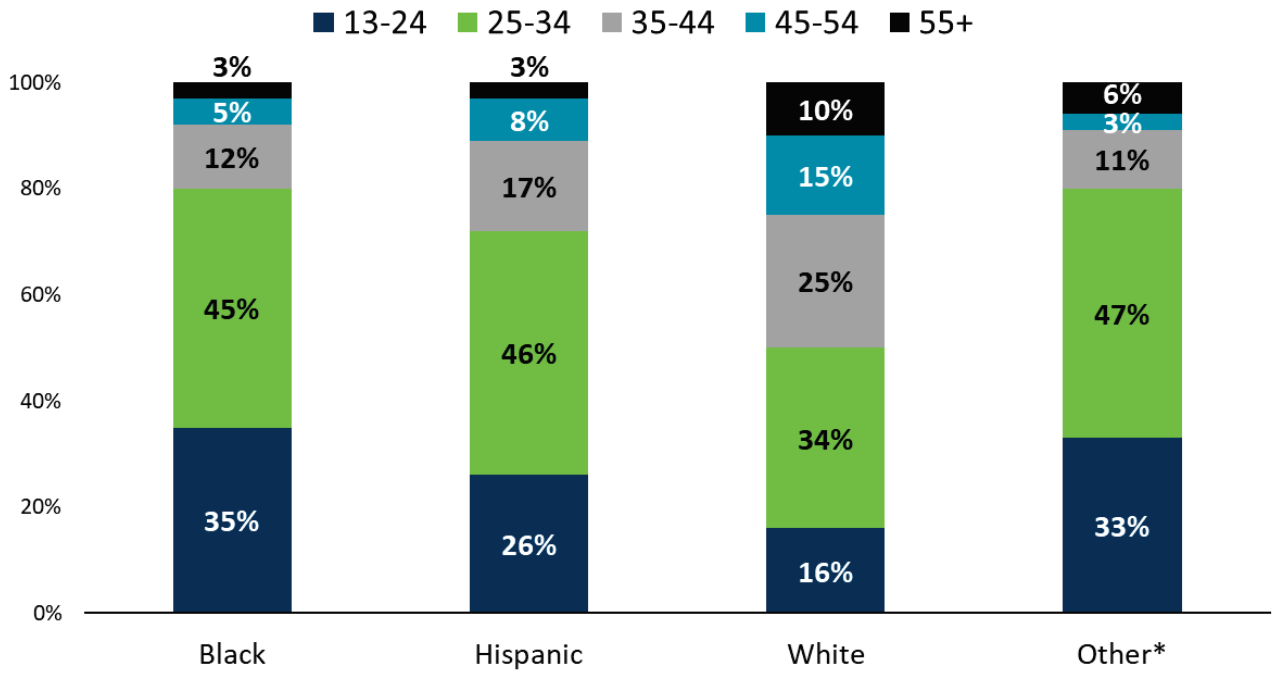
Figure 19. Number of new HIV diagnoses by mode of exposure and year



New diagnoses among MSM and MSM/IDU by race and age

Among specific modes of exposure, the greatest number of new HIV diagnoses each year are among MSM. Within that group (MSM and MSM/IDU combined), the majority of new HIV diagnoses for the last five years have occurred among men aged 25–34 across all race/ethnic categories (Figure 20).

Figure 20. Percent of new HIV diagnoses from 2017–2021 combined among MSM by race and age

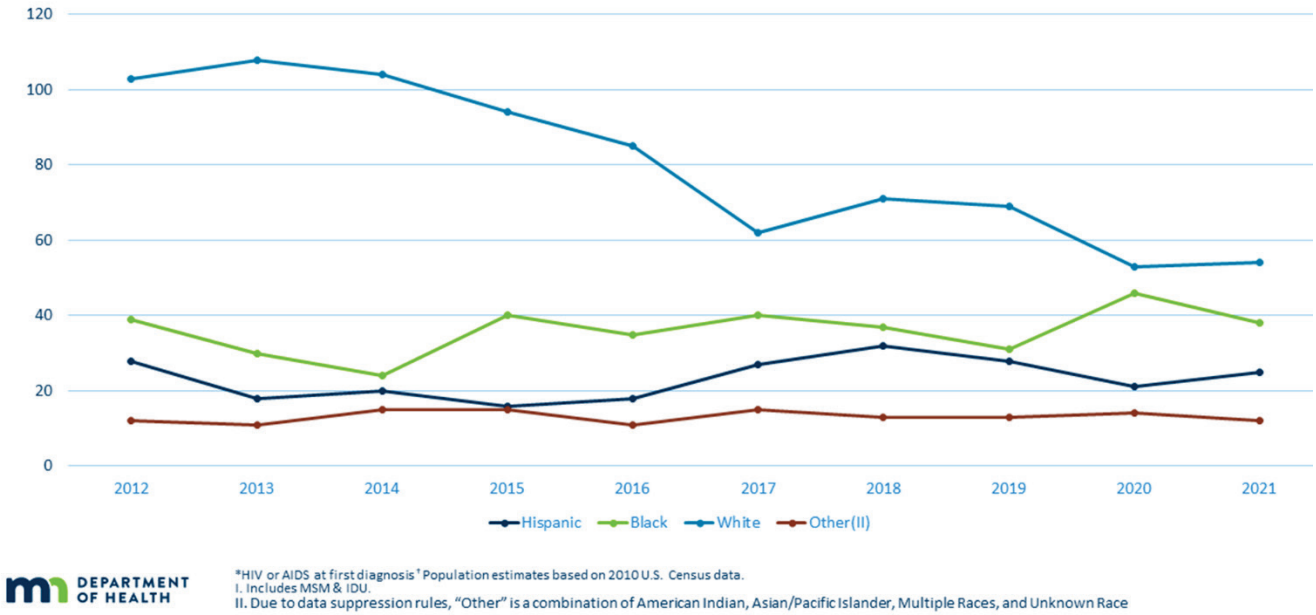


**Due to data suppression rules, "Other" is a combination of American Indian, Asian/Pacific Islander, Multiple races, and Unknown. Data suppression, either not reporting data or combining groups for aggregation, is used to help protect individual privacy.*

Eighty percent of new HIV diagnoses for the previous five years among MSM who are Black occurred in men younger than 35. Seventy-two percent of new diagnoses for the previous five years among MSM who are Hispanic occurred in men younger than 35. This rate was 50 percent for MSM who are White.

While diagnoses among MSM who are White have declined since 2012, new diagnoses among MSM of color have increased or remained relatively flat over the same period (Figure 21).

Figure 21. New HIV diagnoses among MSM by race and year



Note: This graphic was provided by MDH through a separate data request for the Integrated Plan. The exact values were not provided.

Outbreaks in Minnesota

Minnesota is currently experiencing HIV outbreaks in Hennepin and Ramsey Counties, which include the City of Minneapolis and the City of St. Paul, respectively, as well as the City of Duluth area, which includes St. Louis and Lake Counties. Minnesota's outbreak-associated cases have risk factors consistent with the national outbreaks. People at high risk in the current outbreaks include:

- People who use injection drugs (IDU) or share needles/works.
- People experiencing homelessness or unstable housing.
- Men who have sex with men (MSM).
- People who exchange sex for income and other items they need.

Hennepin and Ramsey Counties HIV outbreak

An outbreak was declared in Hennepin and Ramsey Counties in 2020 with cases dating back to 2018. As of October 18, 2022, there are 121 outbreak-associated cases in Hennepin County and 28 in Ramsey County.

This outbreak is occurring among people who:

1. Inject drugs whose residence at diagnosis was (or was unstably housed or incarcerated) in Hennepin or Ramsey County; or

2. Regardless of transmission risk, has spent time in a known encampment corridor in Minneapolis or St. Paul since 2018; or
3. Regardless of transmission risk, is named as a drug injection or needle/works or sex partner, or is in the social network of OR is molecularly linked to a person who meets criteria 1 or 2.

Duluth-area HIV outbreak

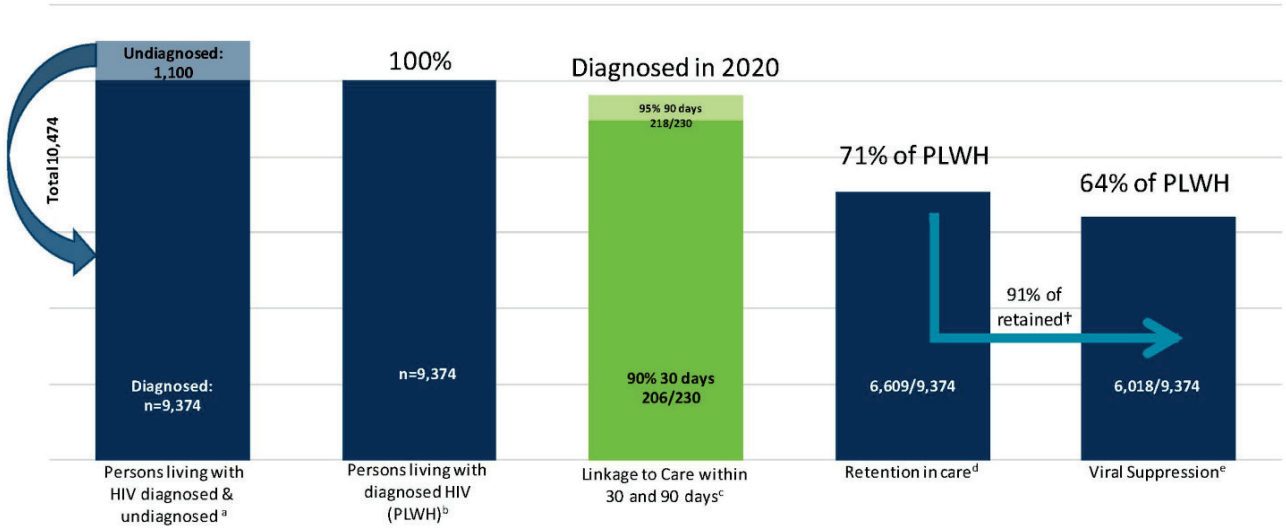
An outbreak was declared in the Duluth area in 2021, with cases dating back to 2019. As of October 18, 2022, there were 26 outbreak-associated cases in St. Louis County and one in Lake County.

This outbreak includes newly diagnosed cases of HIV in people after September 1, 2019, residing in the Duluth area at the time of diagnosis[14] or reported cases of HIV that are linked to cases that are part of the outbreak as a sex partner, drug user sharing partner, person in their social network, or by molecular linkage.

Care Continuum

The Care Continuum, sometimes referred to as treatment cascade, is a calculation of how many Minnesotans are diagnosed, are initially linked to care after diagnosis, are retained in care, and achieve viral suppression. As of September 2022, when this epidemiological profile and needs assessment was written, the most recent Care Continuum data for all groups was from 2021, while demographic breakdowns were from 2019.

Figure 22. Percentages of Minnesotans with HIV engaged in selected stages of the care continuum in 2021[15]



[14] This includes people who are unhoused, known to be in the area or people who are incarcerated or in chemical dependency treatment centers where their regular address is in the outbreak area.

[15] [a] Defined as people undiagnosed (estimate 1,200 (530–1,800), 95 percent CI) and people diagnosed (n=9,185) aged 13 or more with HIV infection (regardless of stage at diagnosis) through year-end 2019, who were alive at year-end 2020.
[b] Defined as people diagnosed aged 13 or more with HIV infection (regardless of stage at diagnosis) through year-end 2019, who were alive at year-end 2020.
[c] Calculated as the percentage of people linked to care within 30 and 90 days after initial HIV diagnosis during 2019. Linkage

Percentage of Minnesotans living with HIV who know their HIV status

As of 2021, 89 percent of Minnesotans living with HIV were estimated to know their HIV status.[16] This measure was at or above the goal of 90 percent before 2020. It is estimated that 1,100 people living in Minnesota with HIV did not know their status in 2021.

Percentage of Minnesotans diagnosed with HIV who are retained in care

As of 2021, 71 percent of Minnesotans diagnosed with HIV are retained in care.[17]

Percentage of Minnesotans who are virally suppressed

Among those people who are retained in care, as of 2021, 91 percent were virally suppressed.[18] Among all people living with HIV/AIDS, the rate of viral suppression in 2021 was 64 percent.[19]

to care is based on the number of people diagnosed during 2019 and is therefore shown in a different color than the other bars with a different denominator.

[d] Calculated as the percentage of people who had ≥1 CD4 or viral load test results during 2020 among those diagnosed with HIV through year-end 2019 and alive at year-end 2020.

[e] Calculated as the percentage of people who had suppressed viral load (≤200 copies/mL) at most recent test during 2020, among those diagnosed with HIV through year-end 2019 and alive at year-end 2020.

[†] Calculated as number of people who had suppressed VL (≤200 copies/mL) at most recent test during 2020, among those who were retained in care during 2020 (5,921/6,572).

[16] Defined as people undiagnosed (estimate 1,200 (530–1,800), 95% CI) and people diagnosed (n=9,185) aged 13 or more with HIV infection (regardless of stage at diagnosis) through year-end 2019, who were alive at year-end 2020.

[17] Calculated as the percentage of people who had ≥1 CD4 or viral load test results during 2020 among those diagnosed with HIV through year-end 2019 and alive at year-end 2020.

[18] Calculated as number of people who had suppressed VL (≤200 copies/mL) at most recent test during 2020, among those who were retained in care during 2020 (5,921/6,572).

[19] Calculated as the percentage of people who had suppressed viral load (≤200 copies/mL) at most recent test during 2020, among those diagnosed with HIV through year-end 2019 and alive at year-end 2020.

HIV Prevention, Care and Treatment Resource Inventory

It should be noted that Table 6, the HIV Prevention, Care and Treatment Resource Inventory, includes several rows for RWHAP Part B, plus related resources. These entries reflect the funding administered by the DHS HIV Supports Section from state grants, federal grants, and special revenue generated through the 340B rebate program. The HIV Supports Section must periodically adjust funding sources for expenditures during each fiscal year to maintain compliance. Due to this funding complexity, RWHAP Part B funding in the inventory reflects as a combination of funding sources. At the time of this plan creation, RWHAP Part B at DHS was receiving approximately $8.6 million from HRSA for Ryan White Part B and approximately $2.2 million from the State of Minnesota for HIV medical case management and the purchase of healthcare coverage for eligible PWH. The remaining funding reflected on this inventory for RWHAP Part B/DHS is generated through rebate revenue.

Table 6. HIV Prevention, Care and Treatment Resource Inventory table

Funder	Funding Source	Organization Receiving the Funding	Annual Award Amount	Sub-recipients	Services Delivered	Diagnose	Treat	Prevent	Respond
CDC	Comprehensive High-Impact HIV Prevention Programs for Community Based Organizations	The Aliveness Project, Inc.	$441,625.00	-	AIDS Drug Assistance Program Treatments, AIDS Pharmaceutical Assistance, Home and Community-Based Health Services , Home Health Care , Medical Case Management, including Treatment Adherence Services, Medical Nutrition Therapy, Mental Health Services, Outpatient/Ambulatory Health Services, Substance Abuse Outpatient Care, Child Care Services, Health Education/Risk Reduction, Medical Transportation, Outreach Services, Psychosocial Support Services , Referral for Health Care and Support Services , Rehabilitation Services , Respite Care, Community engagement, Condom distribution, Partner services, Prevention for persons living with diagnosed HIV infection	X		X	

Funder	Funding Source	Organization Receiving the Funding	Annual Award Amount	Sub-recipients	Services Delivered	Diagnose	Treat	Prevent	Respond
CDC	Integrated HIV Surveillance and Prevention Funding for Health Departments	Minnesota Department of Health (MDH)	$2,984,119.00	Children's Minnesota, Red Door Clinic, Rainbow Health Minnesota, Clinic 555, Native American Community Clinic	Partner services, PrEP delivery, Syringe services programs, Testing, Fetal Infant Mortality Review (FIMR)	X		X	
CDC	Strengthening STD Prevention and Control for Health Departments (STD PCHD) and DIS Workforce Development Supplemental (DISWF Supplemental)	Minnesota Department of Health (MDH)	$3,992,266.00	Red Door Clinic	Partner services	X			X
HOPWA	Housing Opportunities for Persons with AIDS Formula	City of Minneapolis	$1,945,851.00	Rainbow Health Minnesota, Clare Housing, Metro HRA	Housing		X	X	
HOPWA	Housing Opportunities for Persons with AIDS Formula	Minnesota Housing	$283,537.00	Rainbow Health Minnesota	Housing		X	X	
HOPWA	Housing Opportunities for Persons with AIDS COVID CARES Act	City of Minneapolis	$79,457.00	Avivo	Housing		X	X	

Funder	Funding Source	Organization Receiving the Funding	Annual Award Amount	Sub-recipients	Services Delivered	Diagnose	Treat	Prevent	Respond
RWHAP Part A	HIV Emergency Relief Project Grants	Hennepin County	$6,143,418.00	African American AIDS Task Force, Aliveness Project, Allina Health, Children's Minnesota, Health Care for the Homeless, HealthPartners, Hennepin Healthcare, Rainbow Health Minnesota, Minnesota Community Care, Open Arms, Pinnacle Services, Red Door Clinic, Sub-Saharan African Youth and Family Services	Early Intervention Services (EIS), Medical Case Management, including Treatment Adherence Services, Medical Nutrition Therapy, Mental Health Services, Outpatient/Ambulatory Health Services, Food Bank/Home Delivered Meals, Health Education/Risk Reduction, Housing, Legal Services, Psychosocial Support Services, Substance Abuse Services (outpatient)	X	X	X	X
RWHAP Part B + Rebate	Ryan White HIV/AIDS Program HIV Care Grant Program, Part B and Rebate	Minnesota Department of Human Services	$12,568,531.00	Aliveness Project, Clare Housing, Harm Reduction Sisters, Health Management Associates, Indigenous Peoples Task Force, Mayo Clinic, Minnesota Department of Health, Native American Community Clinic, Open Arms, Rainbow Health Minnesota, Rural AIDS Action Network, Somali Community Resettlement, The Family Partnership, Youth and AIDS Project	Medical Case Management, including Treatment Adherence Services, Mental Health Services, Outpatient/Ambulatory Health Services, Substance Abuse Outpatient Care, Emergency Financial Assistance, Food Bank/Home Delivered Meals, Health Education/Risk Reduction, Medical Transportation, Non-Medical Case Management Services, Psychosocial Support Services, Referral for Health Care and Support Services, Capacity building/technical assistance, Outreach Case Management, Training - chemical health		X	X	X

Funder	Funding Source	Organization Receiving the Funding	Annual Award Amount	Sub-recipients	Services Delivered	Diagnose	Treat	Prevent	Respond
RWHAP Part B + Rebate	Ryan White HIV/AIDS Program HIV Care Grant Program, Part B and Rebate	Hennepin County	$4,708,899	African American AIDS Task Force, Aliveness Project, Allina Health, Children's Minnesota, Clare Housing, Health Care for the Homeless, HealthPartners, Hennepin Healthcare, Rainbow Health Minnesota, Minnesota Community Care, Native American Community Clinic, Open Arms, Red Door Clinic, Sub-Saharan African Youth and Family Services, West African HIV Task Force	Early Intervention Services (EIS), Medical Case Management, including Treatment Adherence Services, Medical Nutrition Therapy, Mental Health Services, Outpatient/Ambulatory Health Services, Food Bank/Home Delivered Meals, Health Education/Risk Reduction, Housing, Legal Services, Linguistic Services, Medical Transportation, Non-Medical Case Management Services, Psychosocial Support Services, Substance Abuse Services (outpatient)	X	X	X	X
RWHAP Part B + Rebate	DHS Interagency Agreement—Ryan White Rebate	Minnesota Department of Health	$1,188,932.00	Ramsey County, Hennepin County	Early Intervention Services (EIS), Outreach Services, Partner services	X		X	X
RWHAP Part B + Rebate	DHS Interagency Agreement - EIS	Minnesota Department of Health	$2,251,163.00	African American AIDS Task Force, Aliveness Project, Annex Teen Clinic, Children's Health Care, Harm Reduction Sisters, North Point Health and Wellness, Native American Community Clinic, Clinic 555, Southside Harm Reduction Services, Sherburne County Public Health, Stearns County Public Health, Turning Point, West Side Community Health Services, White Earth Nation	Early Intervention Services (EIS), Outreach Services, Capacity building/technical assistance	X	X	X	X

Funder	Funding Source	Organization Receiving the Funding	Annual Award Amount	Sub-recipients	Services Delivered	Diagnose	Treat	Prevent	Respond
RWHAP Part B + Rebate + State (MCM and ADAP)	Ryan White HIV/AIDS Program HIV Care Grant Program, Part B and Rebate + state funding	Department of Human Services	$13,168,000.00	-	AIDS Drug Assistance Program Treatments		X		
State of Minnesota	HIV Prevention Grant Programs	Minnesota Department of Health (MDH)	$1,281,000.00	African American AIDS Task Force, Face to Face Health and Wellness, North Point Health and Wellness, Red Door Clinic, Indigenous Peoples Task Force, Rainbow Health Minnesota, Lutheran Social Services, Planned Parenthood, Clinic 555, Rural AIDS Action Network, Sub-Saharan Youth and Family Services, Turning Point, Youth and AIDS Project, West Side Community Health Services	Condom distribution, PrEP delivery, Syringe services programs, Testing	X		X	X
State of Minnesota	HIV Prevention General Funds	Minnesota Department of Health (MDH)	$71,440.00	Native American Community Clinic	Condom distribution, Syringe services programs, Testing	X		X	X

Strengths and gaps

Strengths

All of the areas of the integrated plan (diagnose, treat, prevent, and respond) are covered across the inventory. A total of 42 different sub-recipients are included in the inventory as recipients of HIV prevention, care, and treatment funding. Early Intervention Services (EIS)/Outreach services is the service counted the greatest number of times in the inventory (24), followed by Medical Case Management (17) and testing (12). Several community-based organizations funded for HIV care and prevention activities are culturally specific and serve people from priority populations where disparities are greatest.

Additionally, while the Inventory focuses on HIV-specific funding, Minnesota is a nationally recognized leader in efforts to change the health care system to improve the well-being of its residents and to better manage public resources. By coordinating patient-centered and holistic health care, human services, and education, the state is working to prevent and alleviate chronic illnesses, such as HIV, and create an expectation of health and prosperity for all. Minnesota Health Care Programs (MHCP) provide health care services to low-income families and children, low-income elderly people, and individuals who have physical and/or developmental disabilities or mental illness or who are chronically ill.

Medical Assistance (MA—Minnesota's Medicaid Program) and MinnesotaCare are the largest MHCPs. Many low-income Minnesotans impacted by HIV utilize an MHCP for their primary health insurance. For example, as of November 2022, there were 2,844 PWH being served directly by Ryan White Programs directly administered by DHS including Minnesota's ADAP, and 1,495 people were enrolled in an MHCP. MA has different income eligibility guidelines depending on population; for example, single adults without a disability at 133 percent FPG or less are eligible. MinnesotaCare serves Minnesotans who aren't eligible for MA and have incomes at 200 percent FPG or less.

Payment for these services come from a mix of state and federal funding. Claims for these programs are tracked in the Minnesota Medicaid Management Information System (MMIS). Given the complexities of this system, it is challenging to get a precise figure for claims paid for all Minnesotans with HIV as there isn't an HIV diagnostic code attached to an individual's record. People served by Minnesota's ADAP program and other Part B services billed through MMIS have a "Program HH span" in MMIS; this span can serve as a proxy indicator for a person with HIV.

DHS was able to review medical claims paid by other MHCPs in MMIS for people who also had a Program HH span. In SFY 2022, over $32.8 million in claims were paid by other MHCPs to address medical needs for PWH.

Gaps

An important gap identified through the review of this inventory is that a sizeable portion of the identified funding is from the 340B rebate program, which is not guaranteed from year to year. So, the majority of funding for HIV care and prevention activities are not reliable.

Also, while there are 42 sub-recipients included in the inventory, 65 percent of funding is going to seven agencies/organizations. Community members have indicated that funding too many providers makes the system

difficult for people to navigate, while also requesting that funding go to more small, grassroots and community-specific organizations.

When it comes to prevention, as noted above, EIS/Outreach services are well represented in the inventory, but PrEP delivery is counted only four times. A reduction in funding has resulted in a smaller number of providers receiving funding through MDH for PrEP delivery.

Additionally, people who are unhoused or who inject drugs and are frequenting encampment(s) are most at risk for HIV infection related to the two outbreaks in Minnesota. Being able to reach and serve this population has been challenging for government agencies, and the inventory highlights gaps in funding and services needed to end the outbreaks. Less than 5 percent of funding included in the inventory is specifically focused on supporting access to stable housing for PWH. Housing-related services (including support paying for rent, mortgages, and utilities) are counted ten times in the inventory, and syringe services programs (SSPs) are counted nine times.

The majority of PWH and new HIV diagnoses are located in the Twin Cities metropolitan area. However, it is important for PWH or people at risk of infection living in Greater Minnesota to have equitable access to services and supports, and one of the current outbreaks is located in Greater Minnesota. The inventory shows that the majority of sub-recipients are located in the Twin Cities metropolitan area and receive the majority of the funding, although some of these metro-based organizations do provide statewide services.

Finally, while there are some sub-recipients who are culturally specific, serving and working directly with the communities most impacted by HIV (African-born immigrants, African Americans, American Indians), the majority of sub-recipient organizations are not culturally specific.

Approaches and partnerships

MDH, DHS, and Hennepin County staff each provided the information necessary to compile the HIV Prevention, Care and Treatment Inventory. This included gathering information on HOPWA and from The Aliveness Project, a community-based organization that was awarded a grant from CDC through the *Comprehensive High-Impact HIV Prevention Programs for Community Based Organizations*. Since Hennepin County received funding from state agencies, and because MDH receives funding through DHS, efforts were made to ensure that none of the inventory entries were duplicated in the process. The staff from each agency that provided information also reviewed the compiled inventory for accuracy.

Needs assessment

Approach

The Integrated Planning Steering Committee began the needs assessment process by reviewing the data and information described at the beginning of Section III of this document, which included epidemiological data, survey results, and input gathered during other recent jurisdictional plan update processes.

Each Steering Committee member was asked to individually compile, in writing, the successes and challenges they identified in the data and information, using narrative statements to focus on what the data indicates

rather than the causes or solutions. From their list of challenges, each member was asked to highlight the five that they thought were most important to prioritize in the Integrated Plan.

In two facilitated discussions, the Committee reviewed the individually prioritized challenges that were identified through the previous step and came to consensus on what they believed were the highest priorities to focus on moving forward.

The needs assessment information in the next section and the identified priorities were shared with MCHACP, along with an online survey to gather members' feedback. Facilitated discussions were held with the full Council as well as the Disparities Elimination and Needs Assessment & Evaluation committees. Based on the total input from MCHACP, the priorities identified further below were finalized.

There were several ways that input from PWH and other entities most invested in or impacted by the Integrated Plan was included in the needs assessment:

- Much of the data used in the needs assessment came from the 2020 HIV/AIDS Comprehensive Needs Assessment survey, which collected responses from over 800 PWH.
- Feedback gathered during the END HIV MN reprioritization process was also incorporated in the needs assessment. That process included gathering input from:
    - 78 people who participated in a meeting or took a survey, including[20]:
        - 26 percent who identified as a PWH, taking PrEP, or as an advocate or ally;
        - 38 percent who identified as an HIV educator, PrEP navigator, or similar;
        - 29 percent who identified as a government partner, including state and local public health;
        - 26 percent who identified as a Ryan White provider; and
        - 10 percent who identified as a doctor, nurse, PA, NP, pharmacist, or similar.
    - The END HIV MN Advisory Board, which includes the perspectives of consumers, providers, and other partners.
- Feedback gathered during the process of updating Positively Hennepin was also reviewed as part of the needs assessment. Overall, 16 diverse consumers living with HIV took part in listening sessions.
- At least 33 percent of MCHACP members are unaligned consumers who access Ryan White Part A and Part B services. The Council also includes representation from:
    - Public health,
    - Health care providers,
    - Community-based organizations.
    - Social services providers,
    - Mental health and substance abuse treatment providers, and
    - RWHAP Part B, C, and D recipients.

[20] Categories are not mutually exclusive. Total does not equal 100 percent.

Diagnosis and prevalence

- As of 2021, 11 percent of PWH, about 1,100 people, do not know their status.
- There were 298 new HIV/AIDS diagnoses in 2021, an 8 percent increase over 2019.

Disparities in prevalence identified as high priorities

Category	Group	Challenge
Race/Ethnicity	People of color	65 percent of new HIV/AIDS diagnoses in 2021 were among people of color.
Race/Ethnicity	Black people	People who are Black (both African-born and not) have the highest rates of HIV prevalence per 100,000 pop.
Race/Ethnicity	Foreign-born people	• Between 1990 and 2021, the number of foreign-born PWH has increased substantially, especially among the African-born population. • The total number of foreign-born PWH increased 5 percent over 2020 (2,553).
Age	Ages 20–39	• Most new infections are occurring in people ages 20–39. • 30–39 age group had the most new diagnoses in 2021.
Sex	Assigned female at birth	People assigned the sex of female at birth are diagnosed later than those assigned male, on average.

Barriers to diagnosis

- 31 percent of Minnesotans in 2020 reported ever having been tested for HIV. This was a 3-point decline from 2019, and a 6-point decline from a high of 38 percent in 2016–2017 (BRFSS).
    - The rate in 2020 was highest among Black respondents (58 percent) and lowest among Asian respondents (24 percent).

Treatment

- As of 2021, 90 percent of PWH are linked to care within 30 days of initial diagnosis.
- As of 2021, 71 percent of people who have a diagnosis are retained in care.

Disparities in linkage to care identified as high priorities

Category	Group	Challenge
Mode of exposure	IDU	People who inject drugs (IDU) had the lowest rate of linkage to care within 30 days in 2019 (58 percent) compared to other modes of exposure.
Race/Ethnicity	American Indians	American Indian people had the lowest rate of linkage to care within 30 days in 2019 (43 percent) compared to other racial/ethnic groups.
MSM + Geographic area	MSM in Greater Minnesota	MSM in Greater Minnesota had a 20-point lower rate of linkage to care within 30 days in 2019 (67 percent) compared to MSM in the 7-County Metro Area (86 percent) and MSM in the 11-County Metro TGA (85 percent).

Barriers to linkage to care

The rate of linkage to care within 30 days in 2018 was 77 percent. Among 30 cases interviewed by partner services who did not link to care within 30 days identified the following as barriers:

- Lack of insurance at time of diagnosis or waiting for insurance to start.
- Linked to care but shortly after 30 days (linkage rate within 90 days in 2018 was 87 percent).
- Left Minnesota shortly after diagnosis or lived in another state at time of diagnosis.
- Diagnoses in county jails do not have rapid access protocols like state prisons.
- Other health issues where patient/provider decided to delay the start of treatment.
- Initial false positive later confirmed, but after 30 days from initial screening test.

Disparities in retention in care identified as high priorities

Category	Group	Challenge
Mode of exposure	IDU	• IDU had the lowest rate of retention in care in 2019 (69 percent) compared to other modes of transmission. • IDU had the highest rate of people not in care (31 percent) and the lowest rate of people in care and virally suppressed (59 percent) compared to other modes of transmission.
Mode of exposure + race/ethnicity	MSM + Race/Ethnicity	Retention and viral suppression outcomes showed racial disparities when looking specifically at MSM populations.

Category	Group	Challenge
Race/Ethnicity	Hispanic people	• Hispanic people had the lowest rate of retention in care in 2019 (68 percent) compared to other racial/ethnic groups. • Hispanic people had the highest rate of people not in care (32 percent) and the lowest rate of people in care and virally suppressed (61 percent) in 2019 compared to other racial/ethnic groups.
Race/Ethnicity	Black people	Black, African-born people had the second-highest rate of PWH not in care (27 percent), followed by Black, not African-born people (26 percent) in 2019 compared to other racial/ethnic groups.
Race/Ethnicity	Multiple races	According to NA2020, respondents who identified as multiple races were most likely to rarely/never take HIV medication as prescribed (16 percent).
Age	25–44	People aged 25–34 and 35–44 had the lowest rate of people in care and virally suppressed (66 percent each) compared to other age groups.
Gender identity	Transgender people	According to NA2020, respondents who identified as transgender were less likely to always take HIV medications as prescribed.
Ryan White enrollment	Not enrolled in RW	All PWH had lower rates of linkage to care in 30 days (77 percent), retention in care (77 percent), and viral suppression (68 percent) in 2019 than PWH who are enrolled in Ryan White services.
MSM + Ryan White enrollment	MSM not enrolled in RW	All MSM had lower rates of linkage to care in 30 days (82 percent), retention in care (79 percent), and viral suppression (71 percent) in 2019 than MSM who are enrolled in Ryan White services. Retention in care among MSM enrolled in Ryan White services was 94 percent in 2019.

Barriers to retention in care

SERVICES & SUPPORT

- Enrollment in Ryan White services has declined during the pandemic.
- On the NA2020, most service activities (other than MCM, ADAP, and O/AHS) had significant percentages of respondents indicating they needed services but could not access them.
    - Oral health care services continue to be a service gap for PWH.
- Among "other support services," psychosocial support and non-medical case management had the highest rates on the NA2020 survey of respondents saying they needed the service but didn't access it (over 20 percent).

Category	Group	Barriers
Gender Identity	Transgender people	According to NA2020, respondents who identified as transgender were more likely to have transportation as a barrier to care.

Category	Group	Barriers
Race/Ethnicity	Black, African-born	According to NA2020, respondents who identified as Black, African-born were most likely to report not having social and emotional support.
Race/Ethnicity	Multiple races	According to NA2020, respondents who identified as multiple races were most likely to have transportation as a barrier to HIV care.
Age	30–39	According to NA2020, respondents ages 30–39 were most likely to report not receiving social and emotional support.

HOUSING

- Respondents to the NA2020 who were in transitional or temporary housing were more likely to miss medical appointments, not see an HIV provider, have medication adherence problems, and not have a viral load test in the last year. For some, this was due to drug and/or alcohol use and/or mental health challenges.
- Overall, NA2020 found that without stable housing, health outcomes are not consistently achieved. And that nearly half of respondents indicated not being able to pay their housing or utility bills in the last 12 months.
- Participants in the END HIV MN reprioritization process in 2021 most often selected "Housing for all" as the most important priority for the state to focus on in the next two years. Participants said that people cannot focus on their health when they are struggling to meet their basic needs for shelter, food, and safety.
- According to a 2019 Housing Availability Assessment Report, the state's average wait for subsidized housing is 22 months.

Category	Group	Barriers
Gender Identity	Transgender	According to NA2020, respondents who identified as transgender were more likely to stay in a shelter, somewhere not intended as a place to live, or someone else's home.
Race/Ethnicity	American Indian	RWHAP clients who are American Indian are least likely to be stably housed.
Race/Ethnicity	American Indian and multiple races	According to NA2020, respondents who identified as American Indian or multiple races were most likely to not be able to pay for housing/utilities in the last month.

FINANCES & FOOD INSECURITY

Category	Group	Barriers
Race/Ethnicity	American Indians and multiple races	According to NA2020, respondents who identified as American Indian or multiple races were most likely to be unemployed and most likely to run out of food sometimes/often in the last year.
Gender Identity	Transgender	According to NA2020, respondents who identified as transgender were more likely to run out of food.

Category	Group	Barriers
Age	18–39	According to NA2020, respondents aged 18–39 were most likely to be unemployed.
Geographic area	Greater Minnesota	According to NA2020, Greater Minnesota regions were more likely to have respondents who ran out of food in the last year.

ACCESSING MEDICAL SERVICES

- Although the NA2020 survey found most respondents reported being insured, respondents still reported health care costs as a barrier to care.

Category	Group	Barriers
Race/Ethnicity	Hispanic and Black, African-born people	According to NA2020, respondents who identified as Hispanic or Black, African-born worried most about paying medical bills.
Age	18–39	According to NA2020, respondents aged 18–39 were most likely to have trouble paying medical bills.
Geographic area	Greater Minnesota (West Central/ Northwest & South Central/Southwest)	According to NA2020, respondents in West Central/Northwest and South Central/Southwest regions were most likely to have problems paying medical bills.
Geographic area	Greater Minnesota (Northeast)	According to NA2020, respondents in the Northeast regions were most likely to not see a medical provider about HIV and most likely to not have a viral load test in the last year.
Geographic area	Greater Minnesota (Northeast & South Central/Southwest)	According to NA2020, respondents in the Northeast and South Central/Southwest regions were more likely to delay care.

CHEMICAL & MENTAL HEALTH

- 20 percent of respondents to the NA2020 survey said that they needed mental health services but didn't access them.
- Statute-mandated HIV minimum standards, which define expectations for staff competency and programming about HIV in licensed substance use disorder (SUD) treatment centers, haven't been updated since 2015.

Category	Group	Barriers
Race/Ethnicity	Multiple races	According to NA2020, respondents who identified as multiple races were most likely to have medication adherence problems due to alcohol, mental health challenges, and drugs.
Gender Identity	Transgender	According to NA2020, respondents who identified as transgender were more likely to delay care or miss HIV medical appointments due to drug and/or alcohol use and/or mental health challenges.
Age	Younger people	According to NA2020, younger respondents were most likely to have HIV medication adherence problems and most likely to miss medical appointments due to drugs and/or alcohol use and or mental health challenges.
Geographic area	Greater Minnesota (Northeast & South Central/Southwest)	According to NA2020, respondents in the Northeast and South Central/Southwest regions were more likely to have medication adherence problems due to alcohol use.
Housing status	Transitional/ temporarily housed	According to NA2020, respondents in transitional housing or who were temporarily housed were three times more likely to miss an HIV medical appointment due to alcohol use and due to drug use.

Prevention

- There were 298 new HIV/AIDS diagnoses in 2021, an 8 percent increase over 2019.
- As of 2021, 91 percent of people retained in care were virally suppressed, while 64 percent of all PWH who know their status were.

Disparities in prevention identified as high priorities

Category	Group	Barriers
Mode of exposure	Unknown/ Undisclosed	In 2021, mode of exposure was unknown or undisclosed was a plurality of new HIV diagnoses (48 percent).
Race/Ethnicity	People of color	Communities of color continue to be disproportionately impacted by HIV (65 percent of new infections in 2021).
Race/Ethnicity	People of color	While the majority of clients who are tested for HIV at prevention-funded grantee organizations are Black/African American (34 percent) or American Indian/Alaskan Native (21 percent), the majority of HIV-negative clients who are prescribed PrEP at MDH-funded programs are White (42 percent).
Age	18–39	According to NA2020, respondents aged 18–29 and 30–39 were more likely to inject drugs.
Age + Sex	Young females	The exposure risk for young females is mostly unknown (81 percent).

Category	Group	Barriers
Gender	Transgender people	According to NA2020, respondents who identified as transgender were more likely to inject drugs.
Geographic area	Greater Minnesota (Northeast)	According to NA2020, respondents in the Northeast regions were most likely to inject drugs.

Barriers in prevention

- Without knowing the mode of exposure for almost half of new HIV diagnoses in 2021, it is difficult to identify where prevention efforts might be needed the most.
    - Similarly, the exposure risk is unknown for 81 percent of newly diagnosed young female PWH.
- Participants in the END HIV MN reprioritization process selected "Harm Reduction" as the second-most important issue for the state to focus on for the next two years.
    - During the END HIV MN reprioritization process, providers said that not being able to purchase syringes with funding from government agencies is a big barrier. Providers also said that harm reduction funding needs to include safer smoking supplies.
    - Participants also said that harm reduction goes beyond SSPs and should be the overall approach/philosophy for END HIV MN.

Disparities in viral suppression identified as high priorities

Category	Group	Barriers
Race/Ethnicity	People of color	Viral suppression outcomes from 2019 show racial/ethnic disparities between White people and all other racial/ethnic groups (with the exception of multi-racial).
Race/Ethnicity	American Indians	American Indians have the highest rate of PWH in care who are not virally suppressed (16 percent).
Race/Ethnicity	American Indians and Black people	American Indians and Black, not African-born people had the lowest rates of viral suppression (63 percent) in 2019, followed by Black, African-born people (64 percent).
MSM + Race/Ethnicity	MSM + American Indians	American Indian MSM had the lowest rate of viral suppression among MSM racial/ethnic groups in 2019 (56 percent).
Age	18–39	According to NA2020, respondents aged 18–39 were least likely to be virally suppressed.
Age	25–44	People aged 25–34 and 35–44 had the lowest rate of viral suppression (66 percent each) among age groups in 2019, with ages 45–64 and 65+ only slightly higher (67 percent and 69 percent respectively).

Category	Group	Barriers
Mode of exposure	IDU	IDU had the lowest rate of viral suppression in 2019 (59 percent) compared to other modes of exposure.
Geographic area	Greater Minnesota (Northeast)	According to NA2020, respondents in the Northeast regions were most likely to not be virally suppressed.

Barriers to viral suppression

*Many of the same barriers noted above under **Treatment** that are barriers to retention in care (access to services and supports, housing, financial issues, medical access issues, and chemical and mental health challenges) are also barriers that impact the ability of PWH to achieve viral suppression and impacts the same groups of people (American Indians, Hispanic people, Black people, people who identify as transgender, people with unstable housing, younger people, and people living in Greater Minnesota).*

Response

- As of June 28, 2022:
  - 102 cases have been associated with the outbreak in Hennepin and Ramsey Counties.
  - 24 cases have been associated with the outbreak in the Duluth area.

Disparities in outbreak impacts

Minnesota's outbreak-associated cases have risk factors consistent with the national outbreaks. People at high risk in the current outbreaks include:

- People who use injection drugs (IDU) or share needles/works.
- People experiencing homelessness or unstable housing.
- Men who have sex with men (MSM).
- People who exchange sex for income and other items they need.

Priorities

Based on the needs assessment, the following are key priorities to address:

- **Racial disparities** persist across PrEP access and adherence, new HIV diagnoses and prevalence, and across the Care Continuum.
- There are **two outbreaks** in Minnesota, which are impacting people who inject drugs and who are unhoused.
- **Young people** are disproportionately impacted, with higher rates of new diagnoses and lower rates of viral suppression.
- **Transgender people** face increased barriers and stigma, with diagnoses increasing among transgender people while the 2020 Needs Assessment survey found they are most likely to report challenges with accessing housing, paying bills, buying food, accessing medical services, and adhering to medical treatment.
- **Linkage and retention** rates must increase, along with viral suppression, in order to effectively decrease the number of new diagnoses.
- State funding for **PrEP delivery** has decreased and fewer providers are being funded by MDH. Minnesota does not have a good picture of statewide data on PrEP prescription or use because only part of the system is state funded.
- People's **basic needs** must be met before they can focus on their health. On the 2020 Needs Assessment survey, high percentages of PWH reported challenges with affording housing, running out of food, and paying medical bills.
- **Ryan White service levels** are not increasing among people who are eligible. Most PWH who took the 2020 Needs Assessment survey have incomes that would qualify them.
- Minnesota has yet to make progress with **systematic routine, opt-out testing** across the health care system. In 2020, 31 percent of Minnesotans reported ever being tested for HIV.
- The 2020 Needs Assessment survey shows that **mental and chemical health** issues contribute to PWH missing HIV care and/or not taking their medication as prescribed.
- **Lack of coordination** between components of the HIV care and prevention system leads to duplication of services and disconnect between partner organizations.
- **Lack of connection** between the HIV sector and other major sectors (e.g., housing, behavioral health, aging) creates barriers to referring PWH and who are at risk of infection to support services that are not funded with HIV-specific funding sources.
- **Lack of continuity of care for PWH who are incarcerated** leads to some PWH not being automatically enrolled for ADAP or receiving the care they need.

Actions taken

As noted in the description of the approach to the needs assessment, the engagement efforts that informed the needs assessment occurred in the period leading up to plan development in 2022. As this information was gathered, lead agencies applied what was being learned to systems-level decisions wherever possible. Some examples of this include:

- The 2020 Needs Assessment survey results and END HIV MN engagement efforts informed the services and funding levels for a Request for Proposal (RFP) issued by DHS for Ryan White providers in 2021.
- The 2020 Needs Assessment survey results informed funding proposals from Hennepin County and DHS that were connected to Ryan White grants.
- The 2020 Needs Assessment survey results were also used by the Council when completing the prioritization and allocation processes for Ryan White Parts A and B.
- DHS targeted rebate resources to increase funding levels to help meet PWH's basic needs, such as for housing, food, and emergency financial assistance.
- The feedback that was collected through END HIV MN engagement efforts helped inform the 2022 RFP issued by MDH for prevention activities.

While the barrier to entry into Ryan White may seem low, eligibility for different programs and services is currently decentralized, and it can be challenging for some people to ensure they have the right documentation and can complete the paperwork and follow-up to receive services. Because of this, as well as the needs of PWH impacted by the recent outbreaks in Minnesota, DHS HIV Supports is working to pilot Outreach Case Management. Outreach Case Management is funded by a small state grant whose only eligibility requirement is that the person is living with HIV, allowing case managers in this model to, in part, work to help clients enroll in Ryan White services. One early learning from this pilot is that the provider organization funded to do Outreach Case Management has deep, long-standing relationships with clients, so it can feel difficult to "hand off" someone from their support to a Ryan White provider, especially because those hand-off points are especially vulnerable times when someone can fall out of care. A future way to address this issue may be braiding funding sources to offer more flexible navigation services that wouldn't necessarily end once a client officially enrolls in Ryan White services.

Additionally, barriers to maintaining eligibility for Ryan White services, and for getting services, were highlighted by community members in multiple engagement efforts. These barriers were partially addressed through application of new HRSA guidance from Policy Clarification Notice 21-02, which removed a requirement for six-month recertification of eligibility. This has helped clients stay engaged in the services they need, while also reducing the administrative burden on providers, so that they can spend more time on service delivery. Parts A and B in Minnesota continue to make progress in implementing Centralized Eligibility for Ryan White Services (CE). CE is a simplified enrollment and renewal process that will be done centrally by Ryan White Part B, for all clients in all parts of Minnesota's Ryan White Program. The new process will improve efficiency and reduce duplication of efforts among providers. The new process will also reduce barriers to eligibility for people seeking services as they won't have to repeat eligibility at every provider/agency they access. CE is scheduled to launch in 2023.

Section IV: Situational Analysis

Diagnosing all people as early as possible

Successes

- Partners of newly diagnosed individuals who receive partner services and test positive for HIV are referred by Disease Intervention Specialists (DIS) to HIV care and treatment.
    - MDH received a five-year grant through federal COVID-19 relief funding to expand the DIS workforce and is partnering with clinics and Tribal Nations to hire, train, and increase the capacity of DIS staff.
- EIS and HIV testing programs are now implementing rapid-rapid testing, which involves using two rapid HIV tests of different brands and can provide confirmatory results within 15 to 20 minutes.

Challenges

- Stigma related to HIV infection continues to be a substantial challenge.
- Lack of cultural competency, lack of harm reduction utilization, systemic racism, and transphobia all impact the safety and level of care provided to people who are at risk of HIV infection.
- There is not systematic, routine opt-out testing across the health care system.

Needs

- Continue efforts to reduce stigma and increase awareness through public awareness campaigns that are culturally relevant and feature real Minnesotans who are living with HIV or taking PrEP.
- Increase routine opt-out HIV testing across the entire health care system.
- Ensure providers have received training on cultural humility, trauma responsiveness, and harm reduction.
- Expand who is providing HIV care and prevention services by continuing efforts to develop capacity of small and culturally specific organizations.
- Continue work to de-duplicate testing programs and ensure that grantees have enough capacity to meet the needs of priority populations and culturally specific communities.

Treating people rapidly and effectively

Successes

- Individuals who test positive are immediately linked to confirmatory testing and HIV medical care.

    - All funded non-clinical testing sites partner with an HIV specialty clinic to ensure confirmatory testing and linkage to care is completed; these sites are also identifying clinical referral options to support rapid initiation of HIV treatment—within 7 days of diagnosis.
    - Individuals who test positive are also referred to Ryan White services.
- The Care Link Services Program at MDH and Data2Care Program at Hennepin County Red Door Services use HIV surveillance data to identify people who are believed to be out of care because they have not had a CD4 or viral load result reported to MDH within the past 15 months. The Data2Care Program focuses on people living in Hennepin County and the Care Link Services Program focuses on people living in 86 other counties, as well as all HIV-positive pregnant women regardless of county of residence.
    - The Care Link Services and Data2Care programs also routinely assess patients' barriers to retention in care. Care Link Services and Data2Care staff provide active referrals to needed supportive services, including case management, as an effort to remove those barriers.
- In response to the COVID-19 pandemic, jurisdictions adapted policies that allowed for continuity in care and services for PWH despite their inability to receive in-person care from medical professionals. There is a commitment to maintaining these innovations and adaptations into the future.

Challenges

- People cannot focus on their health when they are not having their basic needs met, such as stable housing, food security, and reliable transportation.
- Lack of cultural competency, lack of harm reduction utilization, systemic racism, and transphobia all impact the safety and level of care provided to PWH.
- While social determinants of health can help identify people who may be at risk of dropping out of HIV care, it is difficult to identify specific individuals who have dropped out of care in a timely manner and then get connected to them to offer support to reengage.
- PWH face barriers to accessing mental and chemical health services, especially substance use disorder treatment.
- Currently, rebates are available to cover co-pays, but require the person to have the resources to pay the co-pay initially.
- Lack of continuity of care for people who are incarcerated.

Needs

- Ensure providers have received training on cultural humility, trauma responsiveness, and harm reduction.
- Expand who is providing HIV care and prevention services by continuing efforts to develop capacity of small and culturally specific organizations.
- Address people's basic needs for food, shelter, and safety to support prevention and adherence, linkage to care, and retention.
- Continue to explore new and innovative ways to provide HIV care; support providers with continued improvement in and access to telehealth services.
- Ensure PWH who are eligible to receive Ryan White services are aware of all of the services that exist.

- Support the development and expansion of telemedicine and other innovative service delivery models to ensure PWH and people at risk of infection can access the care and services they need, when they need it, wherever they are (e.g., RAPID ART, service integration, mobile medicine).
- Ensure that the entire system of care have the knowledge and capacity to make appropriate referrals to HIV care, and that the system of care has supports available to refer people to.
- Ensure correctional institutions provide consistent levels of care to and adequately support PWH.
- HIV surveillance data that can assist providers in the coordination and provision of care, and who may be best equipped to re-engage PWH in care, is not always accessible. DHS and MDH continue efforts to improve the quality and completeness of this data, as well as train providers on how to access it to inform care retention efforts.
- DHS is working toward solutions to remove prescription drug co-payments at point-of-sale for PWH who meet Ryan White eligibility requirements and use Medical Assistance or MinnesotaCare.

Preventing new HIV transmissions

Successes

- Minnesota was the third state to endorse the Undetectable = Untransmittable (U=U) campaign. DHS, MDH, and Hennepin County continue ongoing efforts to educate and raise awareness among providers, PWH, and people who are at risk of HIV infection on U=U.
- PrEP is available at no cost through health insurance plans, including Medical Assistance and MinnesotaCare.
- High-risk individuals who test negative through HIV testing and EIS programs are referred to PrEP services and syringe services programs as appropriate.
- Minnesota has not had a case of perinatal HIV transmission since 2019.
    - All newly diagnosed HIV-positive pregnant women are assigned to MDH's Care Link Services Program by the HIV Surveillance Team. The Care Link Services Program works to ensure that those who are not in medical care are immediately linked.
    - The Minnesota Perinatal and Pediatric HIV Program at Children's Hospital and Clinics provides time-sensitive interventions to HIV-positive pregnant women and their exposed infants, as well as consultation and support for their health care providers related to preventing mother-to-child HIV transmission. Hennepin Healthcare provides similar services for HIV-positive pregnant women referred within the Hennepin Healthcare system.

Challenges

- Stigma continues to be a significant challenge.
- Discussion of, and efforts around, harm reduction are often limited to syringe service programs while there are also other needs (e.g., safer smoking supplies).
- Some prevention funding is restricted and often cannot be used by grantees to purchase syringes.

Needs

- Continue efforts to reduce stigma and increase awareness through public awareness campaigns that are culturally relevant and feature real Minnesotans who are living with HIV or taking PrEP.
- Continue efforts to expand U=U awareness through trusted messengers.
- Increase the availability, access, and use of harm reduction practices that prevent HIV infections, including and beyond syringe services programs.
- Expand who is providing HIV care and prevention services by continuing efforts to develop capacity of small and culturally specific organizations.

Responding quickly to outbreaks

Successes

- Recent HIV outbreaks have helped inform the areas of greatest need for immediate action and resources when determining Ryan White funding allocations.
- State and local public health are working closely together, along with key partner providers, to monitor and respond to the current outbreaks in Minnesota.
- Provider learning series events on the HIV outbreaks in Minnesota will continue in collaboration with MDH, DHS, Hennepin County Local Public Health (LPH), and St. Louis County LPH.
- New outbreak cases are assigned to DIS immediately.
- In October 2021, the US Department of Housing and Urban Development (HUD) directed the Disaster Technical Assistance (TA) team to work with Hennepin County to assess the outbreak in that county, providing recommendations to address that outbreak.

Challenges

- The current HIV care and preventions system was not designed for, and faces challenges in, providing effective care to people who are impacted by the outbreaks and people who are most at risk.
    - Even when public health and providers are connected to people who have been or need to be diagnosed, they are not always able to convince people to get tested or linked to care.
- The HUD TA assessment found that cases related to the outbreak in Hennepin County include people who inject drugs and who also *frequent* the encampment; this population has been linked to the outbreak but are not themselves experiencing homelessness. Additionally, this is a population that existing service models have historically failed to serve effectively.
- Along with encampment-related clusters, the outbreaks are also attributed to anonymous sex among MSM and MSM/IDU.

Needs

- More capacity within the service system to address the needs of people who are unhoused and/or people who inject drugs.
    - This could include on-site medical care for people living in encampments, while remaining discreet about HIV testing and treatment.
- Additional resources to help living in encampments to access safe and stable housing.
    - Housing options are often restricted to people who are not actively using drugs.
- Expanded services for more mainstream needle exchanges and similar harm reduction strategies.

Priority populations

Based on the needs assessment and situational analysis, as well as processes used by MDH to identify priority populations for prevention grant funding, the following are priority populations for HIV care and prevention in Minnesota:

- Black, Indigenous, and people of color (BIPOC) MSM,
- young people (especially young BIPOC MSM),
- Black women,
- transgender people,
- people experiencing homelessness and/or housing instability,
- people who inject drugs/people who use drugs, and
- people in Greater Minnesota.

Section V: 2022–2026 Goals & Objectives

DIAGNOSE

Ensure all people know their HIV status to close the gap between infection and diagnosis.

- **1.1:** Increase the estimated percent of **people living with HIV who know their status** from 90 percent to 95 percent.
- **1.2:** Decrease the percent of people who are **diagnosed with AIDS at initial HIV diagnosis** from 18 percent to 13 percent.
- **1.3a:** Decrease the percent of people who are **diagnosed with AIDS within one year** of their initial HIV diagnosis from 20 percent to 15 percent.
- **1.3b:** **Address disparities** for priority populations in the percent of people **diagnosed with AIDS within one year** of their initial HIV diagnosis.
- **1.4:** Increase the **percent of tests conducted** by Ryan White-funded and CDC prevention-funded grantees **for people within priority populations**.
- **1.5:** **Train** all EIS provider organizations on **culturally responsive and trauma-informed HIV testing**.

TREAT

Ensure all people with HIV have the equitable care and comprehensive resources they need to achieve sustained viral suppression and maintain optimal health and wellness.

Linkage to care

- **2.1a:** Increase the percent of all PWH **linked to HIV care[21] within 30 days** of diagnosis from 90 percent to 95 percent.
- **2.1b:** **Address disparities** for priority populations in the percent of people **linked to HIV care within 30 days** of diagnosis.

[21] Calculated as the percentage of people aged 13 and older linked to care within 30 days after initial HIV diagnosis in Minnesota during the calendar year prior to follow-up for retention in care and viral suppression.

Retention in care

2.2a: Increase the percent of all PWH **retained in HIV care**[22] from 71 percent to 85 percent.

2.2b: **Address disparities** for priority populations in the percent of people **retained in HIV care**.

2.3: Sustain the percent of people **enrolled in Ryan White services who are retained in HIV care**[23] to at 96 percent or higher.

2.4a: Increase the percent of PWH who report they **did not have trouble paying medical bills** from 69 percent to 80 percent.

2.4b: **Address disparities** for priority populations in the percent of PWH who report they **did not have trouble paying medical bills**.

Viral suppression

2.5a: Increase the percent of all PWH who are **virally suppressed**[24] from 64 percent to 75 percent.

2.5b: **Address disparities** for priority populations in the percent of PWH who are **virally suppressed**.

2.6: Increase the percent of people **enrolled in Ryan White services who are virally suppressed**[25] from 91 percent to 95 percent.

Services

2.7: Increase the percent of diagnosed PWH **who are enrolled in Ryan White services** from 52 percent to 60 percent.

2.8a: Increase the percent of PWH who report they were **able to access needed mental health services** from 67 percent to 80 percent.

2.8b: **Address disparities** for priority populations in the percent of PWH who report they were **able to access needed mental health services**.

Quality of life

2.9a: Increase the percent of PWH who report they are **stably housed** from 84 percent to 95 percent.

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[22] Calculated as the percentage of people aged 13 and older who had ≥1 CD4 or viral load test results reported to MDH during the follow-up year among those alive and living in Minnesota during the entire calendar follow-up year.

[23] Denominator is consumers who received a Ryan White service that year. Numerator is consumers in the denominator who had at least one of the following: viral load, CD4 Count, completed Form 1, Outpatient Ambulatory Health Service Visit that year.

[24] Calculated as the percentage of people aged 13 and older who had a suppressed viral load (≤200 copies/mL) at most recent test during the follow-up year among those alive and living in Minnesota during the entire calendar follow-up year.

[25] Denominator is consumers with an HIV viral load test that year. Numerator is consumers in denominator with an HIV viral load less than 200 copies/ml at their last HIV viral load test that year. Missing viral load tests are not included.

2.9b: **Address disparities** for priority populations in the percent of PWH who report they are **stably housed**.

2.10a: Increase the percent of PWH who report they **never or rarely ran out of food** in the last year from 56 percent to 75 percent.

2.10b: **Address disparities** for priority populations in the percent of PWH who report they **never or rarely ran out of food** in the last year.

2.11: **Establish a baseline** for the percent of PWH who report that their **overall health is good or excellent** on the 2025 Needs Assessment survey.

2.12: **Establish a baseline** for the percent of PWH who report that they have **achieved their definition of wellness** on the 2025 Needs Assessment survey.

2.13: **Establish a baseline** for the percent of PWH who report that they **received support to overcome barriers to accessing HIV care** on the 2025 Needs Assessment survey.

PREVENT

Prevent new HIV transmissions by ensuring equitable access to evidence-based interventions and community-informed best practices.

3.1a: Decrease the **annual number of new HIV diagnoses** by 50 percent, from about 300 annually to 150.

3.1b: **Address disparities** for priority populations in the **annual number of new HIV diagnoses**.

3.2a: Increase the **PrEP-to-Need Ratio**[26] for all groups from 19.4 to 27.5.

3.2b: **Address disparities** for priority populations in the **PrEP-to-Need Ratio**.

3.3: Increase the percent of **HIV-negative clients** tested by grantees **who are screened for PrEP eligibility** by at least 20 percent above baseline (to be established using 2022 data).

3.4: Increase the percent of **people in priority populations who are eligible for PrEP** who are **referred and linked to a site for PrEP care** by at least 20 percent above baseline (to be established using 2022 data).

3.5: Increase the percent of **HIV-negative clients** who are eligible for PreP who are **prescribed PrEP** at MDH-funded programs by at least 5 percent above baseline (to be established using 2022 data).

[26] Calculated as the ratio of the number of PrEP users in the measured year to the number of people newly diagnosed with HIV the previous year.

3.6: Address **disparities in PrEP access and use** among priority populations with the highest rates of new HIV diagnoses and low PrEP use.

3.7: Require MDH-funded grantees to track and **establish a baseline for the percent of people prescribed PrEP who refill their prescription**.

3.8: Decrease the percent of PWH who report that **someone else has used a needle after them** within the last year from 22 percent to 10 percent.

3.9: Develop a **rapid referral and eligibility process** for people with HIV diagnoses connected to an outbreak, for justice-involved PWH, and for newly diagnosed and out-of-care PWH.

***Objectives 2.5a, 2.5b, and 2.6**, increasing rates of viral suppression and addressing disparities for priority populations, also impact prevention.*

RESPOND

Detect and respond effectively to growing HIV transmission clusters using molecular and surveillance data plus on-the-ground insights and quickly respond to other emerging health issues that impact people with HIV and people at risk for HIV infection.

4.1: Prevent further transmission of HIV associated with the current **outbreak in Ramsey and Hennepin** Counties.

4.2: Prevent further transmission of HIV associated with the current **outbreak in the Duluth** region.

4.3: Identify growing HIV transmission clusters and respond to **interrupt potential future outbreaks**.

4.4: Respond effectively to **connect HIV cases in transmission clusters to care** through data-to-care interventions.

STRATEGIES

The following strategies are directly aligned to several existing jurisdictional plans for HIV care and prevention, which are included in the appendix: END HIV MN (Appendix A), Positively Hennepin (Appendix B), and the Minnesota HIV Cluster and Outbreak Detection and Response (CODR) Plan (Appendix C). Much more detail on the specific activities and tactics of these plans, including jurisdictional roles and responsibilities, can be found in the appendices.

#	Strategy	Alignment to other plans	Diagnose	Treat	Prevent	Respond
1	Focus efforts on HIV education and awareness for all Minnesotans, especially health professionals, students, and priority populations.	END HIV MN Strategy 1.1 & Positively Hennepin Tactics A.1.C, A.3.C., B.1.A, C.2.A, C.2.B, and C.2.C	●		●	
2	Increase routine opt-out HIV testing and early intervention services.	END HIV MN Strategy 1.2 & Positively Hennepin Tactic A.1.C	●		●	
3	Ensure people at risk of HIV have access to supports and services that overcome barriers to testing, such as mental and chemical health services, access to support services, service navigation, and culturally appropriate HIV health and service information.	Positively Hennepin Tactics A.3.A and A.3.B			●	●
4	Immediately link newly diagnosed individuals to person-centered HIV care and treatment.	END HIV MN Strategy 1.3 & Positively Hennepin Tactics B.1.B, B.1.C, and B.2.A		●		●
5	Ensure availability, access, and use of evidence-based interventions that prevent HIV infections, such as PrEP, PEP, SSPs, and partner services.	END HIV MN Strategy 1.4 & Positively Hennepin Tactics A.2.A and C.3.B			●	
6	Protect and enhance advancements in health care policies, coverage for people with pre-existing conditions, and access to preventive treatments without cost sharing.	END HIV MN Strategy 2.1			●	
7	Engage community leaders, non-profit agencies, PWH, and other community members to identify and address barriers to testing and person-centered care.	END HIV MN Strategy 2.2 & Positively Hennepin Tactics C.1.A and C.2.A	●	●		
8	Focus adequate resources to address the population-specific needs of American Indians and populations of color most impacted by HIV to eliminate health inequities.	END HIV MN Strategy 2.3 & Positively Hennepin Goal C tactics	●	●	●	●

#	Strategy	Alignment to other plans	Diagnose	Treat	Prevent	Respond
9	Reduce HIV-related stigma, systemic racism, and other forms of structural discrimination that prevent people from accessing HIV care and prevention services.	END HIV MN Strategy 2.4 & Positively Hennepin Tactic A.2.B	●	●	●	●
10	Employ high-impact public health approaches to identify and re-engage individuals who are out of HIV care and treatment.	END HIV MN Strategy 3.1 & Positively Hennepin Tactic B.3.A		●		●
11	Ensure person-centered strategies that support long-term retention in care.	END HIV MN Strategy 3.2 and Positively Hennepin Tactic C.3.C		●		
12	Provide culturally and linguistically appropriate services, as well as gender and sexual orientation appropriate services in clinical and/or community support settings.	END HIV MN Strategy 3.3 & Positively Hennepin Tactics B.3.B	●	●	●	●
13	Identify and reduce barriers to mental and chemical health services and care.	END HIV MN Strategy 3.4 and Positively Hennepin Tactic A.3.A		●		
14	Ensure access to services that meet the basic needs of PWH.	END HIV MN Strategy 3.5 & Positively Hennepin Tactics B.2.A and C.3.C		●		●
15	Identify gaps in affordable housing statewide.	END HIV MN Strategy 4.1		●	●	●
16	Build partnerships that increase the supply of safe, affordable housing units for PWH and those at high risk of infection.	END HIV MN Strategy 4.2 & Positively Hennepin Tactic B.2.C		●	●	●
17	Ensure that PWH and those at high risk of HIV infection have access to necessary supports that maintain their housing stability.	END HIV MN Strategy 4.3 & Positively Hennepin Tactic B.2.C		●	●	●

#	Strategy	Alignment to other plans	Diagnose	Treat	Prevent	Respond
18	Secure long-term, sustainable resources to meet the growing need for affordable housing and supportive services.	END HIV MN Strategy 4.4		●	●	●
19	Integrate HIV prevention, care, and treatment throughout all sectors of government, health care systems, and social services.	END HIV MN Strategy 5.2 & Positively Hennepin Tactic B.3.A	●	●	●	●
20	Identify, research, and replicate new, effective interventions through partnerships between local public health and state governments, tribal nations, HIV providers, community-based and religious organizations, the University of Minnesota and other academic institutions, research partners, and others.	END HIV MN Strategy 5.3 & Positively Hennepin Tactic C.1.A and C.1.B	●	●	●	●
21	Establish policies that encourage an innovative culture and delivery of comprehensive statewide services.	END HIV MN Strategy 5.4		●		●
22	Create effective information-sharing partnerships and systems that produce reliable data and that inform decision-making, strategy development, and program accountability.	END HIV MN Strategy 5.5 & Positively Hennepin Tactic B.3.A	●	●	●	●
23	Continue to implement, track, and update the Minnesota HIV Cluster and Outbreak Detection and Response Plan (CODR).	Minnesota CODR				●
24	Support MCHACP members to address social and cultural needs of priority populations and all PWH, as they related to HIV prevention and care services.	END HIV MN Strategy 2.3 & Positively Hennepin Tactics C.1.B and C.2.A	●	●	●	●
25	Improve recruitment and retention efforts of African American, African-born, and Latinx participants on MCHACP.	END HIV MN Strategy 2.3 & Positively Hennepin Tactic C.1.B	●	●	●	●

Section VI:
2022–2026 Integrated Planning Implementation, Monitoring & Jurisdictional Follow Up

2022–2026 Integrated Planning implementation approach

Implementation

Implementation of the strategies, tactics, and activities will involve stakeholders across DHS, MDH, Hennepin County, MCHACP, providers, and grantees. Detailed work and action plans will be updated to reflect assignment of tasks needed to implement the elements of the strategic plan. The 2022–2024 Priority Tactic Action Plan within END HIV MN (Appendix A) is an example of the detail needed for implementation of the plan's strategies.

There are several mechanisms through which the jurisdictions, partners, providers, and community members will stay connected and coordinated around implementation of the Integrated Plan's strategies. These include:

- Regular updates from DHS, MDH, and Hennepin County at MCHACP Council and committee meetings.
- Monthly meetings of DHS and MDH staff on the coordination of implementing END HIV MN.
- Quarterly meetings of the Government HIV Administration Team (GHAT).
- Annual meetings of the GHAT with the Part F AETC recipient.
- Regular trainings and town halls for providers.
- Regular meetings for HIV prevention and care grantees.
- Quarterly meetings of the END HIV MN Advisory Board.
- Coordination with the Minnesota HIV Housing Coalition.
- Engagement processes for updating END HIV MN and Positively Hennepin.

In addition to annual data reports on progress toward meeting the goals and objectives, the jurisdictions involved will collaborate to present a report bi-annually (twice a year) to the Council on the progress of strategy, tactic, and activity implementation. This type of reporting will help draw connections between the plan's implementation and the monitoring data, informing decisions about changing or revising the plan.

Routinely reviewing the progress on implementation and achievement of the goals and objectives will ensure the plan remains central to the work of MDH, DHS, Hennepin County, and the Council. As the decision-making body for Part A funds and the advisory body for Part B funds, MCHACP members will keep at the forefront the goals and objectives laid out in the Integrated Plan and this principle is included in the Council's Resource

Allocation Process from Ryan White HIV/AIDS Program Funds. Funding decisions will be made based on what is necessary to achieve successful implementation of the plan.

Monitoring and evaluation

The monitoring tables included on the following pages will be used to monitor progress on the Integrated Plan's goals and objectives. This data will be collected and reported annually. Most of the data comes from MDH surveillance reporting, which is released in June–August for the previous year's data. Each jurisdiction that owns or monitors the required data sources will collaborate to complete this annual report.

The indicators in the monitoring tables will be presented annually in October to a joint meeting of MCHACP's Planning & Allocations Committee, Needs Assessment & Evaluation Committee, and Disparities Elimination Committee. All Council members, as well as community members, will be invited to attend the presentations.

Improvement

Decisions about revising or improving the plan will generally be made annually, at the point when monitoring data and implementation progress is reported to the Council in October. Additionally, changes or improvements will be considered at any point, if monitoring data sources change or are no longer available, or if emerging situations result in a call to action outside of the annual process.

Based on implementation progress and monitoring information, Council members and jurisdictions will be empowered to suggest changes to the Integrated Plan. Any changes will need to have consensus among the jurisdiction representatives and a majority of the Council before being adopted.

Reporting and dissemination

In addition to reporting progress at Council and committee meetings, progress on the Integrated Plan will be shared on the Council's website (https://www.mnhivcouncil.org) and jurisdictions' public websites. Reporting will also be disseminated by jurisdictions through GovDelivery email updates to HIV prevention and care-related listservs and social media, as appropriate. Lastly, jurisdictions will coordinate on messaging about the plan's goals and strategies at relevant community celebrations and events, such as World AIDS Day.

Monitoring tables

Indicators in the following tables will be monitored throughout plan implementation to determine progress toward achievement of the plan's objectives and to identify areas of focus.

Goal 1: Ensure all people know their HIV status to close the gap between infection and diagnosis

Obj.	Indicator	Group	Baseline year	Baseline	Data source
1.1	Estimated percent of people living with HIV who know their status	All	2021	90%	Surveillance
1.2	Percent of people diagnosed with AIDS at initial HIV diagnosis	All	2021	18%	Surveillance
1.3a	Percent of people diagnosed with AIDS within one year of their initial HIV diagnosis	All	2021	20%	Surveillance
1.3b	Percent of people diagnosed with AIDS within one year of their initial HIV diagnosis	Black, African-born	2020	38%	Surveillance
1.3b	Percent of people diagnosed with AIDS within one year of their initial HIV diagnosis	Black, not African-born	2020	23%	Surveillance
1.3b	Percent of people diagnosed with AIDS within one year of their initial HIV diagnosis	Foreign-born	2020	30%	Surveillance
1.4	Percent of tests conducted by Ryan White-funded and CDC prevention-funded grantees for people within priority populations	Priority populations	2023	TBD	Grantee reporting
1.5	Percent of EIS provider organizations trained on culturally responsive and trauma-informed HIV testing	EIS providers	2023	TBD	Grantee reporting

Goal 2: Ensure all people with HIV have the equitable care and comprehensive resources they need to achieve sustained viral suppression and maintain optimal health and wellness

Obj.	Indicator	Group	Baseline year	Baseline	Data source
2.1a	Percent of PWH linked to HIV care within 30 days of diagnosis	All	2021	90%	Surveillance
2.1b	Percent of PWH linked to HIV care within 30 days of diagnosis	American Indian	2021	67%	Surveillance
2.1b	Percent of PWH linked to HIV care within 30 days of diagnosis	Black, African-born	2021	88%	Surveillance
2.1b	Percent of PWH linked to HIV care within 30 days of diagnosis	Black, not African-born	2021	88%	Surveillance
2.1b	Percent of PWH linked to HIV care within 30 days of diagnosis	BIPOC MSM[27]	2020	88%	Surveillance
2.1b	Percent of PWH linked to HIV care within 30 days of diagnosis	PWID	2021	58%	Surveillance
2.1b	Percent of PWH linked to HIV care within 30 days of diagnosis	MSM 13 to 24	2021	79%	Surveillance

[27] Identified as MSM who are American Indian/Alaska Native, Asian/Pacific Islander, Black/African American, Black/African-born, Hispanic of any race, multiple races, or other race/ethnicity.

Obj.	Indicator	Group	Baseline year	Baseline	Data source
2.1b	Percent of PWH linked to HIV care within 30 days of diagnosis	Transgender	2019	80%	Surveillance
2.1b	Percent of PWH linked to HIV care within 30 days of diagnosis	Greater Minnesota	2021	85%	Surveillance
2.2a	Percent of PWH retained in HIV care	All	2021	71%	Surveillance
2.2b	Percent of PWH retained in HIV care	American Indian	2021	66%	Surveillance
2.2b	Percent of PWH retained in HIV care	Black, African-born	2021	66%	Surveillance
2.2b	Percent of PWH retained in HIV care	Black, not African-born	2021	68%	Surveillance
2.2b	Percent of PWH retained in HIV care	Hispanic	2021	64%	Surveillance
2.2b	Percent of PWH retained in HIV care	BIPOC MSM	2021	68%	Surveillance
2.2b	Percent of PWH retained in HIV care	PWID	2021	62%	Surveillance
2.3	Percent of people enrolled in Ryan White services retained in care	All Ryan White enrollees	2021	96%	CAREWare
2.4a	Percent of PWH who report not having trouble paying medical bills	All	2020	69%	Needs Assessment (NA)
2.4b	Percent of PWH who report not having trouble paying medical bills	American Indian	2020	60%	NA
2.4b	Percent of PWH who report not having trouble paying medical bills	Black/African-born	2020	65%	NA
2.4b	Percent of PWH who report not having trouble paying medical bills	Hispanic	2020	60%	NA
2.4b	Percent of PWH who report not having trouble paying medical bills	Multiple races	2020	65%	NA
2.5a	Percent of PWH who are virally suppressed	All	2021	64%	Surveillance
2.5b	Percent of PWH who are virally suppressed	American Indian	2021	48%	Surveillance
2.5b	Percent of PWH who are virally suppressed	Black, African-born	2021	61%	Surveillance
2.5b	Percent of PWH who are virally suppressed	Black, not African-born	2021	58%	Surveillance
2.5b	Percent of PWH who are virally suppressed	Hispanic	2021	60%	Surveillance
2.5b	Percent of PWH who are virally suppressed	BIPOC MSM	2021	61%	Surveillance
2.5b	Percent of PWH who are virally suppressed	PWID	2021	53%	Surveillance
2.5b	Percent of PWH who are virally suppressed	MSM 25 to 34	2021	62%	Surveillance
2.5b	Percent of PWH who are virally suppressed	Greater Minnesota	2021	57%	Surveillance
2.6	Percent of people enrolled in Ryan White services who are virally suppressed	All Ryan White enrollees	2020	91%	CAREWare
2.7	Percent of people diagnosed with HIV who are enrolled in Ryan White services	All	2021	52%	CAREWare
2.8a	Percent of PWH who report they were able to access needed mental health serv.	All	2020	67%	NA
2.8b	Percent of PWH who report they were able to access needed mental health serv.	Black/African American	2020	60%	NA
2.8b	Percent of PWH who report they were able to access needed mental health serv..	Black/African-born	2020	50%	NA
2.8b	Percent of PWH who report they were able to access needed mental health serv.	Hispanic	2020	63%	NA

Obj.	Indicator	Group	Baseline year	Baseline	Data source
2.8b	Percent of PWH who report they were able to access needed mental health serv.	Transgender	2020	65%	NA
2.8b	Percent of PWH who report they were able to access needed mental health serv.	30 to 39	2020	52%	NA
2.9a	Percent of PWH who report they are stably housed	All	2020	84%	NA
2.9b	Percent of PWH who report they are stably housed	American Indian	2020	79%	NA
2.9b	Percent of PWH who report they are stably housed	Hispanic	2020	77%	NA
2.9b	Percent of PWH who report they are stably housed	Transgender	2020	69%	NA
2.9b	Percent of PWH who report they are stably housed	18 to 29	2020	71%	NA
2.10a	Percent of PWH who report they never or rarely ran out of food in the last year	All	2020	56%	NA
2.10b	Percent of PWH who report they never or rarely ran out of food in the last year	American Indian	2020	36%	NA
2.10b	Percent of PWH who report they never or rarely ran out of food in the last year	Black/African American	2020	46%	NA
2.10b	Percent of PWH who report they never or rarely ran out of food in the last year	Hispanic	2020	43%	NA
2.10b	Percent of PWH who report they never or rarely ran out of food in the last year	Multiple races	2020	35%	NA
2.10b	Percent of PWH who report they never or rarely ran out of food in the last year	Transgender	2020	41%	NA
2.10b	Percent of PWH who report they never or rarely ran out of food in the last year	18 to 29	2020	44%	NA
2.11	Percent of PWH who report their overall health is good or excellent	All	2025	TBD	NA
2.12	Percent of PWH who report they have achieved their definition of wellness	All	2025	TBD	NA
2.13	Percent of PWH who report they received support to overcome barriers to accessing HIV care	All	2025	TBD	NA

Goal 3: Prevent new HIV transmissions by ensuring equitable access to evidence-based interventions and community-informed best practices

Obj.	Indicator	Group	Baseline year	Baseline	Data source
3.1a	Number of annual new HIV diagnoses	All	2021	298	Surveillance
3.1b	Rate per 100,000 population of annual new HIV diagnoses	American Indian	2021	18.0	Surveillance
3.1b	Rate per 100,000 population of annual new HIV diagnoses	Black, African-born	2021	36.5	Surveillance
3.1b	Rate per 100,000 population of annual new HIV diagnoses	Black, not African-born	2021	53.8	Surveillance
3.1b	Rate per 100,000 population of annual new HIV diagnoses	Hispanic	2021	17.2	Surveillance
3.1b	Rate per 100,000 population of annual new HIV diagnoses	MSM	2021	137.9	Surveillance
3.2a	PrEP-to-Need Ratio	All	2021	19.41	aidsvu.org
3.2b	PrEP-to-Need Ratio	Black	2021	3.80	aidsvu.org
3.2b	PrEP-to-Need Ratio	Hispanic	2021	6.97	aidsvu.org

Obj.	Indicator	Group	Baseline year	Baseline	Data source
3.3	Among people tested by EIS and prevention-funded grantee organizations, percent of HIV-negative clients who are screened for PrEP eligibility.	All	2022	TBD	Evaluation Web
3.4	Among people tested by EIS and prevention-funded grantee organizations, percent of people in priority populations who are eligible for PrEP who are referred and linked to a site for PrEP care.	Priority populations	2022	TBD	Evaluation Web
3.5	Among people tested by MDH-funded PrEP programs, percent of HIV-negative clients who are eligible for PrEP who are prescribed PrEP.	All	2022	TBD	PrEP Grantees Progress Report Review
3.6	Among people tested by MDH-funded PrEP programs, percent of HIV-negative clients from priority populations who are eligible for PrEP who are prescribed PrEP.	American Indian	2022	TBD	PrEP Grantees Progress Report Review
3.6	Among people tested by MDH-funded PrEP programs, percent of HIV-negative clients from priority populations who are eligible for PrEP who are prescribed PrEP.	Black, African-born	2022	TBD	PrEP Grantees Progress Report Review
3.6	Among people tested by MDH-funded PrEP programs, percent of HIV-negative clients from priority populations who are eligible for PrEP who are prescribed PrEP.	Black, not African-born	2022	TBD	PrEP Grantees Progress Report Review
3.6	Among people tested by MDH-funded PrEP programs, percent of HIV-negative clients from priority populations who are eligible for PrEP who are prescribed PrEP.	Hispanic	2022	TBD	PrEP Grantees Progress Report Review
3.6	Among people tested by MDH-funded PrEP programs, percent of HIV-negative clients from priority populations who are eligible for PrEP who are prescribed PrEP.	BIPIOC MSM	2022	TBD	PrEP Grantees Progress Report Review
3.7	Among people tested by MDH-funded PrEP programs, percent of people prescribed PrEP who refill their prescription.	All	2023	TBD	De-identified data submitted to MDH quarterly
3.8	Percent of PWH who report that someone else has used a needle after them within the last year.	All	2020	22%	Needs Assessment (NA)
3.9	Percentage of PWH identified through Ryan White-funded EIS as newly diagnosed or out-of-care clients who achieve viral suppression within 60 days of reconnection to HIV care.	All	2023	TBD	CAREWare

Goal 4: Detect and respond effectively to growing HIV transmission clusters using molecular and surveillance data plus on-the-ground insights and quickly respond to other emerging health issues that impact people with HIV and people at risk for HIV infection

Obj.	Indicator	Group	Baseline date	Baseline	Data source
4.1	Number of HIV diagnoses associated with outbreak in Hennepin and Ramsey counties.	All	Oct. 4, 2022	149	Surveillance
4.2	Number of HIV diagnoses associated with outbreak in the Duluth region.	All	Oct. 4, 2022	26	Surveillance
4.3	Number of clusters identified that are closed out due to successful interruption.	All	2022	TBD	MDH cluster spreadsheet
4.4.1	Number of HIV cases not in care that are referred to care by DIS.	All	2022	TBD	MDH cluster spreadsheet
4.4.2	Percent of people who are retained in care, of HIV cases that are referred to care by DIS.	All	2022	TBD	MDH cluster spreadsheet
4.4.3	Percent of people who achieve viral suppression, of HIV cases that are referred to care by DIS.	All	2022	TBD	MDH cluster spreadsheet

Section VII:
Letter of Concurrence

On the next page is the required letter of concurrence from the Minnesota Council for HIV/AIDS Care and Prevention (MCHACP), which is the combined planning body for CDC prevention funding, Ryan White Parts A and B, and the Integrated Plan.

Minnesota Council for HIV/AIDS Care and Prevention

Dear Kelli Abbott, Karen Gooden, and Jan Scott:

The Minnesota Council for HIV/AIDS Care and Prevention (planning council) concurs with the following submission by the Minnesota Department of Health, Hennepin County Public Health, and Minnesota Department of Human Services, in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need (SCSN) for calendar year (CY) 2022-2026. The planning council has reviewed the Integrated HIV Prevention and Care Plan submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas with high rates of HIV. The planning council concurs that the Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the CDC's Notice of Funding Opportunity for Integrated HIV Surveillance and Prevention Programs for Health Departments and the Ryan White HIV/AIDS Program legislation and program guidance.

This plan was a collaborative effort with the planning council. The three council co-chairs served as members of the integrated plan steering committee and participated in developing the plan. The planning council received monthly updates on the planning progress and were presented draft sections for input and feedback, and selected priorities for the Needs Assessment section of the plan. Additional meetings were held for input on the priorities, goals, and objectives of the plan with the planning council's Needs Assessment and Evaluation Committee, Disparities Elimination Committee, Planning and Allocations Committee, and Community Voices Committee. Input gained by planning council members was integral to the process and all input received was incorporated into this plan.

The Minnesota Council for HIV/AIDS Care and Prevention is an integrated HIV care and prevention planning body and serves as the single community planning body for the Minnesota Department of Health (CDC Prevention Program), Hennepin County Public Health (RWHAP Part A), and Minnesota Department of Human Services (RWHAP Part B).

The signatures below confirms the concurrence of the planning council with the Integrated HIV Prevention and Care Plan.

Signatures: Date: December 5, 2022

Lesa Nelson
Council Co-Chair

Tyrie Stanley
Council Co-Chair

McKinzie Woelfel
Council Co-Chair

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Checklist

CY 2022–2026 CDC DHP and HRSA HAB Integrated Prevention and Care Plan Guidance Checklist

Requirement:	New Material and/or Existing Material Used to Meet Requirement:	Document Title/File Name of Existing Material Attached to Meet Requirement	Page Number(s) Where Requirement is Addressed in Existing Material	Notes (If Applicable)
Section I: Executive Summary of Integrated Plan and SCSN				
1. Executive Summary of Integrated Plan and SCSN	New Material	N/A	N/A	N/A
a. Approach	New Material	N/A	N/A	N/A
b. Documents Submitted to Meet Requirements	New and Existing Material	Appendix A; Appendix B; Appendix C	Appendices pages are separately numbered	N/A
Section II: Community Engagement and Planning Process				
1. Jurisdiction Planning Process	New Material	N/A	N/A	N/A
a. Entities Involved in Process	New Material	N/A	N/A	N/A
b. Role of the RWHAP Part A Planning Council/Planning Body (not required for state only plans)	New Material	N/A	N/A	N/A
c. Role of Planning Bodies and Other Entities	New Material	N/A	N/A	N/A
d. Collaboration with RWHAP Parts – SCSN Requirement	New Material	N/A	N/A	N/A
e. Engagement of People with HIV – SCSN Requirement	New and Existing Material	Appendix A; Appendix B	Appendix A: pages 9–12; Appendix B: pages 3–4.	N/A
f. Priorities	New Material	N/A	N/A	N/A

Requirement:	New Material and/or Existing Material Used to Meet Requirement:	Document Title/File Name of Existing Material Attached to Meet Requirement	Page Number(s) Where Requirement is Addressed in Existing Material	Notes (If Applicable)
g. Updates to Other Strategic Plans Used to Meet Requirements	Existing Material	Appendix A; Appendix B	Appendix A: pages 12–30; Appendix B: pages 6–10.	N/A
Section III: Contributing Data Sets and Assessments				
1. Data Sharing and Use	New Material	N/A	N/A	N/A
2. Epidemiologic Snapshot	New Material	N/A	N/A	N/A
3. HIV Prevention Care and Treatment Resource Inventory	New Material	N/A	N/A	N/A
a. Strengths and Gaps	New Material	N/A	N/A	N/A
b. Approaches and Partnerships	New Material	N/A	N/A	N/A
4. Needs Assessment	New Material	N/A	N/A	N/A
a. Priorities	New Material	N/A	N/A	N/A
b. Actions Taken	New Material	N/A	N/A	N/A
c. Approach	New Material	N/A	N/A	N/A
Section IV: Situational Analysis				
1. Situational Analysis	New Material	N/A	N/A	N/A
a. Priority Populations	New Material	N/A	N/A	N/A
Section V: 2022–2026 Goals and Objectives				
Goals and Objectives Description	New Material	N/A	N/A	N/A

Requirement:	New Material and/or Existing Material Used to Meet Requirement:	Document Title/File Name of Existing Material Attached to Meet Requirement	Page Number(s) Where Requirement is Addressed in Existing Material	Notes (If Applicable)
a. Updates to Other Strategic Plans used to Meet Requirements	Existing Material	Appendix A; Appendix B; Appendix C	Appendix A: pages 21–30; Appendix B: pages 6–10; Appendix C: pages 26–37.	N/A
Section VI: 2022–2026 Integrated Planning Implementation, Monitoring, and Jurisdictional Follow-Up				
1. 2022–2026 Integrated Planning Implementation Approach	New Material	N/A	N/A	N/A
a. Implementation	New Material	N/A	N/A	N/A
b. Monitoring	New Material	N/A	N/A	N/A
c. Evaluation	New Material	N/A	N/A	N/A
d. Improvement	New Material	N/A	N/A	N/A
e. Reporting and Dissemination	New Material	N/A	N/A	N/A
f. Updates to Other Strategic Plans Used to Meet Requirements	Existing Material	Appendix A; Appendix B; Appendix C	Appendix A: pages 21–30; Appendix B: pages 6–10; Appendix C: pages 33–37.	N/A
Section VII: Letters of Concurrence				
1. CDC Prevention Program Planning Body Chair(s) or Representative(s)	New Material	N/A	N/A	N/A
2. RWHAP Part A Planning Council/Planning Body(s) Chair(s) or Representative(s)	New Material	N/A	N/A	N/A
3. RWHAP Part B Planning Body Chair or Representative	New Material	N/A	N/A	N/A

Requirement:	New Material and/or Existing Material Used to Meet Requirement:	Document Title/File Name of Existing Material Attached to Meet Requirement	Page Number(s) Where Requirement is Addressed in Existing Material	Notes (If Applicable)
4. Integrated Planning Body	New Material	N/A	N/A	N/A
5. EHE Planning Body	Not applicable	N/A	N/A	Does not apply; no EHE funding

Appendices

Appendices follow:

- Appendix A: Addendum to END HIV MN
- Appendix B: Positively Hennepin
- Appendix C: Minnesota CODR

Appendix A:
Addendum to END HIV MN

Addendum to the Minnesota HIV Strategy: A Comprehensive Plan to End HIV/AIDS *END HIV MN*

September 2022

Addendum to the Minnesota HIV Strategy: A Comprehensive Plan to End HIV/AIDS (*END HIV MN)*
http://www.health.state.mn.us/divs/idepc/diseases/hiv/strategy/index.html

Minnesota Department of Health
STD/HIV & TB
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-5414
https://www.health.state.mn.us/diseases/hiv/index.html

Minnesota Department of Human Services
HIV Supports
P.O. Box 65967
St. Paul, MN 55164-0967
651-431-4300
https://mn.gov/dhs/people-we-serve/adults/health-care/hiv-aids/

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Acronyms

Please refer to Appendix B: Glossary for definitions of terms used in this report.

AIDS: Acquired Immunodeficiency Syndrome

ART: Antiretroviral therapy

CDC: Centers for Disease Control and Prevention

CBO: Community-based Organization

DHS: Minnesota Department of Human Services

HIV: Human Immunodeficiency Virus

IDU: Injection Drug Users

MDE: Minnesota Department of Education

MDH: Minnesota Department of Health

MSM: Male-to-Male Sexual Contact

MSM/IDU: Men Who Have Male-to-Male Sex and Inject Drugs

NHAS: National HIV/AIDS Strategy

PEP: Post-exposure Prophylaxis

PrEP: Pre-exposure Prophylaxis

PLWH: People Living With HIV

PWID: People Who Inject Drugs

STD: Sexually Transmitted Disease

U=U: Undetectable = Untransmittable

UNAIDS: Joint United Nations Programme on HIV/AIDS

Rationale

This is an Addendum to END HIV MN, the comprehensive long-term plan to end new HIV infections and improve health outcomes for people living with HIV in Minnesota. Minnesota HIV Strategy: A Comprehensive Plan to End HIV/AIDS (END HIV MN or the strategy) was launched in January 2019.

Administrative Responsibility 5 of END HIV MN requires the state to develop and implement a process for ongoing review and reprioritization of tactics. The responsibility details that it should be an "ongoing two-year process" that includes returning to the regions and communities that helped prioritize the original tactics to gather input on what's worked, what hasn't, and what's missing.

Overall, reprioritizing the tactics on a regular basis ensures that the state's efforts to end HIV are:

- guided by the lived experiences of people living with HIV and the expertise of frontline providers;
- responsive to changes over time, such as the COVID-19 pandemic or recent HIV outbreaks; and
- focusing resources on areas where the state can have the greatest impact.

Engaging community members and people affected by END HIV MN is also an opportunity for them to:

- see the state taking accountability and being transparent;
- feel ownership and a sense of partnership with the state; and
- have a positive experience partnering with the state wherein they feel heard.

Update on progress of the initial priority tactics

The initial focus of END HIV MN was on the following ten priority tactics:

- **PROVIDER EDUCATION and TRAINING:** Implement provider education and training. The training should benefit all types of providers (e.g., primary care, specialists, nurses, interpreters). The training should focus on evidence-based, behavioral, and biomedical interventions for HIV prevention and care, as well as cultural competence.
- **AWARENESS CAMPAIGNS:** Implement messaging campaigns, advertising, and public service announcements (PSAs) to increase awareness of HIV and increase knowledge about evidence-based, behavioral, and biomedical interventions for HIV prevention and care. Tailor content and delivery of messaging to meet the needs of specific communities and regions.
- **COMMUNITY OUTREACH:** Increase education and outreach to culturally specific communities.
- **PREVENTION EDUCATION:** Implement comprehensive HIV prevention and sex education in and beyond public schools.
- **CAPACITY BUILDING:** Increase the organizational capacity of small, new, or yet-to-be-formalized culturally specific, community-based organizations necessary to successfully apply for, secure, and implement state and federal HIV funding.

- **INCLUSION:** Increase meaningful inclusion of voices of disproportionally affected populations in decision-making about HIV programs and funding.
- **WRAPAROUND SUPPORTS:** Enhance wraparound supports for people at risk of dropping out of care.
- **HOUSING SUPPORT:** Support implementation of Minnesota HIV Housing Coalition's HIV Housing Plan.
- **INVENTORY EFFORTS:** Develop a comprehensive inventory of all ongoing efforts being made to address HIV across Minnesota in order to: (a) identify opportunities to collaborate and leverage services; and (b) identify gaps in services.
- **TELEMEDICINE:** Develop a regional telemedicine model to ensure the adequate provision of care and prevention services.

Impacts of COVID-19 pandemic

Many staff from the Minnesota Department of Human Services (DHS) and Minnesota Department of Health (MDH) whose work was integral to implementing the initial activities of END HIV MN were reassigned to coronavirus response efforts in 2020 and 2021.

The pandemic response shifted the work for state staff who work on HIV prevention and care. This required MDH and DHS to make changes to business as usual, including:

- Making critical changes to the Program HH/AIDS Drug Assistance Program to ensure that eligible clients continued to receive HIV medications.
- Providing funding so that clients could receive additional food vouchers and personal protective equipment for themselves and their family members.
- Providing guidance and flexibility to partner organizations who had to adapt their service delivery models.
- Working with the AIDSLine to maintain an HIV/AIDS Community Services Directory throughout the pandemic, so that people had a centralized place to find up-to-date information.

Completed priority tactics

Between 2019 and 2021, the activities of END HIV MN under the following two priority tactics were completed.

Housing support

DHS provided requested funding and other support for implementation of the Minnesota HIV Housing Coalitions HIV Housing Plan 2017. The state's ongoing commitment to the HIV Housing Plan continues.

Inventory efforts

DHS and MDH worked with Management Analysis and Development (MAD), a consulting firm housed in Minnesota Management and Budget (MMB), to develop an internal, electronic database of providers, programs, and organizations across Minnesota whose work is directly or indirectly aligned to the goals of END HIV MN.

Priority tactics that are now core work

The work of the following initial priority tactics will continue moving forward as part of MDH and DHS's existing portfolio of HIV care and prevention work. Below are some brief highlights of what has been accomplished so far in these areas.

Provider education and training

In 2021, the state hosted two virtual town hall events on the HIV outbreaks in Minnesota and two virtual provider professional development days targeting HIV care and prevention providers. In 2022, virtual provider learning series on the HIV outbreaks in Minnesota (formerly called virtual town hall events) have continued, and further provider education efforts are being planned now that the MDH HIV Nurse Specialist is back from full-time COVID-19 reassignment.

Awareness campaigns and community outreach

DHS and MDH sponsored the development of an HIV awareness toolkit, featuring people in Minnesota who are living with HIV or who are on PrEP. MDH and DHS also partnered on using some of the initial images and messaging in advertisements about U=U and PreP. In 2022, the HIV Prevention, Care, and Anti-Stigma Social Media Toolkit was released. Dependent on resource availability, DHS will be funding grants for culturally and community-specific organizations to use the Toolkit or to develop their own messaging campaigns. DHS is also exploring options to support an Ambassador Program to train, support, and provide the technology that individual advocates need to fight stigma and share information about HIV care and prevention.

Capacity building

A series of key informant interviews were done with previous, existing, and potential HIV care and/or prevention grantees. The findings from these interviews resulted in changes to the RFP process for the most recent DHS Ryan White grant opportunity, to make the process more equitable. MDH will be incorporating the feedback and making changes to their future RFPs, as well.

DHS and MDH are exploring the feasibility to offer non-competitive HIV grants to tribal nations, as participants in the interviews said that competitive RFPs do not honor the sovereign-to-sovereign relationship with tribal nations.

Grant funding will be available in the future from MDH for small or yet-to-be-formalized community-based organizations to develop capacity to take on more HIV grant funding in the future. This new grant opportunity is in response to input from smaller, culturally specific organizations for whom the traditional RFP process has not been equitable in the past, often because they may lack the infrastructure to apply for and manage grants.

Inclusion

DHS, MDH, and Hennepin County conducted a Partner Engagement Survey, which gathered input from staff at community-based organizations on how the agencies could more effectively engage partners. The survey also asked for input on how the agencies can better engage people with lived experience.

When new federal funding became available in response to the pandemic, DHS worked with partner organizations to survey people living with HIV and used that input to directly inform funding decisions.

MDH and DHS have processes and policies in place to support their commitment to paying people with lived experience for sharing their time and expertise.

In 2022, MDH and DHS will work with the current END HIV MN Advisory Board on plans to add more people with lived experience to the advisory group.

Wraparound supports

DHS has been piloting outreach case management, which helps people overcome eligibility barriers for HIV case management. The agency plans to expand outreach case management in the future. Additional funding is also being used for emergency financial assistance, food vouchers, housing support, and case management.

Priority tactics that could not be completed

There were two initial tactics of END HIV MN where the planned activities were not able to be completed.

Prevention education

As written, the activities of this tactic required a partnership with the Minnesota Department of Education (MDE). MDH and DHS were unable to partner with MDE, both because of capacity issues on MDE's end, especially once the pandemic had such a substantial impact on public education. This work was also not possible because generating support and funding from the legislature was not feasible. While the need for comprehensive sex education in public schools persists, this effort is likely to require advocacy at the state legislature, first.

Telemedicine

Once health care began shifting rapidly in response to the pandemic, it became clear that the activities, as written, in END HIV MN to develop a regional telemedicine model needed to be paused.

Reprioritization process and engagement input

Overview of the engagement process

From August to October 2021, MDH and DHS reviewed input the agencies received in the time since END HIV MN was adopted in early 2019. They also reviewed the progress that had been made on the initial priority tactics (Appendix A).

Based on this work, MDH and DHS identified the following as potential new priority tactics:

- Innovative service delivery
- Harm reduction
- PrEP access and retention
- Capacity development in areas with urgent unmet needs
- Staff reflective of the community
- Community-driven messaging
- Authentic engagement
- Culturally humble and trauma-informed providers
- Greater Minnesota
- Youth and older adults
- Ryan White services
- Mental and chemical health
- Basic needs
- Incentives for care
- Housing for all
- Communication and data sharing

MDH and DHS staff got feedback on this list from the Government HIV Administration Team, the DHS–HIV Supports Section, Executive Directors of the Minnesota HIV/AIDS Service Organization, the END HIV MN Advisory Board, the Minnesota Council for HIV/AIDS Care and Prevention Disparities Elimination Committee, and culturally specific organizations before moving forward with the next phase.

In November and December 2021, with support from Management Analysis and Development (MAD), MDH and DHS hosted a series of online engagement sessions to get broader input and prioritize the potential tactics.

At these meetings, participants heard about the progress of END HIV MN so far and provided feedback on the list of potential tactics identified in Phase 1, identifying what they thought should be the highest priorities for the next two years (2022–2024).

There were eight different sessions offered, organized around the type of participants:

1. Health care
2. Prevention and education

3. Harm reduction
4. Government partners
5. Ryan White providers
6. Consumers and people with lived experience
7. Other health and social service professionals
8. General session (open to all)

During the same period, MAD administered an online survey to gather similar input and feedback from interested participants who were not able to attend one of the online meetings. The survey was promoted during World AIDS Day activities in December.

In total, 67 people attended at least one of the engagement sessions in November or December. Eleven people participated in the online survey.

Table 1. Demographics of participants in the reprioritization process

Self-identified as a/an…	Percent of participants
PLWH, person taking PrEP, advocate, or ally	26%
HIV educator, PrEP navigator, or similar	38%
Doctor, nurse, PA, NP, pharmacist, or similar	10%
Syringe service provider, substance treatment provider, peer support specialist, or similar	26%
Ryan White provider	26%
Government partner (fed, state, local)	29%
Other health or social service provider	9%

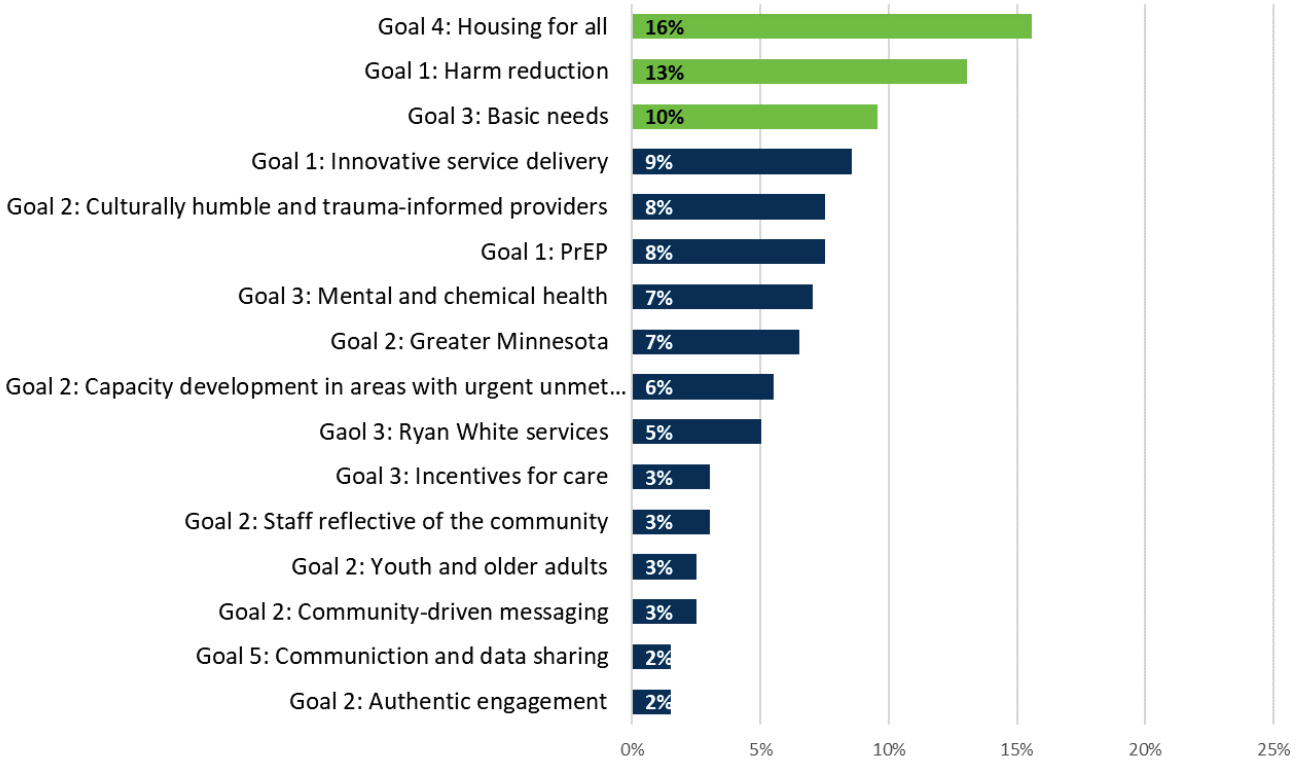
Engagement input

Voting on potential priority tactics

When asked which potential priority tactics were the most important for the state to focus on for the next two years, engagement participants voted most often for:

1. Housing for all
2. Harm reduction
3. Basic needs

Figure 1. Voting results from Phase 2 engagement



Other input received during discussions with participants

Below is a summary of what came up most often in discussions with participants at the engagement sessions.

Focus on people who are unhoused and people who use drugs

- The current outbreaks show where the most work needs to be done, both for prevention and increasing retention in care.
- People cannot focus on their health when they are struggling to meet their basic needs for shelter, food, and safety. That must be addressed first.
- Housing is a key lever for change, but the current system is burdensome, with high barriers.

Harm reduction is more than Syringe Service Programs (SSPs)

This potential tactic was drafted as: "Increase resources and support for existing syringe service programs (SSPs) and support development of new SSPs," but participants said:

- If there is a tactic focused on harm reduction, it needs to encompass more than just SSPs.
    - Harm reduction should be used as an overall approach or philosophy.
    - Harm reduction needs to include safe smoking supplies.
- Not being able to use funding to purchase syringes is a big barrier.

Tactics overlap and are related

While some of the tactics weren't always selected as participants' top three most important, many are related and need to work hand in hand.

- Training for providers on trauma-informed care needs to address harm reduction.
- Access to mental and chemical health services is essential to meet people's basic needs and help folks who access housing to remain housed.

Analysis and decision-making

The above input was presented to the END HIV MN Advisory Board in January 2022.

With additional feedback from the Advisory Board, MDH and DHS staff developed a list of recommended new priority tactics, as well as three new recommended operating principles for the strategy. Input was also gathered from the Minnesota HIV Housing Coalition's HIV Housing Plan Work Group, specifically on the Housing tactic. Based on this feedback, additional revisions were made to the wording and intention of some of the new priority tactics.

The Advisory Board approved the new operating principles and priority tactics in February. DHS and MDH staff are currently working to complete an implementation plan for the new priority tactics, which will be presented to the Advisory Board in August 2022.

Updated operating principles

END HIV MN was built on three operating principles first developed by the Advisory Board in 2017. Operating principles are the lens through which MDH and DHS approach implementation of the tactics and activities of the Strategy. The END HIV MN Advisory Board approved adding three additional operating principles starting in 2022.

- **A strategy that requires all hands on deck.** Creating and implementing the Strategy will require broad support, coordination, and collaboration among state, local, and tribal government agencies; community-based organizations (CBOs); health care providers; faith communities; community members; academic institutions; correctional and drug treatment facilities; and other key stakeholders. All Minnesotans, working in partnership, have a part to play in helping to achieve the Strategy's vision.
- **A strategy that calls for dynamic action.** Ending the HIV epidemic will require policy changes to further the implementation of the Strategy's goals.
- **A strategy that focuses on equity and social justice.** The HIV epidemic does not affect Minnesotans equally. It disproportionately affects historically marginalized communities that continue to face discrimination. The epidemic will end when these communities are equal and active partners in the Strategy's implementation. These partnerships will create new solutions and ensure that all Minnesotans benefit from efforts to end the epidemic.
- **(NEW) A strategy that meaningfully includes people most impacted in decision-making.** People living with HIV and people most at risk for infection are the experts on their own experiences and what is

necessary to end the HIV epidemic. Decisions made as part of implementing the Strategy must start by centering the voices of people who will be impacted by that decision.

- **(NEW) A strategy that centers the foundational principles of harm reduction.** The Strategy recognizes that harm reduction is an effective public health model for reducing the spread of infectious diseases, including HIV. The Strategy will not achieve its vision without meeting people where they're at and without applying harm reduction principles when implementing the activities of the Strategy.
- **(NEW) A strategy that acknowledges solutions must be tailored to meet the needs of different geographic areas.** People living with HIV and who are at risk of infection who live in rural areas of Minnesota have different needs and face different challenges than people living in large, metropolitan areas of the state. The solutions to end the HIV epidemic in Minnesota cannot be one-size-fits-all, but instead must be tailored to the specific needs of each geographic community.

Reprioritized tactics

Based on input received regarding current areas of need and the greatest barriers to ending the HIV epidemic in Minnesota, the END HIV MN Advisory Board approved focusing on the following eight priority tactics for new or enhanced efforts in 2022–2024.

Each of them aligns with a specific goal and strategy within END HIV MN. Some of them also overlap across goals and strategies. This alignment to goals and strategies, in addition to current activities, is included in Appendix A: Updated Goals, Strategies, and Tactics.

- **BASIC NEEDS:** Address people's basic needs for food, shelter, and safety to support prevention and adherence, linkage to care, and retention.
- **CAPACITY DEVELOPMENT IN AREAS WITH URGENT UNMET NEEDS:** Increase capacity within the service system to address the needs of people who are unhoused and/or who use drugs.
- **CULTURALLY HUMBLE AND TRAUMA-RESPONSIVE PROVIDERS:** Update, revise, or develop provider education and training to include a consistent focus in all training on cultural humility and trauma-responsive practices, including using harm reduction principles and practices, and serving people who use drugs. Training should be differentiated for providers who serve clients in Greater Minnesota.
- **HARM REDUCTION:** Increase availability, access, and use of harm reduction practices that prevent HIV infections, including and beyond syringe services programs. Target areas in Greater Minnesota and tailor implementation to meet the needs of providers serving people in rural areas and on tribal lands.
- **HOUSING FOR ALL:** Increase access to housing and support retention in stable housing for PLWH and those at risk of infection. Acknowledge that burdens differ for people depending on where in Minnesota they live.
- **INNOVATIVE SERVICE DELIVERY:** Support the development and expansion of telemedicine and other innovative service delivery models to ensure PLWH and people at risk of infection can access the care and services they need, when they need it, wherever they are (e.g., RAPID ART, service integration, mobile medicine).
- **MENTAL AND CHEMICAL HEALTH:** Address barriers that prevent PLWH and people at risk for infection from accessing mental and chemical health services.

- **STAFF REFLECTIVE OF THE COMMUNITY:** Increase hiring and retention of staff at state agencies, providers, and community-based organizations (CBOs) with lived experience and who reflect the communities being served.

2022–2024 Priority Tactic Action Plan

Below are the specific actions that DHS and MDH will take separately and in conjunction to achieve the goals of END HIV MN through the newly reprioritized priority tactics.

1.1.1: Culturally humble and trauma-responsive providers

Update, revise, or develop provider education and training to include a consistent focus in all training on cultural humility and trauma-responsive practices, including using harm reduction principles and practices, and serving people who use drugs. Training should be differentiated for providers who serve clients in Greater Minnesota.

Action	Responsible agency
Include completion of training and demonstration of cultural humility and respect for others as part of internal state agency staff annual reviews; work to expand this requirement to subrecipients.	**DHS + MDH**
Assess internal state agency policies and systems and make revisions to ensure the system is LGBTQ+ friendly (e.g., expanded gender categories in information systems).	**DHS + MDH**
Develop a model for cultural humility and trauma-responsiveness training for DHS and MDH staff who work on HIV prevention and care; explore expanding such a model to train providers/grantees.	**DHS (lead) + MDH**
Host conversations and trainings where community members are the experts in the room (e.g., HIV Tester Training) that are regionally specific, with folks from that community.	**DHS + MDH**
When updating HIV Minimum Standards in 2022, work to include requirements for staff training on cultural humility and trauma-responsiveness.	**DHS**
Update existing or planned provider and community trainings to include focus on cultural humility and trauma-responsiveness (e.g., Provider Professional Development, MATEC trainings/Town Halls).	**DHS**
Explore using HIV and Substance Use training as a model to expand to other sectors (e.g., mental health professionals).	**DHS**
Explore how to advocate for updated gender categories in EvaluationWeb.	**MDH**
Add training or education for staff on harm reduction to MDH grantee requirements.	**MDH**

1.4.1: Harm reduction

Increase availability, access, and use of harm reduction practices that prevent HIV infections, including and beyond syringe services programs. Target areas in Greater Minnesota and tailor implementation to meet the needs of providers serving people in rural areas and on tribal lands.

Action	Responsible agency
Continue building relationships with tribal nations to expand partnerships that support increased Ryan White and Prevention programing focused on harm reduction and HIV care and supportive services.	**DHS + MDH**
Assess awareness, knowledge, and comfort discussing harm reduction and making referrals among infectious disease medical care providers, housing and shelter providers, and culturally specific organizations.	**DHS + MDH**
Explore ways to expand state support for harm reduction beyond SSPs (e.g., safer smoking supplies, medication treatment).	**DHS + MDH**
Expand Outreach elements of Case Management to reduce access barriers, meet people where they are at, and better support folks who are actively using drugs and alcohol.	**DHS**
Continue working with tribal nations on Joint Powers Agreements related to infectious diseases.	**MDH**
Engage with SSPs and other providers to assess current demand and providers' ability to meet that demand.	**MDH**
Implement a DIS role that specializes in working with people who use drugs.	**MDH**
Explore funding opportunities for SSPs and other harm reduction efforts/programs.	**MDH**
Consider and support new possibilities of SSPs and other harm reduction activities, especially in Greater Minnesota (e.g., mail-based distribution, harm reduction vending machines, mobile services, overdose prevention sites, tele-harm reduction).	**MDH**
Coordinate with tribal nations to complete an inventory of SSPs and other harm reduction efforts/programs and locations; understand rules and regulations as they relate to harm reduction (e.g., fentanyl test strips) and interest in providing new or additional harm reduction efforts/programs.	**MDH**
Raise awareness around harm reduction services in shelters/transitional housing spaces, unhoused spaces, and within organizations that specialize in working with unhoused communities (e.g., folks staying in encampment settings).	**MDH**
Stay informed of shelter and transitional housing spaces in Minnesota and around the country that are designed and managed with a harm reduction lens (e.g., Avivo tiny village, CHUM in Duluth); use finding to educate other providers.	**MDH**

2.4.1: Staff reflective of the community

Increase hiring and retention of staff at state agencies, providers, and CBOs with lived experience and who reflect the communities being served.

Action	Responsible agency
Continue work to ensure state agency job postings for roles working on HIV prevention or care do not require unnecessary degrees or types of education.	**DHS + MDH**

Action	Responsible agency
Continue work to make lived experience a minimum or preferred qualification for relevant roles, including for higher levels of state agencies.	**DHS + MDH**
Intentionally recruit state job applicants from the communities being served.	**DHS + MDH**
Require respondents to RFPs to answer questions about the reflection of the intended client base among staff, leadership, and boards.	**DHS + MDH**
Share best practices at grantee and provider meetings from grantees and sub-recipients who are excelling at recruiting and retaining staff who reflect the communities served.	**DHS + MDH**
Research and get input directly from existing staff on how to retain staff.	**DHS + MDH**
Explore retention strategies with MDH Center for Health Equity and develop a statement with the Center on valuing people with lived experience.	**DHS + MDH**
Practice Inclusive Leadership; check in on a regular basis with staff about needs.	**DHS + MDH**
Support emerging leaders in DHS and MDH with their professional development, including through access to NASTAD's Minority Leadership Program.	**DHS + MDH**
Increase awareness among both state and subrecipient human resources staff of the importance of targeted recruitment, continuing to advocate for seeing lived experience and identity(ies) as relevant in hiring decisions to improve screening of applicants.	**DHS + MDH**
Work with state and subrecipient human resources to use culturally relevant recruiting methods through work with Center for Health Equity.	**DHS + MDH**
As Ryan White Service Standards are reviewed, look closely at requirements for staff qualifications, get community feedback, and reduce requirements for unnecessary degrees or types of education where appropriate.	**DHS**
Explore increased partnerships with MATEC to increase reflectiveness of the clinical workforce, with focus on providers of color, in the Duluth area, and throughout Greater Minnesota.	**DHS**
Expand contract requirements regarding organizational diversity, equity, and inclusion efforts and implement reporting/oversight mechanisms.	**DHS**
Continue working with human resources to ensure employment opportunities are posted/advertised in communities reflective of the communities the positions will serve.	**MDH**

3.4.1: Mental and chemical health

Address barriers that prevent PLWH and people at risk for infection from accessing mental and chemical health services.

Action	Responsible agency
Connect with the new Opioids, Substance Use, and Addiction Subcabinet (on which Commissioners of MDH and DHS serve), new Governor's Addiction and Recovery Director, and Governor's Council on Opioids, Substance Use, and Addiction.	**DHS + MDH**
Identify and connect with other State Advisory Councils that are working to address chemical health issues (e.g., Alcohol and Other Drug Abuse Advisory Council; American Indian Advisory Council on Chemical Dependency).	**DHS + MDH**
Organize and offer a follow-up Triple Threat training for state staff, providers, clinicians, and other stakeholders.	**DHS + MDH**

Action	Responsible agency
Continue training providers and stakeholders on the intersection of HIV and Substance Use Disorder; continue to update to curriculum to offer the most current information.	**DHS**
Identify and connect with State Advisory Councils that are working to address mental health issues (e.g., American Indian Mental Health Advisory Council; State Advisory Council on Mental Health; Governor's Task Force and Mental Health).	**DHS**
Complete an analysis of the Program HH Mental Health Benefit to identify options to improve billing and claims processes, understand which providers are currently billing for these services and identify opportunities to increase awareness and utilization of benefit. Explore barriers to accessing chemical health services for Ryan White eligible people and identify options to address barriers.	**DHS**
Explore ways to increase the number of mental health providers who support clients in active use.	**DHS**
Improve or offer an alternative to the provider portal to make it easier (less challenging to navigate) for people to find providers.	**DHS**

3.5.1: Basic needs

Address people's basic needs for food, shelter, and safety to support prevention and adherence, linkage to care, and retention.

Action	Responsible agency
Strengthen relationships within and between state agencies and organizations helping people access services to meet their basic needs.	**DHS + MDH**
Maintain, expand, and share the inventory of efforts to address HIV as a resource for DIS and other state staff, as well as provider staff, to know where services are available and who to refer clients to.	**DHS + MDH**
Train and provide resources to providers and organizations on service referrals.	**DHS + MDH**
Expand linkage and re-engagement services, including additional cultural and language-specific services for linkage, re-engagement, and retention follow-up.	**DHS + MDH**
Review Needs Assessment 2020 data and other survey data to understand unmet basic needs for PLWH.	**DHS**
Develop and refine tools to model impact of expanding basic needs services for PLWH.	**DHS**
Explore ways to increase access to essential services for categorically ineligible PLWH.	**DHS**
Continue strengthening relationships between DISs and providers that are seeing clients during the outbreak and continue close DIS work with agencies serving people who are living in encampments (i.e., Healthcare for the Homeless).	**MDH**

4.1.1: Housing for all

Increase access to housing and support retention in stable housing for PLWH and those at risk of infection. Acknowledge that burdens differ for people depending on where in Minnesota they live.

Action	Responsible agency
Increase coordination between MDH, DHS, and Minnesota Housing (including, but not limited to HOPWA).	**DHS + MDH**
Bring additional awareness to, and better coordinate with, the state Interagency Council on Homelessness and the Minnesota Heading Home Alliance to ensure statewide plans to end homeless explicitly include and address the needs of PLWH and people at risk of infection.	**DHS + MDH**
Provide information to consumers so that they can act as their own self-advocates and navigate the system without needing case management or similar support.	**DHS + MDH**
Increase awareness among PLWH of where and how to access services to obtain or retain housing without needing to disclose their status, especially in Greater Minnesota.	**DHS + MDH**
Support development of a new Minnesota HIV Housing Coalition strategic plan through a consultant position in the RHM contract.	**DHS**
Coordinate with funders as part of the HIV Housing Plan.	**DHS**
Map the housing service system and ensure providers, case managers, clinicians, and others who have contact with PLWH and people at risk of infection know how and where to refer people to region-specific resources.	**DHS**

5.3.1: Capacity development in areas with urgent unmet needs

Increase capacity within the service system to address the needs of people who are unhoused and/or who use drugs.

Action	Responsible agency
Engage with people and communities impacted by the HIV outbreaks, and with providers working with the populations of focus, to prioritize regions and/or services and understand what support/technical assistance is most needed.	**DHS + MDH**
Audit current systems, policies, and practices to identify ways DHS and MDH can reduce barriers to access and retention in care for people who are unhoused and/or use drugs (e.g., Program HH exploring Foundational Service practices; can we stop requiring addresses?; can we provide phones?).	**DHS + MDH**
Make the END HIV MN website a more robust portal with information for the public and providers about the HIV system of prevention and care, including referrals to services, including an online resource for service providers, agencies, and clients to find related services.	**DHS + MDH**
Break down silos and more intentionally engage with other state agency sections/divisions to collaborate and provide trainings (e.g., OD prevention section at MDH, Opioid Response section at DHS; Behavioral Health/SUD section at DHS).	**DHS + MDH**

Action	Responsible agency
Create a Community of Practice for HIV outbreak response that meets and shares resources and best practices to improve service delivery. Include Ryan White providers to ensure there is a "warm handoff" once people are diagnosed (including ADAP and other RWP services).	**DHS + MDH**
Identify existing or potential funding that could be used to support work in this area (e.g., shelter funding; OERAC funding; upcoming RFPs from federal agencies).	**DHS + MDH**
Explore increasing state staff capacity dedicated to working directly or indirectly to support the populations of focus.	**DHS + MDH**
Implement Eligibility Navigators/Specialists (Centralized Eligibility program) in the field to meet clients where they are.	**DHS**
Review Needs Assessment 2020 data and other survey data to understand regional service needs for people who are unhoused and/or who use drugs.	**DHS**
Conduct and/or share research on the health impacts of continual displacement of people staying in encampments and provide a brief or recommendations based on the findings.	**MDH**
Continue documenting and evaluating the current HIV outbreak response to identify learnings and improve.	**MDH**
Continue coordination of active HIV outbreaks responses, such as the Metro and Duluth area, by MDH Incident Command System (ICS) and HIV Outbreak Partner Engagement (HOPE) Group(s).	**MDH**
Develop capacity-building grants to address the needs of smaller organizations with little to no experience with state RFP process.	**MDH**
Include an HIV testing track for people experiencing homelessness in the next RFP.	**MDH**

5.4.1: Innovative service delivery

Support the development and expansion of telemedicine and other innovative service delivery models to ensure PLWH and people at risk of infection can access the care and services they need, when they need it, wherever they are (e.g., RAPID ART, service integration, mobile medicine).

Action	Responsible agency
Document policies and procedures that have supported telemedicine/telehealth and increased access during the pandemic, refine, and formalize.	**DHS + MDH**
Explore ways to develop or support mobile service delivery (e.g., food truck-style services), including pairing mobile services with existing public resources people use (e.g., libraries).	**DHS + MDH**
Use existing data to identify gaps in types or quality of existing services.	**DHS + MDH**
Work with providers to understand which services can/should use telehealth; what barriers providers are experiencing around building or implementing telehealth; which providers are interested and have capacity to implement telehealth services; best practices from agencies working with populations who face barriers to accessing telehealth services (e.g., Native American Community Clinic).	**DHS + MDH**
Create a Community of Practice and provide technical assistance around RAPID ART.	**DHS + MDH**
Create a Community of Practice and provide technical assistance around service integration.	**DHS + MDH**

Action	Responsible agency
Support providers with obtaining technology and/or hardware needed for telehealth.	**DHS + MDH**
Build online formats for submitting program applications.	**DHS**
Review Needs Assessment 2020 results for services that had reported access issues.	**DHS**
Gather additional feedback from consumers on what kinds of innovative services they would like to see in areas with access issues.	**DHS**
Identify options to provide funding or equipment essential for PLWH to access telehealth services.	**DHS**

Appendix A: Updated Goals, Strategies and Tactics

The goals and strategies, which were developed by the END HIV MN Advisory Board in 2017, are remaining the same as those described in the original strategy plan. Below are how the newly reprioritized tactics align with each goal and strategy, including the other current activities that support all of the goals and strategies.

Goal 1: Prevent new HIV infections

Strategy 1.1: Increase HIV education and awareness for all Minnesotans, especially health professionals, students, and high-risk populations.

Priority Tactics and Current Activities	Tactic/Activity
NEW Priority Tactic 1.1.1 ***Culturally humble and trauma-responsive providers*** *(Revised PT 1.1.1)*	Update, revise, or develop provider education and training to include a consistent focus in all training on cultural humility and trauma-responsive practices, including using harm reduction principles and practices, and serving people who use drugs. Training should be differentiated for providers who serve clients in Greater Minnesota.
Current Activity 1.1.2 *(formerly PT 1.1.2 & 1.1.3)*	As part of the implementation of the initial END HIV MN priority tactics, DHS funded the creation of an HIV awareness toolkit that features Minnesotans who are living with HIV or taking PrEP. Dependent on resource availability, DHS is in the process of funding organizations that can utilize the toolkit, adapt it, or create their own messaging campaign to education and raise awareness in culturally specific ways across communities in Minnesota.
Current Activity 1.1.3 *(formerly PT 1.1.2 & 1.1.3)*	DHS is exploring the creation of an Ambassador Program that will train and support individual advocates to be ambassadors and increase awareness within their own communities.
Current Activity 1.1.4 *(formerly CA 1.1.5)*	The Minnesota Midwest AIDS Training and Education Center (MATEC) provides training and education programs to health care professionals in the field of HIV clinical care and management. Provider learning series events on the HIV outbreaks in Minnesota will continue in collaboration with MDH, DHS, Hennepin County Local Public Health (LPH), and St. Louis County LPH.
Current Activity 1.1.5 *(formerly CA 1.1.6)*	DHS funds a vendor to provide training to licensed alcohol and drug counselors and related providers regarding the intersection of HIV and substance use.
Current Activity 1.1.6 *(formerly CA 1.1.7)*	MDH funds agencies to provide HIV prevention education as part of comprehensive HIV testing and syringe services programs. MDH is in the process of updating its routine RFP process to address input provided by current and potential grantees that will make the grant making process more equitable.

Strategy 1.2: Increase routine opt-out HIV testing and early intervention services.

Priority Tactics and Current Activities	Tactic/Activity
Current Activity 1.2.1	MDH is working to de-duplicate testing programs to ensure that grantees have enough capacity to meet the needs of priority populations and culturally specific communities.
Current Activity 1.2.2 *(formerly FT 1.2.2)*	MDH has hired a nurse to provide HIV education to clinical providers. Part of this training focuses on routine opt-out HIV testing.
Current Activity 1.2.3 *(formerly CA 1.2.1)*	Early intervention services (EIS) under 2022 HIV Prevention Projects Grants will reach the following priority populations: BIPOC MSM (11 county metro), Black Women (11 county metro), Transgender People (11 county metro), People Experiencing Homelessness and/or Housing Instability (11 county metro), and People at Greatest Risk (Greater Minnesota).
Current Activity 1.2.4 *(formerly CA 1.2.2)*	All DHS- and MDH-funded EIS and HIV testing programs are now implementing rapid-rapid testing, which involves using two rapid HIV tests of different brands and can provide confirmatory results within 15 to 20 minutes.

Strategy 1.3: Immediately link newly diagnosed individuals to person-centered HIV care and treatments.

Priority Tactics and Current Activities	Tactic/Activity
Current Activity 1.3.1	Individuals who test positive through MDH- or DHS-sponsored HIV testing and/or EIS programs are immediately linked to confirmatory testing and HIV medical care. All funded non-clinical testing sites partner with an HIV specialty clinic to ensure confirmatory testing and linkage to care is completed; these sites are also identifying clinical referral options to support rapid initiation of HIV treatment—within 7 days of diagnosis. Individuals who test positive are also referred to Ryan White services.
Current Activity 1.3.2	Partners of newly diagnosed individuals who receive partner services and test positive for HIV are referred by Disease Intervention Specialists (DIS) to HIV care and treatment. MDH received a five-year grant through federal COVID-19 relief funding to expand the DIS workforce and is partnering with clinics and tribal nations to hire, train, and increase the capacity of DIS staff.
Current Activity 1.3.3	All newly diagnosed HIV-positive pregnant people are assigned to MDH's Care Link Services Program by the HIV Surveillance Team. The Care Link Services Program works to ensure that those who are not in medical care are immediately linked. The Minnesota Perinatal and Pediatric HIV Program at Children's Hospital and Clinics provides time-sensitive interventions to HIV-positive pregnant people and their exposed infants, as well as consultation and support for their health care providers related to preventing parent-to-child HIV transmission. Hennepin Healthcare provides similar services for HIV-positive pregnant people referred within the Hennepin Healthcare system.

Strategy 1.4: Increase availability, access, and use of evidence-based interventions that prevent HIV infections, such as PrEP, PEP, syringe services programs, and partner services.

Priority Tactics and Current Activities	Tactic/Activity
NEW Priority Tactic 1.4.1 ***Harm Reduction***	Increase availability, access, and use of harm reduction practices that prevent HIV infections, including and beyond syringe services programs. Target areas in Greater Minnesota and tailor implementation to meet the needs of providers serving people in rural areas and on tribal lands.
Current Activity 1.4.2 *(formerly CA 1.4.1)*	High-risk individuals who test negative through HIV testing and EIS programs are referred to PrEP services and syringe services programs as appropriate.

Goal 2: Reduce HIV-related health disparities and promote health equity

Strategy 2.1: Protect and enhance advancements in health care policies, including Minnesota Health Care Programs expansion, coverage for people with pre-exiting conditions, and access to preventive treatments without cost sharing.

Priority Tactics and Current Activities	Tactic/Activity
Current Activity 2.1.1	DHS is working toward solutions to remove prescription drug co-payments at point-of-sale for PLWH who meet Ryan White eligibility requirements and use Medical Assistance or MinnesotaCare. Currently, rebates are available to cover co-pays, but require the person to have the resources to pay the co-pay initially.

Strategy 2.2: Engage community leaders, non-profit agencies, PLWH, and other community members to identify and address barriers that prevent testing and person-centered care.

Priority Tactics and Current Activities	Tactic/Activity
Current Activity 2.1.1	MDH-funded HIV testing and syringe services programs integrate ongoing input from high-risk populations to continually improve programming efforts. This includes addressing barriers to testing, linking to HIV medical care, retention in HIV medical care, and viral suppression. MDH also works with the Minnesota Council for HIV/AIDS Care and Prevention's Disparities Elimination Committee to gather information about barriers and how to address them.

Strategy 2.3: Dedicate adequate resources to American Indians and populations of color most impacted by HIV to eliminate health inequities.

Priority Tactics and Current Activities	Tactic/Activity
Current Activity 2.3.1 *(**formerly PT** 2.3.1)*	MDH and DHS conducted key informant interviews and focus groups with past, current, and potential grantees to improve the grant making process for small, new, or yet-to-be-formalized culturally specific community-based organizations (CBOs). Based on this input, DHS revised its most recent RFP process for Ryan White grant funding to make it easier for grantees. MDH is currently reviewing its own RFP processes for areas that can be changed to align with the input received. DHS and MDH are exploring options to better partner with and support tribal nations through mechanisms such as non-competitive HIV grants, which would eliminate the need for tribal nations to submit competitive proposals.
Current Activity 2.3.2 *(**formerly PT** 2.3.1)*	MDH will be offering an RFP starting in 2022 to specifically support capacity building of small, new, or yet-to-be-formalized culturally specific CBOs.
Current Activity 2.3.3 *(**formerly PT** 2.3.2)*	MDH and DHS, in partnership with Hennepin County, conducted a survey of partner organizations, which gathered input on how to improve the inclusion of voices most impacted by HIV. Based on that feedback, MDH and DHS made changes to ensure that people with lived experience are compensated for their time and expertise, whenever they are asked to provide input or feedback on decision-making about HIV programs and funding. A survey was conducted in 2021 among PLWH to decide how to allocate supplemental COVID-19 relief funding, and MDH and DHS will continue to engage in similar input gathering activities in the future. Finally, MDH and DHS will be refreshing the END HIV MN Advisory Board starting in 2022 to add additional Board members with lived experience.
Current Activity 2.3.4 *(formerly CA 2.3.3)*	The Minnesota Council for HIV/AIDS Care and Prevention considers current surveillance and other relevant data when prioritizing populations for prevention services and when prioritizing care and service funding. Recent HIV outbreaks have helped inform the areas of greatest need for immediate action and resources.

Strategy 2.4: Reduce HIV-related stigma, systemic racism, and other forms of structural discrimination that prevent people from accessing HIV care and prevention services.

Priority Tactics and Current Activities	Tactic/Activity
NEW Priority Tactic 2.4.1 ***Staff reflective of the community***	Increase hiring and retention of staff at state agencies, providers, and CBOs with lived experience and who reflect the communities being served.
Current Activity 2.4.2 *(formerly CA 2.4.1)*	MDH and DHS continue to work to include more community members and care providers from communities most impacted by HIV in the grant review process, which directly impacts funding decisions.
Current Activity 1.1.2	Current Activity 1.1.2, under Goal 1, also supports reducing HIV-related stigma.

Goal 3: Increase retention in care for people living with HIV

Strategy 3.1: Employ high-impact public health approaches to identify and re-engage individuals who are out of HIV care and treatment.

Priority Tactics and Current Activities	Tactic/Activity
Current Activity 3.1.1	The Care Link Services Program at MDH and Data2Care Program at Hennepin County Red Door Services use HIV surveillance data to identify people who are believed to be out of care because they have not had a CD4 or viral load result reported to MDH within the past 15 months. The Data2Care Program focuses on people living in Hennepin County and the Care Link Services Program focuses on people living in all other counties, as well as all HIV-positive pregnant women regardless of county of residence. The two programs follow up with the last known provider to find out if the people are truly out of care. If they are out of care, the programs reach out to the individuals and assist those who are willing with becoming re-engaged in care.
Current Activity 3.1.2	HIV surveillance data about CD4 and viral load tests are imported on a monthly basis into the data system used to collect demographic, service utilization, and limited clinical information for HIV-positive clients served through Ryan White, state, and rebate funding. The HIV surveillance data can assist medical case managers and other providers in the coordination and provision of care; however, this information is not always accessible to the organizations or providers who may be best equipped to re-engage PLWH. DHS and MDH will continue efforts to improve the quality and completeness of this data and train relevant providers on how to access the data to support retention efforts.

Strategy 3.2: Ensure person-centered strategies that support long-term retention in care.

Priority Tactics and Current Activities	Tactic/Activity
Current Activity 3.2.1 *(formerly CA 3.2.2)*	Ryan White Parts A and B fund wraparound services such as medical transportation, medical case management, non-medical case management, psychosocial support groups, emergency financial assistance, food support, housing, and others. Programs funded through Ryan White must demonstrate that program activities support people to stay in care. DHS piloted, and plans to expand, Outreach Case Management, which addresses eligibility barriers to accessing Ryan White services.
Current Activity 3.2.2 *(formerly CA 3.2.3)*	The Care Link Services and Data2Care programs routinely assess patients' barriers to retention in care. Care Link Services and Data2Care staff provide active referrals to needed supportive services, including case management, as an effort to remove those barriers

Priority Tactics and Current Activities	Tactic/Activity
Current Activity 3.2.3 *(formerly CA 3.2.4)*	DHS provides funding to implement health education and psychosocial support services, typically through support groups, for individuals living with HIV. A key purpose of these support groups is to provide peer support and peer-identified strategies to keep group members engaged in HIV medical care and reach viral suppression.

Strategy 3.3: Provide culturally and linguistically appropriate services, as well as gender and sexual orientation appropriate services in clinical and/or community support settings.

Priority Tactics and Current Activities	Tactic/Activity
NEW Priority Tactics 1.1.1 and 2.4.1	New Priority Tactics 1.1.1 and 2.4.1 are intended to ensure that clinical and community support settings offer culturally appropriate and affirming services.
Current Activity 3.1.1	Ryan White, state, and rebate funds are used to fund culturally, linguistically, gender, and sexual orientation appropriate services at CBOs and clinics.
Current Activity 3.1.2	All previously diagnosed HIV-positive people who become pregnant are assigned to the Care Link Services Program by the HIV Surveillance Team if the pregnancy is reported to MDH as required. The Care Link Services Program works to ensure that those who are not in medical care are connected immediately. The Minnesota Perinatal and Pediatric HIV Program at Children's Hospital and Clinics provides time-sensitive interventions to HIV-positive pregnant people and their exposed infants, as well as consultation and support for their health care providers related to preventing parent-to-child HIV transmission. Hennepin Healthcare provides similar services for HIV-positive pregnant people referred within the Hennepin Healthcare system.

Strategy 3.4: Identify and reduce barriers to mental and chemical health services and care.

Priority Tactics and Current Activities	Tactic/Activity
NEW Priority Tactic 3.4.1 ***Mental and chemical health***	Address barriers that prevent PLWH and people at risk for infection from accessing mental and chemical health services.

Priority Tactics and Current Activities	Tactic/Activity
Currently Activity 3.4.2 *(formerly CA 3.4.1)*	Ryan White Part B provides access to mental health therapists statewide through the Minnesota Medicaid Information System (MMIS) for individuals who have no other means to pay for the service (i.e., no insurance or public program). Ryan White Part A funds several agencies to provide mental health services. Ryan White Parts A and B fund substance abuse assessment and support care coordination for those individuals seeking this service, harm reduction services through funded programs, and training to chemical health providers to help increase skill around working with PLWH and individuals at risk.

Strategy 3.5: Ensure access to services that meet the basic needs of PLWH.

Priority Tactics and Current Activities	Tactic/Activity
NEW Priority Tactic 3.5.1 ***Basic Needs***	Address people's basic needs for food, shelter, and safety to support prevention and adherence, linkage to care, and retention.
Current Activity 3.5.2 *(formerly CA 3.5.1)*	Ryan White Parts A and B support several types of services that meet basic needs of PLWH. Food assistance is provided through on-site meals, home-delivered meals, food shelf, and food certificates. Transportation is provided for medical appointments. Housing activities funded through Ryan White or Housing Opportunities for Persons With AIDS (HOPWA) include supportive housing; emergency assistance for mortgage, rent, deposits and housing applications; and transitional housing and permanent subsidies through HIV housing certificates and apartments specifically for PLWH.
Current Activity 3.5.3	MDH Disease Intervention Specialists (DISs) provide active referrals for support services to meet clients' basic needs.

Goal 4: Ensure stable housing for people living with HIV and those at high risk for infection

Strategy 4.1: Identify gaps in affordable housing statewide.

Priority Tactics and Current Activities	Tactic/Activity
NEW Priority Tactic 4.1.1 ***Housing for all***	Increase access to housing and support retention in stable housing for PLWH and those at risk of infection. Acknowledge that burdens differ for people depending on where in Minnesota they live.

Priority Tactics and Current Activities	Tactic/Activity
Current Activity 4.1.2 *(**formerly PT** 4.1)*	MDH and DHS continue to support implementation of the Minnesota HIV Housing Coalition's HIV Housing Plan.
Future Activity 4.1.3	Commission a Statewide HIV & Housing Report through partnership with Housing Opportunities for Persons with AIDS (HOPWA) and the Minnesota HIV Housing Coalition. Utilize the findings of the report to act on more targeted tactics to increase access to housing for all.

Strategy 4.2: Build partnerships that increase the supply of safe, affordable housing units for PLWH and those at high risk of infection.

Priority Tactics and Current Activities	Tactic/Activity
Current Activity 4.2.1	In addition to supporting implementation of the HIV Housing Plan, DHS and MDH continue to develop and maintain their partnerships with HOPWA and the Minnesota HIV Housing Coalition, as well as provide funding to organizations that support PLWH and people at risk of infection with accessing housing.

Strategy 4.3: Ensure that PLWH and those at high risk of HIV infection have access to necessary supports that maintain their housing stability.

Priority Tactics and Current Activities	Tactic/Activity
NEW Priority Tactics 3.4.1 and 3.5.1	New Priority tactics 3.4.1 and 3.5.1 will, based on research, provide necessary supports to help PLWH and those at high risk of infection access and maintain housing.
Current Activity 4.1.3 *(**formerly PT** 4.1)*	MDH and DHS continue to support implementation of the Minnesota HIV Housing Coalition's HIV Housing Plan.

Strategy 4.4: Secure long-term, sustainable resources to meet the growing need for affordable housing and supportive services.

Priority Tactics and Current Activities	Tactic/Activity
Current Activity 4.4.1 *(**formerly PT** 4.1)*	MDH and DHS continue to support implementation of the Minnesota HIV Housing Coalition's HIV Housing Plan.

Goal 5: Achieve a more coordinated statewide response to HIV

Strategy 5.1: Create a leadership structure that is held accountable for implementing and updating this Strategy.

Priority Tactics and Current Activities	Tactic/Activity
Current Activity 5.1.1 *(**formerly FA** 5.1.1)*	The END HIV MN Advisory Board advises MDH and DHS on priority tactics, gathering community input, and evaluation of the Strategy's implementation. DHS has taken steps to establish the advisory council in statute but has not been successful to this point. MDH and DHS will be refreshing the END HIV MN Advisory Board starting in 2022 to add additional Board members with lived experience.

Strategy 5.2: Integrate HIV prevention, care, and treatment throughout all sectors of government, health care systems, and social services.

Priority Tactics and Current Activities	Tactic/Activity
Current Activity 5.2.1 *(**formerly CA** 5.2.3)*	DHS, MDH, and Hennepin County Public Health meet regularly as the Governmental HIV Administration Team (GHAT) to share information among the agencies, coordinate planning for clients' continuum of prevention and care, develop consistent messages for communication, provide peer support, and consider Minnesota Council on HIV/AIDS Care and Prevention decisions in administrative planning.

Strategy 5.3: Identify, research, and replicate new, effective interventions through partnerships between local public health and state governments, tribal nations, HIV providers, community-based and religious organizations, the University of Minnesota and other academic institutions, research partners, and others.

Priority Tactics and Current Activities	Tactic/Activity
NEW Priority Tactic 5.3.1 ***Capacity development in areas with urgent unmet needs***	Increase capacity within the service system to address the needs of people who are unhoused and/or who use drugs.
NEW Priority Tactic 1.4.1	In order to increase the availability, access, and use of harm reduction practices through New Priority Tactic 1.4.1 to prevent HIV infections, including and beyond syringe services programs, MDH and DHS will need to rely on research the demonstrates the effectiveness and benefits (including economic benefits) of harm reduction.

Strategy 5.4: Establish policies that encourage an innovative culture and delivery of comprehensive statewide services.

Priority Tactics and Current Activities	Tactic/Activity
NEW Priority Tactic 5.4.1 ***Innovative service delivery***	Support the development and expansion of telemedicine and other innovative service delivery models to ensure PLWH and people at risk of infection can access the care and services they need, when they need it, wherever they are (e.g., RAPID ART, service integration, mobile medicine).
Current Activity 5.4.2 *(formerly CA 5.4.1)*	Minnesota was the third state to endorse the U=U campaign. DHS and MDH continue ongoing efforts to educate and raise awareness among providers, PLWH, and people who are at risk of HIV infection on U=U.
Current Activity 5.4.3	In response to the COVID-19 pandemic, MDH and DHS adapted policies that allowed for continuity in care and services for PLWH despite their inability to receive in-person care from medical professionals. MDH and DHS are committed to maintaining these innovations and adaptations into the future and explore further ways to increase access and reduce barriers.

Strategy 5.5: Create effective information-sharing partnerships and systems that produce reliable data and that inform decision-making, strategy development, and program accountable.

Priority Tactics and Current Activities	Tactic/Activity
Current Activity 5.5.1	DHS, MDH, and Hennepin County Public Health have current data sharing agreements and are also engaged in a process to identify additional data needs and potential data sources to enhance planning and implementation of HIV prevention and care services, and to evaluate effectiveness of efforts.

Appendix B: Glossary

AIDS is Acquired Immunodeficiency Syndrome, the most advanced stage of HIV infection. HIV destroys the CD4 T lymphocytes (CD4 cells) of the immune system, leaving the body vulnerable to life-threatening infections and cancers. To be diagnosed with AIDS, a person with HIV must have an AIDS-defining condition or have a CD4 count less than 200 cells/mm3 (regardless of whether the person has an AIDS-defining condition).

Care Link Services and Data2Care programs: The Care Link Services Program at MDH and Data2Care Program at Hennepin County Red Door Services use HIV surveillance data to identify people who are believed to be out of care because they have not had a CD4 or viral load result reported to MDH within the past 15 months. The Data2Care Program focuses on people living in Hennepin County and the Care Link Services Program focuses on people living in all other counties, as well as all HIV-positive pregnant women regardless of county of residence. The two programs (which both fall under the category of data to care programs) follow up with the last known provider to find out if the people are truly out of care. If they are, the programs reach out to the individuals and assist those who are willing with becoming re-engaged in care.

CD4 count is a test that measures the amount of CD4 cells in the blood. CD4 cells, or T-cells, are a type of white blood cell that play a role in the immune system response. Usually the CD4 count increases as the HIV virus is controlled with effective HIV treatment.

Cultural humility, as defined by the National Institutes of Health (NIH), is "a lifelong process of self-reflection and self-critique whereby the individual not only learns about another's culture, but one starts with an examination of her/his own beliefs and cultural identities."

Culturally and linguistically appropriate services (CLAS) consist of 14 standards organized by the themes of culturally competent care, language access services, and organizational supports for cultural competence. The standards are primarily directed at health care organizations but individual providers are also encouraged to use the standards to make their practices more culturally and linguistically accessible. Some of the standards are requirements for all recipients of federal funds. CLAS is a way to improve the quality of services provided to all individuals, which helps reduce health disparities and achieve health equity. CLAS is about respecting the whole individual and responding to the individual's health needs and preferences.

Early intervention services (EIS) include the following components (although the specific components vary slightly based on the category of Ryan White HIV/AIDS Program funding): counseling individuals with respect to HIV, targeted HIV testing, referral and linkage to HIV care and treatment services, outreach and health education/risk reduction services related to HIV diagnosis, and other clinical and diagnostic services related to HIV diagnosis.

Goal is simply what you would like to accomplish.

Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm reduction refers to policies, programs and practices that aim primarily to reduce the adverse health, social and economic consequences of the use of legal and illegal psychoactive drugs without necessarily reducing drug consumption. Syringe services programs fall within the realm of harm reduction.

Health equity is the attainment of the highest level of health for all people. Health equity means efforts to ensure that all people have full and equal access to opportunities that enable them to lead healthy lives.

Health inequities are differences in health that are avoidable, unfair, and unjust. These are avoidable inequalities in health between groups of people within countries and between countries.

Health disparities are preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations

High-impact public health approach is an approach to medicine that is concerned with the health of the community as a whole. Public health is the science of protecting the safety and improving the health of communities through education, policy making, and research for disease and injury prevention.

HIV (human immunodeficiency virus) is the virus that can cause AIDS (acquired immune deficiency syndrome). HIV is most commonly transmitted during anal and vaginal sex, while sharing syringes or equipment to inject drugs or other substances, and less commonly, during pregnancy, childbirth, or breastfeeding.

Housing Opportunities for Persons With AIDS (HOPWA) program is the only federal program dedicated to the housing needs of people living with HIV (PLWH).

Incidence in epidemiology is a measure of the probability of occurrence of a given medical condition in a population within a specified period of time. Although sometimes expressed simply as the number of new cases during a specific time period, it can also be expressed as a proportion or a rate with a denominator. Incidence conveys information about the risk of contracting the disease.

Incidence rate is the number of new cases per 100,000 population in a given time period.

Incidence of diagnosed HIV/AIDS cases is the number of new HIV/AIDS cases diagnosed in a given time period.

Indicator is a specific, observable, and measurable characteristic or change that represents achievement of a goal.

Late tester is a person living with HIV who is diagnosed with AIDS within a year of their HIV diagnosis or who is first diagnosed at the AIDS stage. The immunity of a late tester is already severely impaired by the time the disease has been first diagnosed. This designation includes those who have a CD4 Tlymphocyte count of less than or equal to 200 copies/mL at the time of diagnosis and those who are first recognized as having HIV/AIDS because they have an AIDS-defining illness even though they did not seek medical care earlier.

New HIV diagnoses refers to individuals who were diagnosed in a particular calendar year and reported to the health department. This includes persons whose first diagnosis of HIV infection is AIDS (AIDS at first diagnosis).

Outcome is the final result of a process or activity.

Opt-out testing means a health care provider tells the patient an HIV test will be part of their routine bloodwork unless the patient specifically declines the HIV test.

Partner services include a variety of related services that are offered to persons with HIV or other sexually transmitted diseases (STDs) and their sexual or needle-sharing partners. By identifying infected persons,

confidentially notifying their partners of their possible exposure, and providing infected persons and their partners a range of medical, prevention, and psychosocial services, partner services can improve the health not only of individuals, but of communities as well.

Person-centered HIV care involves keeping the person at the center of their HIV care, using individualized interventions and honoring the person's preferences.

Pre-exposure prophylaxis (PrEP) involves taking HIV medicines daily to lower a person's risk of getting infected. PrEP can stop HIV from taking hold and spreading throughout the body. It is highly effective if used as prescribed. Daily PrEP reduces the risk of getting HIV from sex by more than 90 percent. Among people who inject drugs or other substances, it reduces the risk by more than 70 percent. A person's risk of getting HIV from sex can be even lower if PrEP is combined with condoms and other prevention methods.

Prevalence is the number or proportion of cases in the population at a given time rather than rate of occurrence of new cases. Prevalence is the proportion of the total number of cases to the total population and is a measure of the burden of the disease on society.

Populations most affected by the HIV epidemic in Minnesota:

- Gay, bisexual, and other men who have sex with men
- People who inject drugs (PWID), including gay and bisexual men who inject drugs
- Populations of color (African Americans, African-born, Hispanic, Asian/Pacific Islanders, multiracial) and American Indians
- Transgender people

Post-exposure prophylaxis (PEP) means taking antiretroviral medicines (ART) after a potential HIV exposure to prevent becoming infected. PEP must be started within 72 hours after a potential exposure to HIV. If a person thinks they have been recently exposed to HIV during sex or through sharing syringes or other injection-related equipment, they should talk with a health care provider or an emergency room doctor about PEP right away.

Resource allocation modeling is a methodology for determining how resources should be allocated to most effectively reach the desired outcome(s).

Ryan White HIV/AIDS Program is a federally funded comprehensive system of care that includes primary medical care and essential support services for people living with HIV who are uninsured or underinsured. The program distributes funds to cities, counties, states, and local community-based organizations and clinics to provide HIV care and treatment services to more than half a million people in the United States each year. The Ryan White HIV/AIDS Programs consists of different parts (i.e., Parts A, B, C, D, and F) that each have specific areas of focus.

Serostatus is the state of either having or not having detectable antibodies against a specific antigen, as measured by a blood test (serologic test). For example, HIV seropositive means that a person has detectable HIV antibodies; HIV seronegative means that a person does not have detectable HIV antibodies.

Strategy is the approach you take to achieve your goal. Strategies are broadly stated activities required to achieve the goals.

Structural discrimination (also known as structural inequality or systemic discrimination) is an unintentional form of discrimination resulting from policies that were enacted with the intent to be neutral with regard to characteristics such as race and gender. Structural discrimination occurs when these policies, despite apparently being neutral, have disproportionately negative effects on certain groups. Some structural discrimination is a result of past policies that continue to impact present-day inequality, while other policies still exist today and with disproportionately negative effects on minority groups.

Structural racism is the normalization of an array of dynamics—historical, cultural, institutional, and interpersonal—that routinely advantage white people while producing cumulative and chronic adverse outcomes for populations of color and American Indians. Structural racism is deeply embedded in American society and is a potent factor leading to inequities in all major indicators of success and wellness.

Supportive housing is affordable housing with on-site services that help formerly homeless, disabled tenants live in the community.

Surveillance is the ongoing, systematic collection, analysis, and interpretation of health data essential to the planning, implementation, and evaluation of public health practice, closely integrated with the timely dissemination to those who need to know. HIV surveillance data describe who is infected (age, gender, race, ethnicity), geographical location of cases, when cases were diagnosed, and dates and results of subsequent CD4 and viral load tests.

Syringe services programs (SSPs) is an umbrella term for services to clients who use injection drugs, including hormones. Most syringe services programs offer other prevention materials (e.g., alcohol swabs, vials of sterile water, condoms) and services, such as education, on safer injection practices and wound care; overdose prevention; referral to substance use disorder treatment programs including medication-assisted treatment; and counseling and testing for HIV and hepatitis C.

Systemic racism is about the way racism is built right into every level of our society. It is a popular way of explaining, within the social sciences and humanities, the significance of race and racism both historically and in today's world.

Systemic means that the core racist realities are manifested in each major part of U.S. society—the economy, politics, education, religion, the family—reflects the fundamental reality of systemic racism.

Tactics are the activities you do to accomplish a goal and implement a strategy.

Temporary or short-term housing means that the housing situation is intended to be very short-term or temporary (30, 60, or 90 days or less). It includes the following:

- Transitional housing for homeless people
- Temporary arrangement to stay or live with family or friends
- Other temporary arrangement such as a Ryan White HIV/AIDS Program housing subsidy
- Temporary placement in an institution (e.g., hospital, psychiatric hospital or other psychiatric facility, substance abuse treatment facility, or detoxification center)
- Hotel or motel paid for without emergency shelter voucher

Trauma-informed care, as defined by the Administration for Children and Families, is a framework of thinking and interventions that are directed by a thorough understanding of the profound effects trauma has on people, recognizing people's interdependent need for safety, connections, and ways to manage their emotions and impulses.

Trauma responsive care, as defined by the Administration for Children and Families, builds on trauma-informed care/systems and focuses on being responsive to the individual as a whole, knowing that trauma is only part of who they are. Becoming trauma-responsive includes looking at an entire organization's programming, environment, language, and values and involving all staff in better serving clients.

Treatment as prevention refers to the use of antiretroviral medication to prevent HIV transmission. Treatment as prevention involves prescribing antiretroviral medication to PLWH in order to reduce the amount of virus in their blood to undetectable levels so there is effectively no risk of HIV transmission.

Underserved populations are specific groups of people who face economic, geographic, cultural, linguistic and/or other barriers to accessing health care and other supportive services.

Unstable housing includes the following:

- Emergency shelter, a public or private place not designed for, or ordinarily used as, a regular
- sleeping accommodation for human beings, including a vehicle, an abandoned building, a bus/train/subway station/airport, or anywhere outside.
- Jail, prison, or a juvenile detention facility.
- Hotel or motel paid for with emergency shelter voucher.

Undetectable = Untransmittable (U=U). As of October 23, 2017, Minnesota became the third state to endorse the U=U consensus statement and sign on as a community partner. With this endorsement, Minnesota joined more than 400 organizations from 60 countries to endorse the U=U Campaign, which describes the scientific consensus that people living with HIV who take antiretroviral therapy daily and achieve and maintain an undetectable viral load have effectively no risk of transmitting HIV to their sex partners. The U=U campaign destigmatizes HIV because it removes fear of PLWH as "risky" and "infectious" to their sexual partners thus dismantling HIV stigma at the community, clinical, and personal level further improving the lives of people living with HIV.

Viral load refers to the number of copies of HIV per mL of blood. In other words, it's the amount of virus in the blood.

Viral suppression is when the level of circulating virus in the blood is reduced to a very low level of less than or equal to 200 copies/mL.

Appendix B:
Positively Hennepin

Positively Hennepin
HIV: PREVENTABLE. TREATABLE. STOPPABLE

Hennepin County HIV Strategy

A Plan to achieve 'No New HIV Infections in Hennepin County' by 2030

Executive Summary

In January 2015, Hennepin County Public Health embarked on a process to develop a coordinated HIV/AIDS Strategy in support of the National HIV Strategy. How Hennepin County responds to the epidemic will have a great impact on Minnesota's HIV/AIDS epidemic with 52% of Minnesotan's living with HIV in Hennepin County and 130 new cases of HIV diagnosed in the county each year. New infections in Hennepin County have stayed steady for several years with areas of growth among disproportionately impacted communities that face significant stigma and health disparities.

Halting the spread of HIV, long an elusive goal, is now achievable, thanks to emerging advances in treatment and prevention and the Affordable Care Act (ACA) provides equitable access to health care. New HIV medications are easier to take, have fewer side effects and are more effective. People with HIV on anti-retroviral treatment whose virus is suppressed, do not transmit HIV to their sexual partners.

An increasingly popular and effective prevention strategy called Pre-exposure prophylaxis, or PrEP, is a way for people who do not have HIV but who are at substantial risk of getting it to *prevent* HIV infection by taking a pill every day.

In Hennepin County as of December 31, 2019 there were 4,804 County residents living with HIV who were diagnosed and aware of their infection. Overall, 32% of Hennepin County residents living with HIV were out of care and 40% did not have suppressed virus.

A broad cross-section of stakeholders collaborated on developing the Strategy. The input of people living with HIV has been sought at every stage.

The planning process resulted in a vision, two operating principles, and three goals:

Vision: We envision a Hennepin County where:

- All people living with HIV/AIDS have healthy, vibrant lives
- There are NO new HIV infections
- All people have equitable access to HIV prevention and health care services

Operating Principle 1: Reduce health disparities and promote health equity

Operating Principle 2: Achieve a fully integrated public and private response to the HIV epidemic

Goal A: Decrease New HIV Infections

Goal B: Ensure Access to and Retention in Care for People Living with HIV

Goal C: Engage and Facilitate the Empowerment of Communities Disproportionately Affected by HIV to stop new infections and eliminate disparities

Introduction

In January 2015, Hennepin County Public Health embarked on a process to develop a coordinated HIV/AIDS Strategy in support of the National HIV Strategy. Halting the spread of HIV, is achievable, thanks to highly effective treatment and prevention. But ending this epidemic requires equitable access to comprehensive, cost effective treatment and prevention. It also relies on a concerted effort involving multiple community partners working together under a common strategic plan. The purpose of this plan, therefore, is to set priorities and focus resources for a coordinated public and private effort that can eliminate the spread of HIV in Hennepin County.

Vision

This Vision statement represents our desired future for Hennepin County:

We envision a Hennepin County where:

- All people living with HIV/AIDS have healthy, vibrant lives
- There are NO new HIV infections
- All people have equitable access to HIV prevention and health care services

Why develop this plan?

The development of this Hennepin HIV Strategy is important for several reasons:

- Nationally, there is a shift in both strategy and funding to improve both care and prevention outcomes. Hennepin County is modeling that approach.
- To advance health and racial equity Hennepin County is integrating a range of medical and non-medical services to address the health care needs of people who face multiple challenges to receiving medical care. This is a way to expand that effort.
- New infections in Hennepin County have stayed steady for many years and, while there is a slow decline in some populations, the areas of growth are in disproportionately impacted communities that face stigma and barriers that keep people from being tested and connected to care.

What makes this the right time?

Federal HIV treatment guidelines now recommend antiretroviral treatment (ART) for all HIV-infected individuals. New HIV medications are easier to take, have fewer side effects and are more effective. The risk of HIV transmission can be reduced by 100% in those who have achieved viral suppression. If HIV can be suppressed sufficiently, the number of new HIV infections can be dramatically reduced or eliminated.

An increasingly popular and effective prevention strategy called Pre-exposure prophylaxis, or PrEP, is a way for people who do not have HIV but who are at substantial risk of getting it to *prevent* HIV infection by taking a pill every day. When taken consistently, PrEP has been shown to reduce the risk of HIV infection in people who are at high risk by up to 99%.

So, the tide is moving in a positive direction. If HIV can be suppressed sufficiently through adherence to medication and use of PrEP or PEP, the spread of HIV can be dramatically reduced or eliminated. The primary prevention strategies, therefore, are to

- identify people living with the disease who are unaware or aware and out-of-care and get them into health care as quickly as possible
- utilize preventive medications that reduce disease transmission such as PrEP and PEP with those who are at risk of HIV.
- create equitable access to prevention and care strategies to eliminate disparities

Why Hennepin?

Hennepin County has a huge impact on Minnesota's HIV/AIDS epidemic with 52% of Minnesotan's living with HIV in Hennepin and 130 new cases of HIV diagnosed in Hennepin each year.

At present, unfortunately, up to 32 percent of those in Hennepin with HIV/AIDS are not currently accessing care and far too few have achieved viral suppression. So, it follows that Hennepin should take a leadership role in ending the epidemic in Minnesota. While the Strategy is designed to ensure all people with HIV find and remain in care, African Americans, African-born and Latinos are among those least likely to currently be in care.

How is this related to other plans around the nation?

Hennepin County is using the HIV National Strategic Plan (2021-2025) to structure its planning process, goals, and vision. The County has also studied the work of New York, San Francisco, and Seattle/King County to learn from their experiences. Briefly, those key learnings were to: ensure broad involvement of stakeholders at all levels, ground the plan in the local data and the current environment, and engage communities and subject matter experts to overcome specific challenges to ending HIV in Hennepin County.

Who has been involved?

Within Hennepin, a broad cross-section of people collaborated on developing the original Strategy. The input of people living with HIV was sought at every stage. At various trusted community agencies, consultants hosted listening sessions involving over 80 individuals living with HIV who lived in or received services in Hennepin County.

Also included in the original planning process were HIV service providers, members of the Minnesota Council for HIV/AIDS Care and Prevention, public health agency representatives, community leaders, and HIV advocates involved these groups:

- A Core Workgroup — led by Jonathan Hanft (Ryan White Program Coordinator) and Mary Jo Meuleners (Red Door Clinic Manager)
- A Strategists Group, made up of over 40 county and community leaders
- Leaders and staff of Hennepin County service areas, met in small groups to identify ways to integrate the Strategy into procedures and policies

In 2021, the strategy actions, tactics and milestones were updated. A crosswalk analysis assessing progress-to-date was conducted and presented to a steering committee of key stakeholders to provide inputs on a way forward. Additionally, small group feedback sessions were conducted with HIV service providers, clinicians, Hennepin County staff, community leaders and organizations, clients and HIV advocates on key focus areas such as PrEP, HIV care and treatment, provider services, housing, and client needs. Lastly, an online feedback survey was distributed to Hennepin County providers and clients to gain broad inputs on the strategy's action and tactics. 96 individuals completed the survey.

How are we Working Together to Eliminate HIV?

As time goes on, progressively more people and organizations are involved in identifying ways to implement the Strategy in relation to their specific services and procedures. This work began with Hennepin County staff but spread to service providers in Hennepin County who are not directly funded by Hennepin County but work with people living with HIV. This happened as the Strategy gained momentum and recognition as a Hennepin County upheld plan to eliminate HIV and through the connections made by dedicated staff.

What are the available and new resources to do this work?

The Strategy seeks to make the most of current resources by aligning existing funding with the Strategy's goals, actions and tactics, and/or making simple changes in policies and procedures as identified by the staff involved in managing and providing services. As more individuals and service providers emerge to support the Strategy, it is anticipated that new sources of foundation or public funding will become available. This funding can be used to advance HIV prevention and care in communities in Hennepin County disproportionately affected by HIV and for the coordination and the integration of Hennepin County services. Additional resources needed to implement the plan are identified in the Strategy as appropriate.

Strategy Elements

Operating Principles

The following two Operating Principles are basic values and commitments for this Strategy. The principles and overarching approaches are woven into the fabric of the Strategy and guide implementation of the plan.

Operating Principle 1: Reduce Health Disparities and Promote Health and RACIAL Equity[1]

Context: Significant and persistent health disparities exist for many people in Hennepin County. These disparities exist because opportunities to receive services are not equitably available, accessible or culturally responsive, services are not integrated and coordinated, and people are unaware of those services that are available and accessible.

Overarching approaches:

To mitigate these disparities, approaches must ensure that:

1. **Policies, structures, and systems open doors to receiving services –** Establish a health-in-all policies approach to related policies, structures and systems, so that institutional, systemic ways of working don't create barriers but instead provide opportunities to all people living with HIV or at risk of HIV to be as healthy as they can be.
2. **People find programs and resources to be readily accessible and meet their needs –** Ensure all existing Hennepin County operated programs and resources are readily accessible and culturally responsive to people living with HIV or at risk of HIV, so that the range of needs is addressed as efficiently and effectively as possible. This will also require collaboration among public and private organizations to remove barriers and increase points of entry for people living with HIV and at risk of HIV.
3. **All HIV related communications reduce health disparities and promote health equity –** All county public marketing programs, publications and communications targeting HIV prevention and care include components of reducing health disparities and promoting health and racial equity so they become a standard part of people's thinking

[1] Health equity is a state where all persons regardless of race, income, creed, sexual orientation, gender identification, age or gender have the opportunity to be as healthy as they can.

Operating Principle 2: Achieve a Fully Integrated Public and Private Response to the HIV Epidemic

Context:

It is vital to integrate services in Hennepin County that support people living with or at risk of HIV to ensure there are opportunities available to all for prevention and care. Integration of Hennepin County services that both directly and indirectly support people living with HIV will make the best use of resources – both public and private. It will be essential that the integration of services is linked to an ongoing monitoring of results of service coordination and integration.

Overarching approaches:

To provide the most needed services effectively and efficiently, approaches must:

1. **Integrate and coordinate all services among public and private health care and social service providers –** Ensure that there is integration and coordination among public and private health care and service providers, so services are delivered efficiently and effectively to people living with HIV and at risk of HIV. There may be a need to secure additional resources to integrate services in Hennepin County.
2. **Incorporate information, planning, and monitoring to ensure needs are met and resources well used –** All Hennepin County data related to services for people living with HIV and at risk of HIV need to be analyzed so service providers can better anticipate service demand and use of resources. Ongoing, data will be monitored to determine the effectiveness and efficiency of the services being provided.
3. **Establish communication channels among HIV service providers to ensure flexible, coordinated services that adapt to individual needs –** Formalize ongoing methods for communication among service providers and look for ways to respond flexibly to a variety of needs as they arise for people living with HIV or at risk of HIV. Good communication among providers can ensure coordinated services that adapt to changing needs and situations.

Goals, Actions, Tactics, and Milestones

Achieving these three goals moves us in the direction of the Vision. Actions and Tactics identify how we will get there and the related Milestones under each Goal are measures for achievement of the Goal. The Goals, Actions, Tactics and Milestones are:

Goal A: Decrease New HIV Infections

Context: A key to reducing new infections is to identify all people living with HIV/AIDS and quickly provide them with medical care that results in viral suppression. People unaware that they have HIV need to be tested, counseled, and provided with linkage services that connect them to a primary medical care setting. Prevention requires routine testing of people at risk of HIV infection as well as integrating high impact prevention (such as PrEP and PEP) into medical care plans.

Actions and Tactics

Increase Routine HIV Testing – Increase opportunities for routine HIV testing, so that people who are unaware they have HIV can be connected to care

- Work with private, FQHCS, other community health centers and Hennepin County provider networks to develop a plan establishing routine testing for HIV as part of standard healthcare screenings
- Expand the number and type of community settings (including faith organizations) that implement routine HIV testing by offering providers incentives and supports
- Conduct public awareness campaigns to emphasize the importance of routine screening and ongoing testing for people at risk

Expand PrEP and PEP programming – Provide access to PrEP and PEP programming to individuals who engage in high-risk behaviors so that the transmission of the disease can be dramatically reduced

- Convene a network of Hennepin County providers to scale up access to PrEP & PEP for everyone who needs it and offer supports for those who cannot afford it
- Provide education and marketing campaigns with clear messaging that HIV medications are more effective and easier to take than ever before
- Target marketing on the effectiveness of PrEP and how to access it

Testing for people who are at high-risk – Resolve barriers to testing for high-risk populations as determined by epidemiologic data so people are willing and able to access testing, and can be connected to care if HIV positive

- Ensure people at risk of HIV have access to address complex mental health/chemical use issues that are barriers to testing for people who are at risk of HIV
- Ensure that people at risk of HIV have access to support services that overcome barriers to testing including stable and safe housing for people with mental illness and substance use disorder, transportation, service navigation, and accurate and culturally appropriate HIV health and service information
- Provide accurate information on basic health practices, sexual health (including HIV risk factors), comprehensive sex education and HIV testing

Two-Year Milestones – By 2023:

- Late testers will account for no more than 25% of new infections
- There will be a 10% decline in the number of new HIV infections
- 225 people will start PrEP annually through Red Door Clinic

Goal B: Ensure Access to and Retention in Care for People Living with HIV

Context: Eliminating barriers to care is vital. People living with HIV/AIDS must have access to services to support their rapid movement through the stages of the HIV Care Continuum to stable viral suppression. They adhere to their medical plan because they have access to a range of life

supports including housing, food, and transportation and co-occurring conditions such as chemical dependency and mental illness are effectively treated.

Actions and Tactics

Ensure 'All Doors Open' – No matter where people who test positive for HIV access services or community resources they are connected to health care and supportive services, so that more people living with HIV are efficiently and effectively connected to care or re-engaged in care

- Provide ongoing HIV education of staff and volunteers at key entry points to the system
- Offer access to a clinic/medical care by having an appointment scheduled within 24 hours that a person tests positive for HIV
- Provide coordination and access to care for people living with HIV who are exiting Chemical Dependency treatment, correctional, or other institutional settings

Eliminate barriers to care – Improve access to services that meet basic needs for people living with HIV, so that any barriers to adhering to their HIV medical care plan are eliminated

- Offer up to 6 months of no cost HIV care to individuals who are
  - HIV-positive
  - linked to care
  - unable to afford care
- Expand options for facilitating adherence to medical care including programs that employ Community Life Navigators (HIV+ peer support), non-medical case managers and community health and mental health workers.
- Ensure access to and availability of low barrier affordable and safe housing options, particularly for people who inject drugs and are experiencing homelessness, and services to meet other basic needs (food, transportation, and economic supports that lead to income stability)

Engage and retain in care – Engage those people living with HIV who left care or were never connected to care, so that they are retained in care and achieve viral suppression

- Utilize and coordinate surveillance and public and private clinical data to find people not in care and to re-engage those who left care
- Recruit and retain diverse support and medical staff who understand and are able to provide linguistically and culturally responsive services
- Provide incentives for people to stay in care (program facilitated, culturally specific, evidence-based incentives)

<u>Two-Year Milestones – By 2023:</u>

- 80% of people living with HIV will be retained in care
- 72% of people living with HIV have suppressed virus

100 people with HIV experiencing homelessness will be moved along the housing continuum to stable housing

Goal C: Engage and Facilitate the Empowerment of Communities Disproportionately Affected by HIV to stop new infections and eliminate disparities

Context:

In Hennepin County, certain communities are disproportionately affected by new HIV infections. The communities experiencing the largest number of new infections include:

- Men of Color in particular African-born and gay/bi-sexual/MSM who are African-American or Latino.
- Women of Color (cisgender and transgender) in particular African-American and African-Born
- People who inject drugs
- People who experience homelessness

Organizing community action to implement new and creative programs is needed to stop new infections and help eliminate disparities. These efforts employ strategies chosen and approved as effective by these targeted communities.

Actions and Tactics

Partner with communities – Understand stigma and why some communities are disproportionately affected by HIV, so that effective strategies can be identified and supported to achieve increased awareness of HIV status, retention in care, and viral suppression

- Gather and review pertinent information with disproportionately affected communities regarding the strength of the communities and the barriers they face in order to increase awareness of HIV status, retention in care and viral suppression through focus groups, listening sessions, regularly collected health information and data from community leaders
- Create strategies with communities disproportionately affected by HIV so all services are culturally responsive and specific to the strengths and barriers identified through the information review
- Coordinate with the community so service systems in Hennepin County (e.g. corrections, library, or public health) better serve people who are disproportionately affected and build broad community trust in these systems (e.g. community members serve as trusted connectors and navigators)

Develop education and marketing campaigns to reduce HIV related stigma in disproportionately affected communities – Develop and implement education and marketing campaigns with community stakeholders that are culturally tailored and specific to disproportionately affected groups. These messages will reduce stigma, inform communities, and increase awareness of service options available

- Engage disproportionately affected communities in developing messages and identifying appropriate ways to distribute information including supporting people living with HIV as speakers to tell their stories and disseminate information in their communities.
- Provide comprehensive age-appropriate, accurate, realistic, accessible and inclusive (of all ages, genders, and sexual orientations) sexual and health education to disproportionately affected communities

- Train providers on cultural responsiveness that includes holding community conversations in community centers, faith communities, and medical providers to build trust in care systems

Provide community access – Increase testing services and access to care in community settings, so more isolated, marginalized people in communities are tested and stay in care

- Provide options for testing, and education in non-traditional community settings identified by the community
- Make PrEP and PEP accessible and affordable
- Reduce barriers that keep people from adhering to their medical plan including attending to their basic needs and offering incentives to stay in care

Two-Year Milestones – By 2023:

- Late testers from these communities will account for no more than 25% of new infections
- 80% of people from these communities living with HIV will be retained in care
- 72% of people from these communities living with HIV have suppressed virus

Appendix C:
Minnesota CODR Plan

HIV Cluster and Outbreak Detection and Response Plan

MINNESOTA DEPARTMENT OF HEALTH

7/15/2021, Version 2

Primary point of contact for this plan: Christine Jones

Version History

Version #	Revision Date	CDC Submission Date	Responsible Party	Comments
Version 1		09/30/2020	Christine Jones	First draft for CDC review and feedback
Version 2	6/25/2021	07/15/2021	Christine Jones	Revised to address CDC feedback and partner input

Table of Contents

HIV Cluster and Outbreak Detection and Response Plan

Introduction and purpose

About this document

This plan was developed in accordance with the Centers for Disease Control and Prevention (CDC) template, which was provided jurisdictions funded via PS18-1802, for use in developing an HIV Cluster and Outbreak Detection and Response Plan. Each jurisdiction is required to develop and maintain a comprehensive and tailored plan that is useful and feasible to implement.

Throughout this document, the title of the responsible party for each activity is bolded.

About this plan

The following table summarizes who contributed to the development and writing of the plan in the table below.

Table 1: Key Contributors to Development of the Plan Updated 7/15/2021

Title/Program	Name
Section Manager, STD/HIV/TB Section	Christine Jones
Assistant Section Manager, STD/HIV/TB Section	Julie Hanson Perez
Epidemiology (Epi) & Surveillance Manager, Epi & Surveillance Unit	Allison La Pointe
Partner and Care Link Services (PCLS) Manager, PCLS Unit	Marcie Babcock
Prevention Unit Manager, Prevention Unit	Peggy Darrett-Brewer
HIV Testing Program Supervisor, Prevention Unit	Jose Ramirez
Planning & Evaluation Specialist, Planning & Improvement Unit	Tara Carmean
Communications Specialists, Communications Unit	Emily Regan and Emily Beltt
Specialty Epidemiologist, Epi & Surveillance Unit	Cheryl Barber
HIV Surveillance Coordinator, Epi & Surveillance Unit	Jennifer Mark

The HIV Cluster and Outbreak Detection and Response (CODR) Plan was developed by the Minnesota Department of Health (MDH) STD/HIV/TB Section (referred to as the Section throughout this document) managers and staff. Staff assignments were made based on roles and responsibilities. Meetings, both formal and informal, were used to consult and discuss questions and decisions related to the CODR. Shared documents were used to compile and revise content. The **Planning & Evaluation Specialist** compiled information from Section staff for the **Management Team** review, feedback, and approval.

Partner input for the HIV CODR was received between January – April 2021 through interactive presentations, key informant interviews (KII), and surveys. The following entities (listed alphabetically) participated:

- Interactive presentations and follow-up surveys:
  - END HIV MN Advisory Board: service providers and people living with HIV (PWH)

  - HIV Collaborative Group: Local Public Health (LPH) agencies and community partners
  - Minnesota Council for HIV/AIDS Care and Prevention (MCHACP or the Council): service providers and PWH
  - Monthly MDH grantee call: MDH prevention and syringe services provider grantees
  - Provider Professional Development Day: MDH, the Department of Human Services (DHS), and Hennepin County grantees
- KIIs and follow-up surveys:
  - Healthcare for the Homeless
  - Hennepin County Public Health (HCPH): Ryan White Part A recipient
  - Midwest AIDS Training & Education Center (MATEC)
  - Minnesota Department of Human Services (DHS)
  - Native American Community Clinic (NACC)
  - Ramsey County Clinic 555
  - Southside Harm Reduction Services

The Section intended to engage Tribal Nations, considering their input a priority. Initial plans with the IDEPC Tribal Liaison included holding KIIs with 11 Minnesota Tribes in the spring of 2021, with an option to provide feedback through a survey. However, Tribes had limited capacity to provide feedback while focusing on the COVID-19 response and vaccination efforts, so the KII were not held as planned and the response to the survey was low. Plans for future engagement are expected, when Tribes have more capacity, and collected information will be used to update future iterations of the CODR.

Partner input is being incorporated into Section activities in real time and through intentional planning. Some feedback has already been incorporated, such as developing an internal procedure for responding to HIV concerns reported by community partners (as described in Section 3), creating an HIV outbreak response and case counts webpage[1], presenting recurring HIV outbreak updates at partner meetings, and collaborating with providers through the HIV Outbreak Partner Engagement (HOPE) group. In addition, Section staff formed a small group to look more closely at the wealth of partner input received and identify how to prioritize, implement, and address all the input received during this process. As of June 2021, this process is ongoing, with expectations to continue incorporating partner feedback.

[1] HIV Outbreak Response and Case Counts - Minnesota Dept. of Health (state.mn.us)

Section 1: Internal collaboration to support cluster and outbreak detection and response

Oversight and management

The STD/HIV/TB Section management and staff work collaboratively to provide management and oversight of the cluster[2] and outbreak[3] detection and response plan. Surveillance staff routinely run time/space and molecular analyses to conduct real-time analysis on HIV data and identify potential clusters and/or outbreaks. This data is shared monthly with the **Section Manager, Assistant Section Manager, Epi & Surveillance Manager, Prevention Unit Manager, HIV Testing Program Supervisor, PCLS Unit Manager, and PCLS Supervisor** on a regular basis. If a potential cluster and/or outbreak response is needed the Section Manager activates an elevated response.

Once an elevated response is activated the **IDECP Medical Director**, **IDEPC Communications Supervisor, and Infectious Disease American Indian Liaison,** along with lead prevention, surveillance, planning and communications staff, begin working with local partners to identify, implement and evaluate an appropriate response. These individuals meet on a regular basis to provide updates on interventions and activities, evaluate response activities and make necessary adjustments, and assure needed resources are available for the response. The **Section Manager** works closely with internal and external staff to determine when the elevated response can be deactivated and assures activities that need to be maintained are adequately in place.

The individuals and groups providing management and oversight of the HIV cluster and outbreak detection and response are:

- Infectious Disease, Epi, Prevention and Control (IDEPC) Division Director
  - Oversees Section activities
- STD/HIV/TB Section Manager
  - Informs and updates IDEPC Division Director
  - Leads Section Management Team
  - Oversees Section activities
  - Leads the Incident Command System (ICS) as the Incident Manager (when engaged)
- STD/HIV/TB Management Team: Section Manager, Assistant Section Manager, Epi & Surveillance Manager, Prevention Unit Manager, HIV Testing Program Supervisor, PCLS Unit Manager, PCLS Supervisor, TB Prevention & Control Unit Manager
  - Oversees respective unit activities
  - Reviews Section data
  - Participates on ICS team, as needed

[2] A cluster is defined as a group of PWH who are connected by transmission.
[3] An outbreak is an increase, often sudden, above what is normally expected in a population or area and an urgent or emergency level public health response is needed.

    - Follows up on the progress of cluster and outbreak response activities
- IDEPC Medical Director
    - Assists with drafting and approving clinical guidance and HANs
    - Providing clinical direction to IDEPC and Section staff
    - Liaison with clinically focused associations and organizations
- IDEPC Communications Supervisor
    - Oversees communications activities
    - Assigns communications staff
- American Indian Health Director and Infectious Disease American Indian Liaison
    - Communicates with tribes regarding outbreaks
    - Coordinates with the Section
    - Participates on ICS teams, as needed
    - Communicates with Metropolitan Urban Indian Directors (MUD), as needed

Additional MDH staff with other subject matter expertise are involved based on the characteristics of specific clusters or outbreak and the population most impacted.

See Appendix 1 for the IDEPC Org Chart and Appendix 2 for STD/HIV/TB Section Org Chart.

Staff capacity and training

Staff Training*:* Section staff with roles and responsibilities related to HIV cluster and outbreak detection and response come from the following units: Epi & Surveillance, Prevention Services, Partner and Care Link Services, and Planning & Improvement.

All MDH staff are required to complete the following trainings:

- Data Practices Act
- Records and Information Management Overview
- Security Awareness
- Code of Ethics and Conduct
- Health and Racial Equity 101
- Advancing Racial Equity
- Local Public Health 101
- Prohibition of Harassment and Discrimination Policy Review
- Preventing Sexual Harassment
- Respectful Workplace
- Readiness
    - Introduction to the Incident Command System
    - Introduction to Continuity of Operations

In addition to required Department trainings, HIV/STD/TB Section staff hired after 2019 also complete the following trainings:

- National HIV Curriculum
- Minnesota Molecular HIV Data Presentation
- National STD Curriculum
- TB 101 for Health Care Workers
- Quality Improvement 101

Specific trainings are also required for staff roles in the following units:

Epi & Surveillance: Epi & Surveillance Unit staff can attend and benefit from national webinars, meetings, and technical assistance provided by CDC and/or CSTE concerning outbreak detection and response when offered, and epidemiologists have access to subject matter experts for questions concerning MicrobeTrace and Secure HIV-TRACE, as well as access to demo sites. Training and orientation will be self-taught for these software/online systems.

Partner and Care Link Services: All new PCLS Disease Intervention Specialists (DIS) are required to participate in Passport to Partner Services. They also receive instruction from the direct supervisor and are also assigned to shadow senior DIS who demonstrate how to conduct job duties such as field investigations and case interviews. All DIS are encouraged to participate throughout the year in webinars and training opportunities available to improve their knowledge and skills.

Prevention Services: Prevention Unit staff complete the HIV testing training.

See Appendix 3 for a table that outlines staff roles, responsibilities, and training information.

Partner Training*:* The same training and ongoing development opportunities that are available to the MDH PCLS DIS are also made available to the DIS that are funded by MDH at the Hennepin County Red Door Clinic, the largest STD clinic in Minnesota.

The following trainings are provided to MDH grantees and partners:

- HIV Testing Trainings (required for funded agencies)
  - Rapid HIV Testing
  - Fundamentals of HIV Prevention Counseling
  - HIV Test Results
  - HIV Testing Data and Bloodborne Pathogens
- Minnesota Molecular HIV Data Recorded Webinar
- HIV Clinical Trainings (CDC HIV Screening and Testing Guidelines Trainings)

Content of the HIV Testing Trainings also includes educational information on Undetectable = Untransmittable (U=U), pre-exposure prophylaxis (PrEP), harm reduction and syringe services programs, syphilis, partner services, and the CDC national HIV testing database EvaluationWeb.

Additional professional development offerings are provided during the annual Provider Professional Development Day hosted by DHS, HCPH, and MDH.

Funding for cluster response activities

Much of the funding for routine cluster response activities comes from the HIV surveillance and prevention cooperative agreement with CDC, although PCLS DIS positions are funded through a combination of HIV prevention, STD Prevention and Control for Health Departments (PCHD), and Ryan White dollars. Ryan White funding is also used for HIV care and support services for eligible clients. State general funds are used to fund staff at many of Minnesota's HIV testing and syringe services programs (SSPs). State funds are also used to purchase syringes and other related harm reduction supplies that cannot be purchased with federal funds. If additional funds were needed for a response, Minnesota would look at the availability of state general funds and reach out to the Ryan White Part A and B recipients for assistance as appropriate.

Data sharing

Relevant data is shared between Section units for business purposes only. Access to electronic files on MDH drives is restricted and role-based (staff are only able to access information needed to perform their job duties). Data for public consumption will follow the Data Re-Release Suppression Rules for HIV Surveillance Analysis at Geographic Areas (see *Appendix 4*). Data with private health data can be shared with local public health in the geographic areas of concern for clusters or outbreaks when granted through a Commissioner's Order, which may specify sharing among multiple counties as needed.

The Section may share data with other IDEPC sections to perform data matches when an integrated response to an HIV outbreak and other co-occurring diseases, such as hepatitis A, C, or syphilis, is needed. This is assessed on a case-by-case basis.

MDH and the MDH-funded DIS at Red Door Clinic have a contractual agreement to share data, as the Red Door DIS is an extension of MDH PCLS.

In Minnesota, the Ryan White HIV/AIDS Part B Program is located at DHS. A data sharing agreement is currently in place between MDH, DHS and HCPH[4] that governs which HIV surveillance data are shared with Parts A and B via CAREWare and how these data can be used. As of June 2021, the three government agencies are in the process of developing another data sharing agreement that will govern which Ryan White client-level data in CAREWare can be shared between the three agencies and for what purposes.

The following identifiable individual-level data variables are currently imported into CAREWare by MDH staff monthly for CAREWare clients who are also in eHARS:

- Date of HIV diagnosis
- Date of AIDS diagnosis
- Current HIV status
- Date(s) and result(s) of CD4 tests

[4] MDH receives CDC funding for surveillance and prevention services. HCPH receives the federal Ryan White Part A grant for care services in the 13-county metro area. DHS receives the Ryan White Part B grant for care services, ADAP, and a supplemental grant. DHS transfers funding to MDH for early interventions services (EIS) through an interagency agreement.

- Date(s) and result(s) of viral load tests
- Vital status
- Date of death

The data cannot be further released except in aggregate form. DHS, HCPH and their funded sub recipients can only use the HIV surveillance data in CAREWare for clients who receive services through their respective programs for the following purposes:

- Locate a patient (case) who has fallen out of care to link the person back into care
- Provide lab data to ensure the patient is in care and has reached viral suppression
- Have more complete diagnosis status for Ryan White clients
- Understand if a patient is not locatable due to vital status
- Coordinate and facilitate comprehensive HIV care for Ryan White Program clients
- Conduct program planning, program evaluation, and develop policy
- Provide summary data to the public

Data protection

All HIV data requests are submitted through an online request portal on the MDH website (STD/HIV/TB Data and Presentation Request Form (https://survey.vovici.com/se/56206EE3662437AB)) and processed by both HIV prevention and HIV surveillance staff as appropriate and needed. All data requests follow Minnesota's re-release guidelines for HIV surveillance data, which mirror CDC guidelines for the same datasets. For any public health partners who receive de-identified datasets instead of completed analyses, all requests are approved in consultation with the legal department at MDH and submitted to the requestor with Minnesota's re-release guidelines attached. All datasets containing PII are shared with requestors in a secure fashion, typically password protected files for which a follow-up communication provides the password, and if emailed, then the email is encrypted. MDH also uses secure cloud data uploads to restricted requestors.

Because MDH imports CD4 and viral load results for PWH currently enrolled in Ryan White services from eHARS to CAREWare on a monthly basis, there is an additional policy for the use of eHARS data from CAREWare.

See Appendix 4 for Data Re-Release Suppression Rules and Appendix 5 for Use of eHARS Data.

Data protection policies and practices*:* Current Minnesota Statutes classifies health data, including HIV data, as private data and not public.

- MN Statute 13.3805: Classifies identifiable health data as private data
- MN Statute 144.658: Health surveillance data are not accessible to law enforcement or other entities in a legal action

The Section follows all MDH data practices and data security statues, rules, and policies.

To help protect data, all MDH employees receive information security awareness training. New employees are required to complete a 90-minute training within the first month of employment. All MDH employees are required to complete a "refresher" training annually.

Section 2: External partnerships to support cluster and outbreak detection and response

The Section has partnerships with other state agencies, tribal nations, local jurisdictions, and community-based organizations. Developing relationships with new partners, strengthening current partnerships, and building community engagement practices is ongoing.

Community engagement

The Section's community engagement activities include routine engagement activities and response-specific engagement activities.

Engagement activities with relevant communities

Routine engagement activities are conducted annually with the purpose of proactively sharing information and building relationships related to potential HIV cluster or outbreak response activities. These activities are summarized in Table 2.

Table 2: Routine Engagement Activities

Activity	Description	Population
Annual HIV Data Release	Community data release providing updated statewide data	PWH, grantees, tribal nations, LPH, providers of medical care, supportive services, mental health services and substance-use services, community coalitions, planning groups, general public, etc.
Community presentations	Share information related to HIV clusters and outbreaks, including surveillance tools and data privacy practices	Grantees, tribal nations, LPH, providers of medical care, supportive services, mental health services and substance-use services, community coalitions and planning groups
Provider Professional Development Day presentations	Share information about HIV cluster and outbreak related activities and plans	MDH-, DHS- and HCPH-funded grantees
END HIV MN Advisory Board engagement	Share information, request input, and relationship building	PWH; providers of medical care, supportive services, mental health services and substance-use services; representatives from tribes and other state agencies
Minnesota Council for HIV/AIDS Care and Prevention Engagement, aka The Council	Share information, request input, and relationship building	PWH, AIDS service organizations (ASOs), providers of medical care, supportive services, mental health, and substance-use services,
HIV Cluster and Outbreak Virtual Town Hall	Provide education and training on topics related to HIV clusters and outbreaks for service providers statewide	Grantees, tribal nations, LPH, providers of medical care, SSPs, supportive services, mental health and substance-use services, community coalitions, planning groups, PWH

Venue: Due to the duration of the COVID-19 pandemic, in-person meetings are put on hold and replaced with virtual meetings.

Response-specific informing activities are conducted when an HIV outbreak is declared to communicate, share information, and engaging partners and community for input. These activities are tailored for the population impacted by the outbreak and are summarized in Table 3.

Table 3: Response-Specific Engagement Activities

Activity	Description	Population	Frequency	Mode
Health Action Network (HAN) alerts	Alert with time-sensitive information	Health officials, clinicians, providers	As needed	Electronic correspondence
Notification to MDH grantees	Key time-sensitive information	Organizations receiving MHD funding	As needed	Email correspondence
HIV outbreak case count updates	Accessible data and case definitions descriptions	General public	Weekly, or as needed	MDH website
Email updates	Key updates regarding case counts, response efforts and public engagement the outbreak	Subscribers (which include the public, grantees, providers, etc.)	Monthly, or as needed	Email correspondence via GovDelivery
MDH grantee calls	HIV updates and information	MDH grantees providing HIV prevention, testing and SSP services	Monthly	Conference call
HIV Outbreak Public Engagement (HOPE) Group meetings	Engaging community in "real-time," information sharing, and incorporating input into response activities	Service providers and organizations working directly with impacted communities	Regularly, as determined	In-person or virtually
Minnesota Council for HIV/AIDS Care and Prevention Engagement, aka The Council	Share information related to HIV cluster and outbreak activities and plans, request input, and relationship building	PWH, AIDS service organizations (ASOs), providers of medical care, supportive services, mental health, and substance-use services,	Monthly - quarterly, as needed	In-person or virtually
End HIV MN Advisory Board	Share information related to HIV Cluster and outbreak activities and plans, request input, and build relationships	PWH, impacted populations, AIDS service organizations (ASOs),	Quarterly	In-person or virtually
HIV Cluster and Outbreak Town Hall	Provide education and training on topics related to HIV clusters and outbreaks for service providers statewide	Grantees, tribal nations, LPH, providers of medical care, supportive services, mental health and substance-use services, community coalitions, planning groups, PWH	As determined	Virtually
Community presentations	Information and updates regarding the outbreak, with option for collecting input	Varies, may include grantees, providers, coalitions, networks, PWH	As determined or requested	In-person or virtually

Engagement descriptions and processes

HIV Outbreak Public Engagement (HOPE): When an HIV outbreak is declared, a HOPE group is formed. The purpose of HOPE is to include the expertise of local partners into the ICS response to better understand what is happening and what is needed in the outbreak region. The group makeup includes the **HIV Testing Coordinator, Planning & Evaluation Specialist, and/or a Communications Specialist** and external providers who are actively involved in working with the impacted communities. External partners are identified by their involvement or association with impacted populations, and may include PWH, HIV service providers, MDH grantees, and other MDH or state agency representatives, etc. In a spirit of collaboration and shared leadership, the group will develop goals, establish meeting frequency, share information, and plan for meaningful engagement using best practices. Each group may function differently, depending on the providers involved. Meeting notes are documented for each meeting. MDH staff participating on the HOPE group provide regular updates to Section management and Section staff working on response activities during meetings, conversations, and in email, as needed.

Additional community engagement activities: engagement activities may vary depending on the unique outbreak population and circumstances. Engagement activities are identified and implemented as needed and may include focus groups, key informant interviews, surveys, brainstorming sessions, informational gathering through social media, interactive presentations (virtually or in-person), work groups, etc. The HOPE group may provide consultation and input in planning these activities.

Process for incorporating community and partner input: Input received through engagement activities is documented, assessed, shared, and implemented, as able. The **Planning & Evaluation Specialist** supports engagement activities in collaboration with other Section staff.

- Documentation: Input is documented and saved. Documentation varies depending on how the input was received (i.e., input during a collaborative meeting is included in meeting notes, input from a survey is documented in the survey results).
- Assessment: Input is reviewed and analyzed. Staff involved in collecting the data reviews the input to summarize findings, key highlights, and recommendations. This may include putting it in a format that is easy to share, such as pulling out key themes from focus groups or key informant interview and identifying recommendations and feedback for consideration.
- Sharing: Once input is received and assessed, it is shared with the Management Team and other relevant staff. Input is shared electronically and presented during meetings.
- Implementing: After input is shared, management and staff determine if and how input can be incorporated into outbreak and cluster response activities. Action steps, assignments, and timelines are developed, as needed. Section staff report back to the community to share how input was used and/or to explain why input may not have been used.

Collaboration with external partners

Community partners

The Section collaborates with multiple external partners, including MDH grantees, the END HIV MN Advisory Board, the Council, MDH funded grantees and non-grantees. The Section also continues to explore and evaluate how to strengthen existing and new collaborative efforts.

MDH Grantees*:* Partnerships with MDH grantees begin with identifying organizations best equipped to work for and with a targeted demographic. Once MDH grantees are identified through a Request for Proposals (RFP) process, roles and expectations are established, such has testing goals, outreach events conducted, PrEP referrals and others. Prevention Unit staff will provide MDH grantees, and non-grantees, with the tools and resources needed to create and maintain an HIV testing program. In the case of a cluster or outbreak, designated MDH grantees will be asked to assist in the outbreak response. This can include increased HIV testing, expanding services, and collecting community concerns about gaps in outreach and engagement.

END HIV MN Advisory Board*:* **The Planning & Evaluation Specialist, Section Manager, and Prevention Manager** collaborate with DHS staff to support and implement the END HIV MN (EHM) statewide plan, Minnesota's plan to end the HIV epidemic. Information related to HIV clusters and outbreaks are shared with EHM Advisory Board members during quarterly meetings, and through emails as needed. EHM Advisory Board members may provide consultation and input, help with outreach, disseminating information with their networks and communities.

The Council*:* **The HIV & STD Prevention Planning Coordinator, HIV Care and Prevention Epidemiologist, Section Manager and Prevention Manager** work with Hennepin County staff to support the HIV/AIDS Minnesota Council. Section staff attend monthly meetings and provide surveillance and HIV outbreak updates on a quarterly basis. Council members may provide consultation and input, help with outreach, and assist with disseminating information with their networks and communities.

MDH funded grantees and non-grantees*:* Section staff work with the MDH-funded partners and non-funded partners. Non-funded partners include providers of medical services, social services, housing, mental health and well-being, substance use disorders, and other applicable services. A list of the funded and unfunded partners is included in *Appendix 6*.

Collaboration with external partners is an ongoing process. New partners or areas of collaboration are identified through discussions with current partners and activities, attending community events, following up on recommendations from other partners. During an outbreak response, Section staff follow up on recommendations from HOPE group members about other partners and trusted leaders or "gate keepers" in the impacted community. Section staff also partner with other IDEPC sections, state agencies, LPH, or county agencies.

Framework and process

The Section uses the Public Engagement Spectrum as a framework for engaging community partners (*see Appendix 7: Public Engagement Spectrum*). This framework is also used by Minnesota's Governor's Office. The spectrum includes a range of engagement activities; on one

end of the spectrum is informing the community partners of information and on the other end of the spectrum is fully empowering the public and community partners in making decisions. Section public engagement activities currently fall under Inform, Consult, Involve, and Collaborate levels of the spectrum. Examples of these activities include:

- Inform
  - Health Alert Network (HAN) notices
  - Presentations at community group meetings
- Consult
  - Partner surveys
  - Partner interviews
- Involve
  - Interactive presentations and town hall events
- Collaborate
  - HOPE Group
  - END HIV MN Advisory Board
  - The Council

Identifying and addressing gaps

Community input and feedback are key in identifying gaps in available services. Gaps are identified informally and formally. Informally, gaps may be identified during conversations or meetings with partners. Formally, the **Planning & Improvement Unit** will work with Section staff to collect, document, and incorporate input from partners and stakeholders. Input may be collected during facilitated meeting discussions, through key informant interviews, interactive community presentations and/or survey tools to identify gaps and potential solutions, as needed. Gaps that are identified are documented, assessed, shared, and implemented as described in Section 2.

During an outbreak, the Section will also assess gaps in outbreak response activities during recurring meetings and during mid-point evaluations (as described in Section 7).

Data sharing

Data sharing agreements (DSA)

MDH has established a Commissioner's Order that allows the Section to share private health data with and between Hennepin and Ramsey counties where an outbreak is currently occurring.

Existing DSAs

The Commissioner's Order for the Hennepin/Ramsey County declared outbreak allows MDH to share the following data elements with the public health departments in Hennepin and Ramsey counties on cases involved in the current outbreak:

- First/Middle Name
- Last Name
- DOB
- Last Address
- Date of HIV diagnosis
- Residence at diagnosis
- Current residence
- City at diagnosis
- History of homelessness (yes/no)
- Other locating info (intersection, encampment)
- Known history of incarceration (yes/no)
- Known history of sex work (yes/no)
- Known drugs used
- History of syphilis
- Date address of current residence
- Transmission category
- Sex
- Age
- Race/Ethnicity
- Stage zero at diagnosis
- AIDS status
- Risk Factors
- Last HIV Viral Load
- Diagnosis Facility
- Last Known Facility
- Last Negative HIV Test/<180 days
- Use of Syringe Exchange
- Hepatitis C status
- Outcome of disease investigation by partner services

This information is used by both counties in attempts to locate known or suspected cases of HIV involved in the current outbreak and to provide individuals with testing and/or linkage to HIV and other infectious disease care.

These data are shared with Hennepin County Public Health via a Cloud-based secure upload/download folder. They are currently shared with Ramsey County Public Health via

encrypted email using a password-protected Excel file, but MDH hopes to set up a Cloud-based secure exchange with them, as well.

At Hennepin County, the data are stored in a restricted access space on the Hennepin County Microsoft Office 365 Government Community Cloud. The infrastructure/service is controlled by Hennepin County and audited to meet Federal Risk and Authorization Management Program under the Federal Information Security Management Act. At Ramsey County, the file is stored in a secure folder.

Access to the data is limited to individuals whose work assignments reasonably require access in accordance with MN Rule 1205.0400. At Hennepin County, groups that have a business reason to access private data include members of Epi, Ryan White, Health Care for the Homeless, and DIS/Red Door Clinic. At Ramsey County, access is limited to epidemiologists and staff on the outreach team.

Summary/aggregate data are classified as public. Hennepin County has a Power BI report that displays summary data and is currently only accessible to two epidemiologists. Going forward, the report is intended to be shared with the Drug-Related Infectious Disease ICS group and internal leadership of Epi, Ryan White, Health Care for the Homeless, and DIS/Red Door Clinic. Ramsey County does not share the data with anyone outside of Epi and outreach staff.

Data sharing procedures or agreements with other state health departments

MDH has a Commissioner's Order that allows IDEPC to share private health data with appropriate government public health officials in other states, territories or on tribal lands. Private health data will only be released to those jurisdictions where a person (case, suspected case, or carrier) has traveled, sought care, or lived and it is necessary to control and prevent the spread of a communicable disease. The data may only be used to 1) locate a case or carrier; 2) conduct a disease investigation; and 3) provide appropriate services. In these instances, the method of transfer is determined on a jurisdiction-by-jurisdiction basis, depending on the technology available to them. Epi & Surveillance staff share data over the phone with authorized staff appearing on the Council of State and Territorial Epidemiologists (CSTE) HIV Contact Board. Partner Services data may be shared with contacts on the Interstate Communications Control Records (ICCR) list via phone or fax.

As of June 2021, the **Infectious Disease American Indian Liaison** is also working on obtaining signed DSAs with 11 tribes to share infectious disease data, including HIV data. The current goal is to have DSAs in place by December 2021.

Minnesota worked with CDC to modify the language in the data use agreement (DUA) related to Secure HIV-TRACE. The DUA has been approved and fully signed. Minnesota will be able to compare molecular sequence data with other participating Class II and Class III jurisdictions.

Section 3: Detecting and describing HIV clusters and outbreaks

This section describes plans for detecting HIV clusters and outbreaks.

Time-space cluster detection

Epi & Surveillance staff follow the process for time-space cluster analysis as described in: 'Detecting and Responding to HIV Transmission Clusters: A Guide for Health Departments, June 2018'.

HIV Surveillance staff conducts the statewide time-space cluster analysis once a month and increases analysis to every two weeks during an escalated response to an outbreak. Below is a description of the analysis process and steps for prioritizing and determining a cluster.

The **Specialty Epidemiologist** uses a SAS program provided by CDC to conduct time-space analysis statewide, by region, at the local level and by individual risk category. Risk categories include: IDU, MSM/IDU, and MSM/IDU and IDU combined. Staff can modify the code as to add regions relevant to our health districts, as well as combine geographies as they are being monitored or involved in case definitions of declared outbreaks. The program implements the current approach:

- Define the time period of interest for analysis as the most recent 12 months of HIV diagnosis (e.g., Jan 2019-Dec 2019).
- Define the comparison group as the previous 36 months (e.g., Jan 2015-Dec 2018).
- Define the geographic area of interest. Minnesota reviews county and regional areas of the state and other special breakdowns with specific counties that are involved in a current or recent HIV cluster (e.g., Hennepin County and Ramsey counties, as a region to review for a current HIV cluster).
    - Calculate the HIV case counts for each county (or other relevant geographic area) for the most recent 12 months (or other time period of interest). The program also calculates the average HIV case counts per year for the same areas for the previous 36 months for comparison to help in determining an alert.

The **Specialty Epidemiologist** conducting the time-space analysis performs the following steps:

- Calculate the standard deviation for the mean number of cases during the 36-month comparison group.
- Construct an interval of +2 standard deviations around the mean.
- Compare the results to the most recent 12 months of data. The CDC-provided SAS code creates an "alert" for case counts that fall more than two standard deviations above the mean.
- Comparisons for geography include Hennepin County and Ramsey County and MDH public health regions.
- Additional criteria for geographic regions or time intervals may be applied, as needed.

The spreadsheets generated and line lists resulting in areas for which there are alerts are saved in a secure drive, and can be viewed by partner services, surveillance, and Section management.

After the initial month an alert is identified with time-space analyses, data is monitored for continued concern. If more cases are added in the subsequent month(s), district epidemiologists (representing the geographic area of interest) are notified. Investigation with MDH grantees or other local providers may also be initiated.

During an escalated response, the time-space analyses are run at least bi-weekly in advance of bi-weekly meetings held between partner services and surveillance staff. These meetings focus on the affected populations of declared outbreaks. At a minimum, results from the statewide analyses are reviewed by Section Management Team monthly.

Additionally, internal SAS programs are created for an escalated response to an outbreak for in-dept analysis of additional data needed for programs working on the outbreak to help prioritization of cases, as well as, useful for ICS and CDC meetings.

Molecular cluster detection

Program used for analysis, frequency of analysis, and staff involved

The Epi & Surveillance Unit has been granted approval to use MicrobeTrace. In December 2020, the **Epi & Surveillance Manager** and **Assistant Section Manager** submitted authorization for Secure HIV-TRACE to CDC as a Class III participant. Authorization was granted by CDC in February 2021, and the CDC Secure HIV-TRACE point of contact established the **Epi & Surveillance Manager** as the administrator for Minnesota's site. User accounts were established for MDH surveillance staff, including the **Specialty Epidemiologist, Lab Surveillance Epidemiologist, and the HIV Surveillance Coordinator**, and an executive account was established for the **PCLS Manager.** The Epi & Surveillance Manager downloaded documents from the Secure HIV-TRACE website, made them available to surveillance staff, and shared a demo site with staff for practice prior to using the production database. Once staff are comfortable with the methodology for Secure HIV-TRACE, monthly molecular sequence analyses will move from MicrobeTrace to Secure HIV-TRACE for routine monitoring, and bi-weekly analyses for monitoring of enhanced outbreak response areas. It is expected that initiation of Secure HIV-TRACE will occur in the third quarter of 2021.

Lab Surveillance Epidemiologist extracts laboratory data from MEDSS bi-weekly. Each month, the **HIV Surveillance Coordinator** extracts a subset of records that include genotyping data and compares data against datasets within molecular analysis software (i.e., Microbe Trace and/or Secure HIV-Trace) to identify potential clustering ≤1.5% genetic distance. Clusters of 3-5 cases within 12 months of diagnoses of each other and ≤ 0.5% genetic distance are reviewed for epidemiologic linkages prior to labelling a cluster of public health interest. HIV Surveillance Coordinator/Lab Epidemiologist alert Surveillance staff about cluster for potential enhanced Partner Services investigative response. Molecular analyses will be increased in frequency to bi-weekly to monitor for growth of cluster over 6 months, or over the duration of an outbreak.

Statewide analyses of molecular data will be presented to Section Management Team on a monthly basis, and a spreadsheet of output/visuals for clusters under investigation, or clusters on observational status only (i.e., clusters 3+ cases having genetic distances 0.5%< X ≤1.5%, or diagnoses occurring just >1 year relative to clustering cases) is saved in a secure folder.

Status of nucleotide sequence reporting via electronic lab reporting (ELR)

As of summer 2020, all four national labs processing Molecular HIV Surveillance (MHS) specimens have been onboarded with the Minnesota Electronic Disease Surveillance System (MEDSS).

In 2020, it was discovered that a local lab (Hennepin Healthcare) is also performing sequencing of specimens, but maintains a de-identified database, and is therefore currently unable to provide individual name-based electronic lab reports (ELR). As of 2021, a workaround has been set up to request sequences directly from the Hennepin Healthcare Molecular Lab point of contact and receive results with viable sequences via secure file transfer to MDH. A workgroup consisting of IT staff at both Hennepin Health Care and MDH, as well as Surveillance Staff, the molecular lab and representation from their vendor, and the **Assistant Section Manager** is working to onboard this data in our ELR system, MEDSS. It is anticipated that this automated feed may be in place by the end of the second quarter of 2021. ELR submitted through MEDSS are uploaded to eHARS on a monthly or more frequent basis for inclusion in monthly data transmissions to CDC.

Status on partnerships with outside agencies

MDH is not currently partnering with outside agencies to analyze molecular data. A DUA for Secure HIV-TRACE was submitted to CDC in December 2020, and user accounts established for surveillance staff in February 2021 upon return of the signed document.

Other cluster detection methods

In addition to epi and surveillance tools, HIV clusters may also be detected through PCLS or from direct input from external partners.

PCLS*:* Activities conducted by PCLS DIS may also detect clusters. When a new HIV case is reported to MDH, **PCLS DIS** investigate, interview and re-interview HIV cases to elicit the name of sexual and needle-sharing partners and social contacts that may be at risk for infection and related to a transmission or molecular cluster. Partner and social contacts who are tested and found to be positive for HIV infection are reported to PCLS management by DIS. The **PCLS Supervisor** reviews the investigative and interview data collected by DIS and informs the **Epi & Surveillance Manager** and **Specialty Epidemiologist** of the new cases and any relevant data gathered from the data review conducted. If in the course of case and contact investigation DIS suspect that a potential cluster exists, they discuss the details with the supervisor and inform surveillance.

External Partners*:* A medical or community-based provider or a community partner can report a concerning HIV trend, potential HIV cases or transmission clusters by calling the MDH IDEPC Division or reporting the situation to a Section employee. A detailed process for reporting and responding to concerns is described in *Appendix 8 (Process for responding to HIV concerns reported by community partners).* An internal form for documenting reports from providers and community partners is available in *Appendix 9 (Concern for Trend in New HIV cases Report).* The PCLS program responds to the reports, along with Prevention and Surveillance staff.

Reviewing relevant cluster data

Partner Services data (such as care status, number and type of partner and social contacts, testing and treatment information, risk factors, venues, and interview status) is gathered from record searches in MEDSS, including ELRs, and partner services field and interview records. Data is

recorded by the **PCLS Supervisor** on an outbreak cluster Excel spreadsheet to complement case data gathered by surveillance. The spreadsheet is shared with surveillance and used for cluster investigation and analysis. The spreadsheet is updated weekly, or more often as new information becomes available.

Table 4 provides a summary of the data sources used, who has access, and what type of data and variables are included in each source.

Table 4: Data Elements and Sources

Type of data	Database name	Who has access?	How readily available is it?	Variables included	Notes
HIV	eHARS MEDSS	HIV surveillance/ partner services	Available	All information used for investigations (name, date of diagnosis, risk factors, viral loads/CD4 labs, notes/interviews, acute HIV status)	
Hepatitis C	MEDSS	Hepatitis Unit	Hepatitis team only has access for match with possible HIV outbreak cases	Name, date of birth, date of hepatitis C diagnosis, other notes	Review new HIV cases with no risk factors within people who inject drugs (PWID)-related outbreak regions to determine if they have possible IDU risk factor and should be counted as outbreak cases.
Homeless-ness data	Homeless Management Information System (HMIS)	MDH Senior Advisor on Health, Homelessness, and Housing	Accessible through the Senior Advisor on Health, Homelessness, and Housing, as of Spring 2021	Client-level data and data on the provision of housing and services to homeless individuals and families	Section staff work with the Senior Advisor on Health, Homelessness and Housing to run searches
STD	MEDSS	STD and HIV surveillance	Available	Name, date of birth, date of STD diagnosis, partner services interview	Review for additional risk and partner-related information for outbreak cases.
Partner services data	MEDSS	HIV partner services and surveillance	Available	Risk factors, partners, homelessness, other information related to outbreak	Review for additional risk and partner-related information for outbreak cases.
Vital statistics	Birth certificates/ death certificates	Specialty epidemiologist	Available	Name, date of birth, date of death, cause of death, facility of birth, maternal worksheet (including number of prenatal visits, date of first and last prenatal visit, risk factors, comorbidities)	Review these data sources if information would be useful for a particular outbreak (i.e., related perinatal HIV or pregnant HIV cases) or if an outbreak case died.

Section 4: Review and prioritization of HIV clusters and outbreaks

Process for review and prioritization

Section surveillance and partner service data is reviewed regularly.

- The **PCLS Supervisor** meets with the **DIS** who are conducting cluster investigations on a weekly basis. They discuss the status of investigations and interviews to determine investigative priorities and next steps, if necessary.
- The **Epi & Surveillance Manager, HIV Surveillance Coordinator**, and **Specialty Epidemiologist** meet bi-weekly and may also review outbreak data as part of one-one-one meetings.
- Ad-hoc meetings are scheduled between **Surveillance, PCLS,** and **Prevention Unit staff**. The purpose of these meetings is to discuss the latest cluster investigations updates and determine what additional information is needed and next action steps. During each meeting, the cluster spreadsheet is reviewed and discussed, as well as additional data analyses that are useful for a specific cluster.

Prioritization of clusters

For the time-space analysis, the **Specialty Epidemiologist** uses CDC-provided SAS code to identify areas of concern for HIV cluster outbreaks, which include an overall county or region alert and risk factors related to IDU only and MSM/IDU. The Section has identified the following priority populations: PWID, populations of color, and counties or regions that have a large increase in cases compared to the previous 36 months.

Prioritizing time-space clusters for investigation and intervention

Once time-space clusters have been detected, several factors are considered in prioritizing the clusters for investigation and intervention activities. The **Specialty Epidemiologist** examines the data to determine whether there is evidence that a cluster represents recent and ongoing transmission, or if there are alternative explanations for the increase in diagnoses. The **Specialty Epidemiologist** also includes other staff, including **PCLS DIS**, as needed. Key sources of information for making the determination to investigate a time-space cluster include: the magnitude of increase, information about testing levels (especially recent changes in testing) in the area, demographic information, risk information, presence of early HIV infection, facility of diagnosis, and review of molecular data, when available. Also, partner services interviews are reviewed for all clusters that were identified with an alert status to review if there are any related partners of identified clusters.

Epi & Surveillance staff use the following criteria that to prioritize clusters:

- What is the level of concern?
  - What is the magnitude of increase (absolute and relative)?

    - What population(s) is/are involved in the time-space cluster(s)? Do any of these reflect populations of particular vulnerability, such as PWID? Have there been recent changes in the population of the area?
- Do increased case counts reflect recent increases in infections?
    - Is there evidence that recent diagnoses reflect recent HIV infection?
        - How many stage 0 infections are there?
        - How many diagnoses are acute?
        - How many cases have a self-reported history of a recent negative HIV test?
        - Are there coinfections with other STDs?
        - How many had a high initial viral load (>500,000)?
- Is molecular data available on any of the cases?
    - If so, does molecular analysis indicate the presence of a single transmission cluster?
    - If not, does it show multiple smaller transmission clusters?
- Are there alternative explanations for time-space clusters?
    - Have there been documented increases of HIV diagnoses in this area? If so, consider the following possible alternative explanations:
        - Have there been testing events, population changes, policy changes, or other reasons for increased diagnosis? For example, were a large number identified at testing sites that are new or have dramatically expanded testing? Discussions with HIV Prevention Unit staff (e.g., DIS, field staff, partner services staff) may reveal testing or other prevention initiatives that could have resulted in an increase in diagnoses.
    - Are there any data quality issues that may account for these increases, such as duplicate cases? (Performing a soundex check is recommended.)
    - Were any of the cases previously diagnosed?

Investigating and responding to time-space clusters

All prioritized clusters are investigated. **HIV Epi & Surveillance** and **PCLS staff** review and discuss the data and determine if the information should be discussed with the Management Team. Prevention Unit staff are also be included, as needed.

Investigation efforts for time-space clusters begin with reviewing available data (HIV and STD surveillance, partner services) for the cases that were diagnosed in that county during the previous 12 months. A line list with key variables (transmission mode, gender, race/ethnicity, age, geographic area, care status, initial viral load, and most recent viral load to-date, stage 0 at diagnosis, acute diagnosis, and date of last negative HIV test) is used. The variables are helpful to understand commonalities and potential interventions.

As linkages between cases are identified, or as molecular cluster data becomes available, staff review the data and decide if it is necessary to narrow the investigation to focus on the underlying transmission cluster(s) or broaden it to include other cases that may not have been

identified through time-space analysis but have been identified as part of a molecular cluster. Individuals without HIV sequences may still be a part of the transmission cluster. Defining the transmission cluster and larger risk network, along with common facilities of diagnosis and possible exposure, can provide guidance into which types of interventions would be most useful to interrupt transmission.

PCLS investigates and interviews cases in time-space or molecular clusters according to the following priorities:

- Newly diagnosed cases unaware of their HIV status
- Newly diagnosed cases not interviewed for partner services
- Newly diagnosed cases not linked to HIV medical care
- Previously diagnosed cases with high viral loads
- Previously diagnosed cases in need of re-engagement to HIV medical care

The **Specialty Epidemiologist** reports the results of time-space cluster analysis and response quarterly, with input from the **PCLS Manager** and Prevention Unit staff assigned to the outbreak. The report is completed by using the CDC cluster investigation worksheet for all identified clusters of concern that MDH has determined to be a cluster outbreak that involves an investigation.

Tracking and managing clusters

The tracking and management of clusters happens through the cluster spreadsheet that is maintained by **Epi & Surveillance** and **PCLS staff**. Outcome and disposition of cluster investigations are documented on the spreadsheet. Cases that will remain open for follow-up are noted. Outcome and disposition of sexual/needle-sharing partners and social contacts initiated from interviews conducted by DIS are also documented in a separate spreadsheet.

Closing out clusters

The key consideration in making the decision to close out a cluster will be whether transmission in the cluster has been successfully interrupted. Monitoring of cluster growth and review of cluster outcome data regularly are helpful in making the assessment. Some of the considerations include:

- Has transmission in the cluster been interrupted?
- Are there no or few recent diagnoses (past 6-9 months)?
- Have persons in the transmission cluster without initial evidence of viral suppression been successfully linked to care?
- Have persons in the risk network been tested or re-tested and referred for PrEP?
- Are new diagnoses in the cluster identified through active investigation and intervention activities, such as partner services and testing?
- Does the rate of new diagnoses identified through cluster-focused activities suggest that more testing is warranted to identify undiagnosed HIV-infected persons in the network?

After the alert in the CDC SAS time-space analysis is no longer indicated for a particular cluster outbreak investigation (no or few new cases within 6 months and existing cases not initially virally suppressed are linked to care), the **Surveillance Coordinator**, **HIV Epidemiologist**, and/or **Specialty Epidemiologist** will review the results and additional data for discussion with the ICS team to determine if all 'containment' and services are in place to address HIV within the area of the cluster outbreak that would allow the ICS to step down or lower the response threshold.

When a cluster is closed, the **Specialty Epidemiologist** and **Surveillance Coordinator** will continue to monitor the new cases monthly within the area and previous cases identified as part of the cluster outbreak by reviewing continued HIV care via viral suppression. The **PCLS Supervisor** and **DIS** will continue to monitor new cases within the area and notify HIV surveillance if any of the new HIV cases name partners that were part of the previous cluster outbreak or if there is a new concern for a continuation of the cluster outbreak within the region. **Section staff** will maintain communication with MDH grantees and local service providers within the cluster outbreak area to identify any concerns that may indicate a continuation of the cluster outbreak within the region.

Section 5: Designing and implementing cluster response plans

This section outlines how the Section responds when an HIV cluster is identified, including time-space clusters or molecular clusters.

- Time-space clusters: clusters that occur when the number of people with HIV diagnoses in a particular geographic area is elevated above levels expected given previous patterns.
- Molecular clusters: clusters that occur when a group of persons with diagnosed HIV have genetically similar HIV strains. Because HIV is constantly evolving, persons whose viral strains are genetically similar may be closely related by transmission.

Action planning process

New HIV clusters are identified through monthly time-space analysis, molecular data analysis, through conversations with reporting providers, or via shared contacts named in PCLS investigations. Monthly analysis includes reviewing county/region level alerts and reviewing additional data to determine if an alert needs further discussion. Time-space clusters are confirmed by the Specialty Epidemiologist and molecular clusters are confirmed by the HIV Surveillance Coordinator. When a time-space or molecular cluster is identified, staff notifies the Surveillance Manager.

The **Surveillance Manager** oversees the following initial activities:

- Surveillance staff conducts an in-depth analysis, using surveillance tools (as described in Section 3)
- The PCLS Manager is notified
- Surveillance and PCLS staff schedule a meeting to review the data together

Notification: If the outcome of the surveillance and PLCS meeting results in confirming there is a new HIV cluster, additional staff are notified by the **Surveillance Manager or designee**:

- Section Manager

- Section Management Team
- District Epidemiologist responsible for the area of concern
- Senior Advisor on Health, Homelessness, and Housing (as appropriate)
- IDEPC Tribal Liaison (as appropriate)

Depending on the results of the analysis, staff from other units are notified and involved in cluster response activities as appropriate, including PCLS, Prevention, and/or Planning & Improvement staff.

Cluster Response Activities*:* The following activities are completed by designated staff for the current cluster:

- Bi-weekly monitoring of epi and surveillance data
- Weekly PCLS reviews of DIS and PCLS data
- Cluster spreadsheet is created and monitoring by Epi and PCLS staff
- Ongoing surveillance and PCLS meetings to review and discuss data
- Communication with District Epidemiologists, as needed
- Quarterly cluster reports initiated and sent to CDC (CDC cluster investigation worksheet)
- Contact with local grantees and service providers to explore what they are seeing in the community

Other PCLS, prevention, testing, education, communication, and/or planning activities are initiated, depending on the needs and scope of cluster.

Data to guide cluster response

When a cluster is identified, the time-space analysis will be reviewed bi-weekly for additional new cases. **HIV surveillance staff** monitor new cases for possible cluster-related criteria, including county of residence, risk in case definition, review of co-infection with hepatitis C if PWID are included in the case definition, as well as other co-infections that are related to the case definition, such as syphilis or TB. If a new case is determined to be a possible case in the current cluster, the **PCLS Manager and staff** will be notified upon assignment from surveillance staff and the possible new case will be prioritized for partner services investigation. Additional data from other sources that are relevant to the cluster will be reviewed or matched with new possible cases and existing cases for a better understanding of the cluster. The **HIV Laboratory Epidemiologist** and/or **HIV Surveillance Coordinator** will review molecular data for additional cases that are determined to be part of a cluster and notify **HIV surveillance and PCLS staff** for further investigation.

Investigation approaches*:* MDH grantees and/or outreach workers involved in testing and linkage to care efforts use a modified case interview form to document partner and social contact names, locating and demographic information. The form is sent to the **PCLS Supervisor** who reviews the completed form and initiates any partners and contacts to DIS for investigation. HIV surveillance staff and DIS staff also have access to several provider EMR systems for medical chart abstractions.

Directing/re-directing routine program activities for cluster response

Partner services

Newly diagnosed and previously diagnosed HIV cases who are not in care or virally suppressed or who have not received partner services are assigned by the **PCLS Supervisor** to **DIS** for interview and linkage to care.

HIV cases in transmission clusters are prioritized for data-to-care activities. Re-engagement priorities will include:

- Persons who have no evidence of care ever
- Persons who have no evidence of care within the last 12 months
- Persons who are not currently virally suppressed

Sexual and needle sharing partners are prioritized over social contacts.

HIV care interventions

DIS will refer cases that are not in care to the medical provider of the client's choice. If the client does not have a provider, the client is referred to the Positive Care Center (PCC). The Positive Care Center is part of **Hennepin Healthcare** and is specifically designed for PWH. They have a rapid access program that allows for almost same day appointments. A case manager works to resolve barriers and challenges that may prevent the client from staying engaged in care.

When necessary, DIS will provide case follow-up over time to ensure that cases who may need motivation or assistance to stay in care do can stay in care to achieve viral suppression.

Incentivizing different aspects of the linkage, re-engagement and retention in care are provided as needed and as funding is available.

HIV testing and PrEP

Prevention Unit staff provide increased HIV testing and outreach in the target population identified by the cluster as high risk for HIV infection. Community-based organizations best suited to work within the target population, as well as two MDH-funded clinical PrEP programs, may be asked to create and/or host more testing events, increase PrEP referrals, and raise awareness of the cluster through communication channels such as social media, print and word of mouth. Additional testing models may be explored and encouraged, such as home self-testing (via mail or delivery) and rapid-rapid field testing. Additional partnerships may also be explored and implemented, such as training/supporting other well-placed service providers (street outreach staff, housing navigators, ER providers, pharmacies, community clinics, harm reduction providers) to provide rapid HIV testing and rapid referrals to care and other HIV prevention services such as PrEP, PEP, harm reduction services.

Harm reduction

Improving harm reduction services is accomplished by increasing access to SSPs, HIV testing, PrEP, and PEP services. During an identified cluster, Prevention Unit staff communicate with

MDH grantees and provides guidance as needed to assist with coordinating a response. This may include but is not limited to, expanding agency service hours, adapting grantee work plans (i.e., increasing supplies and HIV testing, expanding service areas, as well as directing resources for incentives). Harm reduction is also obtained through HCV and HIV testing and linkage to care, chemical dependency treatment referral, and naloxone distribution. High risk individuals will be identified by HIV testing grantees and be referred for PEP and PrEP services. In addition, the Section continually seeks opportunities to partner with local public health, and external organizations for extended reach into areas where clusters develop. One example would be exploring relationships with pharmacies to expand HIV testing, build relationships and raising awareness of harm reduction as a public health partnership opportunity.

Social services

PCLS staff refers clients to case management services for assessment of client needs and assistance in linking to the appropriate social services. This may include referring to the Minnesota AIDSLine, an HIV resource guide.

MDH grantees are required to develop and maintain a referral list to be used by program staff to ensure rapid linkage to essential support services. The referral list includes community resources, such as HIV testing, PrEP, food support, transportation, housing, mental health, services for chemical dependency and others. During a cluster response, MDH will also work with Local Public Health, MDH District Epidemiologist, and external partners to identify social services in the cluster area.

Options for enhanced interventions

Section staff may also consider using additional interventions to target gaps in response to clusters (or outbreaks), including but not limited to:

- Providing gift cards to MDH grantees and providers doing outreach to incentivize testing and linkage to care
- Providing syringe service supplies to MDH grantee and non-grantees working with impacted communities
- Providing guidance and support to outreach workers performing HIV testing in community settings or encampments
- Trainings for service providers providing outbreak-related testing in communities most impacted
- Specialized HIV testing trainings for organizations that interface with communities most impacted by the outbreak
- Interventions that pay or incentivize “gatekeepers” or individuals that are part of impacted communities to recruit people who are at-risk
- Community engagement activities to find out what other interventions impacted communities recommend

Communications planning

Two **IDEPC communications staff** are assigned to the Section to provide guidance, support, and assistance with communication activities. Communications staff work with the Section Manager and other Section staff to develop communications messages for routine data releases, awareness campaigns, and ad hoc communication needs. Communications staff may also help create news releases that engage the public and media. This includes fielding media requests, developing talking points, and identifying relevant subject matter experts to respond to inquiries. Additional communications activities may be conducted in response to HIV clusters, as needed. Planning for communications activities includes identifying:

- Communication goals
- Primary audience and secondary audience
- Key messages or content
- Communications platforms or tools for dissemination

The following routine communications activities are used to share HIV data with partners and the community:

- **STD/HIV/TB data release**: annual data release via a webinar, including HIV data trends and epidemiological details
- **GovDelivery messages**: regular coordinated email updates with subscribers
- **Community events**: tabling or other opportunities to share information in-person, when allowable. During the COVID-19 pandemic, virtual events have begun to replace community events, although word of mouth, prior relationships and grant manager communication remain important
- **Data and presentation request**: tailored data requests made through the MDH website for specific partners' data needs
- **Social media**: HIV-related information from MDH and partners
- **Messaging campaigns**: working with vendors to establish and disseminate messaging campaigns

Section 6: Implementing an escalated response

The following section outlines the Section's process for declaring an HIV outbreak, initiating ICS, and implementing ICS activities.

The Section transitions to an escalated response by declaring an outbreak and initiating ICS at the Section level. ICS may be expanded if staff and resources from other IDEPC sections, local jurisdictions, states, and/or the CDC are needed. An expanded ICS response may also occur when the magnitude of the outbreak extends across multiple counties, and/or includes tribal nations or other states.

Initiating ICS, an escalated response

Declaring an outbreak

The process for declaring an HIV outbreak involves a collaborative approach with staff from surveillance, PCLS, district epidemiologists, and the management team. After the initial month an HIV cluster is identified, data is regularly monitored and reviewed (as mentioned in Section 5) to determine if an outbreak should be declared.

Criteria used to declare an outbreak includes following:

- Results of epi data using the two standard deviation methodology indicates rapid transmission for 2 or more months
- How rapidly transmission is occurring (number of acute cases reported)
- Relatedness of the cases
- Size of the population among a certain geographic and/or risk population
- Signs of existing socioeconomic and/or health disparities in the impacted community
- Common risk behaviors among infected individuals
- Community concern
- Following discussions and/or investigations, the **Section Manager** will determine if an escalated response is warranted

The **Section Manager** is responsible for declaring an outbreak in coordination with the Section Management Team, surveillance staff, PCLS staff and district epi. If the investigation results in declaring an outbreak, the **Section Manager**:

- Initiates the Section's ICS process to manage the outbreak response
- Informs the IDEPC Division Director and Assistant Director
- Informs the CDC Project Officer

Notification

When an outbreak is declared, key Section and IDEPC Division staff are notified. The **HIV Surveillance Coordinator** will inform the Epi & Surveillance Manager, PCLS Manager, Section Manager and Assistant Section Manager. The **Section Manager** is responsible for informing the IDEPC Division Director, IDEPC Assistant Division Director, Medical Director, and Communications Unit Supervisor of the suspected outbreak. The **Section Manager** also notifies the CDC and other external partners, as needed.

Escalated response options

Initiating the Section ICS outbreak response

After an outbreak is declared, the **Section Manager** assigns staff to the Section ICS outbreak response team. The **Section Manager** will also work with the **Assistant Section Manager** to determine what funding streams may be used to address needed resources. Funding streams

may include HIV prevention, Ryan White, state funding, and others. Other staff which may be assigned include:

- Communications Unit staff
- Epi & Surveillance Manager
- PCLS Manager
- Prevention Unit staff
- Planning & Evaluation Coordinator
- Planning & Evaluation Specialist
- Local Public Health
- IDEPC Medical Director
- Infectious Disease American Indian Liaison (as needed)
- In addition to Section staff, the **Section Manager** informs the DHS HIV Manager and invites them to participate on the ICS outbreak response team.

See Appendix 10 for ICS structure chart template. See Appendix 11 for roles and responsibilities table.

The ICS outbreak response team supports communications planning efforts, monitors response activities, coordinates across programs, identifies gaps, troubleshoots issues, and performs other relevant activities. Specific ICS activities and responsibilities include:

- Create a case definition for confirmed, probable, and possible cases
- Identify the ICS goals, objectives, activities, and measures
- Develop an org chart and define roles and responsibilities
- Work with the Communications Unit to prepare a media release regarding the outbreak; an advisory will be distributed to providers statewide or geographically targeted via the Health Alert Network (HAN).
- Identify the type of media and messaging needed to inform partner agencies and the community (with consideration of the affected community's cultural or language barriers)
- Discuss the resources needed to respond
- Identify roles for investigating the suspected outbreak
- Identify a schedule for completing the investigation and updating the team
- Monitor data from surveillance and partner services
- Create and support a HOPE group
- Attend ongoing monthly meetings with CDC

The ICS outbreak response team meets during recurring meetings to share epi updates, provide updates on response activities, and clarify next steps (*see Appendix 12 for sample agenda template*). The HIV Outbreak Tracker is used to identify, monitor, and track action steps (*see*

Appendix 13 for outbreak tracker template). Other deliverables include an ICS organizational chart, a communication plan, and an ICS team meeting schedule.

Throughout the response, the **Section Manager** maintains communication with and provides regular updates on response activities to the following:

- CDC Project Officer
- IDEPC Director
- DHS HIV Manager
- HCPH Ryan White Manager

Section staff work with partners to assess needs. Interventions are added or expanded to address identified gaps (also included in Section 5), as needed. These interventions may include:

- Providing gift cards to MDH grantees and providers doing outreach to incentivize testing and linkage to care
- Providing syringe service supplies to MDH grantee and non-grantees working with impacted communities
- Providing guidance and support to outreach workers performing HIV testing in community settings and encampments
- Trainings for service providers providing outbreak-related testing in communities most impacted
- Specialized HIV testing trainings for organizations that interface with communities most impacted by the outbreak
- Interventions that pay or incentivize "gatekeepers" or individuals that are part of impacted communities to recruit people who are at-risk

Data to guide an ICS outbreak response

Epi and surveillance data and PCLS data are analyzed throughout the ICS outbreak response. Data is reviewed bi-weekly, and alerts are investigated by surveillance and PCLS staff. Newly identified cases that meet the outbreak case criteria from either the time-space analyses, molecular analyses, and/or partner services investigations are discussed at the bi-weekly meetings to determine if the new cases should be added to the outbreak case count. Additional ad-hoc meetings are used to review data with Surveillance, PCLS, and Prevention Unit staff, as needed. Updated case counts and other outbreak data is shared during recurring ICS meetings, monthly Section Management Team meetings, and meetings with LPH partners.

Time-space analysis*:* During a declared cluster outbreak, the time-space analysis is reviewed bi-weekly for additional new cases, using CDC provided time-space analysis SAS code. **HIV Surveillance Data Manager** monitor new cases for possible outbreak-related criteria (county of residence, risk in case definition, review of co-infection with hepatitis C if PWID are included in the case definition, as well as other co-infections that are related to the case definitions, such as syphilis or TB). If a newly reported case is determined to be a possible case in the current cluster outbreak, the **PCLS Manager and staff** is notified by the **HIV Surveillance Data Manager**

and the possible new case will be prioritized for partner services investigation. Additional data from other sources that are relevant to the outbreak will be reviewed or matched with new possible cases and existing cases for a better understanding of the cluster outbreak.

Molecular analysis*:* The **HIV Laboratory Epidemiologist** and **HIV Surveillance Coordinator** review molecular data every two weeks for additional cases that are determined to be part of a cluster outbreak and notify **HIV surveillance and PCLS staff** for further investigation (additional cases are linked to existing outbreak cases within threshold <=0.5% genetic distance, with potential for expansion of threshold to 1.5% pending discussion of supporting criteria). Cases that cluster with existing outbreak cases beyond the outbreak threshold for genetic distance, but within 1.5% will be monitored through routine evaluation.

Surveillance staff will ensure that molecular data is obtained when available. Staff reviews previously identified outbreak cases without molecular data and request that data from providers, if available.

In addition, bi-weekly meetings are held with MDH, DHS Ryan White Part B manager, HCPH Ryan White Part A manager and local public health staff, as appropriate. Updated case counts and individual level data, as permitted by data sharing agreements and/or Commissioner's Orders, are provided to designated authorities representing the population/geography affected. Section staff, including the Section Manager and staff on the ICS outbreak response team, share epi updates and data management questions during ongoing discussions with CDC staff regarding outbreak activities.

An expanded ICS response

The ICS outbreak response may be expanded outside of the Section to include more IDEPC staff under the following circumstances:

- The ICS response has exhausted current Section staff capacity
- The outbreak spans over multiple counties or geographic regions and requires coordination with multiple jurisdictions
- The outbreak includes tribal nations and/or extends beyond Minnesota and the ICS response requires coordination with other states

If the outbreak response is expanded, the **Section Manager** will work with the IDEPC Division Director and Assistant Division Director to expand the response using the Section ICS team. The IDEPC Division Director informs the Assistant Commissioner, who will inform the Commissioner. The Section Manager continues as the Incident Manager. Additional roles may be added to the ICS structure, as needed, such as a Logistics Lead.

Initial activities during an expanded ICS outbreak response may include:

- Identifying a Logistics Lead to manage staffing
- Reaching out to identified partners stakeholders (e.g., IDEPC staff, states, local jurisdictions, tribal nations, etc.)
- Providing a situation update and training for new staff and partners
- Establishing joint meetings and/or communication channels between key stakeholders

- Coordinating ICS responses between MDH and other jurisdictions
- Updating the goals, measures, and indicators for the response

Funding

If additional funds are needed during an escalated response, the ICS Financial Lead and Section Manager would first look at current spending on the federal HIV surveillance and prevention grant to identify whether there are salary savings or underspending in other areas that would allow for re-distribution of funds towards the response. If not, they would then look at general funds, first at the Section level and then at the Division level, to identify the amount that could be used to support the response. If the use of Ryan White funds would be appropriate, they will also approach the Part A and/or Part B Ryan White managers (depending on the geographic area of the outbreak) to determine whether funds are available.

Deactivation and transition back to routine program oversight

As mentioned in Section 5, the STD/HIV/TB Section continues to develop the process for ending an ICS outbreak response. Key considerations for ending an outbreak response will include monitoring surveillance data, partner services data, and response activities. The Section will refer to CDC guidance[5] for determining when a cluster or outbreak response should be closed, which includes the following considerations:

- Has transmission been interrupted or is it ongoing?
- Have persons in the transmission cluster without initial evidence of viral suppression been successfully linked to care?
- Have persons in the risk network been tested or re-tested and referred for PrEP?
- Are new diagnoses in the cluster identified through active investigation and intervention activities, such as partner services and testing?
- Does the rate of new diagnoses identified through cluster-focused testing activities suggest that more testing is warranted to identify undiagnosed HIV-infected persons in the network?

Ending an ICS outbreak response may also include identifying more specific procedures, action steps, benchmarks, etc. The **Section Manager** will oversee steps to deactivate the escalated response and transition back to routine program oversite. Ongoing epi and PCLS data monitoring will continue following deactivation.

Communicating during an escalated response

During an outbreak, the **IDEPC Communications Staff** work with the **Section Manager** and ICS outbreak response team members to develop a communications plan for the specific needs of the outbreak. This communication includes the **Section Manager** informing the **IDEPC Division Director** that an escalated response has been activated. The **IDEPC Division Director** will then

[5] Detecting and Responding to HIV Transmission Clusters: A Guide for Health Departments, June 2018, Draft Version 2.0, page 49-50

communicate this to the **Commissioner of Health.** Communications staff and members of the ICS outbreak response team develop outbreak talking points. Talking points may include:

- Key messages about the outbreak
- Frequently Asked Questions
- Recommendations for providers

During the outbreak response, timely and flexible communication with key audiences is essential. These audiences include:

- **CDC***:* The **Section Manager** notifies CDC when an outbreak is declared, and of any updates and changes in the response. Section staff participate in regular meetings with CDC project officers, which provide a place to give updates, troubleshoot, and request assistance.
- **LPH***:* Section staff share information with LPH in the outbreak region and participate in regular meetings with LPH involved in responding to an outbreak. Statewide, LPH is informed of outbreaks through the PartnerLink messaging system and the HAN network.
- **Minnesota Tribes***:* The **Section Manager** notifies the American Indian Health Director and Infectious Disease American Indian Liaison of updates and changes. The **Infectious Disease American Indian Liaison** provides consultation and leads partnerships with Minnesota Tribal Nations. The **Section Manager** participates in Tribal Directors calls or meetings to provide information, as needed and requested.
- **MDH Grantees***:* Email notifications are sent to MDH grantees on a regular basis. Section staff convene monthly HIV grantee calls, which provide a place to give updates, ask grantees to share, and communicate any changes.
- **Community partners***:* Section staff have relationships with other agencies and community partners from previous projects that have historically helped create and share relevant HIV prevention messages.
- **General public***:* MDH's website is reviewed weekly for broken links and errors. Social media is a place where MDH can share HIV prevention content or create its own.

In addition to the routine communication activities (as listed under Section 5.V), information about the HIV outbreak, and other HIV data, is shared using the following methods:

- **Health Alert Network***:* official mass messages with action steps from MDH to health jurisdictions
- **PartnerLink System***:* a messaging system that allows MDH to send messages to Tribal Health and LPH
- **Monthly GovDelivery messages***:* regular coordinated HIV outbreak updates via email
- **MDH HIV Outbreak Response and Case Counts webpage***:* updated case definitions, case counts, action steps and resources
- **Monthly HIV grantee call***:* calls where Section staff share updates and information with grantees
- **Presentations at the Tribal Health Directors quarterly meeting***:* updates and information sharing with Tribal leaders when invited or when MDH asks to attend

- **LPH calls***:* recurring calls with Section staff and LPH
- **Communications materials**: Through development and distribution based off needs and requests of external partners, including HOPE

Information may also be shared during inter-jurisdictional communication opportunities as needed for peer learning and consultation. Examples of this may include calls with CDC and other states, the National Coalition of STD Directors (NCSD) communication roundtable, etc.

The ICS outbreak response team and communications staff will work with other jurisdictions that become involved in the response. This may include updating the current communications plan and key talking points and coordinating communication efforts.

During the Section ICS response activities, the Section holds regular meetings for information sharing and coordination. Regular epi updates and response activity updates are provided.

Staff training for escalated response

All IDEPC staff complete required MDH trainings, and STD/HIV/TB staff complete additional training for the Section and related job responsibilities (see Section 1).

Section managers promote additional professional development opportunities, as offered by MDH, CDC, and other national organizations (such as National Alliance of State and Territorial AIDS Directors [NASTAD], or the Harm Reduction Coalition). Topics may include information related to HIV prevention services, outbreak response, and other related topics. The Section may also utilize the CBA Jurisdictional Team for specific training needs.

At this time, there are no plans for including non-HIV program staff to provide DIS or other staff support during an escalated response. If IDEPC Division staff are included in the response, they will have completed required MDH trainings. In addition, they will be given a situation update and overview of the outbreak and an assessment of additional training needs will be made on a case-by-case basis.

Section 7: Monitoring and evaluation of cluster response activities

Monitoring a cluster or outbreak response

Process for tracking and reporting outcomes required under PS18-1802

An outbreak-specific spreadsheet is maintained by **Epi & Surveillance** and **PCLS staff** and saved in a secure folder with role-based access. The spreadsheet is reviewed every two weeks. During each case meeting, the definition in a declared outbreak, diagnostic dates, status of infection (HIV or AIDS, acute or non-acute), linkage to care, labs, viral suppression information and referrals for contacts are tracked and documented per case. Cases for whom there may be a link to an outbreak are maintained in separate tabs on the spreadsheet and are relocated to the active outbreak case tab if found to have a connection within the outbreak case definition.

Quarterly cluster investigation reports (initial and updates) to CDC are completed by the **HIV Surveillance Coordinator, Specialty Epidemiologist,** and **PCLS Manager** and are uploaded via

SAMS. Summaries of key demographics are prepared and updated monthly by the **Specialty Epidemiologist** using and HIV Cluster Table Shell template provided by CDC, which are used for internal use as well as communicating updates with CDC regarding the evolving distribution of cases in ongoing MDH outbreak(s).

Monitoring tools

The monitoring tools Epi & Surveillance staff uses includes CDC-provided SAS code, Microbe Trace, and Secure HIV-TRACE.

CDC-provided SAS code for time-space analyses is run monthly by the **Specialty Epidemiologist** when not in an outbreak, or at least bi-weekly during an outbreak response and for which modifications are made to group geography relevant to the defined case definitions, and monthly when conducting routine monitoring. Aggregate counts compared to previous rolling 12-month time frames for the last 3 years, and any resulting line lists for cases in regions triggering an alert in the time-space analyses are maintained in a secure folder and reviewed bi-weekly by the Epi/Partner Services/Prevention small group when in an escalated response, and monthly by division management team for routine monitoring.

Molecular data is also analyzed at least monthly during routine monitoring, and bi-weekly during an escalated response, using Microbe Trace and Secure HIV-TRACE lead by the **HIV Surveillance Coordinator** in collaboration with the **HIV Laboratory Epidemiologist**.

Both time-space and molecular data is shared monthly with the Section management team, as well as during monthly calls with CDC concerning the outbreak response and/or with project officers as scheduled.

Line lists of cases included in each outbreak are maintained on a secure drive and reviewed among a subgroup of prevention, PCLS, and surveillance staff at meetings held bi-weekly in advance of full ICS meetings. Additional tabs on the spreadsheet are maintained with suspect cases and other cases of potential interest that do not currently meet the working case definition but may have characteristics that we want to continue to monitor. As new cases are added, a Word document summarizing key demographics of the outbreak are updated.

Process for reporting cluster response activities to CDC via cluster report forms

PCLS, Prevention, and Surveillance staff collaborate to complete the cluster report forms for submission to CDC. Multiple surveillance staff have access to the proper CDC Secure Access Management Services (SAMS) folder and submit quarterly and end-of-year reports according to the appropriate deadline.

Evaluation of cluster and outbreak response

Description how data elements, staff experiences, and other input are brought together to learn and improve in future responses.

In addition to surveillance data, the Section uses quantitative and qualitative data to monitor cluster and outbreak response activities. The Section maintains a list of potential measures, consisting of Section data that is currently collected and available, to help in identifying measures for specific outbreak response activities (*see Appendix 14*).

When an outbreak is declared, outbreak response goals and response activity measures are identified, with support from the **Planning & Evaluation Specialist**. Outbreak measures include outputs and outcomes related to the response activities that are implemented to reach the outbreak goals (this is in addition to surveillance data). Goals and measures are documented and shared with the ICS team.

Throughout the outbreak response, Section staff document response activities using the following:

- ICS outbreak tracker: identifies action steps, timelines, staff lead, and status
- ICS meeting notes: documents attendees, epi and activity updates, decisions, and next steps
- Other related meeting notes: documents attendees, updates, decisions, and next steps
- Epi data: data summaries, epi curve, etc.
- Outbreak response activities measures spreadsheet: quantitative and qualitative internal data summaries
- Communication plan and updates
- Other specific response activities will be documented, as identified

The following ongoing activities offer real-time opportunities to make adjustments and changes, as needed:

- Recurring ICS meetings: standing agenda items include epi updates and response activity updates providing a time to identifying gaps and challenges that need to be address.
- Monthly ICS outbreak tracker reviews: the ICS Operations Lead monitors the tracker to follow-up on activities that are ongoing or past due, adding new activities, as needed, etc.
- Monthly Management Team meetings: managers review and monitor data monthly, and use data to add/modify response activities, as needed.

Quarterly “mid-point” evaluation

The **Planning & Evaluation Specialist** works with the Section Manager and other staff to conducts a “mid-point” evaluation (done either quarterly or bi-annually), to assess the outbreak response. The purpose of a mid-point evaluations is to: 1) assess the current response to make timely adjustments and changes, and 2) provide additional documentation for the overall evaluation of the outbreak, once the outbreak response is over. Both qualitative and quantitative data is used.

Mid-point evaluation activities may include one or more of the following:

- A simplified debrief meeting, or check-in, with ICS team members, HOPE group members, and other partners actively engaged in outbreak activities
- A survey for the ICS staff team members, HOPE team members, and other partners (including internal and external partners)
- Review and assessment of ICS outbreak tracker activities
- Review of outbreak goals and measures, including response activities data

The **Planning & Evaluation Specialist** compiles data from the mid-point evaluation into a written summary or report and shares it with the Section Manager, Management Team, and ICS Response Team. Section Staff review the data and discuss the results during a meeting, which may include the MT meeting, ICS meeting, and/or another ad-hoc meeting. During the meeting discussion, staff will 1) assess the progress for meeting the outbreak response goals, 2) discuss how to address any gaps or challenges that are identified, and 3) add or adjust outbreak goals and response activities.

Evaluating an overall response to a cluster or outbreak

An overall evaluation will take place when an outbreak has been disrupted and the response activities end or transition to regular program activities. The **Section Manager** and other Section managers/supervisors will work with staff from the **Planning & Improvement Unit** to conduct the evaluation. The purpose of the evaluation is to learn from the response and use that information to inform strategies for future cluster activities, including identification, responding, and monitoring.

Overall evaluation activities may include one or more of the following:

- Debrief meeting with everyone included in the response (including Section staff, MDH staff, local jurisdictions, CBOs, and other internal or external partners)
- One-on-one interviews
- Focus groups
- Survey
- Reviewing goals, indicators, and measures

Evaluation steps include:

- The **Section Manager** will assign a core team to oversee the evaluation, led by the **Planning & Evaluation Specialist**
  - The core team will identify the key evaluation questions (e.g., what worked well, what did not work, what could be improved) and make an evaluation plan for collecting input
- Data collection
  - Conduct debriefs with ICS team and partners
  - Collect input from staff and partners through survey, interviews, etc.
  - Compile response activity measures data
  - Collect other qualitative and quantitative data related to response activities
- Analysis
  - Review and analyze all input and compiled data with core team
  - Identify themes, key findings, and recommendations
  - Summarize findings and write preliminary evaluation report
- Review and discussion

  - Share findings with Management Team, key staff, and partners
  - Hold meeting(s) to review and discuss findings and recommendations
- Implementation and follow-up
  - Identify next steps
  - Create a work plan to address report findings and recommendations
  - Report back to partners and stakeholder, how their input will be used
  - Use findings from report to update relevant sections of the HIV CODR

Annual review

Following the submission of the HIV CODR to the CDC in March 2021, Section staff, including the **Section Manager**, **Management Team**, and a **planner from the Planning & Improvement Unit**, will evaluate the HIV CODR annually and as timely updates are identified.

The annual review will consider updated guidance from CDC, recommendations from outbreak evaluations, key stakeholder input (e.g., Provider Professional Development Day presentations feedback, END HIV MN Advisory Board, etc.), and best practice research.

Proposed revisions to the plan will be approved by the Section Manager and Management Team.

Process for refining routine processes based on evaluation and effectiveness findings

As routine processes are evaluated, findings are shared with the Section Manager and the Section Management Team who develop a plan for addressing the findings. The respective Section managers/supervisors responsible for the implementing the changes work with key staff involved. A planner from the Planning & Improvement Unit will assist, as needed.

Acronyms/Glossary

Acronyms

- CDC: Centers for Disease Control and Prevention
- DHS: Minnesota Department of Human Services
- ELR: Electronic Lab Reports or Electronic Lab Reporting
- HAN: Health Alert Network
- HCPH: Hennepin County Public Health
- HIV: Human Immunodeficiency Virus
- HIV CODR: HIV Cluster and Outbreak Detection and Response
- HOPE: HIV Outbreak Public Engagement
- ICS: Incident Command System
- IDEPC: Infectious Disease Epidemiology, Prevention and Control
- IDU: Injection Drug Use
- LPH: Local Public Health
- MATEC: Midwest AIDS Training & Education Center
- MDH: Minnesota Department of Health
- MSM: Men who have Sex with Men
- PCLS: Partner and Care Link Services
- PWH: People with HIV/AIDS
- PrEP: Pre-Exposure Prophylaxis
- PEP: Post-Exposure Prophylaxis
- PWID: People Who Inject Drugs
- SSN: Syringe Services Network
- SSP: Syringe Services Program
- STD: Sexually Transmitted Disease
- TB: Tuberculosis

Glossary

- **AIDS service organization (ASO)**: A non-governmental organization that provides services related to the prevention and treatment of HIV/AIDS.
- **Clusters**:
  - **Transmission Cluster**: A group of PWH who are connected by HIV transmission. Source: *Detecting and Responding to HIV Transmission Clusters: A Guide for Health Departments*, page 6.
  - **Molecular Cluster**: A group of persons with diagnosed HIV infection who have genetically similar HIV strains. Because HIV is constantly evolving, persons whose viral strains are genetically similar may be closely related by transmission. Source: Detecting and *Responding to HIV Transmission Clusters: A Guide for Health Departments*, page 7.
  - **Time-space Cluster**: Occurs when the number of people with HIV diagnoses in a particular geographic area is elevated above levels expected given previous patterns. Time-space clusters may represent recent and ongoing HIV transmission. In some cases, time-space clusters may reflect transmission clusters that have not yet been identified through molecular data or other approaches. Time-space increases may indicate a single transmission cluster or multiple, smaller transmission clusters, both of which are important to investigate for prevention interventions. Increases in the number of diagnoses may also reflect an increase in HIV testing that has identified longstanding infections, which can also indicate a need for focused prevention efforts. Following the identification of time-space clusters, the review of additional data is important to determine whether investigations and interventions are needed. Source: *Detecting and Responding to HIV Transmission Clusters: A Guide for Health Departments*, page 10-11.
- **Grantee**: An organization funded by MDH, HCPH and/or DHS to provide prevention services, including HIV counseling and testing to populations that are hard to reach and at high risk for transmitting or acquiring HIV, essential medical care, and support services for people at risk of HIV or PWH, or other related services (such as syringe service programs.)
- **Outbreak**: The term outbreak can be used in different ways. While a textbook definition of an outbreak is "an increase, often sudden, above what is normally expected in that population or area," the term is often used to describe situations in which an urgent or emergency level public health response is needed. Determining whether an increase in HIV diagnoses or the identification of a transmission cluster warrants an escalated response is an iterative process, and multiple factors are considered.[6]
- **Providers**: Non-funded organizations providing health and social services
  - **Harm reduction service providers**: syringe exchange, overdose prevention, and other harm reduction providers.
  - **Health care providers**: provider of health care services, including testing and linkage to care services

[6] Detecting and Responding to HIV Transmission Clusters: A Guide for Health Departments, page 61

  - **Mental health and substance use providers**: provider of services for mental health and well-being and substance use disorders
  - **Social service providers**: provider of social services, including housing, food, and other basic needs.
- **Public**: Any individual or group of individuals, or organization with an interest in the outcome of a decision. They may be directly or indirectly affected by the outcome of a decision. Also referred to as stakeholders.[7] This includes people who can influence a decision as well as those affected by it.[8]
- **Public Engagement**: The process of working collaboratively with groups of people who are affiliated by geographic proximity, special interests, or similar situations with respect to issues affecting their well-being.[9] It is the process of involving individuals or groups of people in addressing issues that affect their lives or well-being. Engagement types vary from sharing information to influencing decision-making. It should go beyond informing individuals and communities about issues and services of concern to them to asking them for input. It should include ongoing relationships and community involvement in the development and implementation of both services and polities.[10]
- **Section**: STD/HIV/TB Section located in the IDEPC Division at MDH.

Acknowledgements

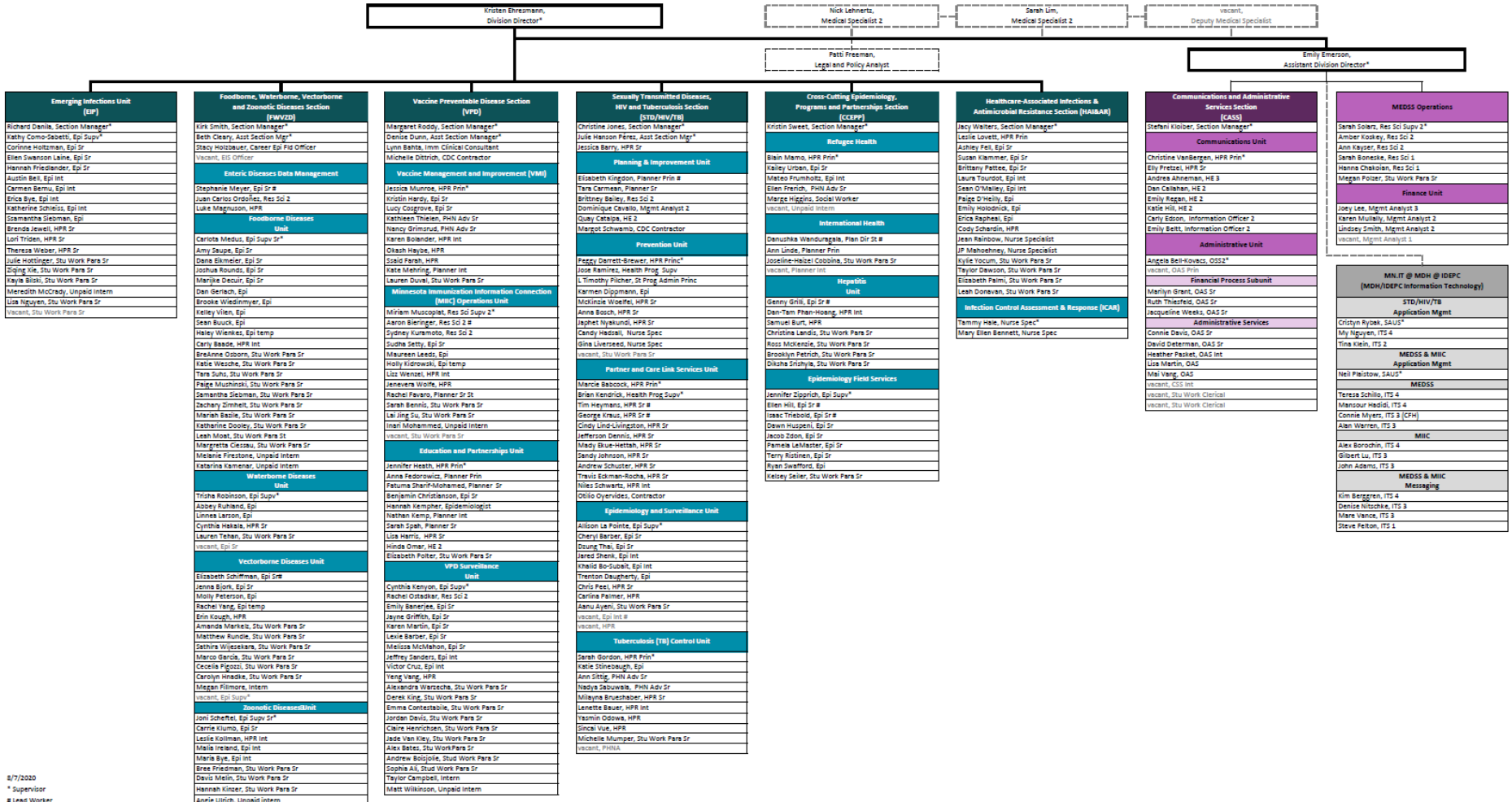
We sincerely appreciate everyone who shared their input, insight, and expertise to create this plan while juggling multiple responsibilities and priorities during the COVID-19 pandemic and racial justice uprisings. We are also deeply grateful for the time and input our community and local public health partners shared to help us continue improving our processes and this plan.

Minnesota Department of Health
STD/HIV/TB Section
651-201-5414
www.health.state.mn.us/hiv

[7] IAP2
[8] Expanding your reach to End the HIV Epidemic: Community Engagement Toolkit, National Minority AIDS Council
[9] Minnesota Department of Health, Community Engagement Plan: 2016-2019, (May 2016), https://www.health.state.mn.us/communities/practice/equityengage/community/docs/ce-plan.pdf
[10] Expanding your reach to End the HIV Epidemic: Community Engagement Toolkit, National Minority AIDS Council

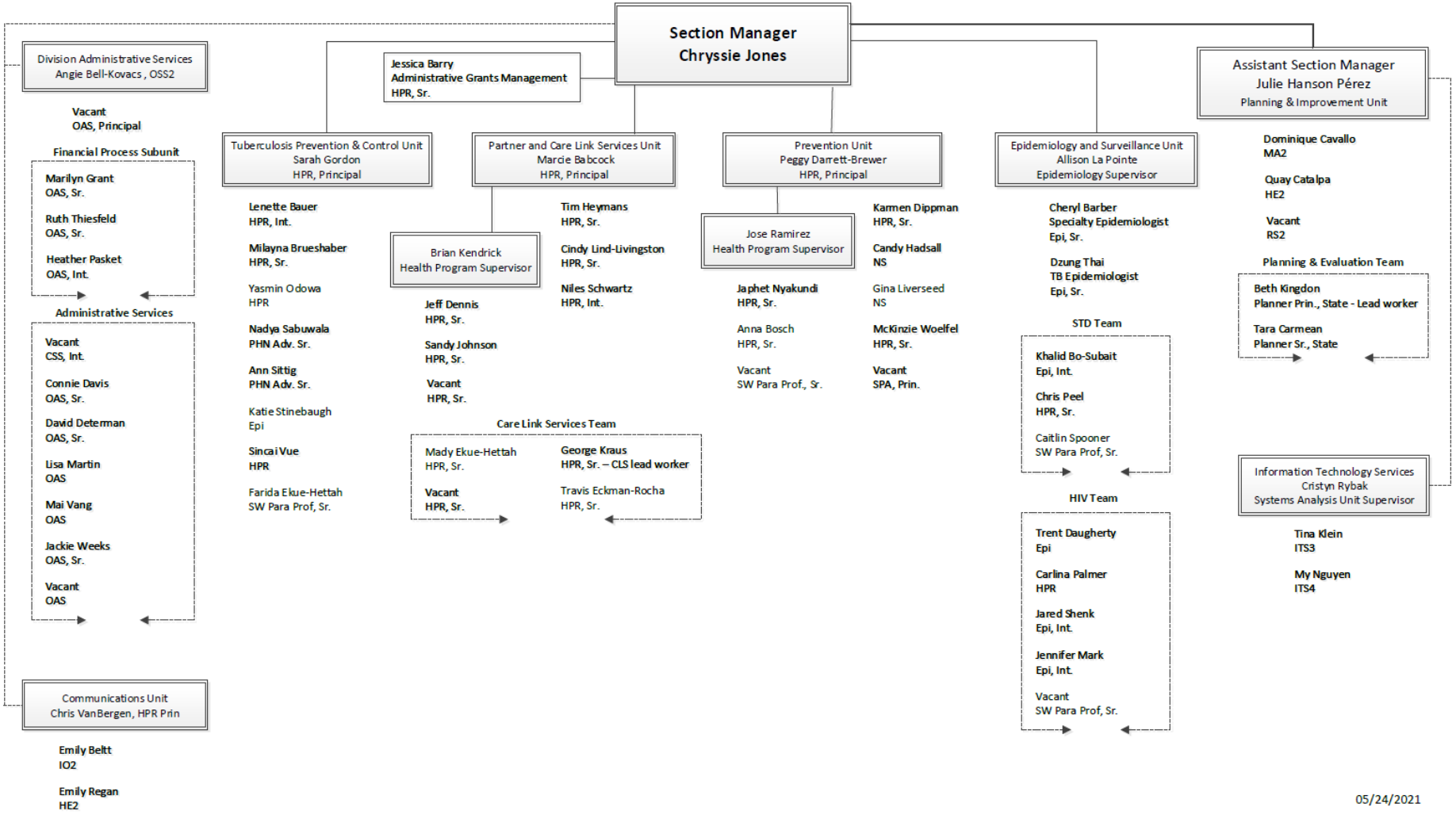
Appendix 1: Organizational chart for the IDEPC Division

Figure 1: IDEPC Organizational Chart



Appendix 2: Organizational chart for the STD/HIV/TB Section

Figure 2: STD/HIV/TB Section Organizational Chart



Appendix 3: HIV CODR staff table

Table 5: Staff Roles in HIV Detection and Response Activities

Staff	**Program** (e.g., Epi, Prevention, Partner Services, etc.)	**Role(s)** (Include all roles staff play during both the detection phase and response activities)	**Program-Specific Trainings** Additional trainings for this role, beyond general MDH or section requirements
STD, HIV, and TB Section Manager	Management	Oversees the management and coordination of detection and response activities	
Assistant Section Manager	Planning & Improvement	Monitors availability of and identifies funding sources for response activities and assists with evaluation activities	
Epidemiology & Surveillance Unit Manager	Epi & Surveillance	Reviews time-space analyses and attends internal ICS meetings, as well as participates in any CDC, local health department, or CSTE discussions concerning ongoing clusters or outbreaks, national or state-specific	National webinars, and technical assistance provided by CDC and/or CSTE
Partner and Care Link Services Unit Manager	Partner and Care Link Services	Assigns and reviews DIS case investigations, hosts weekly check-ins with DIS, updates the cluster spreadsheet with partner and care link services information, maintains ongoing communication with surveillance, and attends internal ICS meetings, as well as participates in CDC discussions concerning ongoing clusters or outbreaks	
Partner and Care Link Services Unit Supervisor	Partner and Care Link Services	Assigns and reviews DIS investigations	
HIV Testing Program Supervisor	Prevention	Provide oversight for HIV testing activities included in response efforts	HIV Testing Training
HIV Testing Coordinator	Prevention	Coordinate response HIV testing activities and serve as key contact for external testing agencies	HIV Testing Training
Planning & Evaluation Specialist	Planning & Improvement	Planning lead for ICS, takes notes and schedules meetings, coordinates CODR development, provides response planning support, assists with planning community engagement in the response, leads evaluation processes.	
Communications Specialist	Communications	Coordinate all communication efforts needed for the response. Work with Department Communications team as needed	
Metro District Epidemiologist	Local Public Health	Serve as the coordinator and liaison between MDH and local public health departments involved in the response	
Surveillance Coordinator	Epi & Surveillance	Serves as primary surveillance liaison to HICSB. Conducts molecular analyses. Participates in MDH ICS outbreak response as well as CDC-sponsored meetings. Presents molecular data to management team monthly	Self-taught trainings for MicrobeTrace and Secure HIV-TRACE. National webinars, and technical assistance provided by CDC and/or CSTE.

Staff	**Program** (e.g., Epi, Prevention, Partner Services, etc.)	**Role(s)** (Include all roles staff play during both the detection phase and response activities)	**Program-Specific Trainings** Additional trainings for this role, beyond general MDH or section requirements
Specialty Epidemiologist	Epi & Surveillance	Runs CDC-provided SAS code to conduct time-space analysis of eHARS data. Participates in MDH ICS outbreak response as well as CDC-sponsored meetings. Presents time-space data to management team monthly. For ICS response, maintains internal spreadsheet to monitor labs and other demographics of cases. Is notified when potential outbreak cases are assigned to partner services.	Attended January 2019 CSTE molecular workshop. Self-taught trainings for MicrobeTrace and Secure HIV-TRACE. National webinars, and technical assistance provided by CDC and/or CSTE
HIV Laboratory Epidemiologist	Epi & Surveillance	Processes all incoming labs through state ELR system and uploads to eHARS. Monitors lab volume and works to incorporate new labs and tests reported to MDH, including MHS data. Assists with molecular analyses. Participates in MDH ICS outbreak response as well as CDC-sponsored meetings. Serves as a back-up to assign cases to partner services.	Self-taught trainings for MicrobeTrace and Secure HIV-TRACE. National webinars, and technical assistance provided by CDC and/or CSTE.
HIV Care and Prevention Epidemiologist	Epi & Surveillance	Provides training on HIV molecular data for internal and public stakeholder consumption (recording archived on our website as well as content used in grantee HIV Testing Trainings). Serves as epi liaison to Council and Ryan White programs regarding outbreaks and surveillance data as well as Minnesota's Data2Care programs. Generates not-in-care (NIC) lists for outbreak monitoring purposes, including viral load data. Has access to CAREWare and can confirm involvement in Ryan White Services.	National webinars, and technical assistance provided by CDC and/or CSTE
HIV Surveillance Data Manager	Epi & Surveillance	As key staff to triage incoming confirmatory labs, case reports, as well as calls from grantees and health care providers, is aware of new diagnoses, their geography, risk factors, and other key demographics that would indicate an ongoing outbreak or whose shift might indicate an emerging area of concern. Assigns cases to partner services and indicates if may be a potential outbreak case. They are also the key staff collecting antiretroviral (ARV) use data for all persons newly diagnosed with HIV as part of core surveillance activities.	National webinars, and technical assistance provided by CDC and/or CSTE.
Disease Intervention Specialists	Partner and Care Link Services	Conduct case and contact investigations and interview activities	
Harm Reduction Program Director	Prevention Unit	Serve as key contact for syringe service programs involved in the response and assure client-centered interventions are implemented based on harm reduction model	Harm reduction trainings
EvaluationWeb Trainer	Planning & Improvement	Reviewing HIV testing data from grantees	

Staff	**Program** (e.g., Epi, Prevention, Partner Services, etc.)	**Role(s)** (Include all roles staff play during both the detection phase and response activities**)**	**Program-Specific Trainings** Additional trainings for this role, beyond general MDH or section requirements
Disease Intervention Specialist	Hennepin County Red Door Clinic	Conducts case and contact investigations and interview activities	
Medical Director	IDEPC	Assists with clinical guidance and direction, acting liaison with clinically focused entities	

Last updated: 7/6/2021

Appendix 4: Data re-release suppression rules for HIV surveillance analysis at geographic areas

OCTOBER 2019

Please refer to Figure 3 on the last page of this appendix for a flowchart of these data re-release suppression rules.

Data will be released in aggregate/summary form as follows:

State and geographic areas ≥500,000

- Data will **not** be released (i.e., data are suppressed) if the denominator (i.e., population size) of the population of people living with HIV (PLWH) within a given stratum is <100

Geographic areas <500,000

- Data will not be released if either of the following conditions are true:
  - The denominator of the population of PLWH within a given stratum is <100
  - The numerator is 1 - 4, for all frequencies and stratifications ≥100 but <500,000

All geographic levels

- A cautionary note on stability will be included for all levels of analyses when numbers are less than 12, rates are calculated on numbers less than 12, or when trends or estimates are determined to be unstable or unreliable through other statistical methods (e.g., relative standard error).

Variables

The main variables of interest covered by the re-release suppression rules are listed below.

General

- Location (state, MSA, MSA subdivision, county, city) based on standard definitions
- Year (report, diagnosis, death, prevalence, stage of disease, infection [incidence], perinatal exposure)

Demographic/transmission

- Sex at birth (or current gender identity, when available)
- Age group (at diagnosis or calculated age at end of year for prevalence; using five-year groups or larger for state-level and smaller geographic populations)
- Mutually exclusive race/ethnicity (based on OMB and state-specific classifications [i.e., African-born Black, non-Hispanic and non-African-born Black, non-Hispanic])
- Transmission or exposure category (as defined in *HIV Surveillance Report*)

Stratifications (examples)

Stratifications are at the variable level. Note that "male-to-male sexual contact" and the dual "male-to-male sexual contact *and* injection drug use" transmission categories include stratifications by sex (males only) but will be treated as one-way frequency for data releases.

One-way

- Race/ethnicity
- Sex at birth (or current gender identity, when available)
- Age group
- Transmission category

Two-way

- Sex at birth (or current gender identity) and age group
- Sex at birth (or current gender identity) and race/ethnicity
- Age group and race/ethnicity
- Age group and transmission category
- Transmission category and race/ethnicity
- Transmission category and sex at birth (or current gender identity)

Three-way

- Transmission category by age group and race/ethnicity
- Transmission category by age group and sex at birth (or current gender identity)
- Transmission category by sex at birth (or current gender identity) and race/ethnicity
- Race/ethnicity by sex at birth (or current gender identity) and age group

Four-way

- Transmission category by age group, race/ethnicity, and sex at birth (or current gender identity)

Geographic areas with ≥500,000 population

Data releases will be limited to presenting measures by the variables of interest noted in section II for MSAs, MSA subdivisions, counties, cities, and other geographic areas with ≥500,000 population.

Suppression rules

A denominator rule of <100 will be applied for all frequencies and stratifications in MSAs, MSA subdivisions, counties, cities, and other geographic areas with ≥500,000 population (i.e., when the stratum-specific population size of PLWH is <100 for a subgroup, count data will not be

presented). No numerator suppression rule will be applied if the population size of PLWH is ≥100.

- Totals, one-way frequencies, two-way, three-way, and four-way stratifications (as defined in section III) of variables of interest (including sex at birth, age group, race/ethnicity, and transmission/exposure category) by location (e.g., MSAs, MSA subdivisions, counties, cities, or other geographic areas with ≥500,000 population) and year may be released with the denominator rule suppressing data for stratum-specific populations of PLWH <100.
- Any public release of data that falls outside the scope of these data re-release rules will require discussion with the Minnesota Department of Health (MDH). Refer to section VII for a list of people to contact.

Geographic areas with 50,000 - 499,999 population

Suppression rules

Each option for release of data specifies that data will be suppressed. A denominator rule of <100 will be applied for all frequencies and stratifications in areas with 50,000 - 499,999 population (i.e., when the stratum-specific population size of PLWH is <100 for a subgroup, count data will not be presented). In addition, data will be suppressed when numerators are 1 - 4.

- If the release of a total number would allow for calculation of the number for a stratum-specific population that should be suppressed, secondary suppression will be applied by either:
    1. combining two or more categories of data (aggregation of values within the stratification parameter); or
    2. excluding all data in a subcategory (e.g., blocking disaggregation below a pre-selected value for the stratification parameter) across multiple areas.
- Totals, one-way frequencies, two-way, three-way and four-way stratifications (as defined in section III) of variables of interest (including sex at birth, age group, race/ethnicity and transmission/exposure category) by location (e.g., MSAs, MSA subdivisions, counties, cities or other geographic areas with 50,000 - 499,999 population) and year may be released with the denominator rule suppressing data for stratum-specific populations of PLWH <100 and the numerator rule suppressing data for numerators 1 - 4.
- Any public release of data that falls outside the scope of these data re-release rules will require discussion with MDH. Refer to section VII for a list of people to contact.

Geographic areas <50,000 population

Data will not be released by any area/location with <50,000 population other than counties.

Suppression rules

A denominator rule of <100 will be applied for all frequencies and stratifications in counties with <50,000 population (i.e., when stratum-specific population size of PLWH is <100 for a subgroup, count data will not be presented).

- If the release of a total number would allow for calculation of the number for a stratum-specific population that should be suppressed, secondary suppression will be applied by either:
    1. combining two or more categories of data (aggregation of values within the stratification parameter); or
    2. excluding all data in a subcategory (e.g., blocking disaggregation below a pre-selected value for the stratification parameter) across multiple areas.
- Totals, one-way frequencies, two-way, three-way, and four-way stratifications (as defined in section III) of variables of interest (including sex at birth, age group, race/ethnicity, and transmission/exposure category) by location (i.e., counties with <50,000 population) and year may be released with the denominator rule suppressing data for stratum-specific populations of PLWH <100 and the numerator rule suppressing data for numerators 1 - 4.
- Any public release of data that falls outside the scope of these data re-release rules will require discussion with MDH. Refer to section VII for a list of people to contact.

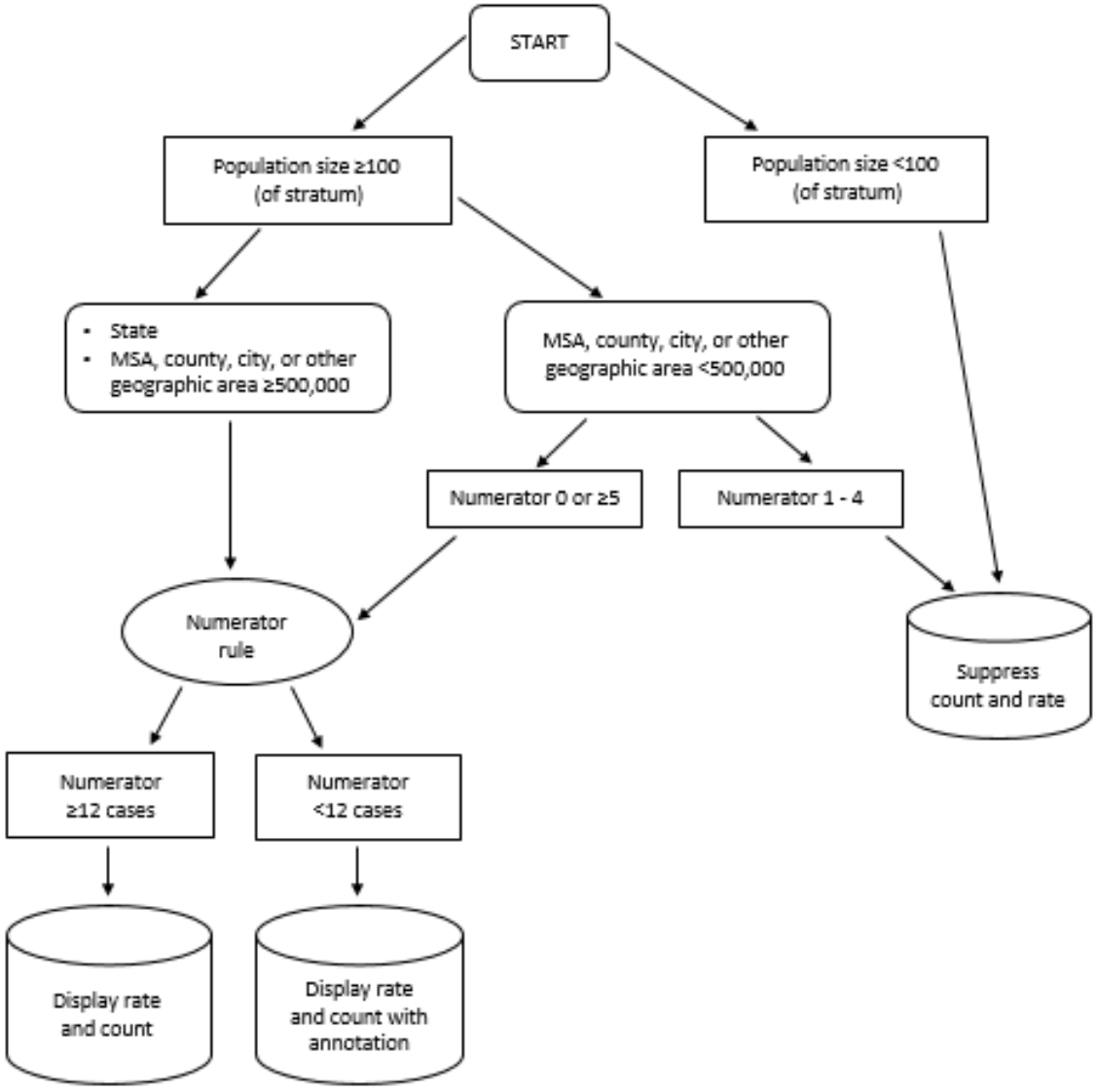
MDH contacts

To discuss public release of data that falls outside the scope of these data re-release rules, or for any other questions related to this document, please contact one of the following three people at MDH (or any future MDH employees who are in these positions):

- HIV Surveillance Coordinator (Jennifer Mark)
- HIV Care and Prevention Epidemiologist (Jared Shenk)
- Epidemiology and Surveillance Unit Supervisor (Allison La Pointe)

Please call 651-201-5414 to be connected with any of the staff listed above.

Figure 3: Flowchart of Data Re-Release Suppression Rules



Appendix 5: Procedure for the use of eHARS (HIV public health) data in planning, evaluation, and research by Ryan White entities

Background

The Minnesota Department of Health (MDH), under section 4605 of the Minnesota Communicable Diseases Reporting Rule (https://www.revisor.mn.gov/rules/4605/), collects public health data relating to HIV/AIDS infection in the state of Minnesota, specifically for preventing the spread of infection. Because MDH is neither a HIPPA entity, nor a part of the Welfare System, data collected by the HIV surveillance unit are not obtained undersigned informed consents or releases of information from people living with HIV (PLWH) in the state.

Monthly, clinical laboratory data – including CD4 and viral load results – are extracted from eHARS and uploaded into CAREWare, the database for Ryan White patients in the state. Data included in the upload are as updated as the eHARS dataset frozen at the time of an upload. The purpose of this upload is to support coordination of care for Ryan White patients between providers within the Ryan White system. This is clearly outlined in the Commissioner of Health's order, Section 13.3805, subdivision 1(b)(3):

Private health data may only be used in the following ways: (1) to locate the patient (a case) who has fallen out of care to link the patient back into care; (2) to provide laboratory data to ensure the patient (case) is in care and has reached viral suppression; (3) to have more complete diagnosis status for Ryan White clients; and (4) to understand if a patient (a case) is not locatable due to vital status.

Once eHARS data are uploaded into CAREWare, they are subject to all CDC guidelines for security and confidentiality. This applies to all care coordination and administrative activities at both the Ryan White grantee and subrecipient levels. This procedure only applies to eHARS lab data uploaded into CAREWare, which make up a portion of lab data in the CAREWare database.

Procedure

Whenever a Ryan White entity would like to propose the use of eHARS laboratory data in CAREWare for planning, evaluation, and/or any other use, the following procedures must be followed:

1. **Contact MDH:** To propose a research/evaluation project or presentation, contact one of three staff at MDH. The staff who may be contacted are the HIV Care and Prevention Epidemiologist (Jared Shenk), the HIV Surveillance Coordinator (Adrianna Sonnek), and/or the HIV Surveillance Supervisor (Allison La Pointe), or any future MDH employees who are in those positions. This contact may be made through either phone call, e-mail, or in-person meeting.
2. **Describe the proposed analysis/research project:** Submit a written description of the proposed analysis or research project, including exactly which eHARS data will be used, who has requested the analyses, who will have access to data, how confidentiality will be assured, and data re-release guidelines met, how the analyses will be conducted, and how the results of all analyses will be shared. At this point in the process, any of the

MDH staff described in step 1 will approve or deny the request, subject to any additionally requested information for clarification.

3. **Coordinate with MDH staff to complete analyses:** MDH employs three epidemiologists in the HIV surveillance unit who, with some lead time and planning, are available for data analysis projects. Any Ryan White entity may request data analysis support from MDH for these kinds of analyses. Decisions about who will analyze eHARS data and how they will be analyzed must be made in consultation with any of the MDH staff described in step 1 of this procedure.
4. **Submit drafts of any public release of eHARS data:** Once analyses are complete and any drafted publications, tables, and/or presentations are ready, they should be submitted to the MDH staff member who initially approved the analysis project. MDH staff will help to ensure proper scientific interpretation of eHARS data analyses and provide approval for all public releases of data.

Failure to follow procedure

Because eHARS data are collected by MDH under the guidelines set by CDC and the Minnesota Communicable Diseases Reporting Rule, MDH reserves the right to update this procedure at any time. Failure to follow this procedure may result in reconsideration of lab data sharing for planning, evaluation, and any other research purposes in the Ryan White system.

5/9/19

Appendix 6: Funded and non-funded MDH partners

Table 6: MDH-funded Partners

Agency Name	HIV Testing Programs	Syringe Services Programs	Early Intervention Services
The Aliveness Project			X
African American Aids Task Force	X		X
Annex Teen Clinic			X
Clinic 555	X	X	X
Face to Face Health and Counseling Services	X		
Indian Health Services: Red Lake			X
Indigenous Peoples Task Force		X	
Rainbow Health	X	X	
Lutheran Social Services	X		
Minnesota Community Care	X		X
Native American Community Clinic		X	X
NorthPoint Health and Wellness		X	X
Olmstead County			X
Planned Parenthood	X		
Red Door Clinic	X		
Rural AIDs Action Network		X	X
Sherburne County			X
Southside Harm Reduction		X	
Stearns County			X
Sub-Saharan African Youth and Family Services	X		
Turning Point	X		X
Youth & AIDS Projects	X		
White Earth Nation			X

Table 7: Non-MDH-funded Partners

Agency Name	Housing Services	Substance Use Disorder Treatment	Health Care Related Services	Mental Health Services
Clare Housing	X			
Hennepin County Health Care for the Homeless			X	X
Park House		X		
St. Stevens	X			
Urban Home Works	X			
VA Addiction Recovery Services		X		X
RAAN				
Harm Reduction Sisters		X	X	
Sex workers outreach project (SWOP)			X	
CHUM Duluth	X		X	X
Valhalla Place		X		

Last updated 4/20/2021

Appendix 7: Public engagement spectrum*

Table 8: Spectrum of Public Engagement

	INFORM	CONSULT	INVOLVE	COLLABORATE	SHARED LEADERSHIP (Empower)
Public Engagement Goal	To provide the public with balanced and objective information to assist them in the understanding the problem, alternatives, opportunities and/or solutions	To obtain public feedback on analysis, alternatives and/or decisions	To work directly with the public throughout the process to ensure that public concerns and aspirations are consistently understood and considered	To partner with the public in each aspect of the decision including the development of alternatives and the identification of the preferred solution	To place final decision-making in the hands of the public
Promise to the Public	We will keep you informed	We will keep you informed, listen to, and acknowledge concerns and aspirations, and provide feedback on how public input influenced the decision	We will work with you to ensure that your concerns and aspirations are directly reflected in the alternatives developed and provide feedback on how public input influenced the decision	We will look to you for advice and innovation in formulating solutions and incorporate your advice and recommendations into the decisions to maximum extent possible	We will implement what you decide
Examples of Activities	▪ Fact sheets ▪ Websites ▪ Open houses ▪ Press releases ▪ Information sharing through social media	▪ Public comment ▪ Focus groups ▪ Surveys ▪ Town halls or other public meetings ▪ Information gathering through social media	▪ Workshops ▪ Round tables ▪ Panels ▪ Work sessions ▪ Brainstorming sessions ▪ Interactive webinars ▪ Conferences	▪ Advisory committees ▪ Planning committees or sub-committees ▪ Task forces or work groups ▪ Online community forums and groups	▪ Steering committees ▪ Policy councils ▪ Standing committees ▪ Citizen juries ▪ Ballots

**Adapted from the International Association for Public Participation (IAP2)*

Appendix 8: Process for responding to HIV concerns reported by community partners

4/22/2021

Purpose

The purpose of this document is to outline the steps that the STD/HIV/TB session will when they receive a report from community partners about a suspicious or concerning trend in new HIV cases. Community partners may include: MDH grantees, community-based organizations, medical providers, outreach workers, etc.

Process for reporting concerning trends to MDH

- Preferred method: Call the IDEPC Division at 651-201 -5414 and ask for the HIV testing program or Partner Services
- Other ways we may hear of concerns that would result in making a report (expressing a concern)
  - Grantees may call (or email) their MDH grant manager. If grantees include a concern in submitted reports to MDH, the grant manager should follow-up with the grantee and complete a report form if necessary.
  - Community providers or partners may call STD/HIV/TB staff they have a prior relationship with.

Steps

- **Step 1**: Staff receiving the information will complete an HIV Concerning Trend Report Form, including as much of the following information as possible:
  - Description of concern
  - Case demographic information: name, DOB, gender at birth, address, phone number, risk information, housing status
  - Cluster information (if appropriate): cluster location, risk information, transmission activity
  - Name of caller, organizational affiliation, phone number
- **Step 2:** If a named individual or individuals are provided in the intake form, the staff completing the case intake form will send an encrypted email to Surveillance staff at Health.HIV.Surveillance@state.mn.us.
  - Surveillance staff will use the report to confirm case status
- **Step 3:** Surveillance staff schedules a meeting with STD/HIV/TB Section staff to review reported concerns and outcome of initial investigation
  - Initial meeting should include a representative from:
    - Surveillance
    - Partner Services

    - Prevention
    - Grant manager if the report is coming from an MDH grantee
  - Inform programs and program managers
    - Small scale concern: engage the programs with an FYI to the program manager
    - Identify initial activities needed:
      - Re-interviews, more case investigation, outreach testing event, etc.
- **Step 4:** Follow-up with person or community-based organization (CBO) who made the report
  - Collect additional information, as needed
    - Discuss any information gaps
    - Inquire about existing contracts that could help respond to the issue
    - Explore how MDH can support a response
  - Invite the CBO or partner organization to discuss and to develop an action plan for specific cases or in response to the concern, as needed
  - Inform the person or organization who make the case report the result of review or assessment, including if no further action is taken as a result of the report
- **Step 5:** Finalize and implement action plan
  - Identify action plan activities, including:
    - Education and training
    - Communication and networking
    - Resources and support
  - Use routine engagement activities, as appropriate, to inquire about areas or patterns of concern, such as:
    - HIV virtual townhall
    - Testing data in EvaluationWeb
    - Grantee progress reports and check-ins
    - Recurring all-grantee phone calls (if those continue)
  - Use internal meetings to share and discuss areas of concern, including:
    - Partner Services chalk talk meetings
    - Grant manager meetings
    - Section meetings
    - Meeting with other sections
- **Step 6:** Continue assessing and monitoring data
  - Conduct ongoing surveillance and partner services data monitoring
  - Surveillance can run data checks more frequently to monitor for a potential outbreak and do other surveillance activities that will help in the response to the concern(s).

Appendix 9: Report form

Concern for Trend in New HIV Cases Report*

INTERNAL USE ONLY

The purpose of this form is to document when the Partner and Care Link Services and Prevention Units receive a report from community partners about a suspicious or concerning trend in new HIV cases. Community partners may include: MDH grantees, community-based organizations, medical providers, outreach workers, etc.

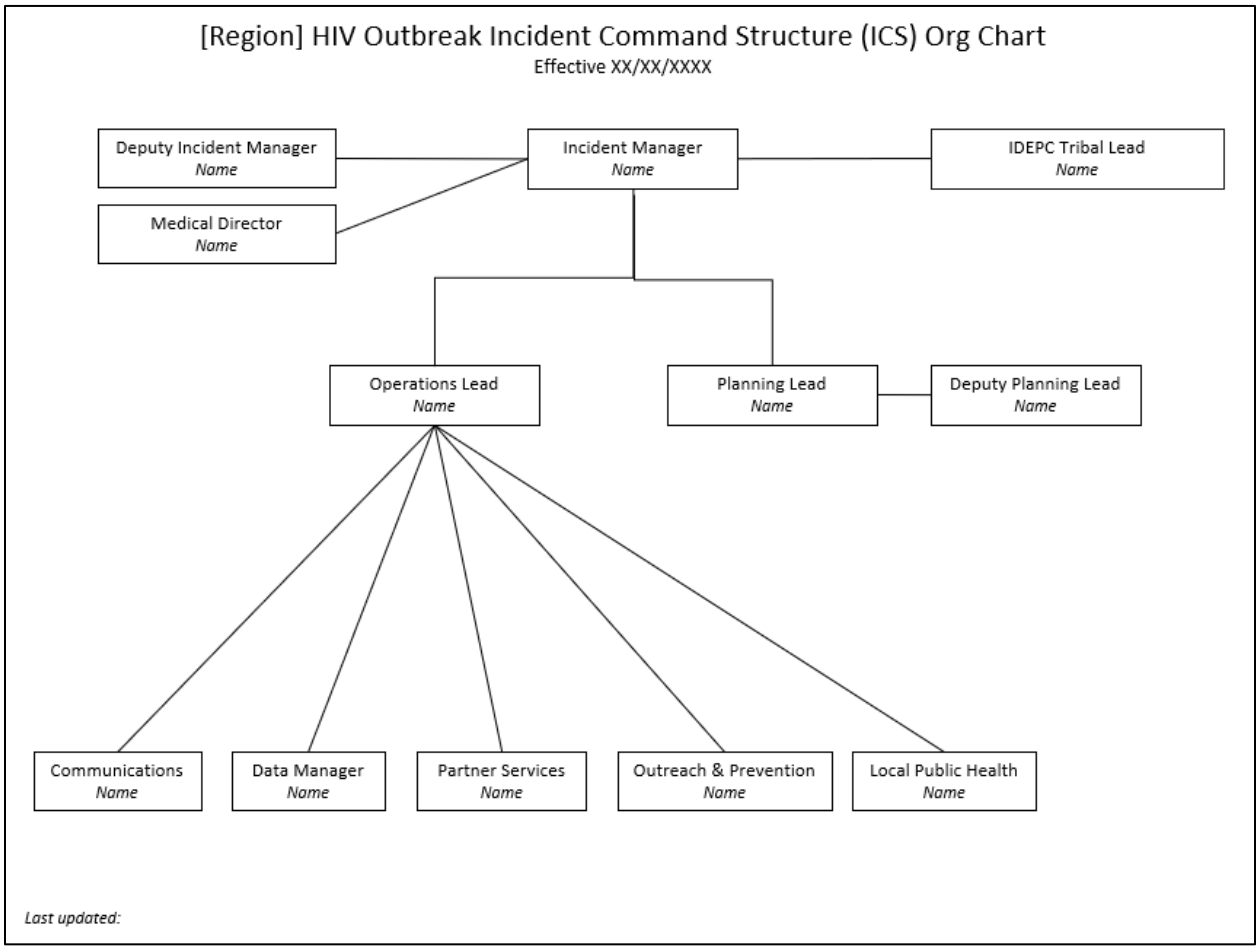
Report date:	**Report taken by:**
Name of Caller:	**Organization:**
	Phone:

Description of Concern:				
Case/suspected case name:	**DOB:**	**Gender at birth:**	**Risk information:**	**Housing Status:**
Address:				
Home phone number:	**Cell number:**	**Other number:**		
Cluster Information				
Cluster location:				
Risk information:				
Transmission activity:				

**Submit the completed report form to HIV Surveillance*

Appendix 10: ICS structure chart template

Figure 4: HIV Outbreak ICS Organizational Chart Template



Appendix 11: ICS roles and responsibilities

Table 9: MDH ICS Roles and Responsibilities

ICS Role	Staff	Responsibilities
Incident Manager	Section Manager	Approves outbreak response initiation and budget. Keeps MDH leadership informed about outbreak response activities and progress. Provides CDC with status updates. Establishes and oversees implementation of incident objectives, strategies, priorities, and activities. Maintains overall responsibility for managing the outbreak response.
Medical Director	IDEPC Medical Director	Assists with drafting and approving clinical guidance and HANs. Provides clinical direction to IDEPC and Section staff. Liaison with clinically-focused associations and organizations.
Operations Lead	Prevention Manager or designee	Oversees response activity operations. Communicates and follows up, with ICS leads and staff implementing strategies and activities.
Data Management Lead	Epi & Surveillance Manager	Oversees all surveillance data and analysis, including data entry and case report forms, follow up with reporting providers, and enhanced surveillance.
Communications Lead	Communications Unit Staff	Develops communication plan. Assists with HANs and other communications, creates materials, manages social media and website updates, and additional deliverables.
Partner Services Lead	PCLS Manager or designee	Oversees partner and care link services investigative activities.
Testing, Awareness and Provider Education Lead	Prevention Manager or designee	Coordinates testing supplies and incentives as available, provides HIV testing to new providers, communicates with providers, assists with engagement activities.
Local Public Health (LPH) Representative	IDEPC Epi Field Staff	Liaisons with LPH in local jurisdictions. Discusses epi data when needed (regionally). Conducts training when needed.
Tribal Relations Representative	IDEPC Tribal Lead	Communicates with tribes regarding outbreaks. Coordinates with the Section and provides guidance. Participates on ICS teams, as needed. Communicates with Metropolitan Urban Indian Directors (MUD), as needed.
Planning Lead	Planning & Evaluation Coordinator	Creates and maintains documentation. Oversees planning for present and future strategies and activities, assists with evaluation.
Finance and Administration Lead	Assistant Section Manager	Facilitates financial tasks. Initiates time tracking studies, if needed.
Logistics Lead	TBD, as needed	Arranges for resources to support the response. Provides scheduling, ordering, and administrative support.

Last updated 7/6/2021

Appendix 12: HIV cluster ICS meeting agenda template

HIV Cluster ICS Meeting Agenda Template

Date: XX/XX/XXXX

Epi Update

- Epi updates, including time-space and molecular

Response Updates

- Response activities updates
  - Overall Response
  - Partner Services
  - Surveillance and Data Management
  - Communications
  - Training and Education
  - Testing and Outreach
  - Local Public Health
  - Tribal Outreach
  - Department of Human Services (DHS)
  - Planning
  - Finance
- Check-in:
  - Any other updates, issues, or questions?

Wrap up

- Recap/identify any next steps
- Upcoming meetings

Appendix 12: Outbreak tracker template

[Outbreak Name] Tracker

LAST UPDATED: ADD DATE

Summary

- Add text to provide summary and background here…
- Case definition: add text to describe the definition of the outbreak or cluster here…
- Goals and Objectives: add goals and objectives for the response here…

Overall Response

Lead:

Action Step	Target Date	Lead(s)	Status	Comments

Category/work area

Lead:

Action Step	Target Date	Lead(s)	Status	Comments

Category/work area

Lead:

Action Step	Target Date	Lead(s)	Status	Comments

Category/work area

Lead:

Action Step	Target Date	Lead(s)	Status	Comments

(Copy and paste additional tables, as needed)

Appendix 13: HIV CODR measures

Description

The following provides background and a list of currently available data that was identified to potentially monitor and evaluate HIV cluster and outbreak response activities, as described in the HIV Cluster and Outbreak Detection and Response (CODR) plan.

Purpose

The purpose of using measures to monitor and evaluate activities is to ensure:

- Accountability: we follow our plan(s) and make progress on our goals
- Insight: we use data to assess the impact of our activities and identify areas that need attention
- Informed decision-making: we use data to make decisions, we adjust as changes are needed
- Transparency: we communicate and share information about our activities
- Capacity-building: we incorporate evaluation and monitoring practices into our work

Uses

The HIV CODR measures will be used for:

- HIV outbreak response mid-point evaluations
- HIV outbreak response after-action evaluations and reports
- Other HIV ICS meeting discussions, as determined
- Monthly check-in calls with CDC, as determined

These measures may also be used for:

- Community presentations: Sharing information or lessons learned with community partners
- National presentations: Sharing information or lessons learned with state or national colleagues
- Grants: Informing future grant processes

These measures are meant for internal evaluation and monitoring and do not replace the reporting requirements to the CDC.

Assumptions

- The following assumptions were made about monitoring and evaluating HIV outbreak response activities:
- Use currently available data
- Measures can be revised and added in the future as staff capacity increases
- Use quantitative and qualitative data to build a fuller picture

- Use meaningful data. Consider what will inform activities and decisions
- Consider data and sharing of data for all areas of response activities, including internal coordination, collaboration, community partnerships, activity efforts, etc.
- Consider different types of measures
  - Capacity measures: the capacity to conduct each service
  - Process measures: the processes used to conduct each service
  - Outcomes measures: the results of the services

Proposed measures

- The following is a list of HIV related data that the STD/HIV/TB Section currently has available. This is a compiled summary and is not exhaustive. Some measures may or may not be applicable for a specific outbreak, depending on the impacted population and case definition, while other meaningful measures may not be listed below. Staff can use this list to identify relevant measures for monitoring current outbreak response activities.

Communications

- HIV outbreak monthly GovDelivery messages
  - Date range
  - Number of messages sent
  - Number of recipients and number of opens (range, average)
- Promotional items and condoms distributed to outbreak areas
  - Number and type of items distributed
  - Number and name of organizations receiving items
- Social media posts focused on HIV prevention and testing
  - Number of posts
  - Reach of each post
- HAN messages
  - Number of messages sent
- Virtual town halls related to HIV outbreak
  - Number of registrants
  - Number of unique viewers
  - Evaluation survey results

Epi & Surveillance

- Demographics (number/percentage)
  - Age

  - Sex
  - Race
  - Ethnicity
- Transmission category (number/percentage)
- Stage zero at HIV diagnosis (number/percentage)
- Linked to care (under 90 days) (number/percentage)
  - If yes, criteria used to determine linkage
- Most recent viral load test was within 6 months (number/percentage)
- Most recent viral load test was within the past 12 months (number/percentage)

Partner & Care Link Services (PCLS)

- Number/percentage of new cases assigned to disease intervention specialists (DIS)
- Number/percentage of cases interviewed by DIS
- Number of unique partners named ("named" partners are initiated for follow-up by DIS)
- Types of partners (drug, sex, or both) (number/percentage)
- Number of partners HIV tested
- HIV test results of partners (number/percentage)
- Number/percentage of cases linked to or re-engaged in care as a result of partner or care link services
- Number of previously diagnosed cases re-interviewed
- Number of previously diagnosed cases re-engaged in care as a result of PCLS

Planning

- Number of ICS meetings
- Number of MDH and CDC monthly calls
- Tracker
  - Number of documented activities
  - Number/percent of completed activities
  - Number/percent of ongoing activities
  - Number/percent of "in progress" activities
- HOPE meetings
  - Number of meetings
  - Number of organizations represented
  - Number of new activities initiated

  - Evaluation survey results
  - Qualitative data regarding accomplishments and lessons learned, etc.
- HIV Collaborative meetings
  - Number of meetings
  - Number of organizations represented
  - Number of new activities initiated
  - Evaluation survey results
  - Qualitative data regarding accomplishments and lessons learned, etc.
- Number of outbreak related presentations (in-person or virtual)

Prevention

- All data is for MDH grantees only
- Number of HIV tests by MDH grantees
  - Number of HIV tests by race, ethnicity
- Number of syringes given (passed out) by MDH grantees
- Number of used syringes received by syringe service programs (SSPs)
- Number of HIV tests by SSPs
- Number of condoms distributed
- Number of linkages to PrEP

Last updated: 6/24/2021