**Minneapolis – St. Paul Transitional Grant Area**
**Ryan White HIV/AIDS Program Part A and MAI Funding - FY 2025 – 2027**
**ii. PROJECT NARRATIVE**

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## ▪ INTRODUCTION

This application describes the evolving needs of people affected by HIV in the Minneapolis – St. Paul Transitional Grant Area (MSP-TGA). Hennepin County Ryan White HIV/AIDS Program (HC RWHAP) Part A and MAI funds critical services that advance HIV care engagement, retention, and viral suppression for people with HIV (PWH). The HC RWHAP seeks to advance health and racial equity focusing on Black (African American and/or African-born), Latinx (Hispanic), and American Indian/Alaska Native subpopulations. Social barriers to advancement along the HIV care continuum (HCC) such as homelessness and injection drug use are addressed through the provision of Part A-funded services. Collaborating with Minnesota's RWHAP parts and the state's CDC HIV prevention grant ensures an integrated continuum of care and services within the MSP-TGA.

Despite improved access to and affordability of healthcare through the Affordable Care Act (ACA) and MinnesotaCare, Minnesota's basic health plan which expands access for immigrants with varying documentation status, significant healthcare barriers remain for low-income PWH. The HC RWHAP FY25 Part A and MAI plan funds a spectrum of high-quality

services across a landscape of culturally affirming providers to ensure that nobody living with HIV goes without healthcare due to social or financial barriers.

Minnesota Centralized Eligibility (MNCE) was implemented in FY23 which pivots from PWH proving eligibility documentation at each service provider, to having Minnesota's Department of Human Services (DHS; Part B recipient) determine eligibility for all Ryan White consumers. Providers verify eligibility annually and support clients in their eligibility process allowing them to focus on the immediate needs of clients rather than the collection of eligibility documentation. The HC RWHAP works closely with DHS to implement the program, supports providers in developing processes for verifying eligibility, and seeks consumer engagement through to ensure consumer concerns are addressed in MNCE messaging.

The HC RWHAP continues to integrate data-driven decision making, participatory community engagement, continuous administrative streamlining and improvement, and disparities elimination. The broad range of RWHAP Part A and MAI funded services is designed to promote early identification of individuals who are unaware of their HIV status, rapid linkage to high quality consistent HIV medical care and antiretroviral treatment, re-engagement in care, health education and literacy, retention in care and treatment adherence, and to address social and financial barriers for rapid movement along the HCC to help more PWH reach and maintain viral suppression.

The Hennepin County Ryan White HIV/AIDS Program respectfully requests $6,512,547 for FY25 to achieve these objectives.

- **ORGANIZATIONAL INFORMATION**

The staffing plan for the HC RWHAP Part A grant administration is presented as ***Attachment 1 Program Organizational Chart***. The extent to which project personnel are qualified by training and/or experience to implement and carry out the project are outlined in ***Attachment 2 Staffing Plan, Job Descriptions, and Biographical Sketches for Key Personnel***.

**A. Grant Administration**

1) Project Organization:

a. Administration of Part A Funds: The chief elected officer (CEO) for the Part A MSP-TGA is the chair of the Hennepin County Board of Commissioners; the CEO designates Hennepin County Public Health (HCPH) responsible for administering the MSP-TGA Part A grant within the Public Health Protection service area of the HCPH. The Program Manager oversees all grant administration operations and reports to the Public Health Protection Manager. The administrative team includes a Grants Supervisor, a Quality Management Coordinator, a Data Analyst, an HIV Services Planner, a Program Officer (vacant), and a Contract Manager. This team procures and oversees the delivery of services, manages subrecipient contracts, conducts program/fiscal monitoring, prepares grant applications and reports, meets conditions of awards, and implements the annual clinical quality management plan. Hennepin County Health and Human Services assigns a grant accountant from their Financial Analysis and Accounting area to submit quarterly HRSA Payment Management System reports for Part A fund draw down and prepare the Federal Financial Report.

The MSP-TGA Part A grant funds support 50% of the costs of staffing for the Minnesota Council for HIV/AIDS Care and Prevention (MCHACP), a single integrated HIV care and prevention community planning body that fulfills planning council responsibilities for the Part A grant, provides community input for Minnesota's Part B grant, and serves as the HIV community planning group for Minnesota's CDC HIV prevention funding. The Minnesota Department of Human Services (DHS; Part B recipient) provides funding for 50% of these positions through a receivable contract as outlined in the Inter-Governmental Cooperative Agreement (presented as ***Attachment 14***). When a staff vacancy occurs, the Grants Supervisor recruits new staff using the county's Human Resources hiring procedures. Council co-chairs and representatives from the state are invited to sit on the Planning Council Coordinator interview panel and provide input.

b. Fiscal Agent: Hennepin County does not use an outside administrator of fiscal agent. All Part A grant administration activities are performed by the MSP-TGA grant recipient.

2) Grant Recipient Accountability:

a. Monitoring: The HC RWHAP has a comprehensive subrecipient monitoring plan that includes quarterly subrecipient reporting, quarterly subrecipient check-in calls, annual subrecipient monitoring visits, and monthly fiscal monitoring. Subrecipient quarterly reports include progress meeting performance goals and contracting requirements, staffing or programmatic changes, wait lists, client grievances, training and technical assistance needs, expenditures to date, client eligibility, and quality improvement efforts. The follow-up check-in calls allow opportunity to discuss these reports in more detail, identify TA/training needs, and ensure transparency and bidirectional trust between the recipient and the subrecipient. At the first quarter, subrecipients provide documentation demonstrating adherence to universal and service standards. Any missing, inadequate, or incomplete documentation is discussed during quarterly calls and a plan is made to reach compliance within the fiscal year. Reports and call notes are reviewed by HC RWHAP staff to assess performance and identify technical assistance needs and shared with the subrecipients for reference.

At annual site visits, the HC RWHAP staff conduct administrative and programmatic review of each subrecipient. An on-site interview is conducted to review successes and challenges from the last year and discuss strategies. To ensure compliance with programmatic requirements and to better understand the site-level logistics of service administration, a sample of client records are reviewed for adherence to universal and service specific standards with all clients reviewed for Ryan White eligibility. Any subrecipient that does not demonstrate at least 90% adherence to service standards and 100% adherence to eligibility must submit and complete a corrective action plan and may be required to remit any funds used for ineligible clients.

Prior to the annual site visit, subrecipients submit their most recent annual audit including their single audit report if the receive more than $750,000 in federal funds. All MSP-TGA Part A contracts with subrecipients include detailed language on single audit requirements and submission for reports. The Contract Manager reviews all audits and financial statements to assess subrecipient fiscal stability and compliance with the HHS Uniform Guidance.

b. Payor of Last Resort: Centralized Eligibility (MNCE) was implemented to determine client eligibility in accordance with *PCN 21-02 Determining Client Eligibility and Payor of Last Resort in the Ryan White HIV/AIDS Program*. With MNCE, the Minnesota Department of

Human Services (DHS; Part B recipient) collects client application materials, determines client eligibility, and documents eligibility for provider verification on the MNCE At-A-Glance Page within CAREWare. MNCE eligibility requirements include proof of HIV diagnosis, income, residency, and health insurance status. Clients are required to renew annually and submit any changes throughout the year.

The HC RWHAP ensures appropriate use of funds by ensuring that any services billed to the RWHAP are exclusively for clients determined eligible via MNCE by including language in contracts and universal standards noting the provider responsibility to verify eligibility prior to initiating services. All subrecipients must provide their eligibility policy annually and a quarterly eligibility review is conducted during the annual site visits for all Ryan White service providers.

To ensure that RWHAP is the payor of last resort in accordance with *PCN 15-03 Clarifications Regarding the Ryan White HIV/AIDS Program and Program Income,* the HC RHWAP reviews subrecipient tracking of other sources of reimbursement at annual site visits. The HC RHWAP's instrument for outpatient ambulatory health services (OAHS) site visits ensures processes in place ensure that all third-party funding sources have been exhausted prior to using RWHAP funds. To ensure that all Medicaid-eligible providers are certified, the Part A Contract Manager confirms with DHS that each OAHS provider receiving RWHAP funds has an active Medicaid provider number. All HC RWHAP subrecipient contracts identify RWHAP funding as the payor of last resort. OAHS subrecipients submit all service claims to any third-party payer of record for each insured patient before invoicing the HC RWHAP. The subrecipient only invoices Part A for changes when third-party claims are denied for allowable OAHS services. All subrecipients submit annual program revenue and expense statements for the concluding fiscal year showing all sources of program income, including third-party reimbursement.

c. Fiscal Oversight: The Part A recipient staff lead the fiscal oversight of the grant with assistance from analysts in Hennepin County's Health and Human Services Financial Analysis and Accounting Area. Subrecipients submit invoices on a monthly or quarterly basis depending on the service category and time needed to ensure payor of last resort. The recipient uses a standard electronic invoice form that reflects contracted budget line items that correspond to HRSA object class categories. Subrecipients submit invoices electronically to Accounts Payable by the fifteenth of the month following the period during which services were provided. All invoices for the fiscal year are due by April 15th. Invoices are reviewed for accuracy, consistency with program budget, and service delivery reports from MN CAREWare, entered into the HC RWHAP invoice ledger, and routed for processing and payment. Invoices that are found to be inaccurate or inconsistent with MN CAREWare are returned to the subrecipient with guidance to resolve discrepancies before routing for processing and payment. Subrecipient contracts stipulate that payment be made within 35 days of receipt of correct invoice. Any shift in budget line-item amounts must be requested in writing and approved by the administrative team.

The Grants Supervisor completes Part A budgets, monitors overall spending, assesses reallocation/redistribution needs, and presents quarterly expenditure reports to the planning council. A financial analyst completes and submits quarterly HRSA Payment Management System disbursement reports for grant payment drawdowns and copies the Ryan White Program

Manager. At least one invoice audit is conducted for each subrecipient annually to ensure that documentation properly supports all expenditures billed. Invoices are not approved for payment if an agency has outstanding fiscal issues or documentation of services provided is not aligned with program goals and allowable expenditures. The Grants Supervisor convenes the administrative team monthly to review expenditures to date, contract payment problems or discrepancies, and to discuss reallocation or redistribution of funds. The Program Manager works with the financial analysts to prepare grant Federal Financial Reports (FFR) and to reconcile any discrepancies between the Ryan White invoice ledger and the county's payment system. Hennepin County Audit, Compliance, and Investigation Services staff conduct comprehensive fiscal audits of at least two Ryan White Part A subrecipients annually.

Administration, CQM, and service expenditures are each divided based on the proportion of the grant award that is formula and supplemental. Carryover funds are obligated separately in provider contracts and expenditures are tracked accordingly. A separate MAI administration and CQM budget is developed and MAI funds for services are obligated separately in MAI subrecipient contract budgets. At the close of the fiscal year, the amount of unobligated funds for administration, CQM, and services are multiplied by the proportion of the award that is comprised of formula and supplemental funds to determine the amounts of unobligated formula and supplemental dollars. Expenditure data is tracked on an Excel invoice ledger where subrecipient invoice amounts are entered by budget line item and viewable on a Power BI report that pulls data on service expenditures from the ledger to summarize expenditures by funding source, service category, and subrecipient. The Hennepin County Office of Budget and Finance uses PeopleSoft for its accounting system. Separate project numbers are assigned to Part A administration, Part A and MAI contracted services, planning council, and CQM.

**B. Maintenance of Effort:** A table demonstrating that RWHAP funding is not the sole source of support for HIV care and treatment in the MSP-TGA, and non-federal local HIV care funding is sustained from FY 2023 to FY 2024 is presented as ***Attachment 3 Maintenance of Effort***.

- **NEEDS ASSESSMENT**

**A. Demonstrated Need**

1) Epidemiological Overview: ***Attachment 4 HIV/AIDS Demographic Table*** provides a description of the demonstrated need for HIV care in the MSP-TGA in terms of the socio-demographic characteristics of those newly diagnosed with HIV, those living with HIV, and those at risk for HIV.

a. Summary of HIV Epidemic in MSP-TGA: The MSP-TGA surrounds the metro area of Minneapolis and St. Paul comprising eleven Minnesota (MN) counties and two in Wisconsin (WI). The 2022 American Community Survey (ACS) 5-year population estimate for the MSP-TGA is 3,622,853 with close to half of that population living in Hennepin and Ramsey Counties (1,817,959) and the rest living in suburban and rural counties. This 5-year estimate is being used to provide disaggregation by race/ethnicity with the population of the MSP-TGA being 73.0% White (non-Hispanic), 8.8% Black or African American (non-Hispanic, including individuals born in Africa), 6.9% Asian/Pacific Islander (API), 6.2% Hispanic/Latinx (of any race), 4.2%

multi-racial, 0.3% American Indian/Alaska Native, and 0.5% other race/ethnicity. The most recent data for men who have sex with men (MSM) in the MSP-TGA is from a 2015 Coalition for Applied Monitoring and Prevention dataset that estimated that 5.8% of men in the TGA are MSM. MSM population among men is highest in Hennepin County at 8.5% and Ramsey County at 8.2%. Black (both African American and/or African-born), Hispanic/Latinx, API populations are all more highly concentrated in Hennepin and Ramsey Counties compared to the rest of the TGA.

The Minnesota Department of Health (MDH) and the Wisconsin Department of Health Services (WI-DHS) reported 264 new cases of HIV in the MSP-TGA in 2023. This significant increase in incidence represents the highest number of cases since 2015. All of these cases were in Minnesota and just over 55% (146/264) of these cases were in Hennepin County.

There were 8,397 people living with a known HIV or AIDS diagnosis (PWH) in the MSP-TGA as of December 31, 2023. The Minnesota counties in the TGA account for over 83% of MN's total prevalence (8,340/9,996), with Hennepin County alone accounting for just over 50% of the state's total prevalence (5,024/9,996). Anoka, Dakota, and Washington Counties account for an additional 16% of the prevalence (1,369/8,397) while the other MN counties account for an additional 5.5% (467/8,397). Less than one percent of prevalent cases are from the Wisconsin Counties of the MSP-TGA (0.67%, 57/8,397).

b. Socio-Demographic Characteristics in the MSP-TGA:

(1) Persons Newly Diagnosed: ***Attachment 4 HIV/AIDS Demographics Table*** presents 2019-2023 HIV incidence for the MSP-TGA. During the initial four years of this period, HIV incidence ranged between 178-228 annual cases. The low period of this range in 2020 may be attributed to the COVID-19 pandemic and the challenges of testing. In 2023, incidence increased 21.7% from the previous year with 264 cases. A significant increase in incidence was among MSM populations from 107 cases in 2022 to 147 cases in 2023. In 2023, MSM remains the predominant exposure category in the MSP-TGA (55.7%). Individuals with no risk reported account for an additional 32.6% of new cases.

Incidence in the MSP-TGA is heavily concentrated among men, accounting for 80.7% of cases in 2023 (213/264). Of male incidence during this timeframe, 73.2% have exposure categories of either MSM or MSM/IDU. Among women, new diagnoses were heavily concentrated among women of color making up 79.1% of new infections. There were 3 new diagnoses among transgender people in 2023.

Black (African American and/or African-born), American Indian/Alaska Native, and Latinx (Hispanic) individuals all have higher incidence rates compared to their proportionate population sizes as outlined in Table 1 below.

Table 1: HIV Impact on Racial/Ethnic Communities, 2019 – 2023

| Demographic Group | Estimated Population Size | 5-Year HIV Incidence | % of MSP-TGA Population | % of HIV Incidence |
|---|---|---|---|---|
| Hispanic (all races) | 223,690 | 183 | 6.2% | 16.4% |
| American Indian/Alaska Native | 12,466 | 29 | 0.3% | 2.6% |
| Black (African American and/or African-born) | 319,882 | 460 | 8.8% | 41.3% |
| White | 2,645,041 | 340 | 73.0% | 30.5% |
| Overall | 3,622,853 | 1,115 | 100% | 100% |

(2) People with HIV: ***Attachment 4 HIV/AIDS Demographics Table*** presents prevalence for the MSP-TGA from 2019 – 2023. Prevalence has increased by 7.2% over the 5-year period, as diagnosed cases rose from 7,836 in 2019 to 8,397 in 2023. Of those in the MSP-TGA, 4,855 had an AIDS diagnosis, while 3,542 had a non-AIDS HIV diagnosis. Prevalence in the MSP-TGA is predominantly male, as males account for 73.6% of cases, while 24.9% are female and 1.6% are transgender. 72.8% of males with HIV are recorded as having MSM or MSM/IDU exposure categories. 29.8% of individuals have no risk category recorded, with 11.2% having a heterosexual contact recorded.

PWH in the MSP-TGA are aging. In 2019, only 49.8% of prevalent cases were aged 50 or older, compared 52.2% in 2023. As of 2023, 21.8% were aged 40-49, 10.2% were aged 35-39, 8.2% were aged 30-34, and 4.3% were aged 25-29. Individuals aged 24 and younger account for less than 4% of prevalence in the TGA.

Prevalence is not evenly distributed across races and ethnicities. Table 2 below shows the numbers and rates among demographic groups in the MSP-TGA in 2023. In particular Latinx (Hispanic), American Indian/Alaska Native, and Black (African American and/or African-born) populations have prevalence rates higher than the TGA average.

Table 2: MSP-TGA Population and HIV Prevalence Rates 2023

| Demographic Group | % of TGA population | % of Diagnosed PWH | HIV Prevalence Rate** |
|---|---|---|---|
| Hispanic (all races) | 6.2% | 12.6% | 471 |
| American Indian/Alaska Native | 0.3% | 1.0% | 677 |
| Asian/Pacific Islander | 6.9% | 2.6% | 85 |
| Black/African American* | 8.9% | 22.0% | 1042* |
| Black/African-born | | 17.9% | |
| White | 72.9% | 39% | 124 |
| Multi-racial | 4.3% | 4.8% | 259 |
| Overall | 100% | 100% | 231 |

*Prevalence Rates for Black/African American and Black/African-born calculated together.
**Per 100,000 persons. Population denominators from 2022 ACS 5-year

(3) Persons at Higher Risk for HIV in the MSP-TGA: New cases are increasing particularly among Black/African American, Latinx (Hispanic), and Multi-racial individuals. Hispanic individuals had a significant increase of incidence over the period, from 34 cases in 2019 to 60 cases in 2023. Incidence among males has increased from 158 in 2019 to 213 cases in 2023. Incidence among MSM has increased from 101 to 147 cases in that period. Incidence among individuals aged 20-24 more than doubled from 20 cases in 2019 to 48 cases in 2023. MSM incidence among individuals aged 20-34 increased from 53 to 101 over the period, predominately due to increases among Hispanic and Black/African American MSM.

Hennepin and Ramsey Counties are experiencing an HIV outbreak with two distinct clusters, an MSM/IDU and IDU-related cluster, and a homeless encampment-related cluster. As of September 2023, 267 cases have been identified in the outbreak, 120 in the encampment cluster, 147 in the MSM/IDU and IDU cluster. The outbreak has disproportionately impacted American Indian/Alaska Native and Black/African American individuals, who account for 18.7% and 21.0% of cases respectively. The MSP-TGA's homeless population remains at increased risk for HIV infection.

Income and Poverty Level: The 2022 1-year American Community Survey estimates that the median income in Minnesota is $82,338. MSP-TGA prevalence is concentrated in Hennepin and Ramsey counties, which have median incomes of $89,399 and $75,113 respectively. Significant income disparities exist in the MSP-TGA. In Hennepin County, Black (African American and/or African-born) median household income is estimated to be $49,307, Hispanic is estimated at $70,755, and American Indian is estimated to be $45,463. The 2022 ACS also estimates that 12.6% of households in the MSP-TGA are below the poverty line, compared to 9.6% of households in Minnesota. However, Black (24.7%), American Indian (30.1%), and Hispanic (16.8%) households in Minnesota are much more likely to be below the poverty line.

Education: In 2022, the national average for those 25 or older without a high school diploma was 10.4%, compared to 6.0% in Minnesota; the number of non-high school graduates is higher among Black (17.0%), American Indian (19.2%), and Hispanic (26.7%) individuals.

Health insurance: The national average of uninsured individuals is 8.0% compared to 4.5% in Minnesota, according to the ACS. Black African American and/or African-born, (7.0%), American Indian (14.1%), and Hispanic (16.3%) individuals have higher rates of uninsurance. Based on MN CAREWARE data, 9.6% of PWH in the MSP-TGA who received a Part A or Part B funded RWHAP services in 2023 were recorded as having no insurance, with an additional 42.95% having Medicaid and 20.83% using Medicare. Black African American and/or African-born, American Indian/Alaska Native, and Latinx (Hispanic) Ryan White consumers were all more likely to be uninsured compared to the average.

Language: Latinx (Hispanic) and Black/African-born individuals are disproportionately impacted by HIV in the MSP-TGA, and language barriers exist for many PWH. The 2022 ACS estimates that 18.0% of Hennepin County and 22.8% of Ramsey County residents speak a language other than English. Language barriers also exist for the 17% of PWH who are Black African-born, as well as other foreign-born PWH in the MSP-TGA.

c. Incidence and Prevalence Estimates: Evidence describing the TGA's incidence and prevalence of co-occurring conditions is presented in ***Attachment 5 Co-occurring Conditions Table.***

d. Overall Description of Health Care Coverage Available to all PWH in the MSP-TGA:

Medicaid: MN's Medicaid program Medical Assistance (MA) is administered by the Minnesota Department of Human Services (DHS), does not require a monthly premium, and offers comprehensive outpatient and inpatient health care services as well as coverage for antiretroviral therapy (ART) medications. Individuals qualify for MA with incomes 135% of FPG or less, though the elderly, blind and disabled can qualify with incomes of 100% FPG or less. MA services are provided as a fee-for-service or through contracted managed care organizations, six of which operate in the MSP-TGA. Pre-Exposure Prophylaxis (PrEP) and Post-exposure Prophylaxis (PEP) medications are exempt from cost-sharing under these plans.

Basic Health Plan: MinnesotaCare is MN's Basic Health Plan and provides similar benefits to families and adults with incomes at or below 200% FPG. MinnesotaCare enrollees also received health care services through one of the states contracted managed health care service organizations. Minnesota Care plans include all major HIV providers in the TGA and

cover all ART medications. Premiums for Minnesota Care plans are based on a sliding scale based on income, ranging from $0 a month for incomes below 34% FPG, to $80 monthly for incomes at 200% FPG.

Qualified Health Plans: MNsure offers four levels of coverage (Bronze, Silver, Golden, and Platinum) through its Qualified Health Plans (QHP). Rates vary, but a 40-year old living in Hennepin County with an income of 225% FPG could expect premiums to range from $67 for a Bronze Plan to $272 for a gold plan after a $214 tax credit. Deductibles range from $950 - $7,200, and co-pays range from $0 to $60. Out of pocket maximums range from $4,800-9,450.

ADAP: Minnesota's AIDS Drug Assistance Program (ADAP) is administered by DHS and supported by premium assistance for eight Medicare IPA Plans, and 12 Individual Plans in 2023. Individuals are eligible for ADAP if they are living with HIV, are uninsured or insured with a drug co-pay, and have an income below 400% FPG.

Ryan White Part A subrecipients include three HIV Specialty Clinics – HealthPartners, Hennepin Healthcare, and Minnesota Community Care – that provide access to HIV outpatient care in the MSP-TGA for un- and underinsured PWH.

The 2023 Minnesota Health Access Survey (MNHA) estimated that although only 3.8% of Minnesotans did not have insurance, 24.5% of individuals went without some type of health care due to cost. Black, Hispanic, and American Indian individuals were all more likely to forgo care due to concerns about cost. According to MN CAREWare, among RWHAP consumers in the TGA who had a service in 2023, 43.4% had Medicaid, 20.3% had Medicare, 9.9% had no insurance listed, and 26.1% had private insurance.

2) Unmet Need: ***Attachment 6 Unmet Need Framework*** is presented to provide unmet estimates in the MSP-TGA.

a) Description of the needs of the number of people who are late diagnosed, have unmet need, and are in care but not virally suppressed:

Late diagnosed: In 2022, there were 217 new HIV diagnoses in the MSP-TGA, with 17.5% (38/217) having a late diagnosis. In previous years, late testers accounted for 20-25% of incidence in the MSP-TGA. American Indian individuals had no late diagnoses in their eight new infections. Black (African American and/or African-born) had 12 late diagnoses among the 89 new infections (13.5%). Hispanic individuals had six late diagnoses among the 31 new infections (19.4%). Only Hispanic individuals had late diagnosis at a higher rate than the MSP-TGA average, however in previous years 26% of Black (African American and/or African-born) incidence was late-to-test.

The high rate of late testing among Hispanic individuals suggest that this population is not receiving necessary HIV testing, despite their higher risk for HIV infection. It is possible that the lower rates late-to-test among Black populations could indicate some success in efforts to increase testing among the population. Rates of uninsurance among these priority populations remains high, and lack of health insurance can contribute to testing barriers and routine HIV medical care. In the 2020 HIV community needs assessment, 23.2% (146/630) of respondents stated they delayed getting medical care because they did not have a way to get there. This rate

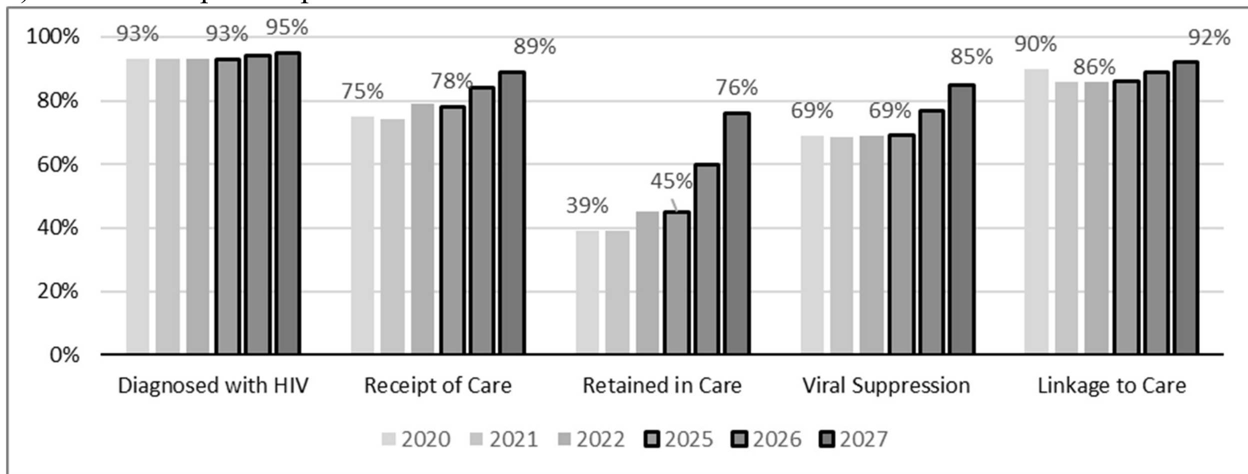
was higher for Hispanic subpopulation (33.3%, 21/63) and the Black/African American subpopulation (27.7%, 44/159). Reliable transportation for newly diagnosed individuals is crucial to increasing linkage to care, retention in care, and viral suppression.

Unmet Need: In 2022 approximately 24.5% of PWH in the MSP-TGA had an unmet need (1,935/7,910) indicating that these individuals did not have a HIV-related lab reported to MDH in 2022, despite having a HIV lab reported during the 2018-2022 period. The unmet need for HIV care was slightly higher for Black (African American and/or African-born) people at 27.6%, and for Hispanic people at 28.9%. Unmet need was significantly higher for American Indian /Alaska Native population at 35.8%. In 2022, the RWHAP system recorded significantly lower proportion of individuals facing unmet need at 7.8% (298/3,845) indicating that RWHAP provides the medical and support services necessary for PWH to stay in care. Unmet Need for RWHAP consumers was slightly lower for Black (African American and/or African-born) consumers (6.4%) and slightly higher for Latinx (Hispanic) consumers (8.0%). American Indian/Alaska Native Ryan White consumers had significantly higher levels of unmet need at 7.8%. In 2022, 30% of Ryan White clients in the TGA utilized ADAP services, while 33% utilized a funded OAHS service. While this number is lower than in recent years, it still indicates a need for Ryan White funded healthcare and medication coverage. Enrolling more PWH into the RWHAP can ensure that healthcare costs don't prevent individuals from accessing the care they need. Food services (55%), Medical Case Management (57%), and Medical Transportation (28.5%) were also heavily utilized by Ryan White consumers in the MSP-TGA.

Not Virally Suppressed: In 2022 HIV surveillance indicates that 11.6% of PWH in the MSP-TGA were in care, but not virally suppressed. Hispanic/Latino populations had slightly lower rates of being in care, but not virally suppressed at 9.8%. For Black (African American and/or African-born) populations, 13.4% were in care but not virally suppressed, while for American Indian populations it was 15.4%. Within the RWHAP system 17.3% (613 / 3,845) clients were listed as in care but not virally suppressed in 2022. At least part of the discrepancy in this data is due to Ryan White clients that received an OAHS visit in 2022 but were missing a viral load test in MN CAREWare. There exist racial disparities when we look at subpopulations. In particular, American Indian/Alaska Natives (19.6%) and Latinx (Hispanic) (22.6%) have higher rates of being in care but not virally suppressed. A previous logistic regression model indicated that housing was the strongest predicator of viral suppression for PWH in the MSP-TGA. The RWHAP continues to prioritize funding for housing options for PWH experiencing unstable housing. RWHAP consumers that are provided stable or temporary housing are much more likely to become virally suppressed, especially if they have a medical case manager. The high rate of medical case management usage among Ryan White consumers indicates that the service is of high need.

3) HIV Care Continuum

a) Table 3: Graphic Depiction of the HIV Care Continuum for MSP-TGA




*2020-2022 is not outlined and represents HIV Care Continuum baseline data (CDC). 2025-2027 is outlined and represents HIV Care continuum performance targets.

**B) Early Identification of Individuals with HIV/AIDS (EIIHA)**

1) Planned EIIHA Activities 2025-2027:

a. Overall EIIHA Strategy: The HC RWHAP conducts Early Identification of Individuals with HIV/AIDS (EIIHA) work through multiple strategies with many engaged partners and stakeholders.

Early Intervention Services: Early intervention services (EIS) continue to be the keystone of the HC RWHAP's EIIHA efforts with three EIS providers funded in FY24 by Part A and 340B ADAP rebate revenue through the HC RWHAP: Red Door Clinic (RDC), The Aliveness Project (TAP), and West African HIV Taskforce (WAHTF). Paired with this funding is comprehensive data collection, tracking, and analysis with focus on linkage of newly diagnosed and out-of-care individuals from RWHAP priority populations. Below are descriptions of the HC RWHAP's overarching strategies and inter-governmental collaborators for the early identification of individuals with HIV/AIDS.

Tailored Approaches for reaching Black and Latinx Gay Communities: While Minnesota has reached the National HIV/AIDS Strategy goal of 90% of PWH being aware of their status, we have from a new look at long-term data identified concerning disparities in the HIV incidence rates among men of color who have sex with men. The Quality Management Advisory Committee (QMAC) has established a specific goal of increasing the number of tests for men of color who have sex with men from a baseline of 469 to 624 (a 33% increase) for 2024 and will use the learning from the resulting PDSA cycles to continue to inform programming. Both RDC and TAP are seeking to reach more members of priority populations, establish meaningful referral relationships with other local services providers, and participate in targeted testing events.

Increasing Capacity and Community Engagement: While incidence is declining and viral suppression is high for the African-born HIV community, the percentage of late diagnoses among this population causes concern. The HC RWHAP continues to engage African immigrant

communities to determine the barriers to getting diagnosed and into care sooner. Two community-specific agencies work within the MSP-TGA to connect with specific cultural communities: the Sub-Saharan African Youth and Family Services in Minnesota (SAYFSM) who serves primarily East African immigrant communities through health education, risk reduction, case management, mental health services, psychosocial support, and medical transportation; and the West African HIV Taskforce (WAHTF) who conducts EIS health education, risk reduction, and testing through community events, social media outreach, and relationship/trust-building with local faith organizations and community representatives. Having learned from past outreach, WAHTF has shifted gears to focus more on events such as soccer where individuals with a higher risk profile are being found in greater numbers.

Reducing Barriers from Diagnosis to Linkage: The County's strategy to end the HIV epidemic is locally referred to as *Positively Hennepin*. This strategy was the result of engaging a wide range of stakeholders and communities disproportionately impacted by the epidemic. *Positively Hennepin* has three goals: (1) Decrease new HIV infections; (2) Ensure access to and retention in care for PWH; and (3) Engage and facilitate the empowerment of communities disproportionately affected by HIV to stop new infections and eliminate disparities.

Using Data-Informed Approaches to Reconnect PWH to Care: RDC has been working with the state enhanced HIV/AIDS Reporting System (eHARS) to identify PWH out of care through their Data to Care (D2C) project since 2016. The project is utilizing protocols adapted from those developed by Seattle/King County Public Health Department. The process starts with state HIV surveillance data on PWH who reside in Hennepin County being sent to the Hennepin County Public Health epidemiologists via the Minnesota Electronic Disease Surveillance System (MEDSS) so that the RDC D2C staff can reach out to these individuals to relink them into care, focusing on disparities, prioritizing patients who are associated with the HIV outbreak, who identify as men who have sex with men (MSM)/injection drug user (IDU), who identify as Black, Hispanic/Latinx, Native, Asian, or multiple races. As part of the disease investigation process, D2C staff also focus on the testing of partners of clients found to be out of care and likely with a detectable viral load.

Minnesota's EIIHA Workgroup: The Minnesota EIIHA workgroup was established in 2009 to ensure a collaborative and coordinated effort to decrease the number of PWH in Minnesota who are unaware of their status. The workgroup shares successful strategies, recommends priority populations based on epidemiological data, determines EIIHA interventions, and reviews outcome measures. Primary workgroup objectives include coordinating activities, fostering partnerships among providers, and assessing overall EIIHA progress in Minnesota and the MSP-TGA. The HC RWHAP facilitates this effort with the mission to recommend coordinated strategies to identify, diagnose, and link those unaware of their status with testing, prevention resources, appropriate referrals, and linkage to HIV medical care. The workgroup includes representatives from the Minnesota Council for HIV/AIDS Care and Prevention; Minnesota's RWHAP Parts A, B, C, D, and F; HIV care, prevention, and testing providers including local PrEP and syringe services providers; and RWHAP consumers. The Part A Program considers the workgroup's recommendations when establishing EIIHA goals.

The 2024 EIIHA workgroup meeting included relevant data and a comprehensive list of relevant services to inform EIIHA priority recommendations for the 2025 – 2027 cycle. Small groups discussed existing work and successes, as well as gaps in service for priority populations, system pain points, and ways to reach priority populations. Participants suggested continuing successes, such as increased collaboration between providers and other entities, an increased interest in PrEP, and the implementation of a Whole Person/Status Neutral Approach testing and support program. The identified challenges included encampment clearings and disruption of housing, care and testing in incarceration systems, a lack of staffing of individuals with lived and/or living experience, staff burnout and turnover, and administratively burdensome data reporting. Opportunities discussed were knowing and sharing where to find priority populations, incorporating more qualitative data, building trust and psychological safety in testing, addressing HIV stigma in testing, partnering with LGBTQ+ and AIDS Service Organizations for job fairs, using culturally affirming language in job fairs and posting, increasing primary care HIV testing, and finding a funding balance to support agencies doing this work. The Quality Management Coordinator will monitor progress towards the four components listed in Part B of this EIIHA section and present for discussion at the upcoming yearly EIIHA progress evaluation meetings.

Minnesota Department of Health (MDH): As the state's CDC HIV prevention and testing recipient, MDH communicates HIV prevention goals, changes, and progress to the planning council. MDH reports the state's HIV data to the Part A recipient and the Planning Council annually including HIV Care Continuum data and estimates of the HIV unaware population. RWHAP Part A EIIHA priority populations are selected based on eHARS, EvaluationWeb, and MN CAREWare data. The Government HIV Administrative Team (GHAT; MDH, DHS, and Hennepin County) meets every other month to coordinate RWHAP-funded services with CDC and state-funded HIV testing and prevention programs to ensure efficiency, consistency, and coordination. MDH administers CAREWare, enabling integration with HIV surveillance data.

MDH is an administrative agent for DHS' 340B ADAP rebate-funded Early Intervention Services funding 13 subrecipients, nine of whom operate within the MSP-TGA. The HC RWHAP is given grantee names, target populations, dates of grants, and geographic scope of each grantee. A primary goal of this collaboration is for government partners to share information freely, allowing for more strategic, aligned, efficient, and effective EIIHA outcomes.

Minnesota Council for HIV/AIDS Care and Prevention: The planning council was established in 2016 and serves as the single integrated HIV care and prevention community planning body for the MSP-TGA and the state and includes community members, unaligned consumers of RWHAP services, government representatives, and HIV prevention and HIV care program staff. Annual EIIHA activity updates are presented during council meetings and many council members actively participate in the EIIHA workgroup. EIIHA activities are incorporated in the council's Integrated HIV Prevention and Care Plan and reported to the council bi-annually.

Minnesota Department of Human Services (DHS): As the state's Part B grant recipient and Medicaid agency, a DHS Part B recipient staff member serves on the Planning Council. DHS' HIV Quality Coordinator and Data Coordinator participate in the EIIHA workgroup and QMAC as convened by the HC RWHAP. DHS funds additional EIS and outreach services through 340B ADAP rebate revenue, some of which is administered by the HC RWHAP to

ensure coordination of RWHAP activities. Coordination of Parts A, B, and rebate funding in the MSP-TGA facilitates linkage to care and supports ongoing retention in care for those who are newly diagnosed or re-engaged in care.

RWHAP and HIV Prevention Service Providers: The HC RHWAP uses Part A funds and 340B ADAP rebate revenue to fund Early Intervention Services within the MSP-TGA. EIS providers are invited to the annual EIIHA workgroup meeting. The HC RWHAP works closely with the state and our local EIIHA service providers to identify successes, challenges, and ways to share lessons and improve future EIIHA activities.

b. Table 4: Description of Activities, Anticipated Outcomes, and Primary Collaborators

| Activities | Anticipated Outcomes | Primary Collaborators |
|---|---|---|
| **i. Identification of Individuals Unaware of their HIV Status:**<br>- Evaluate total testing numbers for men of color who have sex with men<br>- Implementation of Status Neutral programming focusing on serving young Black men who have sex with men with testing and connection to supports coordinated to both negative and positive HIV test results<br>- Increased collaboration between providers to test at targeted events<br>- Increased EIS presence in areas with more subpopulations of focus | - 1,000 HIV tests annually<br>- At least 650 (65%) of total tests will be administered to: men of color who have sex with men, transgender individuals, people who inject drugs, people experiencing homelessness, Latinx, African-born, and American Indian/Alaska Native individuals<br>- At least 500 (50%) of tests being administered to men of color who have sex with men | - EIS Providers<br>- Red Door Clinic<br>- The Aliveness Project |
| **ii. Informing Individuals Who Tested Positive of their HIV Diagnosis**<br>- Further implement Status Neutral programming, including HIV testing and linkage to non-medical case management for a negative HIV test result and linkage into EIS and Case Management for a positive HIV test result | - All individuals tested for HIV with rapid HIV tests are informed of their results and assessed for needed prevention and PrEP (if negative), or care and support services (if positive) at the same visit | - The Aliveness Project<br>- Red Door Clinic<br>- Healthcare for the Homeless<br>- All providers who administer HIV tests<br>- HC Syringe Services Program |
| **iii. Referral to Care of Newly Diagnosed Individuals**<br>- Assessments<br>- Referrals and follow-up<br>- Collaboration between Providers | - 90% of newly diagnosed individuals are assessed for needs and potential barriers to linkage and retention in care, then referred to HIV medical care and support services | - EIS providers<br>- The Aliveness Project<br>- Red Door Clinic<br>- HC Healthcare for the Homeless<br>- HC Syringe Services Program |
| **iv. Linkage to Care of Newly Diagnosed Individuals**<br>- Data evaluation<br>- Increased collaboration between RW providers and with ID clinics and support services<br>- Establishment and implementation of Rapid StART as a standard practice in the MSP-TGA | - 95% of newly diagnosed people in the MSP-TGA are linked to initial HIV medical services within 30 days of their HIV diagnosis<br>- Rapid StART within 7 days of diagnosis will be available to all as a standard of care | - EIS providers<br>- The Aliveness Project<br>- Red Door Clinic<br>- Healthcare for the Homeless<br>- HC Syringe Services Program<br>- NACCHO-led Rapid StART Project Group |

**C) Subpopulations of Focus**

1) Three subpopulations with disparities in HIV health outcomes in MSP-TGA:

(a) American Indian: Although the number of new infections among American Indians is relatively low, they have the highest incidence rate (233/100,000 – Table 1) of any racial demographic group. Among American Indian PWH who have a documented viral load, only 88% were virally suppressed compared to 93.4% overall for the MSP-TGA PWH population, according to 2022 MSP-TGA HIV surveillance data. This subpopulation has a significantly lower receipt of care rate (64.2%) than the overall population (75.5%) although once established in care, retention rates for this population (40.7%) lag only slightly behind the overall population (42.1%). Despite obtaining HIV medical care, this subpopulation is less likely to be virally suppressed. These disparities also exist within the RWHAP system of care, where in the timeframe of our most recently updated data between July 2023 and June 2024, American Indian clients were virally suppressed at 84.8% vs. 92.8% for all RWHAP clients. While this marks a significant improvement from the 2019 rate of 72.2%, the disparity persists. HIV incidence has risen among the American Indian subpopulation to its highest level in ten years of data to eight cases in 2022, four times the rate of 2013 and 2014 where there were only two new cases per year. None of the new diagnoses were late diagnoses. Unlike most racial/ethnic groups, the primary mode of transmission is injection drug use (IDU) with seven of the eight new cases among IDU or MSM/IDU. An ongoing HIV outbreak among an encampment-related cluster and an MSM/IDU non-encampment cluster in the MSP-TGA's two largest counties accounted for 268 new cases since the outbreak began in December 2018. The American Indian subpopulation is overrepresented in this HIV outbreak as they only make up 0.5% of the population but 19% of the HIV outbreak. Housing appears to be the greatest barrier to advancement along the HCC for the American Indian subpopulation. Among RWHAP clients in the TGA in 2020, they were the most likely to be unstably housed at 13.5% compared to 5.4% overall. Data from the most recent 5-year Comprehensive Needs Assessment in 2020 (NA2020), which sampled 631 PWH in the MSP-TGA, highlighted other needs of this subpopulation. American Indian respondents were more likely to have problems paying medical bills in the past 12 months at 37.5% (15/40) compared to 30.3% (190/627) overall. American Indian respondents highlighted a high rate of food insecurity as well with 27.5% (11/40) reporting often running out of food before having money to buy more compared with 12.5% (79/631) of overall respondents reporting the same. Highlighting transportation barriers, forty percent (16/40) of American Indian respondents also reported putting off HIV medical care visits because they didn't have a way to get there compared to 23.2% (146/630) of overall respondents reporting the same. For the American Indian subpopulation, the ability to pay for HIV medical care and lack of access to services that impact social determinants of health (housing, food, and transportation) are barriers to advancement along the HIV care continuum. Fortunately, these can be addressed by the RWHAP with additional funding and culturally responsive housing opportunities. Finally, culturally responsive mental health services are needed as 37.5% (15/40) of American Indian respondents compared to 24.0% (150/625) overall reported mental health as a reason for missing an HIV medical appointment. In a follow up question, 30.0% (12/40) of American Indian respondents compared to 24.0% (150/626) overall reported mental health as a barrier to remaining adherent to HIV medication.

(b) Black/African American: Black/African Americans comprised 41.3% of new HIV cases in the past five years and have the second highest HIV incidence rate among racial groups

at 144/100,000 (Table 1). Individuals who are Black/African American are virally suppressed at a lower rate (62.3%) than the overall population (66.8%). This can be partly attributed to a lower receipt of care rate (70% - the highest percentage of measures beginning in 2014 vs. 75.5%) and retention in care rate (38.5% vs 42.1%). The low viral suppression rate is also found among the Black/African American subpopulation with a viral load where 87.8% are virally suppressed compared to 93.4% overall. This viral suppression gap is also found in the RWHAP system where 92.8% of all RWHAP consumers with a viral load are virally suppressed compared to 89.9% of Black/African American consumers. Among Black/African American incident cases in 2022, 10.1% (9/89) had a late diagnosis, lower than the overall at 17.5% (38/217). While Minnesota has mostly reached the National HIV/AIDS Strategy goal of 90% of the PWH population being aware of their status, disparities are evident. Rates of HIV incidence have significantly declined among white MSM from 2013 to 2022 from 100 to 36 cases per year while the incidence rates for Black MSM increased from 18 to 35 in that time frame, despite representing a significantly smaller proportion of the overall population. Evaluation of the social determinants of health using RWHAP client-level data and the NA2020 reveals housing, transportation, food, and ability to pay medical bills are needs in the Black/African American subpopulation. In 2020, Black/African American RWHAP clients were more likely to be unstably housed at 7.3% (96/1,323) compared to 5.3% (245/4,594) overall. Black/African American respondents in the NA2020 were more likely to report often running out of food before they had money to buy more at 16.9% (27/160) compared to 12.5% (79/631) overall. Also, 27.7% (44/159) of Black/African American respondents reported putting off HIV medical care because they did not have transportation compared to 23.2% (149/630) overall. According to NA2020 data, 25.2% (40/159) of Black/African American respondents reported having trouble paying medical bills in the past twelve months. While this is lower than the overall (30.3%, 190/626), it is alarmingly high.

(c) Latinx/Hispanic: In 2023, new cases among the Latinx/Hispanic population alarming almost doubled from 31 to 60 (Attachment 4A) and was by far the highest increase among racial and ethnic demographic groups. In 2022, according to the MSP-TGA HIV surveillance data, the Latinx subpopulation has a lower receipt of care compared to the overall population (71.1% vs 75.5%) but once care was received, had a slightly higher retention in care (44.3% vs. 42.1%). However, when examined for those who had a documented viral load, it is 94.0% comparable to the overall of 93.4%. These data suggest the barriers to care for the Latinx subpopulation exist at the receipt of care stage, not at the viral suppression stage. Among Latinx incident cases in 2022, 19.4% (6/31) had a late diagnosis. This is higher than the overall at 17.5% (38/217). Similarly to what has been occurring with young Black men who have sex with men, disparities present themselves among young Latinx men who have sex with men (MSM). Contrasted with the declining rates of HIV incidence among white MSM from 2013 to 2022 from 100 new cases per year to 36 (-64%), the rates for Latinx MSM increased from 19 to 31 (+158%) in that time frame, despite representing a significantly smaller proportion of the overall population. The differences are even more stark among young Latinx MSM aged 20-39. Contrasted with the incidence among young white MSM which plunged from 46 newly diagnosed cases per year in 2013 to 19 in 2022, the HIV incidence number of young Latinx MSM more than doubled from 8 to 18, despite being a much smaller proportion of young MSM in the MSP-TGA. Data from the NA2020 shows the Latinx subpopulation has significant barriers to paying for medical care. Among Latinx respondents, 43.6% (27/62) reported problems paying medical bills in the past

twelve months compared to the overall of 30.3% (190/627). This is the highest of any racial/ethnic group. Further, 51.6% (32/62) of Latinx respondents reported being "very worried: about their ability to pay future medical bills" compared to 32.9% (205/623) overall. Among Latinx respondents, 7.9% (5/63) compared to 12.5% (79/631) said they often run out of food before they have money to buy more in the past twelve months. While 47.5% (30/63) of Latinx respondents reported sometimes running out of food. This means that over half of Latinx respondents experienced some level of food insecurity in the past twelve months. Transportation appears to be a significant barrier as 33.3% (21/63) of Latinx respondents report not attending an HIV medical appointment due to lack of transportation. In 2020, 4.5% (24/535) of Latinx RWHAP consumers were unstably housed compared to 5.3% (245/4,594) overall. However, Latinx RWHAP consumers were more likely to be temporarily housed at 10.5% (56/535) compared to 9.0% (412/4,594) overall. This means that nearly 15% of Latinx consumers need a stable/permanent housing solution.

2) EIIHA Activity Alignment with Subpopulation of Focus Needs:

a) Subpopulation of Focus: American Indian and Alaska Native

*Identification of Individuals Unaware of their HIV Status:* At least 650 tests will be administered to a number of populations including American Indian and Alaska Native individuals through programming that includes EIS work in collaboration with community-based syringe services programs at or near the encampments associated with an HIV outbreak cluster.

*Informing Individuals Who Tested Positive of their HIV Diagnosis:* All individuals tested for HIV with rapid HIV testing associated with EIS outreach efforts and as part of EIS-adjacent programming through PrEP and syringe service programs are informed of their results and assessed for needed prevention education and services, including PrEP (if negative), or care and support services (if positive) at the same encounter whether in the field or at a service organization.

*Referral to Care of Newly Diagnosed Individuals:* Ninety percent of newly diagnosed individuals are assessed for needs and potential barriers to linkage and retention in care, then referred to HIV medical care and other necessary core medical and support services. The EIS work will include connection to culturally relevant agencies, services like case management, housing, and support including substance use harm reduction, tailored to the specific needs and/or concerns of individuals.

*Linkage to Care of Newly Diagnosed Individuals:* Ninety-five percent of newly diagnosed people in the MSP-TGA are linked to initial HIV medical services within 30 days of their HIV diagnosis. Confirmation by a medical or social work professional that the linkage has occurred and follow-up with the individual if it has not. Rapid StART within seven days of diagnosis will be available to all as a standard of care.

b) Subpopulation of Focus: Black/African American

*Identification of Individuals Unaware of their Status:* At least 500 tests will be administered to men of color who have sex with men. A particular emphasis for a portion of those will be on serving young Black MSM through culturally specific programming and at clinics that have placed culturally relevant imagery and seek to, when possible, hire staff who are reflective of the

communities served to garner increased trust. Incentivized testing is offered to communities of focus, ads are created geared to these communities, and providers have written Quality Improvement (QI) plans that focus on collaboration across providers and with relevant community agencies as well as holding outreach and testing events in communities with an increased proportion of the population that is representative of this community of focus.
*Informing Individuals Who Tested Positive of their HIV Diagnosis:* All individuals tested for HIV with rapid HIV tests are informed of their results and assessed for needed prevention and PrEP and harm reduction services (if negative), or care and support services (if positive) at the same visit. Hennepin County has been awarded a Whole Person/Status Neutral SPNS implementation grant supporting the work of two providers. This programming will offer increased testing for young Black/African American men in addition to increased testing that is part of providers' QI plans for FY 24-25 to achieve a CQM goal that seeks to increase by 33% HIV tests for men of color who have sex with men. When possible, they will hire staff with lived or living experience.
*Referral to Care of Newly Diagnosed Individuals:* Ninety percent of newly diagnosed individuals are assessed for needs and potential barriers to linkage and retention in care, then referred to HIV medical care and other necessary core medical and support services. EIS providers will work with clients to establish solid care and supports that address social determinants of health. Any individuals receiving a positive diagnosis through status neutral testing will be linked into EIS programming to determine needs and barriers for longer-term linkage.
*Linkage to Care of Newly Diagnosed Individuals:* Consistent with the long-term goal that the HC RWHAP's Quality Management Advisory Committee is moving towards incrementally as part of its CQM systemwide goal, 95% of newly diagnosed people in the MSP-TGA are linked to initial HIV medical services within 30 days of their HIV diagnosis. Providers have begun engaging an FQHC in an area of town largely represented by this community. Confirmation by a medical or social work professional that the linkage occurred and follow-up with the individual if it has not. Rapid StART within seven days of diagnosis will be available as a standard of care.

c) Subpopulation of Focus: Latinx
*Identification of Individuals Unaware of their HIV Status:* At least 500 tests will be administered to men of color who have sex with men. A particular emphasis for a portion of those will be on serving young Latinx MSM through culturally specific programming, including Spanish speaking and culturally reflective staff, outreach to organizations that are culturally relevant for Latinx MSM, having culturally relevant imagery in advertising, educational and promotional materials.
*Informing Individuals who Tested Positive of their HIV Diagnosis:* All individuals tested for HIV with rapid HIV tests are informed of their results and assessed for needed prevention with PrEP and harm reduction services (if negative), or care and support services (if positive) at the same visit with culturally reflective, Spanish-speaking staff, or use of interpretive services to ensure full understanding by the client.
*Referral to Care of Newly Diagnosed Individuals:* Ninety percent of newly diagnosed individuals are assessed for needs and potential barriers to linkage and retention in care, then referred to HIV

medical care and other necessary core medical and support services. Referrals to culturally relevant care, agencies, and case management services to address current and potential barriers. *Linkge to Care of Newly Diagnosed Individuals:* Ninety-five percent of newly diagnosed people in the MSP-TGA are linked to initial HIV medical services within 30 days of their HIV diagnosis. Confirmation by a medical or social work professional that the linkage has occurred and follow-up to the individual if it has not. Rapid StART within seven days of diagnosis will be available to all as a standard of care.

- **APPROACH**

**A. Planning Responsibilities**

1) Letter of Assurance from Planning Council: A letter of assurance signed by the Planning Council Co-Chairs documenting the existence of a functioning planning process is presented as ***Attachment 7 Planning Council Letter of Assurance***.

2) Resource Inventory: ***Attachment 8 Coordination of Services and Funding*** is presented to demonstrate funding sources for HIV prevention, care, and treatment services in the MSP-TGA.

- **WORK PLAN**

**A. HIV Care Continuum Services Table and Narrative**

1) HIV Care Continuum Services Table: The HIV Care Continuum Services Table is presented as ***Attachment 9 HIV Care Continuum Services Table.***

2) HIV Care Continuum Narrative: The Hennepin County Ryan White HIV/AIDS Program (HC RWHAP) and the Minnesota Council for HIV/AIDS Care and Prevention (MCHACP) use the MSP-TGA and Minnesota HIV Care Continua to drive improvement in the Integrated HIV Prevention and Care Plan. At the core of the Integrated Plan is addressing the continued health and racial disparities that persist among Black (African American and/or African-born), Latinx (Hispanic), and American Indian/Alaska Native subpopulations, hence their selection as the three subpopulations of focus. MAI funds are in place for these subpopulations to support care retention and viral suppression through medical case management, including treatment adherence support, and outpatient ambulatory health services.

Changes in the MSP-TGA's HIV care continuum impact services prioritization, resource allocation, population prioritization, and capacity development to address the most persistent gaps along the continuum where improvement in health outcomes is slower, including receipt of care, retention in care, and viral suppression. Service categories as outlined on ***Attachment 9 HIV Care Continuum Service Tables*** will meet the identified needs of PWH in the MSP-TGA and additional priorities set by MCHACP not reflected in ***Attachment 9*** are funded by Part B and 340B ADAP rebate funding including: core medical services AIDS Drug Assistance Program (ADAP), health insurance premium and cost sharing assistance, oral health care, mental health and substance abuse outpatient services; and support services emergency financial assistance, medical transportation, non-medical case management, and referral for health care/supportive services.

Based on MN CAREWare data, consumers who are either temporarily or unstably housed have significantly poorer health outcomes. MCHACP has accordingly increased the Part

A allocation for housing services consistently over the past three years. These additional resources target PWH who are unstably housed, receiving RWHAP, and who are not virally suppressed and aims to link them to affordable/stable housing and/or rental assistance for up to 24 months with the goal of improving their HIV health outcomes during and after their time in the housing program. In FY 2023, MCHACP approved a directive to the Part A recipient to allocate additional funds to housing and prioritize housing unhoused PWH who inject drugs and identify as American Indian/Alaska Native. The purpose is to impact the HIV outbreak occurring in Hennepin and Ramsey Counties because data on case demographics showed these populations as most associated with the outbreak. With this funding, a subrecipient staff person finds and engages with PWH in encampments, shelters, and on the streets and navigates resources that make the most sense for each individual.

Since 2016, the Part A recipient has collaborated with the Minnesota Department of Health (MDH; CDC Prevention recipient) and the Minnesota Department of Human Services (DHS; Part B recipient) to migrate HIV and AIDS diagnosis dates, CD4 counts, and viral load values from eHARS (the state HIV surveillance system) into MN CAREWare to develop complete Minnesota/MSP-TGA HIV care continua for all diagnosed PWH who receive RWHAP services. Hennepin County Part A staff can now access more accurate and timely data on each stage of the HCC. With greater access to timely data, staff can create, analyze, and share HCC data by gender, race, age, risk factor, service, and subrecipient. At present, 91.7% of Part A clients have a viral load in MN CAREWare. The integration of surveillance with client-level services data in MN CAREWare is positively impacting programs and RWHAP consumers by allowing subrecipients to log into CAREWare to develop and analyze their own agency or program specific HCC to understand their real time performance and develop strategies to help improve outcomes along the HCC for their clients. Part A medical case management programs report on viral suppression rates on a quarterly basis as a contractual performance measure. Subrecipients can more effectively monitor consumer health outcomes and identify where, along the HCC, performance is lacking and where the disparities exist. Presently, the RWHAP is working on a more focused approach with this data by having subrecipients run reports on individuals who have met the receipt of care definition but are not retained in care and not virally suppressed. These individuals can then be prioritized to receive the additional core medical and support services needed to advance them along the HCC to sustained viral suppression.

To increase receipt of and retention in care, the HC RWHAP and Hennepin County Public Health (HCPH) colleagues are using innovative data to care (D2C) models to ensure people with HIV who are out of HIV medical care are re-linked to an initial appointment and followed for six months or until a medical case management relationship is established. This project is funded using DHS 340B ADAP rebate revenue. The Minnesota Department of Health (MDH) assigns PWH who are not-in-care for follow up to the HCPH D2C team. The MDH defines not-in-care as no reported lab value in the past 15 months based on surveillance data. HCPH matches Part A clients against this MDH client list. If the individual matches, their service data is used to generate a list of HCPH and Minnesota Department of Human Services (DHS) funded RWHAP services received. HCPH D2C staff reviews electronic health records and the Minnesota Homeless Management Information System (HMIS) system for client

encounters. These data on where and which services PWH are receiving enable public health staff to successfully contact individuals. These PWH have then been re-engaged in HIV medical care and are now working towards durable viral suppression. These partner organizations broker a relationship between their clients and public health professionals. Summary-level data is also informing collaborative partnerships. If a number of PWH meeting the MDH definition of not-in-care are engaging with a program at a RWHAP service provider, the RWHAP will work with them on a systems level approach to improve care retention.

**B. Funding for Core and Support Services**

1) Service Category Plan: The Service Category Plan table is presented as ***Attachment 10 Service Category Plan Table***.

a) MAI Service Category Plan Narrative

i. How MAI Services Meet Needs of Subpopulations of Focus: All anticipated FY25 MAI service funds ($362,711) are allocated to core medical services. The goals and objectives of the FY25 MAI plan emphasize increasing access to HIV medical care and improving health outcomes along the HIV Care Continuum for Black (African American and/or African-born), Latinx (Hispanic), and American Indian/Alaska Native PWH through culturally responsive (CR) medical case management (MCM) and outpatient ambulatory health services (OAHS). The goals for the MAI-funded services are based on the HIV prevalence data through 2023 and HIV surveillance data used to develop the current MSP-TGA HIV Care Continuum (HCC) which helps identify the populations experiencing the greatest HIV-related health inequities. The MSP-TGA's Cultural Responsiveness (CR) standards are multi-faceted strategies that use evidence-based approaches to remove barriers that perpetuate the inequities evident in the HCC. The CR standards include participatory engagement and advisory from members of the population of focus along with planning, implementation, evaluation, and system improvements with the objective of meeting the CR needs of the populations of focus and eliminate health inequities. Culturally responsive MAI MCM and OAHS are designed to assure that the subpopulations of focus are connected to and receive core medical and support services that impact the social determents of health in ways that lead to improved care retention and viral suppression.

As outlined in ***Attachment 4 HIV/AIDS Demographics Table***, Black/African American (U.S. born) comprise 22% of the PWH in the MSP-TGA while 17.9% are Black/African-born. Combined, they make up 39.9% of all PWH in the MSP-TGA but represent only 8.9% of the total TGA population. Latinx (Hispanic) individuals make up 12.6% of all PWH in the MSP-TGA and 6.2% of the population. American Indian/Alaska Natives account for 1.0% of all PWH in the MSP-TGA, while representing only 0.3% of the population.

Disparities in engagement along the HCC as it pertains to the MAI goals are as follows. Comparative measures along the HCC were examined for racial/ethnic groups using 2022 HIV surveillance data (the most recent year available). Linkage to care within 30 days was 83.7%, however only 66.7% American Indian/Alaska Natives were linked within 30 days. Overall, receipt of care (defined as at least one viral load or CD4 count reported to the HIV surveillance system) was 75.5%. Black/African American and Black/African-born individuals have a lower

receipt of care, 74.2% and 70.0%, respectively. Latinx PWH also have a lower receipt of care at 71.1%, and American Indian/Alaska Native at only 64.2%

American Indians with a documented viral load, only 88.0% were virally suppressed compared to 93.4% in the overall population. This means that the American Indian population is both less likely to access HIV medical care, and those that do access HIV medical care are less likely to be virally suppressed. The focus of MAI medical case management for American Indians will be addressing the barriers to medication adherence with the goal of achieving and maintaining viral suppression.

The Black/African-born and Latinx (Hispanic) subpopulations are virally suppressed at a lower rate of 63.4% and 64.1%, respectively, compared to the overall population (66.8%). However, the Latinx subpopulation has a comparable viral suppression rate (94.0%) to the overall percentage (93.4%) when only those with a documented viral load are included. The same is true of the Black/African-born subpopulation at 93.3%. Medical case management for these subpopulations will advance them along the HIV care continuum by ensuring they receive HIV medical care at a comparable rate.

The Black/African American subpopulation is virally suppressed at a rate of 62.3%. Some of this lower rate can be explained by a lower receipt of care. However, 87.8% are virally suppressed when only those with a documented viral load are included in the denominator. The Black/African American subpopulation is experiencing barriers to accessing HIV medical care and achieving viral suppression once retained in care. MAI outpatient ambulatory health services and MCM treatment adherence interventions are designed to improve viral suppression among this subpopulation.

The Part A program has been successful at addressing several disparities highlighted throughout this narrative among PWH in the MSP-TGA. Among those receiving RWHAP Part A services, retention in care is at 95.4%. Disaggregated data shows retention in care being higher than average for Hispanic (98.0%), Black African American (96.1%), Black African-born (96.3%). American Indian/Alaska Native RW Part A consumers are one of the few groups with a lower rate of retention, with only 89.2% of clients in care in 2022. Disparities with viral suppression still exist among American Indian (78.8%), and Hispanic (89.5%), and Black African American (87.5%) populations, compared to the overall rate of 90.3% across all Part A served clients in 2022. Viral suppression within the RWAHP system uses the HRSA definition, which includes only those with a documented viral load in the denominator.

ii. How MAI Services May Prevent New HIV Infections, Improve Health Outcomes, and Decrease Health Disparities and Inequities Among Subpopulations of Focus: Advancements of racial/ethnic-related health equity are best measured by the MSP-TGA's HCC. Empirical data shows that early diagnosis, treatment adherence, and retention in care results in viral suppression. Advancement along the HCC not only improves individuals’ health outcomes but improves community health and prevents new HIV infections. The goal of MAI-funded OAHS is to increase the number of priority population PWH who are continuously engaging in quality HIV medical care. OAHS includes providing health care for individuals who are categorically ineligible for publicly funded Minnesota Health Care Programs and individual Qualified Health Plans accessed through Minnesota’s health insurance exchange, MNSure. OAHS standards require the adoption of a rapid ART model of expedited access and engagement through formal

referral and coordination agreements with Early Intervention Service providers and other HIV testing programs. Culturally Responsive (CR) standards are integrated into the program to address culturally specific needs. Clinical objectives for initial visits and routine care include coverage for all laboratory tests, vaccinations, and radiological imaging.

The goal of MAI-funded CR MCM is to increase access to core medical and support services for priority population PWH. CR MCM prioritizes access to and retention in care and culturally responsive staff and service delivery. The objectives of MCM for these priority populations are to support clients in their Ryan White eligibility process, link clients to health care, psychosocial support, medical transportation, mental health, and substance abuse outpatient services that address clients' barriers to consistently access HIV medical care.

As part of the competitive request for proposals process, subrecipients are asked to provide specific examples of strategies/methods that demonstrate transformative services to address disparities experienced by populations impacted by HIV, explain what evidence-based practices their organization utilizes to address culturally appropriate service provided to persons served, define the diversity levels in their organization, including confirmation of leadership/board members who are reflective of the eligible population served, define how their organization includes members of the eligible population in defining, implementing, and evaluating services, and to define specific examples of how their organization has or plans to achieve organizational equity objectives.

Data collected by MAI-funded agencies are reported through MN CAREWare to demonstrate the impact of MAI-funded services in these priority populations. Viral load values and CD4 counts are uploaded into MN CAREWare for all RWHAP service providers in the MSP-TGA which allows for monitoring of receipt of and retention in care and viral suppression among all RWHAP clients receiving these services. This allows both the Part A recipient and the MAI-funded subrecipients to evaluate progress towards MAI goals and to meet the HRSA requirement of reporting on client level health outcomes.

2) Unmet Need: Unmet Need estimates are presented as ***Attachment 6 Unmet Need Framework***.
a. Specific Interventions: The following table and narrative outline specific Part A programmatic interventions that focus on improving outcomes for individuals with unmet need who are late diagnosed, have unmet need, or are in care and not virally suppressed.

Table 5: Programmatic Interventions to Address Unmet Need

| **Programmatic Interventions** | **Unmet Need Components** | | |
|---|---|---|---|
| | **Late Diagnosed** | **Have Unmet Need** | **In Care, Not Virally Suppressed** |
| Early Intervention Services (EIS) | ✓ | | |
| Food Bank/Home Delivered Meals | | ✓ | |
| Health Education/Risk Reduction | | ✓ | ✓ |
| Housing | | ✓ | ✓ |
| Medical Case Management* | | ✓ | ✓ |
| Mental Health Services | | ✓ | ✓ |
| Outpatient/Ambulatory Health Services | ✓ | ✓ | ✓ |
| Psychosocial Support | | ✓ | ✓ |
| Substance Abuse – Outpatient Services | | ✓ | ✓ |

*includes MAI-funded treatment adherence

(1) Late Diagnosis: Specific interventions for populations with higher rates of late diagnosis include both in-house and community outreach in neighborhoods and at events with a higher number of members of communities of focus, culturally responsive early intervention services provided by two community-based organizations and a public health clinic that prioritize Black (African American and/or African-born) and Latinx (Hispanic) subpopulations for their HIV testing and care linkage. Many staff are racially, ethnically, and linguistically reflective of the communities being served. Healthcare for the Homeless outreach staff collaborate with community partners to deliver pop-up testing at homeless encampments. Targeted, incentivized testing at specialized community testing events is part of the programming designed to establish relationships with these community members. Testing includes an assessment of sexual health and risk reduction tailored to the individual being served. Transportation programming offers eligible individuals services that are free of charge to link them to programming designed to meet needs such as case management to link clients to insurance and resources. Most EIS providers have access to medical transportation funding to enable public transportation, taxi, or ride share trips to get clients to appointments where they are offered a warm handoff to medical providers, in many cases with staff accompanying clients to appointments.

(2) Unmet Need: To address challenges paying for medical bills, food, and transportation indicated in the 2020 Comprehensive HIV Needs Assessment data by American Indian/Alaska Native, Black (African American and/or African-born) and Latinx (Hispanic) survey respondents, Part A funds a culturally responsive food bank and home delivered meals program with emphasis on culturally responsive programmatic standards and oversight. The Part A program coordinates with Minnesota's Part B program to ensure that health insurance premium assistance, emergency financial assistance, and medical transportation are prioritized with emphasis on access for the three subpopulations of focus. Housing is the greatest barrier to advancement along the HIV care continuum to sustained viral suppression. The HC RWHAP has facilitated a lower barrier technical housing workgroup to develop formal recommendations for use in formulating more effective housing interventions and has participated in a create+equity collaborative through the Center for Quality, Improvement and Innovation focused on housing services and client preferences as a tool for achieving viral suppression. Based on suggestions from this group, HC RWHAP staff are seeking to implement using MN CAREWare as a referral source between housing service providers to streamline service access for consumers. *Positively Hennepin*, the county's strategy to end the HIV epidemic, seeks to eliminate consumers' barriers to adherence to HIV medical plans by ensuring access to low-barrier safe housing options, particularly for those who inject drugs and are experiencing unsheltered homelessness. Initiatives also include utilizing integrated surveillance and public and private clinical data to locate out of care PWH and provide support for re-engagement, retention in care and viral suppression.

(3) In Care, Not Virally Suppressed: Housing was listed as the strongest predictor of viral suppression in the MSP-TGA among the subpopulations of focus. Specific interventions beyond offering guidance to the standard Ryan White services offering by Housing providers are outlined in (2) Unmet Need above. *Positively Hennepin* has promoted medical case management

and medication adherence support, outpatient ambulatory health services, and health education/risk reduction, and MAI-funded services that prioritize Black (African American and/or African-born) and Latinx consumers to help reach those who are in care but not virally suppressed. Other interventions identified through the Part A program's community engagement activities to reduce unmet need include food, mental health, psychosocial support, and health education/risk reduction services that support treatment adherence and sustained viral suppression. The HC RWHAP is working with a Senior Program Analyst with the National Association of County and City Health Officials (NACCHO) to establish a jurisdictional standard for Rapid StART. The goal of this standard is that all those newly diagnosed with HIV or re-engaging in care having an opportunity to initiate antiretroviral treatment (ART) for HIV within seven days of HIV diagnosis or re-engagement in care. The services will be easily and equitably accessible, trauma-informed, and culturally competent to expedite initial HIV appointments, ART initiation, and engagement in services that support lifelong retention in care and sustained viral suppression.
3) Core Medical Services Waiver: ***Attachment 11 Core Medical Services Waiver*** is presented to request a HRSA RWHAP Core Medical Services Expenditure Waiver for FY 2025.

- **RESOLUTION OF CHALLENGES**

A. Table 7: Resolution of Challenges

| Challenges and Barriers | Proposed Resolutions | Intended Outcomes | Current Status |
|---|---|---|---|
| **Service Gaps:**<br>On July 18, 2024, a longtime Part A subrecipient and Minnesota's largest community-based HIV services provider, Rainbow Health (RH), announced their same-day closure. RH provided Part A-funded Health Education/Risk Reduction, Transitional Housing, Legal, Psychosocial Support, and Substance Abuse: Outpatient services.<br><br>The HC RWHAP quickly convened stakeholders to identify service gaps, reallocate funding as appropriate, and coordinate efforts with HIV Services partners at DHS and MDH. | a. Reallocate funds remaining in RH contracts to other local providers.<br>b. Ensure that the response and communications from HC RWHAP Are consistent with DHS and MDH.<br>c. Solicit new providers who may fill service gaps created by the closure. | a. PWHs who were receiving services at RH continue to receive the services they need to reach and maintain viral suppression.<br>b. Government entities who were funding RH continue collaborating to ensure adequate services are available throughout the MSP-TGA.<br>c. The joint RFP between Parts A and B will streamline the proposal process and subsequent contracting with qualified providers so that government entities can procure cost-effective and efficient services within the MSP-TGA. | a. DHS (Part B) promptly set up an Incident Command System including representatives from the HC RWHAP and from MDH (CDC Prevention) to monitor and respond to the closure impact.<br>b. HC RWHAP contracts were amended to reallocate RH funds. Providers receiving those funds received tools to prioritize outreach for former RH clients.<br>c. A Joint Multi-Service RFP from the HC RWHAP and DHS was published in September 2024 to determine Part A & B RWHAP providers for the next funding cycle. |

| Challenges and Barriers | Proposed Resolutions | Intended Outcomes | Current Status |
|---|---|---|---|
| **Rapid StART Program Implementation and Monitoring:** The HC RWHAP is consulting with The National Association of County and City Health Officials (NACCHO) to develop a jurisdictional Rapid StART plan that will utilize the NACCHO playbook once it is published.<br><br>Anticipated challenges include defining the Rapid StART model to implement, working with all Early Intervention Services and Outpatient/Ambulatory Health Services to identify and navigate site-level challenges, and developing a shared program monitoring plan with consistent data definitions and reporting. | a. The HC RWHAP is convening a Core Group of staff to create a work plan and ensure consistent progress while developing goals, definitions, and teams responsible to implement Rapid StART programming.<br>b. The Core Group will consult with stakeholders: CAREWare support staff, MN ADAP Coordinator, Data Analysts, site programming staff, and site organizational leadership to determine the local application of the Rapid StART playbook. | a. All newly diagnosed PWH and newly re-engaged PWH will start antiretroviral therapies rapidly through linkage, focused case management and benefits navigation, and pharmacy engagement.<br>b. Each site will have organizational leadership buy-in and front-line staff input on implementation strategies.<br>c. A shared data monitoring process across all implementing stakeholders ensures appropriate oversight of program implementation and ongoing quality improvement. | a. The Rapid StART kickoff meeting with the Core Group of implementation staff first met in July of 2024 to develop a workplan, roles, and next steps in implementation.<br>b. The Multi-Service RFP released in September 2024 included a prompt for OAHS and EIS proposers to outline their current capacity and readiness to deliver Rapid StART programming. |
| **Viral Loads in Minnesota CAREWare:** The HC RWHAP has a goal to have complete viral load data for 90% of Part A clients in CAREWare.<br><br>Systemwide issues in CAREWare can create missing viral loads which leads to incomplete data. | a. Surveillance data is integrated with client-level services data in MN CAREWare.<br>b. Subrecipient contracts include an efficiency measure of percentage of eligible persons missing a viral load in CAREWare in the past twelve months with the performance goal set at <5%. | a. Data integration allows more accurate and timely data on each stage of the HIV Care Continuum (HCC). Subrecipients view their own data to analyze their own agency or program-specific HCC, understanding their real time performance and develop strategies to improve outcomes.<br>b. Subrecipients report client viral load data in CAREWare and comply with data reporting requirements. | a. Data integration is complete; HC RWHAP continues to meet with a client level data workgroup to monitor and address any issues that emerge. Data is reported and discussed at monthly programmatic meetings. Most recent percentage is 91.7%<br>b. Subrecipient contracts include this efficiency measure and contractual requirements are discussed during annual site visits. |
| **Minnesota Centralized Eligibility (MNCE):** Operationalizing a system-wide change to determining client | a. HC RWHAP assesses and monitors subrecipient adherence to MNCE.<br>b. HC RWHAP participates in a | a. Client RWHAP eligibility determination is streamlined and more efficient. | a. All funded subrecipients provide their MNCE policies. Any subrecipient found to be out of compliance is offered |

| Challenges and Barriers | Proposed Resolutions | Intended Outcomes | Current Status |
|---|---|---|---|
| eligibility for Ryan White services.<br><br>Minnesota is one year into a systems-change for determining Ryan White eligibility for Parts A and B which moved the responsibility of verifying and documenting client eligibility from the subrecipient-level to the local Ryan White Part B recipient, the Minnesota Department of Human Services. | MNCE community engagement and communications workgroup to regularly assess and discuss the impact on clients and system improvement.<br>c. Develop and distribute a MNCE provider user manual. | b. Subrecipients have policies for verifying RWHAP eligibility, screening for duplication of services, and ensuring RWHAP is payor of last resort. HC RWHAP monitors clients charged to the RWP through quarterly eligibility reports.<br>c. Recipients understand the impact MNCE has on clients and assess where clients receive eligibility information and resources. | support and guidance to develop an appropriate policy.<br>b. A brief survey was sent to new and renewing clients with their eligibility determination letter to help recipients understand the client impact of MNCE.<br>c. The MNCE user guide has been developed and disseminated to providers. |

- **EVALUATION AND TECHNICAL SUPPORT CAPACITY**

B. Table 8: Clinical Quality Management (CQM) Program:

| Intended Outcome/Impact | Related Service Category | Key Activities | Timeline | Person(s)/Org(s) Responsible | Methodology |
|---|---|---|---|---|---|
| Increase percentage of Black/African American Ryan White consumers who are virally suppressed from 89.5% to 93% by 3/31/25. | Outpatient Ambulatory Health<br><br>Medical Case Management | Pull CAREWare data to find clients who are not virally suppressed<br><br>Use Electronic Medical Record to track and monitor missed lab appts<br><br>Outreach to clients to make appts and link to care and/or pharmacy<br><br>Facilitate social worker team racial equity training | April 2024 – March 2025 | HealthPartners<br><br>Clinical Quality Management Coordinator | Plan, Do, Study, Act (PDSA) Cycles |
| By the end of the fiscal year, at least half of all HIV testing outreach events will be conducted in geographic areas where more than 23.6% of residents identify as Black/African American. | Early Intervention | Obtain census tract information from public health Informatics team<br><br>Develop 4+ new partners to engage key populations at regular outreach to ensure a holistic approach to health for Black/African | April 2024 – March 2025<br><br>Quarterly analysis and reporting<br><br>3 new partners by Q3<br><br>4 new partners by Q4 | Red Door Clinic<br><br>EIS Outreach Staff<br><br>Clinical Quality Management Coordinator | Plan, Do, Study, Act (PDSA) Cycles |

| Intended Outcome/Impact | Related Service Category | Key Activities | Timeline | Person(s)/Org(s) Responsible | Methodology |
|---|---|---|---|---|---|
| | | American populations | | | |
| By the end of the fiscal year, 50% of participants with an HIV diagnosis who visit the Kola* clinic will see an HCH RN or provider. | Case Management | Encourage event participants at encampments to visit Kola Clinic for low barrier service access. | April 2024 – March 2025<br><br>Quarterly analysis and reporting | Healthcare for the Homeless (HCH)<br><br>Clinical Quality Management Coordinator | Plan, Do, Study, Act (PDSA) Cycles |
| Utilize a prioritized patient "Not in Care" list that includes people in the local HIV Outbreak, MSM/IDU, those who identify as Black, Hispanic/Latinx, Native, Asian, or Multiple Races to find 18 case findings from this list resulting in 6 successful linkages to care. | Early Intervention | Monitor Data2Care (D2C) progress using tracker tool for out-of-care client outreach | April 2024 – March 2025<br><br>Quarterly analysis and reporting<br><br>Q1: Create new priority list, update community partners, record client race/ ethnicity<br><br>Q2: Hire and train new D2C staff member; review progress to date; assess tools and strategies to continue | Red Door Clinic<br><br>Clinical Quality Management Coordinator | Plan, Do, Study, Act (PDSA) Cycles |
| Increase percentage of The Aliveness Project's clients using harm reduction services who have been screened for case management services by 10%. | Early Intervention<br><br>Case Management | Increase case management screening for clients accessing harm reduction services | April 2024 – March 2025<br><br>Quarterly analysis and reporting<br><br>Q1: Assess MSM/IDU clients accessing Syringe Services Program within last year<br>Q2 - 3: Identify clients already screened for case management<br>Q2 – 3: Outreach and Case Management staff outreach to clients who have not been screened for Case | The Aliveness Project outreach and case management staff<br><br>Clinical Quality Management Coordinator | Plan, Do, Study, Act (PDSA) Cycles |

| Intended Outcome/Impact | Related Service Category | Key Activities | Timeline | Person(s)/Org(s) Responsible | Methodology |
|---|---|---|---|---|---|
| | | | Management. to offer services<br>Q2 – 3: Screen interested clients for case management<br>Q3 – 4: Adjust intervention based on performance | | |

*Provides culturally responsive clinical services for American Indian/Alaskan Natives.

Each of the outlined subrecipient Quality Improvement (QI) goals in Table 8 are one of many QI goals that contribute to the overall FY24 Part A CQM program goals as determined by the Quality Management Advisory Committee (QMAC), enumerated below.

1. Increase from 86% to 93% viral suppression rates of MSP-TGA Black/African American MSM consumers.
2. Increase HIV tests for men of color who have sex with men by Part A-funded providers from 469 to 624 (+33%).
3. Increase number of people with HIV enrolled in the RWHAP in the MSP-TGA from 2,923 to 4,260 (+8.6%).
4. Increase from 57.8% of a cohort of MSP-TGA PWH who were unstably housed and not virally suppressed as of 12/31/23 who are virally suppressed to 60% of a similar cohort virally suppressed as of 12/31/24.
5. Increase from 32% of outbreak cases in the MSP-TGA are connected to HIV medical case management services to 40% (+8%) by the end of 2024.