MINNESOTA & MINNEAPOLIS – ST. PAUL TRANSITIONAL GRANT AREA INTEGRATED HIV PREVENTION AND CARE PLAN

2017 - 2021

Minnesota Council for HIV/AIDS Care and Prevention

MDH Minnesota Department of Health

Minnesota Department of Human Services

Hennepin

Hennepin County Public Health

TABLE OF CONTENTS

Executive Summary	2
I. Statewide Coordinated Statement of Need	5
A. Epidemiologic Overview	5
B. HIV Care Continuum	43
C. Financial and Human Resource Inventory	57
D. Assessing Needs, Gaps, and Barriers	78
E. Data: Access, Sources, and Systems	102
II. Integrated HIV Prevention and Care Plan	106
A. Integrated HIV Prevention and Care Plan	106
B. Collaborations, Partnerships and Stakeholder Involvement	117
C. People Living with HIV and Community Engagement	128
III. Monitoring and Improvement	133

List of Attachments

Attachment A	Population Density, By County
Attachment B	HIV/AIDS Service Providers, and Persons Living with HIV/AIDS per Square Mile
Attachment C	Minnesota Council for HIV/AIDS Care and Prevention (Council) Description
Attachment D	Comparison of 2010 and 2015 Consumer Needs Assessment
Attachment E	Council Membership Breakdown
Attachment F	Letters of Concurrence

Executive Summary

Executive Summary

The Integrated HIV Prevention and Care Plan is the first effort to integrate prevention and care community planning activities in Minnesota and the Minneapolis – St. Paul Transitional Grant Area (MSP-TGA). The plan covers five years from 2017 – 2021 and describes both the continuing and evolving needs of people affected by the HIV epidemic throughout the state. In an era when effective treatments for HIV are available and adherence can significantly reduce HIV transmission, funding supports services that engage and retain in care the most affected groups including men who have sex with men, disproportionately affected communities of color, at-risk youth and immigrant populations.

With the evolution of rapid testing, pre-exposure prophylaxis (PrEP) for those at risk, quicker connection to care, medication benefits that lead to undetectable viral loads, and more and more people with HIV living normal life spans, the old gaps and differences between HIV prevention and care are blurring and coming together. The National HIV/AIDS Strategy goals have been adapted for the local level and include: 1) Reduce new HIV infections; 2) Increase Access to Care & Improve Health Outcomes for People Living with HIV; 3) Reduce HIV-Related Disparities & Health Inequities; and 4) Achieve a More Coordinated State & Local Response to the HIV Epidemic to reduce the number of Minnesotans at risk of acquiring or living with HIV.

An important outgrowth of the integration of HIV prevention and care is the development of the Integrated HIV Prevention and Care Plan which included the Minnesota Council for HIV/AIDS Care and Prevention (MCHACP), Minnesota Department of Health (MDH), Minnesota Department of Human Services (DHS), Hennepin County Public Health Department, providers, people at higher risk for HIV, and people living with HIV/AIDS (PLWH), in a collaborative process starting in 2015. The involvement of PLWH and those at higher risk in the planning process provided critical insights into the development of a plan that will meet the needs of the people in affected communities.

Historically, Minnesota experienced a steady increase in the annual number of new HIV and AIDS cases from the beginning of the epidemic to the early 1990s. Beginning in 1996, both the number of newly diagnosed AIDS cases and the number of deaths among AIDS cases declined sharply, primarily due to the success of new antiretroviral therapies including protease inhibitors. These treatments do not cure, but can delay progression to AIDS among persons with HIV (non-AIDS) infection and improve survival rates among those with AIDS. Treatment has also been shown to be effective at preventing transmission of HIV. In 2015, there were 256 and 34 new cases of HIV reported in the TGA and outside the TGA, respectively. In the same period there were 89 reported deaths among people with an HIV/AIDS diagnosis in the state. Over the past decade, the number of HIV/AIDS cases diagnosed has remained relatively stable with an average of 318 cases diagnosed each year. By the end of 2015, an estimated 8,215 persons with HIV/AIDS were assumed to be living in Minnesota.[1]

Since the beginning of the epidemic, men having sex with men (MSM) has been the predominant risk category reported. In 2015, MSM accounted for 52% of all new infections. Heterosexual contact has been the predominant mode of HIV exposure among females accounting for 76% of female cases in 2015. The proportion of cases differs not only by gender but also by race and

[1] This number includes persons whose most recently reported state of residence was Minnesota, regardless of residence at time of diagnosis. This estimate does not include persons with undiagnosed HIV infection.

country of birth. Persons of color comprise less than fifteen percent of the population in Minnesota, yet they represented 47% of newly diagnosed AIDS cases in 2015. Foreign-born persons make up 7% of Minnesota's total population and 29% of new HIV infections in 2015. The ability to interrupt the transmission of HIV from mother to child via antiretroviral therapy and appropriate perinatal care is an important accomplishment in the history of the HIV/AIDS epidemic. Newborn HIV infections in Minnesota average less than one case per year.

Minnesota uses the HIV Care Continuum (HCC) to identify issues and opportunities for monitoring emerging trends and improving the delivery of services to PLWH and high-risk individuals, including how care funds are allocated to priority services and prevention funds are targeted. Populations are prioritized based on epidemiologic data and incorporated into the objectives, activities and funding allocations. Over 50 million dollars are reflected in Minnesota's HIV Resource Inventory which details funding sources for HIV prevention, care and treatment. The dollar amount and percentage of the total funds available, services delivered and HCC steps impacted are outlined.

Common misconceptions and fears continue to be roadblocks in addressing HIV making prevention and education critical. Several mechanisms were utilized to assess the needs, gaps and barriers experienced by people at higher risk and PLWH, including a Consumer Needs Assessment (CNA) survey completed by over 500 people living with HIV. Social determinants of health (SDOH) such as income, education and housing have a substantial influence on the health of individuals and the health of communities. There are several disparities in these SDOH that impact people living with HIV, particularly people of color.

Overall Minnesota has one of the lowest rates (4.3%) of uninsured residents in the nation. However, notable differences continue to exist among various race/ethnic groups. While only 3.4% of Whites were uninsured in 2015, the percentages among Hispanics (11.7%), American Indian (8.7%), and Blacks (8.4%) were considerably higher. As implementation of the Affordable Care Act continues to ease the financial burden of those who are without adequate health insurance, the Integrated HIV Prevention and Care Plan focuses on delivery of high quality services designed to promote: early identification of individuals who are unaware of their HIV status; linkage to the best-quality medical care; re-engagement in care; health education and literacy; retention in care and treatment adherence; and addressing social and cultural barriers for rapid movement along the HCC to achieve sustained viral suppression.

The goals, target populations and activities agreed upon and incorporated into the Integrated HIV Prevention and Care Plan serve as an invaluable tool for the state of Minnesota and MSP-TGA in addressing the needs of people living with HIV/AIDS, as well prevention of new HIV infections. Underpinning the strategy to improve the quality of HIV services and health outcomes for people living with HIV is monitoring and improvement. A process improvement cycle (Plan-Do-Study-Act) is the framework to continuously improve data collection, analysis, and use to drive evidence-based decisions. Some measures of the monitoring plan track progress on outcomes or efficacy of the work, while other measures provide key indicators. An annual monitoring plan also outlines accountabilities for MDH, DHS, Hennepin County and the Council.

Section I: Statewide Coordinated Statement of Need/Needs Assessment

A. Epidemiological Overview

Epidemiologic Overview (Section I: A.)
The Epidemiologic overview provides a description of the burden of HIV in the population in terms of geographic, socio-demographic, behavioral, and clinical characteristics of persons newly diagnosed with human immunodeficiency virus (HIV), people living with HIV (PLWH), and people at higher risk for infection.

Geography (Section I: A. a.)
Minnesota is a geographically diverse state. Its 84,363 square miles are comprised of farmlands, river valleys, forests, and lakes. Minnesota has one large urban center made up of Minneapolis and St. Paul (the Twin Cities) in Hennepin and Ramsey Counties, respectively. The Twin Cities are located on opposite banks of the Mississippi River in the southeastern area of the state. The majority (54%) of the state's 5,303,925 residents live in the Twin Cities and the surrounding seven-county metropolitan region. Duluth (northeast), St. Cloud (central), Rochester (southeast), Mankato (south central), and Moorhead (northwest) are other moderately sized population centers. The rest of Minnesota's population resides in smaller towns, many of which have populations of less than 2,000.

Three large interstate highways traverse the state, two of which pass through Minneapolis-St. Paul. I-35 runs north-south and I-94 runs northwest-southeast. I-90 parallels the southern border of Minnesota. A host of state and county roads connect the remaining regions of the state.
The profile presents data for the state as a whole and the Minneapolis-St. Paul Transitional Grant Area (TGA). The Minneapolis-St. Paul TGA includes the following counties: Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington, and Wright in Minnesota and Pierce and St. Croix in Wisconsin. (See Attachment A, *Population Density, By County.)*

National Context
Compared with the rest of the nation, Minnesota is considered to be a low to moderate HIV/AIDS incidence state. In 2014, state-specific HIV infection diagnosis rates ranged from 1.9 per 100,000 persons in Montana to 36.6 per 100,000 persons in Louisiana with an overall national rate of 16.6 per 100,000 persons. Minnesota had the 16th lowest HIV infection diagnosis rate (7.0 HIV infections reported per 100,000 persons[2]). Compared with other states in the Midwest, Minnesota has a moderate rate of HIV diagnosis. In 2014, state-specific AIDS diagnosis rates ranged from 0.7 per 100,000 persons in Montana and Wyoming to 13.7 per 100,000 persons in Louisiana. Minnesota had the 12th lowest AIDS rate (3.0 AIDS cases reported per 100,000 persons[3]). Compared with states in the Midwest region, Minnesota has a moderate AIDS rate.

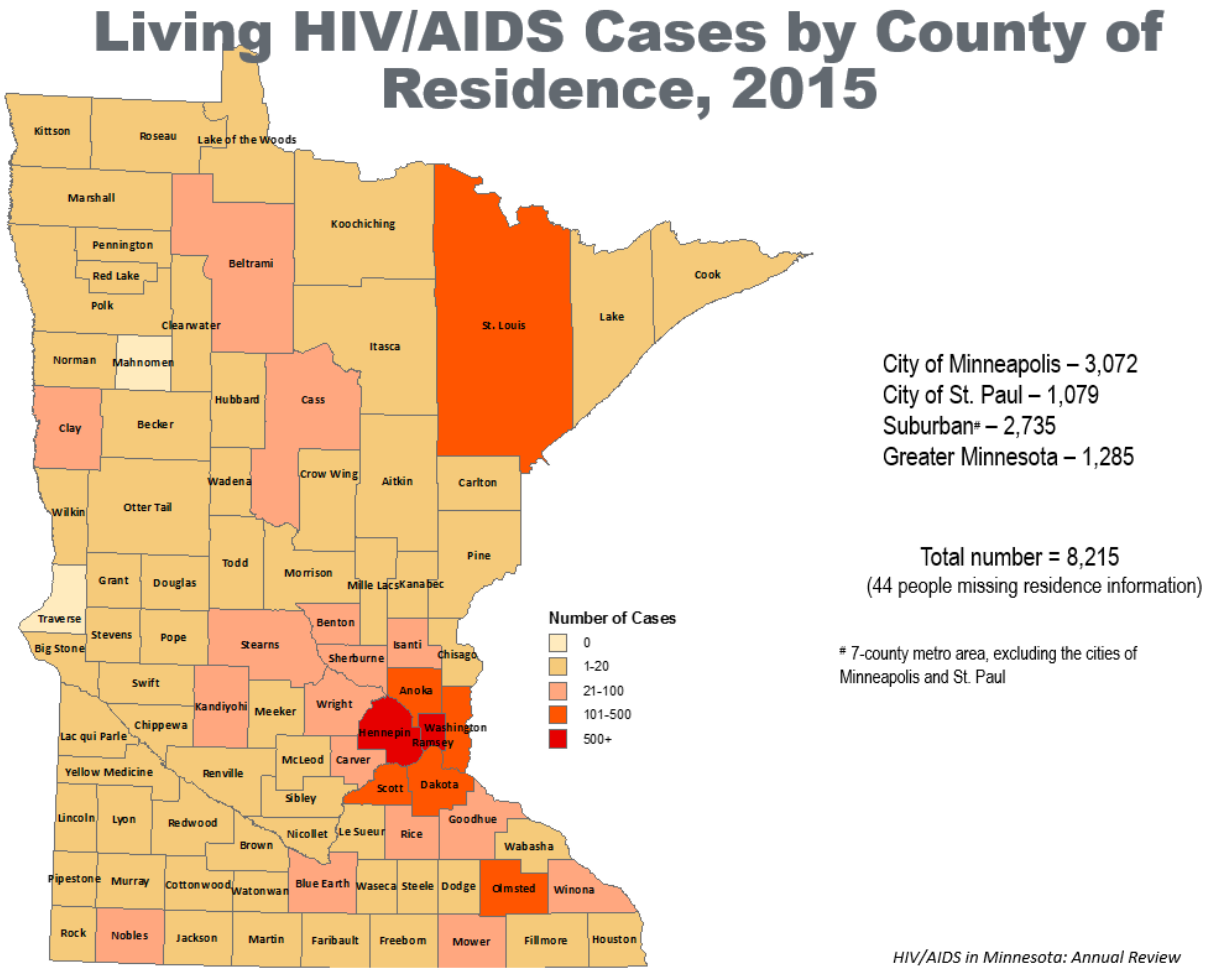
New HIV Diagnoses in Minnesota
The term "new HIV diagnoses" refers to HIV-infected Minnesota residents who were diagnosed in a particular calendar year and reported to Minnesota Department of Health (MDH). This includes persons whose first diagnosis of HIV infection is AIDS (AIDS at first diagnosis). HIV diagnoses data are displayed by earliest known date of HIV diagnosis. In 2015, 294 new HIV

[2] Centers for Disease Control and Prevention. HIV/AIDS Statistics and Surveillance Slide Sets http://www.cdc.gov/hiv/topics/surveillance/resources/slides/general/index.htm accessed April 20, 2016, Slide 15
[3] Centers for Disease Control and Prevention. HIV/AIDS Statistics and Surveillance Slide Sets http://www.cdc.gov/hiv/topics/surveillance/resources/slides/general/index.htm accessed April 20, 2016, Slide 31

diagnoses were reported in Minnesota. This represents a 4% decrease from 2014 when 307 diagnoses were reported.

Historically, about 90% of new HIV infections diagnosed in Minnesota have occurred in Minneapolis, St. Paul and the surrounding seven-county metropolitan area. This has changed slightly over time, and currently about 87% of new diagnoses occur in the metropolitan area surrounding Minneapolis/St. Paul. Additionally, although HIV infection is more common in communities with higher population densities and greater poverty, HIV or AIDS was diagnosed in 28 counties in Minnesota in 2015. Pierce and St. Croix Counties in Wisconsin accounted for less than 1% of the TGA's cases. Although HIV infection is more common in communities with higher population densities and greater poverty, HIV or AIDS has been diagnosed in all but 2 of the 87 counties in Minnesota.

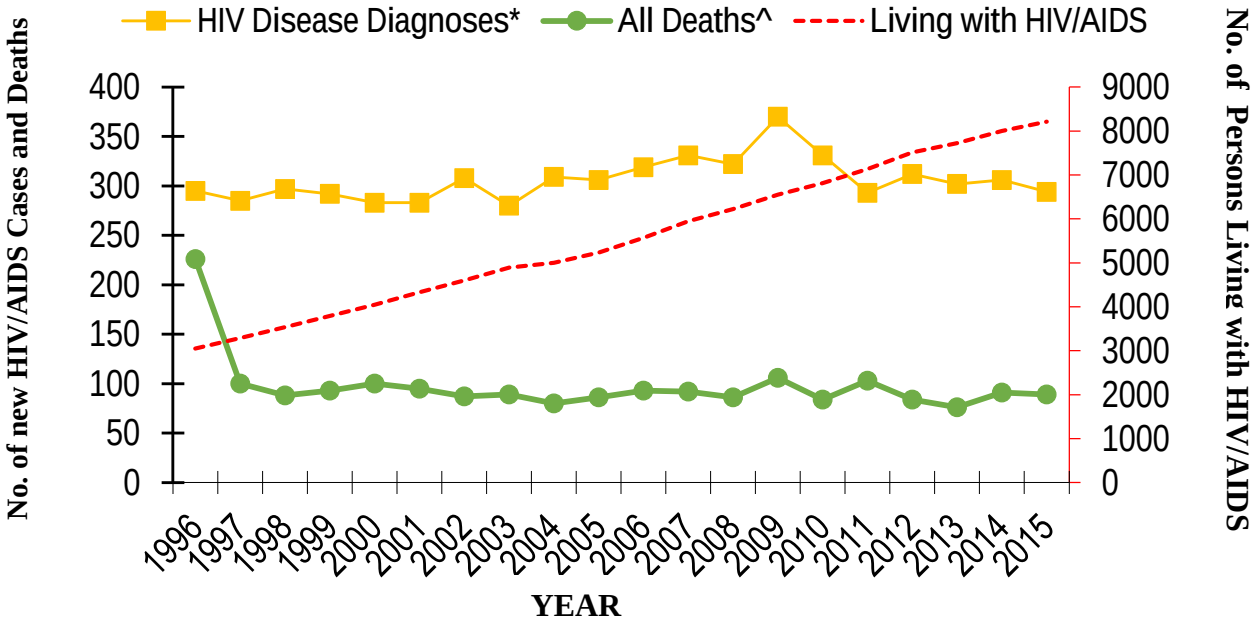
Overall, of the 307 HIV diagnoses in Minnesota in 2014, 40% were among residents of the suburban seven-county metro area, 32% were residents of Minneapolis and 14% were residents of St. Paul and Greater Minnesota at the time of diagnosis. However, the geographic distribution of cases differs by gender. For example, 52% of female cases resided in the suburban seven-county metro area compared to only 36% of male cases. Whereas 35% of male cases resided in Minneapolis at the time of diagnosis, compared to only 23% of females.



Living HIV/AIDS Cases

As of December 31, 2015, there were 8,215 people living with HIV disease in Minnesota with 7,014 of those cases living in the Minneapolis-St. Paul. In Pierce and St. Croix Counties in Wisconsin there were 46 people living with HIV disease, for a total of 7,060 people living with HIV disease in the Minneapolis-St. Paul thirteen county TGA. The vast majority of those cases in the metropolitan area (83%) are in Hennepin and Ramsey Counties. Of the living cases in Minnesota, 3,866 or 47 percent had an AIDS diagnosis, while 4,349 or 53 percent had a (non-AIDS) HIV diagnosis. These percentages are similar in the TGA. (See Attachment B, *HIV/AIDS Service Providers, and Persons Living with HIV/AIDS per Square Mile*.)

HIV/AIDS in Minnesota
New HIV Disease Diagnoses, Deaths and Prevalent Cases by Year, 1996-2015



*Includes all new cases of HIV infection (both HIV (non-AIDS) and AIDS at first diagnosis) diagnosed within a given calendar year.
^Deaths in Minnesota among people with HIV/AIDS, regardless of location of diagnosis and cause.
HIV/AIDS in Minnesota: Annual Review

Overview of HIV/AIDS in Minnesota, 1990s-2015

The annual number of new HIV and AIDS cases increased steadily from the beginning of the epidemic to the early 1990s. Beginning in 1996, both the number of newly diagnosed AIDS cases and the number of deaths among AIDS cases declined sharply, primarily due to the success of new antiretroviral therapies including protease inhibitors. These treatments do not cure, but can delay progression to AIDS among persons with HIV (non-AIDS) infection and improve survival among those with AIDS. These treatments have been shown to be effective at preventing transmission of HIV. In 2015, there were 256 and 34 new cases of HIV reported in the TGA and outside the TGA, respectively. In the same period there were 89 reported deaths among people with an HIV/AIDS diagnosis in the state. Over the past decade, the number of HIV/AIDS cases diagnosed has remained relatively stable with an average of 318 cases

diagnosed each year. By the end of 2015, an estimated 8,215 persons with HIV/AIDS were assumed to be living in Minnesota.[4]

Socio-demographic Characteristics (Section I: A. b.)
This section describes the socio-demographic characteristics of persons newly diagnosed, PLWH, and persons at higher risk.

Gay, Lesbian, Bisexual and Transgender (GLBT) Persons in Minnesota
Accurate estimates of the GLBT[5] population in Minnesota are unavailable. However, the 2010 Census provides some data related to GLBT persons in Minnesota. Although not a valid measure of the extent of same sex relationships in Minnesota, unmarried partners of the same sex made up an estimated 13,718 households in Minnesota in the year 2010, with approximately 70% of those households located in the TGA.

There have been some national studies that have attempted to estimate the prevalence of same sex behavior, which is different than estimating the number of GLBT persons since some people may engage in same sex behavior but not identify as GLBT. In early work by Kinsey and colleagues in the 1940s and 1950s, 8% of men[6] and 4% of women[7] reported exclusively same gender sex for at least 3 years during adulthood. Generalizing these findings to the general population is very questionable because these data were based on convenience samples.

Subsequent to this work, studies more representative of the general U.S. population have been under taken. Comparing national surveys from 1970 and 1991, Seidman and Rieder estimated that from 1% to 6% of men had sex with another man in the preceding year[8]. Another population-based study estimated the incidence of same sex behavior in the preceding five years at 6% for males and 4% for females[9]. Estimates vary for a number of reasons, including varying definitions of homosexuality and/or methods of data collection. Approximately 77,000 men and 50,000 women in Minnesota would be predicted to engage in same sex behavior using the methodology from the Sell study. The accuracy of these numbers is difficult to gauge, at best.

More recently, the SHAPE 2014 study conducted in Hennepin County found that 7.6% of adult males and 4.8% of adult females in Hennepin County identified as GLBT[10]. Applying these percentages to the entire state adult population, we would estimate that approximately 144,000 men and 95,000 women identify as GLBT.

Also relevant to the context of GLBT life in Minnesota is the fact that Minnesota and the Twin Cities, in particular, attract individuals with a variety of sexual orientations. A strong gay community exists in the Minneapolis-St. Paul area. Additionally, Minnesota is one of sixteen

[4] This number includes persons whose most recently reported state of residence was Minnesota, regardless of residence at time of diagnosis. This estimate does not include persons with undiagnosed HIV infection.
[5] The term "GLBT" (gay, lesbian, bisexual, or transgender) refers to sexual identity. "MSM" (men who have sex with men), another term used throughout this document, refers only to sexual behavior and is not synonymous with sexual identity.
[6] Kinsey AC, Pomeroy WB, Martin CE. *Sexual Behavior in the Human Male*. Philadelphia: WB Saunders, 1948
[7] Kinsey AC, Pomeroy WB, Martin CE. *Sexual Behavior in the Human Female*. Philadelphia: WB Saunders, 1953
[8] Seidman SN, Rieder RO. A review of sexual behavior in the United States. *American Journal of Psychiatry*, 151(3):330-341, 1994
[9] Sell RL, Wells JA, Wypij D. The prevalence of homosexual behavior and attraction in the United States, the United Kingdom, and France: results of national population-based samples. *Archives of Sexual Behavior*, 24:235-248, 1995
[10] Hennepin County Human Services and Public Health Department. SHAPE 2014 Adult Data Book, Survey of the Health of All the Population and the Environment, Minneapolis, Minnesota, March 2011

states and the District of Columbia that has laws banning discrimination based on sexual orientation and gender identity.

In 2012 MDH began estimating the population of MSM in Minnesota. This estimate generates a denominator for the most commonly reported risk factor in Minnesota and allows for the calculation of a rate of infection and rate of prevalence among those in the risk group. It should be noted that this is an estimate of a risk behavior and not an estimate of GLBT identification. Estimation is done each year using the most recently available census data for men over the age of 13 and using the model by on Laumann et al where 9% of the urban population, 4% of the suburban population and 1% of the rural population are estimated to be MSM. Using 2010 census data, this methodology estimates that there are 92,788 MSM in Minnesota.

Transgender Persons

Minnesota appears to attract a relatively large number of individuals who describe themselves as transgender due to the available treatment programs and access to hormonal and surgical sex reassignment. A nationally renowned center for individuals seeking transgender support and services is located in Minneapolis. Although transgender people identify as heterosexual, bisexual, gay, and lesbian, variances in gender identity complicate the categorization. Some male to female transgender individuals identify as lesbian, some as heterosexual, and others as bisexual. Similarly, some female to male individuals identify as gay, some are heterosexual, and others are bisexual.

Studies show that transgender individuals have elevated rates of HIV, particularly among transgender sex workers. These studies focus primarily on male to female transgender individuals. Possible reasons for the higher rates among transgender sex workers are more frequent anal receptive sex, increased efficiency of HIV transmission by the neovagina, use of injectable hormones and sharing of needles, and a higher level of stigmatization, hopelessness, and social isolation. Female to male transgender persons who identify as gay or bisexual may be having sexual intercourse with biological men who are gay or bisexual. Because the prevalence of HIV is higher among MSM, female to male transgender persons who identify as gay or bisexual are at greater risk for HIV than those who identify as heterosexual.

Studies by the University of Minnesota's Program in Human Sexuality identified specific risk factors such as sexual identity conflict, shame and isolation, secrecy, search for affirmation, compulsive sexual behavior, prostitution, and found that transgender identity complicates talking about sex.[11] [12]

Politically, and sometimes for access to services, many transgender individuals find alliances within the gay and lesbian community. All of these factors may contribute to a larger GLBT population in Minnesota than would be predicted based upon national averages. Any estimates for the GLBT population must be used with caution.

[11] Bockting WO, Robinson BE, Rosser BR. Transgender HIV prevention: a qualitative needs assessment. *AIDS Care*, 10(4):505-525, 1998

[12] Bockting WO, Robinson BE, Forberg J, Scheltema K. Evaluation of a sexual health approach to reducing HIV/STD risk in the transgender community. *AIDS Care*, 17(3):289-303, 2005

Demographic Data (Section I: A. b. i.)

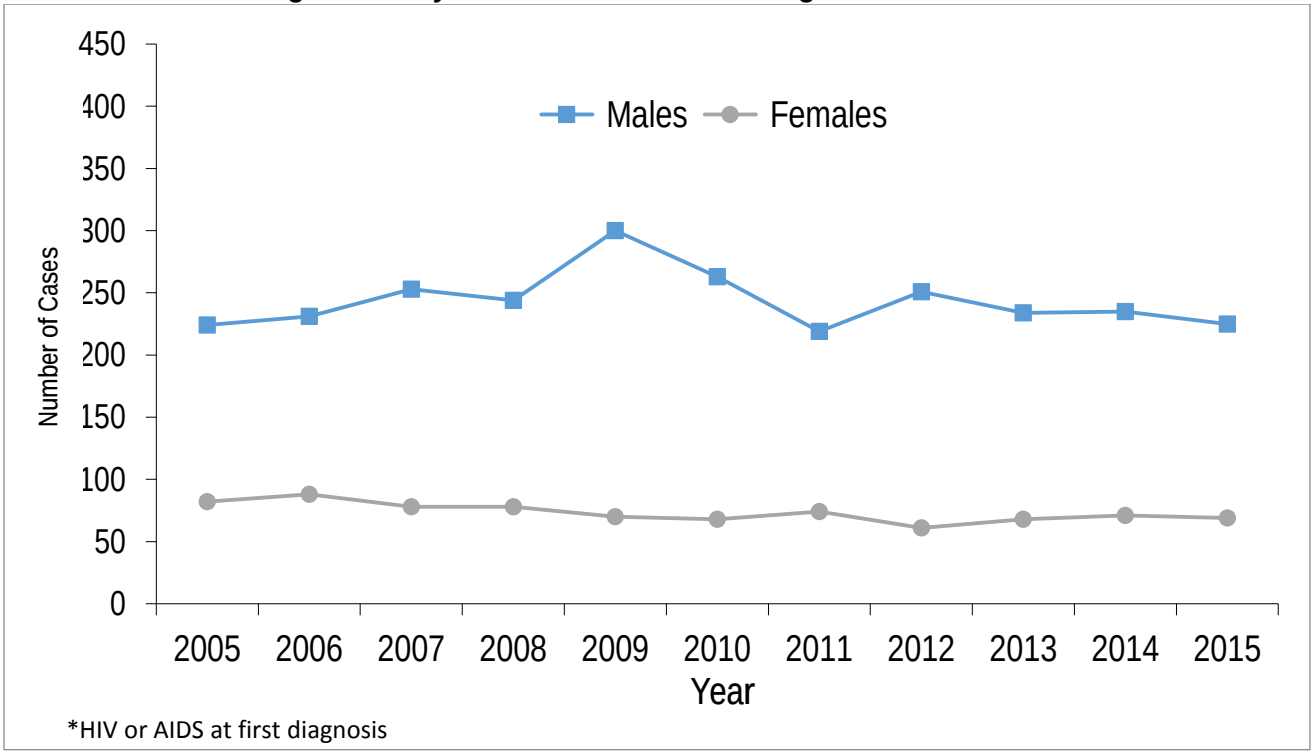
Gender & Race/Ethnicity

The HIV epidemic in the state and TGA remains largely male, 73% for the state and 76% for the TGA. Eighty-six percent of all males living with HIV/AIDS in Minnesota reside in the TGA. In Minnesota, there are a total of 1,965 women living with HIV/AIDS, 887 with an AIDS diagnosis and 1,078 with (non-AIDS) HIV. Eighty-four percent of all females living with HIV/AIDS in Minnesota reside in the TGA.

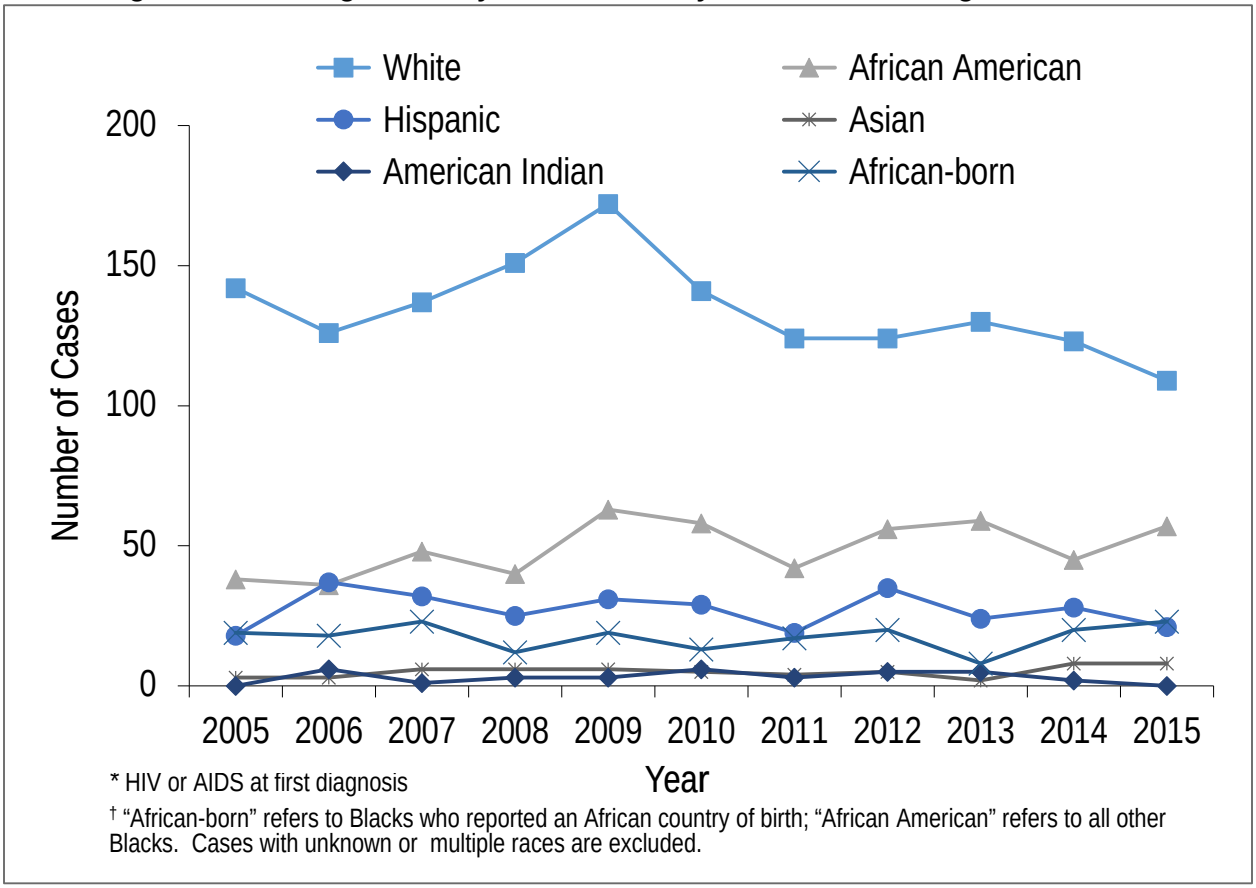
Non-Hispanic Whites comprise 49% of the epidemic (4,041 people) in the state and 48% in the TGA (3,345 people). The second largest ethnic group living with HIV/AIDS is non-Hispanic Blacks at 36% (2,932 people) in the state and 38% (2,641 people) in the TGA. Minnesota has a large East African population affected by HIV/AIDS, therefore, MDH reports for African American and African-born populations, where African-Americans have 22% (1,772 people) in the state and 23% (1,619 people) in the TGA and foreign-born Africans have 14% (1,160 people) in the state and 15% (1,022 people) living with HIV/AIDS. There are 742 people living with HIV disease that are Hispanic/Latinos of any race that represent 9% of the epidemic in the state and 9% in the TGA (623 people). Non-Hispanic Asian/Pacific Islanders and American Indian/Alaska Natives living with HIV/AIDS each comprise less than two percent of the total cases in the state and 2% in the TGA.

While non-Hispanic Whites are the largest racial/ethnic group of people living with HIV disease in Minnesota, it is important to understand that the infection is disproportionately affecting people of color. According to the 2010 U.S. Census, Whites comprise 81% of the TGA population, but they were only 40% of all new AIDS cases in 2015. While populations of color comprise only 19% of the TGA population, they represented an alarming 60% of the new AIDS cases in 2015. Persons of color comprise less than fifteen percent of the population in Minnesota, yet they represented 47% of newly diagnosed AIDS cases in 2015.

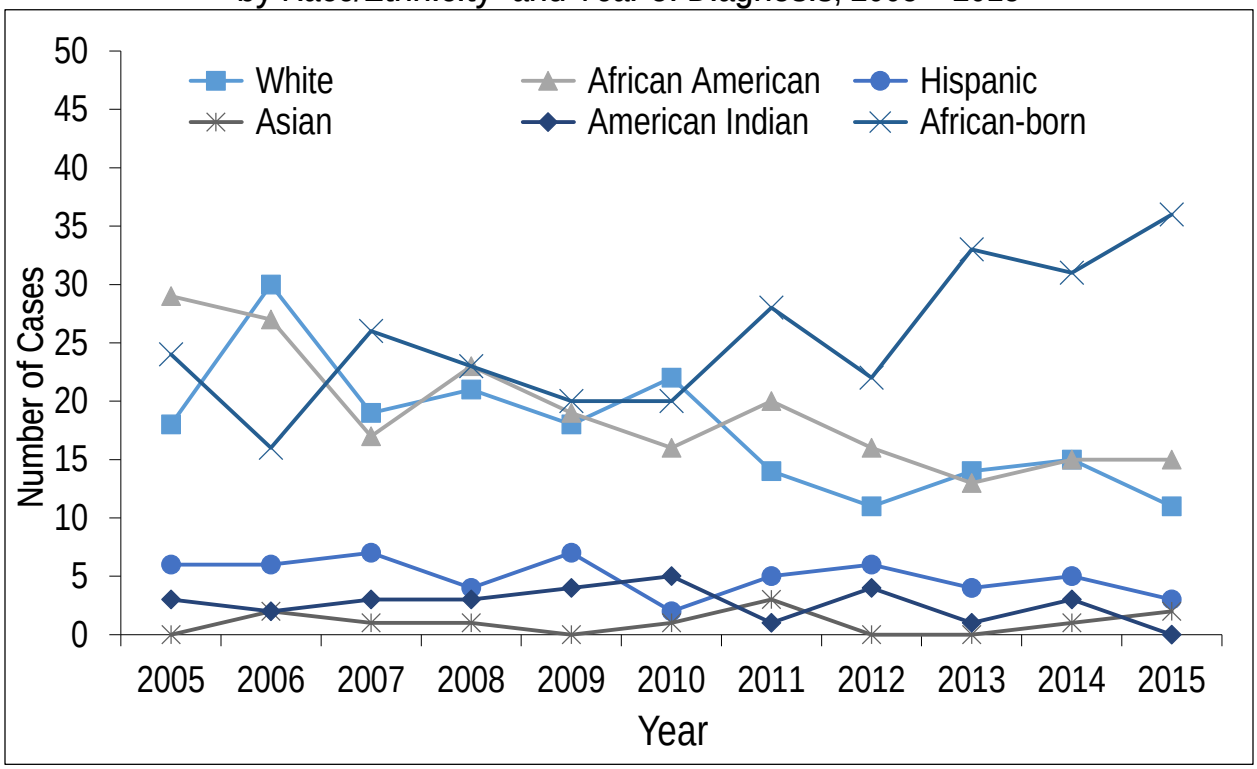
HIV Diagnoses* by Gender and Year of Diagnosis, 2005 - 2015



HIV Diagnoses* Among Males by Race/Ethnicity† and Year of Diagnosis, 2005 - 2015



HIV Diagnoses* Among Females
by Race/Ethnicity† and Year of Diagnosis, 2005 – 2015



* HIV or AIDS at first diagnosis

† "African-born" refers to Blacks who reported an African country of birth; "African American" refers to all other Blacks. Cases with unknown race are excluded.

New HIV Diagnoses by Gender & Race/Ethnicity[13]

Since the beginning of the epidemic, males have accounted for a majority of new HIV diagnoses per year. In 2015 numbers of new cases among males decreased by nine diagnoses from 2014, while the number of newly infected female cases decreased by four diagnoses compared to 2014, which is a 6% decrease for both males and females compared to 2014.

The most recent data illustrate that men and women of color continue to be disproportionately affected by HIV/AIDS. People of color account for 15% of Minnesota's population, yet account for 55% (163/294) of the cases diagnosed in 2015. Men of color make up approximately 17% of the male population and 49% of the infections diagnosed among men in 2015. White, non-Hispanic men make up approximately 83% of the male population in Minnesota and 49% of the new HIV infections diagnosed among men in 2015. Similarly for females, women of color make up approximately 13% of the female population and 81% of the new infections among women. White, non-Hispanic women make up approximately 83% of the female population and 16% of new infections among women in 2015.[14]

Note that race is not considered a biological reason for disparities in the occurrence of HIV experienced by persons of color. Race, however, can be considered a marker for other personal

[13] Black race was broken down into African-born and African American (Black, not African-born). The numbers exclude persons arriving through the HIV-Positive Refugee Resettlement Program and other refugee/immigrants with an HIV diagnosis prior to arrival.
[14] Population estimates based on U.S. Census 2010 data.

and social characteristics that put a person at greater risk for HIV exposure. These characteristics may include, but are not limited to, lower socioeconomic status, less education, and greater prevalence of drug use.

Trends in the annual number of new HIV infections diagnosed among males differ by racial/ethnic group. White males account for the largest number of new infections, but the proportion of cases that White males account for has decreased over time. In 2015, White males accounted for 49% of the new HIV diagnoses among men, with 109 diagnoses. During the past decade, the number of cases among African-American males has fluctuated from year to year, with 57 new HIV diagnoses in 2015. This represents a 27% increase among African-American males from 2014 to 2015.

The annual number of HIV infections diagnosed among Hispanic and African-born males has remained relatively stable, with fluctuation from year to year. A decrease in Hispanic males was observed in 2015, from 28 cases in 2014 to 21 in 2015, representing a decrease of 25%. Twenty three African-born males were diagnosed with HIV in 2015. This is an increase of 15% from 2014 when 20 cases were diagnosed.

Similarly, trends in the annual number of HIV infections diagnosed among females differ by racial/ethnic group. In 2015 women of color women accounted for 81% of the new diagnoses in Minnesota, with 56 new cases while white women accounted for 16% of new diagnoses (11 cases). Since 2005, the annual number of new infections diagnosed among African American females has decreased overall. In 2015 there were 15 cases diagnosed among African American women, compared to 16 in 2014. The number of diagnoses among African-born women has been increasing over the past decade. In 2015 the number of new cases among African-born women was 36, accounting for 52% of all new diagnoses among women. The annual number of new infections diagnosed among Hispanic, American Indian, Asian, and multi-racial females continues to be quite small (10 cases or fewer per year for each of these groups).

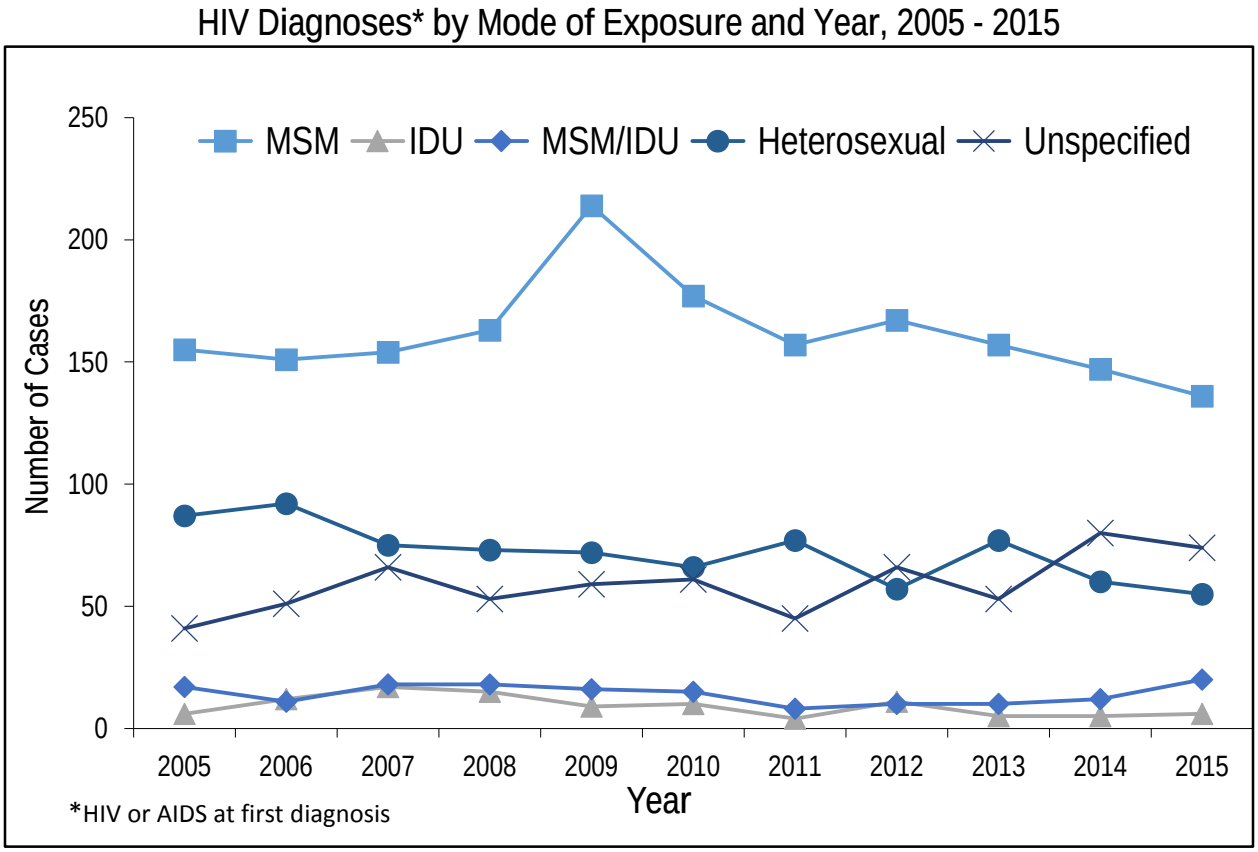
Beginning in 2012, MDH began estimating the number of men who have sex with men (MSM) living in Minnesota. MSM have the highest rate of HIV infection than any other sub-category. In 2015, the estimated rate of HIV infection among MSM was 168.1 per 100,000 population. This is more than 60 times higher than the rate among non-MSM men (2.7 per 100,000 population). It's important to note that MSM contains cases from all racial/ethnic categories and therefore cannot be directly compared to the rates by race/ethnicity. For more information on how this was estimated, see the *HIV Surveillance Technical Notes.*

Mode of Exposure

Exposure data is divided into two categories: Adult/Adolescent and Pediatric. For adults, the largest exposure category, as it has been throughout the history of the epidemic in this TGA and the state, is MSM. MSM comprise 52% of the infected population (3,641 individuals) in the TGA and 50% (4,119 individuals) in the state. At 11% (769 people), heterosexuals without another risk are the second largest exposure group in the TGA. IDU (339 people) and MSM and use injection drugs (347 people) are both 5% of the epidemic, respectively in the TGA. Less than one percent of those currently living with HIV/AIDS in the TGA are in the "Other/ Hemophilia/ Blood Transfusion" exposure group. A full 26% (1,814) of the cases have not had a risk reported or identified thus far in the reporting system in the TGA. Although the order of the risk factors is

identical for the state, the percentage of MSM exposures in the state (50%) is lower than that of the TGA and the remaining risk factors are slightly higher in the state.

The number of cases among children living with HIV disease in the TGA is nominal. Of the 81 living pediatric cases, 64 (79%) were exposed through their mother, 3 are in the "Other/Hemophilia/ Blood Transfusion" category (4%), and 14 (17%) had no risk reported or identified thus far in the reporting system. Of the 144 living pediatric cases in Minnesota, 109 (76%) were exposed through their mother, 6 are in the "Other/Hemophilia/ Blood Transfusion" category (4%), and 29 (20%) had no risk reported or identified thus far in the reporting system.



New HIV Diagnoses by Mode of Exposure

Starting in 2004, MDH has used a risk re-distribution method to estimate mode of exposure among those cases with unknown risk. For additional details on how this was done please read the *HIV Surveillance Technical Notes*. All mode of exposure numbers referred to in the text are based on the risk re-distribution.

Since the beginning, men have driven the HIV/AIDS epidemic in Minnesota and male-to-male sex has been the predominant mode of exposure reported. In 2015, MSM accounted for 52% of all new infections (69% among males) with 152 cases diagnosed. On a much smaller scale, the numbers of male cases attributed to IDU and MSM/IDU as well as heterosexual contact have remained somewhat stable over the past decade. The number of cases without a specified risk has increased overall for the past decade, accounting for 26% of male cases in 2015.

Throughout the epidemic, heterosexual contact has been the predominant mode of HIV exposure reported among females accounting for 76% of female cases in 2015. Injection drug users (IDU) was not reported among females in 2015. Unspecified risk represented 24% of female cases in 2015.

The proportion of cases attributable to a certain mode of exposure differs not only by gender, but also by race. Of the new HIV infections diagnosed among males between 2013 and 2015, MSM or MSM/IDU accounted for an estimated 97% of cases among White males, 94% of cases among Hispanic males, 86% of cases among African American males, and 12% of cases among African-born males. IDU was estimated as a risk in 2% of White male, Hispanic male, and African American male cases diagnosed during 2013-2015. The number of cases among Asian and American Indian men during the years 2013-2015 was insufficient to make generalizations regarding risk (less than 20 cases in each group). There were no cases attributed to IDU alone among African-born males during this same time period.

Heterosexual contact accounted for an estimated 98% of cases among African-born females, 94% of African American females, and 92% of White females between 2013 and 2015.

IDU was estimated as a risk for 8% of cases among White women. No cases were attributed to IDU among African American and African-born females during this same time period. The small number of cases in 2013-2015 among Hispanic, Asian, and American Indian women (less than 20 cases in each group) is insufficient to make generalizations regarding risk.

Mother-to-Child HIV Transmission

The ability to interrupt the transmission of HIV from mother to child via antiretroviral therapy and appropriate perinatal care is an important accomplishment in the history of the HIV/AIDS epidemic. Newborn HIV infection rates range from 25-30% without antiretroviral therapy, but decrease to 1-2% with appropriate medical intervention.

For the past decade the number of births to HIV-infected women increased steadily from 41 in 2005 to 59 births in 2015. The rate of transmission has decreased from 15% between 1994 and 1996 to 1.6% in the past three years, with 2 HIV+ babies born to HIV+ mothers in Minnesota in 2015.

The rate of transmission in Minnesota between 1982 and 1994 (before widespread use of zidovudine[15] to prevent mother-to-child HIV transmission) was 25%. Proper prenatal care, including HIV screening for all pregnant women and appropriate medical intervention for those infected, is a vital element in preventing the spread of HIV.

Age

Minnesota's population is growing and, like the rest of the nation, getting older. The median age in Minnesota increased from 35.4 years in 2000 to 37.4 years in 2010 mainly due to the aging "baby boomer" population. Despite the rising median age, population growth was most apparent in younger age groups, particularly among 20 to 29 year olds whose number increased by 13% between 2000 and 2010. According to the 2010 Census, 3.18 million persons (60%) living in

[15] A common antiretroviral drug.

Minnesota were under the age of 45. There is little difference in the age distribution between the state and the TGA.

In 2015, 44% of all male cases diagnosed with HIV were under the age of 30, compared to 32% of females diagnosed in this age group. The average age at diagnosis among males in 2015 decreased to 35 years compared to an average of 36 years old in 2014. The average age at diagnosis among women was 39 years in 2015.

The largest age group of those in Minnesota living with HIV disease is the 4,860 people in the 45+ age range (59%). Second largest, 3,240 people, is the 20-44 age group (39%). Teens (13-19 years old) make up 0.7% of the epidemic (59 people), while less than 1% (49 individuals) are under the age of 13. These percentages are mirrored almost identically in the TGA.

Age Distribution in Minnesota and in TGA

Age	**Minnesota** (n = 5,303,925)	**Minneapolis – St. Paul TGA** (n = 3,279,833)
< 13	17.3%	18.1. %
13 – 19	9.6%	9.6%
20 – 24	6.7%	6.5%
25 – 29	7.0%	7.6%
30 – 34	6.5%	7.0%
35 – 39	6.2%	6.7%
40 – 44	6.7%	7.2%
45 – 49	7.7%	7.9%
50 – 54	7.6%	7.5%
55 – 59	6.6%	6.3%
60 +	18.2%	15.8%

Race and Ethnicity Distribution by Gender in Minnesota and TGA

	Minnesota		**Minneapolis-St. Paul TGA**	
	(n=2,632,132)	(n=2,671,793)	(n=1,618,907)	(n=1,660,926)
Race / Gender	**Male**	**Female**	**Male**	**Female**
White (non-Hispanic)	82.7%	83.4%	78.3%	78.9%
Black / African American	5.3%	5.0%	7.5%	78.3%
American Indian	1.1%	1.1%	0.7%	0.7%
Asian / Pacific Islander	4.0%	4.2%	5.6%	5.9%
Other race	2.1%	1.8%	2.5%	2.2%
Two or more races	2.4%	2.4%	2.8%	2.8%
Hispanic / Latino*	5.0%	4.4%	5.7%	5.0%

*Includes all races

Of note is the growing number of African immigrants in Minnesota. The Minnesota State Demographer's office estimates there are 72,930[16] African-born persons living in Minnesota in 2011. However, many believe this to be an underestimate of the true African population in Minnesota, with some community members estimating that number at close to 100,000[17]. Somalia, Ethiopia, and Liberia are the most common countries of origin although nearly every country in Africa is represented in Minnesota. Data from the MDH Refugee Health Program indicate that the number of sub-Saharan African primary refugees arriving in Minnesota has declined dramatically between 2006 and 2013 (from 4,764 cases in 2006 to 953 cases in 2013 – a decrease of 80%).

Additionally, in 2000 Minnesota became one of six initial sites in the United States to receive HIV-infected refugees. Prior to November 2009, immigrants, including refugees, were not permitted entry into the U.S. if they tested positive for HIV during their overseas physical exam unless they obtained a waiver. Agencies with local offices in the Twin Cities coordinated the arrival and resettled 200 HIV-infected refugees to Minnesota from August 2000 through December 2010, of which the majority were from African countries. However, beginning in 2010, the Federal Government reversed the statute barring entry for HIV positive immigrants. Consequently, HIV infection is no longer a barrier for entering the United States. Therefore, Minnesota added routine HIV screening to the refugee screening protocol in 2010.

Socio-Demographic Data (Section 1:A.b.ii.)

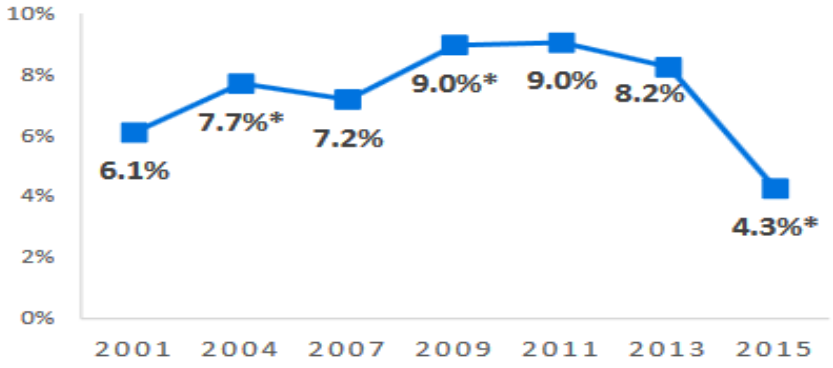
Access to Health Care: Health Insurance

Overall, Minnesota has one of the lowest rates of uninsured residents in the nation with 2015 showing the lowest rates of uninsurance since data started being collected in the early 1990s. According to data released from the 2015 Minnesota Health Access Survey, 4.3% of Minnesotans were not covered by health insurance at the time of the survey compared to 8.2% in 2013, 9.0% in 2011, 9.0 in 2009 and 7.2% in the 2007 survey. However, the findings in this study suggest that significant differences continue to exist according to race/ethnicity, age, and income and country of birth.

[16] Based on U.S. Census 2010 data, the Minnesota State Demographic Center estimates that there are 380,764 foreign-born persons, including 72,930 African-born persons are living in Minnesota out of a total population of 5,303,925.

[17] The American Community Survey is conducted by the U.S. Census Bureau for the years in between the decennial census. Because there are many reasons African-born persons may not be included in the census count (e.g. difficulties with verbal or written English), even 50,000 is likely an underestimate of the actual size of the African-born population living in Minnesota. Anecdotal estimates from African community members in Minnesota are as high as 100,000.

Uninsurance rates in Minnesota, 2001 to 2015



Source: Minnesota Health Access Survey
*Indicates statistically significant difference from previous year shown at the 95% level

Notable differences continue to exist among the different race/ethnic groups. While only 3.4% of Whites were uninsured in 2015, the percentages among Hispanics (11.7%), American Indians (8.7%), and Blacks (8.4%) were considerably higher.

In 2015, persons aged 18-34 experienced uninsurance rates significantly above the statewide rate (7.3%, compared to 4.3% statewide). Persons aged 55-64 have halved their uninsurance rate from 6.2% in 2016 to 2.8% in 2015.

Country of birth is a significant factor in uninsurance rates in Minnesota. In 2013, people born in the United States had significantly lower uninsurance rate than the statewide rate of 6.6% while those not born in the United States had a significantly higher uninsurance rate of 26.4%. 2015 data for this group has yet to be released.

Poverty and Income

Minnesota overall has fared somewhat better than the nation as a whole in regards to poverty and income. According to the 2011-2013 ACS, an estimated 11.6% of Minnesotans were living below the Federal Poverty Level (FPL) compared to 15.9% nationally. Likewise, the per capita income from 2011-2013 for the United States was $27,884 and $30,902 in Minnesota. While these aggregate numbers are favorable, they misrepresent the disproportionate impact poverty has on persons of color. The 2011-2013 ACS estimates that 12% of all Minnesotans were living at or below the poverty level, however, this percent varied greatly by race, with 8% of Whites at or below the poverty level compared to 36%, 35%, 17%, and 24% of Blacks, American Indians, Asians/Pacific Islanders, and Hispanics, respectively.

Employment

According to Minnesota Department of Employment and Economic Development, Minnesota's unemployment rate decreased from 5.6% in 2012 to 4.1% in 2014. This is the lowest rate of unemployment since 2006 and the 2014 unemployment rate in Minnesota is substantially lower than the 2014 national unemployment rate average of 6.2%. However, the overall unemployment rates disguise staggering racial disparities. The 2011-2013 ACS indicated an unemployment rate

of 17.3%, 10.1% and 18.3% for Blacks, Hispanics and American Indians, respectively in Minnesota compared to 5.4% among White (non-Hispanics).

Education
Minnesota's emphasis on education is reflected in the low statewide percentage (7.7%) of people aged 25 years or older who have less than a high school education; the national average is 14.4%. However, the percentage of persons with less than a high school education is greater for persons of color in Minnesota. According to the 2011-2013 ACS, 17% of Black men and 22% of Black women are estimated to have less than a high school education compared to 6% and 5% of White men and women, respectively. High school graduation rates are even lower among Hispanics/Latinos, with 38% and 33% of Hispanic males and females not having a high school diploma, respectively.

Homelessness
Homelessness is also seen as a social determinant of health. According to the 2015 Wilder Homelessness Survey, an estimated 9,312 people were homeless in Minnesota.[18] While the total number of homeless decreased by 9% from 2012, for persons who are HIV positive, homelessness can mean reduced access to treatment and lower survival rates, Also, persons who are homeless (particularly youth) may be at higher risk for having unprotected sex and using injection drugs.

Sensory Disability
Written and/or verbal communication can be hindered for persons with a sensory disability(ies). Depending on the medium, general HIV awareness and prevention messages cannot be assumed to reach such populations. According to 2011 - 2013 American Community Survey (ACS) data, 3.6% of non-institutionalized Minnesotans are estimated to be living with hearing difficulty and 3.9% of non-institutionalized Minnesotans are estimated to be living with vision difficulty.

MDH HIV/AIDS Surveillance, Cumulative cases (Section I: A. c.)
AIDS has been tracked in Minnesota since 1982. In 1985, AIDS officially became a reportable disease to state and territorial health departments nationwide. Also in 1985, when the Food and Drug Administration approved the first diagnostic test for HIV, Minnesota became the first state to make HIV infection a reportable condition. As of December 31, 2015, a cumulative total of 11,009 cases of HIV infection have been reported among Minnesota residents.[19] Of these 11,009 cases, 3,737 (34%) are known to be deceased through correspondence with the reporting source, other health departments, review of death certificates, active surveillance, and matches with the National Death Index and Social Security Death Master File.

Prevalence Rates
Unless otherwise noted, all of the data given in this section comes from the MDH and the State of Wisconsin HIV/AIDS Electronic Reporting Systems (eHARS). This data is used rather than data provided by the Centers for Disease Control (CDC) for several reasons. Minnesota has been collecting HIV infection data since 1985 and has a highly accurate reporting system. Also, the

[18] http://www.wilder.org/Wilder-Research/Research-Areas/Homelessness/Pages/Statewide-Homeless-Study-Most-Recent-Results.aspx

[19] This number includes persons who reported Minnesota as their state of residence at the time of their HIV and/or AIDS diagnosis. It also includes persons who may have been diagnosed in a state that does not have HIV reporting and who subsequently moved to Minnesota and were reported here. HIV-infected persons currently residing in Minnesota, but who resided in another HIV-reporting state at the time of diagnosis are excluded.

MDH data provides more detailed demographic information than the CDC data. All data in this section comes from data collected for all HIV/AIDS cases through December 31, 2015.

HIV Prevalence: Minnesota

Demographic Group/ Exposure Category	**AIDS PREVALENCE IN MINNESOTA AS OF 12/31/2015**		**HIV (NOT AIDS) PREVALENCE IN MINNESOTA AS OF 12/31/2015**	
	AIDS Prevalence is defined as the number of people living with AIDS as of the date specified.		***HIV Prevalence is defined as the estimated number of diagnosed people living with HIV (not AIDS) as of the date specified.***	
Race/Ethnicity	**Number**	**% of Total**	**Number**	**% of Total**
White, non-Hispanic	1816	47.0%	2225	51.3%
Black, African-American/non-Hispanic	848	22.0%	924	21.3%
Black, African-born/non-Hispanic	554	14.3%	606	14.0%
Hispanic, any race	403	10.4%	339	7.8%
Asian/Pacific Islander, non-Hispanic	81	2.1%	83	1.9%
American Indian/Alaska Native, non-Hispanic	60	1.6%	52	1.2%
Multi- Race-non-Hispanic	98	2.5%	112	2.6%
Unknown	6	0.1%	8	0.2%
Total	**3866**	**100.0%**	**4349**	**100.0%**
Gender	Number	% of Total	Number	% of Total
Male	2979	77.1%	3271	75.2%
Female	887	22.9%	1078	24.8%
Total	**3866**	**100.0%**	**4349**	**100.0%**
Age at Diagnosis (Years)	Number	% of Total	Number[1]	% of Total
<13 years	3	0.1%	46	1.1%
13 - 19 years	9	0.2%	50	1.2%
20 - 44 years	1221	31.6%	2019	46.4%
45+ years	2633	68.1%	2227	51.2%
Total	**3866**	**100.0%**	**4349**	**100.0%**

Demographic Group/ Exposure Category	**AIDS PREVALENCE IN MINNESOTA AS OF 12/31/2015** ***AIDS Prevalence is defined as the number of people living with AIDS as of the date specified.***		**HIV (NOT AIDS) PREVALENCE IN MINNESOTA AS OF 12/31/2015** ***HIV Prevalence is defined as the estimated number of diagnosed people living with HIV (not AIDS) as of the date specified.***	
Adult/Adolescent Exposure Category	***Number***	***% of Total***	***Number***	***% of Total***
Men who have sex with men	1845	48.2%	2274	53.5%
Injection drug users	251	6.6%	184	4.3%
Men who have sex with men and inject drugs	220	5.8%	202	4.8%
Heterosexuals	878	23.0%	970	22.8%
Other/Hemophilia/blood transfusion	21	0.5%	10	0.2%
Risk not reported or identified	609	15.9%	607	14.3%
Total	**3824**	**100.0%**	**4247**	**100.0%**
Pediatric Exposure Categories	**Number**	**% of Total**	**Number**	**% of Total**
Mother with/at risk for HIV infection	35	83.3%	76	74.5%
Other/Hemophilia/blood transfusion	4	9.5%	2	2.0%
Risk not reported or identified	3	7.2%	24	2.4%
Total	**42**	**100.0%**	**102**	**100.0%**

HIV Prevalence: MSP-TGA

Demographic Group/ Exposure Category	AIDS PREVALENCE IN TGA AS OF 12/31/2015		HIV (NOT AIDS) PREVALENCE IN TGA AS OF 12/31/2015	
	AIDS Prevalence is defined as the number of people living with AIDS as of the date specified.		***HIV Prevalence is defined as the estimated number of diagnosed people living with HIV (not AIDS) as of the date specified.***	
Race/Ethnicity	**Number**	**% of Total**	**Number**	**% of Total**
White, non-Hispanic	1462	44.9%	1883	50.1%
Black, African-American/non-Hispanic	772	23.7%	847	22.7%
Black, African-born/non-Hispanic	500	15.3%	522	13.9%
Hispanic, any race	332	10.2%	291	7.8%
Asian/Pacific Islander, non-Hispanic	67	2.1%	65	1.7%
American Indian/Alaska Native, non-Hispanic	41	1.3%	42	1.1%
Multi- Race-non-Hispanic	79	2.4%	89	2.4%
Unknown	5	0.1%	6	0.1%
Total	**3258**	**100.0%**	**3756**	**100.0%**
Gender	**Number**	**% of Total**	**Number**	**% of Total**
Male	2502	76.8%	2864	76.3%
Female	756	23.2%	892	23.8%
Total	**3258**	**100.0%**	**3756**	**100.0%**
Age at Diagnosis (Years)	**Number**	**% of Total**	**Number**	**% of Total**
<13 years	0	0.0%	26	0.7%
13 - 19 years	4	0.1%	35	0.9%
20 - 44 years	1016	31.2%	1756	46.8%
45+ years	2238	68.7%	1935	51.5%
Unknown	0	0.0%	4	0.1%
Total	**3258**	**100.0%**	**3756**	**100.0%**

Demographic Group/ Exposure Category	**AIDS PREVALENCE IN TGA AS OF 12/31/2015** ***AIDS Prevalence is defined as the number of people living with AIDS as of the date specified.***		**HIV (NOT AIDS) PREVALENCE IN TGA AS OF 12/31/2015** ***HIV Prevalence is defined as the estimated number of diagnosed people living with HIV (not AIDS) as of the date specified.***	
Adult/Adolescent Exposure Category	***Number***	***% of Total***	***Number***	***% of Total***
Men who have sex with men	1594	49.2%	2047	55.4%
Injection drug users	192	5.9%	147	4.0%
Men who have sex with men and inject drugs	178	5.5%	169	4.6%
Heterosexuals	381	11.8%	388	10.5%
Other/Hemophilia/blood transfusion	16	0.5%	7	0.2%
Risk not reported or identified	877	27.1%	937	25.5%
Total	**3238**		**3695**	**100.0%**
Pediatric Exposure Categories	***Number***	***% of Total***	***Number***	***% of Total***
Mother with/at risk for HIV infection	16	80.0%	48	78.9%
Other/Hemophilia/blood transfusion	2	10.0%	1	0.3%
Risk not reported or identified	2	10.0%	12	19.8%
Total	**20**	**100.0%**	**61**	**100.0%**

Number of Cases and Rates (per 100,000 persons) of Persons Living with HIV/AIDS by Race/Ethnicity† – Minnesota, 2015

Race/Ethnicity	*Cases*	*%*	*Rate*
White, non-Hispanic	4,041	49%	91.7
Black, African-American	1,772	22%	924.9
Black, African-born	1,160	14%	1495.7††
Hispanic	742	9%	296.5
American Indian	112	1%	202.1
Asian/Pacific Islander	164	2%	76.3
Other^	210	3%	X
Total	***8,201***	***100%***	***154.6***

†† Estimate of 77,557 Source: 2010-2012 American Community Survey. Additional calculations by the State Demographic Center.
^ Other = Multi-racial persons or persons with unknown race
Census Data used for rate calculations.
† "African-born" refers to Blacks who reported an African country of birth; "African American" refers to all other Blacks.

Number of Cases and Rates (per 100,000 persons) of Adults and Adolescents* Living with HIV/AIDS by Gender/Risk†, Minnesota, 2015

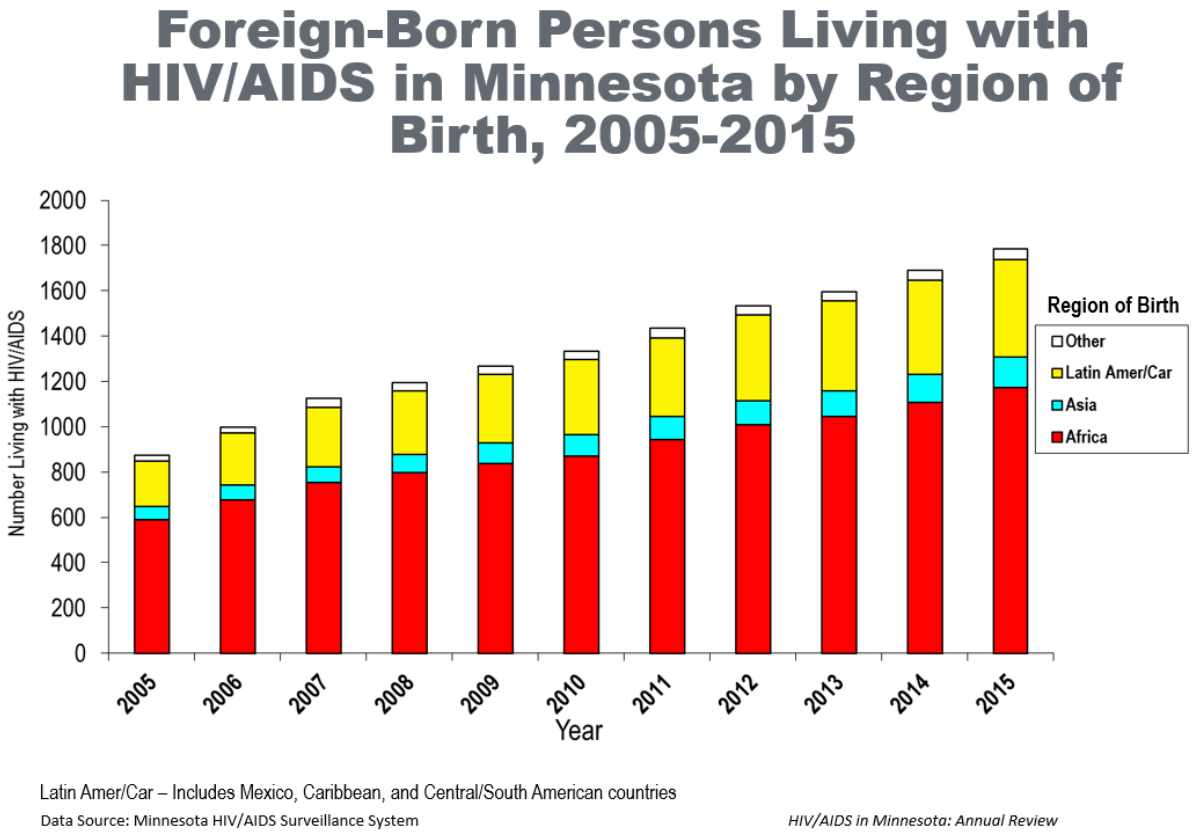
Gender/Risk	*Cases*	*%*	*Rate*
Men (Total)	(6,250)	76%	237.5
MSM†	*4,538*	*73%*	4,891.8††
Non-MSM	*1,712*	*27%*	67.4
Women	1,965	24%	73.5
Total	*8,215*	*100%*	*154.9*

†† Estimate of 92,788
**HIV or AIDS at first diagnosis age 13 and older;*
- *2010 U.S. Census Data for persons age 13 and over used for rate calculations.*

† "MSM" refers to both MSM and MSM/IDU.

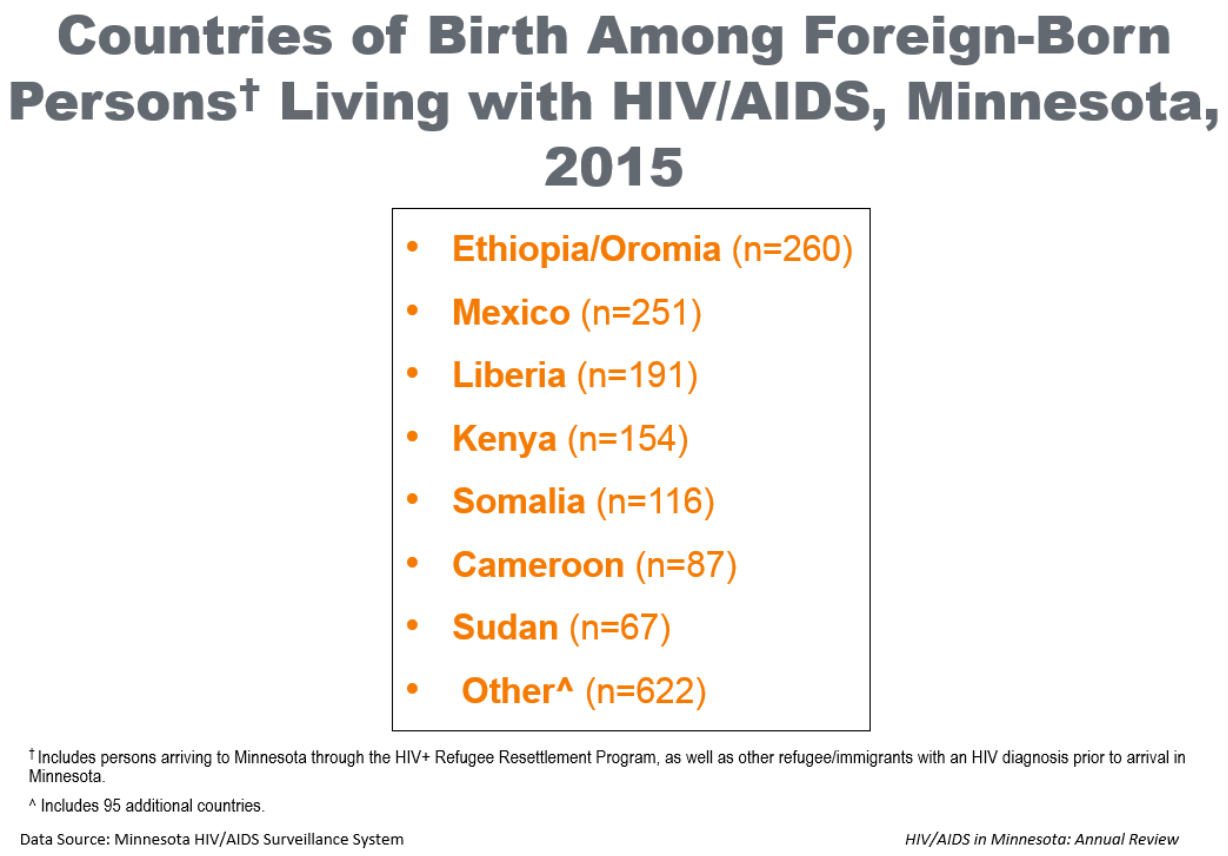
Number of Cases of Adults and Adolescents* Living with HIV/AIDS by Gender Identity and Risk†, Minnesota, 2015

Gender/risk	*Cases*	*%*
Men (Total)	(6,206)	76%
MSM[T]	*4,504*	*73%*
Non-MSM	*1,702*	*27%*
Women	1,957	24%
Transgender (Total)	52	0.6%
Male to Female	*44*	*85%*
Female to Male	*8*	*15%*
Total	*8,215*	*100%*



Between 1990 and 2015, the number of foreign-born persons living with HIV/AIDS in Minnesota increased substantially, especially among the African-born population. In 1990, 50

foreign-born persons were reported to be living with HIV/AIDS in Minnesota, and by 2003 this number had increased twelve-fold to 692 persons. In 2015, the total number of foreign-born persons living with HIV/AIDS in Minnesota was 1,785, a 6% increase from 2014. This trend illustrates the growing diversity of the infected population in Minnesota and the need for culturally appropriate HIV care services and prevention efforts.



Seven countries (Ethiopia, Mexico, Liberia, Kenya, Somalia, Cameroon, and Sudan) account for a majority (64%) of living foreign-born cases, however there are 95 additional countries represented among the 1,748 foreign-born persons living with HIV infection in Minnesota.

Incident Rates

Number of Cases and Rates (per 100,000 persons) of HIV Diagnoses* by Race/Ethnicity†– Minnesota, 2015

Race/Ethnicity	*Cases*	*%*	*Rate*
White, non-Hispanic		42%	2.7
Black, African-American	70	24%	36.5
Black, African-born	59	20%	76.1††
Hispanic	24	8%	9.6
American Indian	0	0%	0.0
Asian/Pacific Islander	10	3%	4.7
Other^	6	2%	#
Total	*289*	*100%*	*5.4*

** HIV or AIDS at first diagnosis; 2010 U.S. Census Data used for rate calculations.*
† "African-born" refers to Blacks who reported an African country of birth; "African American" refers to all other Blacks.
†† Estimate of 77,557 Source: 2010-2012 American Community Survey. Additional calculations by the State Demographic Center.
^ Other = Multi-racial persons or persons with unknown or missing race
#-Number of cases too small to calculate reliable rate

Number of Cases and Rates (per 100,000 persons) of Adult and Adolescent HIV Diagnoses by Gender/Risk†, Minnesota, 2015**

Gender/Risk	*Cases*	*%*	*Rate*
Men (Total)	(225)	76%	8.5
MSM†	*156*	*69%*	168.1††
Non-MSM	*69*	*31%*	2.7
Women	68	23%	2.5
Total	*294*	*100%*	*5.5*

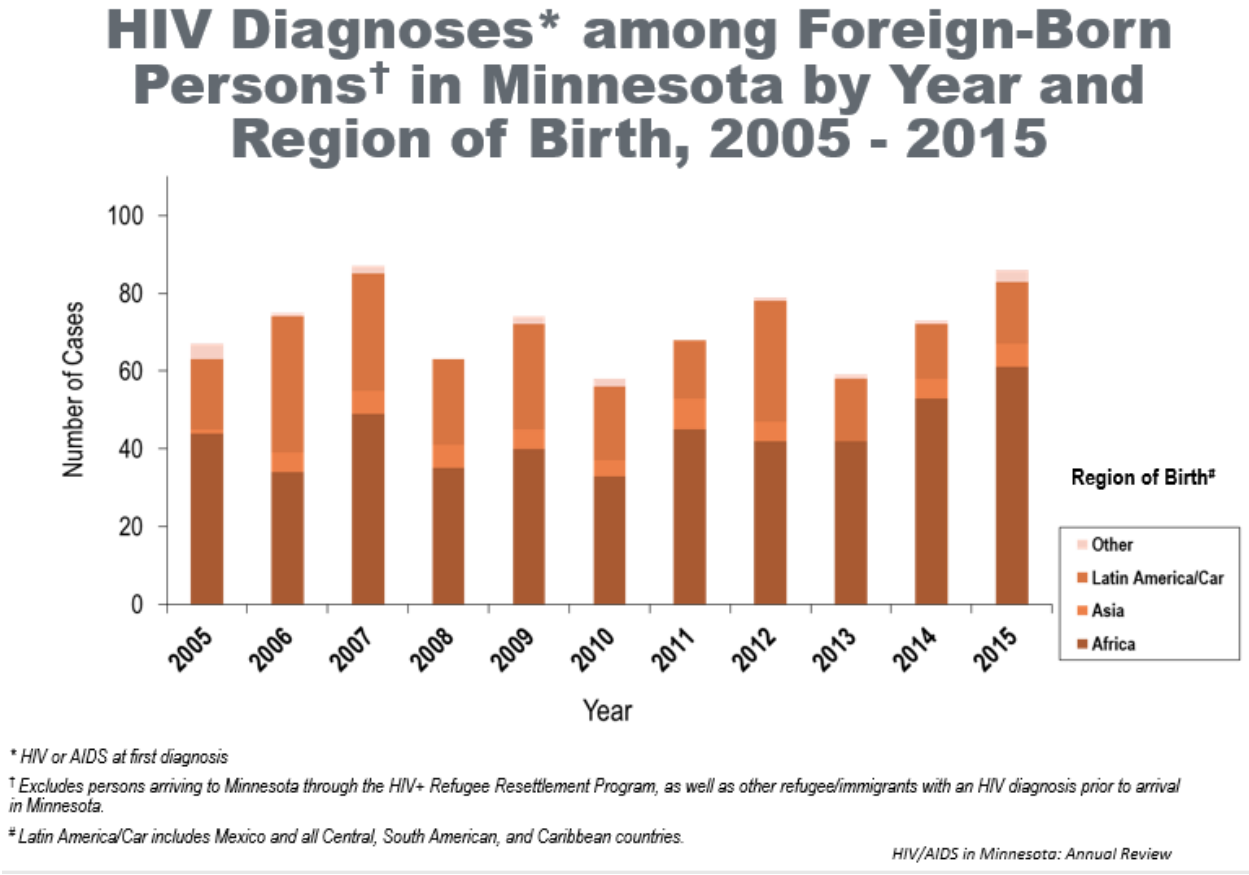
***HIV or AIDS at first diagnosis over the age of 13*
- *2010 U.S. Census Data for persons age 13 and over used for rate calculations.*

† "MSM" refers to both MSM and MSM/IDU.
†† Estimate of 92,788

Number of Cases of Adult and Adolescent HIV Diagnoses by Gender Identity and Risk†, Minnesota, 2015**

Gender/Risk	*Cases*	*%*
Men (Total)	(220)	75%
MSM†	*152*	*69%*
Non-MSM	*68*	*31%*
Women	68	23%
Transgender (Total)	5	2%
Male to Female	*5*	*100%*
Female to Male	*0*	*0%*
Total	*294*	*100%*

***HIV or AIDS at first diagnosis over the age of 13*
† "MSM" refers to both MSM and MSM/IDU.



** HIV or AIDS at first diagnosis*

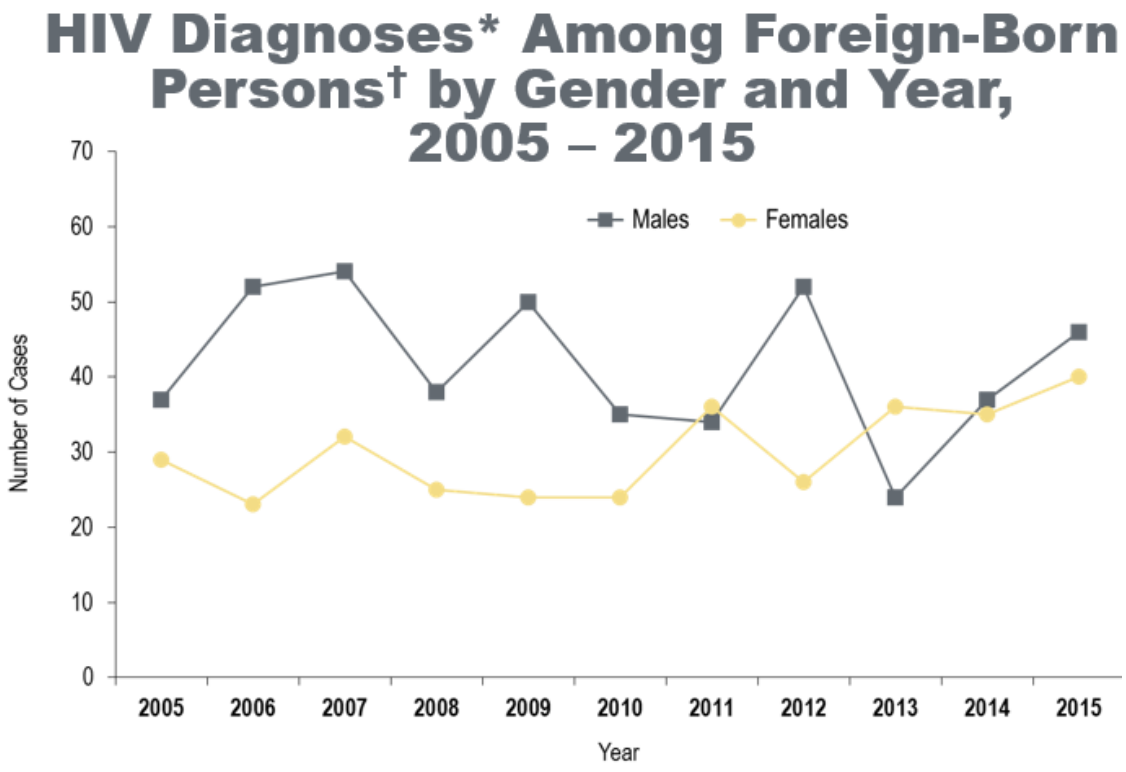
† Excludes persons arriving to Minnesota through the HIV+ Refugee Resettlement Program, as well as other refugee/immigrants with an HIV diagnosis prior to arrival in Minnesota.

‡ Latin America/Car includes Mexico and all Central, South American, and Caribbean countries.

HIV/AIDS in Minnesota: Annual Review

The number of new HIV infections diagnosed among foreign-born persons in Minnesota has steadily increased from 20 cases in 1990 to 86 cases in 2015. This increase has been largely driven by the increase of cases among African-born persons from 8 cases in 1990 to 61 cases in 2015, as well as, persons from Mexico, Central and South America from 6 cases in 1990 to 16 cases in 2015. Among new HIV infections diagnosed in 2015, 29% were among foreign-born persons. Based on 2010-2012 American Community Survey data, foreign-born persons make up 7% of the total Minnesota population and are, therefore, disproportionately affected by HIV. Among African-born this disparity is even more evident, while African-born persons make up just over 1% of the Minnesota population they accounted for 21% of new HIV infections in 2014.

In 2015, there were 86 cases of newly reported HIV among foreign-born persons, representing nearly 3 out of 5 of all new cases. This is up from 73 cases in 2014. The majority of foreign born cases in 2015 were from Africa, followed by Latin America and the Caribbean.

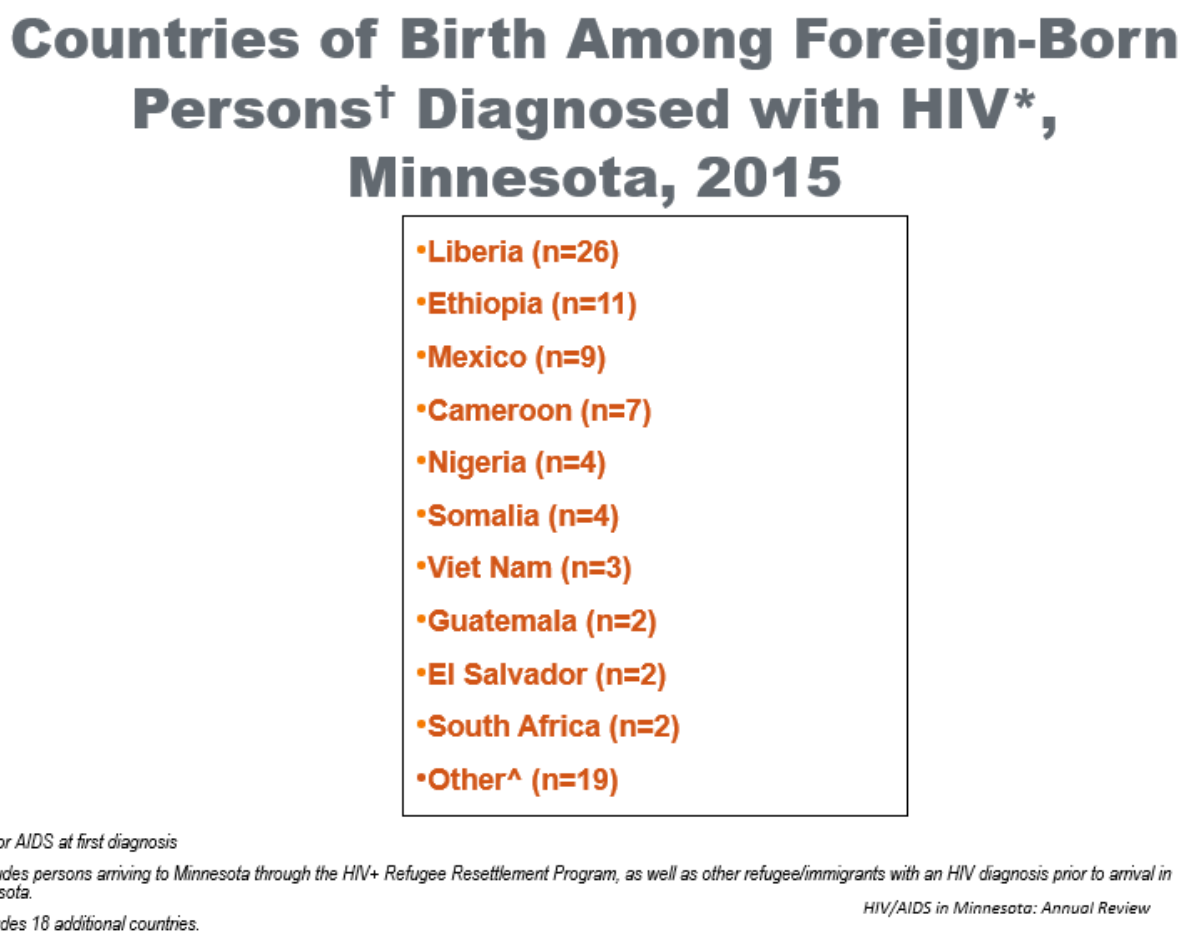


*HIV or AIDS at first diagnosis

†Excludes persons arriving in Minnesota through the HIV+ Refugee Resettlement Program, as well as other refugee/immigrants with an HIV diagnosis prior to arrival in Minnesota.

HIV/AIDS in Minnesota: Annual Review

In 2015, the number of foreign-born males increased from 37 cases in 2014 to 46 in 2015. This represents a 24% increase. There was also an increase for foreign-born females from 35 in 2014 to 40 in 2015.

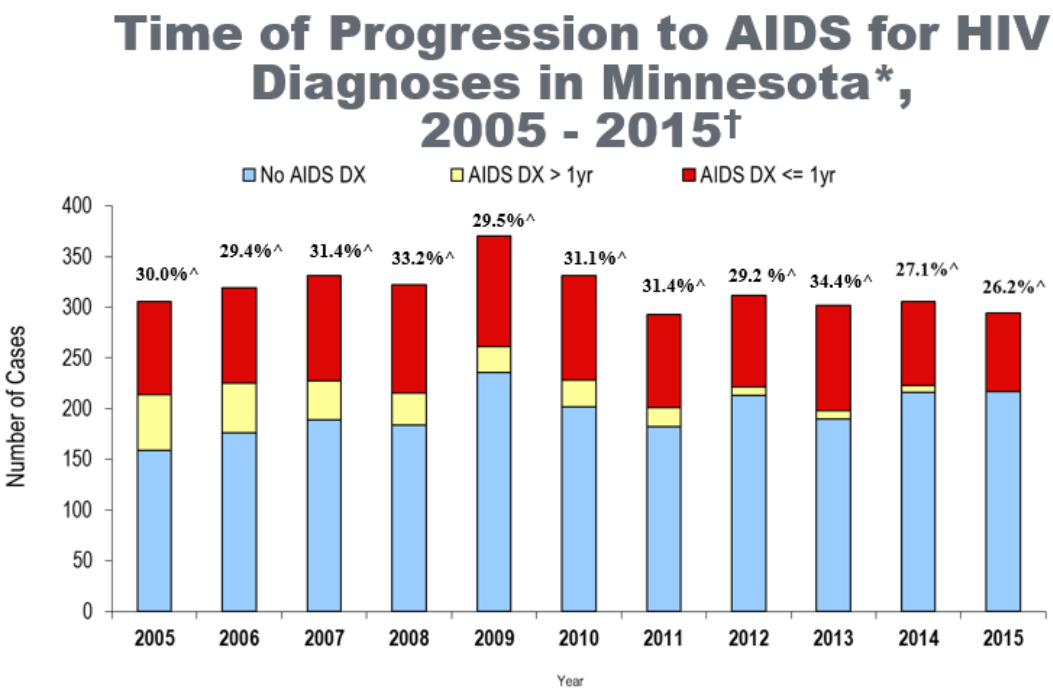


Four countries (Liberia, Ethiopia, Mexico, and Cameroon) accounted for a majority of new infections among foreign-born persons, however there are over 28 countries represented among the 86 new foreign born cases in 2015.

Late Testers

Late testers are defined as anyone with an AIDS diagnosis within one year of their initial HIV diagnosis. This is an important trend to watch as people who progress to AIDS within one year of their HIV diagnosis represent persons who are likely diagnosed well after their initial infection and represent missed testing opportunities earlier in the course of their infection.

In 2015, 26% of new cases were late testers. This proportion of cases has remained relatively the same over the past 10 years. Most late testers, about 85%, are diagnosed with AIDS at the same time they are initially diagnosed with HIV infection. As with other characteristics of the HIV epidemic in Minnesota, the proportion of late testers varies by demographic characteristics. We will review these differences in the next set of graphs.

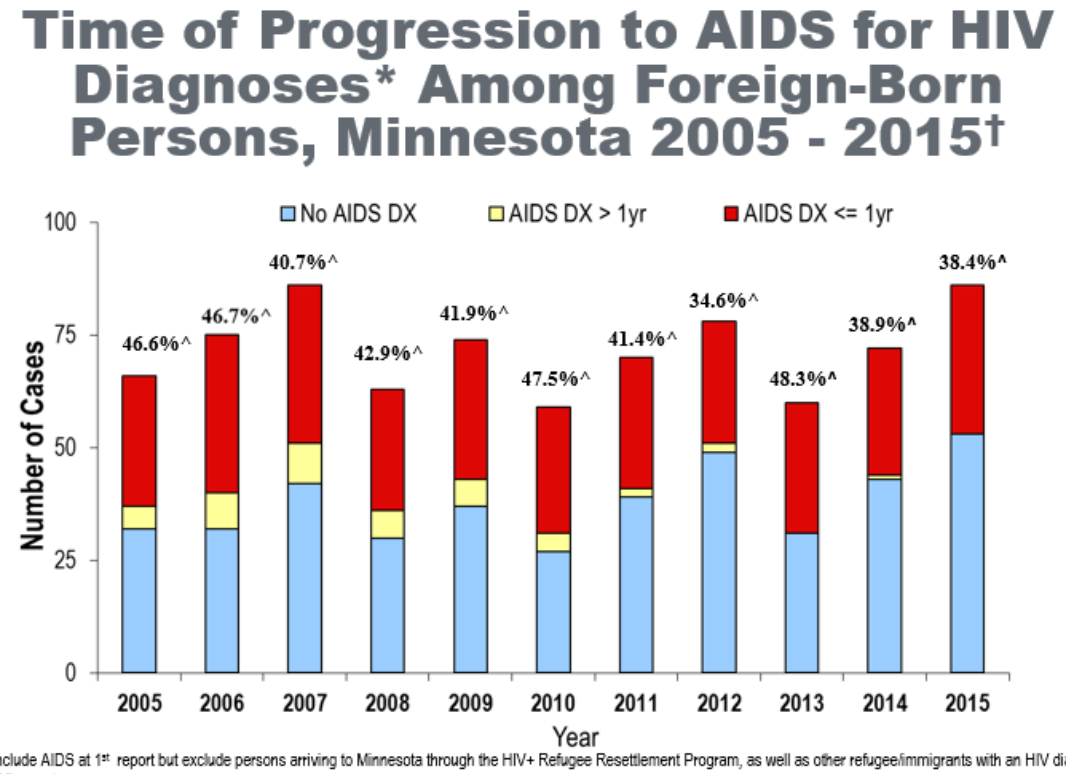


*Numbers include AIDS at 1st report but exclude persons arriving to Minnesota through the HIV+ Refugee Resettlement Program, as well as other refugee/immigrants with an HIV diagnosis prior to arrival in Minnesota.

^ *Percent of cases progressing to AIDS within one year of initial diagnosis with HIV*

† Numbers/Percent for cases diagnosed in 2015 only represents cases progressing to AIDS through April 6, 2016.

HIV/AIDS in Minnesota: Annual Review



During the past decade, foreign-born cases have a higher rate of late testers compared to US-born cases. In 2015, 38% of foreign-born cases were late testers compared to 21% of US-born cases.

Indicators of Risk for HIV in the Population (Section I: A. d.)

Behavioral Surveillance (Section 1: A. d. i.)
MDH collects a small amount of behavioral data as it relates to HIV and AIDS surveillance information. For example, reports of HIV infection received by MDH include information on drug use and sexual behaviors. Additionally, from time to time MDH will undertake special projects with the intent of collecting behavioral data on specific populations. Examples of these are the 2001 Minnesota STD Prevalence Study (ages 12-24) and the 2004 and 2007 Twin Cities Men's Health Surveys (MSM 18 and older) and the 2011 Minnesota Men's Health Study (MSM 18 and older).

There are also recurring surveys conducted throughout Minnesota, such as the SHAPE Survey referred to earlier, an Annual Health Survey of LGBTQ community conducted by the Rainbow Health Initiative, as well as the Behavioral Risk Factor Surveillance Survey (BRFSS), Pregnancy Risk Assessment Monitoring Survey (PRAMS), and the Minnesota Student Survey (MSS) conducted by the MDH. Minnesota is not one of the 22 project areas of the National HIV Behavioral Surveillance (NHBS) project.

In 2014 the BRFSS estimated the percentage of persons living in Minnesota who had ever been tested for HIV to be 27%. In 2011 (most recent data available) the PRAMS estimated that 47%

of women received an HIV test during their most recent pregnancy, and 64% of those surveyed reported that a health care worker talked with them about getting their blood tested for HIV during any of their prenatal care visits. The MSS is conducted every three years across Minnesota school districts, and questions about sexual activity are asked only of high school students. The most recent data available is from the 2013 survey, however a survey was conducted in 2016. This most recent trend report available on the MDH website, included data regarding reported using a condom during last sexual intercourse (64%, a decreasing trend in recent years), sexual orientation, and sexual behavior. There was also data indicating 47% (a slight increase from previous years) of students who were ever sexually active reported talking with every partner about protection from STI or HIV/AIDS.

HIV Testing and Early Identification of Individuals Living with HIV/AIDS (EIIHA) Data (Section 1: A. d. ii.)

The Counseling, Testing and Referral (CTR) System consists of MDH-funded agencies that provide free or low-cost HIV testing to Minnesota residents. The system offers anonymous and confidential testing in clinical and office settings or during outreach, and most of these sites have moved to offering rapid HIV testing instead of the more traditional blood draw. Confidential tests are name-based and can therefore be reported to MDH and added to the yearly surveillance statistics. Anonymous tests are code-based and are not included in yearly surveillance, although positive anonymous results are reported to MDH. Occasionally, an anonymous test will be linked to a surveillance case if the individual mentions having received a previous positive diagnosis and recalls the date and site of that test, as well as the code given to him/her.

The number of tests conducted by the CTR agencies has grown from 10,597 in 2005 to 13,237 in 2014. The positivity rate (percent of positive tests among all tests performed) has ranged from 1.0% in 2010 to 1.5% in 2007. However in 2014, the positivity rate dropped to 0.8%.

The majority of those tested in 2014 were males (70%), between the ages of 20 and 39 (67%), and people of color (52%). Of the 13,237 tests conducted, 33% indicated male-to-male sex, and 6% indicated injection drug use in the past 12 months. The table below shows the number of tests by client characteristics along with positivity rate. Fifteen percent (15%0 of those tested had never had a previous test. Of those with a previous test, 99% reported a negative result for their most recent HIV test. In 2014, 4% of those tested chose an anonymous test, and 28% of the tests were done outside of a health care setting.

CTR System Tests by Gender, Race, Age, and Risk 2014

Client Characteristics*	Number of Tests (percent)	Positivity Rate
Gender		
Male	9,286 (70)	1.0
Female	3,779(29)	0.4
Transgender	83(0.6)	1.2
Unknown	89 (0.6)	0.0
Race/Ethnicity		
White	6,461 (49)	0.7
African American/Black	4,126 (31)	1.1
Asian/Pacific Islander	497 (4)	0.2
American Indian	692 (5)	0.6
Multiple Races	405 (3)	1.0
Unknown	1,056 (8)	0.9
Hispanic†	1,378 (10)	1.0
Age		
19 and under	629 (5)	0.2
20 - 39	8,889 (67)	0.8
40 - 59	3,297 (25)	0.9
60 and older	392 (3)	1.3
Unknown	30 (0.2)	0.0
Risk Category		
MSM	4,143 (31)	1.6
IDU	616 (5)	0.5
MSM/IDU	195 (1)	3.6
High-risk heterosexual contact	3,787 (29)	0.4
Low-risk heterosexual contact	3,507 (27)	0.3
Other#	144 (0.4)	0.0
Unknown Risk	845 (6)	0.8
Total	**13,237 (100)**	**0.8**

* Numbers will not add to total

† Includes all races

Includes low and high risk sex with transgender person and female to female contact

Early Identification of Individuals Living with HIV/AIDS (EIIHA)

The following summarizes EIIHA data from MDH funded CTR system. To date, no changes in data collection, analysis, or utilization have impacted the EIIHA Plan outcomes.

Data for January 1, 2014 – December 31, 2014. (Source: Minnesota Department of Health Evaluation Web).

- Total number of publicly funded Test Events: **12,972**
- Total number of New HIV positive tests: **92**
- Total number of previously diagnosed HIV positive individuals: **12**
- Total number of new HIV positive individuals with results received: **90**
- Total number of new HIV positive individuals linked to medical care: **87**
- Total number of previously diagnosed HIV positive individuals linked to medical care: **11**
- Total number of new HIV positive individuals who received partner services: **48**
- Total number of new HIV positive individuals linked and referred to prevention services: **81**
- Total number of new HIV positive individuals who received CD4 cell count and viral load testing: *The MDH does not routinely collect this variable in the Evaluation Web database.*
- Total number of previously diagnosed HIV positive individuals linked to and accessed CD4 cell count and viral load testing: *The MDH does not routinely collect this variable in the Evaluation Web database.*

Ryan White HIV/AIDS Program Data (Section 1: A. d. iii.)

The table below shows mode of exposure for Ryan White (RW) HIV/AIDS clients for the TGA from 2011-2015. There are little to no changes in mode of exposure over the past five years for RW clients. MSM comprise a smaller proportion as compared to the overall TGA for 2015 (43% vs 52% respectively). Heterosexual sex for RW clients is almost three times higher at 37% as compared to 11% for the overall TGA. One possible explanation for the difference is that mode of exposure for RW clients is more complete as compared to the state surveillance information, with 6% of RW clients having unknown status as compared to 26% for the overall TGA.

Mode of Exposure for Ryan White HIV/AIDS Program Clients 2011-2015, MSP TGA

	2015		2014		2013		2012		2011	
Adult/Adolescent/ Perinatal HIV/AIDS Exposure Category	**Number clients**	**% of Total**	**Number clients**	**% of Total**	**Number clients**	**% of Total**	**Number clients**	**% of Total**	**Number clients**	**% of Total**
Hemophilia	7	0%	8	0%	7	0%	8	0%	12	0%
Heterosexual Sex	1528	37%	1547	37%	1,525	37%	1536	37%	1420	37%
Injecting Drug Use	207	5%	216	5%	222	5%	232	6%	231	6%
Male to Male Sex	1763	43%	1803	44%	1,865	45%	1885	45%	1759	45%
MSM/IDU	138	3%	144	3%	146	4%	143	3%	148	4%
Missing Data	60	1%	37	1%	53	1%	65	2%	41	1%
Other	29	1%	27	1%	31	1%	37	1%	26	1%
Perinatal Transmission	73	2%	76	2%	62	1%	59	1%	45	1%
Transfusion	61	1%	59	1%	63	2%	62	1%	62	2%
Unknown	257	6%	210	5%	171	4%	172	4%	124	3%
TOTAL	4,123	100%	4,127	100%	4,145	100%	4,199	100%	3,868	100%

Hepatitic B and C, STD, and Tuberculosis Surveillance (Section 1: A. d. iv.)

Viral Hepatitis B

In 2015, 19 cases of acute hepatitis B virus (HBV) infection (0.3 per 100,000 population) were reported. In 2012, the case definition for acute hepatitis B was revised to include laboratory confirmed asymptomatic acute cases. Three of the 19 cases of acute hepatitis B were asymptomatic, laboratory-confirmed infections. Acute cases ranged in age from 22 to 65 years (median, 42 years). Fifteen (79%) cases were residents of the metropolitan area, including 9 (47%) in Hennepin County and 3 (16%) in Ramsey County. Fifteen (79%) cases were male and 8 (42%) were adolescents or young adults between 13 - 39 years of age. Race was known for 14 cases; of those, 9 were white, 2 were black, 2 were multi-racial, and 1 was Asian. Hispanic ethnicity was reported for 1 case. Incidence rates were higher among Asians (0.4 per 100,000) and blacks (0.6 per 100,000), than among non-Hispanic whites (0.2 per 100,000).

One hundred sixty-five reports of newly identified cases of confirmed chronic HBV infection were received in 2015. A total of 23,855 persons are estimated to be alive and living in Minnesota with chronic HBV. The median age of chronic HBV cases in Minnesota is 45 years.

Viral Hepatitis C

In 2015, 37 cases of acute hepatitis C virus (HCV) infection (0.7 per 100,000) were reported. In 2012, the case definition for acute hepatitis C changed to include documented asymptomatic seroconversion. Of the 40 acute cases, 5 (14%) were asymptomatic, laboratory-confirmed acute HCV infection. Twenty-four (65%) cases resided in Greater Minnesota. The median age of all cases was 29 years (range, 20 to 53 years). Twenty-two (59%) cases were female. Race was known for 33 cases; of those, 22 (67%) were white and 11 (33%) were American Indian. No cases were known to be of Hispanic ethnicity. We received 2,396 reports of newly identified anti-HCV antibody-positive or HCV PCR-positive persons in 2015, the vast majority of whom are chronically infected. A total of 45,791 persons are estimated to be alive and living in Minnesota with past or present HCV infection. The median age of these cases is 57 years. Because most cases are asymptomatic, medical providers are encouraged to consider each patient’s risk for HCV infection to determine the need for testing.

As of December 31, 2015, there were 932 (11%) of the 8,215 persons assumed alive and living in Minnesota with HIV/AIDS to be co-infected with either Hepatitis B or C. Of the 932, 340 (36%) are living with HIV and Hepatitis B and the remaining 592 (64%) are living with HIV and Hepatitis C.

Sexually Transmitted Diseases (STDs)
In Minnesota, STDs are the most commonly reported communicable diseases and account for nearly 70% of all notifiable diseases reported to the MDH. In 2015 the number of reported bacterial STDs increased to 25,986 cases, representing an overall increase of 6% from the previous year. The change in incidence rates varied by disease, with chlamydia increasing by 7%, gonorrhea remaining at a stable incidence rate compared to 2014, and primary/secondary syphilis decreasing by 4%.

Chlamydia
Chlamydia is the most commonly reported communicable disease in Minnesota. From an all-time low of 115 cases per 100,000 in 1996, the incidence of chlamydia has nearly quadrupled to 400 per 100,000 in 2015. Over these years, increases were seen across all gender, age and geographical groups. The rates have increased more than five times among men (54 to 271 per 100,000) and have tripled among females (175 to 528 per 100,000). Among 30-39 year-olds, the incidence rate is over seven times higher in 2015 compared to 1996. Rates have nearly doubled among Blacks and Hispanics and almost tripled among Whites, American Indians, and Asian/Pacific Islanders.

In addition to an increase of disease in the population, other factors may have contributed to the increases seen during these years including increased reporting by providers, use of improved STD diagnostic tools, improved screening practices by clinicians, counting only lab reports as cases and the addition of an active surveillance component to the MDH's STD surveillance system.

In 2015, the chlamydia rate increased by 7% overall and remained highest among women (528 per 100,000), Blacks (1,701 per 100,000), and 20-24 year-olds (2,336 per 100,000). The rates increased by 11% among males and 5% among females. Adolescents (15-19 year-olds) and young adults (20-24 year-olds) have the highest rates and comprise the majority of cases. Rates among males increased the most among those 40-44 years (24%), and rates among females increased the most among those 40-44 years (26%).

Gonorrhea
In 2015, the gonorrhea rate remained stable at 77 per 100,000 compared to 2014. The rates had previously increased in 2011 for the first time since 2007. From 2004 to 2015, the incidence of gonorrhea in Minnesota increased from 58 to 77 per 100,000 persons (33%). However, as with chlamydia, the incidence of infection was higher among some segments of the population compared to others. Rates during the past decade have increased by 56% among males and have remained relatively stable among females. The rates have increased among American Indians (131%), Whites (132%), & Asian/Pacific Islanders (100%) but decreased among Blacks (55%) while rates among Hispanics have remained relatively stable. However, Blacks continue to have gonorrhea incidence rates far higher than other race groups.

The emergence of *quinolone-resistant Neisseria Gonorrhea* (QRNG) in recent years has become a particular concern. Due to the high prevalence of QRNG in Minnesota as well as nationwide, quinolones are no longer recommended for the treatment of gonococcal infections. Additionally, the CDC changed the treatment guidelines for gonococcal infections in August of 2012. CDC no longer recommends cefixime at any dose as a first-line regimen for treatment of gonococcal infections. If cefixime is used as an alternative agent, then the patient should return in one week for a test-of-cure at the site of infection.

In 2015 the incidence rate of gonorrhea remained stable at 77 per 100,000. Males had a higher gonorrhea rate than females (92 per 100,000 vs 63 per 100,000). As with chlamydia, gonorrhea rates were highest among Blacks (531 per 100,000) and 20-24 year-olds (352 per 100,000). Adolescents and young adults continue to account for a disproportionate amount (47%) of all gonorrhea cases.

Syphilis

Incidence rates of primary/secondary syphilis in Minnesota remained stable from 1998 until 2002 when an outbreak was observed among men who have sex with men (MSM) and the overall rate increased from 0.2 to 1.2 per 100,000 persons. Since 2002, primary/secondary syphilis rates have fluctuated but remained elevated. In addition, the number of early syphilis cases (primary, secondary, and early latent stages) increased from 49 in 2004 to 431 in 2015, with MSM accounting for 65% of all cases among males in 2015. The disparity in early syphilis rates between males and females has remained large and reflects the greater burden within the MSM community; however the rates among females have continued to increase over the past two years. With the increasing rates among females, specifically females of child-bearing age, there were three cases of congenital syphilis reported in 2015.

In 2015, the overall incidence rate of primary/secondary syphilis decreased from 4.8 to 4.6 cases per 100,000 persons compared to 2014. The number of cases among males decreased from 235 in 2014 to 207 in 2015 while among females, the number increased from 21 to 39. Increases in cases, compared to 2014, were only observed across the Greater Minnesota area; however the City of Minneapolis remains to account for the majority of cases (52%).
The number of early syphilis cases increased in 2015 (431 versus 416 in 2014). The number of cases among women increased from 41 cases in 2014 to 88 cases in 2015. Early syphilis cases among men decreased from 374 to 341 (9%). Of all early syphilis cases reported in 2015, 80% were among males and 65% of these were MSM. Of the MSM early syphilis cases 56% were co-infected with HIV. Among all early syphilis cases, 32% were co-infected with HIV.

Tuberculosis

In 2015, 150 tuberculosis (TB) cases (2.7 per 100,000 population) were reported. This represents a 2% increase in the number of cases compared to 2014 (147), but a 37% decrease in the number of cases since 2007, when the highest number (238) in the past decade was reported. As seen in most years, Minnesota's TB incidence rate in 2015 was lower than the national rate of 3.0 cases per 100,000 population. Two (1%) of the cases died due to TB-related causes.

Twenty-three (26%) of the state's 87 counties reported at least 1 new case of TB disease in 2015. The majority (74%) of cases occurred in the metropolitan area, primarily in Hennepin (38%) and Ramsey (19%) Counties. Seventeen percent (25) were from the other five metropolitan counties. The remaining 26% of cases were reported from Greater Minnesota. Among metropolitan area

counties, the highest TB incidence rate in 2015 was reported in Ramsey County (5.4 per 100,000 population), followed by Hennepin County (4.7 per 100,000), and Dakota County (2.7 per 100,000 population). The TB incidence rate for all Greater Minnesota counties combined was 1.6 per 100,000 population.

The vast majority (87%) of TB cases reported in Minnesota in 2015 were identified as a result of individuals seeking medical care for symptoms of disease. Various targeted public health interventions identified a portion of the remaining 13% of cases. Such methods of case identification are considered high priority, core TB prevention and control activities; they included TB contact investigations (3%), follow-up evaluations resulting from abnormal findings on pre-immigration exams performed overseas (3%), and domestic refugee health assessments (2%). An additional 3% were identified through other means (e.g., other immigration medical exams, occupational screening or other targeted testing for TB). Five (3%) cases were diagnosed with active TB disease incidentally while being evaluated for another medical condition.

TB incidence is disproportionately high in racial minorities in Minnesota as well as in the United States. In 2015, only 12 cases occurred among non- Hispanic whites in Minnesota (0.3 cases per 100,000 population). In contrast, among non-Hispanic persons of other races, 84 cases occurred among blacks (24.5 cases per 100,000), 41 among Asian/Pacific Islanders (15.3 cases per 100,000), and 4 among American Indian/Alaskan Natives (6.0 cases per 100,000). Nine cases were Hispanic persons of any race (3.2 cases per 100,000). The vast majority of black TB cases (92%) and Asian TB cases (98%) were foreign-born.

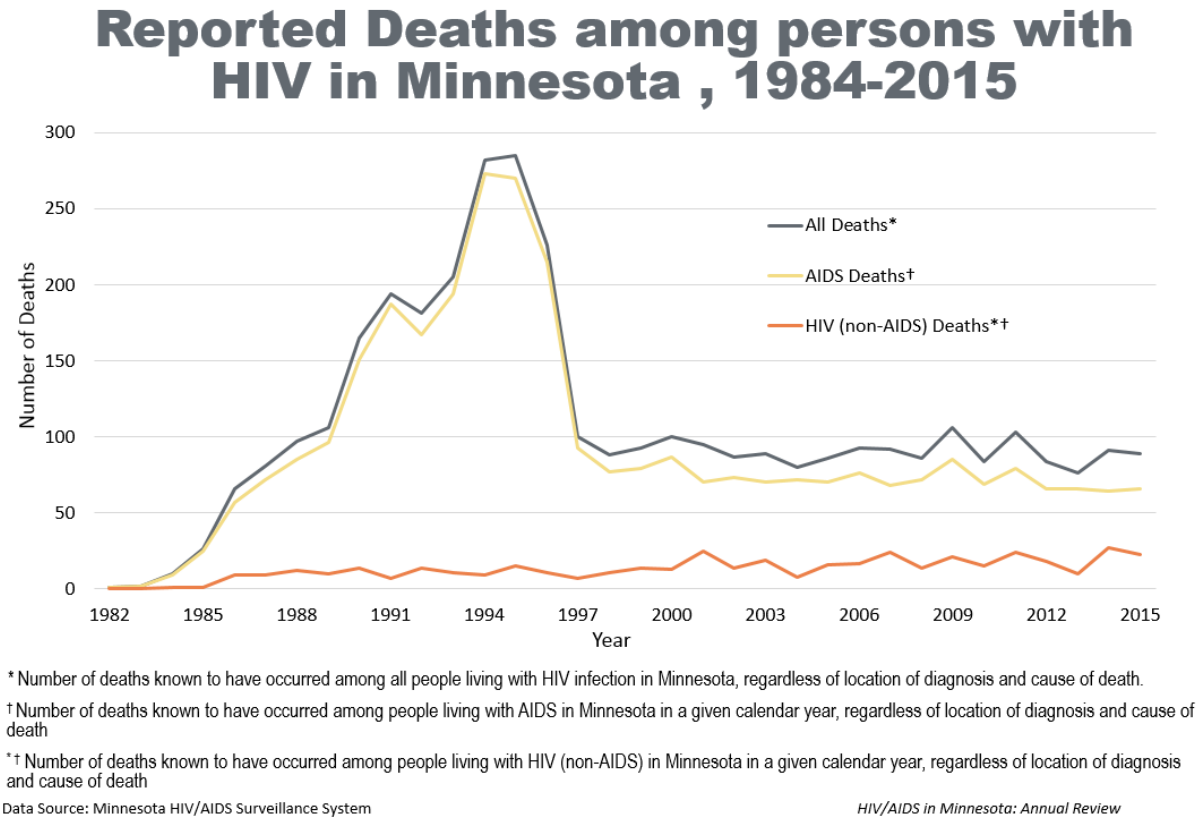
The most distinguishing characteristic of the epidemiology of TB disease in Minnesota continues to be the large proportion of cases occurring among persons born outside the United States. In 2015, the percentage of TB cases in Minnesota occurring in foreign-born persons was 86%, compared to 66% of TB cases reported nationally. The 129 foreign-born TB cases reported in Minnesota represented 26 different countries of birth; the most common region of birth among these patients was Sub-Saharan Africa (60% of foreign-born cases), followed by South/Southeast Asia (22%), East Asia/Pacific (10%), and Latin America (including the Caribbean) (6%) (Figure 7). All 6 U.S. born pediatric TB cases (<15 years of age at diagnosis) had at least one foreign-born parent or guardian. These second-generation children appear to experience an increased risk of TB disease that more closely resembles that of foreign-born persons. In 2015, there were 9 cases of TB (6%) that were co-infected with HIV.

Qualitative data (Section 1: A. d. v.)

No recent additional qualitative data is available that further illuminates indicators of risk for HIV infection.

Vital Statistics (Section 1: A. d. vi.)

Mortality



* Number of deaths known to have occurred among all people living with HIV infection in Minnesota, regardless of location of diagnosis and cause of death.

† Number of deaths known to have occurred among people living with AIDS in Minnesota in a given calendar year, regardless of location of diagnosis and cause of death

*† Number of deaths known to have occurred among people living with HIV (non-AIDS) in Minnesota in a given calendar year, regardless of location of diagnosis and cause of death

Data Source: Minnesota HIV/AIDS Surveillance System *HIV/AIDS in Minnesota: Annual Review*

The number of deaths among all people living with HIV infection in Minnesota decreased dramatically between 1995 and 1997 and has remained relatively constant over the past decade. In 2015, a total of 89 deaths were reported people living with HIV infection in Minnesota. The total number of deaths reported in Minnesota for those living with AIDS was 66 (74% of all deaths) in 2015. Deaths are monitored through review of death certificates, information from other health departments, active surveillance, and matches with the National Death Index and Social Security Death Master File.

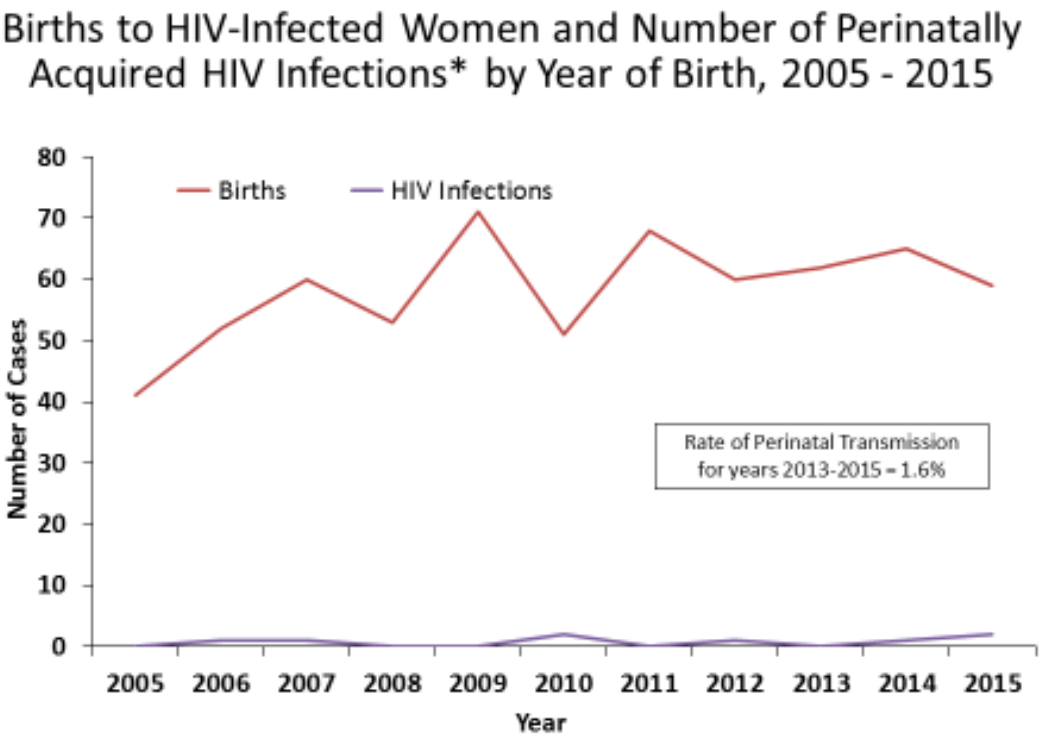
Birth to HIV positive mothers

The ability to interrupt the transmission of HIV from mother to child via antiretroviral therapy and appropriate perinatal care is an important accomplishment in the history of the HIV/AIDS epidemic. Newborn HIV infection rates range from 25-30% without antiretroviral therapy, but decrease to 1-2% with appropriate medical intervention.

For the past decade the number of births to HIV-infected women increased steadily from 41 in 2005 to 59 births in 2015. The rate of transmission has decreased from 15% between 1994 and 1996 to 1.6% in the past three years, with 2 HIV+ babies born to HIV+ mothers in Minnesota in 2015.

The rate of transmission in Minnesota between 1982 and 1994 (before widespread use of zidovudine to prevent mother-to-child HIV transmission) was 25%. Proper prenatal care, including HIV screening for all pregnant women and appropriate medical intervention for those infected, is a vital element in preventing the spread of HIV.

Reporting of births to HIV positive women is known to be incomplete. As a result of a project conducted in 2001, MDH has both implemented an active component for perinatal surveillance in collaboration with pediatric HIV clinicians in the Twin Cities to increase reporting of births to HIV-infected mothers, and in 2005 changed reporting rules to explicitly state that a pregnancy in an HIV-positive woman is a reportable condition. In addition, surveillance staff matches surveillance records with vital statistics records on a yearly basis to identify births to HIV positive women. Despite these efforts, reporting of pregnancy among women living with HIV/AIDS continues to be incomplete.



** HIV or AIDS at first diagnosis for a child exposed to HIV during mother's pregnancy, at birth, and/or during breastfeeding.*

Other relevant program data (Section 1: A. d. vii.)

No recent additional program data is available that further illuminates indicators of risk for HIV infection.

Section I: Statewide Coordinated Statement of Need/Needs Assessment

B. HIV Care Continuum

HIV Care Continuum (Section 1: B. a.)
Recent scientific advances have shown that antiretroviral therapy (ART), the treatment of people with HIV using anti-HIV drugs, helps to sustain the health of people living with HIV and dramatically lowers their risk of transmitting HIV to others by reducing the amount of virus in the body. New infections in the United States can be reduced by ensuring that everyone with HIV is aware of their infection and receiving treatment.

As part of the National HIV/AIDS Strategy for the United States and HIV Care Continuum Initiative (an effort launched by President Obama in 2013 to increase the impact of HIV diagnosis and care efforts), the MDH has calculated an HIV treatment cascade using HIV surveillance data. These calculations help us better understand the HIV epidemic and the disparities that exist in delivery of care among HIV positive people in Minnesota.

The ultimate goal of the HIV treatment is to achieve viral suppression, meaning the amount of HIV in the body is very low or undetectable. This is important for people living with HIV to stay healthy, live longer and to reduce their chances of passing HIV to others.

Development of the Minnesota HIV Care Continuum
As part of the National HIV/AIDS Strategy for the United States, MDH has calculated the HIV care continuum annually using HIV surveillance data since 2013. The calculations help to better understand the HIV epidemic and the disparities that exist in delivery of care among HIV positive people in Minnesota.

Data Sources
In Minnesota, laboratory-confirmed infections of HIV are monitored by MDH through an active and passive surveillance system. State rules (Minnesota Rule 4605.7040) require both physicians and laboratories to report all cases of HIV infection (HIV or AIDS) directly to the MDH. To ensure completeness of reporting, regular contact is maintained with several clinical sites that report a significant number of HIV cases annually. In June 2011, an amendment to the communicable disease reporting rule was passed, requiring the report of all CD4 and viral load (VL) test results. A limitation to the accuracy of the HIV care continuum depends on the complete and accurate reporting of laboratory results.

Definitions of measures used in Minnesota's HIV Care Continuum

People Living with HIV/AIDS (Prevalence-based)
To calculate the diagnosed prevalence of people living with HIV/AIDS in Minnesota used for the HIV care continuum, surveillance data were used to estimate (using CDC programs developed to estimate the proportion of people living in Minnesota with undiagnosed HIV infection) the number of people 13 years of age or more living in Minnesota at the end of 2015 who were diagnosed with HIV infection (regardless of residence at diagnosis) by the year end of 2014. The estimate serves as the underlying population for retention in care and viral suppression measures for Minnesota.

Linkage to Care
Linkage to care is calculated using a denominator that is different than the other measures on the HIV care continuum. Linkage to care is defined as those who are diagnosed in Minnesota during the year 2014 and had a CD4 or VL test performed within 90 days of initial diagnosis. This year,

Minnesota also calculated linkage to care within 30 days of initial diagnosis, which is part of the current NHAS 2020 measure. Because, the passage of the revised communicable disease reporting rule to mandate the report of all CD4 and VL tests for HIV positive patients only occurred in 2011, reports of laboratory tests performed before that time are incomplete. Therefore, estimates for linkage to care are not useful for cases diagnosed prior to 2011.

Retained in Care

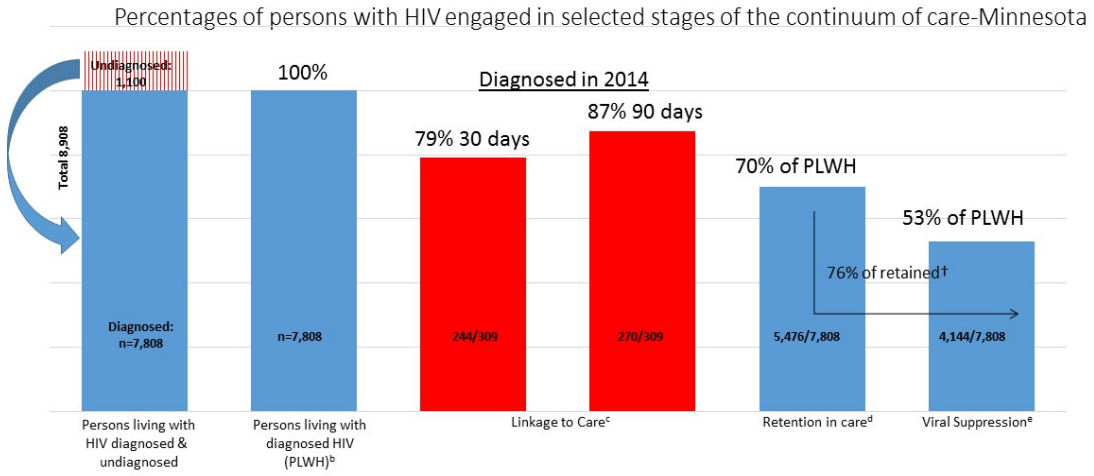
Retention in care is defined in Minnesota as one laboratory test within the year 2015 for patients alive and living in Minnesota at the end of 2015 who were diagnosed through year-end 2014. Because Minnesota's definition of retention in care is different than the national and other local HIV care continuums, caution needs to be used when comparing the retention in care measure to the national estimate. However, currently, it is more acceptable across the nation to use the definition that Minnesota has used (one or more laboratory test) within the year. The most recently released programs for calculating the care continuum from CDC includes a calculation for one or more laboratory tests, as well as, two or more laboratory tests.

Viral Load Suppression

Viral suppression is defined as a viral load (VL) test result of ≤200 copies/mL at the most recent test during 2015 for patients alive and living in Minnesota at the end of 2015 who were diagnosed through year-end 2014.

For more information about Minnesota's care continuum, please refer to the following MDH website: http://www.health.state.mn.us/divs/idepc/diseases/hiv/hivtreatmentcascade.html

Minnesota HIV Care Continuum



[a]Defined as persons undiagnosed (estimate 1,100 (640-1,500), 95% CI) and persons diagnosed (n=7808) aged 13 or more with HIV infection (regardless of stage at diagnosis) through year-end 2014, who were alive at year-end 2015.
[b]Defined as persons diagnosed aged 13 or more with HIV infection (regardless of stage at diagnosis) through year-end 2014, who were alive at year-end 2015.
[c]Calculated as the percentage of persons linked to care within 30 and 90 days after initial HIV diagnosis during 2014. Linkage to care is based on the number of persons diagnosed during 2014 and is therefore shown in a different color than the other bars with a different denominator.
[d]Calculated as the percentage of persons who had ≥1 CD4 or viral load test results during 2015 among those diagnosed with HIV through year-end 2014 and alive at year end 2015.
[e]Calculated as the percentage of persons who had suppressed viral load (≤200 copies/mL) at most recent test during 2015, among those diagnosed with HIV through year-end 2014 and alive at year end 2015.
†Calculated as number of persons who had suppressed VL (≤200 copies/mL) at most recent test during 2015, among those who were retained in care during 2015 (4,144/5,476).

HIV Care Continuum Results & Disparities in Engagement (Section 1: B. b.)

People Living with HIV/AIDS (Prevalence-based)
In Minnesota, there are 8,908 people 13 years of age or more who are estimated to be living with HIV (diagnosed and undiagnosed) through 2014 and were living with in Minnesota at the end of 2015. Of the estimated 8,908 people living with HIV at the end of 2015, 1,100 (640-1,500 (95% CI)) are estimated to be undiagnosed with HIV and 7,808 are diagnosed with HIV (Figure 1, (first bar (diagnosed/undiagnosed) second bar (diagnosed) on the graph).

Linkage to Care
In 2014, there were 309 persons 13 years of age or more who were newly diagnosed with HIV in Minnesota. Of these 309, 244 (79%) had a CD4 or VL test performed within 30 days of their initial diagnosis and 270 (87%) had a CD4 or VL test performed within 90 days of their initial diagnosis (third bar (30 days) fourth bar (90 days) in red on the graph below).

The linkage to care rate in the TGA was about the same, where 79% had a CD4 or VL test performed within 30 days of their initial diagnosis and 88% had a CD4 or VL test performed within 90 days of their initial diagnosis (see graph below).

Retained in Care
Of the 7,808 people diagnosed and living with HIV at the end of 2015, 5,476 (70%) had at least one CD4 or VL test performed in 2015 (fifth bar on the graph below). The TGA was slightly lower, where 4,168 (68%) people diagnosed and living with HIV in the 11 county MSP TGA were retained in care during 2015.

By age groups, for people living with HIV, the range for those 25 years of age and older that were retained in care was between 68-70%, which is similar compared to the overall range of 70%. The age group 13-24 had the highest retained in care at 85%.

In reviewing racial and Hispanic ethnicity of people living with HIV, Hispanics of any race had the lowest retained in care with 63% and non-Hispanic African-American blacks were next lowest with 71% (which is slightly higher than the overall at 70%).

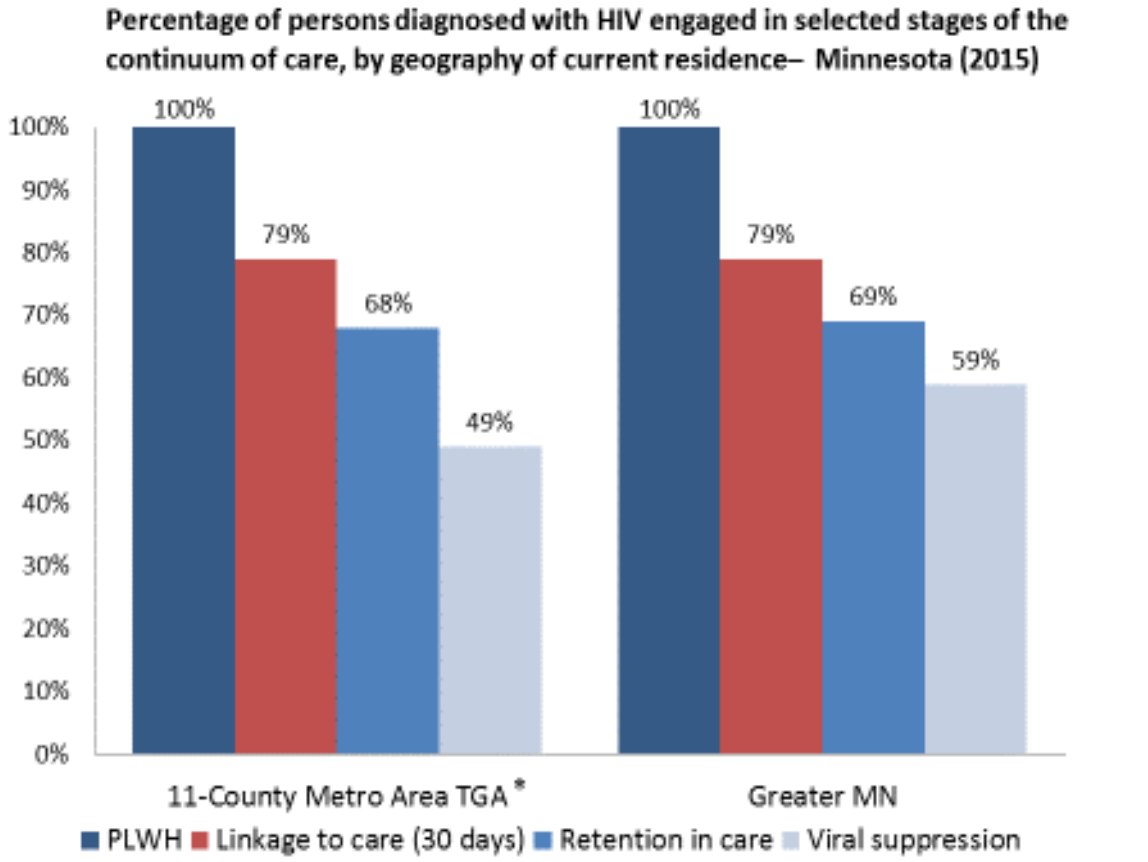
For mode of transmission, injection drug users (IDU) had the lowest retained in care at 64% and MSM were at 71% (slightly higher than the overall at 70%). Yet, in reviewing MSM by racial and Hispanic ethnicity, African-American blacks were low compared to the overall MSM (67% vs 71% respectively). And, for heterosexual women, 75% were retained in care, which is above the overall at 70% (see graphs below).

Viral Load Suppression
Of the 7,808 people diagnosed and living with HIV/AIDS, 4,144 (53%) had a VL test of $\leq$200 copies/mL at their most recent test in 2015 (viral suppression) (sixth bar on the graph below). The TGA was lower, where 3,011 (49%) people diagnosed and living with HIV in the 11 county MSP TGA had viral load suppression at their most recent test during 2015.

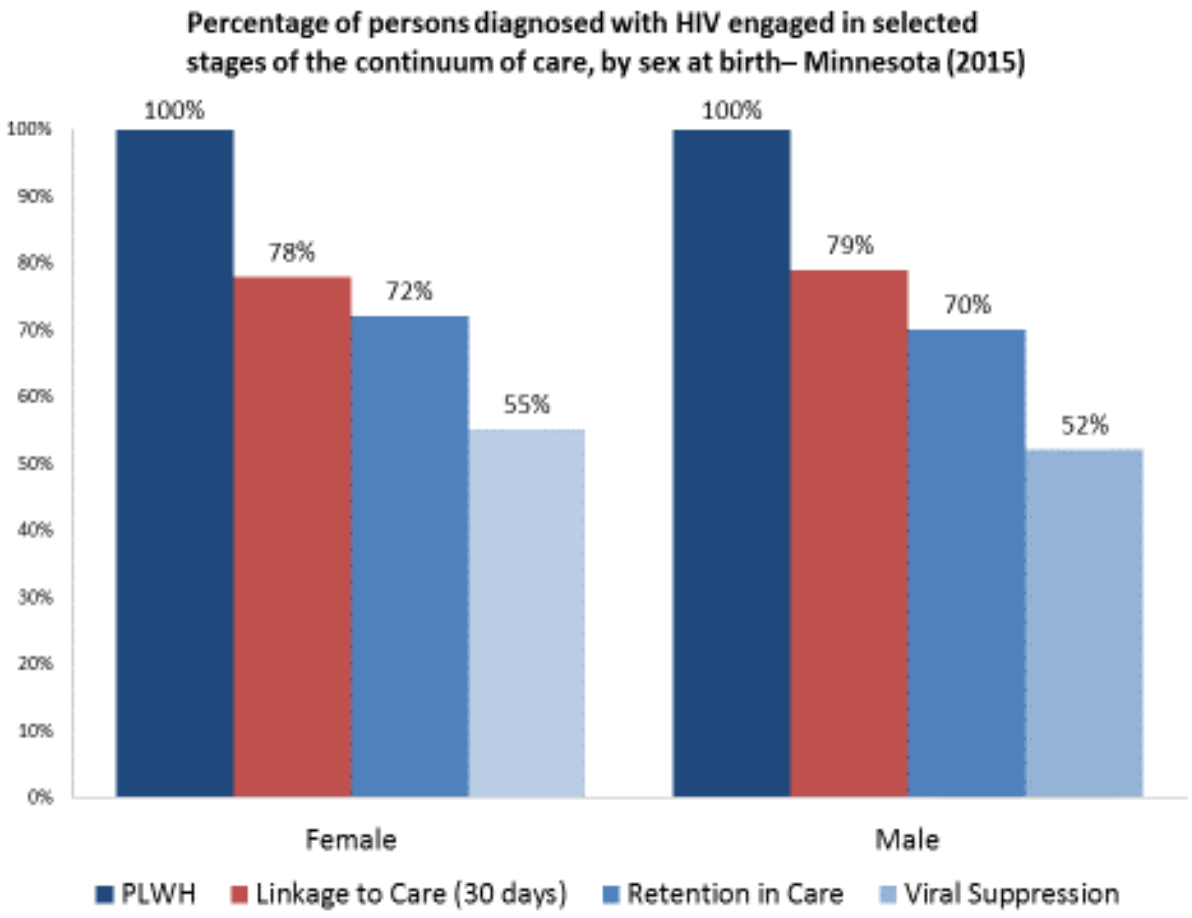
By age groups, for people living with HIV, for those 25-44 years of age 50% had viral load suppression, which is lower than overall at 53%. The other age groups were at or slightly higher than the overall at 53% for viral load suppression.

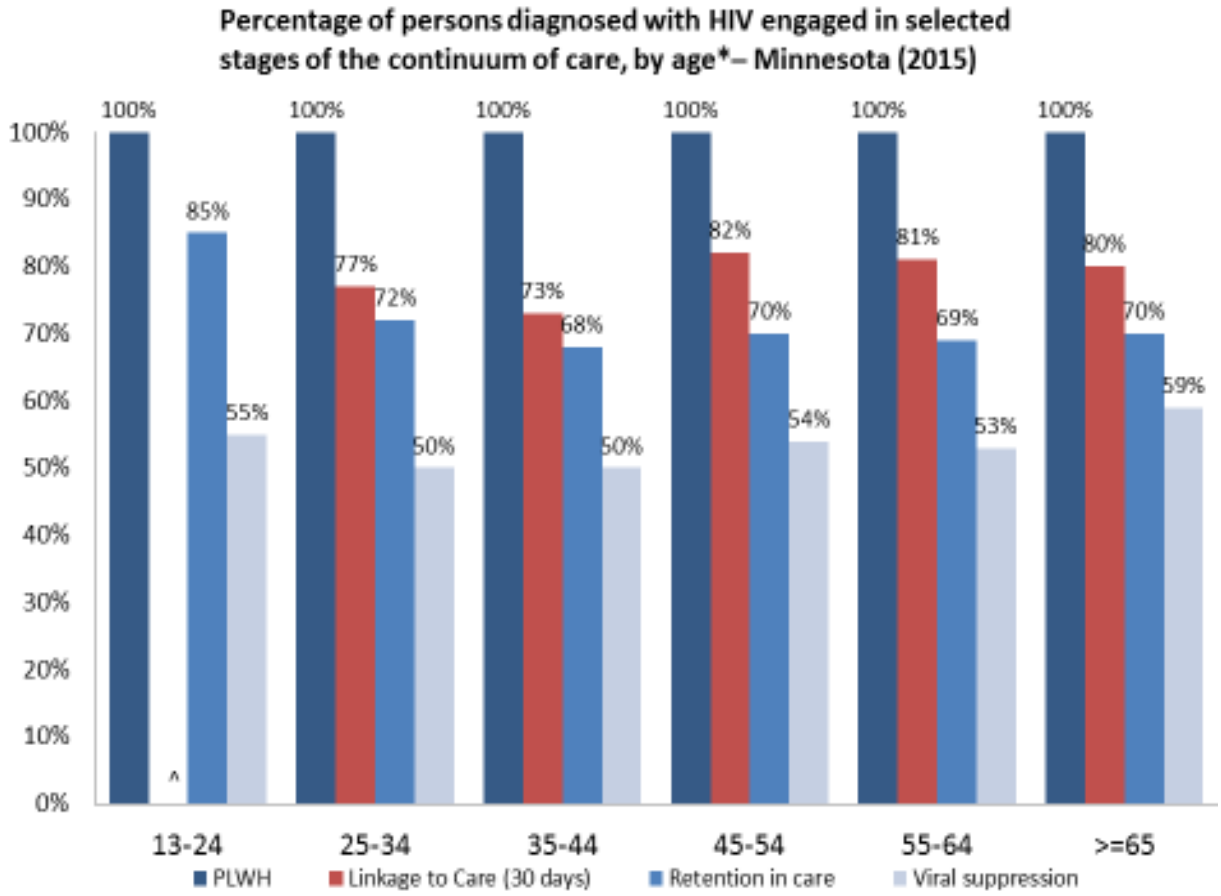
For people of color living with HIV, Hispanics of any race (52%), non-Hispanic African-American blacks (51%), and African-born blacks (53%) viral load suppression were similar to the overall viral load suppression at 53%. And, non-Hispanic whites were slightly higher at 54% viral load suppression.

For mode of transmission, injection drug users (IDU) (53%) and MSM (52%) had viral load suppression similar to the overall viral load suppression. Yet, in reviewing MSM by racial and Hispanic ethnicity, non-Hispanic African-American blacks were low compared to the overall MSM viral load suppression (47% vs 52% respectively). And, for heterosexual women, 58% had viral load suppression, which is above the overall (53%) (See graphs below).

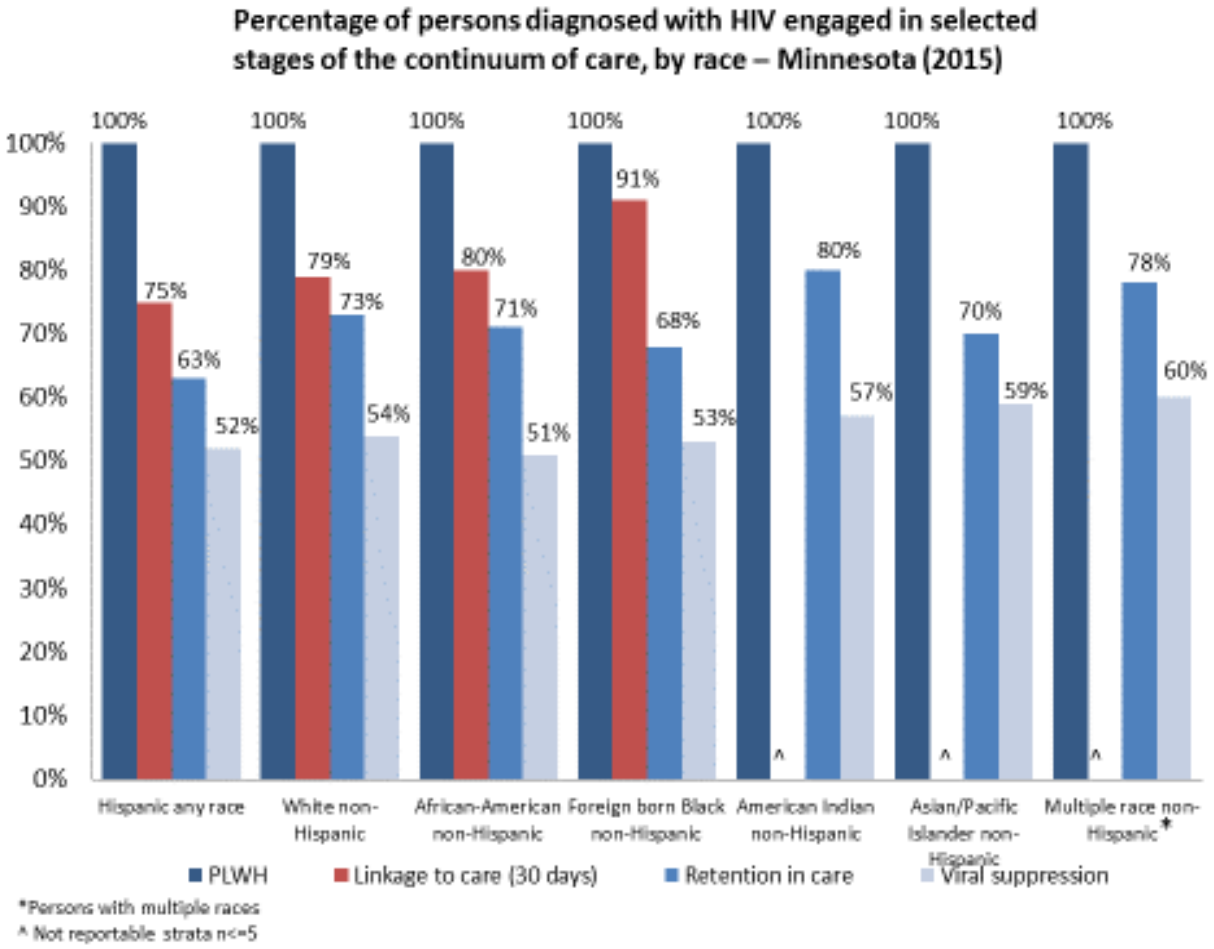


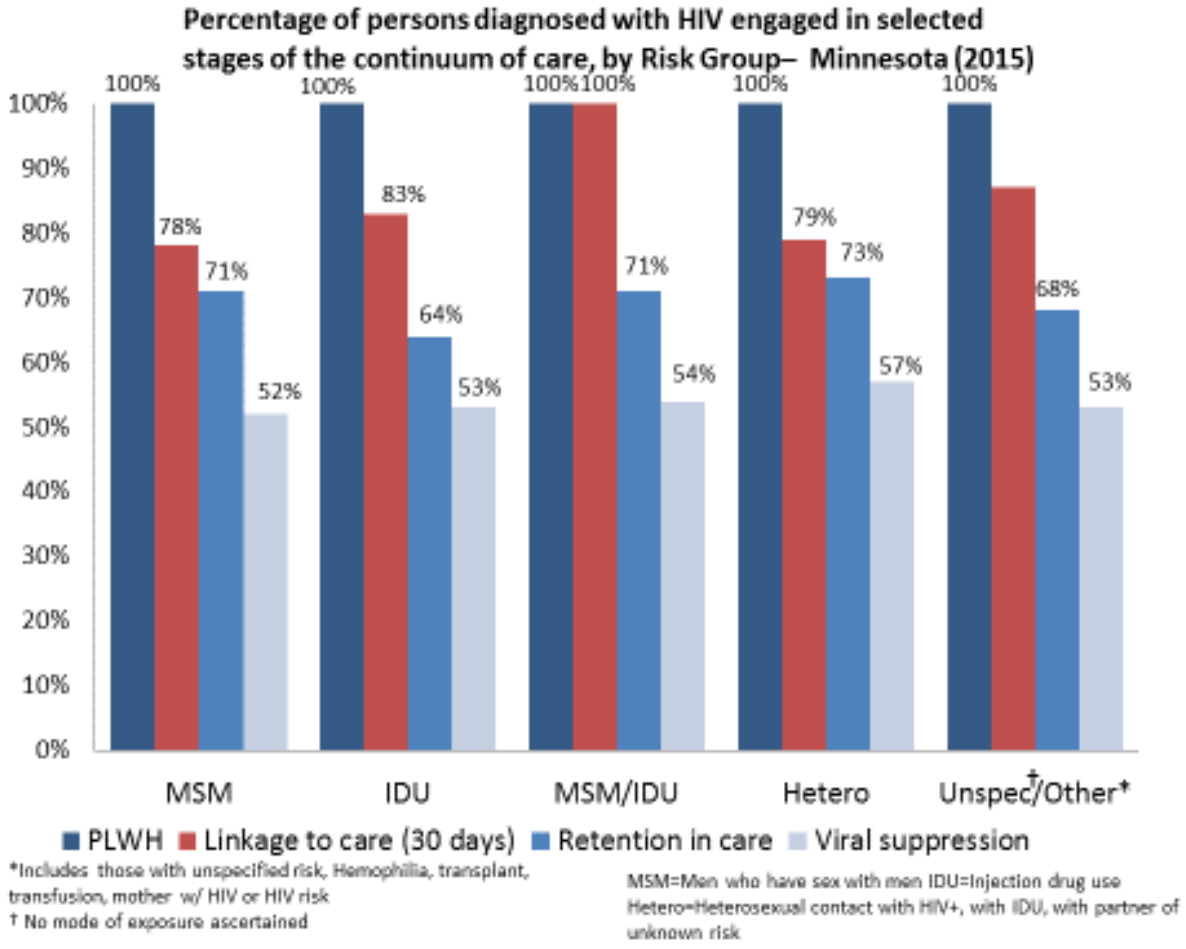
*Includes Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington, Wright Counties

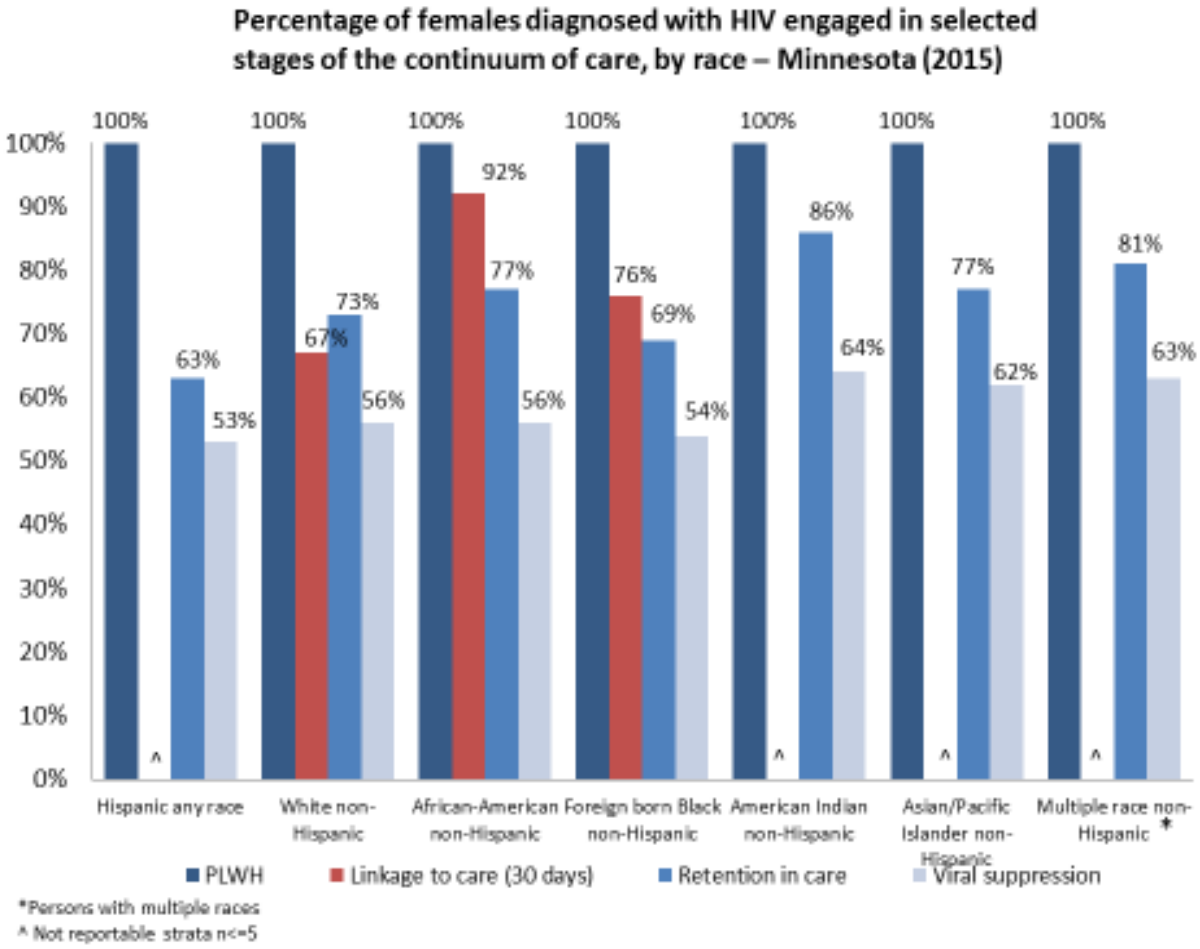

Percentage of persons diagnosed with HIV engaged in selected stages of the continuum of care, by sex at birth– Minnesota (2015)
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
100%
78%
72%
55%
100%
79%
70%
52%
Female
Male
PLWH
Linkage to Care (30 days)
Retention in Care
Viral Suppression



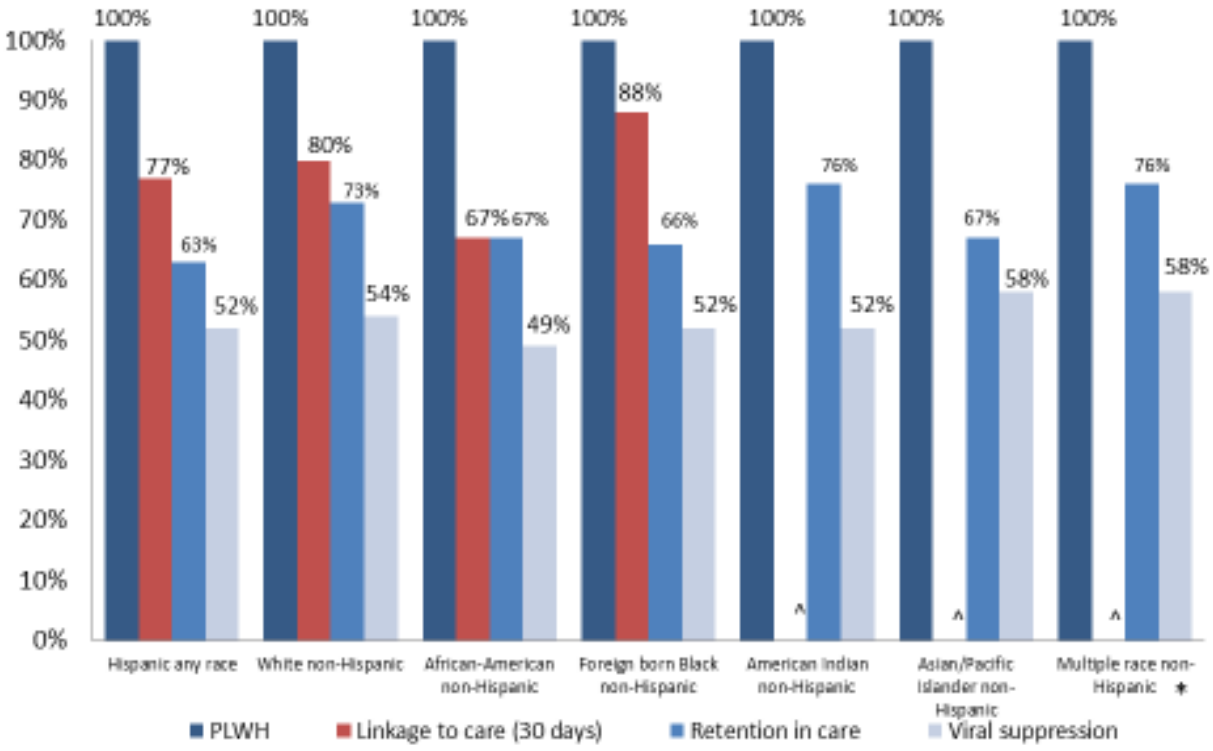
*Current age is used to calculate PLWH, retention in care and viral suppression. Age at HIV diagnosis is used for linkage to care
^ Not reportable strata n<=5


Percentage of persons diagnosed with HIV engaged in selected stages of the continuum of care, by race – Minnesota (2015)
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
100%
75%
63%
52%
100%
79%
73%
54%
100%
80%
71%
51%
100%
91%
68%
53%
100%
^
80%
57%
100%
^
70%
59%
100%
^
78%
60%
Hispanic any race
White non-Hispanic
African-American non-Hispanic
Foreign born Black non-Hispanic
American Indian non-Hispanic
Asian/Pacific Islander non-Hispanic
Multiple race non-Hispanic*
PLWH
Linkage to care (30 days)
Retention in care
Viral suppression
*Persons with multiple races
^ Not reportable strata n<=5

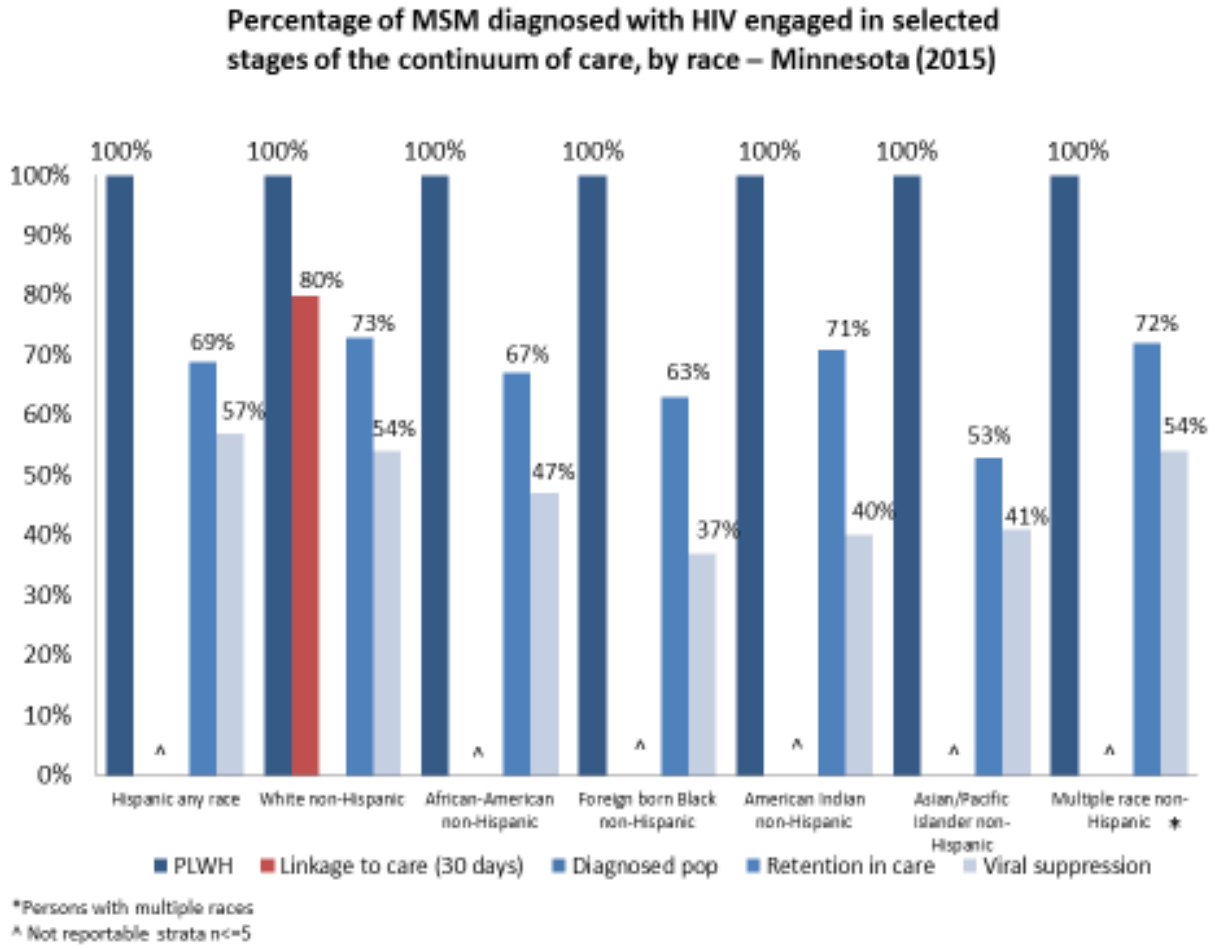

Percentage of persons diagnosed with HIV engaged in selected stages of the continuum of care, by Risk Group– Minnesota (2015)
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
100%
78%
71%
52%
100%
83%
64%
53%
100%
100%
71%
54%
100%
79%
73%
57%
100%
68%
53%
MSM
IDU
MSM/IDU
Hetero
Unspec/Other*†
PLWH
Linkage to care (30 days)
Retention in care
Viral suppression
*Includes those with unspecified risk, Hemophilia, transplant, transfusion, mother w/ HIV or HIV risk
† No mode of exposure ascertained
MSM=Men who have sex with men IDU=Injection drug use
Hetero=Heterosexual contact with HIV+, with IDU, with partner of unknown risk


Percentage of females diagnosed with HIV engaged in selected stages of the continuum of care, by race – Minnesota (2015)
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
100%
63%
53%
^
100%
67%
73%
56%
100%
92%
77%
56%
100%
76%
69%
54%
100%
86%
64%
^
100%
77%
62%
^
100%
81%
63%
^
Hispanic any race
White non-Hispanic
African-American non-Hispanic
Foreign born Black non-Hispanic
American Indian non-Hispanic
Asian/Pacific Islander non-Hispanic
Multiple race non-Hispanic*
PLWH
Linkage to care (30 days)
Retention in care
Viral suppression
*Persons with multiple races
^ Not reportable strata n<=5

Percentage of males diagnosed with HIV engaged in selected stages of the continuum of care, by race – Minnesota (2015)



*Persons with multiple races
^ Not reportable strata n<=5



Use of HIV Care Continuum in Minnesota (Section 1: B. c.)

In Minnesota, state and local agencies use the HIV Care Continuum (HCC) to help monitor and to identify issues and opportunities for improving the delivery of services to high-risk individuals. Increasingly health systems and clinics are using the concept of an HCC to monitor their system outcomes. The MDH has already participated in one clinic-based project resulting in improved retention-in-care estimates, by reclassifying case status (updating residency, current provider, and mortality data by integrating MN HIV Surveillance data). MDH (and recently Hennepin County) has implemented a Care Link program to re-engage persons who are out-of-care.

The HCC is used to determine how all care and prevention funding is allocated throughout Minnesota. Epidemiological data describes the locations, target populations and risk behaviors of those individuals living with HIV/AIDS in the state. The HCC further describes the various populations within each stage of the continuum and allows for more targeted funding to reach those populations in need of HIV prevention and service interventions along the care continuum. Target populations are prioritized based on epidemiological data and incorporated into Ryan White and HIV prevention requests for proposals to solicit clinical and community programming. Each phase of the care continuum is monitored annually and findings are used to re-direct funding and/or respond to emerging trends.

Minnesota has an integrated planning body for HIV care and prevention, Minnesota Council for HIV/AIDS Care and Prevention (MCHACP). The MCHACP is made up of individuals reflecting the HIV epidemic in the state, individuals at high risk for HIV and service providers and is responsible for developing the plan for HIV funding. Information from the HCC directs MCHACP recruitment and planning for addressing HIV/AIDS statewide. The overall goal of this planning process is to provide effective services and prevention interventions to those most affected by HIV in Minnesota.

Section I: Statewide Coordinated Statement of Need/Needs Assessment

C. Financial and Human Resource Inventory

Financial and Human Resources Inventory (Section I: C. a.)
This section of the Statewide Coordinated Statement of Need (SCSN) Needs Assessment provides an inventory of the financial and service delivery provider resources available in a jurisdiction to meet the HIV prevention, care, and treatment needs of the population as well as resource gaps. The Financial and Human Resource Inventory includes:

- Funding sources for HIV prevention, care, and treatment services in the jurisdiction,
- The dollar amount and the percentage of the total available funds in fiscal year 2016 for each funding source;
- The services delivered; and
- HIV Care Continuum steps impacted.

Minnesota HIV Resource Inventory

Funding Sources	Funding Amount ($)	Funded Service Provider Agencies	Services Delivered	HIV Care Continuum Steps Impacted
Minnesota Department of Human Services (DHS)				
ADAP, supplemental, Federal Rebate,	$5,667,634.00	DHS	ADAP Drug Program	ART, Viral Suppression
ADAP, Fed Rebate, State appropriation	$2,257,460.00	DHS	ADAP Insurance Program	ART, Linkage to Care, Retention in Care, Viral Suppression
Federal Rebate	$75,000.00	Mom's Meals	Food Bank/Home Delivered Meals	Retention in Care
Rebate	$113,300.00	University of Minnesota Youth and AIDS Project (contract pending)	Health Education and Risk Reduction	Linkage to Care, Retention in Care, ART, Viral Suppression
Rebate	$215,000.00	Minnesota AIDS Project, Clare Housing	Housing	Retention in Care, ART, Viral Suppression

Funding Sources	Funding Amount ($)	Funded Service Provider Agencies	Services Delivered	HIV Care Continuum Steps Impacted
Part B, Rebate, State appropriation	$2,035,216.00	Aliveness Project, Indigenous Peoples Task Force, Minnesota AIDS Project, Mayo Clinic, Rural AIDS Action network, Youth and AIDS Project	Medical Case Management	Linkage to Care, Retention in Care, Viral Suppression
Part B	$12,000.00	Mayo Clinic	Medical Transportation	Retention in Care
ADAP, Rebate	$55,347.00	DHS	Medication Therapy Management	ART, Viral Suppression
Part B	$10,296.00	DHS	Mental Health	Linkage to Care, Retention in Care
Part B and Rebate	$417,874.00	Minnesota AIDS Project, Rural AIDS Action Network, Hennepin Health Systems Positive Care Clinic	Non-Medical Case Management (Benefits Counseling)	Linkage to Care, Retention in Care
Rebate	$60,000.00	DHS	Nutritional Supplements	Retention in Care, Viral Suppression
Part B	$155,000.00	DHS	Oral Health	Retention in Care
Rebate	$44,829.00	Mayo Clinic	Outpatient Health Care Services	Case Finding, Linkage to Care, Retention in Care, Viral Suppression
MAI, Rebate	$111,000.00	African American AIDS Task Force	Outreach	Linkage to Care, Retention in Care
Part B, Rebate	$267,989.00	Minnesota AIDS Project	Resource and Referral	Linkage to Care, Retention in Care

Funding Sources	Funding Amount ($)	Funded Service Provider Agencies	Services Delivered	HIV Care Continuum Steps Impacted
Rebate	$100,000.00	Minnesota AIDS Project	Capacity Building Housing Advocacy	Retention in Care
Rebate	$72,610.00	Minnesota AIDS Project	Capacity Building Substance Use	Linkage in Care, Retention in Care, ART, Viral Suppression
Rebate	$50,000.00	Family Partnership	Capacity Building MCM Clinical Supervision	Linkage to Care, Retention in Care, ART, Viral Suppression
Rebate	$75,000.00	White Earth Nation – Summit in May 2016	Capacity Building Substance Use	Diagnosis, Linkage to Care, Retention in Care, ART, Viral Suppression
Rebate	$140,000.00	Midwest AIDS Training and Education Center	Capacity Building Medical	Diagnosis, Linkage to Care, Retention in Care, ART, Suppression
Minnesota Department of Health (MDH)				
MN State HIV Prevention	$946,173	African Health Action Corporation, Hennepin County Public Health Department – Health Interventions for Men (HIM) Program at Red Door, High School for Recording Arts, Indigenous People's Task Force, Face to Face, Lutheran Social Service – Duluth, Minnesota AIDS Project, Neighborhood House, Pillsbury United	HIV Testing and Testing Outreach	Diagnosis and Linkage to Care

Funding Sources	Funding Amount ($)	Funded Service Provider Agencies	Services Delivered	HIV Care Continuum Steps Impacted
		Communities, Rural Action AIDS Network (RAAN), Sub-Saharan Youth and Family Services in Minnesota (SAYFSM), Turning Point, West Side Community Health Services, and YouthLink		
MN State HIV Prevention	$236,822	Children's Hospitals and Clinics of MN – Perinatal Program, Hennepin County Public Health Department – Health Interventions for Men (HIM) Program at Red Door Minneapolis Medical Research Foundation – Positive Care Center at Hennepin Health System, Minnesota AIDS Project, and Youth and AIDS Projects (University of Minnesota)	Prevention with Positives	Linkage to Care, Retention and Viral Suppression
MN State HIV Prevention	$300,282	Minnesota AIDS Project, Rural Action AIDS Network (RAAN), and Sacred Spirits – First Nations Coalition,	Syringe Services	Prevention
MN State HIV Prevention	$50,000	Face to Face and Neighborhood House	Prevention for Youth at High Risk for HIV Infection	Prevention
CDC HIV Prevention	$338,699	MDH Public Health Lab, Hennepin County Public Health Department – Red Door Clinic, St. Paul Ramsey County Public Health – Clinic 555, and Minneapolis Medical Research Foundation – Positive Care Center at Hennepin Health System	HIV Counseling, Testing and Referral	Diagnosis and Linkage to Care

Funding Sources	Funding Amount ($)	Funded Service Provider Agencies	Services Delivered	HIV Care Continuum Steps Impacted
CDC HIV Prevention	$313,567	MDH and Hennepin County Public Health Department – Red Door Clinic	Partner Services	Prevention, Diagnosis and Linkage to Care
CDC HIV Surveillance Programs	$432,692	Minnesota Department of Health, STD/HIV/TB Section	Case Surveillance and eHARS	Linkage to care
DHS Contract Funding with MDH	$1,414,163	Minnesota Department of Health, STD/HIV/TB Section	PrEP, HIV Prevention Epidemiology, CareWare Maintenance	Diagnosis, Linkage to Care, Retention in Care
Hennepin County Public Health Department				
Part A	$41,300	Hennepin County Public Health Clinic	Early Intervention Services	Diagnosis, Linkage to Care
Part A	$98,100	Minnesota AIDS Project	Emergency Financial Assistance	Linkage to Care, Retention in Care, ART
Part A	$538,900	Minnesota AIDS Project, Open Arms of Minnesota, Aliveness Project,	Food Bank-Home Delivered Meals/Food Vouchers	Linkage to Care, Retention in Care, Viral Suppression
Part A	$80,800	Minnesota AIDS Project, Hennepin County Public Health, West Side Community Health Services	Health Education-Risk Reduction	Linkage to Care, Retention in Care, Viral Suppression
Part A	$7,300	Minnesota AIDS Project	Health Insurance Premium Assistance	Linkage to Care, Retention in Care, ART, Viral Suppression
Part A	$137,600	Pinnacle Services	Home and Community-Based Health Services	Retention in Care

Funding Sources	Funding Amount ($)	Funded Service Provider Agencies	Services Delivered	HIV Care Continuum Steps Impacted
Part A	$80,800	Minnesota AIDS Project	Housing-Rental Assistance	Linkage to Care, Retention in Care, Viral Suppression
Part A	$1,900	Various Hennepin County Vendors	Linguistic Services	Diagnosis, Linkage to Care, Retention in Care, ART, Viral Suppression
Part A	$96,800	Minnesota AIDS Project	Legal Services	Linkage to Care, Retention in Care
Part A	$1,607,700	Allina Health System¸ African American AIDS Task Force, Children's Hospitals and Clinics HealthPartners, Hennepin Health System, Saharan Youth and Family Services in Minnesota, West Side Community Services	Medical Case Management	Linkage to Care, Retention in Care, ART, Viral Suppression
Part A	$191,800	African American AIDS Task Force, West Side Community Health Services	MAI - Medical Case Management	Linkage to Care, Retention in Care, ART, Viral Suppression
Part A	$30,200	Allina Health System	MCM - Adult Foster Care	Linkage to Care, Retention in Care, ART, Viral Suppression
Part A	$418,200	Allina Health System, Hennepin Health System	Treatment Adherence/ Medication Adherence	ART, Viral Suppression

Funding Sources	Funding Amount ($)	Funded Service Provider Agencies	Services Delivered	HIV Care Continuum Steps Impacted
Part A	$44,000	Aliveness Project, Hennepin Health System	Medical Nutritional Therapy	Retention in Care, ART, Viral Suppression
Part A	$186,000	Hennepin Health System, SubSaharan Youth and Family Service of Minnesota¸ West Side Community Health Services	Mental Health	Retention in Care, Viral Suppression
Part A	$810,700	Hennepin Health System, HealthPartners, West Side Community Health Services,	Outpatient-Ambulatory Medical Care Primary Care	Linkage to Care, Retention in Care, ART, Viral Suppression
Part A	$158,800	Aliveness Project, Hennepin County Public Health Clinic	Outreach	Linkage to Care, Retention in Care
Part A	$88,400	African American AIDS Task Force, Minnesota AIDS Project, Saharan Youth and Family Services in Minnesota, West Side Community Health Services	Psychosocial Support	Linkage to Care, Retention in Care
Part A	$139,900	Hennepin Health System, Minnesota AIDS Project	Substance Abuse Services/Outpatient	Linkage to Care, Retention in Care, Viral Suppression
Part A	$24,000	SubSaharan Youth and Family Service of Minnesota	Transportation-Medical	Linkage to Care, Retention in Care, ART
Part B	$384,300	Minnesota AIDS Project	Emergency Financial Assistance	Linkage to Care, Retention in Care, ART

Funding Sources	Funding Amount ($)	Funded Service Provider Agencies	Services Delivered	HIV Care Continuum Steps Impacted
Part B	$138,000	Rural AIDS Action Network, Minnesota AIDS Project	Food Bank/Home Delivered Meals	Linkage to Care, Retention in Care, Viral Suppression
Part B	$3,600	Minnesota AIDS Project	Health Insurance Premium & Cost Sharing Assistance	Linkage to Care, Retention in Care, ART, Viral Suppression
Part B	$7,500	Minnesota AIDS Project	Legal Services	Linkage to Care, Retention in Care
Part B	$3,900	Interpretation and Translation	Linguistics Services	Diagnosis, Linkage to Care, Retention in Care, ART, Viral Suppression
Part B	$5,100	Aliveness Project	Medical Nutritional Therapy	Retention in Care, ART, Viral Suppression
Part B	$417,200	African American AIDS Task Force, Allina Health System, Aliveness Project, Health Partners, Hennepin County Public Health, Hennepin Health System, Minnesota AIDS Project, Rural AIDS Action Network	Medical Transportation Services	Linkage to Care, Retention in Care, ART
Part B	$45,000	Aliveness Project	Outreach Services	Linkage to Care, Retention in Care

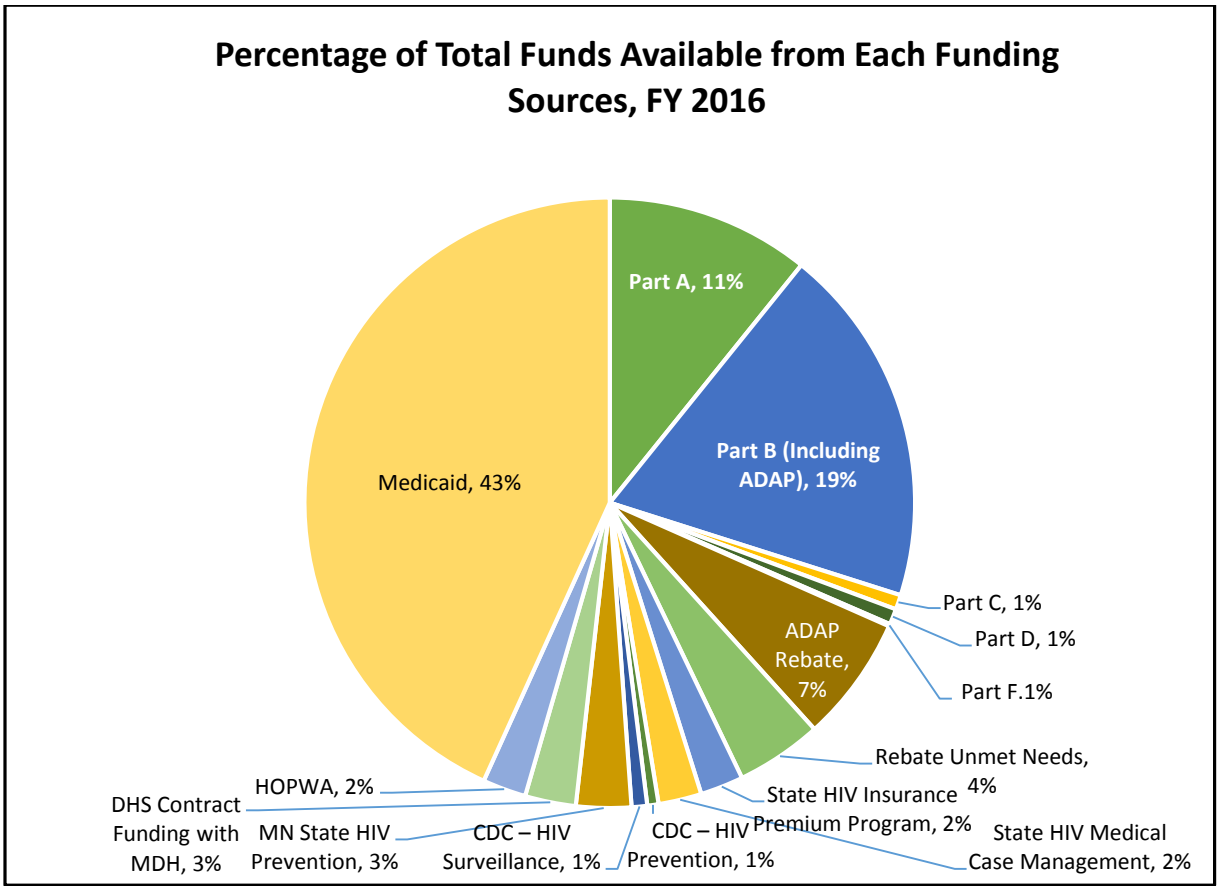
Funding Sources	Funding Amount ($)	Funded Service Provider Agencies	Services Delivered	HIV Care Continuum Steps Impacted
Rebate	$300,200	Aliveness Project, Hennepin County Public Health,	Early Intervention Services - African-born	Diagnosis, Linkage to Care
Rebate	$30,000	Minnesota AIDS Project	Emergency Financial Assistance - All Populations	Linkage to Care, Retention in Care, ART
Rebate	$10,075	Aliveness Project	Food Bank/Home Delivered Meals (GTR MN Food Shelf)- Greater MN	Linkage to Care, Retention in Care, Viral Suppression
Rebate	$96,700	Children's Hospital, Minnesota AIDS Project	Health Education-Risk Reduction – DAC	Linkage to Care, Retention in Care, Viral Suppression
Rebate	$88,350	Minnesota AIDS Project	Housing Services - Statewide	Linkage to Care, Retention in Care
Rebate	$272,000	African American AIDS Task Force, Hennepin Health System	Medical Case Management – DAC	Linkage to Care, Retention in Care, ART, Viral Suppression
Rebate	$34,075	African American AIDS Task Force, Rural AIDS Action Network	Medical Transportation DAC	Linkage to Care, Retention in Care, ART
Rebate	$85,000	Aliveness Project	Non-Medical Case Management – DAC	Linkage to Care, Retention in Care

Funding Sources	Funding Amount ($)	Funded Service Provider Agencies	Services Delivered	HIV Care Continuum Steps Impacted
Rebate	$10,000	Hennepin Health System	Outpatient Ambulatory Care - Statewide	Linkage to Care, Retention in Care
Rebate	$85,000	Hennepin County Public Health	Outreach Services – DAC	Linkage to Care, Retention in Care
Rebate	$30,000	Hennepin County Public Health	Psychosocial Support Services – DAC	Linkage to Care, Retention in Care
Rebate	$70,000	Hennepin Health e System, Minnesota AIDS Project	Substance Abuse Outpatient - Statewide	Linkage to Care, Retention in Care, Viral Suppression
HOPWA	$1,055,090	Metro HRA	Housing – Rental Assistance	Linkage to Care, Retention in Care
HOPWA	$153,742	Minnesota Housing Finance Agency	Housing – Rental and Mortgage Assistance	Linkage to Care, Retention in Care
Medicaid - Federal	$30,063,571	Minnesota Department of Human Services	Outpatient Health Care Services	Diagnosis, Linkage to Care, Retention in Care, ART, Viral Suppression
Minnesota Care – Federal/State	$1,024,419	Minnesota Department of Human Services	Outpatient Health Care Services	Diagnosis, Linkage to Care, Retention in Care, ART, Viral Suppression
Hennepin County	$104,902	Hennepin County Public Health Clinic	Early Intervention Services	Diagnosis, Linkage to Care.

Funding Sources	Funding Amount ($)	Funded Service Provider Agencies	Services Delivered	HIV Care Continuum Steps Impacted
Hennepin County	$166,500	Minnesota AIDS Project	Transitional Housing Services	Linkage to Care, Retention in Care
Hennepin County	$17,234	Hennepin County Public Health Clinic	Outreach Services	Linkage to Care, Retention in Care
City of Minneapolis	$41,200	Department of Health and Family Services	Medical Case Management	Linkage to Care, Retention in Care, ART, Viral Suppression
St. Paul – Ramsey Public Health Department	$121,187	Clinic 555	Early Intervention Services	Diagnosis, Linkage to Care.

Percentage of Total Funds Available from Each Funding Sources (Table), FY 2016

Funding Source	Amount	Percentage of Total Funds
Part A	$5,671,107	11.14%
Part B (Including ADAP)	10,030,522	19.70%
Part C	407,656	0.80%
Part D	437,613	0.86%
Part F	63,185	0.12%
ADAP Rebate	3,503,848	6.88%
Rebate Unmet Needs	2,400,000	4.71%
State HIV Insurance Premium Program	1,063,678	2.09%
State HIV Medical Case Management	1,156,169	2.27%
CDC – HIV Prevention	313,567	0.62%
CDC – HIV Surveillance	432,692	0.85%
MN State HIV Prevention	1,533,277	3.01%
HOPWA	1,208,832	2.37%
Medicaid (Medical Assistance)	22,698,658	44.58%
TOTAL	**$50,920,804**	100.00%



HIV Workforce Capacity (Section I: C. b.)
This section describes the HIV workforce capacity and how it impacts the HIV service delivery system in Minnesota.

Care Workforce
There are 19 organizations including medical clinics and community based non-profit agencies with 111 full-time equivalent (FTE) contracted staff to provide services through either the Part A or Part B recipients. Most of these organizations offer multiple services providing clients a menu of services available at one location. In addition, providers within the HIV-service system have a high level of knowledge of programs and services available at other agencies and there is extensive client referrals among them. In addition, many service activities are available at multiple locations providing not only geographic convenience but also allowing clients to choose their self-determined most suitable provider. This means, for example, that a client may choose to receive medical case management at their HIV medical clinic or, through a community based organization that meets their culturally specific needs.

Minnesota is fortunate to have several excellent HIV care clinics both within the TGA and in Greater Minnesota. These clinics serve a highly diverse population and strive to provide care that serves both the cultural and linguistic needs of all patients. These medical clinics offer a range of medical services with physicians, nurse-practitioners, registered nurses, registered dietitians, licensed social workers, Licensed Alcohol and Drug Counselors (LADC's), Pharm-D's, medical case managers, behavioral health professionals and, paraprofessionals who have long experience

and training in working with HIV-positive clients. Several of these clinics provide services such as HIV testing or PrEP services to partners of patients and other high-risk populations.

Minnesota has a well-developed social safety net both inside and outside the HIV service system. HIV Supportive Services workers include health educators, care linkage specialists, outreach workers, housing specialists, non-medical case managers primarily providing benefits counseling, lawyers, group facilitators, peer navigators, and homemaker service workers. These workers make referrals to and work in coordination with other non-HIV specific providers to meet the needs of their clients which in effect, extends the HIV workforce.

While 86% of known HIV-positive Minnesotans live in the TGA, the remaining 14% are scattered broadly across a large and mostly rural geographic area. In order to provide access to experienced medical and social service providers in rural areas with low prevalence rates, Part B provides training to increase capacity in locations throughout the state. This is a work in progress but as an example, Part B provides funding to train LADC's on substance abuse care needs of individuals living with HIV. In the last year, 50 LADC's attended one of seven two-day trainings. Similarly, the Midwest AIDS Training and Education Center is surveying Community Health Centers to learn their readiness and skill in providing primary care to HIV-positive individuals. Once this data has been analyzed, they will begin to offer training to these clinics based on the outcomes from the data. The goal of these capacity building efforts is to increase the ability of non-HIV specific providers to deliver competent, stigma-free care to a population they may encounter only sporadically.

Minnesota has a systemic lack of mental health capacity especially for outpatient psychiatric appointments and inpatient mental health care. This is not an HIV-specific issue and in fact, the Governor has created a special task force to improve access to a range of needed mental health services for all Minnesotans. As a partial remedy, several HIV clinics have developed relationships with mental health clinics to circumvent the lack of capacity for medication checks or other appointments with psychiatrists, but inpatient care remains a difficulty. Individuals receiving medical care from generalized infectious disease clinics do not have access to mental health services within a clinic and may therefore face long wait times. Dental care also lacks capacity, especially for low-income residents living in Greater Minnesota. Many dentists site low reimbursement rates for limiting the number of Medicaid patients they accept and this impacts individuals with HIV ability to obtain oral health care despite having access to insurance or ADAP oral health care assistance.

In general, the HIV workforce is very experienced and clients can generally find the medical and supportive services they need. This is more difficult for clients living in Greater Minnesota however, medical case management services scattered across the state has allowed access to needed services both HIV specific and non-specific. The lack of mental health and dental services is also somewhat amplified in Greater Minnesota but despite targeted HIV resources remains a systems issue for all populations.

Prevention Workforce

Minnesota's HIV prevention workforce included staff at the Minnesota Department of Health, STD, HIV and TB Section (MDH) and staff at 18 agencies funding through the MDH. The MDH utilizes federal and state funding to support approximately 26 FTEs. These positions

include grant management, capacity building and technical assistance, administrative support services, epidemiology and surveillance, partner and care link services, and administrative management. These funds are also used to support approximately 24 FTEs at community and clinical based organizations to provide HIV testing and outreach testing, prevention with positives, syringe services and condom distribution activities. Staff at these organizations include medical case managers, community health workers, outreach specialists, HIV testing coordinators, prevention case managers, nurses and other licensed providers, and many other paraprofessionals with extensive experience in HIV prevention activities.

Interaction of Funding Sources to Ensure Continuity of HIV Prevention, Care and Treatment Services in Minnesota (Section I: C. c.)

Minnesota coordinates different funding sources at both the prevention, care and treatment levels of the continuum.

Prevention Funding Source Coordination

Minnesota is unique in the country in that Ryan White Part B funding and HIV Prevention funding are administered by different state agencies. The MDH serves as the grantee for the State's CDC prevention funding and the Department of Human Services (DHS) serves as the grantee for Minnesota's Ryan White Part B program. Ryan White Part A funding goes directly to Hennepin County. Due to separate federal funding sources and different priorities, there has historically been minimal integration of prevention and care resource administration and planning in Minnesota.

In more recent years, there has been a greater emphasis at the federal level on diminishing the distinction between prevention and care. In 2010, the White House issued the National HIV/AIDS Strategy (NHAS) to guide the nation's effort to end the epidemic. The fourth goal of the NHAS calls for "increased coordination of HIV programs across the federal government and between federal agencies and state, territorial, tribal, and local governments." In response to the NHAS and the demonstration of early initiation of antiretroviral treatment (ART) as a highly effective prevention intervention, the Centers for Disease Control and Prevention (CDC) refocused its funding priorities to scale up HIV testing, The intent is to identify the estimated 18% of people living with HIV who are undiagnosed, ensure early linkage to care, and implement highly effective prevention interventions with people living with HIV.

Reauthorization of the Ryan White Act in 2009 increased the Ryan White Program's focus on identifying the undiagnosed, linking those infected to early care and supporting lifetime adherence to treatment. In 2016, CDC and HRSA jurisdictions are required to submit a joint statewide HIV prevention and care strategy. Given all of these factors, the three government agencies (MDH, DHS and Hennepin County) and members of the former Planning Council and Community Cooperative Council on HIV/AIDS Prevention (CCCHAP) agreed in early 2014 to merge the two planning groups into one planning body. Through an intergovernmental cooperative agreement supported by all three agencies, the Minnesota Council for HIV/AIDS Care and Prevention (MCHACP) was formed and began meeting in February 2016. Hereinafter MCHACP will be referred to as the "Council". The Council's role is to identify both prevention and care priorities for Minnesota.

With full implementation of the Affordable Care Act (ACA) including Minnesota's expansion of Medicaid and a health insurance exchange in 2014, many more Minnesotans living with HIV have access to affordable health care. At-risk insured Minnesotans also have access to free HIV and STD testing through their health care providers. With flat or diminishing HIV public health resources, these circumstances demand much tighter coordination of HIV prevention and care activities to ensure a more cost effective and integrated approach to ending Minnesota's HIV epidemic. DHS, Minnesota's Part B grantee, is using use ADAP rebate revenue for care linkage, increased epidemiological support to employ data-to-care strategies, and is funding the efforts to develop a statewide HIV strategy to end the epidemic.

Service and Treatment Funding Source Coordination

Minnesota coordinates its Part A and B Ryan White planning efforts by utilizing the newly formed Council to carry out its prioritization and allocation responsibilities. For Part A, Council decisions on priorities and allocations are decisive and for Part B Council decisions are considered to be advisory, although historically nearly always followed. This creates an effective system of care and provides a level of funding coordination that maximizes service provision to people living with HIV/AIDS.

In planning the continuum of care and services, prioritizing services, and allocating Ryan White resources, services funded by sources other than Ryan White interact with Ryan White funds in the following ways:

a) Other sources of funding are considered when the Council sets priorities, makes allocations, and reallocates resources to ensure that Ryan White is the payer of last resort and that Ryan White funds are not supplanting other funding sources.

b) Priority setting and resource allocation processes consider Medicaid and other state-funded healthcare programs. The Minnesota Department of Human Services (DHS), the Part B grantee and agency responsible for Medicaid and all other state-funded healthcare programs, is a party to the Intergovernmental Cooperative Agreement. In addition, DHS has a designated seat on the Council, one from the state Medicaid office and one from the Part B grantee office.

c) DHS staff determines eligibility of PLWH who may qualify for state-sponsored insurance and Ryan White funded programs such as ADAP to ensure the Ryan White program is the payer of last resort.

d) The Part A and B grantees and Council receive an annual report from DHS on the number of PLWH disease enrolled in all Minnesota Healthcare Programs (MHCP), including Medicaid. The report also includes spending on HIV outpatient medical care, dental care, mental health and chemical dependency treatment services, and home and community-based support services.

e) Through ADAP and the HIV Insurance Program, Minnesota's Part B grantee provides additional assistance to individuals with incomes up to 400% of the federal poverty level who are enrolled in Medicare Part D. A state appropriation provides support for the HIV Insurance Program. Part B funds provide benefits counseling (non-Medical Case Management) to help consumers identify the most comprehensive private and public healthcare programs to ensure continued access to affordable treatment. This helps those who are Medicare eligible to enroll in

the Part D prescription drug plans and extra-help programs. DHS provides the Council with information on the number of PLWH on Medicare who are also enrolled in ADAP and the HIV Insurance Program.

f) Through ADAP and the HIV Insurance Program, Minnesota's Part B grantee provides assistance to individuals with incomes up to 400% of the federal poverty level who are enrolled in Medicare Part D insurance. A state appropriation provides support for the HIV Insurance Program. Part B funds provide benefits counseling (non-Medical Case Management) to help consumers identify the most comprehensive private and public healthcare programs to ensure continued access to affordable treatment. This helps those who are Medicare eligible to enroll in the Part D prescription drug plans and the Extra-Help program. DHS provides the Council with information on the number of PLWH on Medicare who are also enrolled in ADAP and the HIV Insurance Program.

g) The Veterans Administration (VA) Medical Center in the TGA has an HIV specialty clinic that currently provides care to qualifying patients statewide. Veterans have access to the same comprehensive drug formulary as Medicaid offers and most veterans with HIV receive comprehensive services through the VA system. Veterans have access to and utilize other Ryan White funded services that are not part of VA benefits, including medical case management, health education, food bank/home delivered meals and medical transportation services.

h) The Minnesota Housing Finance Agency (MHFA) and the City of Minneapolis receive Housing Opportunities for Persons with AIDS (HOPWA) formula funding. The Minneapolis program provides rental subsidies and the MHFA program provides both rental and mortgage assistance outside the TGA. A Council member, a Part B representative, and the Council Coordinator participate in the Minnesota HIV Housing Coalition. The co-chair of the Housing Coalition presents on HOPWA funded services at the Council's informational sessions. The TGA's largest AIDS service organization receives local funds for a transitional housing program, is a sub-recipient of state formula HOPWA funds and also has a Part A contract to provide rental assistance. The grantees works closely with this agency to coordinate Part A, Part B, and HOPWA funds.

i) Other social service programs are considered during the planning and priority setting process in ways similar to those described above. The Minnesota DHS HIV/AIDS program is situated in the DHS's Disabilities Services Division. The DHS HIV/AIDS director apprises the Council of other state funded programs for persons with disabilities such as Minnesota's Pathways to Employment‖ program and the state's Medicaid waiver home and community support programs. Administrators of other state and local support programs, such as targeted case management, participate in the Council and its committees, as well as in formulating the SCSN.

j) The Part A grantee office is co-located with Hennepin County's Public Health Clinic, which is the largest local public health agency in Minnesota. The Council allocates resources to services provided by Hennepin County's Public Health Clinic including: early invention, outreach, health Education and risk reduction, medical transportation and mental health services. As a result, Ryan White funding is closely coordinated with the state's largest CDC-funded HIV counseling, testing and referral provider. Hennepin County's Public Health Clinic also receives both CDC and state funding for HIV and syphilis prevention targeting MSM. The Part A grantee

coordinator meets with both Minnesota's STD and AIDS Director from the MDH and the DHS HIV/AIDS Program Administrator monthly to coordinate local and state prevention and care funding and programming.

k) DHS also administers state and federally funded substance use services and provides key information for the Council about how substance use disorder (SUD) treatment services are funded and utilized by PLWH enrolled in Medicaid and other publicly funded healthcare programs. In general, treatment on demand is available for low income people living with HIV disease. Treatment services are paid for through the state's Consolidated Treatment Fund supported through a Substance Abuse and Mental Health Services Administration Block Grant. The Council allocates Part A funding for chemical health assessment, treatment placement, short term counseling and follow up at the TGA's largest HIV specialty clinic and largest AIDS service organization. These programs facilitate access to SUD treatment funded through other public sources and ensure that a continuum of care exists for PLWH who are substance users. In addition to DHS's oversight of SUD services, its staff participates in the planning, priority setting and allocations processes. DHS also provides training for SUD treatment centers on appropriate care and resources for people living with HIV.

l) Part A and B grantee managers work to ensure coordinated administration of Part A, B, and state appropriations for HIV services. Reimbursement methods and standards for service delivery are uniform across providers regardless of which government agency manages contracts. Grantees work to prevent duplication of state and local funding of HIV services.

Services which are not being Provided & Steps Taken to Secure them (Section I: C. d.)
A key goal of the Integrated HIV Prevention and Care Plan, Ryan White Legislation, the National HIV/AIDS Strategy, and Health People 2020 is to reduce or eliminate the gaps in resources and services that prevent people living with HIV disease from entering into or remaining in care. Unmet need estimates produced by the MDH approximates 27% of all people living with HIV disease in the Minneapolis-St. Paul Transitional Grant Area who know their HIV status and are not receiving medical care. In addition, there are an estimated 12% who are HIV positive and are not aware of their status. The identification of resources and services which are not being provided and the steps taken to secure the needed resources and services is separated into three major themes including resources and services for communities of color, Greater Minnesota, and along the HIV Continuum of Care. There are many steps being taken at each stage in the continuum to ensure there are adequate resources to meet the needs of PLWH.

Linkage to Care
An ongoing challenge is to determine what prevents those who are HIV-positive from being engaged in care. Minnesota, along with the rest of the nation, is challenged to cultivate new ways of delivering prevention and education messages particularly targeted at young people at risk, people who have been diagnosed but are not engaged in care, communities of color, and immigrant (non-English speaking) populations.

To address these resource and service gaps the Council has allocated Part A resources for early intervention services (EIS) at Hennepin County's Public Health Clinic (PHC). This clinic is the largest public health clinic in the TGA and diagnoses 25% of Minnesota's annual number of new infections. At the PHC all newly diagnosed PLWH meet with a nurse practitioner at the time of diagnosis and have their blood drawn for CD4 count and viral load tests. In addition, they meet

with an HIV positive navigator who arranges follow up appointments and brokers both internal and external connections with services that support ongoing retention in care. The PHC has a cooperative referral agreement to have a medical appointment scheduled for a newly diagnosed individual within 48 hours at Hennepin County Medical Center's (HCMC) Positive Care Clinic (PCC) - the largest HIV specialty clinic in the TGA. The PCC is a five-minute skyway walk from the PHC and both clinics share a clinical director. The PHC has referral agreements with the other four largest HIV primary care providers in the TGA. The PHC provides confirmatory testing for many of the community-based organizations in the TGA that provide HIV testing which broadens the reach of their EIS program. In addition, the PHC receives funding for medical transportation, health education/risk reduction and psychosocial support services that facilitate linkage to care and ongoing retention.

Part B recently funded a small EIS program through a HIV Clinic in southern Minnesota. It is the only EIS program outside the TGA. Its service area includes two counties with a much higher than average rate for HIV among rural counties. Both counties are home to industries that employ many Latino and African-born workers. While this EIS program is small, it is hoped that it can reach out to these populations which are both high risk and most likely to be late testers and expand it to high risk communities in other geographic locations in Greater Minnesota

MDH currently has a Care Link Services Program which is funded through DHS. The program uses CD4, viral load (VL), and other surveillance data reported to MDH to increase the proportion of PLWH/A begin and remain or re-engage in HIV medical care, thus improving their health outcomes and reducing the risk of transmitting HIV to others while receiving anti-retroviral therapy. The populations of focus, in order of highest priority first, are: 1) HIV-positive pregnant women not in care or whose care status is unknown; 2) newly diagnosed African women; 3) those newly diagnosed at a facility without an affiliated HIV medical provider; 4) those who have not initiated HIV care within 90 days after their first positive HIV test; and, 5) racial and ethnic minority men who have sex with men (MSM) and who have been out of care (OOC) for more than 12 months. This project addresses the focus areas of 1) enhanced linkage to and retention in care for persons with new and prior diagnoses of HIV infection, and 2) programmatic and epidemiologic use of CD4, viral load and other surveillance data to assess and reduce HIV transmission risk. The program will expand its priorities as Hennepin County begins doing all cases in the jurisdictions.

Although Minnesota has current linkage, engagement and reengagement programs it isn't adequate to meet all of the state's needs. According to the last estimate, Minnesota still has 30 percent of individuals living with HIV not in care. Without all PLWH/A in care, the state will not reach the National HIV Strategy's goal for viral suppression. Without having all PLWH/A reaching viral suppression Minnesota will not get to zero new infections.

Retention

Services designed to retain PLWH in care have proven to be effective in achieving viral suppression and ultimately prevention of the spread of HIV. Data from MN CAREWare suggest that PLWH receiving Ryan White services are more likely to be retained in care and have suppressed HIV compared to the total population of PLWH. Medical case management (MCM) is a key medical care access facilitator that significantly impacts movement across the HIV Care Continuum from linkage to suppressed virus through its support of ART adherence and mitigation of economic and psychosocial barriers to care. The Council's largest allocation of Part

A funds for services is to MCM. Part B, state and rebate funds MCM primarily at community based organizations (CBO's) within the TGA and at both CBO's and HIV clinics in Greater Minnesota. In addition, Part A and MAI funds for MCM are allocated to a Federally Qualified Health Center that provides care to a quarter of Minnesota's Latinos living with HIV. Part A funds are also allocated for MCM to the African American AIDS Task Force that reaches African Americans experiencing significant barriers to health care access and retention. Part B MAI funds are used to promote enrollment of African American men into ADAP ensuring they have access to health care plans and/or medications to promote retention.

Supportive services have a major role in retention in care. Supportive services such as housing, transportation, access to food through home delivered meals and food shelves or Emergency Assistance as well as addressing clients' needs for mental health and substance abuse care all are critical in care retention. Funds from Parts A and B and Rebate are used both in the TGA and statewide to support these services. Part B recently funded increased housing services because it has been well documented that stable housing is a key factor in all aspects of the continuum but may have greatest impact in care retention and subsequent viral suppression. These funded services will provide:

- Additional financial support for emergency housing assistance,
- Provide supportive housing, and
- Fund a program to work to increase housing availability and provide education to HIV service providers on how to access subsidized housing for their clients. This is necessary due to a systemic shortage of affordable and subsidized housing statewide.

Beginning in 2016, Hennepin County's PHC receives HIV surveillance data on PLWH living in Hennepin County from the MDH to implement a *Data to Care* project. The majority of the TGA's population of PLWH reside in Hennepin County. The surveillance data will enable PHC disease intervention and service navigation staff to reach out to those who are out of care and help them restart their movement across the HCC by connecting them to services they need to support retention and achieve viral suppression. In addition, Hennepin County (Part A grantee) in collaboration with the MDH and the DHS (Part B grantee) are finishing up a pilot called "eHARS to CAREWare". This pilot project migrates CD4 counts and viral load values from the eHARS into CAREWare so these values are known for Ryan White Program recipients in Minnesota. This will facilitate both Part A and B funded medical case manager monitoring of retention and viral suppression of their clients so they can more effectively target treatment adherence interventions.

Viral Suppression

With full implementation of the ACA only 4% of Minnesotans are now uninsured providing increased access to health care which should raise retention and viral suppression rates among PLWH. This means that direct funding for HIV clinical services has largely been spared from budget cuts. However, disparities in access to economic supports for health care coverage continue to exist among people of color. This is particularly true for those who were born outside of the United States.

To address these resource and service gaps, Part A and MAI funds are allocated to outpatient health care services (OHCS) provided by two of the largest HIV specialty clinics in the TGA and a Federally Qualified Health Center (FQHC). The FQHC reaches PLWH born in Latin American countries who do not qualify for Medicaid or Medicare and are unable to obtain a qualified

health plan with advanced premium tax credits through Minnesota's health insurance exchange because of immigration status. ADAP is used to purchase health care insurance through the exchange market for many of these individuals but for others, OHCS programs fill gaps in medical care especially for those PLWH who are newly diagnosed or re-entering care and uninsured, temporarily lose coverage due to "churning" caused by changes in eligibility for publicly funded programs resulting from fluctuations in income, loss of employer sponsored coverage, and annual changes in qualified health plans available through Minnesota's insurance exchange during open enrollment. The growth in both the epidemic and the number of PLWH utilizing Ryan White funded services in an atmosphere of flat funding presents a challenge to ensuring access to care.

Section I: Statewide Coordinated Statement of Need/Needs Assessment

D. ASSESSING NEEDS, GAPS, AND BARRIERS

Process Used to Identify, HIV Prevention and Care Service Needs of People at Higher Risk for HIV and PLWH Both Diagnosed and Undiagnosed (Section I: D. a.)
A variety of groups and mechanisms were employed to collect information on the needs of PLWH and those at higher risk of infection to inform the Integrated HIV Prevention and Care Plan, including:

- Minnesota Council for HIV/AIDS Care and Prevention (Council);
- The Council's Needs Assessment & Evaluation Committee (NA&E);
- The Council's Community Voices Committee (CVC);
- The Council's Planning and Allocations Committee (PAC);
- The Council's Disparities Elimination Committee (DEC);
- Provider and Consumer Surveys;
- Three work groups convened to address HIV related health disparities among African American and Latino gay/bisexual/men who have sex with men and Africans; and
- SCSN Community Input Meeting.

Minnesota Council for HIV/AIDS Care and Prevention (Council)
The Council led the development of Minnesota Integrated HIV Prevention and Care Plan. In addition, the Council allocates federal Ryan White funds for Part A for HIV treatment and care services and makes allocation recommendations for Part B HIV treatment and care services. Time is also allotted during an Open Forum section of each Council meeting for community members to discuss service needs and priorities.

As part of the process, the Council has approved values and guidelines that validate the importance of data-based decision making. The SCSN Needs Assessment includes consideration of the needs and input of people living with HIV (PLWH) and people at higher risk of HIV. All of the populations identified as having severe need are represented on the Council, including four (4) African immigrants. The Council is currently composed of 29 members, 14 (48%) of whom identify as living with HIV disease and 12 (41%) of whom are not aligned with a Ryan White provider agency. The Council also has seven committees including Executive Committee, Planning and Allocations Committee, Disparities Elimination Committee, Needs Assessment and Evaluation Committee, Community Voices Committee, Membership and Training Committee, and Grievance Committee. It is important to note that PLWH populate all Council committees, where they provide input on needs assessment data collection and analysis, as well as services and funding allocations.

The Council Committees were actively involved in the Statewide Coordinated Statement of Need including:

Needs Assessment and Evaluation Committee (NA&E)
The Council's Needs Assessment & Evaluation Committee reviewed data from a variety of sources, studies, and surveys. Committee members identified social and structural barriers; federal, state and local barriers; health department barriers; program barriers; service provider barriers; and client barriers.

Community Voices Committee (CVC)
The Council's Community Voice Committee (CVC) meets quarterly and includes HIV-positive Council members as well as HIV-positive community members. The CVC provides perspective

on emerging service needs and problems associated with the current service delivery system. Most importantly, the group provides the Council with key insights into issues associated with living with HIV/AIDS. During the SCSN Needs Assessment consumer input was gathered from members of the CVC.

Planning & Allocations Committee (PAC)
The Planning and Allocations Committee identifies service areas, designs the prioritization process and makes funding recommendations for Council review and approval. It also leads a long-term planning process resulting in the Integrated HIV Prevention and Care Plan and develops Standards of Care for Ryan White funded services areas.

Disparities Elimination Committee (DEC)
The Disparities Elimination Committee exists to develop strategies to ensure that the Council's priorities and resource allocations address and reduce disparities within underserved and disproportionately impacted populations in access to HIV prevention, care services and outcomes based on the stages of the HIV Care Continuum including:

- Awareness of diagnosis;
- Linkage to care;
- Retention in care;
- Receiving ART; and
- Achieving suppressed virus.

Healthy People 2020 defines a health disparity as "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion."

PAC and DEC Combined Meetings
The Council held dedicated joint meetings of PAC and DEC to discuss SCSN barriers and gaps in services. These meetings were held on March 7, 2016 and April 13, 2016. During the first meeting the participants reviewed epidemiological profiles, needs assessments and resources inventories to inform development of the Integrated HIV Prevention and Care Plan. During the second meeting they brainstormed prevention and care needs of people at higher risk for HIV and PLWH (diagnosed and undiagnosed). Then meeting participants grouped the information and ranked the identified gaps and barriers. The meetings were structured to gather and prioritize feedback to identify HIV prevention and care services that currently exist and those that are needed. The goal is to enhance the quality of services for people at higher risk for HIV and PLWH, as well as identify barriers in access to services.
The Council and its subcommittees will continue to remain actively involved in updating and monitoring the Integrated HIV Prevention and Care Plan including the SCSN throughout 2017 – 2021. A complete description of the Council and its Committee's is included in Attachment C: *Minnesota Council for HIV/AIDS Care and Prevention (Council) Description*.

Consumer Needs Assessment (CNA) Survey
In addition to serving on the Council and its respective committees, PLWH and those at higher risk participate in needs assessment surveys. The 2015 SCSN Needs Assessment contains

responses from 500+ consumers, providing direct feedback about barriers to care and gaps in services from affected communities.

Although survey respondents are primarily recipients of Ryan White services, their responses help develop an understanding of the issues faced by those who are not in care. The results of the survey showed that forty-five percent (45%) of respondents got tested because they were sick and 23% waited more than three months before getting medical care. Of those who had detectable levels of the virus, 41% missed doses of ART in the past week. There were also problems identified with access to health insurance. Thirty-One percent (31%) of respondents had problems signing up for insurance or understanding their insurance which negatively affected their medical care. Twenty-eight percent (28%) have been uninsured for three months or longer since their diagnosis. Access to oral health care continues to be a challenge with 14% of respondents reporting that they needed oral health care in the past year but were unable to access it. Other services that were reported as needed but unable to access include nutrition services (8%), and financial assistance with medications (5%) and insurance premiums (6%). Homelessness and unstable housing as social determinates of health continue to be problematic with 19% of respondents reporting homeless or unstable housing.

Other identified needs remained consistent from 2010 to 2015 with a relatively low number of respondents (2-3%) reporting needing but not being able to access the following services: outpatient medical care, early intervention services, home health care, home and community based services, hospice, mental health, medical case management, treatment adherence, and outpatient substance abuse treatment.

Statewide Coordinate Statement of Need (SCSN) Community Forum
On March 22, 2016, the Minnesota DHS and the Council co-sponsored a community forum to solicit additional stakeholder input into the availability of services and gaps and barriers that might exist. The purpose of this meeting was to collect information about the needs of persons at higher risk for HIV infection and PLWH (those receiving care and those not receiving care); identify current resources available to meet those needs, and determine what gaps in HIV prevention and care services exist.

Invitations for the community forum included all Ryan White funded providers, Ryan White consumers and persons directly involved with the former Minnesota HIV Services Planning Council. In addition, efforts were made to include providers to represent people living with HIV/AIDS and members of a federally recognized Indian tribe as represented in the State and public agency representatives. Efforts were made to ensure the inclusion of persons that represent the diversity present in the HIV epidemic in Minnesota by reaching out to a broad spectrum of providers, consumers and community stakeholders. Representation from other major providers and funders of services needed by people living with HIV/AIDS such as substance abuse, mental health, Medicaid, Medicare, Community Health Centers, Veterans Administration and HIV prevention were all involved in this process. If representatives were not able to attend the community meetings, they were still involved through email and phone communication in discussing the 2015 SCSN and the 2017 – 2021 Integrated HIV Prevention and Care Plan.

Forum participants included 34 community members and individuals from HIV prevention and care, health care, mental health and chemical dependency treatment organizations, as well as local and state government to help create a current SCSN. All participants were given access to

the Integrated HIV Prevention and Care Plan guidance and it was made clear that we needed to address the needs of individuals who are unaware of their HIV status in the 2015 SCSN Needs Assessment. The tone was set to be mindful of the importance early identification of PLWH, NHAS goals and improving the proportions of PLWH engaged in stages of the HIV Care Continuum throughout our SCSN Needs Assessment process.

Representatives from all of the following Ryan White grantees participated in the community forum:

- Hennepin County Public Health Department, Part A
- Minnesota Department of Human Services (DHS), Part B/ADAP
- Minnesota Department of Health (MDH)
- Hennepin County Medical Center (HCMC), Part C
- Rural AIDS Action Network (RAAN)
- West Side Community Health Center, former Part D
- Midwest AIDS Training and Education Center (MATEC), Part F

The session started with two presentations including an Epidemiological Overview provided by Allison LaPointe, Epidemiology Supervisor from MDH's HIV/STD/TB Section and the 2015 Comprehensive Needs Assessment (CNA) survey presented by Jonathan Hanft, PhD from Hennepin County's Public Health Department (see Attachment D: *Comparison of 2010 and 2015 Consumer Needs Assessment*). Participants then broke into small groups to brainstorm barriers to accessing HIV prevention and care services, gaps in services and solutions to mitigating the barriers and filling the gaps. A summary of the meeting listing the gaps, barriers and solutions were then presented at the joint Disparities Elimination Committee and Planning Allocations Committee meeting on April 13, 2016 to inform their identification and ranking of gaps and barriers for the SCSN Needs Assessment. The results of these processes produced the SCSN.

HIV Prevention and Care Service Needs for Persons at Higher Risk and PLWH (Section I: D. b.)

On March 22, 2016 thirty-four (34) people participated in an SCSN Needs Assessment stakeholder meeting. The session was co-hosted by the Council and DHS. Participants included representatives from MDH, DHS's Continuing Care Administration, Hennepin County Human Service and Public Health Department, Minnesota AIDS Project, Hennepin County Medical Center, Youth and AIDS Project, Aliveness Project, LynLake Psychotherapy and Wellness, Westside Community Health Services, Northern Pines Mental Health, Rural AIDS Action Network, African American AIDS Task Force, Children's Hospitals and Clinics, and several community members including most importantly individuals who are at higher risk for HIV and PLWH.

The purpose of the SCSN Community Forum was to collect information about the needs of persons at higher risk for HIV infection and PLWH (those receiving care and those not receiving care); identify current resources available to meet those needs, and determine what gaps and barriers in HIV prevention and care services exist. The key points from the CNA presentation are summarized as follows:

- 45% of respondents got tested because they were sick
- 23% waited more than three months before getting medical care
- 41% who had detectable virus missed doses of ART in the past week

- 31% had problems signing up for insurance or understanding their insurance which negatively affected their medical care
- 28% have been uninsured for three months or longer since their diagnosis
- 19% were homeless or had unstable housing
- 14% needed oral health care in the past year but were unable to access it

Prevention Needs of Persons at Risk of HIV, Focus on Populations at Greatest Risk
By focusing efforts in communities where HIV is concentrated, Minnesota can have the biggest impact in improving overall public health and lowering collective risk of acquiring HIV. This includes communities of color specifically African American, African-born and Latino gay and bisexual men and other MSM of all races and ethnicities, young gay and bisexual men, transgender women who have sex with men, sex workers, injection drug users, and those communities where stigma is a major barrier.
At their February 2012 meeting, Community Cooperative Council on HIV/AIDS Prevention (CCCHAP) identified the following target populations as the focus for prevention and care strategies (not prioritized):

- Men having sex with men (MSM)
- Young men having sex with men (YMSM)
- Injection drug users (IDU)
- Young, high risk heterosexuals
- African American high risk heterosexuals
- African born high risk heterosexuals
- The Latino/a high risk heterosexuals
- Native American high risk heterosexuals
- API high risk heterosexuals
- People living in Greater Minnesota (This includes all genders, races, sexual orientations, risk categories)

MSM/IDU is no longer considered a separate target population. Due to reductions in federal HIV Prevention funding levels, CCCHAP made the decision to eliminate the separate category of MSM/IDU. Funded agencies focusing on injection drug users are required to demonstrate cultural competence regarding MSM and staff must be skilled at discussing transmission risks and prevention strategies for oral, anal and vaginal sex. To adjust to reductions in federal funding MDH is re-examining the process for determining allocations for the next HIV prevention request for proposals in 2017.

While the overall rates of new HIV/AIDS infections in Minnesota have been relatively stable, there have been consistent increases in the numbers of new cases in particular populations, including:

- **Men having sex with men (MSM)**: Roughly 75% of new HIV/AIDS cases in Minnesota are among men, the majority of whom are gay, bisexual and other men who have sex with men. Preventive measures are perceived as less important as HIV is seen as a chronic, manageable infection. It remains to be seen what effect the increasing awareness and availability of PrEP has on future HIV incidence.
- **Young men having sex with men (YMSM)**: Sex with men is the predominant mode of HIV exposure among adolescent and young adult males (ages 13 to 24) accounting for an

estimated 93% of new HIV infections diagnosed between 2012 and 2014 in this age group. Since 2001, the number of cases among young males has increased by over 170%.

Funding and prevention work targeting transgender and genderqueer people remains challenging. Minnesota will continue to support and encourage inclusive and culturally competent HIV testing, outreach and prevention projects. Many of MDH's HIV testing projects reach and test transgender and genderqueer clients.

Racial and ethnic minorities experience higher rates of HIV compared to the white population. These groups are disproportionately represented in the HIV epidemic and tend to have poorer health outcomes than Whites due to systemic health disparities. The most recent data illustrate that men and women of color continue to be disproportionately affected by HIV/AIDS. Additionally, the combinations of cultural and community norms often lead to stigmatization of people with the disease.

- **Men of Color**: Men of color make up approximately 17% of the state's male population and 44% of the infections diagnosed among men in 2014. In contrast, white, non-Hispanics make up approximately 83% of the male population in Minnesota and 52% of the new HIV infections diagnosed among Minnesota men in 2014.
- **Women of Color:** Similarly for females, women of color make up approximately 13% of Minnesota's female population and 79% of the new infections among women. In contrast, white, non-Hispanics make up approximately 83% of the state's female population and 19% of new infections among Minnesota women in 2014.
- **African Americans**: Among young men age 13-24, African American males account for 29% and among young women, African Americans made up 13% of new infections in 2014.
- **African-born:** African-born immigrants have the highest HIV incidence and prevalence rates of any Minnesota racial or ethnic group at more than 20 times higher than the rate among whites in 2014. A number of unique challenges are present when providing HIV prevention and care services to African-born individuals including language barriers, cultural issues and intense stigma.
- **Latino/as**: Increases in Minnesota's annual number of HIV infections diagnosed among Minnesota's Latinos have been recorded since the late 1990s. In Minnesota in 2014, 34 Hispanic persons were diagnosed with HIV.
- **Native Americans**: Native Americans have consistently experienced higher rates of HIV than whites. In Minnesota in 2014, 5 Native Americans were newly diagnosed, representing a rate among that population nearly three times higher than whites.
- **Asian Pacific Islanders**: Asian/Pacific Islanders experienced slightly higher rates of HIV than whites. In Minnesota in 2014, 10 Asian or Pacific Islander persons were newly diagnosed.
- **People who inject drugs**: The lack of federal funding for needle exchange programs put injection drug users at greater risk. There were 5 IDU and 11 MSM/IDU diagnosed in Minnesota in 2014.

- **People living in Greater Minnesota**: Although people living outside the Minneapolis – St. Paul metropolitan area may experience geographic barriers to accessing HIV/AIDS services and related public health education, they have experienced a decrease of 16% in the number of new HIV diagnoses compared to 2013. (Note: Greater Minnesota includes all of the other at-risk target populations, especially MSM, high risk heterosexuals, IDU and homeless youth and people living with HIV who happen to live outside the Twin Cities Metro Area.)

Some significant issues to consider include:

- **Women, particularly women of color**: These women face numerous issues including understanding the disease and ways to prevent it, stigma based on community norms, testing options and where to get tested, as well as perinatal transmission issues. Heterosexual contact accounted for an estimated 94% of new HIV infections among adolescent and young adult females from 2012 to 2014.
- **Youth**: Each new generation needs to be informed about the disease, how it is transmitted and risk prevention strategies. For many youth today, the disease is perceived as no longer a threat or easily managed with medication, so HIV prevention does not seem as urgent to them. The lack of accurate, inclusive, comprehensive sex education and the use of abstinence only until marriage curricula have left teenagers, especially LGBTQ youth, woefully uninformed.
- **Late testers**: Persons who receive an AIDS diagnosis concurrently or within one year after receiving their initial HIV diagnosis are considered late testers since they are likely to have had an HIV infection for five to ten years before being tested. These individuals either do not know about testing, have never had the opportunity to be tested, or have avoided testing because they are afraid to find out the results. Additionally, since they have been unaware of their status they will often have done little concerning prevention. Foreign-born Minnesotans living with HIV are more likely to test late with 40% of new HIV diagnoses among foreign-born progressing to AIDS within a year in 2015 comparted to 28% over all new diagnoses.
- **People who are 45 or older living with HIV**: Fifty-eight percent (58%) of all people living with HIV are in this age group. In 2014, 43% of people diagnosed at 45 years and older were late testers compared to 7% of people diagnosed between the ages 13-24.

Due to the one year extension of the CDC funding cycle, a new prioritization process will not be completed until 2017. This prioritization process will utilize epidemiological data, care continuum and other information to describe the epidemic in Minnesota, prioritize populations and funding to those populations at highest risk.

HIV Service Needs of persons at higher risk of HIV and PLWH (Section 1: D. c.)
During the March 22, 2016 SCSN stakeholder meeting participants brainstormed prevention and care service gaps and barriers to persons at risk for HIV and PLWH accessing services. Identified gaps and barriers were then ranked and prioritized during joint meetings of the Council's Planning and Allocations & Disparities Elimination Committees on March 7, 2016 and April 13, 2016. Gaps and barriers were categorized and ranked within each category as follows:

Prevention Gaps:

- Outreach
- Culturally specific providers
- Stigma reduction programs
- Availability (timely) of substance abuse & harm reduction services,
- Mental Health and mental health treatment medication management

Support Services Gaps:

- Housing support services such as rental assistance, coordination, and advocacy.
- Transportation

HIV Care Gaps:

- Culturally specific providers, and peer delivered services
- Access facilitation for minority groups including linguistic services
- HIV specific language interpreters
- Care-retention education

Treatment Gaps:

- Medical adherence programs
- Emotional and mental health support services
- PrEP for high-risk adults

Social & Structural Barriers**:**

- Stigma within faith-based communities
- Lack of affordable housing units
- Lack of outreach to religious communities, collaboration and support

Legislative Barriers:

- Disinterest
- Reduced or discontinued funding of programs
- Invisibility
- Connections to members of the legislature and lack of accountability

Health Department Barriers**:**

- Lack of funding
- Time constraints - bureaucracy/”red-tape”
- Lack of inclusion and cultural knowledge

Service Provider Barriers:

- Culturally competent/culturally specific
- Time constraints
- Shrinking resources & increased demands
- Providers left out of systemic processes
- Reimbursement rates don’t cover the cost of services

Client Barriers:

- Fear, stigma and isolation
- Substance
- Homelessness

Program Barriers:

- Lack of Funding
- Innovation
- Availability

The highest priority unmet needs in ranked order included emergency financial assistance, housing, and transportation.

Emergency Financial Assistance (EFA)

In certain circumstances emergency financial assistance (EFA) is needed to assist with moving, travel, utilities, housing, etc. Respondents in the 2015 Consumer Needs Assessment reported that when PLWH in Minnesota sought emergency financial assistance (EFA), 7% reported being unable to access EFA to pay for housing costs like rent or mortgage though they needed it, with higher percentages for American Indian/Alaska Native (10%) and Asian (20%) respondents.

Housing

Stable housing has been proven to be one of the primary social determinants of health (SDOH). There is a general lack of affordable and appropriate housing, as well as many hoops to jump through in accessing housing. There is a need for increased collaboration among organizations involved in housing and housing supports. Increased collaboration hopefully would help reduce the barriers to housing. Partnerships between HIV specific and youth focused housing programs could improve housing opportunities for LGBTQ (especially transgender) individuals. There are also actions that federal, state and local governments can take to increase access to housing. Some examples include: support government supplemental budget proposals for landlord incentive funds; make waiver availability less restrictive or at least in-line with Centers for Medicare and Medicaid (CMS) proposed guidelines; and provide more funding for supportive housing.

Transportation

Transportation was included as a prevention and service gap in almost every category of service, support and care, and treatment needs. Transportation is connected to broad categories included under the SDOH. There are a wide range of SDOH factors that impact health and prevention for high risk individuals including individual, social, economic, and environmental conditions. The places where people live, work, socialize, and access services, supports and treatment affect access to and the types of transportation services available to meet their needs. Some locations have multiple transportation options including bus, cabs, light-rail, and vehicle transportation options. Other areas such as Greater Minnesota, as well as outer-ring suburban and rural areas, may be limited to private vehicle transportation. This means to get to a medical appointment and support services you must have your own vehicle or access to a vehicle.

Additional Service Needs Identified (not ranked)
Additional service needs identified during the SCSN Needs Assessment meeting included more coordination of services, peer support services, educational programs and community outreach.

Coordination of Services
There is a need to create a 'one stop shop' for access to information statewide. There is also a need to coordinate the flow of data through a centralized eligibility system. Having a one stop shop with a centralized eligibility and coordinated flow of data may assist in finding people who have dropped out of care.

Peers and Peer Support Services
SCSN participants suggested decreasing the education requirements for peer support services providers and including credit for life experience to increase access to these services. Peers may know where to find people who have fallen out of care and re-engage them in care.

Education Programs and Community Outreach
There is increasing public complacency as HIV is seen as a diminishing health issue. This is creating a need for increased HIV/AIDS education. There may also be increasing complacency among people at higher risk of HIV which creates challenges to effectively delivering HIV prevention messages. In addition, HIV has now become entrenched and endemic in specific populations, highlighting the need for culturally appropriate strategies and activities. All of this increases the need for education programs and community outreach. Some ideas from the SCSN Needs Assessment participants include:

- Use public service announcements to help people realize that HIV is still an important public health concern.
- Target leaders within immigrant communities who have status and respect and can broach the topic of HIV/AIDS within their communities.
- Increase the number and variety of formats (webinar, streaming, in person) for training providers on working with people with multiple diagnoses.
- Start education programs in high schools and colleges.
- Engage faith leaders and provide training on providing HIV education for their congregants.

Service Gaps Identified by and for Persons at Higher Risk for HIV and PLWH (Section I: D. c.)
The service needs and *service gaps* of all persons at higher risk for HIV and PLWH including underserved groups, were addressed throughout the process of creating the SCSN, particularly the needs of culturally diverse populations. Representatives from organizations serving a wide range of populations participated throughout the process and were able to express their insights on service needs, gaps and barriers for culturally diverse and special low incident populations.

Participants in the SCSN Needs Assessment processes brainstormed *service* gaps that keep people at higher risk for HIV and PLWH from getting their needs met. Service gaps were then ranked during joint sessions of the Council's PAC and DEC combined sessions. During these sessions, participants ranked service gaps in the areas of prevention gaps, support service gaps, and treatment gaps.

Prevention Gaps
The highest priority ranked *prevention gaps* identified during the SCSN Needs Assessment included outreach and education gaps, stigma reduction programs, pre-exposure prophylaxis (PrEP) for high risk adults, and culturally competent providers.

Outreach and Education Gaps
Increasingly public health officials, providers, and those active in the prevention of HIV/AIDS including persons at risk and PLWH report concerns regarding a lack of knowledge and a growing number of disinterested clients. As a results, there is a need to re-energize public education regarding HIV and its associated stigma. This is especially true in Greater Minnesota.

Improvements are needed in the amount and type of HIV information that is available as well as new and different channels for accessing information. A few examples noted by SCSN participants include:

- HIV Resource Guide, with information on who to call if you have problems or need services, is available only on-line and there was a call for a print version;
- Information on HIV prevention and services is not universally accessible;
- Information on HIV resources could be distributed through other existing channels such as City Resource Guides; and
- Developmentally appropriate information on sex education and HIV should be available in new ways to reach the adolescent population.

There is a need for increased general outreach and educational efforts, as well as outreach to prisons and comprehensive sex education including HIV education in schools that includes information on pre-exposure prophylaxis (PrEP). MDH recently completed a PrEP request for proposals (RFP) process is spring 2016 and awarded contracts to clinics and community providers to improve knowledge of and access to PrEP.

Stigma Reduction Program Gaps
There continues to be significant stigma associated with HIV/AIDS. People report feeling afraid of going to a primary care clinic because they fear, or have experienced, discrimination such as being treated differently or people not willing to help. Continued efforts and education to reduce the stigma of HIV/AIDS are needed across Minnesota.

Pre-exposure Prophylaxis (PrEP) for High Risk Adults
PrEP was cited as a prevention gap. The SCSN Needs Assessment participants particularly cited access to PrEP for high risk adults as a top priority. Youth under age 18 were also noted for PrEP access.

Culturally Competent Prevention Services
Sexual orientation stigma and provider competency in delivering relevant healthcare and prevention messages was noted as a significant factor in seeking healthy behaviors within communities of color. Several programs funded by Part A and Part B serve culturally specific populations. Every effort is made to make information regarding these programs widely available and translated into various languages. Medical case management (MCM) services address the needs of special populations by placing emphasis on services that are culturally appropriate and diminish barriers to care. There is also significant stigma for people of color who identify as transgender. For example, low testing rates among male-to-female transgendered

individuals demonstrates the lack of recognition or lack of support from both their ethnic communities and the gay community.

Support Service Gaps
The highest priority *support service gaps* identified by SCSN Needs Assessment participants include:

- Culturally specific care providers, peers, and services including confidential HIV language interpreters;
- Support services that help people engage and stay in care;
- Support groups;
- Housing;
- Transportation services, particularly in Greater Minnesota; and
- Waivered services.

In general SCSN participants reported that there are multiple program limitations including: a general lack of comprehensive planning; need for more and different types of support; and the need to provide holistic services. Among the respondents to the 2015 Consumer Needs Assessment (2015 CNA), 14% reported oral health care as a core medical service they were not able to access. Nutrition services were cited by 8% of respondents as a needed service they were not able to access. Six (6%) percent of 2015 CNA respondents report needing assistance with access to health care insurance and premium payments.

Culturally Competent Support Services
Participants in the SCSN Needs Assessment consistently ranked culturally relevant services as one of the highest priorities in all categories, particularly support services. Participants highlighted the need for providers who are knowledgeable regarding the cultures that they are serving. Participants report concerns that interpreters will disclose their clients' HIV status to other members of the community. Non-English speaking populations, particularly new immigrants, need access to interpreters who are competent in HIV medical terminology and can keep information confidential.

Minnesota continues to experience high rates of poverty among populations of color, particularly African American, African-born and Latino immigrants. Services that address basic needs such as food and nutrition, emergency financial and housing assistance are crucial to support continued access to HIV treatment and remain a top priority.

Despite achieving high levels of viral suppression in the Minneapolis-St. Paul Transitional Grant Area (MSP-TGA), there clearly exist a number of HIV-related health disparities among racial and ethnic subgroups, by age, and by risk category. A number of approaches have been implemented or will be employed to address and resolve these challenges, including implementation of a new Council subcommittee in FY2016, Disparities Elimination Committee (DEC). DEC is dedicated solely to improving and reducing health disparities. Other efforts include improved outreach employing a *Data to Care* protocol, EIS, and MCM to reach target populations and help get them connected to medical care and reduce unmet needs. Part A efforts will focus on addressing special emerging, under-represented and co-morbid populations of PLWH, in order to reduce the disparities experienced by these groups. Finally, Minority AIDS

Initiative (MAI) programming will continue to address the health care and social support needs of African Americans and Latinos living with HIV across Minnesota.

Engagement and Retention
Outreach and services for PLWH who are not in care was ranked as a very high priority by SCSN Needs Assessment participants. Addressing service needs, gaps and barriers to assist people who have HIV and are not engaged with getting into care and staying on treatment are needed. New and creative strategies may be needed to reach populations who are not in care and have been difficult to engage.

Support Groups
Support groups were also highlighted as an unmet need by SCSN Needs Assessment participants, specifically:

- Culturally specific groups, such as groups for LGBTQ blacks,
- Age-specific support groups,
- Health Education/Risk Reduction (HERR) groups,
- Support groups for pregnant women, and
- Faith-based support groups.

Housing
There is a shortage of good, affordable, and appropriate housing for people at risk of HIV and PLWH. Research has shown that for PLWH, lack of stable housing is strongly linked to inadequate HIV health care, high viral load, poor health status, avoidable hospitalizations and emergency room visits, and early death (National AIDS Housing Coalition). Nationally, socio-economic factors such as income, education and housing are being referred to as 'social determinants of health' (SDOH). SDOH are increasingly receiving recognition at a federal, state and local level as factors that have a substantial influence on the health of individuals and the health of communities.

There is a lack of adequate funding and housing to meet the needs of homeless and unstably housed PLWH throughout Minnesota, including a lack of safe housing options for women, youth, and a lack of emergency shelter services for transgender individuals. Shelters are typically segregated by gender which makes them inaccessible for some people. Additionally, within a shelter setting there may not be adequate way to help PLWH safely take their medications and make needed medical and social support appointments. There is also a lack of landlords who will accept rental subsidies and criminal background checks continue to be a challenge for some individuals in securing housing. Recent housing data suggests that no Minnesota County has adequate low-income housing and this has great impact on individuals living with HIV.

Minnesota Wilder Research conducts a statewide survey every three years of people who are homeless or living in temporary housing programs. The study includes counts and estimates of the number of people who are homeless and interviews with homeless people. Wilder's recent report *Homelessness in Minnesota* indicates that on one night, October 22 2015, there were 9312 people experiencing homelessness in Minnesota. While the total number of people is an overall 9% decrease from the previous study in 2012, homelessness is still a significant concern for PLWH and those at higher risk. In the 2015 CNA nearly 23% of the respondents indicated that they were homeless or their housing was unstable in the last year. This percentage was higher for American Indian/Alaska Native (45%), and Black (28%) respondents. Twelve (12%) percent of

2015 CNA respondents had lived in a car, park, sidewalk, or abandoned building in the past year, with higher percentages for American Indian/Alaska Native (32%), Asian (17%) and Latino (22%) respondents. Twenty seven (28%) percent reported paying more than 30% of their income toward rent in the past year.

Inadequate housing resources combined with other complications for PLWH significantly increases the risk of non-compliance with their medical treatment plans. Housing assistance for homeless and unstably housed PLWH is a good example of a service that lacks adequate funding to meet the needs of PLWH. HIV specific housing programs and Section 8 programs currently have long waiting lists. Waiting lists for HIV specific housing assistance have been closed for up to 1½ years. Additionally, many homeless PLWH require intensive MCM assistance to access mental health or substance use treatment, shelter and supportive social services before successful treatment for HIV is attainable.

Transportation
The places where people live affect both access to transportation and the types of transportation services available to meet their needs. Some locations have multiple transportation options including bus, cabs, light-rail, and vehicle transportation choices. Other areas such as Greater Minnesota, as well as outer-ring suburban and rural areas, may be limited to private vehicle transportation. This means to get to a medical appointment and support services in most areas of Minnesota you must have your own vehicle or access to a vehicle. Medical transportation for residents of Greater Minnesota is a gap experienced by much of the population with this need. Clients have expressed dissatisfaction with reimbursement through gas cards because there may be no vendors taking gas cards in their immediate vicinity. This forces them to drive many miles to be able to access the gas cards.

Waivered Services
Access to waivered services was included in unmet needs for people at higher risk and PLWH. Medicaid waivers provide additional support services for certain populations who might otherwise need to be institutionalized to get their needs met. Currently in Minnesota, certain waivered services programs have limits on the number of people who can be on a waiver. SCSN Needs Assessment participants stated a need for the federal, state and local governments to lift these caps on waivers and waivered services.

Additional Support Service Gaps
Participants in the SCSN Needs Assessment cited additional gaps in support and care services including:

- Family and caregiver support is lacking (cited as an untapped resource);
- Higher level of care is needed for people who are breaking the cycle of generational poverty;
- PLWH, who know their HIV status but are not in care, report that they don’t know how to get help; and
- PLWH and those at risk are worn out and pessimistic which is resulting in discontinuing participation in care and fewer people seeking care.

Treatment Gaps
The third gap area that was addressed by SCSN Needs Assessment participants is *treatment* gaps. Treatment gaps identified, ranked and prioritized include medication adherence programs;

SUD services; mental health services; oral health; health care in general; and medical case management services.

Medication Adherence Programs
Medication Adherence Programs (MAP) are very important for maintaining people on their medication regime. The goal of MAP programs is to optimize adherence rates among patients on an on-going basis and provide a vehicle for education. MAP participants receive medical case management services to achieve this goal. Calls are made and educational letters are sent at two, four and six months after non-refill of ART medications. Letters that outline the importance of medication adherence are sent if the case manager is not able to reach the individual via the telephone. Coordination with ADAP programs is also a component of MAP and MCM. Part A also funds medication adherence services provided by a Doctor of Pharmacy that includes a comprehensive assessment of treatment adherence support needs, ongoing counseling and reminder tools. SCSN participants stated that MAP would be especially valuable for young adults (13-24 years). Part B is developing a contract for MAP focused on youth ages 13 to 29.

Substance Use Disorder (SUD) Treatment Gaps
A large proportion of clients receiving services from RWP funding in the MSP-TGA utilize chemical dependency or SUD services. This also remains an area of great need. In the 2015 CNA, 29% of respondents reported having a SUD (Rule 25) assessment for chemical health services, while 55% of American Indian/Alaska Natives and 40% of Latinos reported the same. Eighteen (18%) percent of respondents overall reported receiving outpatient substance abuse treatment or counseling, with an even greater proportion of Latino respondents (24%) and American Indian respondents (24%) reporting receiving outpatient substance abuse treatment or counseling.

Two funded programs in this service area provide “just-in-time” connection to chemical health treatment. These programs, one housed at the MSP-TGA’s largest HIV primary care clinic and the other at the MSP-TGA’s largest AIDS service organization, provide SUD (Rule 25) assessments required for placement in state-funded treatment programs as well as short-term counseling, treatment placement facilitation, and peer relapse prevention and harm reduction support.

Participants in the SCSN Needs Assessment cited timely access to SUD treatment, including harm reduction approaches as a high need. They also report that the current process in Minnesota for accessing SUD services takes too long. The process includes identifying assessment providers, getting an appointment, and securing a Rule 25 assessment from a licensed alcohol and drug counselor (LADC). As a result of the lengthy and cumbersome process people are not getting connected to care. There is also a need for integrated chemical health and mental health treatment for individuals with a dual mental illness and chemical dependency (MI-CD) diagnosis. Additional SUD care and support services cited by SCSN participants include:

- Assistance with insurance deductibles and the cost for SUD treatment after insurance coverage is exhausted;
- Sober housing, wet housing, and deposits for those transitioning from SUD treatment back to community;
- Transportation (bus passes) to and from SUD treatment centers;
- Harm reduction approaches; and

- Additional syringe exchange programs.

Mental Health Treatment and Coverage Gaps

People living with HIV/AIDS have to deal with many challenges. They may face stigma from other people, lack social supports, unemployment, low income, low self-esteem, experience homelessness, anxiety and depression. Many studies that show PLWH suffer from depression and anxiety at higher rates than the general population. This creates significant challenges to making and sustaining behavior changes that will enable HIV treatment adherence. Mental health services and coverage for medication management are very important services, when needed. Additionally, Minnesota has shortages in mental health services and supports especially in the areas of inpatient mental health services, psychiatric services, rehabilitation and support services including peer support services.

According to 2014 Metro SHAPE data LGBTQ adults age of 25 and older report statistically significant worse levels of mental health distress compared with their non-LGBTQ counterparts. Hennepin County LGBTQ respondents reported previous diagnosis of depression at a rate of 39.7%, compared to their non-LGBTQ counterparts at 21.7%. Similarly, LGBTQ respondents reported serious psychological distress at a rate of 5.4%, compared to 2.7% in non-LGBTQ respondents. Overall, LGBTQ respondents to the Metro SHAPE survey reported mental health distress nearly twice as often as their non-LGBTQ counterparts. DHS estimates that 4.7% of the MSP-TGA's population has serious mental illness or serious and persistent mental illness.

In its *Statewide Health Assessment Part Two: The Health of Minnesota* (2012), MDH notes that individuals with serious mental illnesses are more likely to experience homelessness, be uninsured, and lack social support. These are all issues that complicate the ability of PLWH, if they are also affected by serious mental illness, to access regular HIV medical care. MDH's report also discusses that the difficulty of changing behaviors such as smoking or alcohol use in persons with serious mental illness is compounded by their mental status and life circumstances. Added to this may be the challenges to making and sustaining behavior changes that will enable treatment adherence and successful prevention strategies for those living with HIV.

According to the 2015 CNA, 60% of respondents reported receiving mental health services provided by a licensed clinical professional in an individual or group setting, which was an increase from 49% in the 2010 CNA. Additionally, 84% of American Indian/Alaska Natives living with HIV responding to the 2015 CNA reported receiving mental health services. Since diagnosis, 47% of PLWH in Minnesota who participated in the 2015 CNA have sought individual therapy with a psychiatrist for mental health treatment (71% of American Indian/Alaska Native respondents), 46% have had medication prescribed by a psychiatrist (58% of American Indian respondents), 50% have had individual therapy with a psychologist, social worker, licensed professional counselor, nurse clinician or licensed chemical dependency counselor (58% of American Indian/Alaska Native respondents and 67% of Asian respondents), and 40% have sought help in an HIV-specific support group.

Additionally, gaps in mental health services are exacerbated by other factors for some subpopulations, such as African-born women. Culturally and linguistically specific psychosocial support services for African-born women, especially for those women who fear family and community repercussions from disclosure of HIV status, can reduce isolation and stigma and increase knowledge of HIV treatment and services which will ultimately improve retention in

care. There is a need for mental health services that are not typically covered by health insurance and are outside the HRSA definition of mental health services for people living with HIV. This includes peer support, service coordination of mental health care and among some culturally specific populations, approaches to care that do not lead with a mental health diagnoses.

Oral Health

Another gap in services is oral health. Oral health was listed as the highest unmet service need amongst respondents to the 2015 CNA with 14% of respondents indicating a need in the areas of oral health. It is estimated nationally that anywhere between 32% and 46% of PLWH will have at least one HIV-related oral health problem during the course of their disease, and yet studies show that 58% to 64% of PLWH do not receive regular dental care (HRSA, HIV/AIDS Bureau). There are many barriers PLWH experience in accessing oral health care including lack of insurance, low and limited incomes, perceived and real stigma, and lack of providers trained to treat PLWH. Low Medicaid reimbursement rates also limits the number of providers who will serve Medicaid covered patients. Access to high quality oral health care is a critical part of overall care for PLWH, and is a service gap in the MSP-TGA, especially in Greater Minnesota.

Among the respondents to the 2015 CNA, 49% of PLWH in MN reported wanting or needing to see a provider for oral health care and not being able to do so. The need appeared to be even greater for some communities of color, with 71% of American Indian/Alaska Natives and 67% of Latinos reporting the need to see an oral health care provider and not being able to do so. In terms of actual service utilization, Black PLWH represent 37% of those living with HIV/AIDS in the MSP-TGA and 44% of people in the MSP-TGA receiving RWP services, but only 7% of Black clients in the MSP-TGA utilized RWP funded Oral Health Care services in 2015. In the MSP-TGA, the DHS HIV/AIDS Program administers ADAP, the state's RWP Part B funded HIV Oral Health Care services through their centralized *Program HH*, providing services to 13% of Part A and B recipients. Oral health care is an important part of maintaining overall health for PLWH, and needs more attention in the MSP-TGA.

Health Care

The Council reviewed information from and about the Patient Protection and Affordable Care Act (ACA). The intent of the ACA is to expand health insurance while also reforming the health care delivery system to improve quality and value. The ACA includes provisions to eliminate disparities in health care, strengthen public health and health care access, invest in the expansion and improvement of the health care workforce and encourage consumer and patient wellness in both the community and the workplace. Because of the ACA, more people are being covered with pre-existing conditions and AIDS Drug Assistance Program (ADAP) funds may be used to pay the cost of insurance premiums under certain circumstances. The ACA also forces health insurance companies to treat consumers fairly. Insurance companies are now required to offer insurance to everyone, even if they have a pre-existing condition like HIV. Insurance companies are no longer able to charge higher rates because of HIV.

The development of the Integrated HIV Prevention and Care Plan, including SCSN Needs Assessment took into account the impact the implementation of the ACA has had in Minnesota. 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/AIDS and create an expectation of health and prosperity for all.

With full implementation of the ACA health insurance coverage provisions on January 1, 2014, there has been a significant impact on health insurance coverage in Minnesota. According to data released by MDH, Minnesota cut its uninsured rate nearly in half between 2013 and 2015, and the rate of Minnesotans without health insurance has now reached an all-time low falling to 4.3% in 2015, the lowest rate in state history. More than 200,000 Minnesotans, including 35,000 children gained health insurance coverage between 2013 and 2015. This increase in health insurance coverage was primarily driven by an increase in the number of Minnesotans enrolled in state health insurance programs, Medical Assistance (Minnesota's Medicaid program) and MinnesotaCare. Enrollment increased by over 155,000 for these two programs combined. Coverage in the private health insurance market also increased with 10% of Minnesotans receiving individual coverage through MNSure, the State's health insurance exchange. All groups of Minnesotans, regardless of income, racial or ethnic group or age, reported increases in health insurance coverage. For example, uninsured rates for Hispanic/Latino Minnesotans fell by nearly 200 percent from 34.8 percent in 2013 to 11.7 percent in 2015. However, the Commissioner of Health noted the disparity in insurance coverage persists between white Minnesotans and American Indians and Minnesotans of color.

While the ACA has had a significant impact on eligibility for health insurance and thus who pays for the services needed to care for PLWH in the MSP-TGA and in Greater Minnesota, the continuum of HIV services has not changed because it is based on the needs of Minnesotans living with the disease.

The Council's 2015 Comprehensive Needs Assessment (2015 CNA) survey of 504 PLWH asked whether participants had needed but not received HIV care and related core medical and support services in the previous 12 months. Nine percent (9%) reported being denied HIV medical care because they were uninsured or couldn't afford the co-payment. Of the 2015 CNA respondents, 23% reported waiting more than three months before receiving care and 11% reported waiting more than a year. Although the ACA provides new resources for PLWH who were previously uninsured, an increasingly complex system of obtaining public or private insurance in the marketplace along with limited open enrollment periods has not eliminated "churning" or temporary loss of coverage and access to HIV medical care due to changing circumstances that impact eligibility for publicly funded or subsidized private health coverage.

Of the 504 PLWH who responded to the 2015 CNA, 156 or 31% reported difficulty signing up for insurance or understanding their policy negatively affected their medical care. The rates are higher in racially and culturally specific populations including American Indian/Alaskan Native (44%) respondents and Latino (41%) respondents. Twenty-eight percent of PLWH reported that they have been without health insurance for three months or longer since they received their HIV diagnosis. Higher levels are reported for some communities of color including American Indian (42%) respondents, Asian (33%) respondents, and Latino (48%) respondents. In addition, PLWH without citizenship are not eligible for publicly funded health care and need additional help navigating the private insurance market and accessing ADAP to cover premiums and other out-of-pocket costs. Among the 2015 CNA respondents, the RWP or the clinic covered the cost of care for 21% of those who received medical care in the past 12 months.

For people with HIV who are on Medicare, the Part D prescription drug benefit is also more affordable. ADAP funds allocated to pay for HIV drugs count towards out-of-pocket expenses. As a result, a person living with HIV gets through the coverage cap (or donut hole) faster. Preventive screenings at no cost are also a very important aspect of the ACA. Screenings aide in early identification which has become increasingly important to the elimination of HIV disease.

Overall the ACA has resulted in more people being able to access health insurance. ADAP pays for open market policies for eligible clients who are not usually eligible for Minnesota Health Care Programs or MNSure subsidies due to documentation status. However, there have been a few negative impacts on PLWH with individuals who are undocumented and may be unaware of ADAP. In addition, people who are experiencing homelessness report having more difficulties accessing Medicaid coverage due to changes in regulations and processes. The increasingly complex system of obtaining public or private insurance in the marketplace along with limited open enrollment periods has not eliminated "churning" or temporary loss of coverage and access to HIV medical care due to changing circumstances that impact eligibility for publicly funded or subsidized private health coverage.

Overall sixty-three (63%) percent of PLWH who participated in the CNA survey reported receiving assistance in paying for health insurance premiums, while 66% of American Indian/Alaska Natives and 79% of Latinos participating in the survey reported receiving assistance for premiums. Nineteen percent (19%) of American Indian and Latino respondents and 20% percent of Asian respondents reported they had been denied medical care because they couldn't pay for treatment due to not having insurance compared to only 3% of Black respondents and 2% of white respondents. In terms of service utilization in 2014, though they represent 9% of those living with HIV/AIDS in the TGA and 11% of clients receiving RWP services, only 5% of Latinos utilized RWP funded Health Insurance Premium (HIP) services. Though young PLWH represent 20% of both those living with HIV and those utilizing RWP services in the TGA, only 5% of PLWH between the ages of 31 and 39 utilized HIP services. While this could be because neither group needed insurance or financial assistance, it is more probable that they needed the services but had trouble accessing these services for one reason or another.

Medical Case Management (MCM)

Challenges in accessing health care, health insurance and financial services for HIV/AIDS care can be mitigated by strong MCM programs. There are also benefits counseling programs that assist PLWH in accessing needed financial and health insurance programs. The largest gap on Minnesota's HIV Care Continuum is a 15% drop in the proportion of PLWH who are retained in care compared to the proportion of those linked to care. MCM also assesses and links clients to a comprehensive set of services that support treatment adherence and assist in securing stable housing, nutritional and economic supports, transportation and accessing mental health and substance abuse treatment services to address co-morbidities.

In the 2015 CNA, 91% of respondents said that a knowledgeable medical professional or HIV clinician was most helpful in finding and connecting to HIV-related medical care. All of the major HIV specialty medical providers have on-site medical case managers or partner with community-based organizations that provide MCM services. Part A funds support five clinic-based and one community-based MCM provider in the MSP-TGA and both Part B and state

funds support MCM programs at five additional organization, including two major Greater Minnesota HIV clinics three of which serve PLWH who reside outside of metropolitan area. Two MCM programs receive Minority AIDS Initiative funds to focus on meeting the needs of African American and Latino PLWH who are at risk of not connecting or losing access to HIV medical care. In FY2015, MCM services served 1,668 or 58% of Part A clients and 94% were retained in care. Eighty-four (90%) percent of those receiving Part A funded MCM services in fiscal year (FY) 2015 were below 200% of FPL.

Additional Gaps in Prevention, Support and Treatment Services
SCSN participants reported that sexually transmitted diseases (STDs) are being missed in some cases because medical doctors are not consistently asking about sexual behavior. SCSN participants also mentioned that gaps in prevention, support and treatment services can be created or exacerbated by various programs access or intake requirements. Many programs have unique and often separate qualifying requirements, funding sources, and processes to access services. As a result these disparate requirements, funding and gatekeeper processes in and of themselves can result in additional gaps.

Barriers to HIV Prevention and Care Services (Section I: D. d.)
SCSN Needs Assessment participant's brainstormed *barriers* in the HIV system that keep people from getting their needs met. Barriers to HIV prevention and care services included but are not limited to social and structural barriers; federal, state, and local legislative barriers; health department barriers; program barriers; service provider barriers; and client barriers. Barriers identified were then ranked during joint sessions of the Council's PAC and DEC subcommittees. During these sessions, participants ranked barriers to HIV prevention, support services, treatment services. The needs of various populations were included throughout the process including:

- Persons at higher risk for HIV infection;
- PLWH who know their HIV status and are in care; and
- PLWH who know their HIV status, but are not in care.

Attention was also paid to special populations and underserved groups (both those individuals who are in and those who are not in care); coordination among HIV prevention, care and treatment programs; and coordination with other necessary support services (e.g., substance abuse, mental health, housing, etc.).

Social & Structural Barriers (Section I: D. d. i.)
SCSN Needs Assessment participants ranked and prioritized social and structural barriers impacting people at higher risk and PLWH. The barriers that were ranked and prioritized as having the greatest impact included stigma within faith-based communities; a lack of outreach to religious communities including collaboration and support; and housing barriers.

There is a lack of outreach to faith-based communities and significant HIV stigma within certain communities that impacts people at higher risk for HIV and PLWH. There is a lack of involvement and myths or misperceptions including "doesn't affect me" and "not in my backyard" attitudes. There are also "invisible rules" that make people afraid to disclose their status for fear of visibility and negative attitudes towards PLWH in their communities. Other concerns include demonizing those who don't use condoms or those who are on PrEP, and a lack of inclusion for certain groups (youth, transgender, and women).

Housing is another area included as a social and structural barrier to people at higher risk and PLWH to get the care and services that are needed. Health is shaped by weaving a number of factors together including conditions beyond traditional healthcare, one of the most frequently accepted is safe, affordable and appropriate housing. Paying attention to the social determinant of health (SDOH) and adopting strategies such as "Health in All Policies" approach recognize that there are many factors impacting the lives of people at higher risk of HIV and PLWH.

Legislative Policy Barriers (Section I: D. d. ii.)
SCSN participants reported concerns that HIV prevention, support services and treatment services are not a high enough priority at the legislative and executive levels of state and local government. The primary legislative barriers identified as part of the SCSN were related to the sentiment that there is disinterest on the part of legislators and others with regard to HIV and HIV funding. SCSN participants listed invisibility, lack of understanding, lack of priority status, lack of accountability, and avoidance as the primary legislative barriers. There is also a concern regarding reductions or discontinued funding of programs which impact HIV/AIDS clients.

Health Department Barriers (Section I: D. d. iii.)
SCSN participants ranked and prioritized health department barriers impacting people at risk and PLWH. The lack of funding was the most frequent barrier listed as impacting people at risk and PLWH have access to prevention, support services and treatment services. There was concern with the high cost of administration of HIV prevention services. A lack of funding for HIV prevention programming and high risk case management was specifically noted. Other comments under the category of health department barriers included:

- Bureaucracy ("red-tape") and "Ivory Tower" complex, an example cited is time spent entering data verses serving clients,
- Lack of cultural knowledge,
- Lack of conflict resolution, and
- Public health approach vs client-centered approaches.

Program Barriers (Section I: D. d. iv.)
SCSN participants ranked and prioritized program barriers impacting people at higher risk and PLWH. The top program barriers were lack of funding; lack of innovation; lack of availability of services; and transportation. The lack of funding, insurance and the high cost of health care was prevalent throughout the feedback. There were several program barriers cited related health care program and funding barriers including being uninsured or under-insured. Also, it was noted that the health system is unique in that there is no up-front disclosure of cost when you are accessing services.

A lack of innovation, lack of availability of some services, and complicated and prolonged processes to access care were also included as barriers. There is a need for a simplified, transparent "one-stop shop" to access services. One example that was given is that substance use disorder assessments (Rule 25) and treatment need to be available "just in time" when the client is willing and ready to receive services.

There is a lack of prevention services and resources to engage people who are not engaged in care. Reimbursement for the time it takes to follow-up with people who are out of care is not adequate and in many situations non-existent. Also, there is a lack of coordination amongst

service providers, lack of system coordination, and lack of coordination in the flow of data throughout the system.

Transportation continues to be listed as a barrier that impedes access for people at higher risk and PLWH. Specific comments include:

- Public transportation takes so much time. This makes it hard to be employed and attend to health care and social needs;
- Transportation should be for non-medical services as well because social support services make a difference in the lives of PLWH; and
- HRSA has made it more difficult to get reimbursed for transportation expenses. This has a huge impact on transportation for people in Greater Minnesota.

Finally, the lack of culturally specific services, programs and systems was included as a barrier in almost every SCSN category.

Service Provider Barriers (Section I: D. d. v.)
SCSN participants ranked and prioritized service provider barriers impacting people at higher risk and PLWH. The highest ranked service provider barriers included: culturally competent and culturally specific service providers; time constraints; shrinking resources and increased demands experienced by service providers; providers left out of systemic processes; and reimbursement rates that don't cover the cost of services.

Minnesota lacks sufficient culturally competent and culturally specific providers to meet the needs of people at higher risk and PLWH. This is especially true in Greater Minnesota (outside of the Twin Cities Metropolitan area) which is also impacted by additional barriers such as transportation, fewer providers who have the language and expertise to adequately serve low income PLWH.

Providers and other stakeholders including people at higher risk and PLWH included time constraints and lack of inclusion in systematic processes as additional barriers. They indicated that there is not enough time to spend with clients and too much time is taken up entering data into different systems. Also, noted is that reimbursement rates are not keeping up with the cost of the services. This can result in staff turnover and other negative consequences. Participants noted that MCM rate needs to be reconciled every year but doesn't regularly happen.

Additional service provider barriers included a lack of comprehensive sex education; conflict resolution and grievance procedures not present at each agency; and people at higher risk of HIV and PLWH are not always clear how to access conflict resolution and grievance procedures.

Client Barriers (Section I: D. d. vi.)
SCSN participants ranked and prioritized client barriers impacting people at risk and PLWH. The three top *client barriers* listed by SCSN Needs Assessment participants included fear, stigma and isolation; substance abuse; and homelessness and unstable housing.
There is a fear of disclosure and the associated stigma which drives the need for people to want to stay private throughout the process. It is difficult to remain anonymous when going in for testing, treatment and other services. For example, young people have a fear of their parents finding out when the explanation of benefits arrives in the mail.

Substance abuse and the complications of being dually diagnosed or having multiple diagnoses complicates adherence and the ability to focus on HIV care and treatment. Homelessness, unstable housing, and the lack of affordable and appropriate housing options especially for large families continues to be a barrier. The lack of affordable housing can also lead to sex for shelter survival strategies especially during cold Minnesota winters.

It was also noted that technology is important to access information (insurance applications, housing searches, etc.) and some individuals lack access (or consistent access) to technology.

Section I: Statewide Coordinated Statement of Need/Needs Assessment

E. Data: Access, Sources, and Systems

Main sources of data used to conduct the needs assessment, including the development of the HIV Care Continuum (Section I: E. a.)

Minnesota uses a number of different data sources and data systems for both the development of the Statewide Coordinated Statement of Need (SCSN), as well as on-going monitoring. All of the stakeholders collaborated in the development of the Integrated HIV Prevention and Care Plan, including the SCSN contributed including state and local health and human service departments. There were no private data sources used in the development of the SCSN.

CAREWare

CAREWare is free, scalable software for managing and monitoring HIV clinical and supportive care and was used to generate data for the Epidemiologic Overview (section 1A) and the Statewide Coordinated Statement of Need. CAREWare connects multiple Minnesota providers into one central database. These network setups have contributed greatly to the ability to track service usage and monitor the quality of care across multiple agencies.

The Minnesota Ryan White Program (MN RWP) management information system is called MN CAREWare. MN CAREWare is a shared database for Part A and B client-level data (CLD) collection and reporting. Housed on a secure, dedicated central server, data are available to providers in their individual domains and to the Part A (Hennepin County) and B (Minnesota DHS) grantees in aggregate format. MDH serves as the system administrator. Reporting responsibilities are maintained by each grantee for planning, policy and grant development. Contracted providers receive training and updates about CLD requirements and data reports to monitor performance measures, and how to incorporate these measures into their annual quality improvement (QI) work plans. The grantee uses the collected data to assess progress on meeting annual quality goals in collaboration with the Part A Quality Management and Assessment Committee (QMAC) as it completes its annual evaluation of the Part A CQM Plan.

Client Level Data (CLD) Collection and Reporting Capabilities

Since 2010 all CLD elements required for the Ryan White Service Report (RSR) have been submitted by 100% of Part A and Part B base funded providers into MN CAREWare. Before RSR data are submitted to HRSA from MN CAREWare, providers implement a data quality assurance (QA) protocol designed to ensure data completeness and validity. The protocol lays out a series of steps to identify missing data elements identified by QA reports from MN CAREWare and to clean up missing data and resubmit as needed. This process is completed twice a year to allow time to identify and address issues with individual provider's data systems or processes ahead of the deadlines for submitting annual RSR data to HRSA.

Minnesota Medicaid Management System (MMIS)

MMIS is the largest health care payment system in Minnesota, and one of the largest payment systems in the nation. Health care providers throughout the county – as well as DHS and county staff – use MMIS to pay the medical bills and managed care payments for over 525,000 Minnesotans enrolled in MinnesotaCare, Medical Assistance (MA), General Assistance Medical Care (GAMC) and the Alternative Care Grants Program (ACG). These public programs (collectively referred to as the Minnesota Health Care Programs, or MHCP) provide health care services to low-income families and children, low-income elderly people and individuals who have physical and/or developmental disabilities, mental illness or who are chronically ill. MMIS is state-owned and operated and has 15 subsystems, more than five years of online provider billing history, and over 500 screens and 900 claim edits to ensure appropriate payment.

AIDS Drug Assistance Program (ADAP) Data Report
ADAPs use the ADAP Data Report (ADR) system to report information to the HIV/AIDS Bureau on this program and the clients served. Each client record contains information on clients enrolled in ADAP during the reporting period regardless of whether or not they received services. Information reported includes demographic status, enrollment and certification information. A client's record may also include HIV clinical information as well as information about the ADAP-funded insurance and/or medications received.

Enhanced HIV/AIDS Reporting System (eHARS)
eHARS is a browser-based application provided by the Centers for Disease Control and Prevention (CDC). Minnesota's HIV Surveillance Program uses eHARS to collect, manage and report Minnesota's HIV/AIDS cases surveillance data to CDC and also to develop the Epidemiologic Overview and the HIV Care Continuum of SCSN. The data are population-based for ongoing surveillance.

Minnesota Electronic Disease Surveillance System (MEDSS)
MEDSS is a browser based application to collect, monitor and analyze laboratory-confirmed infections of human immunodeficiency virus (HIV) reported the MDH. Surveillance data is gathered through an active and passive surveillance system.

Consumer Needs Assessment (CNA) Survey Data
The Council collects survey data about the needs of people in Minnesota living with HIV/AIDS (PLWHA). Survey participants respond to questions about the services they need and whether they were able to access them. The results of the surveys inform the SCSN and how the Council prioritizes services; and allocates Ryan White Part A and B funds. The survey takes consumers approximately 30 minutes to complete and they receive a small gift card for completing the survey. Information on the survey was disseminated via:

- Posting fliers and distributing survey business cards;
- Planning Council ambassadors conducting surveys at provider agencies; and
- Providers reinforcing to clients how important it is that their voice is heard.

As a result of these efforts surveys were received from over 500 PLWH in both 2010 and 2015. (Results from the CNA survey are included above in section 1C.)

Data policies that facilitated and/or served as barriers to the conduct of the needs assessment, including the development of the HIV Care Continuum (Section I: D. b.)
In July 2016, the Minnesota DHS (Part B) and the MDH (Prevention) reached an agreement allowing data sharing between the two agencies related to care, surveillance and prevention data. This agreement removes a previous barrier to data sharing.
Currently, MDH is working on an agreement with Hennepin County Public Health which will allow a more seamless sharing of Ryan White Part A, HIV Prevention and HIV Surveillance data. By having these data sharing agreements in place, prevention, surveillance and care data can begin to work together and improve the data in the Minnesota HIV Care Continuum and show a better case for where gaps are when doing needs assessments.

To eliminate the gaps in our HIV Care Continuum (diagnosis, linkage, retention and viral suppression) Minnesota launched "eHARS to CAREWare" in March, 2016. This initiative will

coordinate Minnesota's HIV surveillance system with our Ryan White Program client level database (Minnesota CAREWare). This will help community-based providers improve their tracking of clients' retention in care and viral suppression. "eHARS to CAREWare" will also improve Hennepin County, DHS, and MDH's ability to evaluate the effectiveness of our HIV care and prevention efforts which ultimately helps reduce new infections and secure public funding for the future.

Unavailable Data and/or Information (Section I: E. c.)
The previous Minnesota HIV Service Planning Council and the new Minnesota Council for HIV/AIDS Care and Prevention (referred to as Council) have increased efforts over the past few years to collect and utilize data related to the needs of Minnesotans living with HIV. Unfortunately, these efforts may not have led to increased data from persons who are out of care. The State of Minnesota and TGA could benefit from technical assistance and capacity development to improve the process of assessing the needs of person not in care.

Fortunately, Minnesota has access to a substantial amount of data and information to conduct the needs assessment, develop the HIV Care Continuum and create the Integrated HIV Prevention and Care Plan, including the SCSN. Two significant sources of data that would be helpful are private commercial insurance data and Medicare data, including health plan data. Additional Medicaid data may also be beneficial to bolster surveillance data.

Section II: A. Integrated Prevention and Care Plan

Integrated HIV Prevention and Care Plan (Section II. A. a.-d.)

This section The Integrated HIV Prevention and Care Plan establish the blueprint for achieving HIV prevention, care, and treatment goals.

Timeframe	Objectives (2.A.a)	Target Population(s)	Measure(s)/Metrics (2.A.d.)	Stage of Care Continuum	Strategies and Activities (2.A.b-c)	Responsible Parties
Goal #1: Reduce New HIV Infections **Key**: **Council** (MN Council for HIV AIDS Care & Prevention); **DEC** (Disparities Elimination Committee); **NA&E** (Needs Assessment & Evaluation); **PAC** (Planning & Allocations Committee); **DHS** (Department of Human Services); **HC** (Hennepin County); **MDH** (Minnesota Department of Health)						
By 2/28/21	1.1 Increase from 86% (current CDC estimate) to 90% (NHAS) of individuals living with HIV in TGA & MN aware of HIV status. 1.2 Increase by 60% access and utilization of PrEP (bio-medical interventions) at MDH funded organizations (baseline to be determined in 2017) 1.3 Increase by 60% access and	1.1 Individuals at high-risk for HIV 1.2 High-risk HIV negative individuals	1.1 Estimated HIV prevalence and undiagnosed HIV infection in eHARS data 1.2 Percent of individuals eligible for PrEP as determined by MDH funded organizations that utilize PrEP using program database (TBD).	1.1-1.6 HIV diagnosis 1.1-1.6 Linkage to Care	1.1a Fund targeted testing & counseling & linkage to care services. 1.1b Provide capacity building and evaluation around high impact prevention. 1.2a Fund Pre-Exposure Prophylaxis (PrEP) services. 1.2b Fund service that will increase PrEP community awareness and utilization.	1.1 MDH, DHS, HC, Council, PAC 1.1b MDH 1.2a – 1.5 MDH

Timeframe	Objectives (2.A.a)	Target Population(s)	Measure(s)/Metrics (2.A.d.)	Stage of Care Continuum	Strategies and Activities (2.A.b-c)	Responsible Parties
	utilization of PrEP (bio-medical interventions) to African American communities at MDH funded organizations (baseline to be determined in 2017) 1.4 Increase by 20% utilization of MDH funded harm reduction and syringe exchange activities (baseline to be determined in 2017) 1.5 Decrease by 20% new infections within	1.3 High risk HIV negative individuals 1.4 Injection Drug Users	1.3 Percent of three-year average incident count of African-Americans, Latinos, African-born, MSM, young MSM and MSM of color HIV cases in eHARS data. 1.4 Number of individuals utilizing MDH funded harm reduction and syringe exchange services using reporting data.	1.1-1.6 HIV diagnosis (continued) 1.1-1.6 Linkage to Care (continued)	1.3 Fund service that will increase PrEP amongst African American community awareness and utilization. 1.4a Fund services that provide harm reduction and syringe exchange. 1.4b Fund prevention case management for high risk individuals	1.2a – 1.5 MDH (continued)

Timeframe	Objectives (2.A.a)	Target Population(s)	Measure(s)/Metrics (2.A.d.)	Stage of Care Continuum	Strategies and Activities (2.A.b-c)	Responsible Parties
	each of the following populations: African American, African-born, Latinos and their 1.5 (continued) subpopulations (MSM, transgender, and women). These populations experience disparities due to culture and stigma. (Baseline to be determined in 2018.)	1.5 African American, African-born, Latinos and the subpopulations (MSM, transgender, and women). These populations experience disparities due to culture and stigma.	1.5 and 1.6 Number of African American, African-born, Latinos and the subpopulations (MSM, transgender, and women). These populations experience disparities due to culture and identity related stigma. MDH and RW funded agencies will use reporting data, including eHARS data.	1.1-1.6 HIV diagnosis (continued) 1.1-1.6 Linkage to Care (continued)	1.5 Fund testing and counseling services that target African American, African-born, Latinos and the subpopulations (MSM, transgender, and women). These populations experience disparities due to culture and related stigma.	1.2a – 1.5 MDH (continued)

Timeframe	Objectives (2.A.a)	Target Population(s)	Measure(s)/Metrics (2.A.d.)	Stage of Care Continuum	Strategies and Activities (2.A.b-c)	Responsible Parties
	1.6 Increase by 20% the number of African American, African-born, Latinos and the subpopulations (MSM, transgender, and women) These populations experience disparities due to culture and stigma) getting tested through MDH and RW funded organizations (Baseline to be determined in 2018.)	1.6 African American, African-born, Latinos and the subpopulations (MSM, transgender, and women). These populations experience disparities due to culture and related stigma.			1.6a Fund CTR and EIS services that focus African American, African-born, Latinos and the subpopulations (MSM, transgender, and women), These populations experience disparities due to cultural and identify related stigma. 1.6b Fund services which "scale-up" programs & targeted services that promote testing of African American, African-born, Latinos and the subpopulations (MSM, transgender, and women). These populations experience disparities due to cultural and identify related stigma.	1.6 MDH, DHS, HC, Council, PAC
Goal #2: Increase Access to Care & Improve Health Outcomes for People Living with HIV **Key**: **Council** (MN Council for HIV AIDS Care & Prevention); **DEC** (Disparities Elimination Committee); NA&E (Needs Assessment & Evaluation); **PAC** (Planning & Allocations Committee); **DHS** (Department of Human Services); **HC** (Hennepin County); **MDH** (Minnesota Department of Health)						
By 2/28/21	2.1 Increase to 85% the proportion of individuals who attend a HIV medical care visit within 30 days	2.1- 2.4 All persons living with HIV in MN	2.1–2.4 Based on reported data	2.1 Linkage 2.2 Retention 2.3 Retention and Viral Suppression	2.1-2.4 Fund services that link individuals living with HIV to care within 30 days of diagnosis to achieve retention and viral suppression. Services include but are not limited to:	2.1-2.3 PAC, The Council, DHS, MDH, HC, PAC

Timeframe	Objectives (2.A.a)	Target Population(s)	Measure(s)/Metrics (2.A.d.)	Stage of Care Continuum	Strategies and Activities (2.A.b-c)	Responsible Parties
	(linked to care) of HIV diagnosis. 2.2 Increase to 90% the proportion of individuals living with HIV and retained in care. 2.3 Increase to 80% the proportion of individuals living with HIV w/viral load of <200 copies/mL at last test in 12-month measurement period (viral suppression). 2.4 Increase to 92% the proportion of Ryan White Outpatient Ambulatory Care (OAC) clients who are prescribed ART in the 12-month measurement period.			2.4 Prescribe ART and Viral Suppression	• Medical case management, • Mental health, • Outpatient ambulatory care • Substance abuse treatment outpatient • EIS • Medical Transportation • Medical Nutrition Therapy • Housing • Peer Navigators 2.1-2.4 Review policies and protocols (including standards of care, quality improvement plan, etc.,) to identify opportunities to update and revise current systems to more effectively respond to needs of the population being served 2.1-2.4 Fund or support training to providers to increase/enhance their understanding, knowledge, and skills in assessing the needs of individuals living with or at risk of HIV, particularly for behavioral health.	2.4 DHS & HC

Timeframe	Objectives (2.A.a)	Target Population(s)	Measure(s)/Metrics (2.A.d.)	Stage of Care Continuum	Strategies and Activities (2.A.b-c)	Responsible Parties
Goal #3: Reduce HIV-Related Disparities & Health Inequities **Key**: **Council** (MN Council for HIV AIDS Care & Prevention); **DEC** (Disparities Elimination Committee); **NA&E** (Needs Assessment & Evaluation Committee); **PAC** (Planning & Allocations Committee); **DHS** (Department of Human Services); **HC** (Hennepin County); **MDH** (Minnesota Department of Health)						
By 2/28/21	3.1 Increase to 90% the proportion of African Americans, African-born, and Hispanic RW clients retained in care	3.1 African Americans, African-born and Hispanic subpopulations; women & their partners and MSM.	3.1 CD4 or VL with the reporting period.	3.1 Retention in Care	3.1a Fund services which provide culturally competent EIS and outreach services to hard-to-reach African Americans, African-born, and Hispanic clients including; high-risk heterosexuals, MSM, young MSM, and transgender individuals who are unaware of their status and/or out of care. 3.1b Support African Americans, African-born and Hispanic women & their partners and MSM HIV advisory workgroups to ensure that the needs of the communities are understood and addressed. 3.1c Fund services that will address population specific needs, increase retention and improve treatment adherence. Services that support retention include: • Outpatient/Ambulatory Medical Care, • Medical Case Management, • Health Insurance Premium/Cost Share Assistance,	3.1a PAC, DEC, The Council, DHS, MDH, HC 3.1b DHS, HC, MDH 3.1c PAC, DEC, The Council, DHS, MDH, HC

Timeframe	Objectives (2.A.a)	Target Population(s)	Measure(s)/Metrics (2.A.d.)	Stage of Care Continuum	Strategies and Activities (2.A.b-c)	Responsible Parties
	3.2 Increase to 92% the proportion of Ryan White OAC African American, African-born, and Hispanic clients who are prescribed ART in the 12-month measurement period	3.2-3.5 African American, African-born and Hispanic subpopulations; women & their partners and MSM.	3.2 Percentage of clients who receive Part A funded OAC who are prescribed HIV/AIDS medications consistent with PHS Treatment Guidelines.	3.2 Prescribed ART	• Mental Health Services, • Early Intervention Services, • Oral Health, • Substance Abuse Services (Outpatient), • Medical Nutritional Therapy, • Home & Community-Based Health Services, • Housing Services, • Medical Transportation, • Emergency Financial Assistance, • Food Bank/Home Delivered Meals, • Non-MCM, • Psychosocial Support, • Outreach, • Health Education/Risk Reduction, • Resource and Referral, • Legal Services, and • Linguistic Services. 3.2 Fund services that will address the population specific needs of African Americans, African-born, and Hispanic clients; and prescribe & educate clients about ART including: • ADAP, • Outpatient/Ambulatory Care,	3.2 PAC, DEC, The Council, DHS, HC, MDH.

Timeframe	Objectives (2.A.a)	Target Population(s)	Measure(s)/Metrics (2.A.d.)	Stage of Care Continuum	Strategies and Activities (2.A.b-c)	Responsible Parties
	3.3 Increase to 80% proportion of African American, African-born, and Hispanic clients who achieve viral suppression		3.3 The percentage of clients who receive Ryan White Part A funded OAC who have a viral load of <200.	3.3 Viral Suppression	• Medical Case Management (Treatment Adherence), and • Non-MCM. 3.3 Fund services that provides culturally competent health education around the importance of treatment and treatment adherence that will support viral suppression, including: • ADAP, • Outpatient Ambulatory Care, • MCM (Treatment Adherence), and • Health Education/Risk Reduction.	3.3 PAC, DEC, The Council, DHS, HC, MDH.
	3.4 Implement systems changes to improve engagement from African American, African-born, and Hispanic communities in community planning and program development.		3.4a The percentage of participants from African American, African-born, and Latino communities that rate their involvement in planning and development activities favorably.		3.4a Support African American, African-born, and Latino/a workgroups and Council members to address population and sub-population social and cultural needs as they relate to HIV prevention and care services. 3.4b Improve recruitment and retention efforts of African American, African-born, and Latino/a participants on the Council	3.4a PAC, DEC, The Council, DHS, HC, MDH.

Timeframe	Objectives (2.A.a)	Target Population(s)	Measure(s)/Metrics (2.A.d.)	Stage of Care Continuum	Strategies and Activities (2.A.b-c)	Responsible Parties
			3.4b The Council membership will reflective goals based on representative of the epidemic (include disproportionately affected subpopulations).		3.4c Evaluate satisfaction of participants' involvement on the Council and other supported workgroups and committees.	3.4b PAC, DEC, MAT, The Council 3.4c DEC, MAT, The Council
<u>Goal #4</u>: Achieve a More Coordinated State & Local Response to the HIV Epidemic to reduce the number of Minnesotan's at risk of or living with HIV **<u>Key</u>**: **Council** (MN Council on HIV AIDS Care & Prevention); **DEC** (Disparities Elimination Committee); **NA&E** (Needs Assessment & Evaluation); **PAC** (Planning & Allocations Committee); **DHS** (Department of Human Services); **HC** (Hennepin County); **MDH** (Minnesota Department of Health)						
By 2/28/21	4.1 Increase coordination of HIV programs across state, local, and tribal government agencies, and the Council so that	4.1 – 4.2 All people in MN, specifically Minnesotan's at risk of or living with HIV	4.1a Percentage of Council members who report receiving timely epi, service utilization, and other needed available data to make evidence based decisions.	4.1 – 4.4 Entire Care Continuum	4.1a Search for opportunities to integrate HIV testing/awareness with other health disparities groups/programs/activities such as the Center for Health Equity (OHE) at MDH.	4.1a: MDH

Timeframe	Objectives (2.A.a)	Target Population(s)	Measure(s)/Metrics (2.A.d.)	Stage of Care Continuum	Strategies and Activities (2.A.b-c)	Responsible Parties
	planning for funded services are completed in a timely manner.		4.1b Percentage of Council members who report being satisfied with their involvement in development of the statewide strategy as defined by MDH		4.1b Search for opportunities to collaborate with partners, including but not limited to MDH's CareLink, Partner Counseling & Referral Services, Syphilis, and HC Public Health Clinic elimination programs to provide an enhanced system to connect newly diagnosed individuals to core medical & support services.	4.1b: MDH, DHS, HC
	4.2 Develop and improve mechanisms to monitor and report on progress towards achieving goals so that all goals can be measured		4.2 Percent of Council members who report being satisfied with mechanisms to monitor and report on progress towards achieving goals		4.2a Collaborate with state agencies/partners to obtain race categorization data along the HIV Care Continuum from the MDH Surveillance Unit on ages broken down into finer categories to better assess the needs of adolescents and young adults	4.2a: MDH
					4.2b HC, MDH, DHS will integrate surveillance data with CARE Ware	4.2b: HC, MDH, DHS
					4.2c MDH will explore the possibility of linking evaluation web data to surveillance data	4.2c: MDH
					4.2d MDH will provide HIV reports to the Council as requested to include all combinations of variables such as: age, gender, race/ethnicity, and exposure categories.	4.2d: MDH

Section II: Integrated Prevention and Care Plan

B. Collaborations, Partnerships, and Stakeholder Involvement

Specific Contributions of Stakeholders and Key Partners to the Development of the Plan (Section II. B. a.)

The purpose of the Integrated HIV Prevention and Care Plan is to reduce the number of new people acquiring HIV infection, increase access to care and improve health outcomes for people living with HIV, reduce HIV related health disparities, maximize integration and ensure effective linkages across prevention and care including all Ryan White HIV/AIDS Program Parts and CDC and state funded prevention programs. The Integrated HIV Prevention and Care Plan describes the evolving needs of people affected by the HIV epidemic in Minnesota and two counties in Wisconsin.

The development of the 2017-2021 Minnesota Integrated HIV Prevention and Care Plan included many stakeholders in a collaborative process throughout 2015 and the first half of 2016. The priorities agreed upon serve as an invaluable tool for the state of Minnesota in addressing the needs of people living with HIV/AIDS, as well as prevention of new HIV infections. The Integrated HIV Prevention and Care Plan includes input and approval from all Ryan White HIV/AIDS Program (RWHAP) Parts as well as other key stakeholders in Minnesota including providers, people at higher risk of HIV, and PLWH. Key partners include the Council, DHS, MDH, and Hennepin County's Public Health Department, providers and people at higher risk for HIV and PLWH. It should also be noted that all of these groups are represented on the Council and each of the Council's subcommittees and participated throughout the SCSN process.

Road to Integration

Historically Minnesota has had two planning bodies responsible for segregated oversight of prevention and care services. With the evolution of rapid testing, pre-exposure prophylaxis (PrEP) for those at risk, quicker connection to care, medication benefits that lead to undetectable viral loads, and more and more people with HIV living normal life spans, the old gaps and differences between HIV prevention and care are blurring and coming together.

Pre-exposure prophylaxis, taken by people who are at risk for HIV disease (IV drug users, partners of PLWH), has been proven effective in lowering chances of acquiring HIV. People living with HIV are receiving higher quality treatment and are living longer than ever before and babies born to HIV positive women are being protected from acquiring the disease. These advancements and other factors have influenced federal guidelines to change and require jurisdictions to integrate their planning for HIV care and prevention services. During 2015, Minnesota took the integration one step further, with the help and support of community members and organizations, a project was initiated to integrate community HIV planning bodies.

In January, 2015 the road to integration and the development of an integrated planning and oversight process began with a joint listening session including both legacy planning groups:

- Community Cooperative Council on HIV/AIDS Prevention (CCCHAP) historically provided planning for CDC and state funded prevention services administered by MDH.
- Minnesota HIV Services Planning Council (MNHSPC) historically provided planning for Ryan White Part A and Part B. MNHSPC was administered by Hennepin County

Public Health and collaborated with the Minnesota DHS to fulfill the community input obligation for Part B funding.

At this joint listening session Ryan White Part A and B and CDC HIV prevention program grantee organizations (DHS, MDH and Hennepin County) presented the CDC and HRSA communications on integrated planning and listened to ideas and concerns from members of both bodies. In addition, a survey was collected from members of both groups to assess willingness to have a single integrated planning body in Minnesota for HIV prevention and care. Following the listening session, co-chairs from the Council participated in a CCCHAP meeting to provide an overview of the roles and responsibilities of the Council and to hear CCCHAP member concerns about integrating planning. Likewise, CCCHAP chairs attended a Council meeting to describe CCCHAP roles and responsibilities. Discussions between members of Minnesota's two bodies and results of the survey indicated a strong willingness to develop a single HIV prevention and care community planning body for Minnesota. With strong support from both bodies, the workgroup charged grantees to develop a model body and a plan for implementation. The grantee integrated implementation workgroup worked with members from the Planning Council and CCCHAP to develop the structure and bylaws and select members to serve on the new body.

The planning resulted in the creation of a new joint community planning group called the Minnesota Council for HIV/AIDS Care and Prevention (MCHACP) herein referred to as the "Council". The Council held its first meeting in February 2016. The goals accomplished during the integration process included:

- Minnesota has one integrated community planning body that meets HRSA Ryan White Part A, Part B and CDC HIV prevention community planning requirements;
- Combined efforts streamline activities such as needs assessment and community involvement and avoid duplication of processes;
- Efficiencies have been created around planning costs and will continue to be realized in the years to come;
- Easier monitoring of outcomes across the continuum of care; and
- A more coordinated cross-jurisdictional response to HIV planning, program implementation and monitoring.

The newly formed Council convened for its first official meeting in February 2016. The integrated Council fulfills the community planning responsibilities for RWHAP Parts A and B and CDC HIV prevention planning in Minnesota. Additionally, the Council provided input, oversight, and approval for the Integrated Prevention and Care Plan.

Stakeholder and Key Partner Involvement with Integration

The involvement of key partners and stakeholders is critical to the successful integration of prevention and service planning, as well as ultimately the development of the Integrated HIV Prevention and Care Plan. Specific contributions included:

- Grantee staff secured agreement with stakeholders to fully integrate community planning thus initiating the need for the project.
- Jurisdictions from Wisconsin and LA County, California were contacted to research their process of integration.

- Workgroup members also interviewed staff who founded the Minnesota HIV Services Planning Council in 1995.
- Grantee staff completed side by side analysis of current documents pertinent to this work and identified items that were outdated, mandated or required to go forward, and/or could be changed with the new planning body. An example of this is the process of the new bylaws for the new planning body. Previously CCCHAP and MHSPC had their own set of bylaws that needed to be compared and combined into a new set of by-laws. This was completed and opportunities for stakeholder feedback were made available on three separate occasions via a community meeting and e-mail input. Once all updates were made, they were posted online for 30 days and were adopted by the new planning body on March 8, 2016.
- Intergovernmental Collaborative Agreement, a requirement of Ryan White Services Part A that establishes a formal collaboration for the allocation of resources among local and state jurisdictions was updated and officially signed by the following grantees or boards of health including: Hennepin County, MDH, DHS, Ramsey County (which also serves as the public health authority for the City of St. Paul) and the City of Minneapolis.
- Project team created a communication plan. The work products from this included monthly updates to stakeholders via PowerPoint, frequently asked questions (FAQ) document about the effort, official letters and creation of e-mail messages to be used by project team to stakeholders.
- Stakeholders were involved in the integration process and additional avenues were created to hear input and feedback. These included facilitating conversations with planning body members to hear from them; sharing work products on the websites of CCCHAP and MHSPC, updates by project manager at monthly committee meetings, and clearly communicating a point of contact to ask questions at any time. Specific opportunities involving stakeholder participation included:
    - Naming contest to empower stakeholders in the choice of the name of the new planning body
    - Created a Structure Committee that included members from the project team and stakeholders. This group was tasked with identifying the subcommittees for the new planning body. This included determining duties for each subcommittee and their meeting schedule.
    - Created a Membership Selection Committee who included members from the project team and stakeholders. This group was tasked with identifying the mandated positions needed on the new planning body, creating a membership application and process, interviewing candidates and recommending members for the new planning body to be appointed by the authorizing officials as specific in the RWHAP legislation and CDC HIV prevention program policy.
- The new joint planning body was convened and new member orientation and training for members was conducted.

Key Partner & Stakeholder Contributions

Key partners to the development of the new five-year Integrated HIV Prevention and Care Plan include the Council and its sub-committees, DHS, MDH, Hennepin County, providers, people at higher risk of HIV, and PLWH. Each of these groups had a role in development of

the Integrated HIV Prevention and Care Plan, including the SCSN/Needs Assessment is described below.

Minnesota Council for HIV/AIDS Care and Prevention (Council)
The newly formed Council began its work in February 2016. The Council is a collaborative effort between the Minnesota DHS (Ryan White Part B Grantee), Hennepin County Public Health (Ryan White Part A Grantee), and MDH (CDC HIV Prevention Grantee). The Council is comprised of up to 33 individuals and currently meets all reflectiveness and mandated category requirements. The Council's membership includes a broad representation from the affected communities and those who have a stake in HIV prevention and care. Representation includes persons working in the areas of prevention, corrections, education, social services, mental health, faith, health care, tribal health, and local public health. The Council bylaws also require that one of the two Council co-chairs must openly acknowledge their HIV-positive status, ensuring consumer participation on all levels. At least 33 percent of the members must be people living with HIV disease who are consumers of Ryan White services and not aligned with any Ryan White providers.

The Council, mandated by the Ryan White HIV/AIDS Treatment Extension Act of 2009, is also responsible for comprehensive planning, needs assessment, evaluation and assessment of the administrative mechanism. The ability to do is this enhanced by the Council's membership reflection of the local epidemic and inclusion of members who have specific expertise, such as health care planning, housing for the homeless, incarcerated populations, substance abuse and mental health treatment, or who represent other Ryan White and Federal programs. The Council is responsible for determining which services are of the highest priority amongst people living with HIV disease. Because some services may not be of significant enough priority or may be provided through other venues and sources of funding, the Council may opt not to prioritize or fund all allowable CDC and HRSA areas.

The Council functions as the joint planning body for Parts A and B, thus Part A and B services and funding are prioritized and allocated together. This ensures that funds are allocated efficiently and effectively, and resources are maximized for core medical and supportive services. The planning process has worked well to meet the needs of people living with HIV disease since the TGA has always been the epicenter of Minnesota's HIV epidemic, with 85% of the state's reported cases. Many people living with HIV disease in greater Minnesota travel to HIV specialty clinics in the TGA for their primary HIV medical care. Some services prioritized by the Council are not allocated either Part A or Part B base dollars because funding for those services is available through other programs, such as the State HIV insurance continuation program.

The Council also recommends priority target populations for CDC and state funded HIV prevention programming in the state. The recommended priorities inform the MDH's funding allocations for HIV prevention services in Minnesota based on their request for proposals process that is conducted every four years. With declining HIV prevention funding in Minnesota, the Council's recommended priority populations for prevention helps focus resources to maximize their impact on reducing HIV incidence among the most disproportionately impacted communities.

The Council receives information on Minnesota and the TGA's updated HCC for 2015 by the MDH's HIV epidemiologist using 2015 HIV eHARS data. This information was also presented at the Community meeting on March 22, 2016. MDH's presentation includes care continua by gender, race/ethnicity, age, geography and mode of exposure to help identify potential disparities in movement along the HCC.

The Council's Planning and Allocations Committee (PAC) began using a local version of this HCC framework developed by the Part A grantee's Quality Management Advisory Committee (QMAC) showing RWHAP services superimposed on the stages of the continuum to provide greater focus on where resources will have the greatest impact on gaps in the continuum, especially between linkage to care and retention, and populations that are least likely to be retained in care and have suppressed virus.

The Council continually encourages input from people at risk of HIV, people living with HIV, and community members. Individuals who want to know how to get involved or need more information can do so via the Council's web site www.mnhivcouncil.org. All Council meetings are open to the public and membership applications are always welcome from the community. Additional ways for individuals to get involved in planning and have their voices heard include participating in Council sub-committee meetings, completing surveys and participating in the annual SCSN needs assessment.

The initial goals, target groups, and activities for the Integrated HIV Prevention and Care Plan were developed by the Planning and Allocations Committee and Disparities Elimination Committee and presented for input to the other committees and approval by the Council. Members, who represent grantees, funded providers and consumers are active participants in the Council and its sub-committees. This integrated planning approach is helping those working on both care and prevention in Minnesota to be even more collaborative, making all efforts even more efficient.

Council Committees

In recognition of the disparities realized by people with HIV, particularly African Americans, African-born and Latinos, a new committee of the council was formed, Disparities Elimination Committee (DEC). DEC is composed of stakeholders with an interest and expertise in advancing HIV health equity for populations disproportionately impacted by HIV within the TGA and state.

The new DEC will be involved in monitoring these efforts and their outcomes, with both the Needs Assessment & Evaluation; Planning and Allocations Committee; and the Early Identification of Individuals with HIV/AIDS (EIIHA) workgroup, to ensure services and activities to address disparities are being prioritized, implemented and measured. Input from the DEC around disparities and emerging communities were incorporated into the Integrated HIV Prevention and Care Plan to ensure health outcomes for these populations are improved.

Early Identification of Individuals with HIV/AIDS (EIIHA) workgroup is an outgrowth of a legislative requirement that focuses on individuals who are unaware of their HIV status and how best to bring HIV positive individuals into care, and refer HIV negative individuals into services that are going to keep them negative. Part A grantee and Council, along with Minnesota's Part B (DHS) and CDC HIV prevention (MDH) grantees, have collaborated with

an EIIHA workgroup to develop recommendations for a coordinated strategy to identify, diagnose and link the HIV unaware with care. The EIIHA workgroup comprises stakeholders including HIV care, prevention and testing providers, representatives from all Ryan White grantees (Parts A, B, C, D and F), consumers, and providers from outside the Ryan White funded care system. The workgroup's recommendations were presented as part of the planning process. The Part A grantee established its goals based on the EIIHA workgroup's recommendations. They were developed to be consistent with the National HIV/AIDS Strategy (NHAS) goals.

This innovative approach fits well into the White House Care Continuum Initiative goal to address barriers to testing and treatment for communities in need. Activities such as expanded testing, outreach services, CareLink, Fast Track and Concierge services and referrals to care for YMSM, MCSM, and African-born communities are targeted at improving disparities experienced by these communities.

Minnesota Department of Health (MDH)
MDH's AIDS Director provides a monthly update on CDC and state-funded HIV prevention funding and programming at Council meetings. MDH also holds a seat on the Council. Additionally, MDH took the lead in the development of the Epidemiologic Overview and HIV Continuum of Care sections of the Integrated HIV Prevention and Care Plan with data and input from the DHS, Hennepin County Public Health and numerous providers and PLWH. Historically, Part A and B grantees and the Council have a long history of coordination with the CDC grantee (MDH). The previous Minnesota HIV Services Planning Council and the Community Cooperative Council on HIV/AIDS Prevention (CCCHAP) developed a plan that identified where care and prevention intersect, formulated strategies to maximize resources and improve coordination between care and prevention. The plan culminated in the expansion of the HIV continuum of care to include prevention. As a result, improved awareness of the full spectrum of HIV service needs has assisted in effective planning for prevention, care and the TGA's EIIHA effort. This approach and information has been and will be continued in the Integrated HIV Prevention and Care Plan.

Minnesota Department of Human Services (DHS)
DHS serves as the Part B grantee providing Ryan White services throughout the state. Geographically the Part B service area includes 76 counties in addition to the eleven Minnesota counties in the TGA and includes both small urban and extensive rural areas.

The States HIV Part B unit is housed within the Disability Services Division and is responsible for administering Part B base funds which includes the ADAP program. Staff are responsible for procurement and evaluation of direct service activities and provision of the ADAP program. Part B works with Part A in the TGA to provide Core Medical and Supportive Services, including activities that target disproportionately affected populations. This working relationship increases the availability of services while avoiding duplication. In Greater Minnesota Part B funds medical case management, medical transportation, outpatient ambulatory care and benefits counseling as well as several services that may be delivered from a centralized location statewide in order to reach PLWH living in low-prevalence communities. In addition, the program uses rebate funding to provide capacity building opportunities to local providers of needed core medical or supportive services so that while

they may have very few clients living with HIV, they are able to provide culturally appropriate, non-stigmatizing services.

Hennepin County Human Service and Public Health Department
In the case of the Part A MSP-TGA, Hennepin County provides health care services to the greatest number of people living with HIV/AIDS in the TGA. Therefore, the Chairperson of the Hennepin County Board of Commissioners serves as the Chief Elected Official (CEO) for the Part A award. Acting on behalf of the CEO, the Part A award is administered through the Hennepin County Public Health Department. The Ryan White Program Coordinator and staff are responsible for applying for and administering Part A funds. This includes the procurement and evaluation of direct services as prioritized and allocated by the Council. Additionally these staff are responsible for coordination of the Integrated HIV Prevention and Care Plan.

The Part A grantee office is co-located with the Hennepin County Public Health Clinic, which is the largest local public health agency in Minnesota, serving diagnosing 25% of the TGA's population of PLWH. As a result, Part A funding is closely coordinated with the state's largest CDC-funded HIV counseling, testing and referral provider. The Public Health Clinic also receives both CDC and state funding for HIV and syphilis prevention targeting MSM. The Part A grantee coordinator meets with Minnesota's STD and AIDS Director from the MDH monthly to coordinate local and state prevention and care funding and programming.

Minnesota Health Care Programs
To ensure that priority setting and resource allocation consider Medicaid and other state-funded healthcare programs including Minnesota Care (Minnesota's basic health plan), the grantees and Council have taken several steps including:

- The Minnesota DHS, the Part B grantee and agency responsible for Medicaid and all other state-funded healthcare programs, is a party to the Intergovernmental Cooperative Agreement.
- DHS has two seats on the Council: one from the state Medicaid office and one from the Part B grantee office;
- DHS Part B staff sit on all Council standing sub-committees and attend the monthly co-chairs and Executive Committee meeting. These committees are responsible for priority setting, long-range planning, resource allocation, standards development and PLWH and prevention needs assessments and Council governance;
- The Parts A and B grantees monitor program usage and identify emerging issues related to the coverage of healthcare services and medications;
- DHS staff determine eligibility of PLWH who may qualify for state-sponsored insurance and Ryan White funded programs such as ADAP to ensure that the RWHAP is the payer of last resort; and
- The grantee and Planning Council receive an annual report from DHS on the number of PLWH enrolled in all Minnesota Healthcare Programs (MHCP), including Medicaid, and spending on HIV outpatient medical care, dental care, mental health and chemical dependency treatment services and home and community-based support services.

Federal, State and Local Funds for Substance Abuse and Mental Health Treatment
In addition to being the Part B grantee, DHS also administers state and federally funded substance use disorder services and provides key information for the Council about how substance use disorder treatment services are funded and utilized by people living with HIV enrolled in Medicaid and other publicly funded healthcare programs. In general, treatment on demand is available for low income residents. Substance use disorder treatment services are paid for through the state's Consolidated Treatment Fund supported through a Substance Abuse and Mental Health Services Administration Block Grant. These programs facilitate access to substance use disorder treatment funded through other public sources and ensure that a continuum of care exists for people living with HIV disease who are also substance users. In addition to DHS's oversight of substance use treatment services, its staff participates in the planning, priority setting, and allocations processes. DHS also provides training for substance use treatment centers on appropriate care and resources for PLWH.

Children's Health Insurance Program (CHIP)
The number of children aged 19 or younger living with HIV/AIDS in the TGA and State remains relatively small at less than one percent (<1%) of prevalence rates. Most low-income children with HIV can get coverage under Medicaid or MinnesotaCare (the State's basic health insurance plan). Because of this, few children access Ryan White funded insurance or drug programs. A representative from DHS sits on the Council and provides information about MinnesotaCare and other DHS programs to reduce duplication of services.

Other State Social Service Programs
Other social service programs are considered and participate during the Integrated HIV Prevention and Care Plan development process in ways similar to those described above. The Minnesota DHS HIV/AIDS program is situated in DHS's Disabilities Services Division. The DHS HIV/AIDS Director apprises the Council of other state funded programs for persons with disabilities such as Minnesota's ―Pathways to Employment program and the state's Medicaid waiver community support programs. Administrators of other state and local support programs, such as targeted case management (such as Adult and Child Mental Health, Child Welfare, and Vulnerable Adult/Developmental Disability), participate in the Council and its committees as well as in formulating the Integrated HIV Prevention and Care Plan, including Statewide Coordinated Statement of Need development.

Providers
An enhanced continuum of HIV prevention, testing and care will increase access to care and improve health outcomes by providing accessible resources for providers throughout the healthcare and social services systems to link their clients to care and services. Many providers who offer RWHAP funded services partner in the delivery of Part A and B activities. The Part A grantee works in partnership with Hennepin County Public Health clinics to increase routine HIV testing for: patients presenting for STI tests; MSM outreach programs; Health Care for the Homeless clinics; and the County's refugee health clinic. The grantee also works with a community-based organization that provides RWHAP outreach, food bank and onsite meals, and medical transportation services to coordinate with its HIV testing program. These programs are expanding outreach and HIV testing efforts, specifically to young MSM, African American and African-born individuals, and those with substance use issues. All RWHAP funded providers participate at some level in the development of the

Integrated HIV Prevention and Care Plan. While many providers are represented on the Council or participate in sub-committees, other providers provide input through the SCSN stakeholder meeting and encourage their clients to complete the Consumer Needs Assessment survey. Additionally all funded providers contribute data that informs planning, program implementation and monitoring.

Culturally Specific Organizations and Providers
Part A MAI funds allocated to medical case management and outpatient/ambulatory medical care services and ADAP MAI funds are used to connect African American, Latino and African-born individuals who know their status. Part C supports a collaboration between Hennepin County Medical Center (HCMC) in Minneapolis and Health Partners Specialty Clinics in St. Paul which reaches a significant proportion of Minnesota's minority populations disproportionally impacted by HIV including Africans. Part D supports a collaboration between HCMC and Children's Hospitals and Clinics with over half of its patient population from communities of color. Both Part C and D providers are represented on the Council.

Representatives from West Side Community Health Services, which receives Part A, Part A MAI and Part B for core medical and support services, are a voice for the needs of Latino consumers. A representative from West Side Community Health Services also sits on the Council. Finally, a representative from the Rural AIDS Action Network, that serves non-urban counties of the TGA and Greater Minnesota, sits on the Quality Management Advisory Committee (QMAC). The Council considers the TGA's Part C and D resources in allocating funds to prioritized services as the Council's Part C and D representatives share information about its program and funding including the populations they serve. The coordinator of the Midwest AIDS Training and Education Center (MATEC) is also a member of the Part A Quality Management Advisory Committee. Both Part A and Part B grantee directors attend the annual regional AIDS Training and Education Center Policy Training and Advisory Council.

Community Health Centers
There is currently one Community Health Center funded with RWHAP resources, West Side Community Health Services (WSCHS). WSCHS provides HIV medical care and other core medical and support services. In addition, WSCHS has a representative on the Council that participates in the prioritization of services and the allocation of resources. The Minnesota AIDS Training and Education Center also provides capacity building assistance statewide to community health centers on implementing routine HIV screening.

Early Identification of Individuals with HIV/AIDS (EIIHA) Workgroup
Minnesota's EIIHA workgroup will continue to meet annually to plan and assess EIIHA activities and outcomes. As the state's CDC prevention and testing grantee, the MDH has a position on the Council to facilitate understanding of HIV prevention programs and outcomes. MDH also reports to the Part A grantee and Council routinely on changes in the state's HIV epidemiological data. Data from the state's eHARS and MDH's Testing and Disease Intervention/Partner Services databases, informed the selection of the target populations for the grantee's EIIHA efforts.

The initial goals, target groups, and activities of the Integrated HIV Prevention and Care Plan were presented for input and approval by the Council. Regular updates on all related EIIHA activities are presented during Council meetings. Members, who represent funded providers and consumers, as well as Council staff, are active participants in the workgroup. An EIIHA/prevention goal is incorporated in the Council's 2017-2021 Integrated HIV Prevention and Care Plan.

Government HIV Administrative Team
The Government HIV Administrative Team (MDH, DHS and Hennepin County) holds three meetings annually to coordinate all state and local RWHAP funded care programs with CDC and state-funded testing and HIV prevention programs to ensure efficient use of resources and consistent policies and standards of care.

In summary, the Integrated HIV Prevention and Care Plan was developed in collaboration with all key partners and other stakeholders including all RWHAP grantees in Minnesota, providers, people at higher risk of HIV and people living with HIV. Recent national, Minnesota and MSP-TGA Minnesota HIV Care Continuum (HCC) make clear where the greatest needs arise in the process of helping people to become aware of their HIV status and engage in prevention, linkage, care retention, optimal treatments, and viral suppression. The Integrated HIV Prevention and Care Plan outlines the needs assessment, continuum of care, resources and services available across Minnesota and especially in the Twin Cities metropolitan area where 85% of Minnesotans living with HIV reside.

Stakeholders and Partners <u>not</u> Involved in the Planning Process, but who are needed to More Effectively Improve Outcomes along the HIV Care Continuum (Section II: B. b.)
Minnesota has a very inclusive planning process for HIV/AIDS. There are two primary partners who are not involved in the planning process who may be able to assist with more effective planning, Medicare and Commercial Insurance. Both Medicare and Commercial insurance have a role in the delivery of services to PLWH. The state of Minnesota has begun to take steps to integrate Medicaid and Medicare in other areas such as coordinated care for seniors. Additional collaboration and involvement from both Medicare and commercial insurance would benefit HIV prevention and care planning.

Letter of Concurrence to Integrated HIV Prevention and Care Plan Goals and Objectives (Section 11: B. c.)
Minnesota is pleased to present a letter of concurrence from the Minnesota Council for HIV/AIDS Care and Prevention. The letter signed by the Council's co-chairs following a unanimous vote of concurrence by the Council. In addition, we have included concurrence letters from the Minnesota Department of Health, Minnesota Department of Human Services, and Hennepin County Public Health. These letters of concurrence are included in Attachment F.

Section II: Integrated Prevention and Care Plan

C. People Living with HIV and Community Engagement

People involved in developing the Integrated HIV Prevention and Care Plan are reflective of the epidemic in the jurisdiction (Section II. C. a.)
All populations identified as having severe need are represented on the Council, including four African immigrants. The Council is currently composed of 29 members, 14 (48%) of whom identify as people living with HIV (PLWH). Twelve (12) of the Council members are PLWH who are not aligned with any of the providers funded to deliver Ryan White HIV/AIDS Program services. PLWH are members of all Council committees.

All populations identified as having severe need are represented on the Council. The Council includes nineteen (19) male and ten (10) female representatives. The Council is currently composed of 14 members or 48% who identify as people living with HIV (PLWH) and those at higher risk. PLWH and those at higher risk are also members of all Council sub-committees. Additionally, Council representatives meet all of the mandated demographic categories and identify with the following racial and ethnic categories:

- Sixteen (16) White representatives,
- Nine (9) Black representatives including four (4) African immigrants,
- Three (3) Hispanic representatives,
- One Asian representative, and
- One Native American/Native Alaskan.

Please see Attachment E: *Council Membership Breakdown*.

PLWH also participated in the development of the Integrated HIV Prevention and Care Plan, including Statewide Coordinated Statement of Need through completing a Consumer Needs Assessment (CNA) survey. In 2016, 504 individuals with HIV completed the CNA. Of the 504 respondents:

- 72% report being male, 27% female, and 1% transgender (male to female);
- 44% report being heterosexual or straight, 47% report being gay, lesbian or homosexual, and 12% report being bisexual;
- 53% report being White, 37% Black, 1% Asian, 0.4% Hawaiian or Pacific Islander, 7% other. Out of the total, 12% report being Hispanic; and
- 61% report having been diagnosed with AIDS.

Please see Attachment D: *Comparison of 2010 and 2015 Consumer Needs Assessment.*

PLWH contribution to Integrated Plan Development (Section II: C. b.)
A central tenet of the Council and Ryan White legislation is that decisions are to be made based on an assessment of local needs and an identification of service gaps, including people at higher risk for HIV, PLWH, and community engagement. This approach can be summed up as “Doing it with us, not for us”. As consumers of HIV services, PLWH can provide a practical perspective on service design and direct feedback on service accessibility and quality. They can also identify barriers to services which may not be evident to service providers and can assist the Council and providers in more effectively reaching and serving the community, especially minority and other emerging populations. Only through effective involvement of PLWH, those at risk and affected communities can the Council, Ryan White funded agencies, and ultimately the Integrated HIV

Prevention and Care Plan ensure that the services are truly responsive to the needs of the users of these services.

Consumers living with HIV and those at higher risk of HIV are a very important link between the Council and the community. They play two important roles in the planning process: bringing community issues to the table and taking treatment and service issues and bringing information back to the community. The Council understands that their primary constituent group is people at higher risk of HIV and people living with HIV. It is the needs of people at higher risk and PLWH that the Council is committed to serving and it is their full participation that is critical to the planning, priority setting, allocation of resources, and program implementation of Ryan White Part A and Part B programs. (For more information about involvement in the MN Council for HIV/AIDS Care and Prevention, please visit the Council's website at www.mnhivcouncil.org.)

The full Council, including at least 33% PLWH who are not aligned with any of the Ryan White HIV/AIDS Program funded providers, provides input and oversight to the development of the Integrated HIV Prevention and Care Plan. Additionally throughout the year the Council provides direction on the allocation of resources, prioritization of target populations for prevention, data collection and analysis, and planning. There is also time allotted through a standing agenda item for community members, including individuals at higher risk of HIV and PLWH, to discuss service needs at each Council meeting. In addition to serving on the Council and its committees, people at higher risk of HIV and PLWH participate in needs assessments and consumer surveys. Additionally, the Council's Community Voices Committee (CVC) meets quarterly and includes HIV+ Council members HIV positive community members and people at-risk. The CVC provides perspective on emerging service needs and problems associated with current service delivery. Most importantly, CVC provides the Council with key insights on issues for people at higher risk of HIV and PLWH's feedback on priorities, allocations, and care standards.

The Council considers numerous data sources in the development of the Integrated HIV Prevention and Care Plan, including the SCSN. One of the data sources is the Consumer Needs Assessment survey. This survey collects data from PLWH on their needs and accessibility of services. The data collected is used to inform the planning process. Also, the Council and DHS facilitated planning meetings that included people at higher risk of HIV and PLWH in the identification of service needs and barriers to develop the SCSN. Information from all of these sources informed the development of the plan.

Methods used to Engage Communities, People Living with HIV, Those at Substantial Risk of Acquiring HIV Infection and other Impacted Population Groups (Section II: C. c.)

There is genuine commitment and effort from the Council, grantees, providers and others to facilitate meaningful consumer participation in the development of the Integrated HIV Prevention and Care Plan. The Council has led the implementation of consumer participation in HIV care and prevention planning in Minnesota and the Part A MSP-TGA through recruitment of its diverse membership and outreach to communities most impacted by HIV. The Council plays a major role in developing and disseminating consumer information, and assisting consumers to be actively involved in development of the Integrated HIV Prevention and Care Plan.

The Council and grantees understand that people at high risker of HIV and PLWH know what is working well (strengths) and not working well in accessing services and living day-to-day with HIV and therefore provide invaluable input in the planning, oversight and monitoring. Methods used to engage communities, people living with HIV, those at higher risk of acquiring HIV infection and other impacted population groups to ensure that HIV prevention and care activities are responsive to their needs in the service area include:

- Membership on the Council, including participation in planning, allocations and
- monitoring,
- Membership on Council sub-committees,
- Participation in Council meetings through a standing open forum agenda item,
- Participation in the Consumer Needs Assessment survey,
- Participation in Community meetings,
- Feedback to Council members, staff, grantee staff, providers and others,
- Participation on ADAP formulary committee,
- Participation in focused group on Latino Gay, Bisexual MSM and Transgender individuals,
- Participation in focused group on African American Gay and Bisexual MSM,
- Participation in African Leaders focused group, and
- Providing web-based information and resources for consumers.

How impacted communities are engaged in the planning process to provide critical insight (Section II: C. d.)

Consumer involvement and community engagement in the Integrated HIV Prevention and Care Plan, including development of the SCSN Needs Assessment is both a practical necessity and core principal shared by the Council, grantees, participating organizations including providers and advocacy groups, people at higher risk of HIV, and especially PLWH. The involvement of people at higher risk of HIV and PLWH on Ryan White Part A Council and in Part B planning is also a legislative requirement. The Ryan White CARE (Comprehensive AIDS Resource Emergency) Act, first enacted in 1990 and reauthorized in 1996, 2000, 2006 (Ryan White HIV/AIDS Treatment Modernization Act of 2006), and 2009 (Ryan White HIV/AIDS Treatment Extension Act of 2009) requires planning councils and Part B consortia to include members from affected communities, including people at higher risk and PLWH, and requires that members be diverse, active, and well informed. In addition, the HIV/AIDS Bureau at the Health Services Administration (HRSA), which administers the Ryan White legislation and associated funding allocations, believes that effective programs and services must be developed based on the input and perspectives of those for whom the services are intended.

The legislation requires that a minimum of thirty three percent (33%) of the Council members are recipients of Ryan White funded HIV services and are otherwise unaligned with any Ryan White funded agency. In other words, the person may be receiving services from a Ryan White funded agency but may not be an officer, employee, or consultant in any capacity to an agency that receives Ryan White funds. These Council members are considered unaligned consumers. The bylaws of the Council allow for up to 33 members. Therefore, at least ten of the members must be unaligned consumers. Currently there are 12 unaligned consumers on the Council, comprising 41% of the current Council membership and over half of the Council membership is living with HIV. This requirement does not preclude further consumer involvement. In fact,

because the Council believes cost-effective services are far more likely to be developed when the Council involves a diverse group of participants, the Council has a long tradition of exceeding the 33% requirement for unaligned consumers and has engaged more than the legislatively mandated level of involvement from affected communities, people at high risk of HIV and PLWH.

When the structure of the Council was developed in 2015 to integrate HIV care and prevention planning in Minnesota and the Minneapolis-St. Paul Part A TGA, a Disparities Elimination Committee was created to increase engagement from communities disproportionately impacted by HIV. This committee developed the objectives and activities of the third goal of the plan which is to reduce HIV health related disparities.

PLWH and people at high risk of HIV on the Council and those from the community who participate in the Council's Community Voices Committee represent and assist others using their knowledge and experience with aspects such as:

- Familiarity (or lack thereof) with the local health system, services available and how to access them,
- Varying concepts of health and illness which may affect understanding of treatment and impact compliance,
- Promoting the needs of vulnerable and marginalized consumers,
- Language and cultural barriers to understanding information, developing trusting relationships with health professionals, and providing informed consent, and
- An understanding (or lack thereof) of consumer rights and responsibilities.

These are all invaluable to effective planning and implementation of prevention and care services, as well as ultimately slowing or stopping the spread of HIV.

Section III: Monitoring and Improvement

Process for Regularly Updating Planning Bodies and Stakeholders on the Progress of Plan Implementation, Soliciting Feedback, and Using the Feedback from Stakeholders for Plan Improvements. (Section III. a.)

Monitoring the Integrated HIV Prevention and Care Plan assists grantees and the Council with identifying ways to measure progress toward goals and objectives, selecting strategies for collecting information; and analyzing information to inform decision- making and improve HIV prevention, care, and treatment efforts within the jurisdiction.

Annually, the following process will be used to monitor progress on achieving the goals and objectives (Section II: A) of the Integrated HIV Prevention and Care Plan. The evaluation and monitoring activities begin with gathering available data from as many sources as possible and creating a summary report to inform participants. For each goal, a Council committee or government agency will take the lead in using available data to identify progress on the goal.

Specifically:

- Goals 1 and 2 will be monitored by the Needs Assessment Committee
- Goal 3 will be monitored by the Disparities Elimination Committee
- Goal 4 will be monitored by the Grantees

Once all parties have completed their reviews, they will send monitoring reports to the PAC for discussion and recommendation which will then go to the Executive Committee and the full Council.

Annually the following activities will occur to ensure regular updates to planning bodies and stakeholders on the progress of plan implementation, opportunity to solicit feedback, and utilization of the feedback from stakeholders for plan improvements.

Integrated HIV Prevention and Care Plan Monitoring Activities

Date	Lead Parties	Monitoring Activities
April	MDH and other agencies	Pull together reports on data and submit to lead monitoring groups
May	Needs Assessment Committee	Reviews data re: Goal 1 and 2 and prepares a report on results to go to the PAC
May	DEC	Reviews data re: Goal 3 and prepares a report on results to go to the PAC
May	Grantees	Review Goal 4 and prepares a report on results to go to the PAC
May	PAC	Meets to review reports on Goals 1-4 and prepares a final report to go to the Council
June	Council	Reviews PAC report on progress made on Goals 1-4
September	MDH and PAC	Evaluate services against the MN Care Continuum for that year and prepare report for Council

Date	Lead Parties	Monitoring Activities
September	Council	Reviews report on MN Care Continuum
Ongoing	All	Provide updates to Council as needed

Plan to Monitor and Evaluate Implementation of the Goals and SMART Objectives (Section III: b.)

Timeframe	Objectives	Measure(s)	Activities	Monitoring Plan	Due Dates	Responsible Parties
By 2/28/21	1.1 Increase from 86% (current CDC estimate) to 90% (NHAS) of individuals living with HIV in TGA & MN aware of HIV status. 1.2 Increase by 60% access and utilization of PrEP (bio-medical interventions) at MDH funded organizations (baseline to be determined in 2017.) 1.3 Increase by 60% access and utilization of PrEP (bio-medical interventions) to African American communities at MDH funded organizations (baseline to be determined in 2017.)	1.1 Estimated HIV prevalence and undiagnosed HIV infection in eHARS data. 1.2 Percent of individuals eligible for PrEP & PEP as determined by MDH funded organizations that utilize PrEP or PEP using program database (TBD). 1.3 Percent of three-year average incident count of African-Americans, Latinos,	1.1a Fund targeted testing & counseling & linkage to care services. 1.1b Provide capacity building and evaluation around high impact prevention. 1.2a Fund Pre-Exposure Prophylaxis (PrEP) services. 1.2b Fund service that will increase PrEP community awareness and utilization. 1.3 Fund service that will increase PrEP amongst African American community awareness and utilization. 1.4a Fund services that provide harm reduction and syringe exchange.	1.1a- 1.6b. PAC reviews prioritization and allocations results. Needs Assessment & Evaluation assess progress through Service Area Reviews. 1.1b MDH provides capacity building and evaluation around high impact prevention. PAC assess progress.	2/28/2017 2/28/2018 2/28/2019 2/28/2020 2/28/2021	PAC, NA&E and The Council

Timeframe	Objectives	Measure(s)	Activities	Monitoring Plan	Due Dates	Responsible Parties
	1.4 Increase by 20% utilization of MDH funded harm reduction and syringe exchange activities (baseline to be determined in 2017.) 1.5 Decrease by 20% new infections within each of the following populations: African American, African-born, Latinos and their subpopulations (MSM, transgender, and women). These populations experience disparities due to culture and stigma. (Baseline to be determined in 2018.) 1.6 Increase by 20% the number of African American, African-born, Latinos and the subpopulations	African-born, MSM, young MSM and MSM of color HIV cases in eHARS data. 1.4 Number of individuals utilizing MDH funded harm reduction and syringe exchange services using reporting data. 1.5 and 1.6 Number of African American, African-born, Latinos and the subpopulations (MSM, transgender, and women). These populations experience	1.4b Fund prevention case management for high risk individuals. 1.5 Fund testing and counseling services that target African American, African-born, Latinos and the subpopulations (MSM, transgender, and women). These populations experience disparities due to culture and related stigma. 1.6a Fund CTR and EIS services that focus African American, African-born, Latinos and the subpopulations (MSM, transgender, and women), These populations experience disparities due to cultural and identify related stigma.			

Timeframe	Objectives	Measure(s)	Activities	Monitoring Plan	Due Dates	Responsible Parties
	(MSM, transgender, and women) These populations experience disparities due to culture and stigma) getting tested through MDH and RW funded organizations (Baseline to be determined in 2018.)	disparities due to culture and identity related stigma. MDH and RW funded agencies will use reporting data, including eHARS data.	1.6b Fund services which "scale-up" programs & targeted services that promote testing of African American, African-born, Latinos and the subpopulations (MSM, transgender, and women). These populations experience disparities due to cultural and identify related stigma.			
By 2/28/21	2.1 Increase to 85% the proportion of individuals who attend a HIV medical care visit within 30 days (linked to care) of HIV diagnosis. 2.2 Increase to 90% the proportion of individuals living with HIV and retained in care. 2.3 Increase to 80% the proportion of individuals living with HIV w/viral	2.1–2.4 Based on reported data.	2.1-2.4 2.1-2.4 Fund services that link individuals living with HIV to care within 30 days of diagnosis to achieve retention and viral suppression. Services include but are not limited to: • Medical case management, • Mental health, • Outpatient ambulatory care • Substance abuse treatment outpatient • EIS • Medical Transportation • Medical Nutrition Therapy • Housing	2.1. - 2.4. PAC reviews prioritization and allocations results.	2/28/2017 2/28/2018 2/28/2019 2/28/2020 2/28/2021	PAC, NA&E and The Council

Timeframe	Objectives	Measure(s)	Activities	Monitoring Plan	Due Dates	Responsible Parties
	load of <200 copies/mL at last test in 12-month measurement period (viral suppression.) 2.4 Increase to 92% the proportion of Ryan White Outpatient Ambulatory Care (OAC) clients who are prescribed ART in the 12-month measurement period.		• Peer Navigators 2.1-2.4 Review policies and protocols (including standards of care, quality improvement plan, etc.,) to identify opportunities to update and revise current systems to more effectively respond to needs of the population being served. 2.1-2.4 Fund or support training to providers to increase/enhance their understanding, knowledge, and skills in assessing the needs of individuals living with or at risk of HIV, particularly for behavioral health.			
By 2/28/21	3.1 Increase to 90% the proportion of African Americans, African-born, and Hispanic RW clients retained in care.	3.1 CD4 or VL with the reporting period.	3.1a Fund services which provide culturally competent EIS and outreach services to hard-to-reach African Americans, African-born, and Hispanic clients including; high-risk heterosexuals, MSM, young MSM, and transgender	3.1- DEC and PAC reviews prioritization and allocations results. Needs Assessment & Evaluation assess progress through Service Area Reviews.	2/28/2017 2/28/2018 2/28/2019 2/28/2020 2/28/2021	3.1-3.5 DEC, PAC, and Council.

Timeframe	Objectives	Measure(s)	Activities	Monitoring Plan	Due Dates	Responsible Parties
			individuals who are unaware of their status and/or out of care. 3.1b Support African Americans, African-born and Hispanic women & their partners and MSM HIV advisory workgroups to ensure that the needs of the communities are understood and addressed. 3.1c Fund services that will address population specific needs, increase retention and improve treatment adherence. Services that support retention include: • Outpatient/Ambulatory Medical Care, • Medical Case Management, • Health Insurance Premium/Cost Share Assistance, • Mental Health Services, • Early Intervention Services, • Oral Health,	3.1b DEC and PAC review prioritization and allocations results and incorporation of workgroup recommendations into the Council decisions.		
	3.2 Increase to 92% the proportion of Ryan White OAC African American, African-born, and Hispanic clients who are prescribed ART in the 12-month measurement period. 3.3 Increase to 80% proportion of African American, African-born, and Hispanic	3.2 Percentage of clients who receive Part A funded OAC who are prescribed HIV/AIDS medications consistent with PHS Treatment Guidelines. 3.3 The percentage of clients who receive Ryan				

Timeframe	Objectives	Measure(s)	Activities	Monitoring Plan	Due Dates	Responsible Parties
	clients who achieve viral suppression. 3.4 Implement systems changes to improve engagement from African American, African-born, and Hispanic communities in community planning and program development.	White Part A funded OAC who have a viral load of <200. 3.4a The percentage of participants from African American, African-born, and Latino communities that rate their involvement in planning and development activities favorably. 3.4b The Council membership will reflective goals based on representative of the epidemic	• Substance Abuse Services (Outpatient), • Medical Nutritional Therapy, • Home & Community-Based Health Services, • Housing Services, • Medical Transportation, • Emergency Financial Assistance, • Food Bank/Home Delivered Meals, • Non-MCM, • Psychosocial Support, • Outreach, • Health Education/Risk Reduction, • Resource and Referral, • Legal Services, and • Linguistic Services. 3.2 Fund services that will address the population specific needs of African			

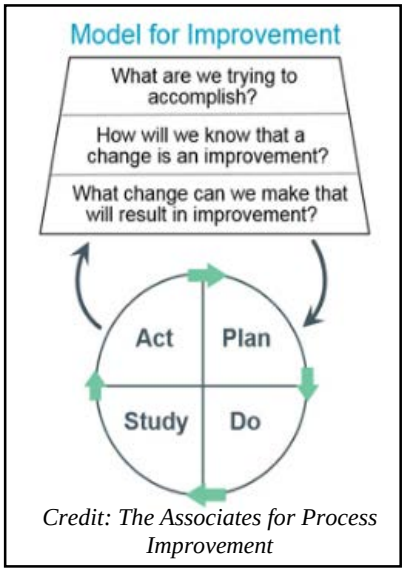
Timeframe	Objectives	Measure(s)	Activities	Monitoring Plan	Due Dates	Responsible Parties
		(include disproportionately affected subpopulations).	Americans, African-born, and Hispanic clients; and prescribe & educate clients about ART including: • ADAP, • Outpatient/Ambulatory Care, • Medical Case Management (Treatment Adherence), and • Non-MCM. 3.3 Fund services that provides culturally competent health education around the importance of treatment and treatment adherence that will support viral suppression, including: • ADAP, • Outpatient Ambulatory Care, • MCM (Treatment Adherence), and • Health Education/Risk Reduction. 3.4a Support African American, African-born, and			

Timeframe	Objectives	Measure(s)	Activities	Monitoring Plan	Due Dates	Responsible Parties
			Latino/a workgroups and Council members to address population and sub-population social and cultural needs as they relate to HIV prevention and care services. 3.4b Improve recruitment and retention efforts of African American, African-born, and Latino/a participants on the Council 3.4c Evaluate satisfaction of participants' involvement on the Council and other supported workgroups and committees.			
By 2/28/21	4.1 Increase coordination of HIV programs across state, local, and tribal government agencies, and the Council so that planning for	4.1a Percentage of Council members who report receiving timely epi, service utilization, and	4.1a Search for opportunities to integrate HIV testing/awareness with other health disparities groups/programs/activities such as the Center for Health Equity (OHE) at MDH.	4.1-.4.3. PAC reviews develops and implement a Council Survey and monitor progress.	2/28/2017 2/28/2018 2/28/2019 2/28/2020 2/28/2021	4.1-4.3 PAC, Council, and Grantees (DHS, MDH and HC)

Timeframe	Objectives	Measure(s)	Activities	Monitoring Plan	Due Dates	Responsible Parties
	funded services are completed in a timely manner. 4.2 Develop and improve mechanisms to monitor and report on progress towards achieving goals so that all goals can be measured.	other needed available data to make evidence based decisions. 4.1b Percentage of Council members who report being satisfied with their involvement in development of the statewide strategy as defined by MDH. 4.2 Percent of Council members who report being satisfied with mechanisms to monitor and report on progress towards achieving goals.	4.1b Search for opportunities to collaborate with partners, including but not limited to MDH's CareLink, Partner Counseling & Referral Services, Syphilis, and HC Public Health Clinic elimination programs to provide an enhanced system to connect newly diagnosed individuals to core medical & support services. 4.2a Collaborate with state agencies/partners to obtain race categorization data along the HIV Care Continuum from the MDH Surveillance Unit on ages broken down into finer categories to better assess the needs of adolescents and young adults. 4.2b HC, MDH, DHS will integrate surveillance data with CARE Ware.			

Timeframe	Objectives	Measure(s)	Activities	Monitoring Plan	Due Dates	Responsible Parties
			4.2c MDH will explore the possibility of linking evaluation web data to surveillance data. 4.2d MDH will provide HIV reports to the Council as requested to include all combinations of variables such as: age, gender, race/ethnicity, and exposure categories.			

Strategy to Utilize Surveillane and Program Data to Assess and Improve Health Outcome Along the HIV Care Continuum (Section III. c.)



Credit: The Associates for Process Improvement

Underpinning the strategy to improve the quality of HIV services and health outcomes for people living with HIV/AIDS is to continuously improve data collection, analysis, and use to drive evidence-based decisions and to draw into relief areas of needed focus. In line with public health in general and Ryan White performance and quality management in specific, the Model for Improvement with Plan-Do-Study-Act (PDSA) by The Associates for Process Improvement Cycle will be utilized as a framework for making sense of data and using data to improve outcomes in the HIV care continuum and quality of HIV service delivery. The Model for Improvement is the structure by which this plan's strategy data use is based.

Broadly, the goals of this plan are to reduce HIV incidence, improve health outcomes for all people living with HIV/AIDS and the quality of care they receive throughout the jurisdictions. Specifically, how progress will be made toward these large goals is reflected in the Monitoring Plan in Section III b. Some of the measures identified in the monitoring plan track progress on outcomes or efficacy of the work while others track effort taken to achieve the desired outcomes or efficiency of the work. HIV surveillance data from the MDH's Enhanced HIV/AIDS Reporting System provides the key indicator data to measure RWHAP client outcomes along the Care Continuum with CD4 and viral load values serving as surrogates of retention in care based on periodicity of these lab tests. Viral loads also provide the measure of ultimate arrival at optimal health for PLWH who have successfully moved through the Care Continuum. Monitoring of HIV health outcomes will drive quality improvement projects to improve both Minnesota's and the MSP-TGA's HIV Care Continua.

Paramount to tracking progress is the quality, accuracy, and timeliness of data collection and monitoring. Steps are being taken to improve consistency, efficiency, and common understanding of data collection. Regular analysis of measures using HIV surveillance, HIV testing and RWHAP client-level by the State's HIV epidemiologists and RWHAP quality management and data coordination staff help identify where progress is being made and what areas need greater attention. These staff will report the results of data analysis to the Integrated Plan stakeholders responsible for monitoring the plan. They will then help make sense as to where progress is being made, and what changes, activities, or interventions are helping achieve the plan's goals effectively and efficiently. From this analysis, stakeholders will be able to identify what changes result in the greatest improvements most effectively and use this knowledge to plan further work.

Data alone will not lead to better outcomes for people living with HIV/AIDS in the jurisdictions but it will highlight what is working, what is not, and where focus is needed. First, a process for assuring that the data is truly illuminating what it is intended to, must be in place. The data will be verified through quality assurance practices including monitoring of completeness of both surveillance and client-level services data reporting, file reviews and audits. The plan's responsible parties work collaboratively as members of the RWHAP Client

Level Data workgroup to continuously improve the accuracy, accessibility, and timeliness of data that will help monitor progress. Secondly, data will be contextualized by comparing historical performance and peer performance across the country. Thirdly, targets will be set annually or semi-annually distilled from the plan's objectives by the Council, a Council sub-committee, or related workgroup that will then share targets with the Council. In instances where targets may be set for overall aggregate performance such as 80% of all people living with HIV/AIDS will be virally suppressed, data will be disaggregated to identify if there are disparities in outcomes achieved by disproportionately affected populations. Equipped with baseline data, current performance and the Integrated Plan activities under each objective, the plan's responsible parties can draft, check, and revise strategies to garner the greatest improvements most efficiently. This strategy will be take place on an inter-recipient level, a recipient level, and a sub-recipient level. Collaboration and alignment will occur through all levels of plan implementation.

The PDSA cycle begins with a hypothesis that specific actions will lead to a desired effect. This plan identifies in detail activities thought to bring about the greatest improvements towards desired objectives. The plan also identifies measures by which to monitor how well these activities are helping achieve those objectives. Through the Study or Check process of monitoring progress of activities outlined in Section III b coupled with the context of historical performance, evidence-based practices, and other influencing variables, the plan's responsible parties will be able to identify what activities are working, if they are not working why are they not working, and what to do next. As a PDSA cycle concludes, lessons learned will be documented and incorporated into implementing this plan for improved outcomes among people living with HIV in the relevant jurisdictions.

Integrated HIV Prevention and Care Plan Attachments

Attachment A: Population Density, By County

Attachment B: HIV/AIDS Service Providers, and Persons Living with HIV/AIDS per Square Mile.

Attachment C: Minnesota Council for HIV/AIDS Care and Prevention (Council) Description

Attachment D: Comparison of 2010 and 2015 Consumer Needs Assessment

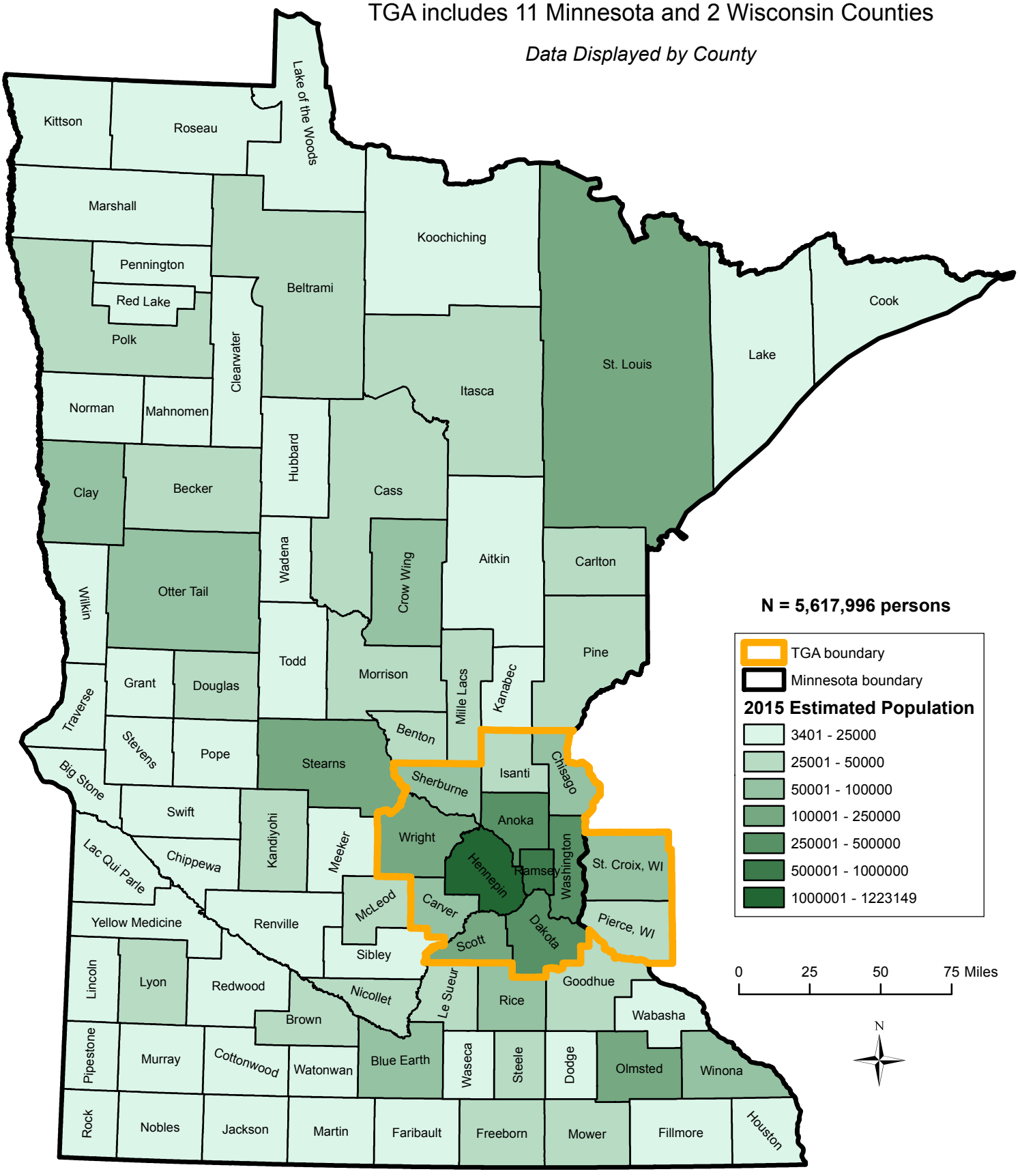
Attachment E: Council Membership Breakdown

Attachment F: Council Letter of Concurrence. Additional Letters of Concurrence include Minnesota Department of Health, Minnesota Department of Human Services, and Hennepin County Public Health.

Attachment A: Estimated 2015 Population by County for Minnesota and TGA

TGA includes 11 Minnesota and 2 Wisconsin Counties

Data Displayed by County



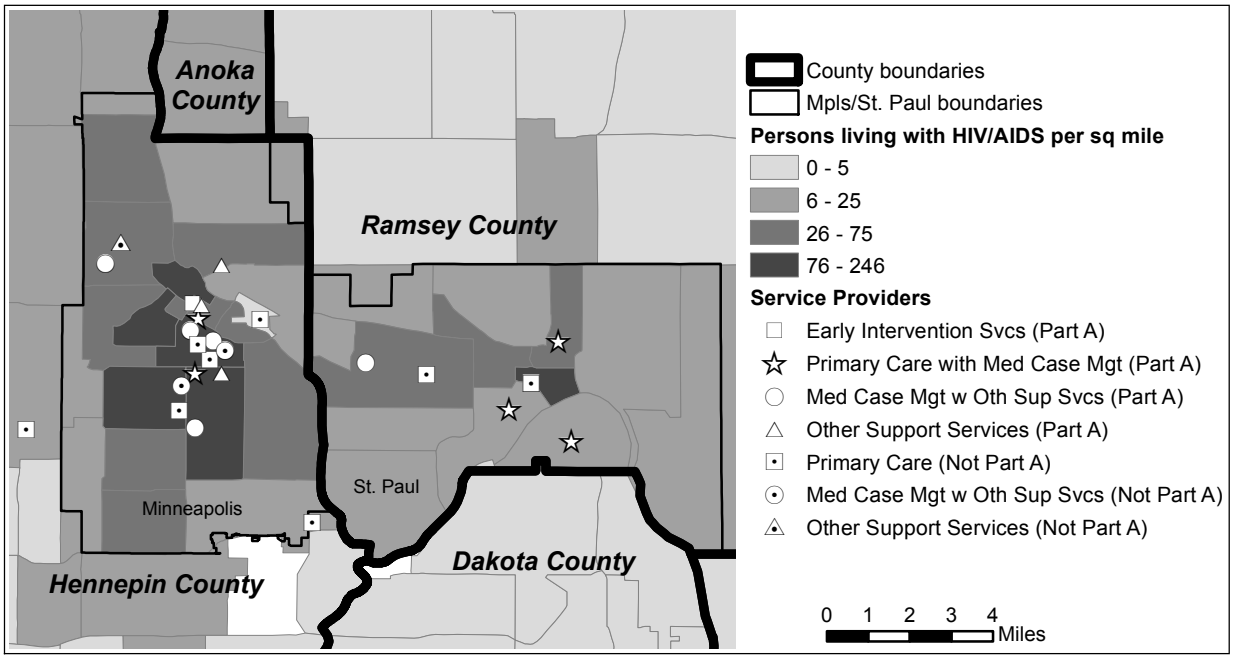
Source: U.S. Census Bureau, 9/2016
Prepared by: Hennepin County HSPHD ITRM / IPA_TJZ_09/20/2016
Estimated Population by County_2015_Ryan White TGA

HIV/AIDS Service Providers, and Persons Living With HIV/AIDS Per Square Mile
(as of 12/31/2014)

Ryan White HIV/AIDS Treatment Extension Act Part A

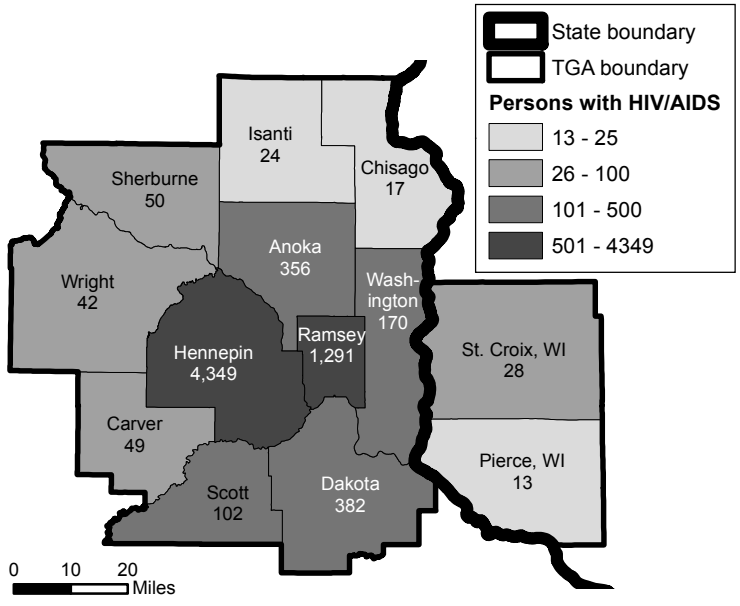
Minneapolis/St. Paul Transitional Grant Area

Data Aggregated and Displayed by ZIP Code



Persons Living With HIV/AIDS
(as of 12/31/2014) by County

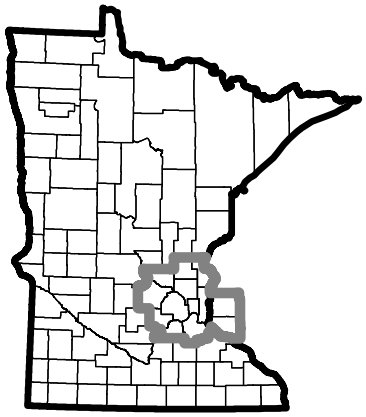
Minneapolis/St. Paul Transitional Grant Area



Minneapolis/St. Paul
Transitional Grant Area

Ryan White Part A

State of Minnesota



Source: Hennepin County HSPHD - Public Health, September 2015; Minnesota Dept of Health, September 2015

Prepared by: Hennepin County HSPHD ITRM / IPA_TJZ_10-15-2015

ryan white year 21.mxd

Attachment C

MN Council for HIV/AIDS Care and Prevention

Mission

The mission of the Minnesota Council for HIV/AIDS Care & Prevention is to:

- Establish priorities for the allocation of Part A and Part B funds of the federal Ryan White HIV/AIDS Treatment Extension Act of 2009 within the thirteen county Transitional Grant Area (TGA) and the state of Minnesota. In other words, the Council is responsible for deciding which services are most needed for people with HIV and how much funding will be used for each of those service areas.
- Develop and prepare the Integrated HIV Prevention and Care plan for the Minneapolis/St. Paul thirteen county TGA and the state of Minnesota. This plan defines short and long term goals for organizing and delivering HIV prevention and care services.
- Assure community participation in the gathering of information related to needs and service priorities.
- Assess the efficiency of the system the grantees use to distribute funds. This includes evaluating how quickly contracts with service providers are signed, how quickly the grantee pays the providers, whether the funds were used for services identified as priorities by the Council and whether all the funds were spent.
- Participate in developing a Statewide Coordinated Statement of Need (SCSN). Representatives of the Council must participate with representatives of all the other Parts of the legislation in developing a Coordinated Statement of Need. The purpose of the SCSN is to encourage all of the Ryan White programs to work together and to avoid the duplication of services.

Vision

The vision of the Minnesota Council for HIV/AIDS Care & Prevention is to extend and improve the quality of life for people living with and affected by HIV and AIDS in an accessible, fair, compassionate, flexible and efficient manner, regardless of age, gender, race, culture (including language), sexual orientation and means of transmission. This will be addressed through:

- Developing and evaluating an effective system for assessing current and emerging needs;
- Reviewing existing Council related systems and insuring that measures for accountability are included;
- Establishing funding priorities;
- Prioritizing target populations for focusing prevention resources;
- Building the capacity of all health and social service providers;
- Responding comprehensively through the coordination of prevention, HIV health and support services and housing;
- Advocating when appropriate regarding HIV related issues in the state of Minnesota and the TGA.

Principles

- We value cultural diversity, inclusion, parity, and expertise.
- We expect and will pursue diversity of membership.
- We are all advocates for reducing/preventing disease.

- We have a responsibility to bring forth voices from the communities we represent. These voices, along with data, drive overall priority prevention and service needs in the state.
- We are a community planning group, not a direct action or advocacy organization.

Integrated HIV Prevention and Care Plan

It is the responsibility of the Council to inform the development, update, and monitoring of the Minnesota Integrated HIV Prevention and Care Plan. This plan will facilitate the prevention, care and treatment of HIV; guide allocation of federal Ryan White funds for Part A for HIV treatment and care services; and help to make allocation recommendations for Part B HIV treatment and care services. All Council and Committee meetings are open to the public. The Council meets on the 2nd Tuesday of the month from 9 am-12 pm in the Health Services Building, room L15 in the lower level.

Additionally the Council's responsibilities include:

- Elect community co-chairs
- Identify and collaborate with appropriate stakeholders in HIV prevention and treatment planning.
- Engage in a planning, prioritization, allocation process that is results-oriented to ensure that the goals of the National HIV/AIDS strategy (NHAS) (i.e., reduce new HIV infections, increase access to care and to improve health outcomes for people living with HIV; and reduce HIV-related health disparities) are achieved.
- Conduct needs assessments.
- Prioritize target populations most at risk for HIV infection or transmission and co-factors that impact that risk.
- Establish service area priorities for funding, based on needs assessment.
- Allocate resources to service areas that have been prioritized.
- Evaluate the speed and efficiency of the disbursement of Part A and Part B funds.
- Inform, develop/update a comprehensive plan for the development, organization and delivery of HIV prevention and care services in collaboration with state and local service providers.
- Submit a letter of concurrence, concurrence with reservations, or non-concurrence to document whether or not the MDH's jurisdictional HIV prevention plan shows that programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas that bear the greatest burden of HIV disease.
- Ensure broad community involvement in all phases of operations and establishing community needs and priorities.
- Ensure membership structure achieves community and key stakeholder representation (parity and inclusion).
- Identify and include disproportionately affected populations in all phases of the planning process, and in Council leadership.
- Make decisions that are data-driven and informed by the understanding of: behavioral science, epidemiology, research and program evaluation; how to gather and apply appropriate community input to the planning process; broad community health issues that

impact HIV transmission and HIV/AIDS care; racism, sexism, homophobia, and other social determinants of health that create and maintain disparities in HIV/AIDS.

Community Voices Committee (CVC)
The Community Voices Committee provides a representative voice for persons living with HIV and those affected by HIV by reporting on issues and activities to the Minnesota Council for HIV/AIDS Care and Prevention and its committees. It also seeks out and maintains communication with groups who have an interest in the needs of and services for people living with HIV/AIDS but with barriers to participate in the Council. This committee meets on a quarterly schedule on the 3rd Tuesday of the month. Please check the Calendar of the website or contact Council staff for a listing of upcoming meeting dates.

Planning & Allocations Committee (PAC)
The Planning & Allocations Committee identifies service areas, designs the prioritization process and makes funding recommendations for Council review and approval. It also leads a long-term planning process resulting in Minnesota's Integrated HIV Prevention and Care Plan and develops Standards of Care for Ryan White funded services areas. Please check the Calendar or contact Council staff for a listing of upcoming meeting dates and locations.

Disparities Elimination Committee (DEC)
The Disparities Elimination Committee exists to develop strategies to ensure that the Council's priorities and resource allocations address and reduce disparities within underserved and disproportionately impacted populations in access to HIV prevention, care services and outcomes based on the stages of the HIV Care Continuum: awareness of diagnosis; linkage to care; retention in care; receiving ART; and achieving suppressed virus. Healthy People 2020 defines a health disparity as "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion." Please check the Calendar or contact Council staff for a listing of upcoming meeting dates and locations.

Needs Assessment & Evaluation (NA&E)
The Needs Assessment & Evaluation Committee identifies areas of unmet service needs through various research methods. It also evaluates service areas and monitors epidemiological data. This process allows the Council to make decisions based on data. This committee meets on the 4th Tuesday of each month from 9-11:30 am in the Health Services Building.

Membership & Training Committee (M&TC)
The Membership & Training Committee develops guidelines and Council operating procedures and assures and encourages broad representation from affected communities and unaligned consumer participation and engagement. They help to identify, recruit, nominate and train new

members and maintain a communications plan for the Council. This committee meets on the 3rd Friday of each month from 10 am-12 pm in the Health Services Building, 3rd floor, room 313.

Executive Committee
The Executive Committee is made up of the Minnesota Council for HIV/AIDS Care and Prevention co-chairs, the co-chairs of each standing committee, the co-chair(s) of any ad hoc committees and the Parliamentarian. The Executive Committee reviews the recommendations of standing and ad hoc committees and may return them to the drafting committee for alteration, forward them to the full Minnesota Council for HIV/AIDS Care and Prevention for action with support, or forward them without recommendation or comment. This committee meets on the 1st Tuesday of each month from 1-3 pm in the Health Services Building, 9th floor, room 917.

Grievance Committee
The Grievance Committee considers and takes action regarding grievances related to the priority setting process, including the needs assessment process, the comprehensive planning process, the allocation of funds to service categories, compliance with the nominations process and issues of conflict of interest. This committee meets on an as-needed basis.
Make a difference and be a leader in Minnesota's effort to end the HIV epidemic. By joining the Minnesota Council for HIV/AIDS Care and Prevention you will help decide how money is used to provide prevention and care services for people living with HIV/AIDS or at high risk for acquiring HIV.

Membership Requirements - Each member is expected to:

1. Serve a term of two (2) years; one (1) subsequent term is allowed contingent upon reappointment*;
2. Attend monthly meetings and serve on at least one (1) standing committee;
3. Commit to a minimum of 5-8 hours per month to MN Council for HIV/AIDS Care and Prevention business including attendance at full MN Council for HIV/AIDS Care and Prevention meetings, committee meetings and preparation time;
4. Attend new member orientation before being allowed to vote on issues under consideration by the MN Council for HIV/AIDS Care and Prevention or their committee, and participate in other training opportunities as appropriate. This stipulation applies to those newly elected to the MN Council for HIV/AIDS Care and Prevention and those who are returning after sitting out the requisite year before reapplication/reappointment.
5. Participate fully in all responsibilities as mandated by federal legislation, including but not limited to the following:
    - Comprehensive planning and other planning processes and review relevant reports;
    - Needs assessment activity and review relevant reports;
    - Prioritization process and complete the prioritization instrument;
    - Allocation and reallocation of resources;
    - Evaluation of the administrative mechanism.

* Half of the initial MN Council for HIV/AIDS Care and Prevention members will be appointed for a one-year term and half for a two-year term. This will ensure staggering to make sure that there is continuity of knowledge. Thereafter, members may be re-appointed to a second two-year term, but no member shall serve more than two (2) consecutive terms. Members who were initially appointed to serve for a one year term may be reappointed for a two year second term.

Membership Options

MN Council for HIV/AIDS Care and Prevention Membership
Council members commit to two-year terms during which they prepare for and attend monthly Council meetings. These meetings occur on the second Tuesday of each month from 9 am-12 pm. The Council operates through a committee structure and being a member means attending monthly Council meetings in addition to participating in at least one committee. Committees meet once a month for two to three hours either monthly or quarterly.

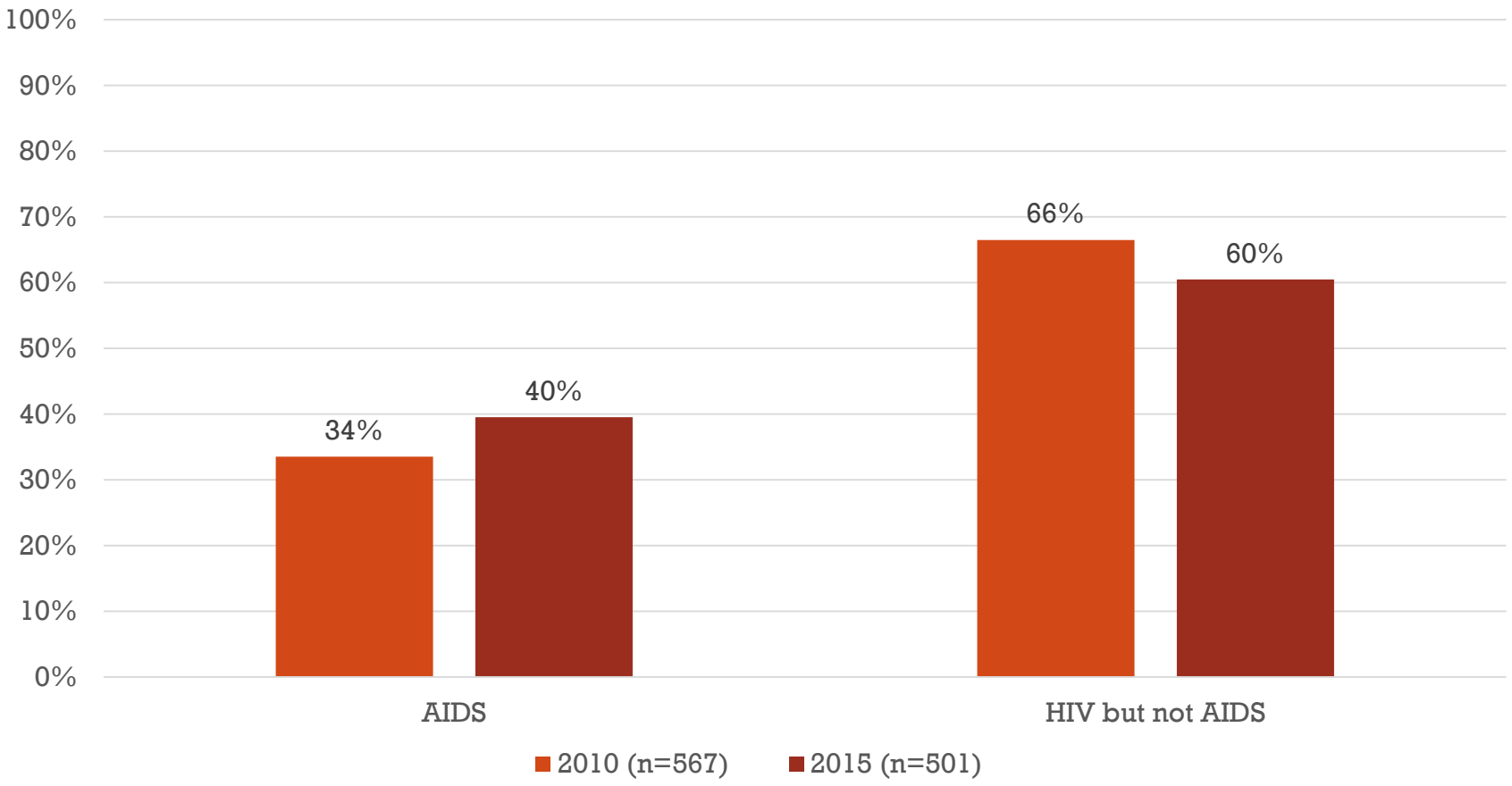
Community Membership
There is an alternative to full Council membership. The Community Membership option offers participants who wish to participate on the committee level to become a community member for any committee. Once they have satisfied the committee's eligibility requirements, they are eligible to vote on issues brought before the committee. Community members may also attend full Council meetings but voting privileges are limited to their committee.

COMPREHENSIVE NEEDS ASSESSMENT OF MINNESOTANS LIVING WITH HIV DISEASE

2010 vs. 2015

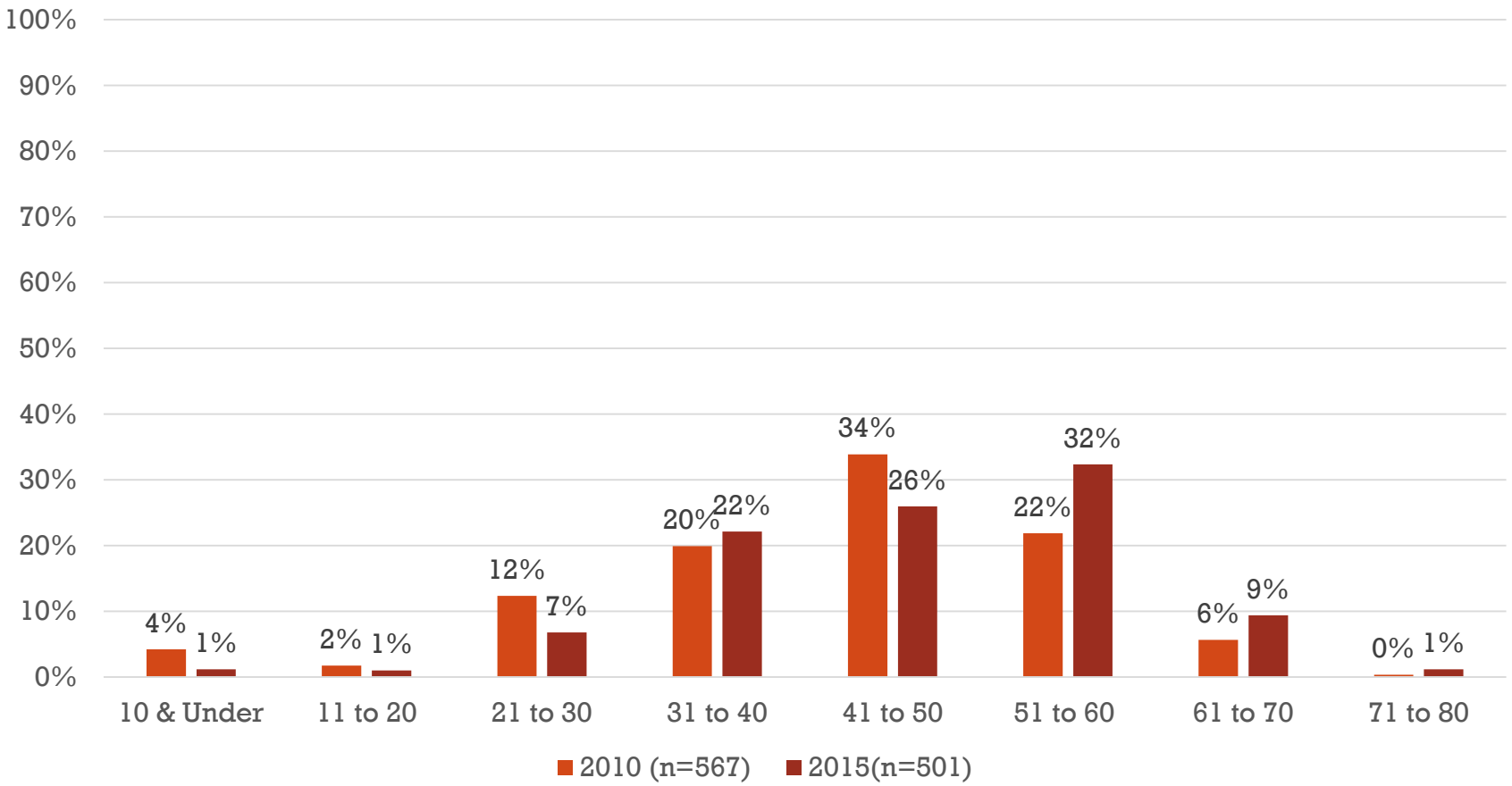
Attachment D

DIAGNOSIS



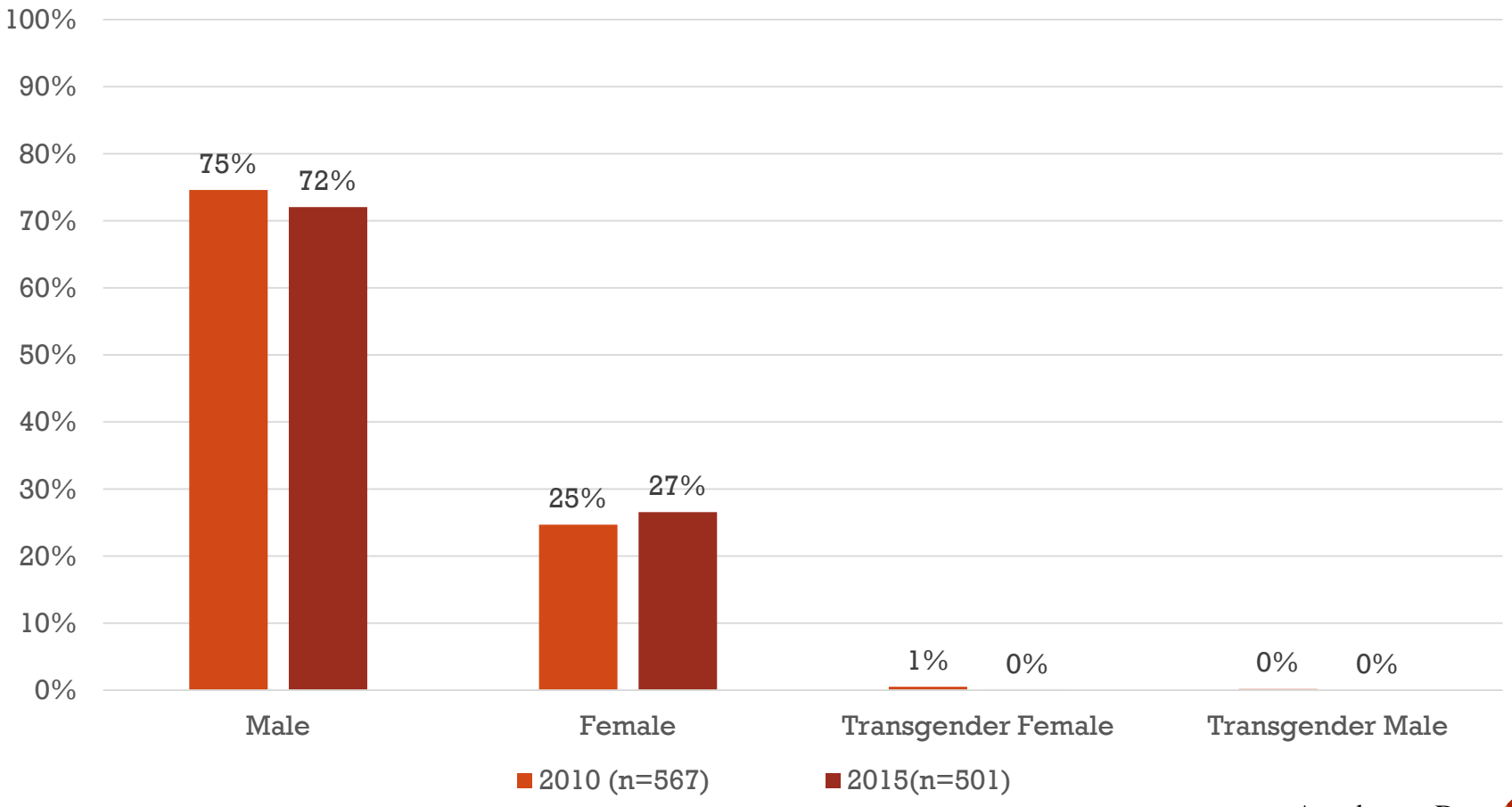
Attachment D

AGE



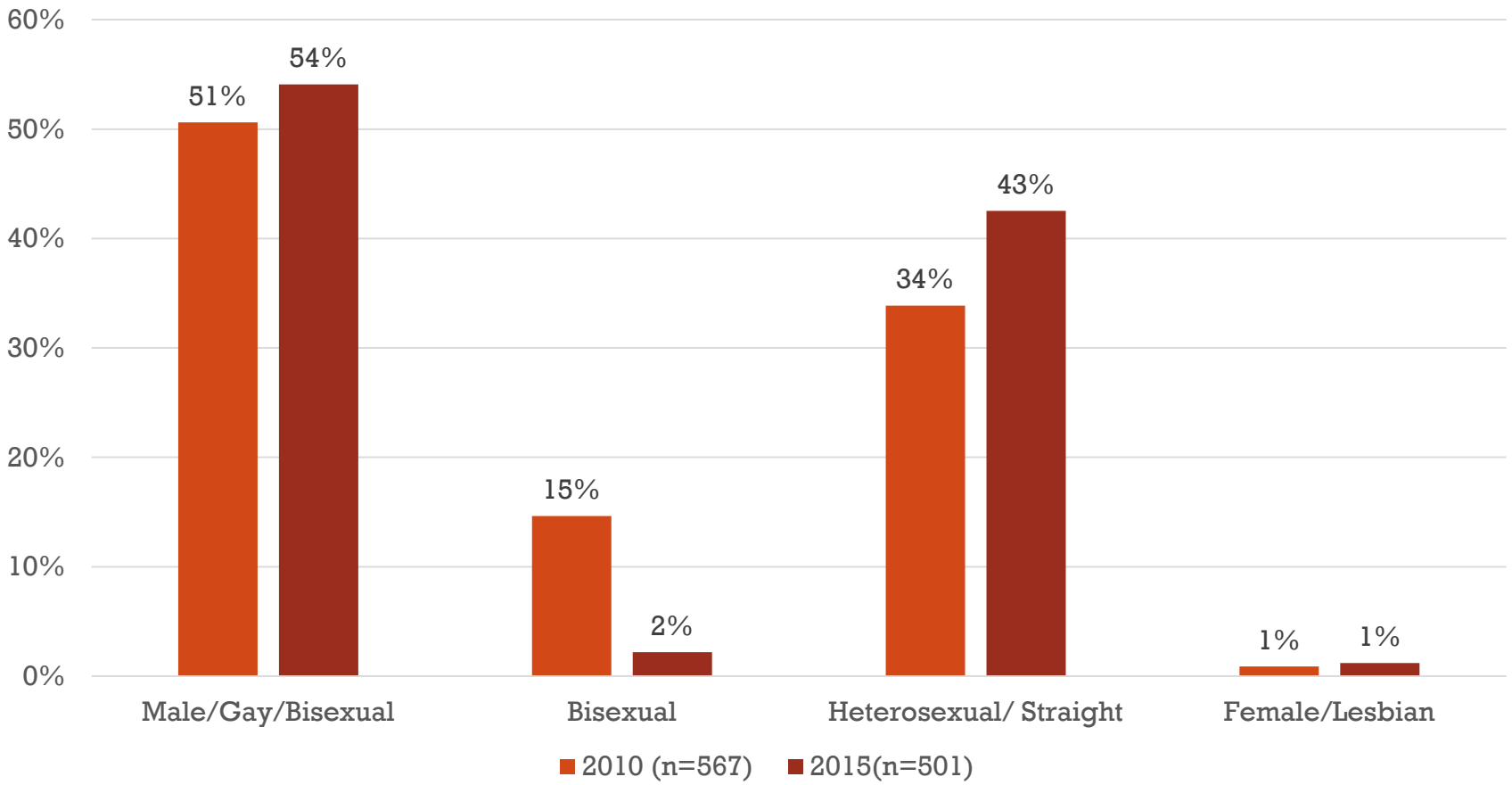
Attachment D

GENDER



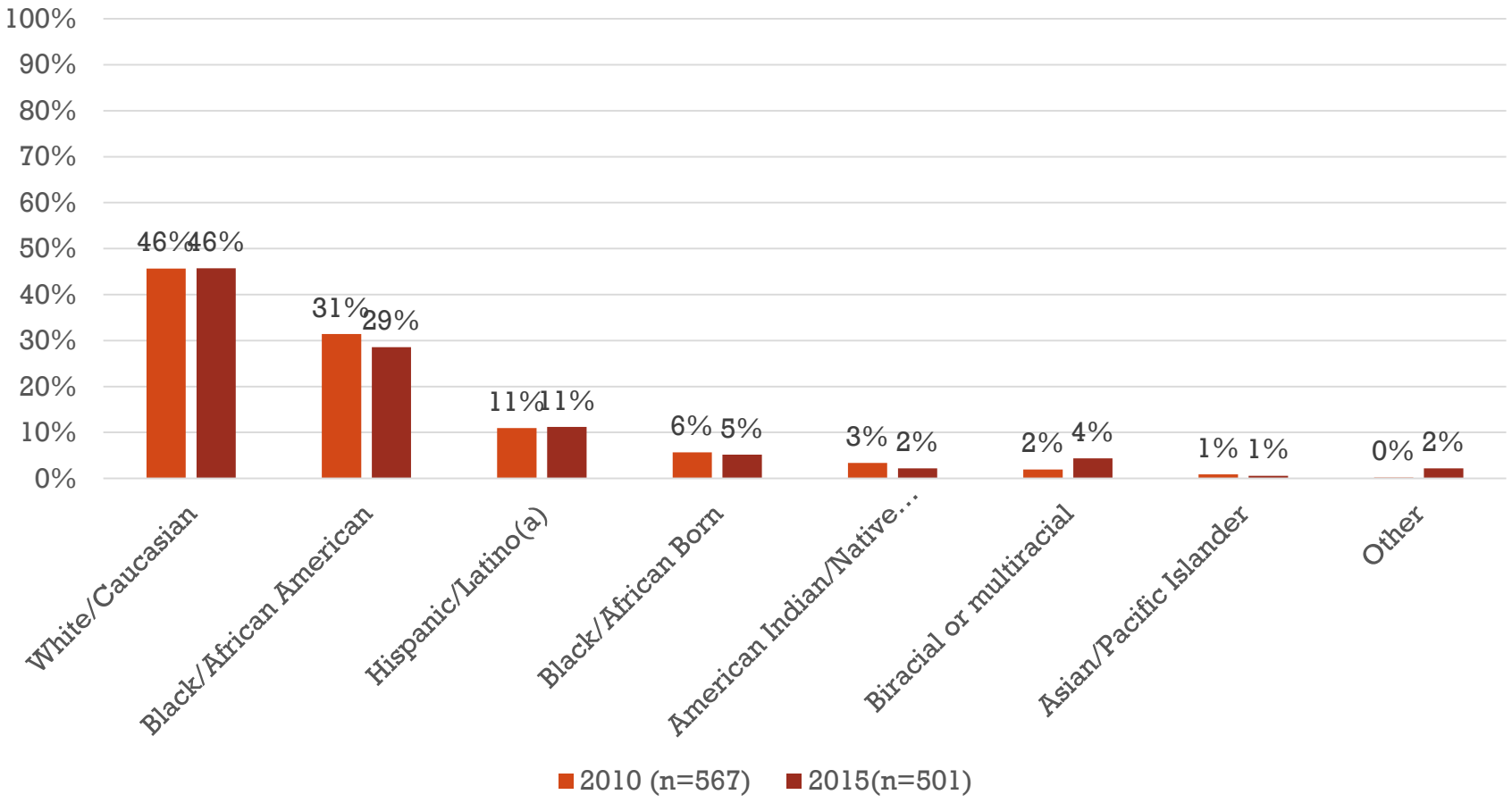
Attachment D

SEXUAL IDENTITY



Attachment D

RACE/ETHNICITY*



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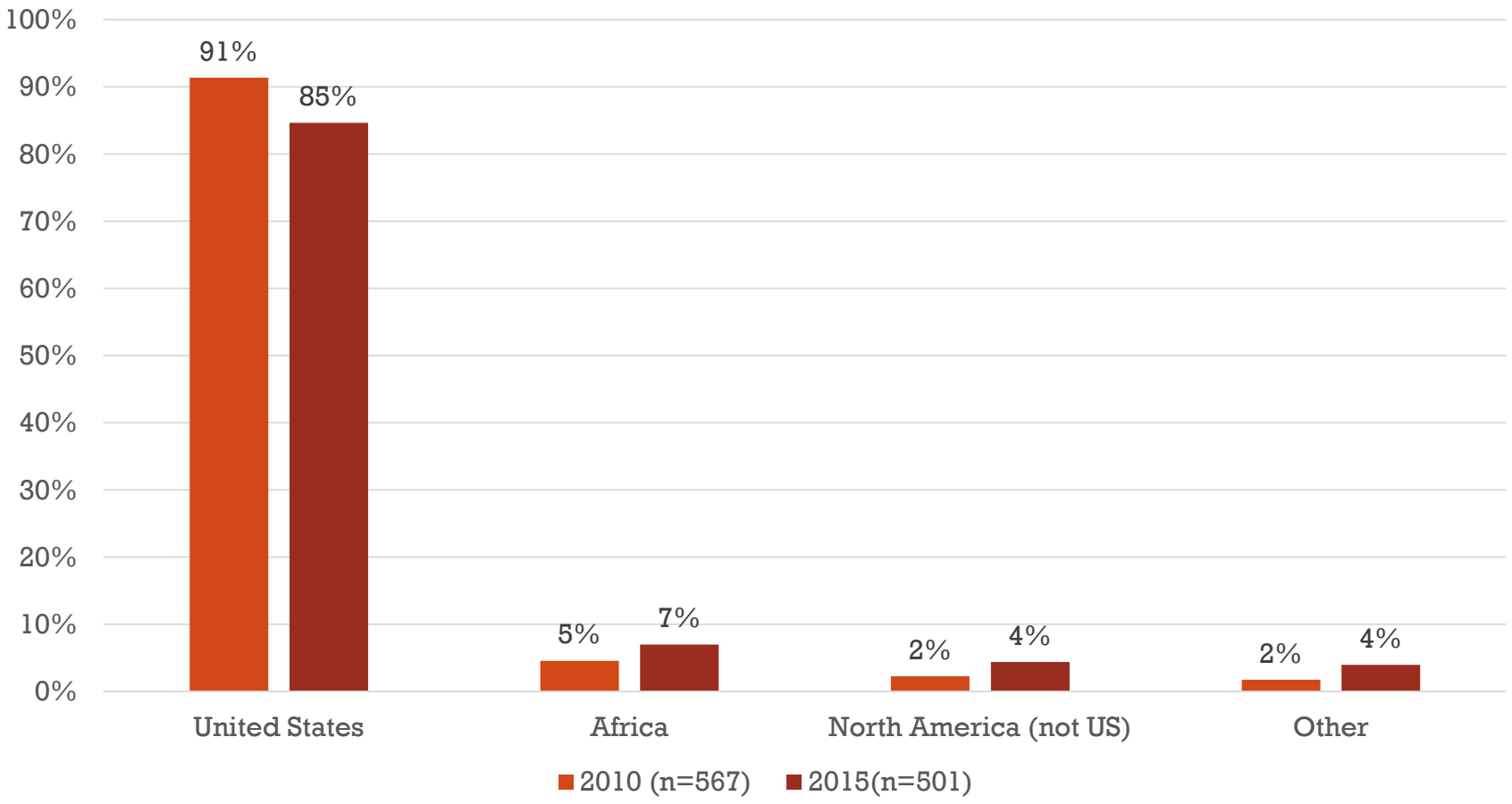
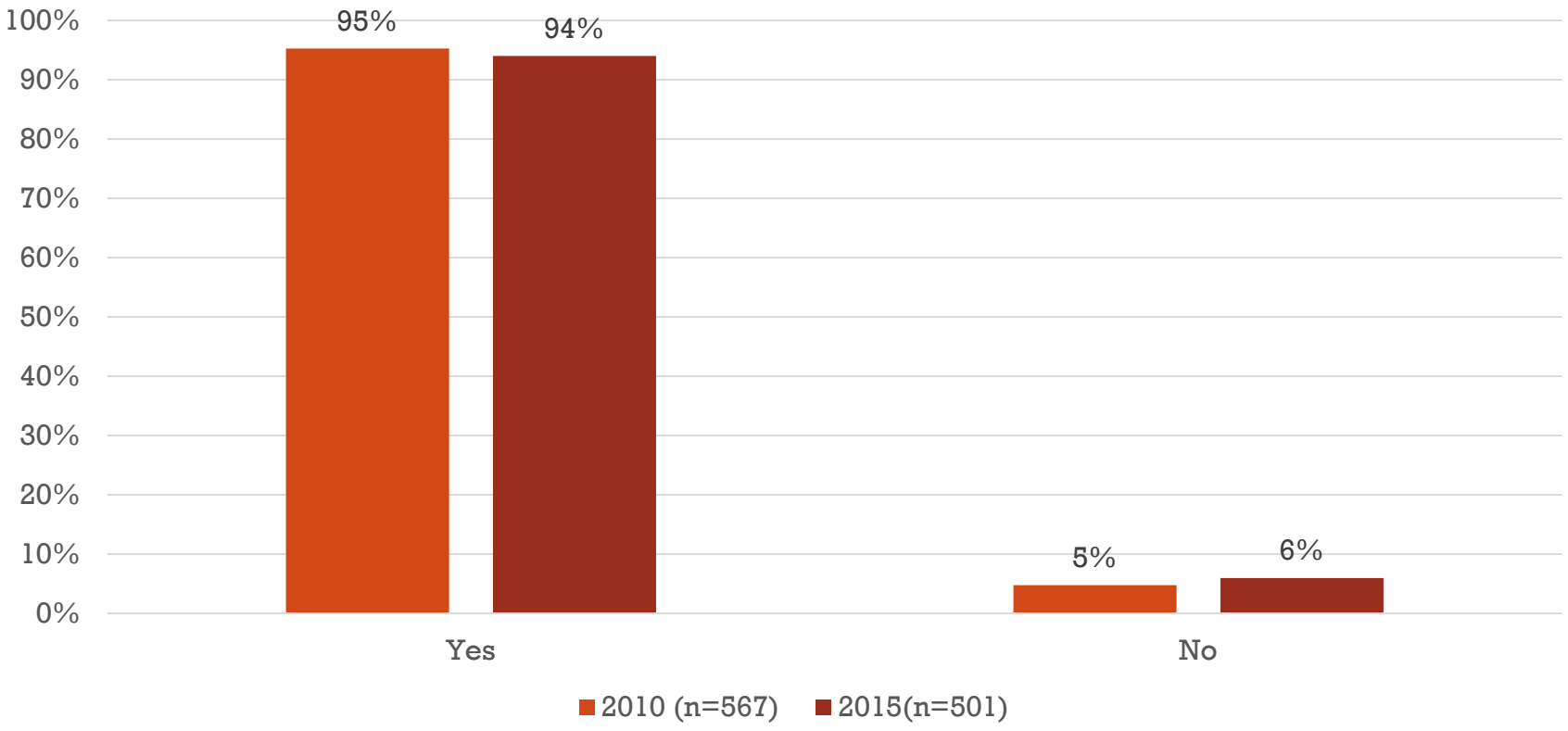
COUNTRY OF BIRTH



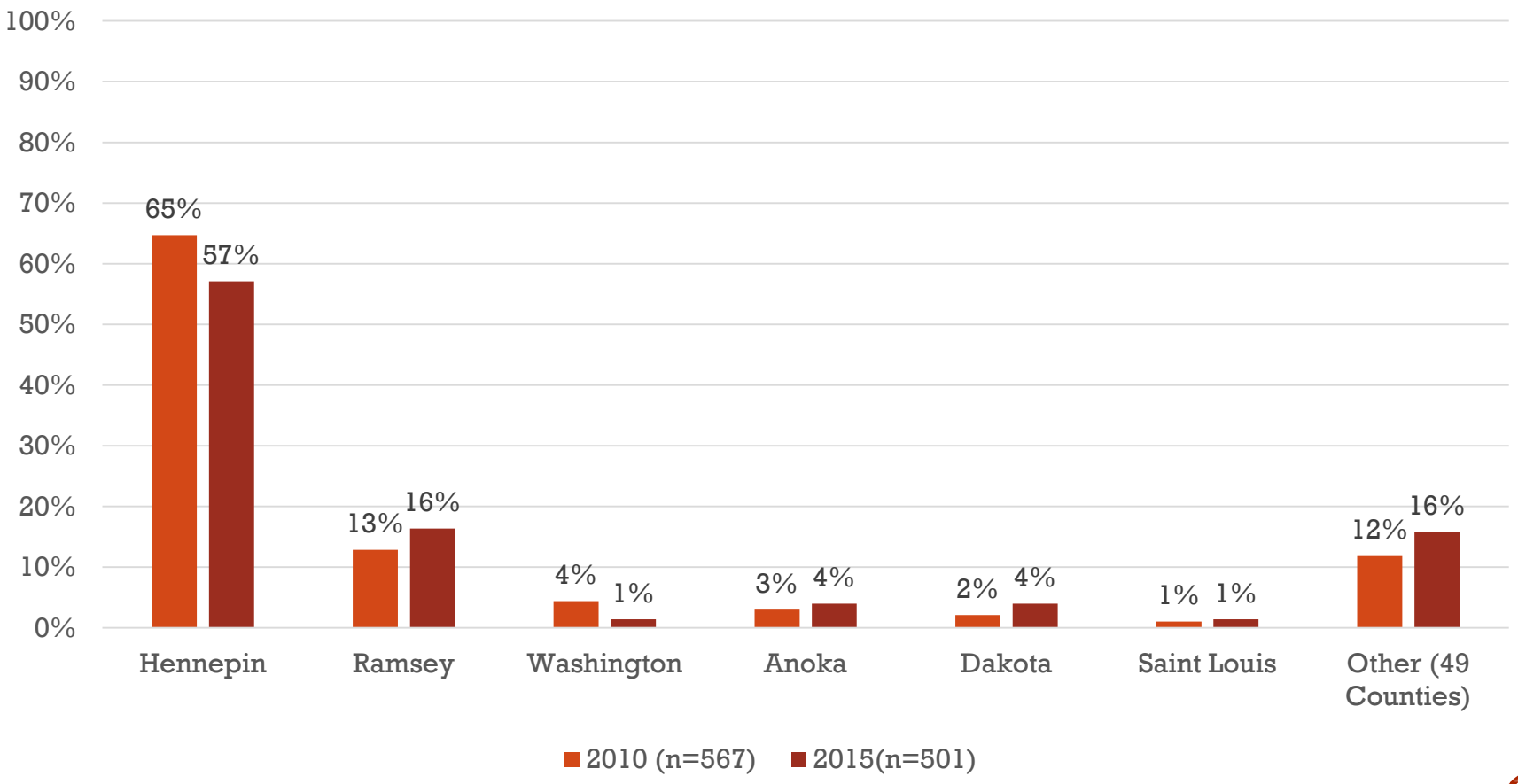
Attachment D

COMFORTABLE SPEAKING ENGLISH



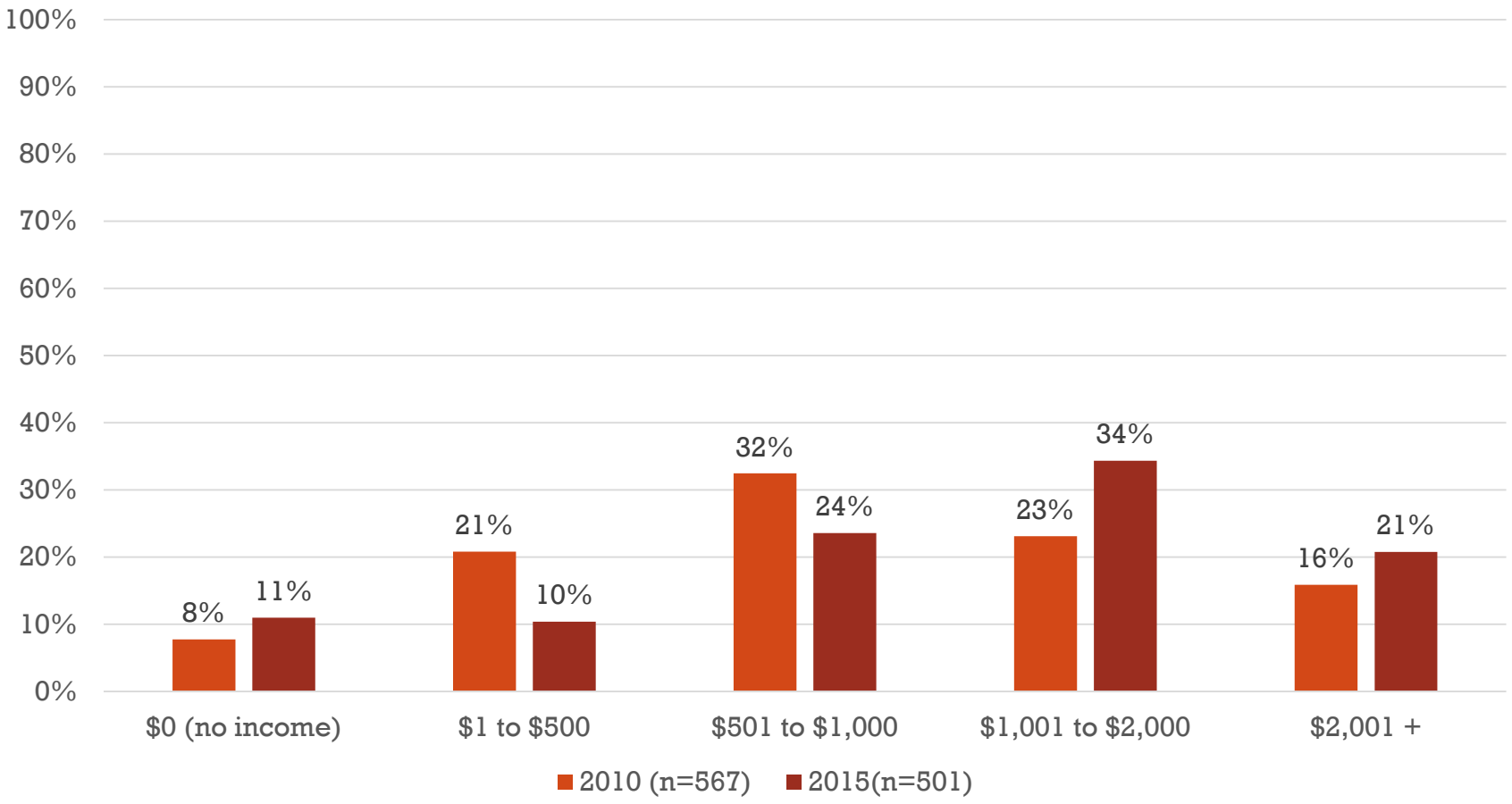
Attachment D

COUNTY CURRENTLY LIVING



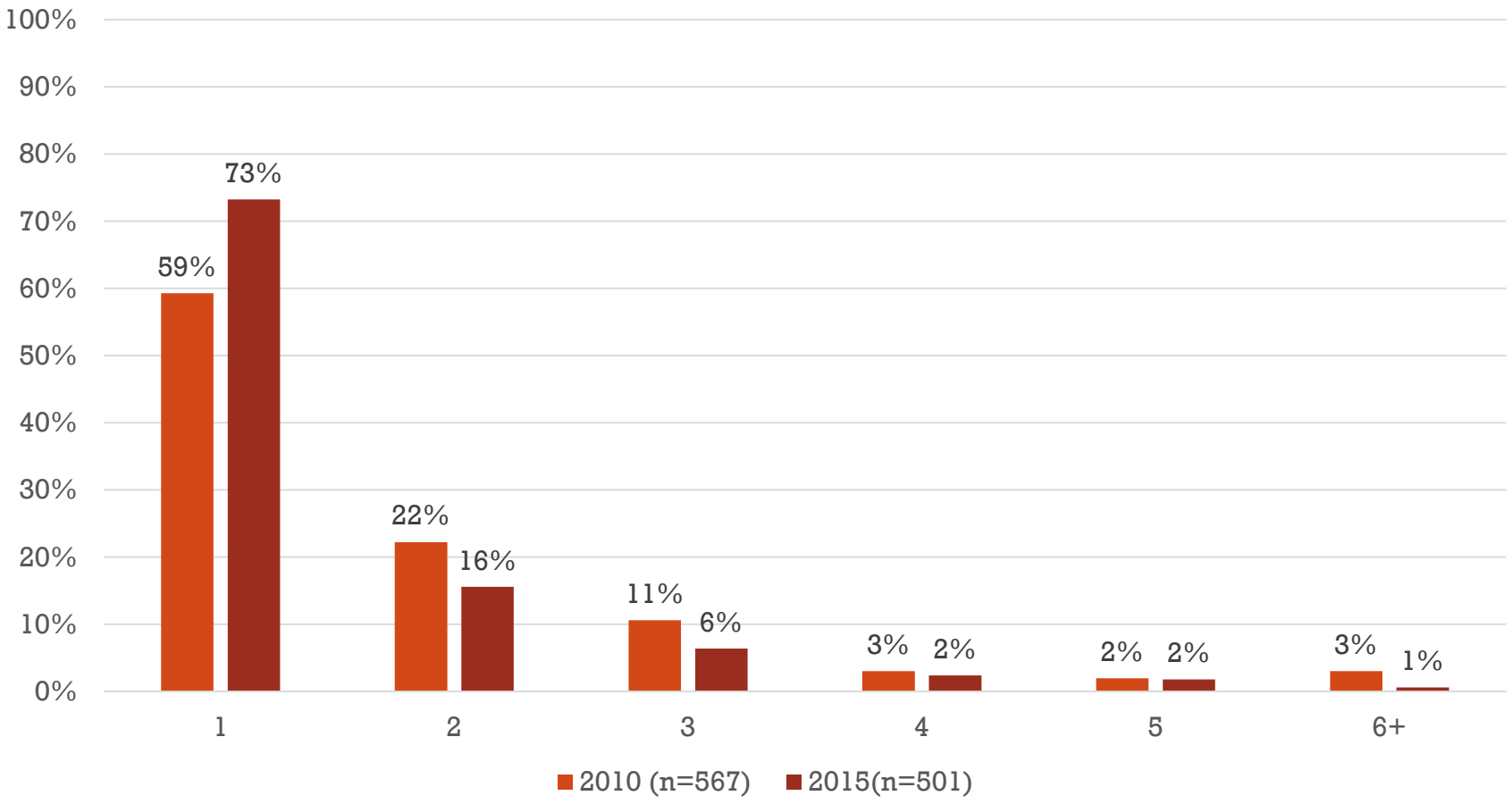
Attachment D

MONTHLY INCOME



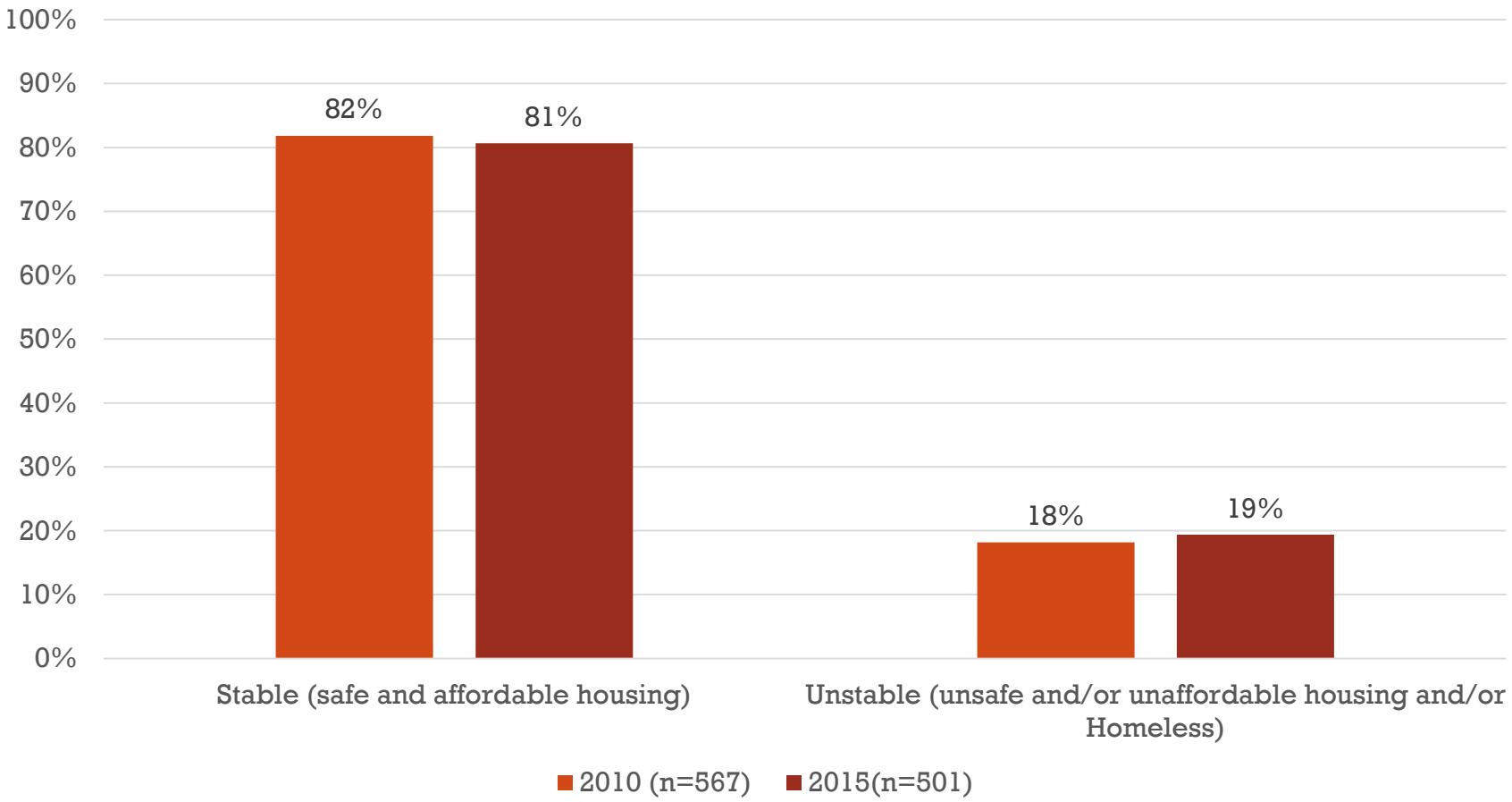
Attachment D

INDIVIDUALS DEPENDING ON MONTHLY INCOME



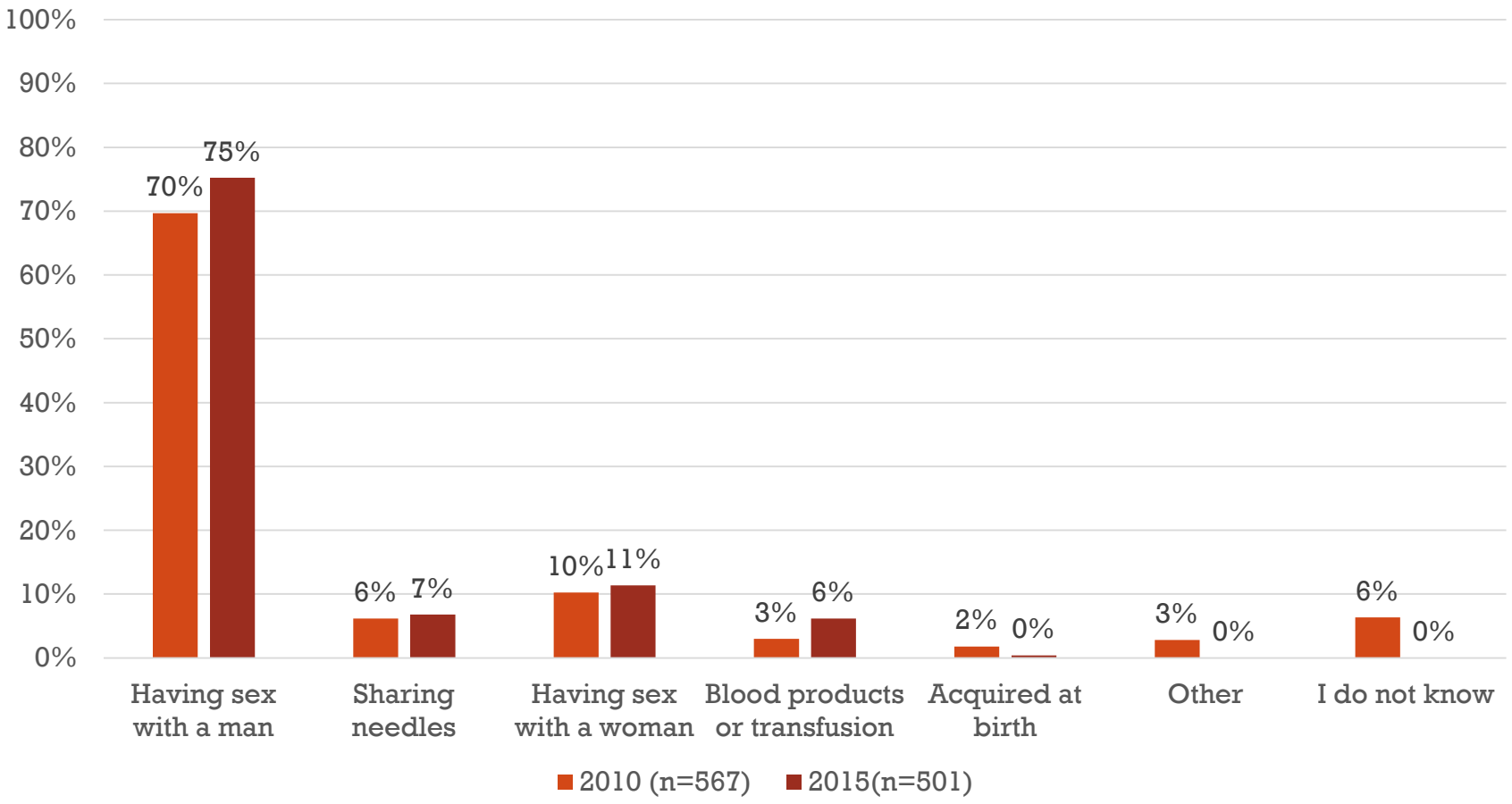
Attachment D

HOUSING



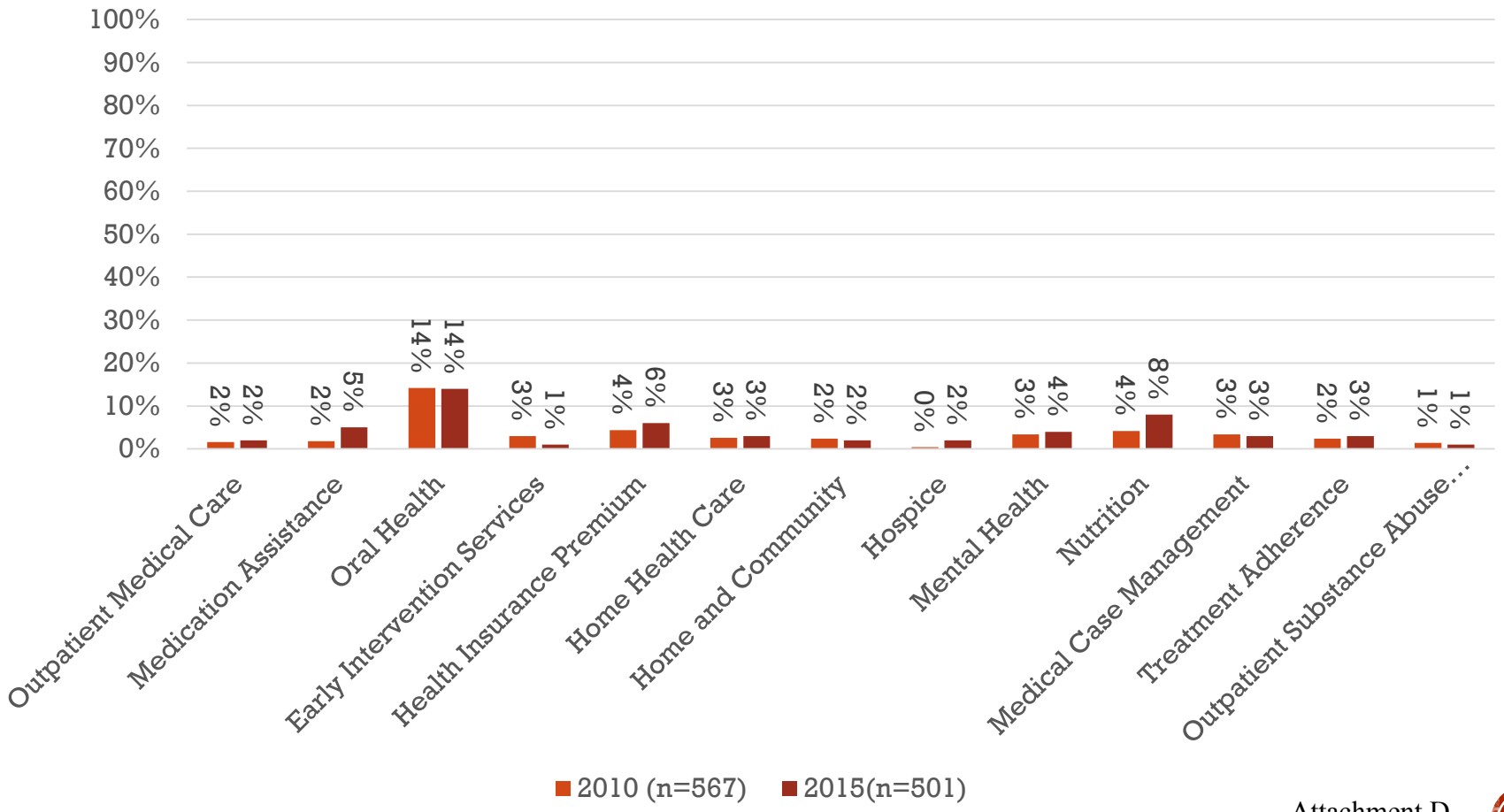
Attachment D

RISK FACTOR



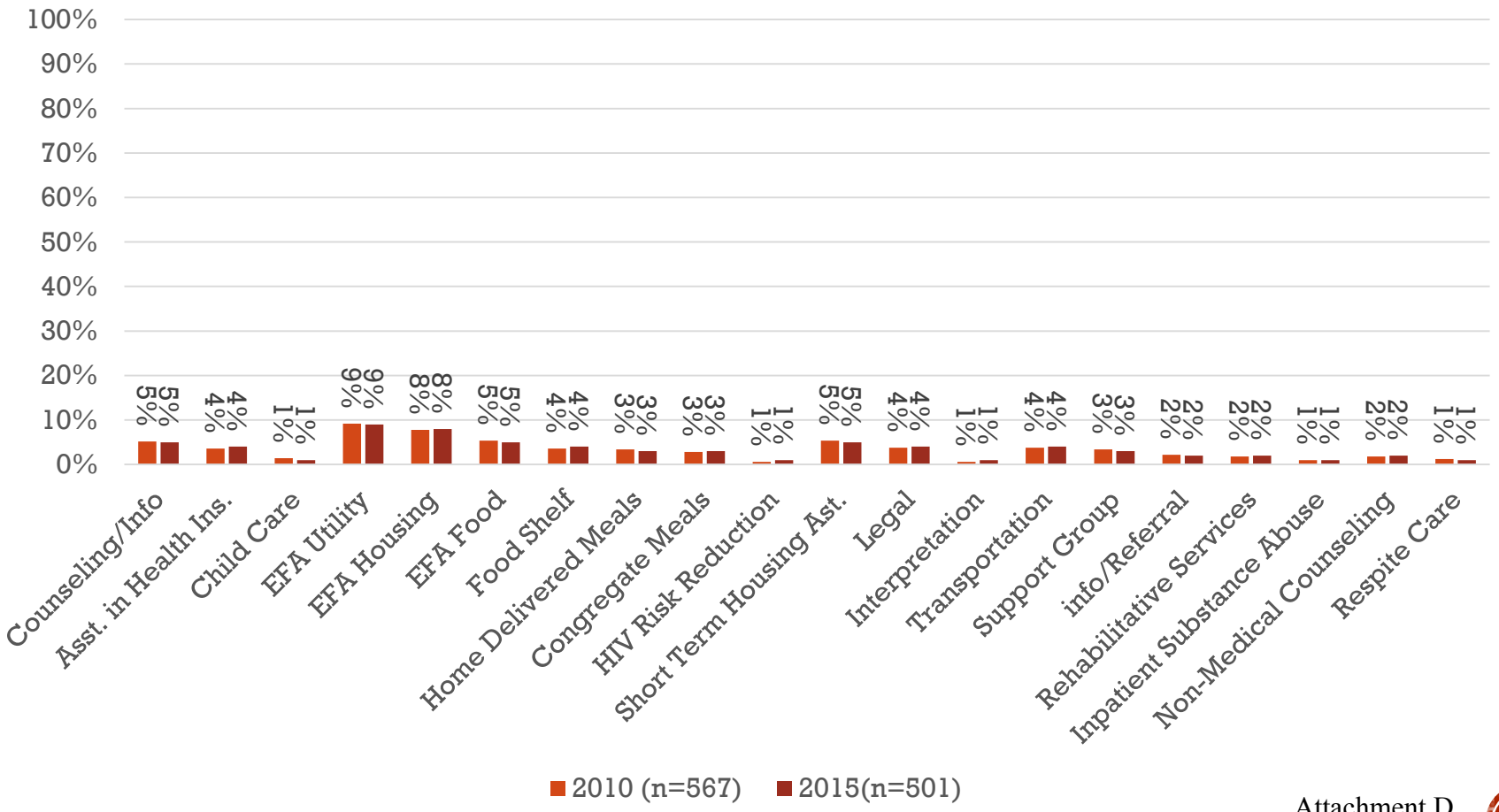
Attachment D

CORE MEDICAL: NEEDED, BUT UNABLE TO ACCESS



Attachment D

SUPPORT SERVICE: NEEDED, BUT UNABLE TO ACCESS



Attachment D

Attachment E Breakdown of Council Membership

Mandated Categories of Representation and Reflectiveness of the Epidemic in the TGA	Target	Actual	White/Non-Hispanic		Black/Non-Hispanic		Hispanic		Asian/Pacific Islander		AM Indian/Native Alaskan		Total Individuals from Greater MN
			Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	
Health care providers, including FQHC	1	1		1									
Community-based organizations serving affected populations and AIDS service organizations organizations	1	6	1	1	1	2		2					1
Social service provider, including housing and homeless services	1	1	1										
Mental health providers	1	1	1										
Substance abuse providers	1	1	1										
Local public health agencies	1	1			1								
Hospital planning agencies or health care planning agencies	1	*			1								
Unaligned consumers	11	12	8	1	1		1				1		3
Non-elected community leaders	1	2				2							
Religious leaders or representatives from faith communities	1	1	1										
Representative from the Department of Corrections	1	0											
Representative from the Department of Education	1	0											
State Medicaid agency	1	0											
Part A grantee	1	1							1				
State Part B agency	1	1		1									
Part C grantee	1	*		1									
Part D grantee, or if none present, representatives of organizations addressing the needs of children youth and families living with HIV	1	1				1							
Grantees of other Federal HIV programs, including but not limited to HIV prevention programs	1	1	1										
Representatives of/or formerly incarcerated PLWH	1	*											

Individuals co-infected with Hepatitis B or C	1	*											
Member of Federally Recognized Indian Tribe	1												
Representative of a high risk population	1	*											
Current or former IDU	1	*											

TOTAL MEMBERS	33	30	14	4	4	5	1	2	1	0	1	0
Total Male & Female			18		9		3		1		1	
TARGET (Ethnicity and Gender)			52% (17)		35% (12.0)		9% (3.0)		2% (1.0)		2% (1.0)	
TARGET UNALIGNED CONSUMERS			5	1	3	1	1	0	0	0	1	0
Total Unaligned Male & Female			9		1		1					
UNALIGNED CONSUMER TARGETS (Ethnicity and Gender)			52% (6)		35% (4.0)		9% (1.0)		2% (0.2)		2% (0.2)	

	Target	Target P	Actual	Actual Percentage
Male	25	76%	20	67%
Female	8	24%	10	33%

	Target	Target P	Actual	Actual Percentage
Unaligned Male	9	27%	11	37%
Unaligned Female	2	6%	1	3%

	Target	Target P	Actual	Actual Pe
TGA	29	88%	26	87%
Greater MN	4	12%	4	13%

(Because the Planning Body is required for Part A and not Part B, HRSA does not require or monitor Greater MN participation)

Under represented	
Over represented	
Under Consideration	
Also included in another category	

* Included in another category

Attachment F

Letter of Concurrence from Minnesota HIV/AIDS Care and Prevention Council

Letter of Concurrence from Minnesota Department of Health

Letter of Concurrence from Minnesota Department of Human Services

Letter of Concurrence from Hennepin County Public Health

Minnesota Council for HIV/AIDS Care and Prevention

September 13, 2016

Cathleen Davies
Lieutenant Commander, U.S. Public Health Service
Division of State HIV/AIDS Programs
HAB/HRSA
5600 Fishers Lane, 09W65B
Rockville, MD 20857

Monique Richards
Lieutenant Commander, U.S. Public Health Service
Division of Metropolitan HIV/AIDS Programs
Western Branch, HAB/HRSA
5600 Fishers Lane, 09W05B
Rockville, MD 20857

Sam Van Leeuwen
Public Health Analyst
Centers for Disease Control and Prevention
E 03 1600 Clifton Road
Atlanta, Georgia 30333

Re: Letter of Concurrence

Dear Ms. Davis, Ms. Richards and Mr. Van Leeuwen:

The Minnesota Council for HIV Care and Prevention (MCHACP) Council concurs with the joint submission of the Integrated HIV Prevention and Care Plan to the Centers for Disease Control and Prevention (CDC) and Health Resources and Services Administration (HRSA). This plan was developed under the leadership of the Council in collaboration with the Minnesota Department of Human Services, Minnesota Department of Health, Hennepin County's Human Service and Public Health Department, providers and community members, as well as most notably people at higher risk of HIV and people living with HIV. The Integrated HIV Prevention and Care Plan is in line with the guidance set forth by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB).

The Integrated HIV Prevention and Care Plan document describes both the continuing and evolving needs of people affected by the HIV epidemic in Minnesota and two counties in Wisconsin. In an era when effective treatment for HIV is available and resultant viral suppression can significantly reduce HIV transmission, the Minneapolis-St. Paul Part A TGA's and Minnesota's Integrated HIV Prevention and Care Plan provides a blue print for further integration of planning and service delivery, as well as fostering new approaches to closing the gaps along the HIV Care Continuum. After nearly a year of planning, we are pleased to report that Minnesota has fully integrated prevention and care planning for people at risk and people living with HIV. This plan reflects the integration that has occurred at the state and local levels.

525 Portland Ave., MC L963, Minneapolis, MN 55415 • (phone) 612-596-7894 (toll-free) 888-638-3224 (fax) 612-348-3830
www.mnhivcouncil.org

The Council has reviewed the Integrated HIV Prevention and Care Plan and confirms that it describes how programmatic activities are to be implemented and resources will be allocated to the most disproportionately affected populations and geographical areas that bear the greatest burden of HIV disease. The Council concurs that the Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the Funding Opportunity Announcement PS12-1201 and the Ryan White HIV/AIDS Program legislation and program guidance.

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

Signature:

Date: September 13, 2016

Roger Ernst
MCHACP Council Co-Chair

Larry McPherson
MCHACP Council Co-Chair

Krissie Guerard
Manager, STD/HIV/TB
Minnesota Department of Health

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

September 13, 2016

To Whom It May Concern:

On behalf of the Minnesota Department of Health's STD/HIV/TB Section, I am writing in support of the 2017-2021 Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need. I endorse the implementation of this plan as a vital piece in combating HIV in Minnesota. This plan sets a stage for increasing coordination of care as well as promoting the improvement of prevention services for Minnesotans living with and at risk for HIV.

The plan incorporates ideas from community partners including people at risk for and living with HIV, funded agencies receiving care and/or prevention funding, community stakeholders, the Minnesota Council for HIV/AIDS Care and Prevention, and the grantee Agencies which includes; the Minnesota Department of Health (CDC Prevention), Minnesota Department of Human Services (HRSA Part B) and Hennepin County Public Health (HRSA Part A). The combined efforts from this group to make this plan showed true collaboration to make this plan a useful tool to Minnesota.

I am pleased to endorse this plan as we seek to improve the health and lives of Minnesotans.

Sincerely,

Krissie Guerard, MS
STD/HIV/TB Section Manager

KG:rad-k

STD/HIV/TB Section • Infectious Disease Epidemiology, Prevention and Control Division •
625 Robert Street North • P.O. Box 64975 • St. Paul, Minnesota 55164-0975 • 651-201-5414
http://www.health.state.mn.us
An equal opportunity employer

Attachment F

Minnesota Department of **Human Services**

September 26, 2016

To Whom It May Concern:

I am writing in support of the 2016 Comprehensive Plan developed by the Minnesota Council for HIV/AIDS Care and Prevention. The State of Minnesota is fortunate to have the expertise and involvement of the volunteers who collaborated on the development of this plan and those who will contribute to the implementation of the vital continuum of services for people living with HIV/AIDS.

This plan will assist our State in improving the services system for people living with HIV/AIDS, eliminate health disparities among infected populations, and develop methods to increase the number of HIV positive individuals seeking medical care and maintaining quality care and adherence in alignment with the National HIV/AIDS Strategy for the United States. The plan also encourages the best possible use of resources through collaborative efforts of local and state service providers.

I am pleased to endorse this plan as we seek to accomplish the important goals and objectives that will improve the lives of thousands of people living with HIV/AIDS across the State of Minnesota.

Sincerely,

Alexandra Bartolic

Alexandra Bartolic
Director, Disability Services

Hennepin County Public Health

Health Services Building, Level 3 MC – L963
525 Portland Avenue South
Minneapolis, MN 55415-1569

612-348-3045, Phone
612-348-7548, Fax
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September 27, 2016

Cathleen Davies
Lieutenant Commander, U.S. Public Health Service
Division of State HIV/AIDS Programs
HAB/HRSA
5600 Fishers Lane, 09W65B
Rockville, MD 20857

Monique Richards
Lieutenant Commander, U.S. Public Health Service
Division of Metropolitan HIV/AIDS Programs
Western Branch, HAB/HRSA
5600 Fishers Lane, 09W05B
Rockville, MD 20857

Sam Van Leeuwen
Public Health Analyst
Centers for Disease Control and Prevention
E 03 1600 Clifton Road
Atlanta, Georgia 30333

Dear LCDR Davies, LCDR Richards and Mr. Van Leeuwen:

I am writing in support of the 2017 – 2021 Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need. Minnesota is fortunate to have extensive involvement of the Minnesota Council for HIV/AIDS Care and Prevention and people living with HIV and those individuals at higher risk in the development of this plan. Minnesota also enjoys a very high level of collaboration amongst grantees at the state and local level. This was demonstrated this past year through combining planning efforts that culminated in the development of the Integrated HIV Prevention and Care Plan.

This plan serves as a blue print to assist our community in improving prevention efforts targeted at higher risk populations, improve the service delivery system for people living with HIV and AIDS, eliminate disparities among disproportionately impacted populations, and increase the number of HIV positive individuals seeking medical care and maintaining adherence with quality care. The plan also focuses resources targeted at specific goals and objectives through collaboration at the state and local levels.

I am pleased to endorse this plan as we seek to accomplish the defined results that will improve the lives of thousands of people living with HIV in Minnesota.

Sincerely,

Susan Palchick, Ph.D., MPH
Public Health Director

Attachment F