

Minnesota Department of Human Services
Disability Services Division – HIV/AIDS Unit



**2012 Minnesota Statewide
Coordinated Statement of Need**

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Purpose, Participation and Process

Purpose

The purpose of the Statewide Coordinated Statement of Need (SCSN) is to provide a collaborative mechanism to identify and address the most significant HIV issues related to the needs of people living with HIV/AIDS (PLWH/A) and to maximize coordination, integration and effective linkages across all Ryan White HIV/AIDS Program Parts. The 2012 Minnesota SCSN was a collaborative process resulting in a document that reflects the input and approval of all Ryan White HIV/AIDS Program Parts as well as other key stakeholders in Minnesota. The 2012 SCSN supports HIV planning statewide. The priorities agreed upon, and the overall final document will be invaluable for the state of Minnesota in addressing the needs of people living with HIV/AIDS as well as prevention of new HIV infections. The 2012 SCSN will provide direction for collaborative work to enhance HIV care and service delivery statewide.

Participation

According to the HRSA guidance, “provider” is defined as any individual or institution either receiving Ryan White HIV/AIDS Program funds or generally involved in the provision of health care and/or support to people living with HIV/AIDS. For the 2012 Minnesota SCSN a list of over 70 providers was prepared by staff at the Minnesota Department of Human Services – HIV/AIDS Unit for invitation to join in the collaborative efforts of creating the new SCSN.

The invitations included all Ryan White funded providers, Ryan White consumers and persons directly involved with the Minnesota HIV Services Planning Council. In addition, efforts were made to include providers to represent people living with HIV/AIDS, members of a federally recognized Indian tribe as represented in the State and public agency representatives. Efforts were made to ensure the inclusion of persons that represent the diversity present in the HIV epidemic in Minnesota by reaching out to a broad spectrum of providers, consumers and community stakeholders. Representation from other major providers and funders of services needed by people living with HIV/AIDS such as substance abuse, mental health, Medicaid, Medicare, Community Health Centers, Veterans Administration, HIV prevention etc. were all involved in this process. If representatives were not able to attend the community meetings, they were still involved through email and phone communication in discussing the 2012 SCSN.

Representatives from Ryan White grantees that were unable to attend any of the meetings were involved via email and/or phone communication. Representatives from all of the following Ryan White grantees participated in one or more of the community meetings:

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

Invitations were sent via email, beginning in early January 2012. In addition, personal phone calls were made early on in the process to invitees who had not yet responded to the initial invite. Emails were sent throughout the process, notifying invitees of meeting dates/times, reminding invitees of the importance of their participation and explaining how they could still be involved if they could not attend the meetings. Emails were also sent out before and after each meeting with updated notes throughout the process, again encouraging invitees to send feedback if unable to attend. A list of providers who attended one or more of the community meetings is included in the Appendix.

Process

The Minnesota Department of Human Services (DHS), the AIDS Drug Assistance Program (ADAP) and Ryan White Part B administrator for the state, coordinated the collaborative process for creating the 2012 Minnesota SCSN. A consultant was hired to help facilitate the meetings and overall process. The consultant worked closely with DHS staff throughout the process.

Three community meetings were conducted. All of the providers discussed in the Participation section above were invited to these meetings and sent correspondence in between meetings encouraging them to send feedback, and/or other representatives, if they were unable to attend a meeting.

The first community meeting was held February 10, 2012. Prior to the meeting, electronic copies of the two previous SCSN documents were sent out, along with other data and informational documents, including the National HIV/AIDS Strategy, to begin to review in preparation for the meeting. The meeting began by discussing the purpose of the SCSN and the importance of the collaborative process. A brief review of when the last two SCSN documents were completed and the plan for the 2012 SCSN process was discussed.

All providers were given access to the Guidance and it was made clear that we needed to address the needs of individuals who are unaware of their HIV status in this SCSN. The Early Identification of Individuals living with HIV/AIDS (EIIHA) is a legislative requirement that focuses on individuals who are unaware of their HIV status and how best to bring HIV positive individuals into care and refer HIV negative individuals into services that are going to keep them HIV negative. The group discussed that the EIIHA initiative supports all three of the National HIV/AIDS Strategy (NHAS) goals. The tone was set to be mindful of the EIIHA initiative and NHAS goals throughout our SCSN process.

Representatives from DHS, MDH and Hennepin County talked about their understanding of the current HIV environment in Minnesota. There was a thorough review of the most recent Planning Council Needs Assessment. A facilitated discussion of brain storming thoughts about the overall HIV related issues impacting Minnesota occurred. Ultimately, the previous SCSN Issues, Gaps and Needs section as well as the previous SCSN Priorities sections were reviewed. Providers discussed what still seemed relevant for the 2012 SCSN.

Prior to the second meeting, which occurred April 4, 2012, notes were compiled to summarize the discussions and input that occurred at the initial meeting. Participants were sent emails with documents that included draft versions of different sections of the SCSN i.e. the Issues, Gaps and Needs section and the Priorities section. Participants were asked to continue to review the previous SCSN and to review the

draft documents prior to the meeting. Participants were reminded that if they could not attend the meeting, that their input was valued and needed and they were given contact information, both phone and email, in order to be able to provide their feedback with either DHS staff or the consultant working with DHS on this process.

During the second meeting, the group thoroughly reviewed the draft documents and agreed on the key issues, gaps and needs related to HIV in Minnesota currently as well as the priorities. Thorough discussions in this meeting led to the decision to include the three National HIV/AIDS Strategy (NHAS) goals into the 2012 MN SCSN priorities. It was agreed upon that all of the issues in Minnesota related to HIV care and prevention are encompassed in these goals. This decision also supported the inclusion of the Early Identification of Individuals living with HIV/AIDS (EIIHA) in the Minnesota priorities as the EIIHA initiative supports all three of the NHAS goals. The other sections of the SCSN were discussed as well and a draft version of the Objectives and Outcomes was created.

Prior to the final meeting, which was May 16, 2012, more draft documents, including Proposed Objectives and Outcomes, were sent out for review. During the final meeting, the draft documents were reviewed thoroughly. Again, participants were encouraged to contact DHS and/or the consultant if they had further feedback.

Throughout the process, providers were encouraged to actively participate in this process and to provide feedback via email, phone call, or during the community meetings. The consultant and DHS staff had several additional meetings in between the community meetings in order to review notes, update drafts and ensure that we were capturing input from all participants.

HRSA Expectations

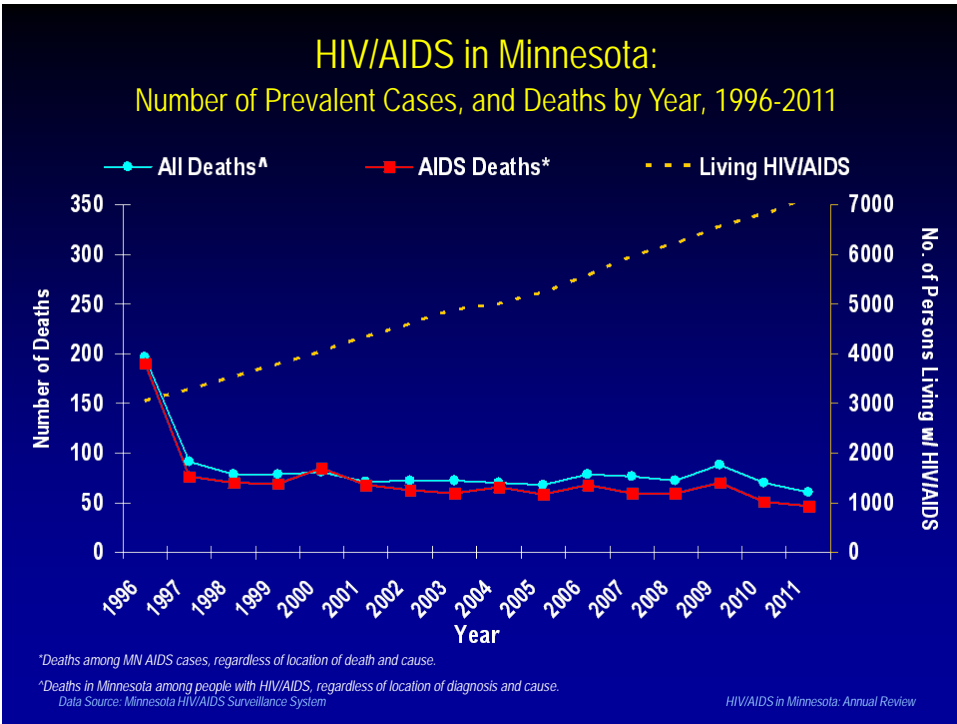
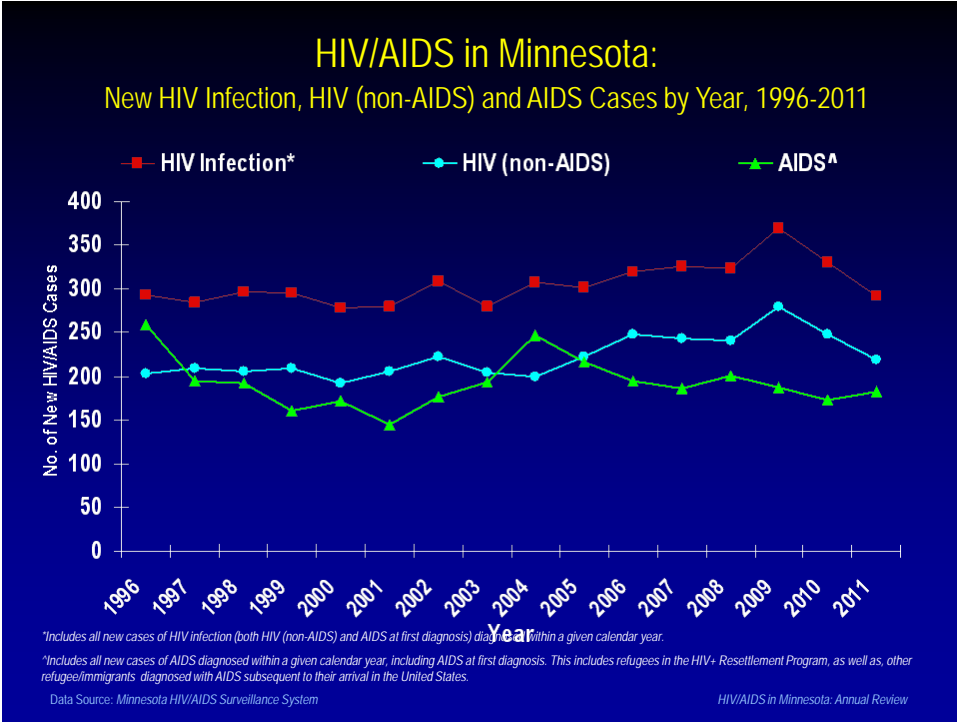
The following HRSA Expectations have been addressed throughout the process of developing the 2012 SCSN.

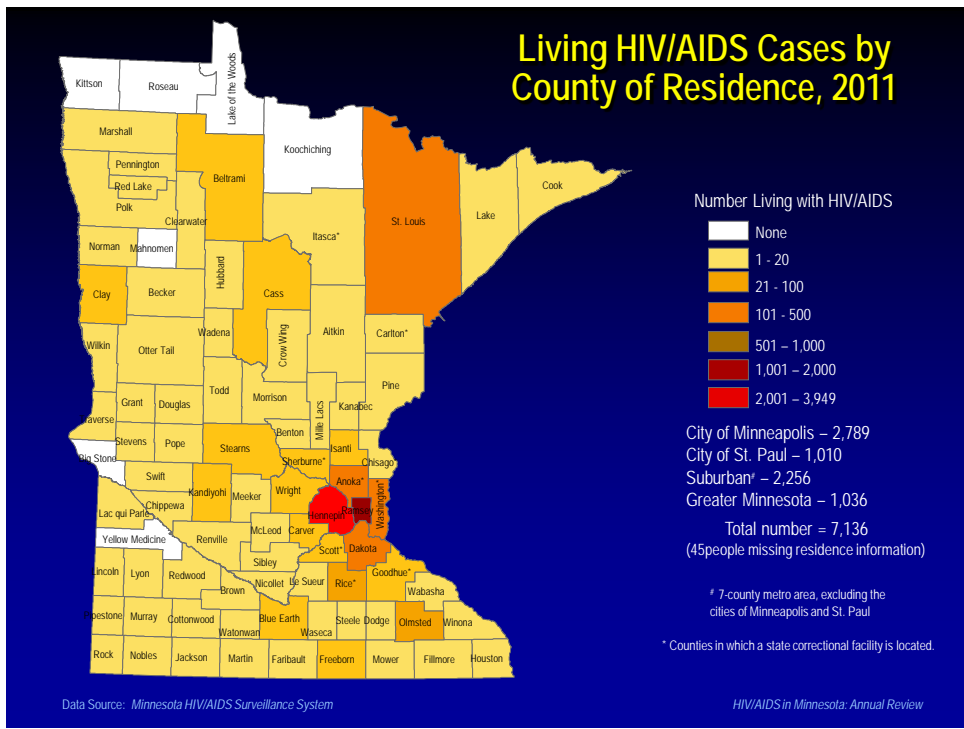
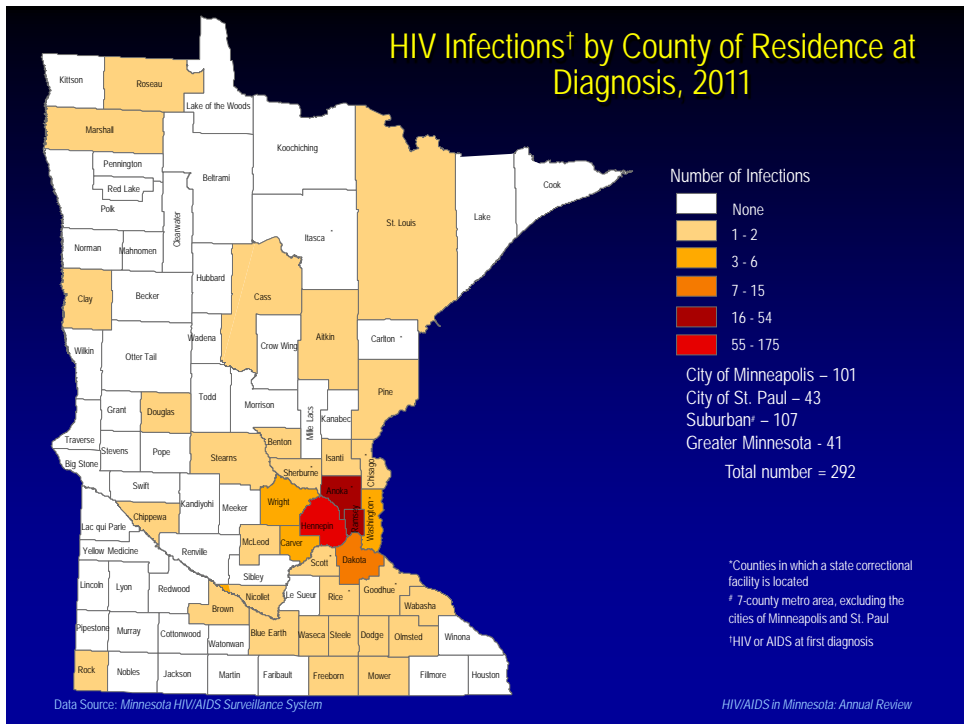
Epidemiological Profile of HIV/AIDS in Minnesota

As of December 31, 2011 there were 7,136 persons assumed alive and living in Minnesota with HIV/AIDS. Of that number, 3,775 are living with HIV infection and 3,361 are living with AIDS. There were 292 reported cases in Minnesota in 2011. This represents a 12% decrease in new cases since 2010 and the lowest number seen since 2003. While overall cases decreased in 2011 there were still 30.5% of those tested who were diagnosed with AIDS within the first year of their HIV diagnosis. The vast majority of those cases occurred in populations of foreign born persons living with HIV/AIDS. In terms of CDC reported data, Minnesota has historically separated African born persons from African American persons in surveillance data although the CDC still captures this population in the black category nationally.

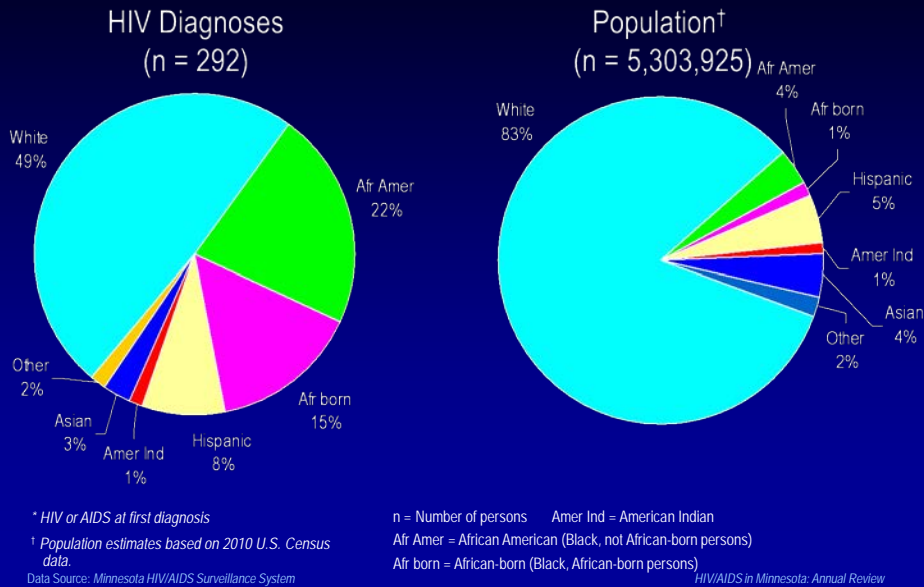
A summary of the epidemiological profile in Minnesota is summarized below:

1. People living with HIV/AIDS live in 80 of Minnesota's 87 counties.
2. New infections are still heavily concentrated in the metro area, particularly in the suburbs.
 - 35% of new cases reside in Minneapolis,
 - 15% in St. Paul,
 - 37% in the Twin Cities' suburbs, and
 - 14% in greater Minnesota
3. Gay and bisexual men of all races make up 92% of new cases among men.
 - Young gay and bisexual men (age 24 and under) continue to be disproportionately impacted accounting for approximately 16% of the new cases.
 - All racial/ethnic male populations saw a decrease in cases, except African born men who saw a 31% increase.
4. Women represent 25% of new infections with women of color accounted for 81% of those new cases.
 - Of women overall, African born women comprised 36% and African American women comprised 28% of new infections.
5. Communities of color continue to be disproportionately impacted. Overall, 49% of newly reported cases occurred in Whites who make up 83% of the population.
 - African Americans comprise 22% of new infections yet represent only 4% of the state's population.
6. Of the 7,136 persons living with HIV/AIDS, 855 are co-infected with either Hepatitis B or C.
 - 288 (34%) are living with HIV and Hepatitis B
 - 855 (62%) are living with HIV and Hepatitis C
 - 44(5%) are living with HIV, Hepatitis B and C

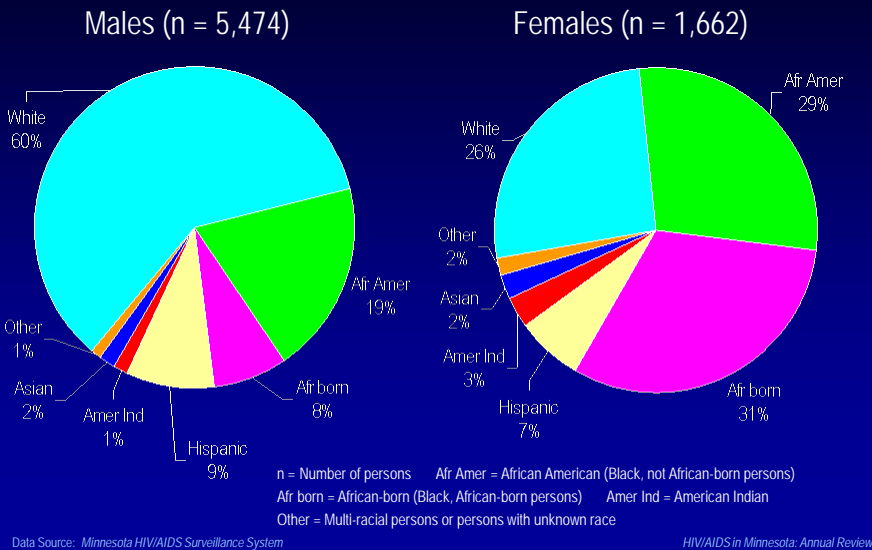




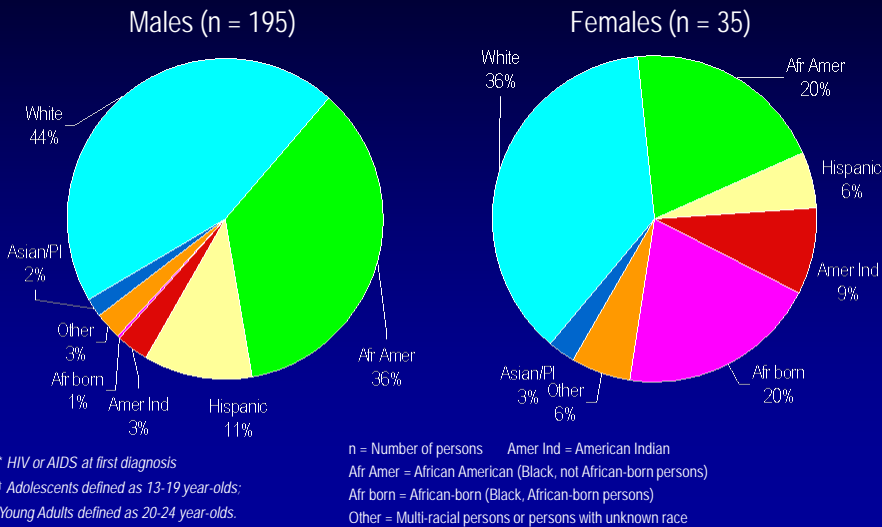
HIV Infections* Diagnosed in Year 2011 and General Population in Minnesota by Race/Ethnicity



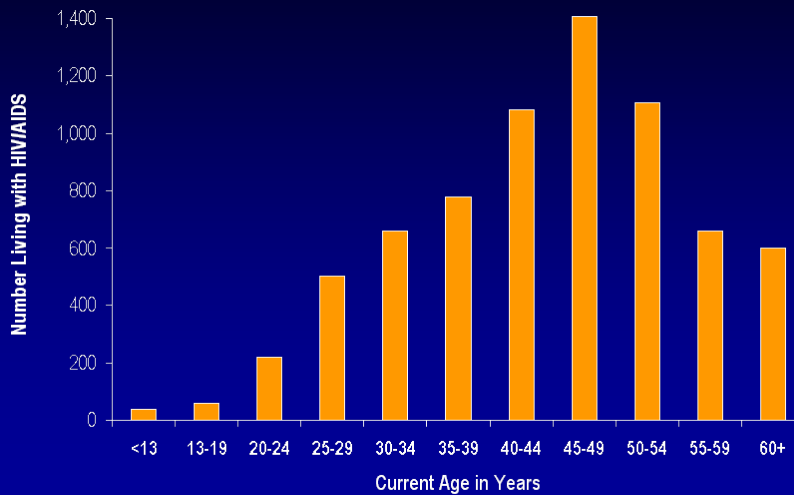
Persons Living with HIV/AIDS in Minnesota by Gender and Race/Ethnicity, 2011



HIV Infections* Among Adolescents and Young Adults† by Gender and Race/Ethnicity, 2009 - 2011 Combined



Persons Living with HIV/AIDS in Minnesota by Age Group†, 2011



Number of Cases and Rates (per 100,000 persons) of HIV Infection* by Race/Ethnicity† – Minnesota, 2011

<i>Race/Ethnicity</i>	<i>Cases</i>	<i>%</i>	<i>Rate</i>
White, non-Hispanic	143	49%	3.2
Black, African-American	64	22%	32.6
Black, African-born	44	15%	60.3
Hispanic	24	8%	9.6
American Indian	4	1%	7.2
Asian/Pacific Islander	8	3%	3.7
Other^	5	2%	x
<i>Total</i>	292	100%	

* HIV or AIDS at first diagnosis; 2010 U.S. Census Data used for rate calculations.

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

†† Estimate of 72,930 Source: Retrieved from MNCompass.org on 3/22/12. Additional calculations by the State Demographic Center.

^ Other = Multi-racial persons or persons with unknown race

Data Source: Minnesota HIV/AIDS Surveillance System

HIV/AIDS in Minnesota: Annual Review

Number of Cases and Rates (per 100,000 persons) of Persons Living with HIV/AIDS by Race/Ethnicity† – Minnesota, 2011

<i>Race/Ethnicity</i>	<i>Cases</i>	<i>%</i>	<i>Rate</i>
White, non-Hispanic	3,715	52%	84.3
Black, African-American	1,539	22%	784.4
Black, African-born	941	13%	1,290.3††
Hispanic	595	8%	237.8
American Indian	121	2%	218.3
Asian/Pacific Islander	129	2%	60.0
Other^	96	1%	X
<i>Total</i>	7,136	100%	134.5

Census Data used for rate calculations.

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

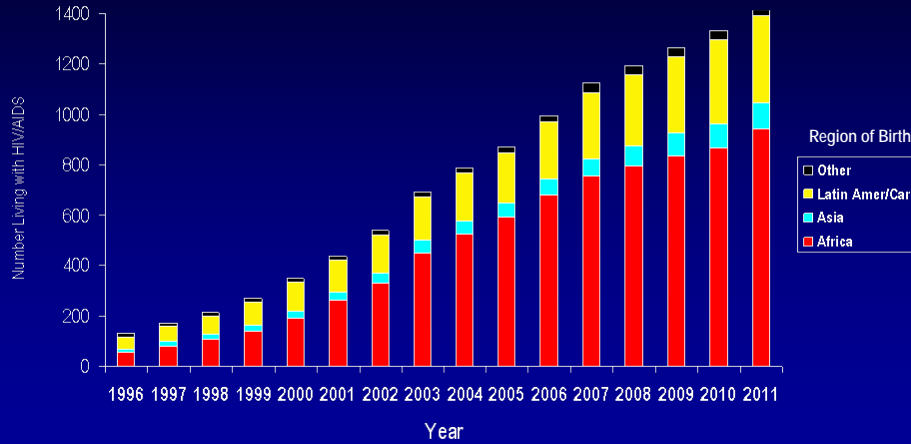
†† Estimate of 72,930 Source: Retrieved from MNCompass.org on 3/22/12. Additional calculations by the State Demographic Center.

^ Other = Multi-racial persons or persons with unknown race

Data Source: Minnesota HIV/AIDS Surveillance System

HIV/AIDS in Minnesota: Annual Review

Foreign-Born Persons Living with HIV/AIDS in Minnesota by Region of Birth, 1996-2011

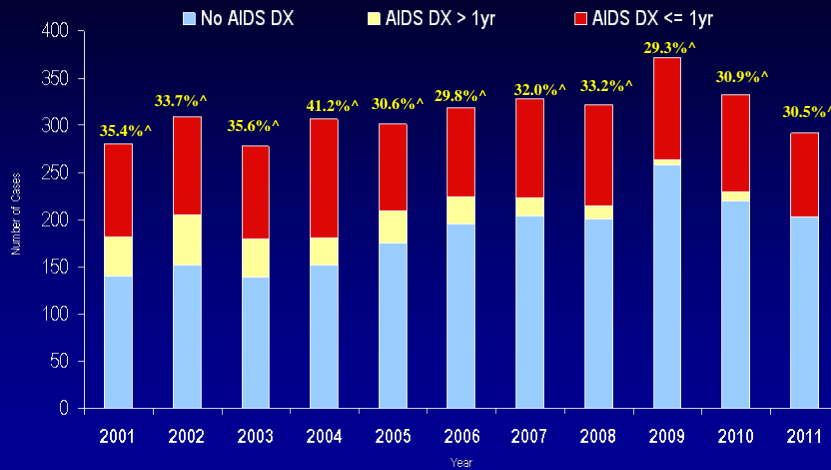


Latin Amer/Car – Includes Mexico, Caribbean, and Central/South American countries

Data Source: Minnesota HIV/AIDS Surveillance System

HIV/AIDS in Minnesota: Annual Review

Time of Progression to AIDS for HIV Infections Diagnosed in Minnesota*, 2001 - 2011†



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

[^] Percent of cases progressing to AIDS within one year of initial diagnosis with HIV Infection.

† Numbers/Percent for cases diagnosed in 2011 only represents cases progressing to AIDS through April 2, 2012.

Data Source: Minnesota HIV/AIDS Surveillance System

HIV/AIDS in Minnesota: Annual Review

Description of the needs which obstruct access to care for HIV-positive individuals

The 2010 Consumer Needs Assessment Survey had responses from 494 consumers. Although they are primarily recipients of Ryan White services (60%), their responses help develop an understanding of the issues faced by those who are not in care. The results of the survey showed that 22% of respondents said they had not received outpatient HIV medical care in the previous twelve months. Of those who said they did not access care, 90% said they did not need it, demonstrating a need for increased health education among those who do access services. Of those who had received care, 11% said they had difficulties in accessing it due to lack of transportation. Twenty-two percent had been turned away from a pharmacy because they were unable to pay for medications; 12% said they had gone without medical care or prescriptions in the previous 12 months because they were unable to pay for them; 10% said they did not currently have health insurance. Forty-nine percent acknowledged a mental illness or substance abuse diagnosis. Fourteen percent said that in the past month, they had had little or nothing to eat for two days. Stigma, poverty, substance abuse and chemical dependency are all factors obstructing access to care for HIV-positive individuals.

Improved data collection and assessment of Unmet Need in Minnesota along with continued efforts to address barriers to care, were discussed throughout the SCSN process. The Issues, Gaps and Needs section, along with the Priorities and subsequent Outcomes and Objectives refer to persons from special populations, underserved populations, populations at highest risk. In particular, the first three Priorities address underserved populations.

Description regarding the needs of individuals who are aware of their HIV-positive status but are not in care

Process and estimation method

Using eHARS data and the Framework developed by HRSA and revised in September 2011 by the Minnesota Department of Health (MDH), population estimates for people living with HIV/AIDS were computed for the state. Prior to June of 2011, reporting rules in Minnesota did not explicitly require labs to report viral loads and CD4 counts to the state every time these tests are performed. Two large HIV clinical providers reported new HIV+ and new AIDS cases, but did not routinely report all CD4 counts and viral loads. The Unmet Need Estimate follows the original Framework formula, in which all cases listing either of these providers as their current clinic in 2010 are considered to be “in care” since MDH, prior to the rule change requiring all state clinicians and labs to report all CD4 and viral load test results, has been able to determine if reported cases were out of care only through patient record reviews. However, eHARS data that are provided by the two non-reporting clinics are used to estimate the percentage of individuals who have AIDS or HIV/non-AIDS. Thus, by applying the corresponding percentages to the aggregate numbers determined when including the non-reporting clinics, unmet need is calculated.

Minnesota's Demographic Characteristics of PLWH In-care and Out of care January 1 – December 31, 2010 (Source: Minnesota Dept. of Health)				
	Number in care	Number out of care	Number in surveillance	(%) out of care
Race and Ethnicity *				
White, not Hispanic	2,163	1,423	3,586	40%
Black, not Hispanic	1,542	800	2,342	34%
African American	956	520	1,476	35%
<i>African-born</i>	586	280	866	32%
Hispanic	349	216	565	38%
American Indian	82	36	118	31%
Asian/Pacific Islander	78	41	119	34%
Gender**				
Male	3,187	2,056	5,243	39%
Female	1086	485	1,571	31%
Mode of exposure				
MSM	1,969	1,510	3,479	43%
IDU	230	197	427	46%
MSM/IDU	172	183	355	52%
Heterosexual contact	861	-51	810	-6%
Mother with HIV	62	17	79	22%
Other/hemophilia/blood transfusion	33	6	39	15%
Unspecified risk	951	674	1,625	41%
Total	4,278	2,536	6,814	37%

*Excludes individuals of multiple races and individuals of unknown race.

**Does not include transgender individuals

Data source: Minnesota Department of Health (MDH) 2011

The Minnesota Department of Health (MDH) relies on viral loads and CD4 counts to identify those who are in care. Reporting rules in MN only explicitly required labs to report viral loads and CD4 counts to MDH every time these tests are performed as of July, 2011.¹ Despite this barrier, MDH received regular updates of viral loads and CD4 counts from most major labs prior. However, one major clinical system – Hennepin County Medical Center (HCMC) – does not report these values on a regular basis. We get a scattering of reports from this source, but not enough to get an accurate estimate of those in care.

To compensate for the lack of data from HCMC, MDH contacts them to get aggregate numbers of people living with HIV/AIDS who have received services in the past year. Limitations are that these are aggregate numbers, not a list of individual names, so we cannot de-duplicate them from the HIV/AIDS Surveillance System records. It is possible that they are listed in the system with a different primary care clinic, in which case that individual would be counted twice.

¹However, facilities were required to report CD4 counts that fall below 200, as they are AIDS-defining.

In addition to focusing on obtaining more accurate estimates, work has been underway and continues in Minnesota to get individuals who are aware of their HIV-positive status into medical care. In collaboration with Minnesota's Parts A and C grantees and the Minnesota Department of Health (MDH), the CDC grantee, a multi-pronged approach has been implemented. Components of this 2009-2011 Comprehensive Plan, designed to reduce Unmet Need, include Medical Care Retention as part of Medical Case Management/Treatment Adherence. This is a focused intervention designed to identify patients of HIV primary care clinics who are not current with their care and facilitate a return to care. Medical case managers assess factors that keep patients from attending appointment and help them connect to services, such as transportation, that mitigate barriers to care. Medical Care Retention will continue to be funded as a service activity.

Three community-based organizations are funded to identify people who know their status and are not in care and to coordinate their entry into primary medical care. The grantee collaborates with MDH to coordinate prevention and care outreach activities. Many high-risk individuals targeted for these activities are partners of those who already know their status. Outreach targets injection drug users, other substance abusers, African Americans, African immigrants and MSM. The Planning Council allocation for Outreach will be sustained in FY2012. Also planned are increased levels of Mental Health services and culturally appropriate Mental Health Access services, as well as Outpatient Substance Abuse assessments and treatments to address behavioral health barriers to accessing HIV medical care. Health Education/Risk Reduction programs tailored to meet the needs of several populations that are disproportionately represented among those out of care (MSM, women of color, African-born individuals) will receive continued funding.

Description regarding the needs of individuals who are unaware of their HIV status

As referenced earlier, the Early Identification of Individuals living with HIV/AIDS (EIIHA) is a legislative requirement. EIIHA focuses on individuals who are unaware of their HIV status. The EIIHA initiatives focus on getting individuals who are HIV positive into care. Simultaneously, the initiatives focus on getting individuals who test negative for HIV into services that will help them remain HIV negative.

Minnesota has been actively working on the EIIHA initiatives. In April 2010, an EIIHA workgroup was established. The group includes representatives from DHS, MDH, all Ryan White grantees, consumers and other invested stakeholders. This workgroup established clear goals and recommendations for moving forward and thoroughly addressing the EIIHA initiatives. The group established recommendations to ensure individuals living with HIV who are unaware of their status become aware and get connected to medical services.

HIV testing standards warrant risk assessment as well as counseling and education to help individuals reduce their risks for HIV exposure. When an individual tests positive, barriers to getting into care are assessed and addressed and individuals are referred to care right away. Increasing testing among partners and social networks of people who are recently diagnosed is one example of helping to reduce new HIV infections because it simultaneously reduces stigma and promotes education of at-risk peers in knowing their status.

An Outreach effort to link people living with HIV/AIDS to medical care right away reduces further transmission. Beginning treatment early increases overall health outcomes and reduces community viral load. Using peers to work with those who are newly diagnosed creates additional confidence because information is often received better when it is delivered by someone who has experience living with HIV and the challenges that it can present. The EIIHA workgroup strategies have helped to create a seamless system from diagnosis to care, with minimal steps and barriers, by using early intervention and outreach service providers.

Throughout the process of establishing the 2012 MN SCSN, all participants were mindful of the importance of thoroughly assessing and addressing both individuals who are unaware of their status (EIIHA initiatives), and those who are aware of their status but are not in care (Unmet Need). Addressing both of these key focuses throughout the process of developing the 2012 SCSN and moving forward will be essential in supporting the National HIV/AIDS Strategy goals, ultimately reducing the number of new HIV infections, optimizing health outcomes for persons living with HIV/AIDS and reducing HIV related health disparities.

Description of the needs of special populations

Several programs funded by Part A serve culturally specific populations. Many of the Part B programs, due to their statewide nature, e.g., ADAP, insurance, dental, nutrition and mental health programs are not culturally specific; however, every effort is made to make information regarding these programs widely available and translated. Medical case management services address the needs of special populations by placing emphasis on services that are culturally appropriate and diminish barriers to care. Data from interviews conducted for the 2004 Brief Survey and 2006 Consumer Needs Assessment Survey demonstrates a high level of poverty among populations of color, particularly African-born and Spanish-speaking immigrants. Services that address basic needs such as food and nutrition, emergency financial and housing assistance are crucial to support continued access to HIV primary medical care and remain a top priority.

In addition to the needs in communities of color, there is disparate care and services available for people who identify as transgender. For example, low testing rates among male-to-female transgendered individuals demonstrates the lack of recognition or denial of risk and lack of support from both their ethnic communities and the gay community. Sexual orientation stigma and provider competency providing relevant healthcare and prevention messages is a significant factor in seeking healthy behaviors within this group.

The needs of special populations were addressed throughout the process of creating the SCSN. Representatives from organizations serving individuals from special populations were represented throughout the process and they were able to express their assessment of the issues/needs of the populations they work with. Examples of assessing the needs of special populations can be found throughout the Issues, Gaps and Needs sections and the Priorities, and Objectives and Outcomes sections. Ultimately, it was determined that the SCSN will reflect the need of “special populations” in general, rather than specifically calling out any given special population in the final SCSN document.

References to special populations occur in several places. In particular, the Objectives and Outcomes in Priority number three address the issue of special populations.

Description regarding any shortfalls in healthcare workforce

The issue of the healthcare workforce was discussed during the collaborative process of creating the SCSN. Minnesota is fortunate to be the home of several prominent HIV specialty doctors. There does continue to be an access issue in terms of mental health and oral health related services in particular. Clinicians providing mental health and oral health services do not understand the unique nuances of working with people living with HIV/AIDS. In addition, Minnesota is a geographically large state with driving distances of four hours or more if clients have medical appointments in the metro area.

Some of the Issues, Gaps, and Needs address this and, in particular, one of the Objectives and Outcomes for Priority two addresses the issue of maintaining and training the HIV workforce to best serve persons living with HIV/AIDS.

Description of how input from each of the entities below has been incorporated into the SCSN

- *Ryan White Part A Program*
- *Ryan White Part B Program*
- *Ryan White Part C Program*
- *Ryan White Part D Program*
- *AETC Administrators*
- *People living with HIV/AIDS*
- *Providers*

The Purpose, Participation and Process section thoroughly discusses how all of these groups were involved in the overall 2012 SCSN document.

HIV/AIDS Funding in Minnesota

Ryan White Funding

Part A – Provides emergency assistance to Eligible Metropolitan Areas and Transitional Grant Areas that are most severely affected by the HIV/AIDS epidemic.

Hennepin County Human Services and Public Health Department is the Part A grantee.

Part B – provides grants to all 50 states, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands and five Pacific territories or associated jurisdictions.

The Minnesota Department of Human Services – HIV/AIDS Unit is the Part B grantee.

Part C – provides comprehensive primary health care in an outpatient setting for people living with HIV disease.

Hennepin County Medical Center – Positive Care Center and Rural AIDS Action Network are the Part C grantees.

Part D – provides family-centered care involving outpatient or ambulatory care for women, infants, children and youth with HIV/AIDS.

Currently there is no Part D funded grantee in Minnesota.

Part F – provides funds for a variety of programs including Special Projects of National Significance, AIDS Education and Training Centers (AETC) and Dental Programs.

Minnesota receives funding for AETC activities through the Midwest AIDS Training and Education Center in Chicago.

Hennepin County Medical Center and the University of Minnesota’s Dental School receive funding for dental programs. In 2011, Hennepin County received \$126,762 for the dental reimbursement program.

Minority AIDS Initiative – provides funding to evaluate and address the disproportionate impact of HIV/AIDS on African Americans and other minorities.

Hennepin County (Part A) and the Department of Human Services (Part B) receive funds for Minority AIDS Initiative (MAI) activities.

Ryan White Part	2012 Allocation and Use of Funds (services in order of Planning Council priority)
Part A Hennepin County Human Services and Public Health Department Formula & Supplemental = \$5,228,076	Outpatient/Ambulatory Care - \$865,800 Health Insurance Premium/ Cost Share Assistance - \$8,100 Medical Case Management - \$1,602,200 Treatment Adherence - \$417,100 Clinical Retention (Inreach) - \$50,300 Medical Case Management – Adult Foster Care - \$35,000

Ryan White Part	2012 Allocation and Use of Funds (services in order of Planning Council priority)
Minority AIDS Initiative = \$313,699	Oral Health Care - \$120,400 Mental Health Services - \$328,400 Early Intervention Services - \$42,000 Medical Nutrition Therapy - \$73,200 Substance Abuse Services (outpatient) - \$139,500 Home & Community-based Health Services - \$114,700 Food Bank/Home-delivered Meals - \$505,800 Medical Transportation Services - \$25,000 Emergency Financial Assistance - \$149,700 Legal Services - \$90,300 Health Education/Risk Reduction - \$86,300 Outreach Services - \$149,400 Linguistic Services - \$1,800
Part B Minnesota Department of Human Services Base = \$1,963,514 AIDS Drug Assistance Program = \$5,976,431 Minority AIDS Initiative = \$55,377	ADAP - \$5,976,400 Health Insurance Premium/ Cost Share Assistance - \$3,600 Medical Case Management - \$333,300 Oral Health Care - \$46,500 Mental Health Services - \$78,200 Early Intervention Services - \$5,000 Medical Nutrition Therapy - \$8,200 Food Bank/Home-delivered Meals - \$124,600 Medical Transportation Services - \$466,000 Emergency Financial Assistance - \$336,000 Non-medical Case Management - \$109,000 Referral for Healthcare/Supportive Services - \$144,600 Legal Services - \$7,500 Health Education/Risk Reduction - \$6,000 Outreach Services - \$55,400 Linguistic Services - \$500
Part C	Hennepin County Medical Center (HCMC) - \$612,344 Rural AIDS Action Network - \$331,637
Part D	No funded agencies at this time
Part F	HCMC Dental Program - \$126,762

Other HIV/AIDS Funding and the Complexities

The Minnesota legislature contributes \$1.2 million dollars for insurance continuation to provide the most comprehensive coverage available so clients are able to meet their primary care needs. Minnesota does not have a PDP or consortia. However, Minnesota's ADAP is part of Minnesota Healthcare Programs and client healthcare benefits are coordinated through MMIS billing system.

There are currently no caps on ADAP enrollment in Minnesota, nor is there an implemented waiting list. Minnesota anticipates budget shortfalls will begin to surface in 2015. A waiting list

contingency plan has been completed and medically based criteria, maintained by the ADAP Formulary Committee, have been set and approved in the event it is needed.

Minnesota coordinates its Part A and B Ryan White planning efforts by utilizing the Planning Council to carry out its prioritization and allocation responsibilities. This creates an effective system of care and provides a level of funding coordination that maximizes service provision to people living with HIV/AIDS in the state.

Ryan White funding has decreased in the state in the last year, with the loss of Part D, due in large part to low-incidence of HIV compared to other states. There is a need to identify ways to sustain HIV programs and services with fewer dollars.

CDC funding and the focus of prevention work has recently changed to incorporate the goals of the National HIV/AIDS Strategy of finding people who don't know their status and working to reduce community viral load. The new prevention strategy and reduction of prevention funding available will create unique challenges for government agencies and community based agencies.

The still unknown changes to the healthcare system as the Affordable Care Act is implemented and uncertainty about the reauthorization of the Ryan White Treatment Modernization Act of 2009 will require Minnesota to monitor and adapt plans developed so we can continue to respond to the needs of people living with HIV/AIDS.

While these issues are not unique to Minnesota, the service delivery system as we know it will not look the same.

Issues, Gaps and Needs

Stakeholders reviewed the issues, gaps and needs from the previous SCSN process conducted in 2009. The list was updated to reflect the current situation and areas of concern for the State of Minnesota. The existing needs, critical gaps in care and emerging trends and issues affecting HIV care and service delivery are as follows, updated for 2012:

- Healthcare reform will have a noticeable impact on all prevention work and services related to HIV/AIDS.
- The new focus for prevention work – focusing on prevention for persons that are already HIV positive or are unaware of their status – will be a big shift in funding expectations, and how the new system of prevention programs will work in Minnesota moving forward.
- It will be necessary to be responsive as a state to the ever-changing political environment impacting funding and expectations for prevention and care related to HIV.
- The Affordable Care Act changes will have unknown impact on HIV in Minnesota and, in particular, will likely have differing effects on special populations.
- The unknown status of the Ryan White reauthorization will also have differing effects on special populations.
- There is a need to address the aging population in the Minnesota HIV workforce. There is nationwide concern for lack of new HIV physicians. In Minnesota, the broader HIV workforce is of concern in addition to HIV physicians.
- Overall prevalence of HIV in Minnesota continues to increase. There are more people living with HIV that need to be treated. This will be an ongoing challenge to the system to provide services for a growing population.
- Due to the inevitable changes occurring in so many areas, the need to develop an HIV service sector vision for an integrated HIV service delivery system that includes both government and community agencies seems critical. Realigning HIV sectors to be able to respond to changes in service delivery, funding approaches etc. will maximize the effectiveness of publicly funded HIV programs. The Impact Initiative project, which includes executive leadership, board members, government officials, funders and other stakeholders, will be valuable in this process.
- Additional analysis of data is needed in order to most efficiently assess the number and populations of persons living with HIV/AIDS that are not aware of their status as well as for persons who are aware of their status but are currently out of care.
- There is a need to continue to look at the interface between STD's, Hepatitis and HIV. Minnesota Department of Health is looking at a data link between STD data and electronic HIV/AIDS Reporting System (eHARS). Further data analysis will be needed.
- Service parity continues to be an issue to some degree. Access to a primary HIV doctor or mental health services with a provider who understands potential relevant issues related to HIV for persons in greater Minnesota, for instance, varies. Persons from special populations or individuals living with HIV/AIDS who have special needs i.e. dual diagnoses with mental illness and substance abuse may have more difficulty in receiving services.

- Sustainable, affordable housing continues to be an issue due to poverty, unemployment, criminal histories, etc. Additionally, housing units that include services are in jeopardy.
- The Federal correctional facilities are handling the needs of persons incarcerated who are living with HIV/AIDS. Significant progress has been made on the State level since the previous SCSN. There is still a gap in HIV services in the County correctional facilities, with less funding and less services available. Further assessment and data regarding overall HIV related issues in the County correctional facilities will hopefully lead to more specific ideas of how to address HIV in that system i.e. perhaps HIV status can be added to the initial health screening.
- Although, there is more affordable health care coverage now available for low income persons than there was in the previous SCSN, healthcare coverage for undocumented immigrants is still problematic. Most persons who are undocumented may not have health care coverage or may have inadequate healthcare coverage at best.
- Minnesota Comprehensive Health Association (MCHA) is the high-risk insurance pool in Minnesota. Coverage will change January 2013, likely closing to new enrollees and beginning a phase out of the program. This could dramatically increase costs to the AIDS Drug Assistance Program (ADAP) program. Advocacy to support ongoing MCHA services is necessary. It will be especially important to address this situation with regard to persons who are undocumented.
- Minnesota's only safety net hospital, Hennepin County Medical Center (HCMC) is now only able to serve Hennepin County residents for free – others are on a sliding fee scale, therefore leaving a gap in the safety net for medical care.
- Improvement in the area of teaching persons living with HIV/AIDS to independently manage their health care is needed. Referrals into other systems of care will likely be more necessary.
- There is still a need for sustained access to dental care for persons living with HIV/AIDS.
- Access to substance abuse services have improved in the past several years in Minnesota. There are at least two organizations providing HIV specialized assessments and referrals, making it easier for a person living with HIV to get into substance abuse treatment. Further assessment of the effectiveness of substance abuse services when working with persons with HIV/AIDS would be beneficial in determining potential special needs and/or alternate models such as harm reduction.
- Utilization in mental health services continues to increase annually in MN. Access to mental health services for some special populations and in greater Minnesota continues to be challenging. Further assessment of the availability of mental health providers who are knowledgeable and skilled to work with persons living with HIV/AIDS is needed.
- Continued assessment of the appropriateness and effectiveness of both mental health and substance abuse services for persons living with HIV/AIDS as well as continued partnerships in training and service delivery is needed. Based on HRSA performance measures, both mental health and substance abuse services could improve overall quality of care.
- The overall number of new HIV infections in Minnesota is slightly down in 2011 however, there is an increase in the numbers of new infections in specific populations.
- Effective prevention messages that can be tailored to targeted populations are needed.
- Assessing what written prevention materials are approved and available for populations with special needs.

- Communities of color are disproportionately represented in the HIV epidemic in Minnesota.
- Late diagnosis continues to be an issue for communities of color, especially those born outside of the United States.
- It is estimated that by the year 2015 that over half of the total number of persons living with HIV/AIDS will be over the age of fifty. HIV physicians in some ways have become primary care physicians “by default” as their patients age. It is also estimated that persons living with HIV/AIDS begin to experience “aging issues” about 10 years earlier than average. In general, as HIV becomes more of a chronic illness, and as persons are living longer with HIV, a shift in care for this special population is necessary.
- Simultaneously to the issue of some people living longer with HIV, there are still a number of “late testers” in Minnesota and special populations where HIV is still an epidemic.
- MSM continues to be a special population. White MSM remains the group with the highest level of HIV prevalence in Minnesota. Communities of color within this group continue to be disproportionately represented in new HIV infections.

Priorities for 2012

The following priorities were agreed upon by stakeholders during the process of developing the 2012 SCSN.

Priority #1

Reduce the number of people who become infected with HIV.

Priority #2

Increase access to care and optimize health outcomes for people living with HIV/AIDS.

Priority #3

Reduce HIV related health disparities.

Priority #4

Improve and coordinate the integration of prevention and care services for people living with HIV/AIDS among HIV agencies and partnerships outside of the HIV field.

Priority #5

Develop statewide capacity to collect and use process and outcomes evaluation data.

During the collaborative process, previous and current SCSN issues, gaps, and needs were assessed. Additionally, the previous SCSN priorities and current priorities were discussed thoroughly. It was agreed upon that all of our priorities that were related to direct prevention and care services fit into the National HIV/AIDS Strategy (NHAS) goals. Thus, the initial three priorities reflect the NHAS goals and also encompass the Early Identification of Individuals living with HIV/AIDS (EIIHA) initiatives.

In addition to the needs and priorities related directly to prevention and care, it was agreed that it is becoming even more critical that the government agencies working with HIV in Minnesota (MDH, Hennepin County, DHS) work more closely together, supporting one another's efforts to address the overall issues of concern in Minnesota around HIV. It will also be important to develop more partnerships with other entities that can help in our prevention and services efforts. For instance, assessing whether or not we can work with homeless shelters more consistently to provide HIV testing, or whether more education and partnerships can happen with substance abuse treatment centers and with mental health providers. Throughout our collaborative process, the need for more efficient ways to gather and analyze data is important. Improved data will lead to overall improvement and support all of our priorities.

It is important to note that all of these priorities have been and continue to be addressed on some level already. This collaborative process will ensure that assessment and improvement of continued progress will continue and expand moving forward. The 2012 SCSN is a living document that will guide our efforts towards success with these priorities.

Objectives and Outcomes

Priority 1: Reduce the number of people who become infected with HIV.

Objective	Desired Outcomes
Support community efforts to identify individuals unaware of their status, test and connect them to care	Suppress community viral load
Ensure eligible Minnesotans have access to ADAP and/or other health insurance programs	People Living with HIV/AIDS (PLWH/A) will be able to access needed treatments and medications
Support MDH's prevention planning and programming efforts to provide targeted prevention services	Reduce the number of new HIV infections annually in disproportionately impacted communities
Encourage access to treatment regardless of CD4 count (test & treat)	Suppress community viral load
Mobilize communities most severely impacted/high risk populations to reduce stigma and promote awareness of benefits of testing and treatment	People are diagnosed and connected earlier to care (within three months of diagnosis)
Refer negative testers to appropriate services to keep them negative	Reduce new infections

Priority 2: Increase access to care and improve health outcomes for people living with HIV/AIDS.

Objective	Desired Outcomes
Engage consumers in service planning, delivery, assessment and quality improvement	People living with HIV/AIDS will enter into care earlier and will have better health outcomes
Develop capacity of Community Health Centers (CHCs) to provide competent primary care to people living with HIV/AIDS in partnership with HIV specialist providers	Healthcare providers will have the knowledge to treat patients living with HIV/AIDS and/or the resources and proper referrals
Educate consumers about services available	Consumers will know what services are available for them and be able to navigate the system
Provide consumers with the skills to advocate for and manage their healthcare	Consumers will gain skills in how to understand and manage their healthcare needs more independently
Continue to develop and evaluate HIV peer programs	More people living with HIV/AIDS, engaged by peer programs, will enter into and stay in care
Assess barriers and challenges to filling the HIV provider shortages that will come with retirement, aging, etc.	Maintain and train an HIV workforce that can meet the needs of people living with HIV/AIDS with an increase in new providers who enter the field
Continue to assess current housing issues in MN for persons living with HIV/AIDS	Increase the number of persons living with HIV/AIDS who have stable, affordable, and supportive (if necessary) housing
Engage staff working in Aging to ensure HIV/AIDS issues are represented and addressed	Providers serving an aging population will understand health issues related to HIV/AIDS and aging

Priority 3: Reduce HIV-related health disparities.

Objective	Desired Outcomes
Develop and maintain programs, such as wellness support services that integrate health education and risk reduction, psycho-social support, outreach and information and referral that target communities disproportionately impacted by HIV/AIDS	Prevention/care/services that meet the needs of special populations will reduce the number of people who test positive for AIDS within one year of their HIV diagnosis
Advocate that people living with HIV/AIDS who are undocumented maintain health insurance	All people living with HIV/AIDS in Minnesota will have options for health insurance that meets their health needs
Inventory current resources and materials (both prevention and care related) that are culturally and linguistically appropriate for special populations and identify an accessible, centralized reference and location for these materials	Providers will be able to easily find appropriate resources and materials that consumers will be able to understand and learn about HIV prevention and care messages
Identify current centers of excellence, i.e. treatment programs/providers that are successfully treating MI/CD and HIV, and build on the good work already being done	Persons living with HIV/AIDS and mental illness/chemical dependency will have access to programs that are truly helpful and other programs/providers will have resources from which to develop improved programming state-wide
Develop capacity of organizations that serve special populations, populations most impacted by HIV/AIDS in MN	Persons living with HIV/AIDS from special populations will have access to organizations that can most effectively serve them

Priority 4: Improve and coordinate the integration of prevention and care services for people living with HIV/AIDS among HIV agencies and partners outside of the HIV field.

Objective	Desired Outcomes
Create and identify linkages and interfaces between other programs and/or services related to STDs and/or hepatitis	Develop collaborative relationships to ensure appropriate HIV screening is being conducted, providing education, support and resources to other STI and hepatitis testing providers to ensure appropriate HIV testing and counseling is being conducted
Determine current level of care available for persons living with HIV/AIDS who are incarcerated in a county facility and develop protocol or best practices for care	Improving the quality of care for people living with HIV/AIDS while in a county correctional facility, including access to HIV medications, MI/CD treatment if necessary and continuity of care when transitioning out of the facility
Ensure the needs of people living with HIV/AIDS are represented in the implementation of the	Minnesotans living with HIV/AIDS will continue to receive the quality of care that meets their needs

Objective	Desired Outcomes
Affordable Care Act in Minnesota	
Develop an HIV service sector vision for an integrated HIV service delivery system that includes both government and community agencies that will maximize the effectiveness of publicly funded HIV programs	Providers and partners will know the expectations for program development and integrated service delivery, having developed a strategic plan

Priority 5: Develop statewide capacity to collect, measure and evaluate outcomes data.

Objective	Desired Outcomes
Through outcome evaluation identify support services that effectively help people living with HIV/AIDS connect to and stay in medical care	Data will identify programs that are effective and/or needed to HIV medical care adherence i.e. data on the impact of case management services helping people living with HIV/AIDS get into and maintain health care
Transfer of eHARS data to CAREWare to collect clinical indicators	Determine effectiveness of Ryan White/State HIV services as well as programs that are not funded by Ryan White
Better utilize health information to identify people living with HIV/AIDS that connect to the healthcare system but are not adherent to care	More effective use of data to assess and address the issue of persons living with HIV/AIDS that are out of care, increasing likelihood of better adherence to care
Increase capacity of providers and grantees to use data in order to improve programs	More effective use of data to assist providers and grantees in assessing and improving their programs
Develop inventory of existing MN HIV related data sources, limits on data sharing, etc.	More effective use of data to better meet the needs of people living with HIV/AIDS

Data and Information Used

Several data sources were available and reviewed in the development of the 2012 Statewide Coordinated Statement of Need (SCSN) including:

- 2011 Needs Assessment of HIV Positive Minnesotans
- Minnesota FY 2012 Part B/ADAP Application Project Narrative
- Path to Care Report
- 2011 Epidemiological HIV Profile
- Comparative Cost Analysis of Housing and Case Management Program for Chronically Ill Homeless Adults Compared to Usual Care
- Kaiser Family Foundation State Health Facts for Minnesota
- Hennepin County SHAPE Data
- Two Epidemics: Incarceration and HIV
- HIV/AIDS Bureau Monitoring Standards for Ryan White Part A and B Grantees
- 2010 Census Data
- 2010 CY Unmet Need Estimate for the TGA
- 2010 CY Demographic Characteristics of Residents in the TGA Living with HIV Disease (In Care)
- EIIHA Workgroup Recommendations
- Oral & Behavioral Health Service Assessment 2008
- CAEAR/NAPWA Consumer Study
- 2012 Comprehensive Plan
- 2006 – 2009 Statewide Consolidated Statement of Need and 2009 Update
- CAREWare Client Level Data
- eHARS
- Healthy People 2020

Appendix – List of 2012 SCSN Participants

- Karin Sabey, Hennepin County Medical Center – Positive Care Center (Part C)
- Duane Bandel, Community Member
- Tina Armstrong, Minnesota Department of Commerce
- Beth Nelson Sather, Park House
- Paula Nelson, Hennepin County Red Door Services
- April Beachem, Minnesota Department of Human Services – HIV/AIDS Unit (Part B/ADAP)
- Peter Carr, Minnesota Department of Health – STD/HIV Section
- Sarah Fryberger Madison, Project for Pride in Living
- Crystal Brown, The Salvation Army
- Leah Cameron, Clare Housing
- Jim Maurer, Park House
- Thuan Tran, Hennepin County Ryan White Program (Part A)
- Darcy Dungan-Seaver, West Side Community Health Services (former Part D recipient)
- Allison LaPointe, Minnesota Department of Health – STD/HIV Section
- Dave Rompa, Minnesota Department of Human Services – HIV/AIDS Unit (Part B/ADAP)
- Nick Metcalf, Minnesota Department of Human Services – HIV/AIDS Unit (Part B/ADAP)
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- Sharon Day, Indigenous Peoples Task Force
- Susan Wyatt, Midwest AIDS Training and Education Center (Part F)
- Lauri Wollner, independent consultant