Goal 1: Reduce New HIV Infections	Status	Plan to address gaps
1.1 Increase from 86% to 90% of individuals living with HIV in TGA and MN aware of HIV status	Met	
1.2 Increase by 60% access and utilization of PrEP at MDH funded organizations	On track	● MDH support PrEP funded providers to increase collaboration, education, and information sharing between funded organizations
1.3 Increase by 60% access and utilization of PrEP to African American communities at MDH funded organizations	Not on track	● MDH support PrEP funded providers to increase collaboration, education, and information sharing between funded organizations
1.4 Increase by 20% utilization of MDH funded harm reduction and syringe exchange activities	Not on track	● MDH sustain funding for syringe exchange programs
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)	Unknown*	● When providing outreach to communities, agencies can collaborate to test, offer PrEP, and provide needle exchange services, or provide education and/or referrals. ● Government agencies post a list of agencies providing services so providers can build a network of referrals (council staff explore if this could be on council website) ● MDH engages medical associations (including those who have not historically been part of the HIV prevention and care network) about PrEP
1.6 Increase by 20% the number of African American, African-born, Latinos and their subpopulations (MSM, transgender, and women) getting tested through MDH and RW funded organizations	On track	● Provide opportunities at council meetings for community based organizations to give updates related to testing and community initiatives during open forum ● Recipients support and provide capacity building for new and creative approaches to promote community testing initiatives ● Recipients support providers to combine efforts on joint campaigns for testing, PrEP, and other prevention activities ● 2019 monitoring plan will include data on all transgender populations and for people who use intravenous drugs for Objective 1.6

*Incidence is determined by a variety of factors that go beyond programmatic outcomes. Without at least 5 years of historical data, projections are not possible.

Goal 2: Increase Access to Care & Improve Health Outcomes for People Living with HIV	Status	Plan to address gaps
2.1 Increase to 85% the proportion of individuals who attend a HIV medical care visit within 30 days of HIV diagnosis	Unknown	● Council can fund services that impacts these numbers ● Work towards rapid access to treatment ● Recipients combine efforts to target primary care clinics to educate on rapid access to treatment ● MDH engages medical associations (including those who have not historically been part of the HIV prevention and care network) rapid access to treatment
2.2 Increase to 90% the proportion of individuals living with HIV and retained in care	Not on track	● Fund services that show correlation to retention in care ● Coordination of core medical and support services for PLWH
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	Not on track	● Fund services that show correlation to viral suppression ● Coordination of core medical and support services for PLWH
2.4 Increase to 92% the proportion of Ryan White Outpatient/Ambulatory Health Services clients who are prescribed ART in the 12-month measurement period	Met	

Goal 3: Reduce HIV-Related Disparities & Health Inequities	Status	Plan to address gaps
3.1 Increase to 90% the proportion of African American, African born, and Hispanic clients retained in care statewide	Not on track	● Fund a buddy system for newly diagnosed clients to help them navigate the Ryan White system ● Through case management and non-medical case management provide a trusted person who takes clients to medical appointments with trusted and culturally competent medical personnel ● Agencies provide a regularly updated list of culturally competent and trusted providers for different cultures or communities ● Improve access to mental health services within the Ryan White system
3.1 a. Increase to 95% the proportion of African American, African born, and Hispanic Ryan White clients retained in care	On track	● Expand funding for Care Linkage Services
3.1 b. Increase number of PLWH in MN accessing Ryan White services to 60%	Unknown	● PAC and DEC work together to come up with strategies ● FIMR and statewide strategy could increase RW enrollment ● Market Ryan White services with advertisements ● Agencies provide a list of trusted providers for different cultures or communities to access Ryan White services
3.2 Increase to 92% the proportion of RW OAC African American, African born, and Hispanic clients who are prescribed ART in the 12-month measurement period	On track	● Increase engagement in all Ryan White services ● Map plot where RW residents live and look at available resources in these areas (i.e. large African born population in northern suburbs but services are further south - could impact RFP process when providers from these areas apply
3.3 Increase to 80% proportion of African American, African born, and Hispanic clients who achieve viral suppression	Not on track	● Evaluate which services positively affect the HIV care continuum ● Agencies offer peer health education ● Find new, fun ways for clients to remember to take medications ● Connect people who are experiencing homelessness to care ● Determine if agencies can hold medications for clients ● Establish support groups that work with people who are using drugs in order to maintain adherence to medications ● Explore opportunities to provide support for mothers so they adhere to medication regimens post childbirth ● Agencies provide lockboxes for clients to keep their medications in