Integrated Plan: 2022 Data Update

MN Department of Human Services | MN Department of Health | Hennepin County

DEPARTMENT OF HUMAN SERVICES

DEPARTMENT OF HEALTH

Hennepin

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

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Goal 1 Objectives

1.1 Increase estimated percent of people living with HIV who know their status to 95%

1.2 Decrease percent of people diagnosed with AIDS at initial HIV diagnosis to 13%

1.3 Decrease percent of people diagnosed with AIDS within one year of their initial HIV diagnosis to 15%

1.4 Increase percent of tests conducted by Ryan White-funded and CDC prevention-funded grantees for people within priority populations

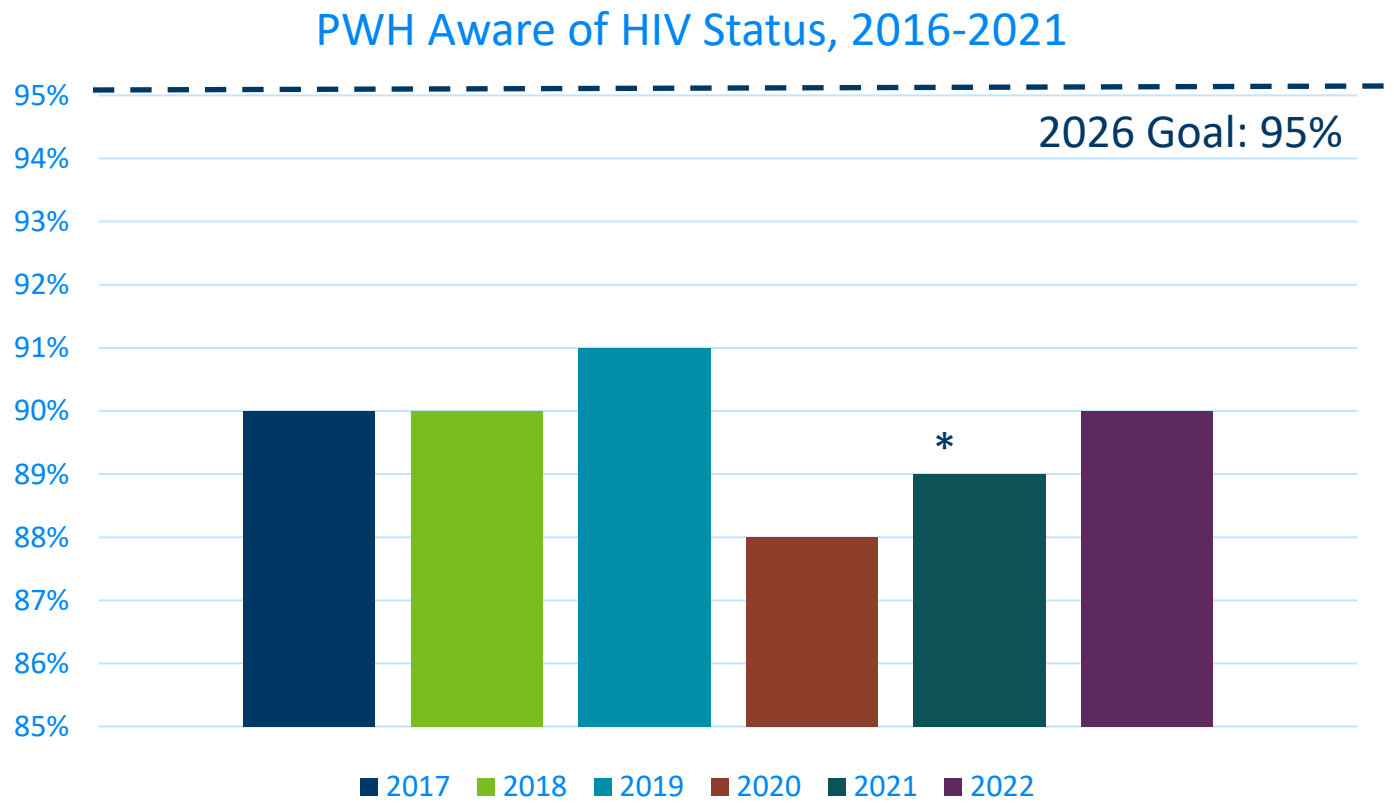
1.5 Train all EIS provider organizations on culturally responsive and trauma-informed HIV testing

1.1 Aware of HIV status

Definition:

Aware:
PLWH in MN /
(PLWH in MN + undiagnosed estimate)

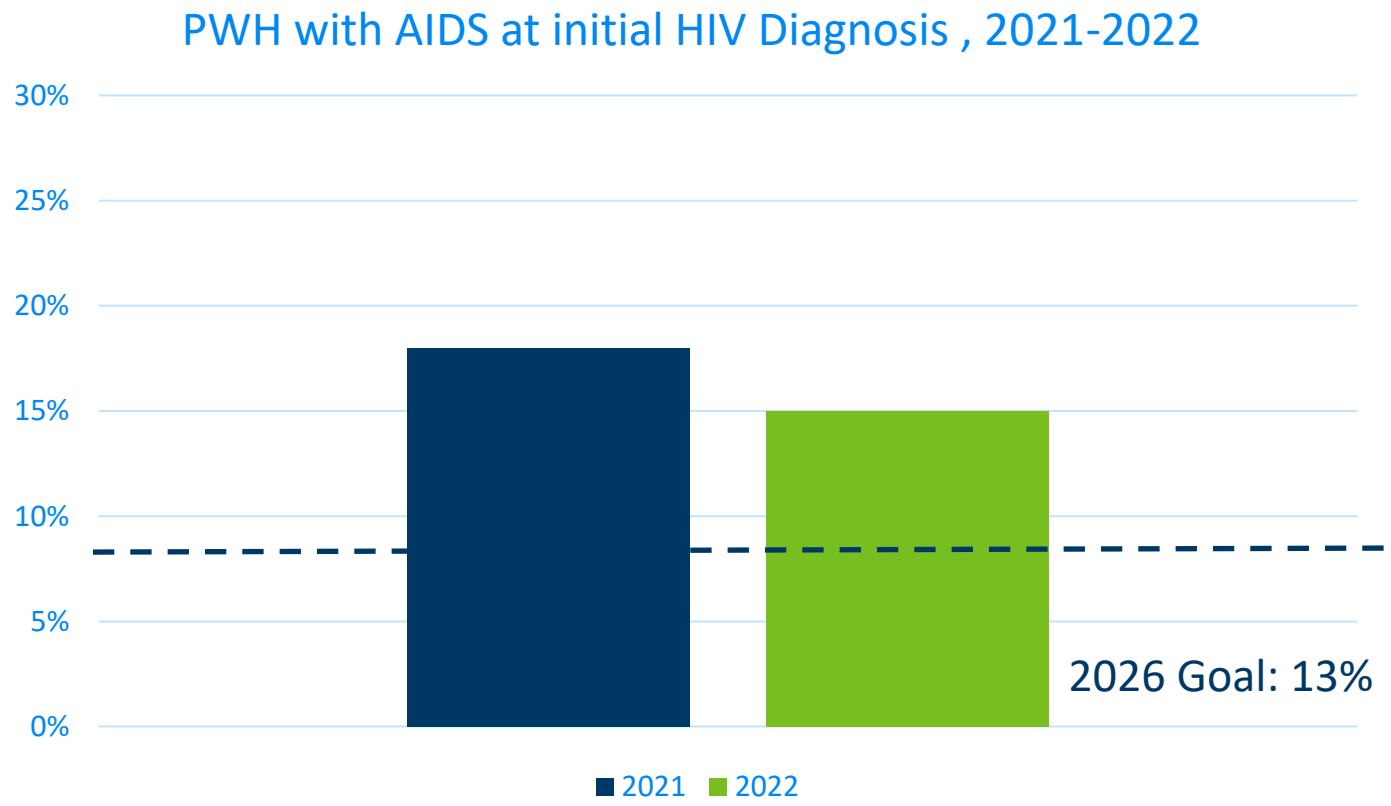
**2020 – 2022 undiagnosed method based on cd4 estimation. Previous years used a different CDC method.*



1.2 Diagnosed with AIDS at HIV Diagnosis

Definition:

People who had had initial HIV Test
AND diagnosed with AIDS at initial test /
People who had initial
HIV Positive Test

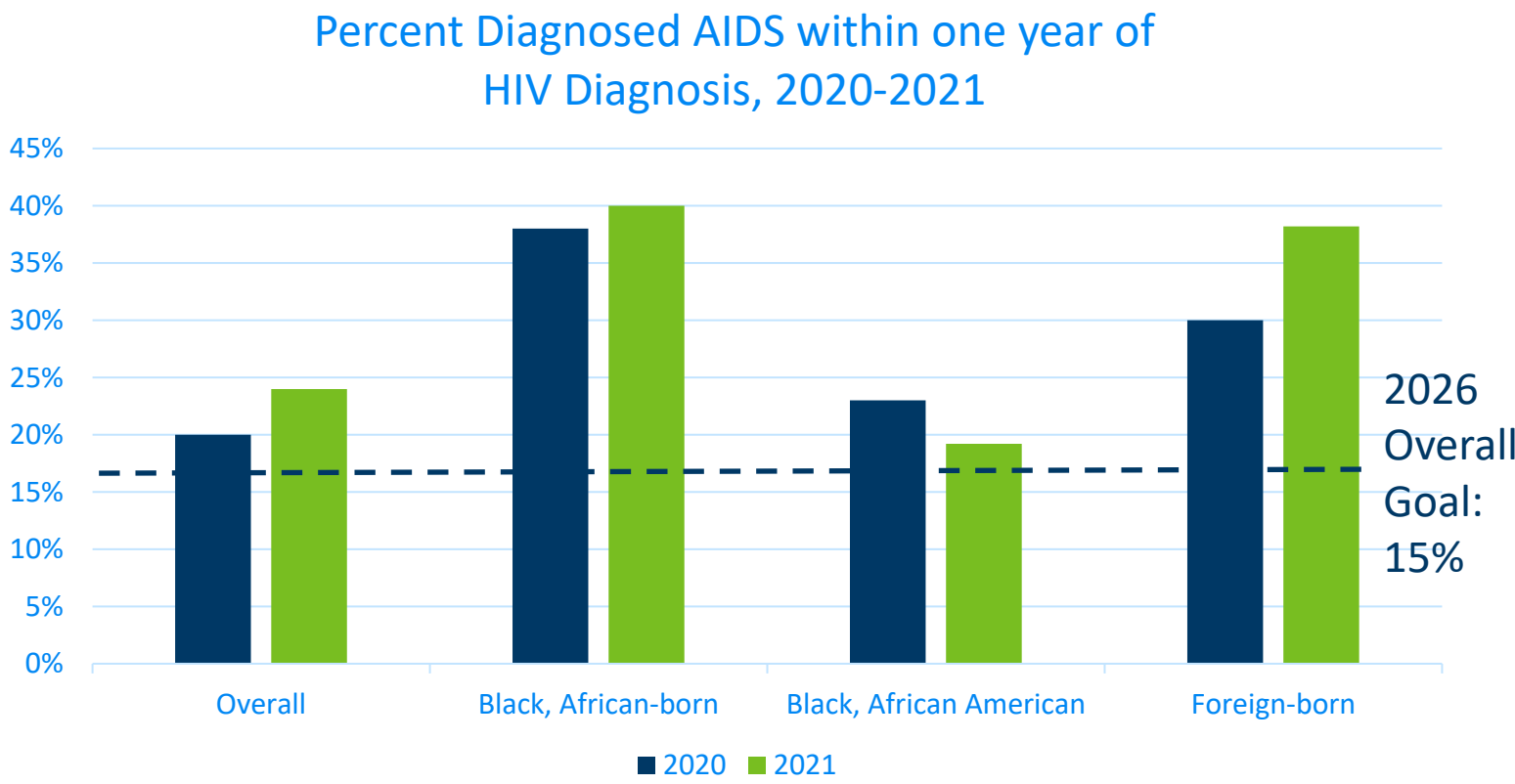


1.3 Diagnosed with AIDS at within 1 year of HIV Diagnosis

Definition:

People who had had initial HIV Test AND diagnosed with AIDS at within one year of initial test /
People who had initial
HIV Positive Test

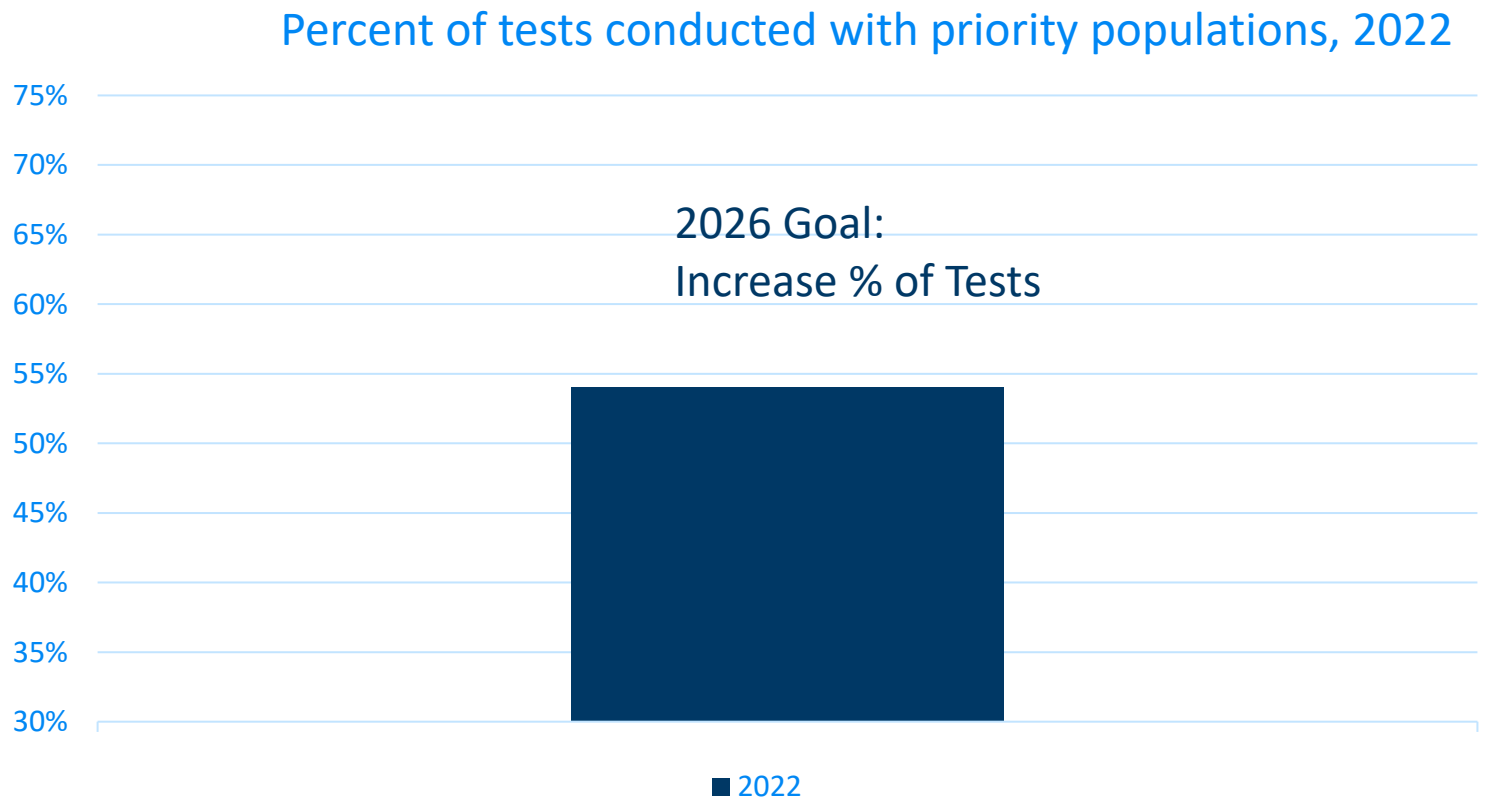
*Goal for priority population is to address disparities



1.4 Percent of tests given to priority populations

Definition:

Tests conducted by Ryan White and CDC funded grantees given to people Within priority populations / Tests conducted by Ryan White and CDC funded grantees



1.5 Percent of EIS provider organizations trained on culturally responsive and trauma-informed HIV testing

All EIS provider organizations attend the three-day HIV Tester Training delivered by MDH staff (in collaboration with community workers who also reflect clients served). These trainings include cultural humility, motivational interviewing, and harm reduction approaches.

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

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Goal 2 Objectives

2.1 Increase percent of PWH linked to care within 30 days of diagnosis to 95%

2.2 Increase percent of PWH retained in HIV care to 85%

2.3 Increase percent of people enrolled in Ryan White services retained in care to 96%

2.4 Increase percent of PWH who report not having trouble paying medical bills to 80%

2.5 Increase percent of PWH who are virally suppressed to 75%

2.6 Increase percent of people enrolled in Ryan White services who are virally suppressed to 95%

Goal 2 Objectives (cont)

2.7 Increase percent of PWH who are enrolled in Ryan White services to 60%

2.8 Increase percent of PWH who report they were able to access needed mental health services to 80%

2.9 Increase percent of people who report they are stably housed to 95%

2.10 Increase percent of PWH who report they never or rarely ran out of food in the last year to 75%

2.11 Increase percent of PWH who are report their overall health is good or excellent

2.12 Increase percent of PWH who are achieved their definition of wellness

2.13 Increase percent of PWH who are report they received support to overcome barriers to accessing HIV care

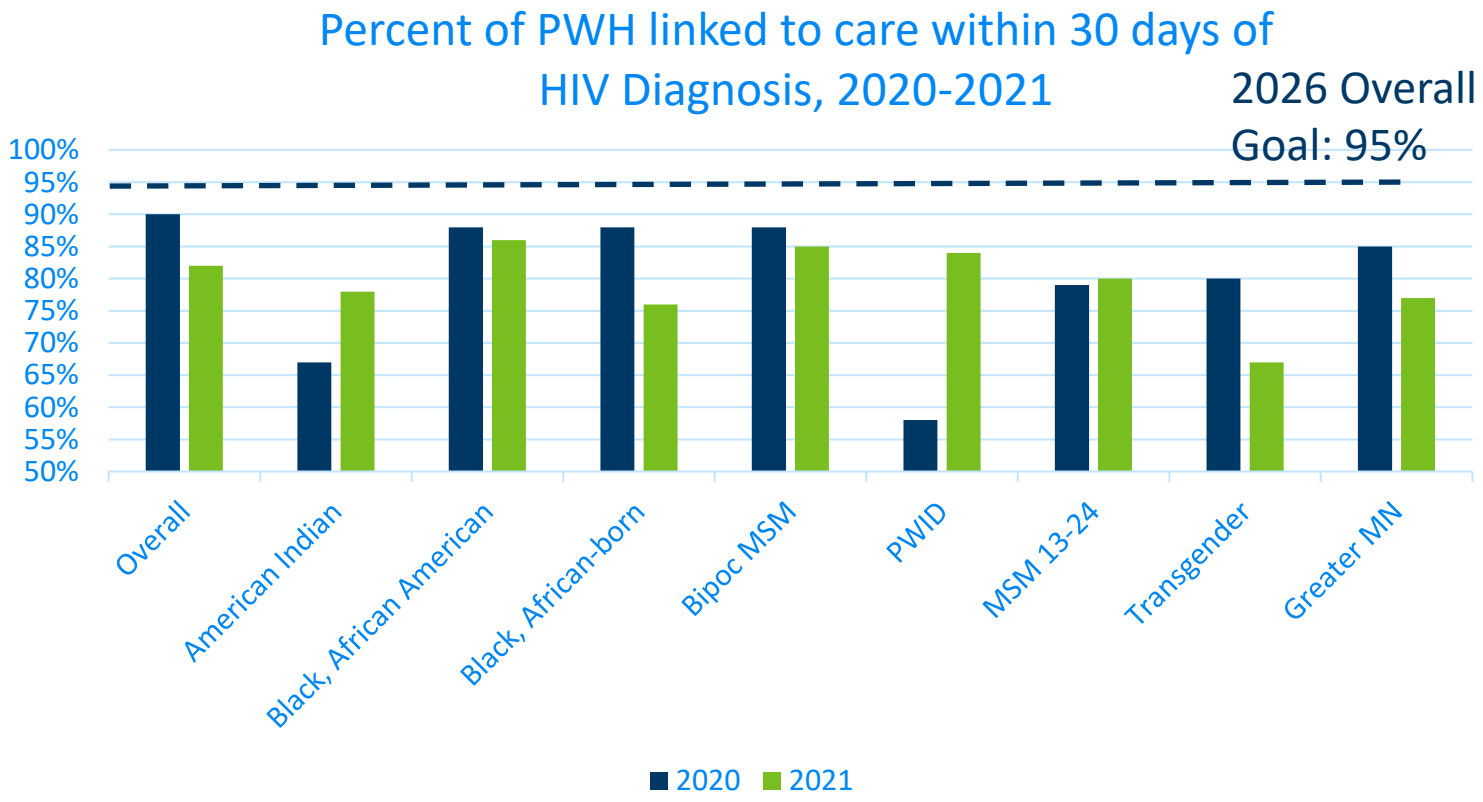
2.1 Percent of PWH linked to care within 30 days of Diagnosis

Definition:

And linked into care within 30 Days of their diagnosis /
All people diagnosed within HIV In a calendar year

*2022 care continuum looks at percent of PWH linked to care in 2021

**Goal for priority population is to address disparities



2.2 Percent of PWH retained in HIV care

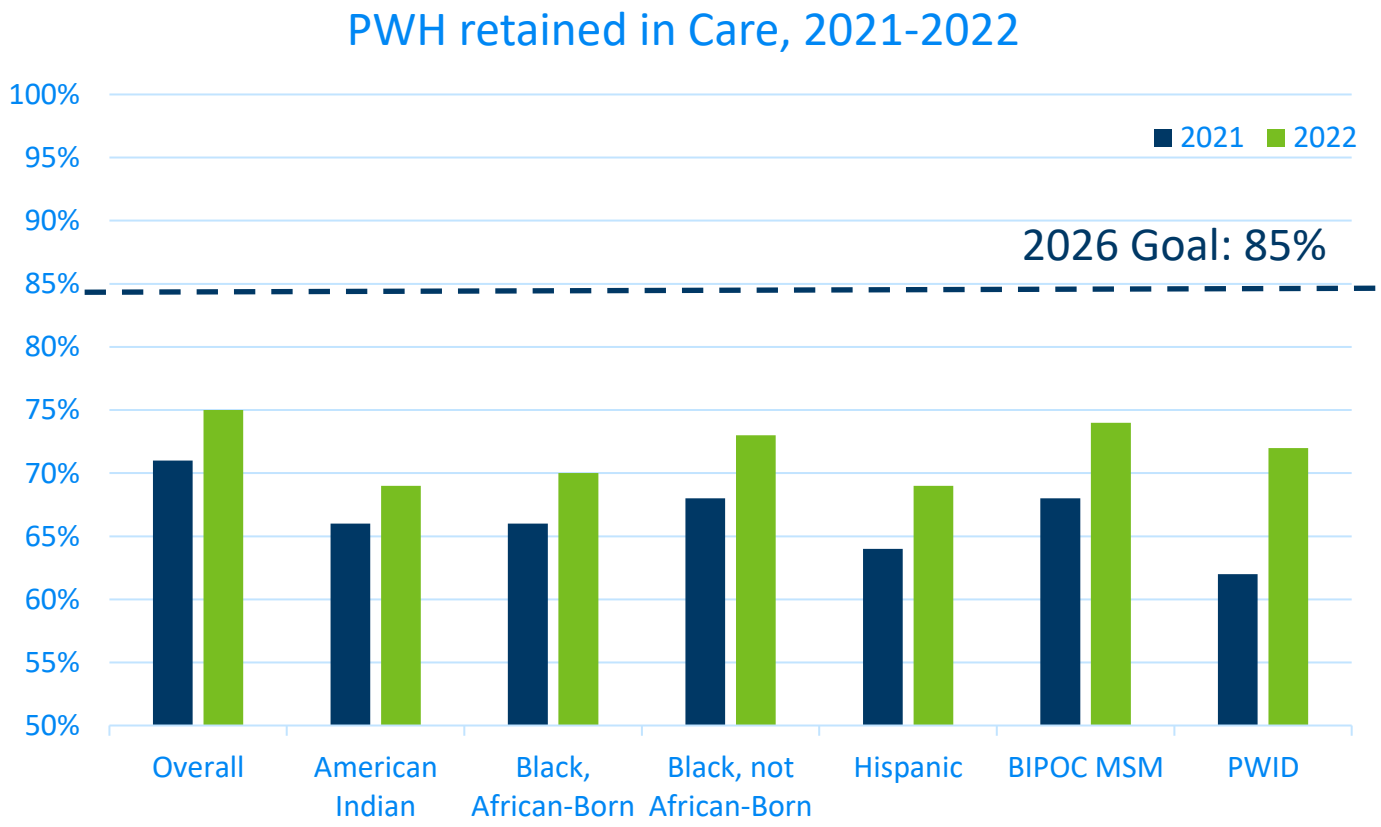
Definition:

PWH who had a CD4 test or Viral load test During the calendar year

/

All PWH living in Minnesota at end of Calendar year

**Goal for priority population is to address disparities

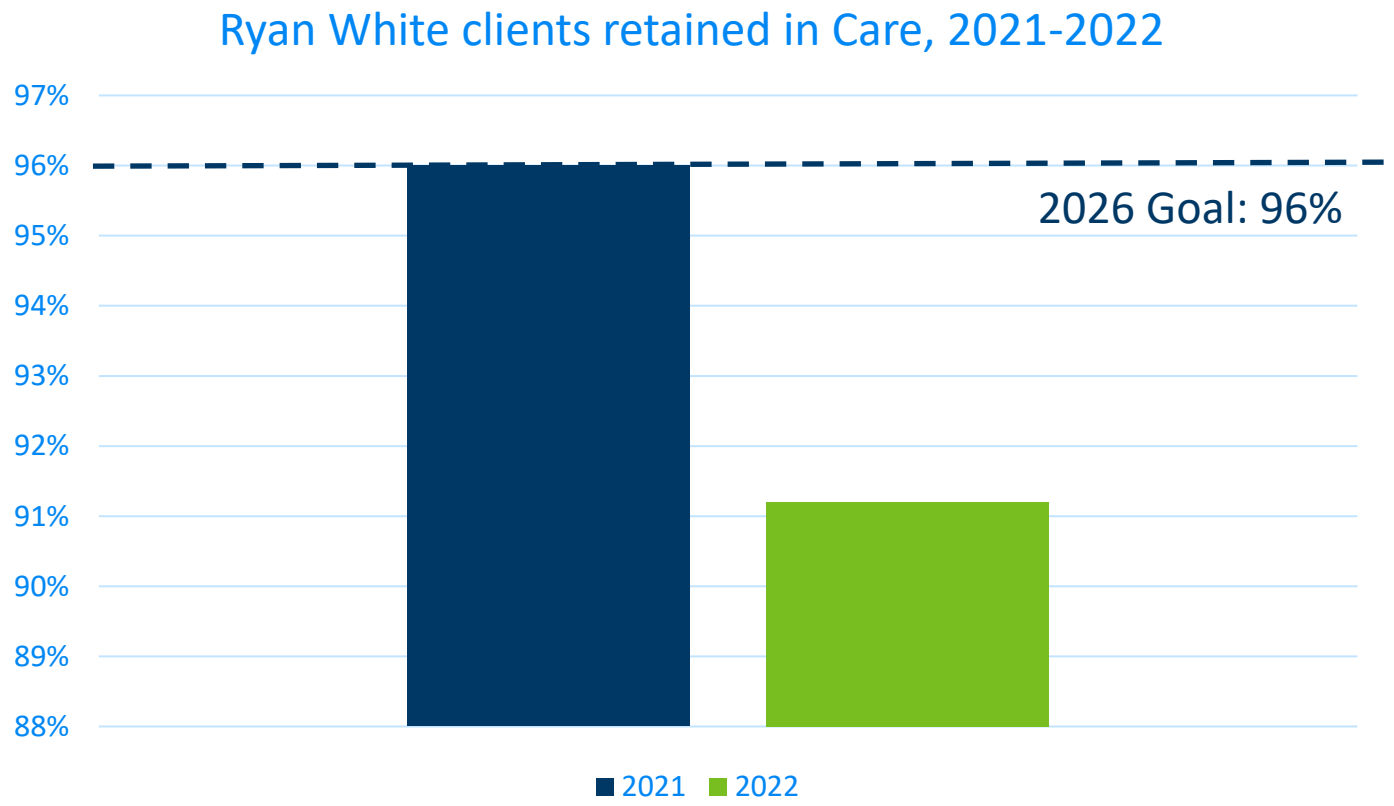


2.3 Percent of Ryan White clients retained in care

Definition:

People who had a Ryan White service AND a CD4 test, Viral load test, OAHS Service, or Form 1 during the calendar Year /
People who had a Ryan White service During the Calendar year

In 2022, Form 1s did not record doctors Visits, so were not included in retention In care. This accounts for the decline in Retention in Care.



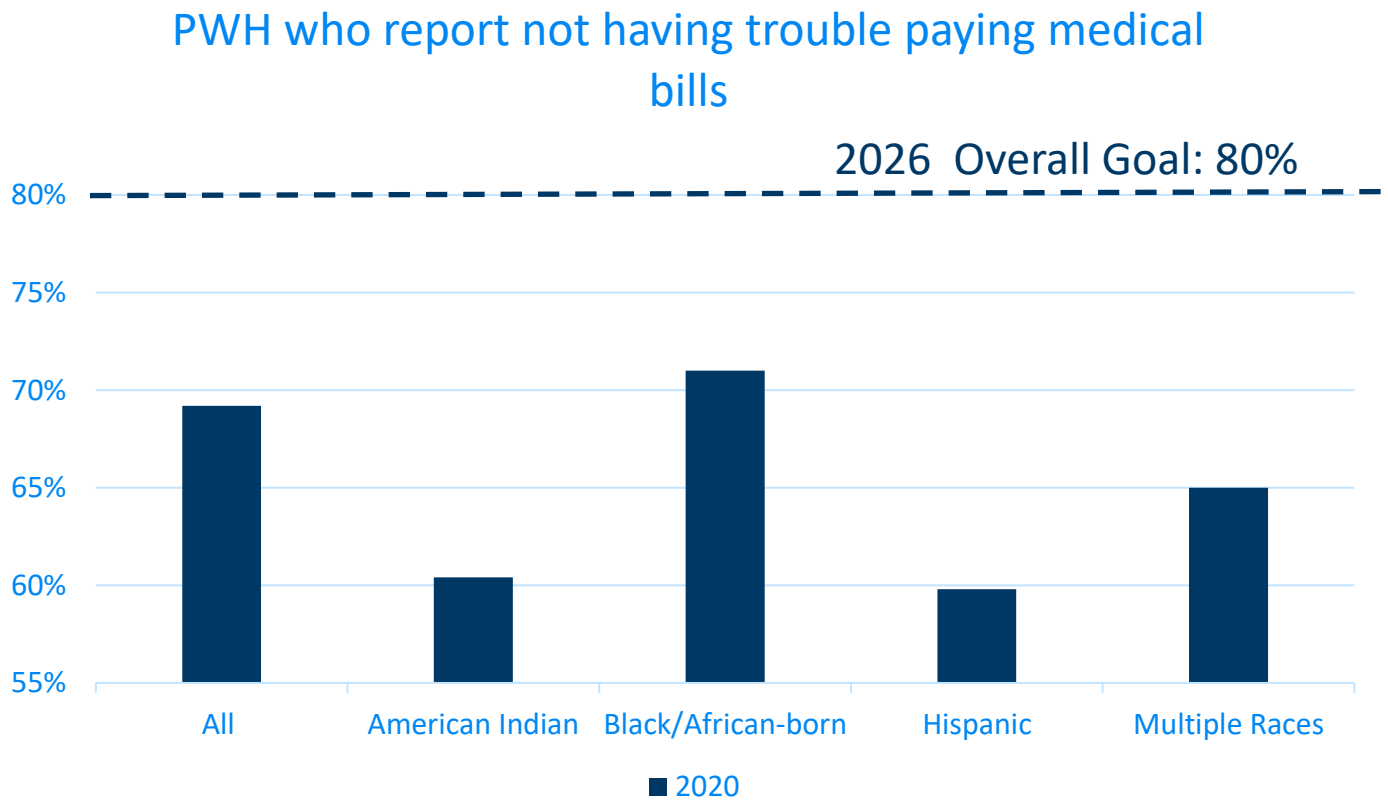
2.4 Percent of PWH who report not having trouble paying medical bills

Definition:

People who reported not having trouble paying medical bills on the 2020 Needs Assessment

*Question will be asked on the 2025 needs assessment

*Goal for priority population is to address disparities

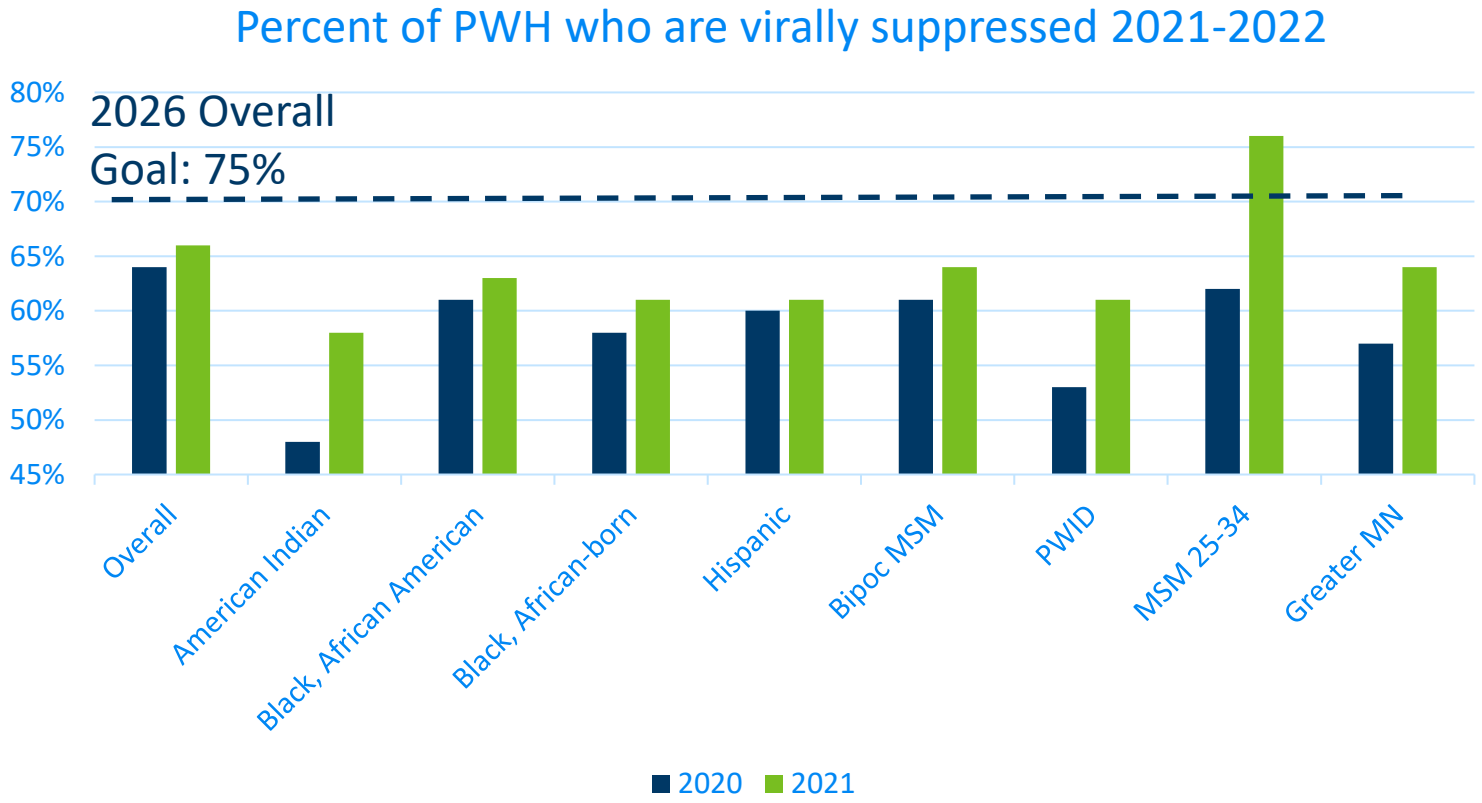


2.5 Percent of PWH who are virally suppressed

Definition:

People living with HIV who had a Viral Load Test within the Calendar Year, and were Virally Suppressed at their most recent Viral Load
/
All PWH living in Minnesota at end of Calendar year

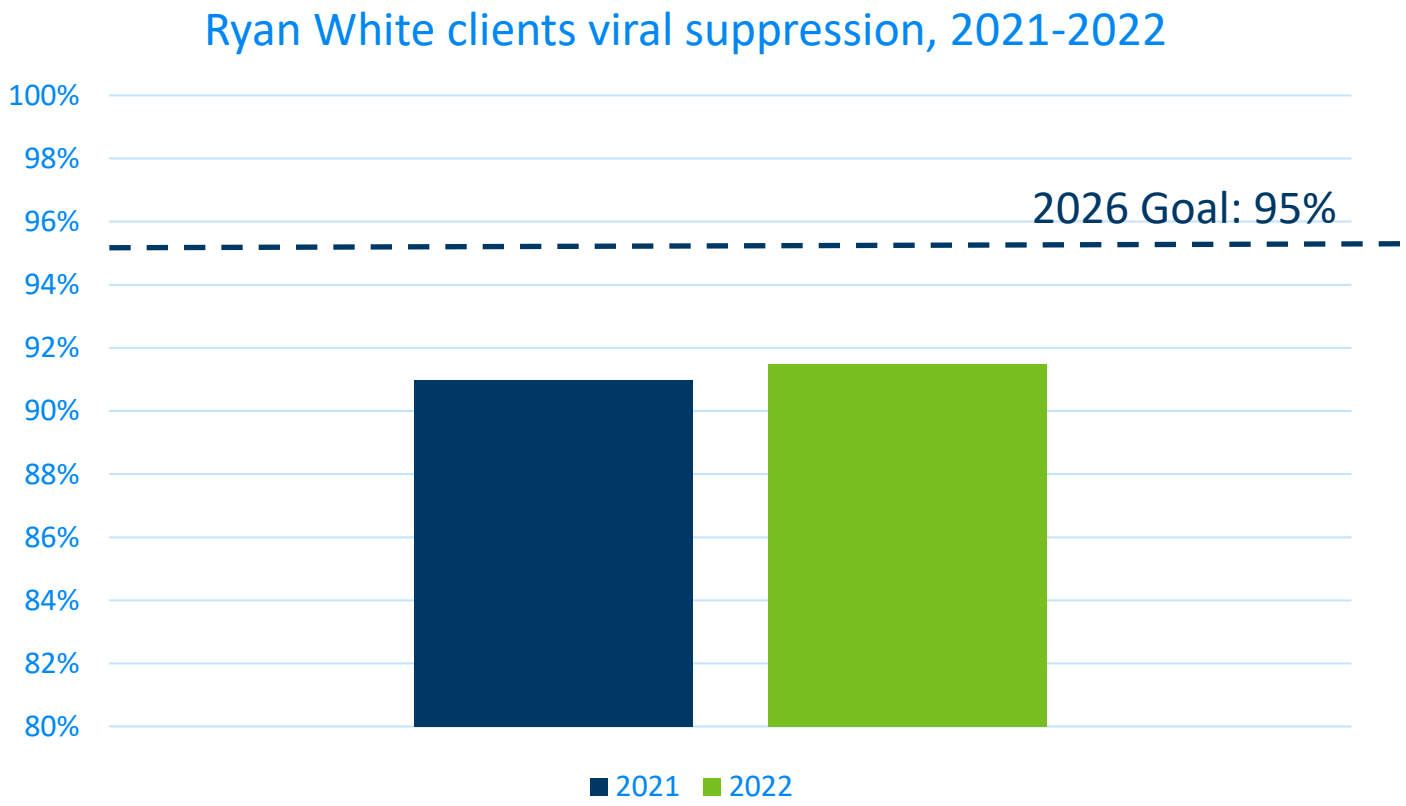
**Goal for priority population is to address disparities



2.6 Percent of people enrolled in Ryan White services who are virally suppressed

Definition:

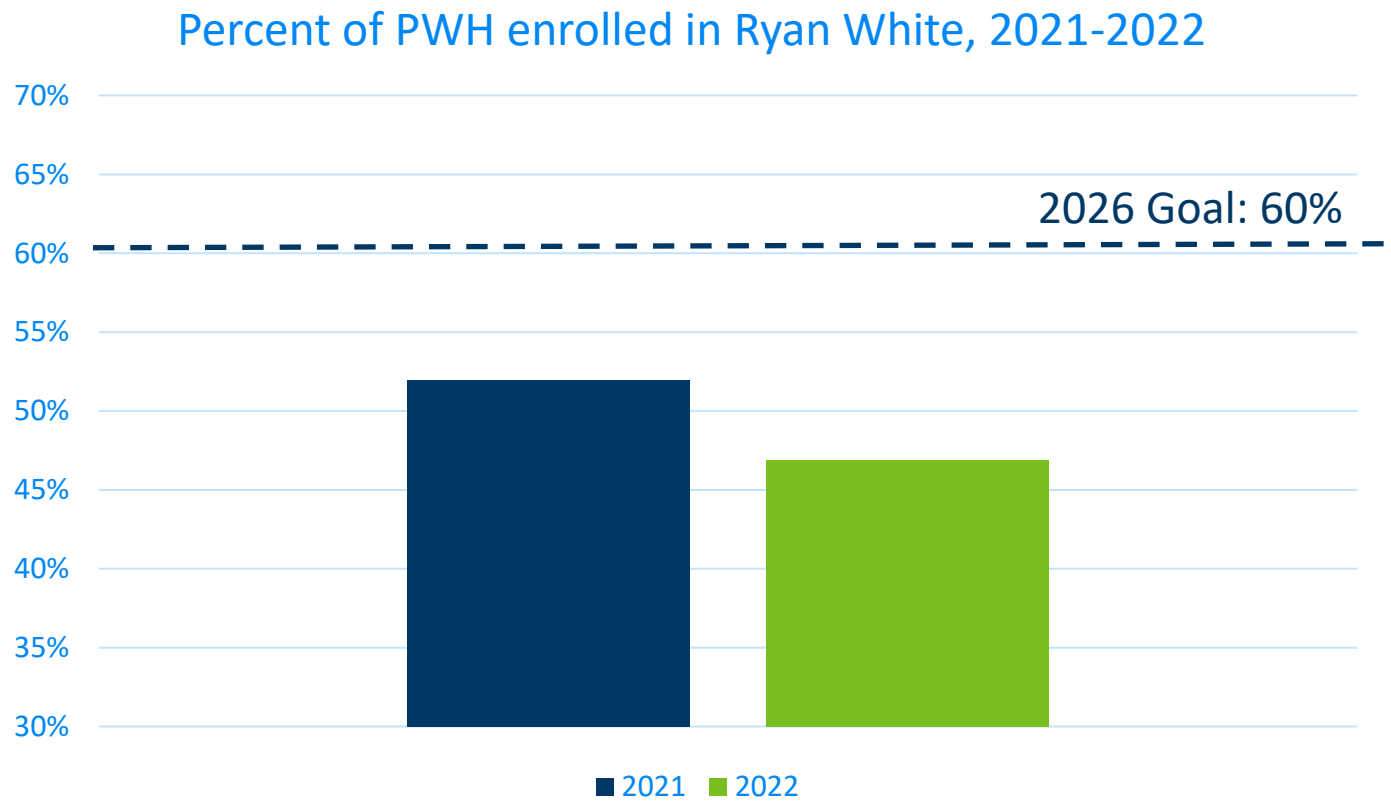
People who had a Ryan White service AND were unsuppressed at their most recent viral load test in the calendar year
/
People who had a Ryan White service AND a viral load test in the calendar year



2.7 Percent of people diagnosed with HIV who are enrolled in Ryan White services

Definition:

People who had a Ryan White service
During the calendar year
/
People diagnosed with HIV living in
Minnesota in the calendar year

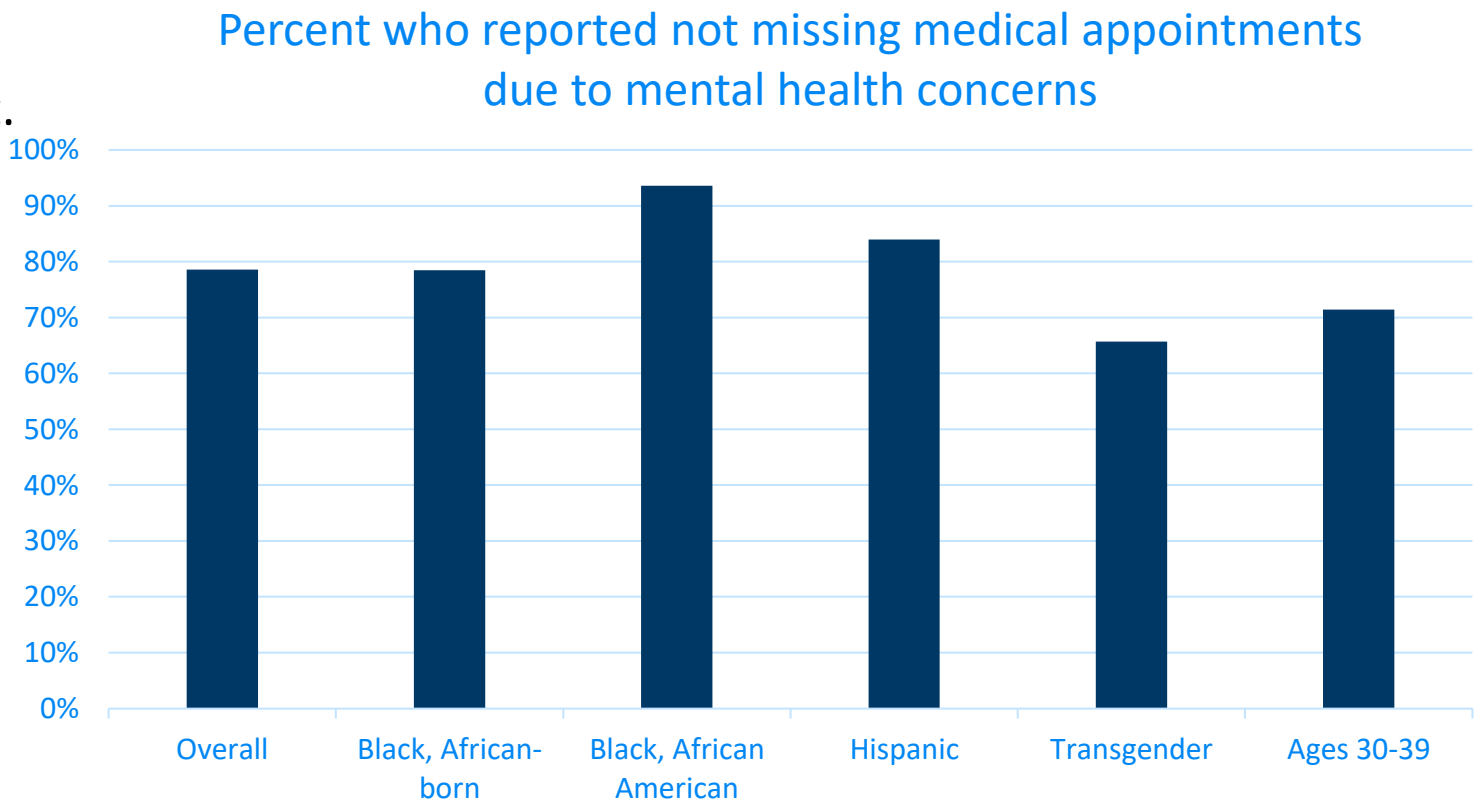


2.8 Percent of PWH who report they were able to access needed mental health services

This question was not asked on The 2020 needs Assessment, so a Proxy is used. The question will be Added to the 2025 Needs Assessment.

Proxy: Percent of PWH who reported That emotions, nerves, or mental health did not cause them to miss an HIV medical appointment on the 2020 Needs Assessment

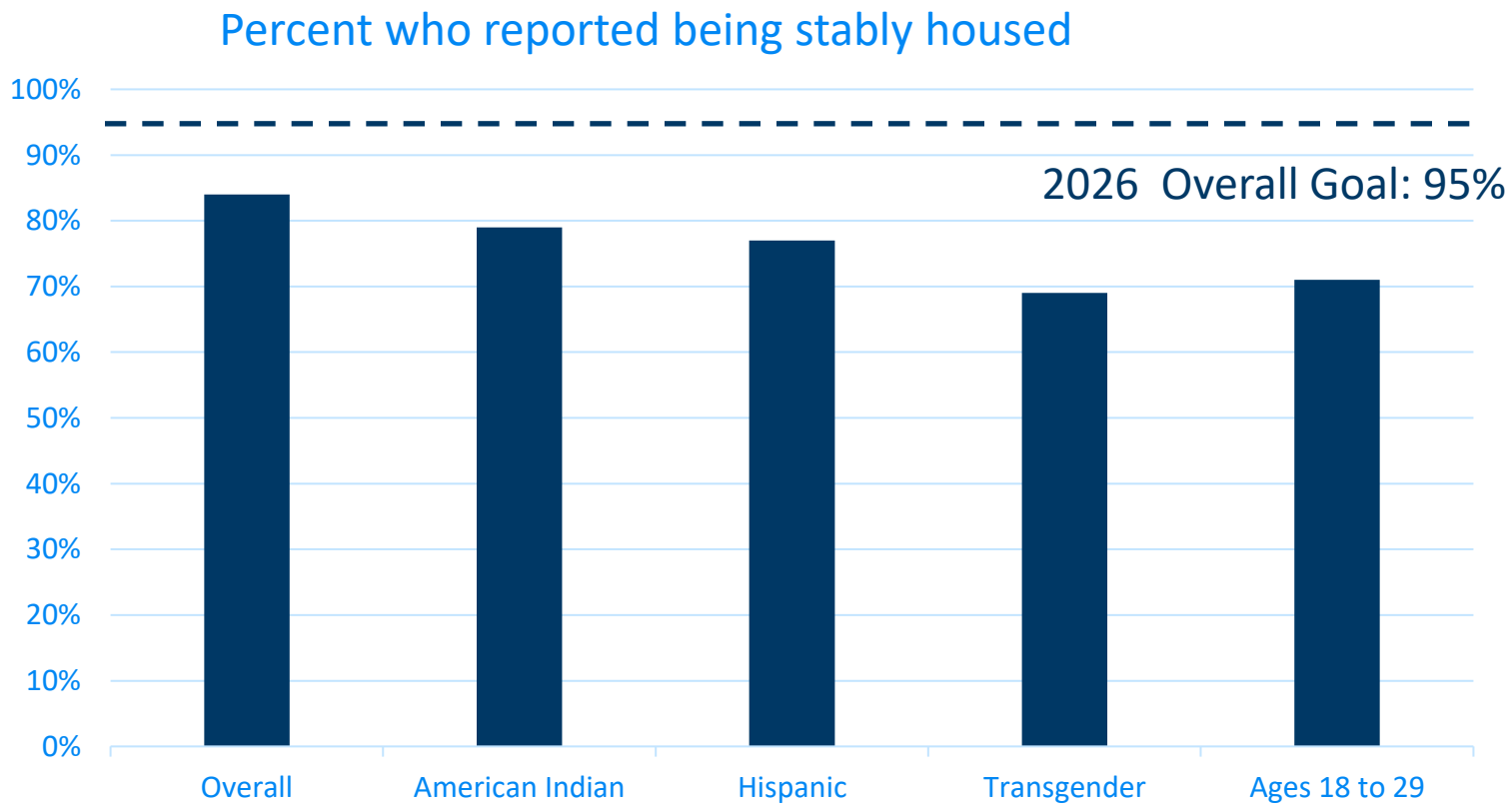
*Goal for priority population is to address disparities



2.9 Percent of PWH who report they are stably housed

Percent of PWH who reported
That they were stably housed on
The 2020 Needs Assessment

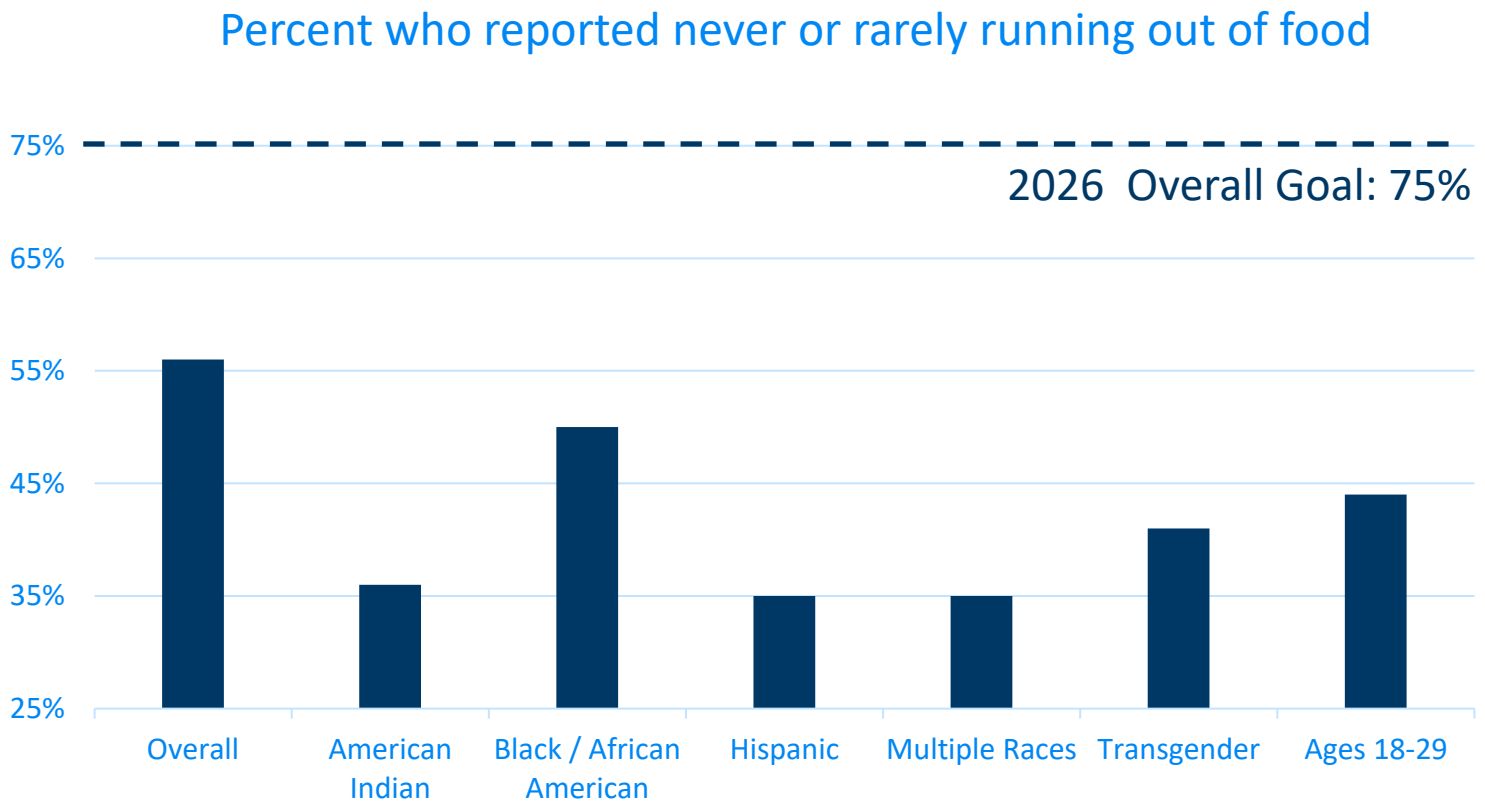
*Goal for priority population is to address disparities



2.10 Percent of PWH who report they never or rarely ran out of food in the last year

Percent of PWH who reported
That they never or rarely ran out of
Food in the last year on the
2020 Needs Assessment

*Goal for priority population is to address disparities



Goals 2.11 Through 2.13

Goals 2.11, 2.12. and 2.13 were not asked on the 2020 Needs Assessment, so we don't have any baselines or data for them. They can be added to the 2025 Needs Assessment

2.11 Increase percent of PWH who are report their overall health is good or excellent

2.12 Increase percent of PWH who are achieved their definition of wellness

2.13 Increase percent of PWH who are report they received support to overcome barriers to accessing HIV care

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

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Goal 3 Objectives

3.1a Decrease the number of new HIV infections to 150 annually

3.1b Address disparities in the rate of new HIV diagnosis among priority populations.

3.2 Increase PrEP-to-Need Ratio among priority populations

3.3 Increase the percent of HIV-negative clients tested by EIS and prevention that are screened for PrEP eligibility (increase 20% from baseline)

3.4 Increase the percent of HIV-negative clients tested by EIS and prevention that are referred and linked to a site for PreP care (increase 20% from baseline)

Goal 3 Objectives (cont)

3.5 Increase the percent of HIV-negative, PrEP eligible clients tested by MDH funded PrEP programs who are prescribed (increase 5% from baseline)

3.6 Increase the percent of HIV-negative, PrEP eligible clients tested by MDH funded PrEP programs who are prescribed among priority populations (address disparities for priority populations)

3.7 Increase the perfect of people who refill their PrEP prescription, among people tested by MDH-funded PrEP programs (baseline needs to be established).

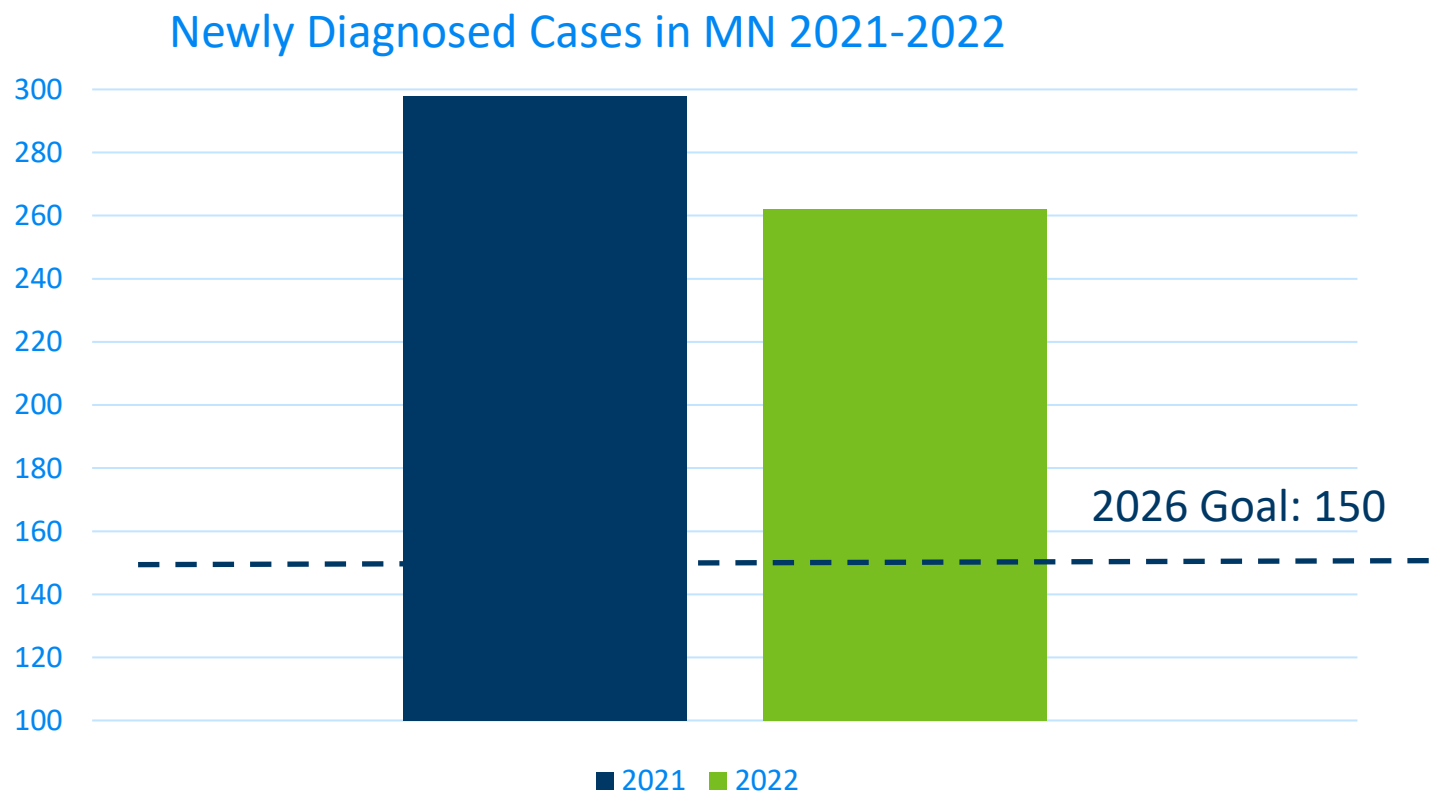
3.8 Decrease in the percent of PWH who report that they used a needle after someone else in the last year (10%)

3.9 Increase the percentage of PWH identified through Ryan White funded EIS programs that are either newly diagnosed or out of case who achieve viral suppression within 60 days of reconnection to HIV care. (Goal TBD)

3.1 Number of annual new HIV diagnoses

Definition:

Number of people newly diagnosed with HIV within a calendar year

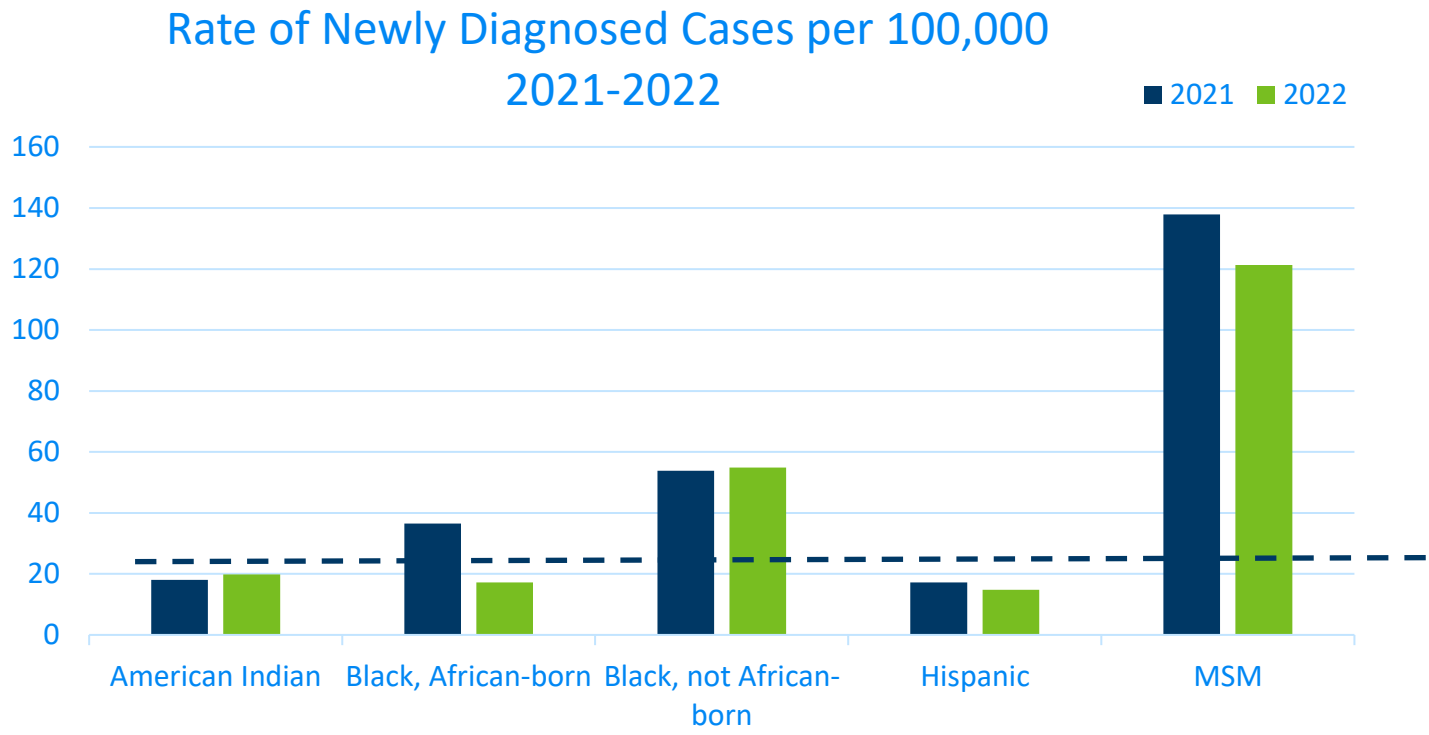


3.1b Rate per 100,000 of annual new HIV diagnoses

Definition:

Number of people newly diagnosed with HIV within a calendar year

*Goal for priority population is to address disparities

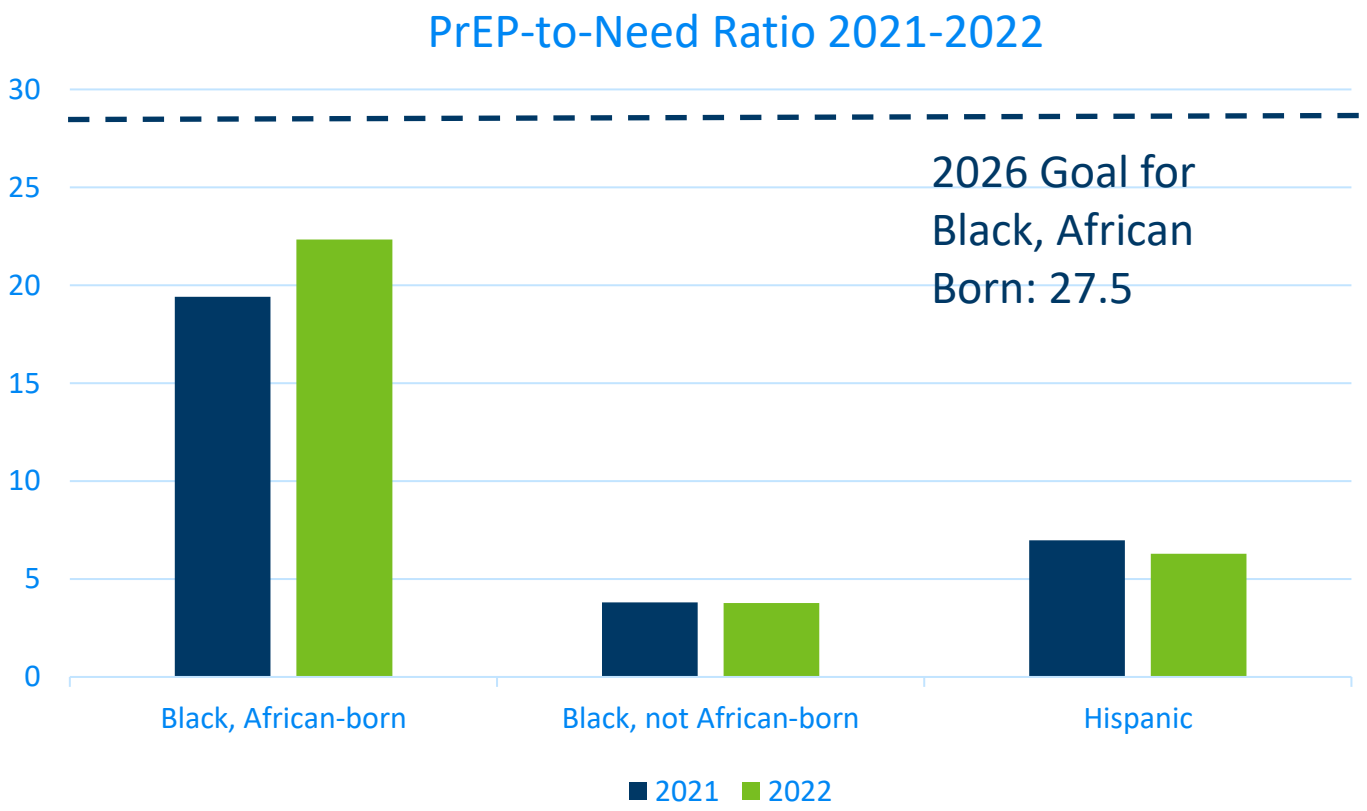


3.2 PrEP-to-Need Ratio

Definition: PrEP to Need

Ratio :
Number of PrEP users /
Number of newly diagnosed HIV cases

*Goal for Black, not African-born and Hispanic is to address disparities

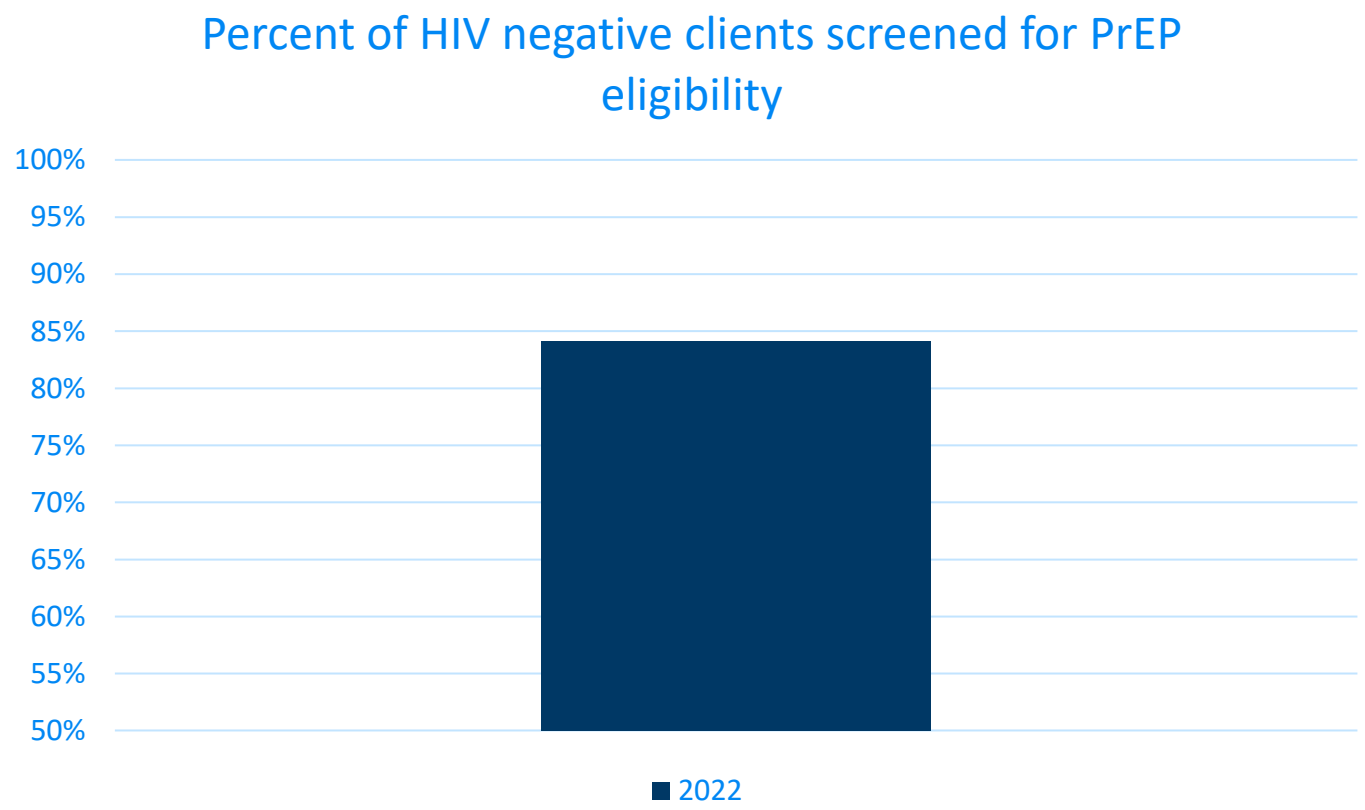


3.3 Percent of HIV negative clients screened for PrEP, among those tested by EIS and prevention funded grantee organizations

Definition:

People who tested negative for HIV
By EIS and prevention-funded grantee
Organizations who are screened for
PrEP eligibility
/
All people who tested negative for HIV
By EIS and prevention-funded grantee
Organizations

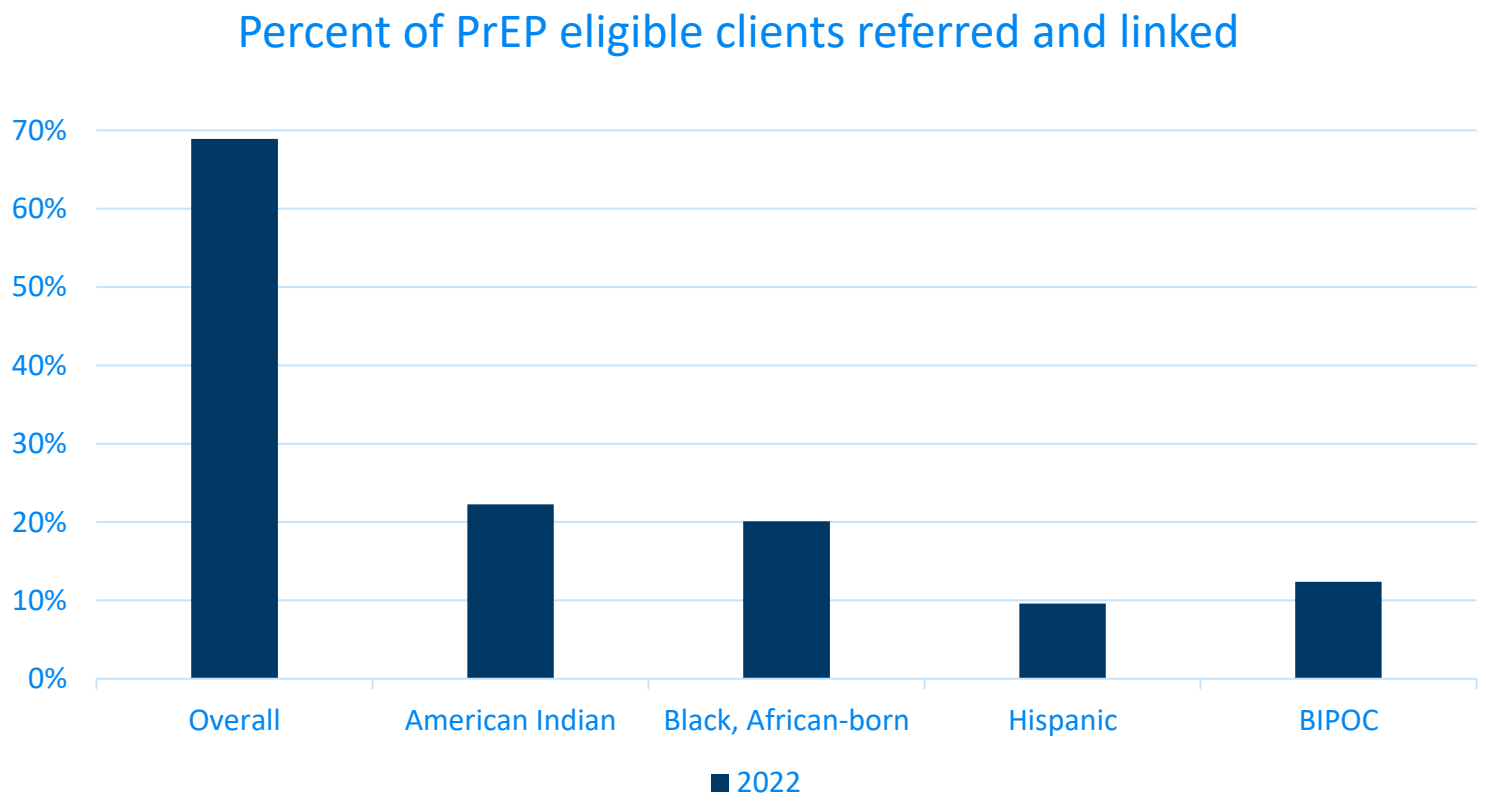
Goal: 20% increase from Baseline



3.4 Percent of PrEP eligible HIV negative clients referred and linked to a site for PrEP care

Definition:

People who tested negative for HIV
By EIS and prevention-funded grantee
Organizations who are eligible for
PrEP and referred and linked to a
PrEP site
/
All People who tested negative for HIV
By EIS and prevention-funded grantee
Organizations who are eligible for
PrEP

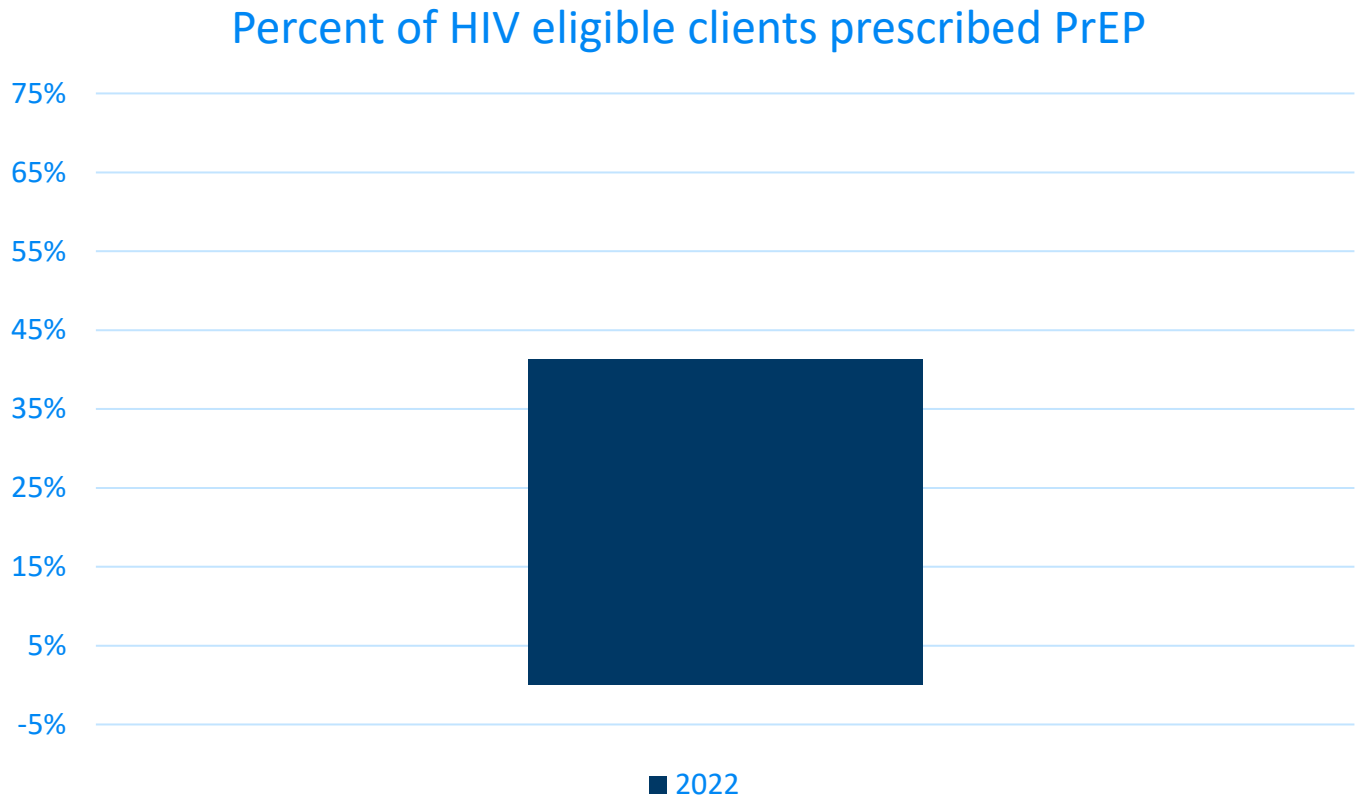


Goal: 20% increase from Baseline

3.5 Percent of HIV negative clients who are prescribed PrEP among those eligible (tested by MDH-funded PrEP programs)

Definition:

People who tested negative for HIV
By MDH-funded PrEP programs and were
Prescribed PrEP /
People who tested negative for HIV
By MDH-funded PrEP programs and were
Eligible for PrEP

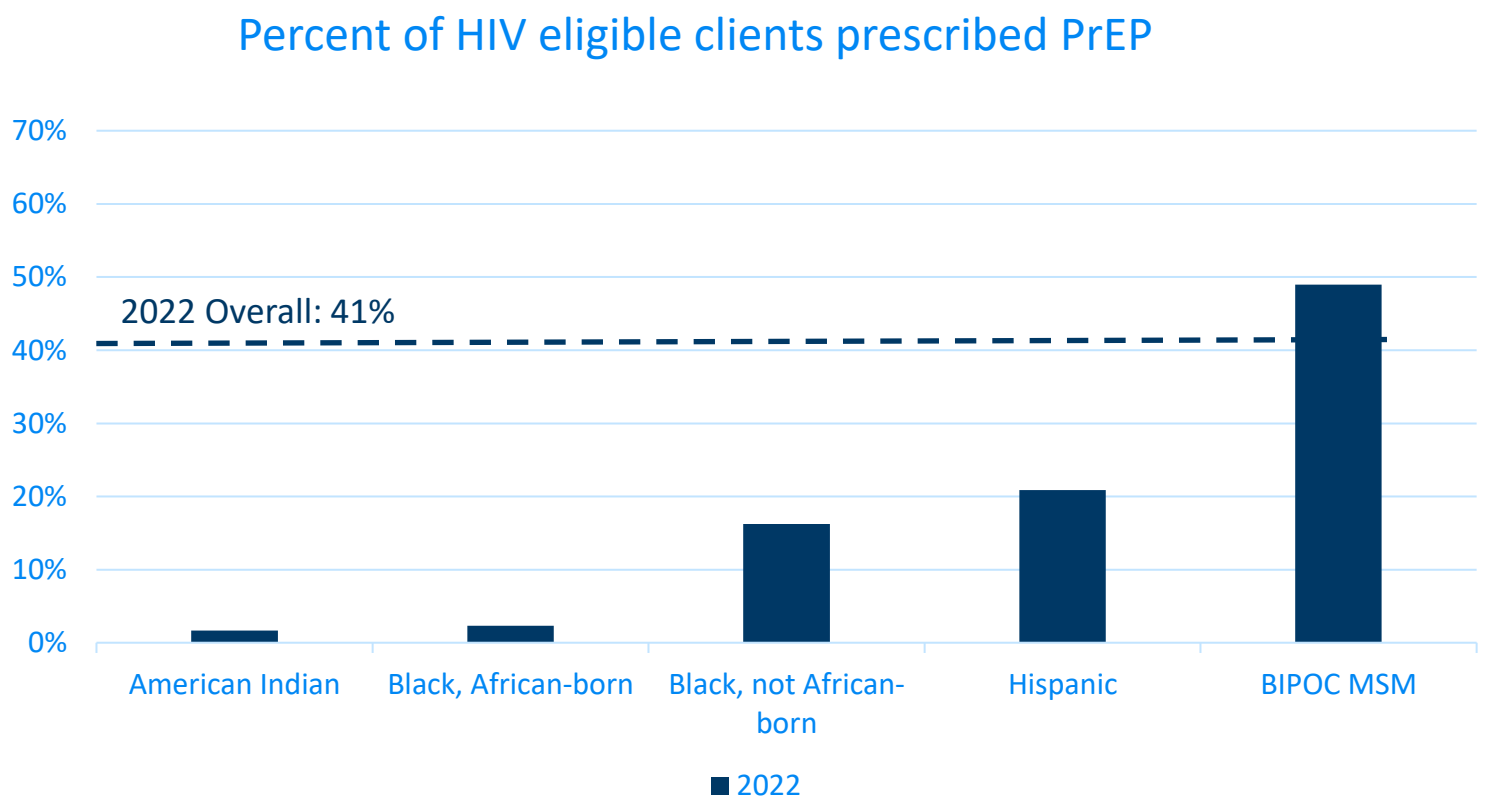


Goal: 5% increase from Baseline

3.6 Percent of HIV negative clients in priority populations who are prescribed PrEP among those eligible (tested by MDH-funded PrEP programs)

Definition:

People in priority populations
who tested negative for HIV
By MDH-funded PrEP programs
and were Prescribed PrEP
/
People in priority populations
Who tested negative for HIV
By MDH-funded PrEP programs
and were Eligible for PrEP



Goal: Address Disparities for Priority Populations

Goal 3.7 Percent of people who refill their PrEP prescriptions among those tested by MDH funded PrEP programs

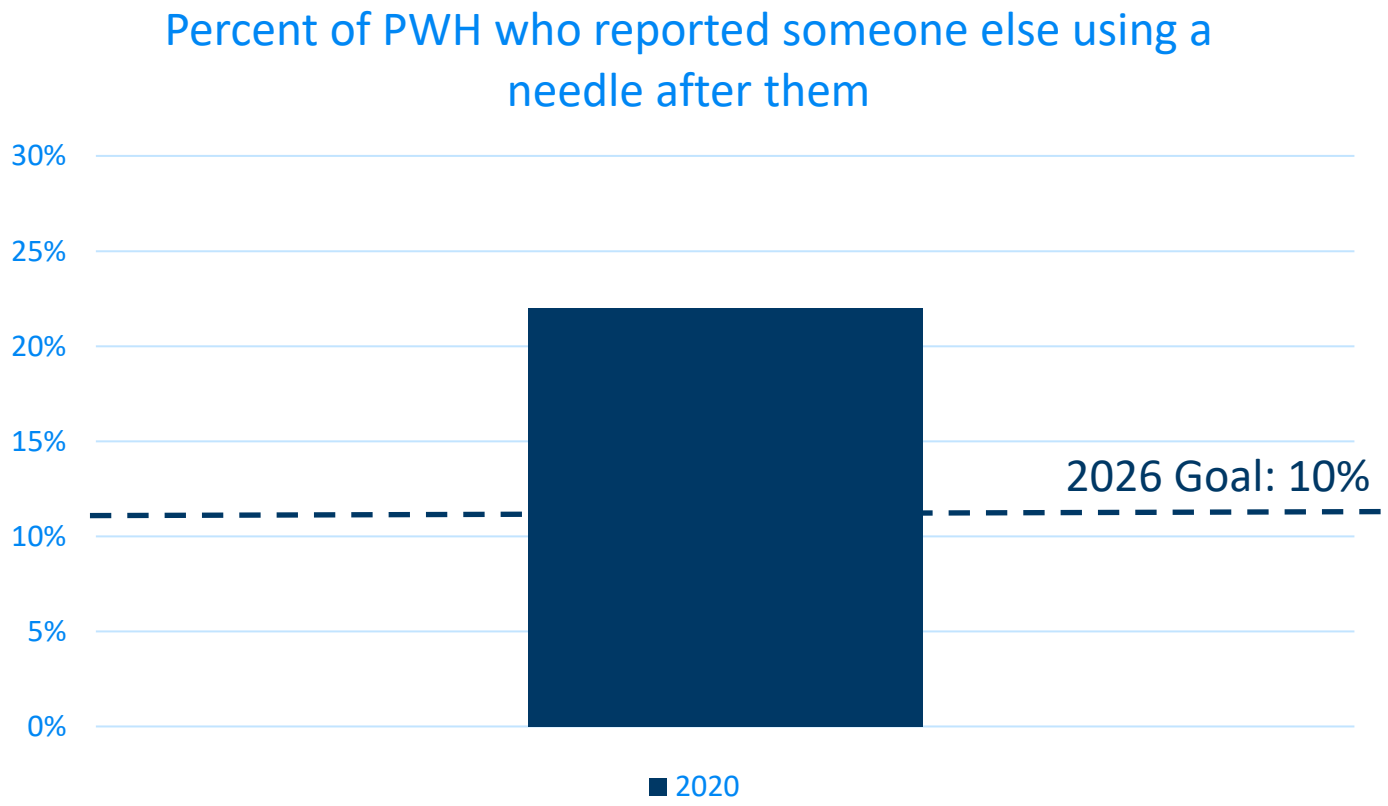
No Data Available for 2022.

Refill for PrEP meds were never collected or reported

3.8 Percent of PWH who reported that someone else used a needle after them within the last year

Definition:

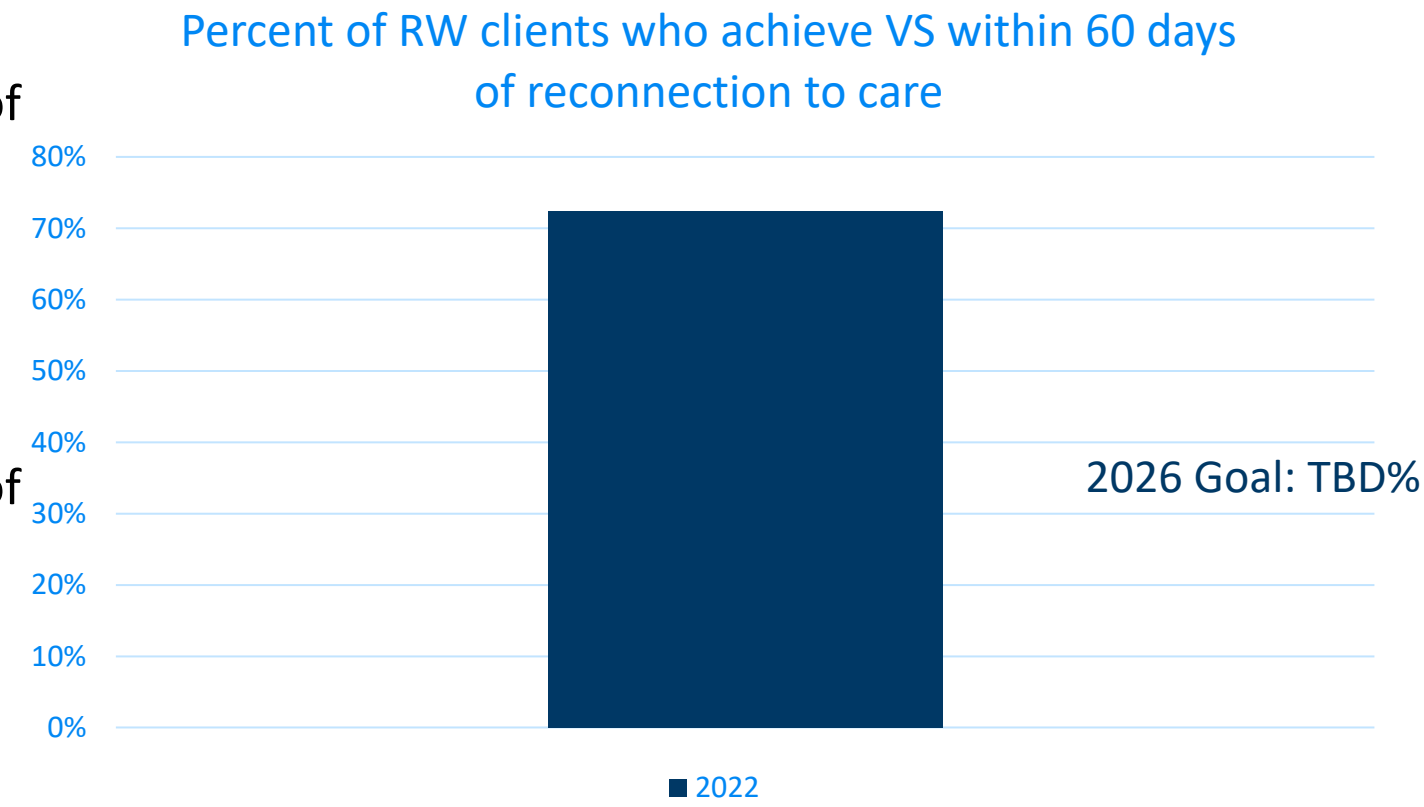
Percent of people that reported someone
Used a needle after them within the
Last year on the 2020 Needs Assessment



3.9 Percent of PWH who achieved viral suppression within 60 days of reconnection to HIV care (Ryan White EIS)

Definition:

Ryan White funded EIS clients
That were either newly diagnosed or out of Care, who were reconnected to HIV care, And achieved viral suppression within 60 days of reconnection to HIV care.
/
Ryan White funded EIS clients
That were either newly diagnosed or out of Care, who were reconnected to HIV care



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

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Goal 4 Objectives

4.1 Monitor the number of HIV diagnoses associated with outbreak in Hennepin and Ramsey

4.2 Monitor the number of HIV diagnoses associated with outbreak in the Duluth region

4.3 Monitor the number of clusters identified that are closed out due to successful interruption

4.4.1 Monitor the number of HIV cases not in care that are referred to care by DHS

4.4.2 Increase the percent of people who are retained in care of HIV cases referred by DHS

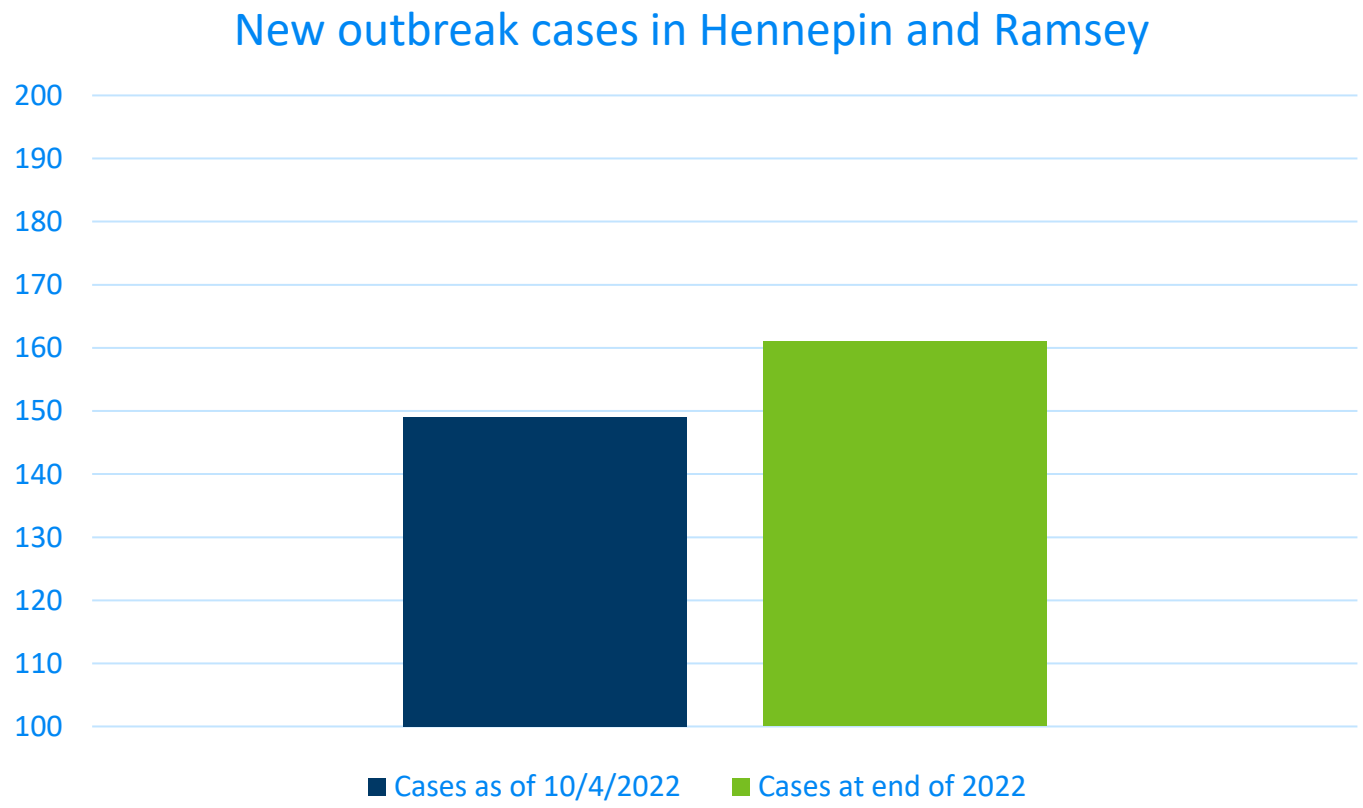
4.4.3 Increase the percent of people who achieve viral suppression of HIV cases that are referred to care by DHS

4.1 Number of HIV diagnoses associated with outbreak in Hennepin and Ramsey counties

Definition:

Any new HIV diagnosis associated With the outbreaks in Hennepin and Ramsey Counties

Goal is to prevent further transmission

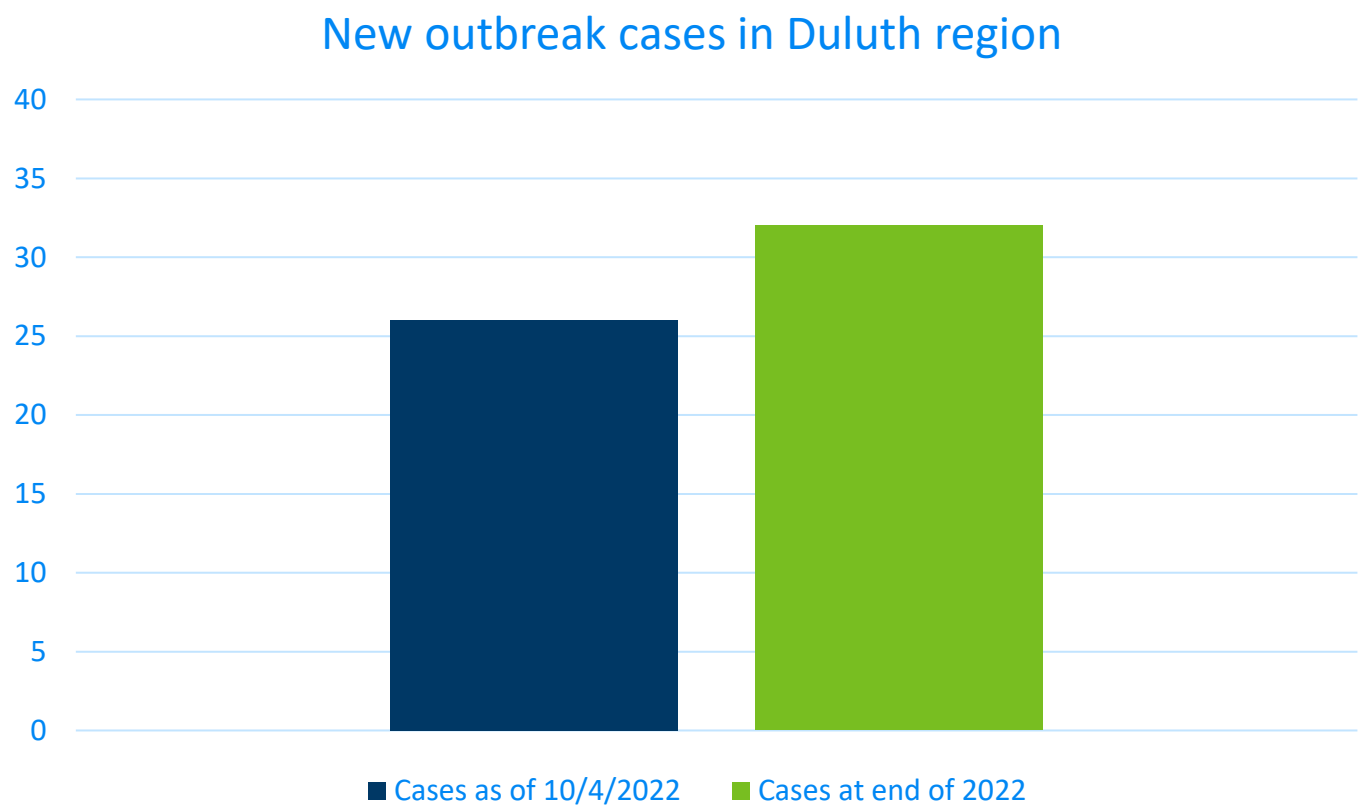


4.2 Number of HIV diagnoses associated with outbreak in Duluth Region

Definition:

Any new HIV diagnosis associated
With the outbreaks in the Duluth Region

Goal is to prevent further transmission



4.3 Number of clusters identified that are closed out due to successful interruptions

Definition: Any outbreak cluster that is officially closed due to successful interruptions

Goal: Identify clusters & respond to interrupt potential future outbreaks

Currently no outbreak cluster has been closed

Goals 4.4.1 and 4.4.2

Baseline Numbers and Data are TBD for the following goals:

Goal 4.4.1: Number of HIV cases not in care that are referred to care by DHS.

Goal 4.4.2: Percent of people who are retained in care, of HIV cases that are referred to care by DIS.

4.4.3 Percent of people who are referred to care by DIs that achieve viral suppression

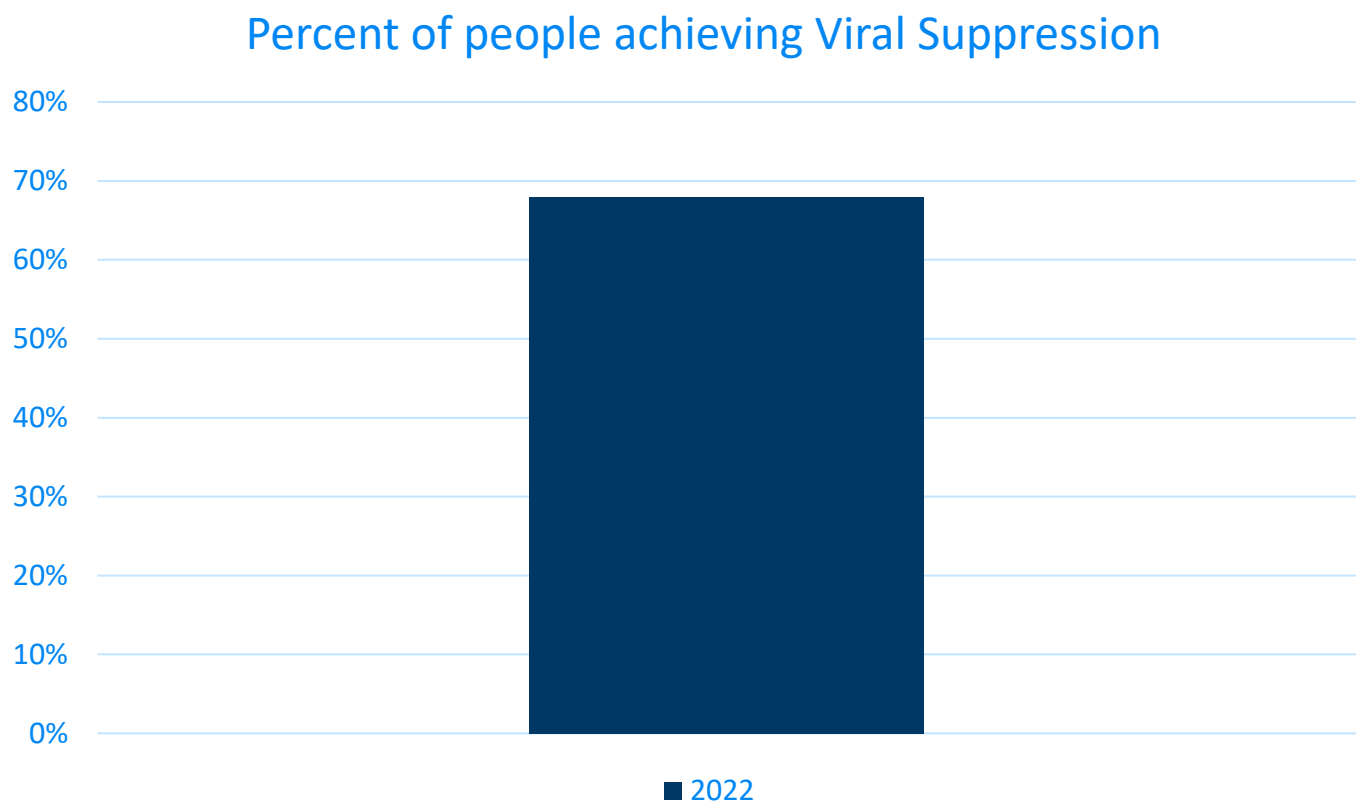
Definition:

People referred to care by DIs

/

People referred to care by DIs who Achieve Viral suppression

Goal: Respond to and connect HIV cases in transmission clusters to care via data-to-care interventions

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Thank You!