

**Minneapolis-St. Paul TGA Application for 2010 Ryan White HIV/AIDS
Treatment Modernization Act Part A Funding**

PROJECT NARRATIVE

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Program Narrative

1. Demonstrated Need

1.a. HIV/AIDS Epidemiology– AIDS incidence and prevalence and HIV (non-AIDS) prevalence data for the Minneapolis–St. Paul TGA are presented in **Attachment 3**. These data are from the Minnesota Department of Health (MDH) and the State of Wisconsin’s HIV/AIDS Reporting Systems (eHARS). Both states have collected names-based AIDS and HIV infection data since 1985 through a passive and active HIV/AIDS surveillance system. The MDH data also provide detailed demographic information that includes country of birth, which has proved valuable since 2000 in understanding how the epidemic is emerging among African-born people living with HIV/AIDS (PLWH/A).

HIV/AIDS Cases and Disproportionate Impact–The Minneapolis-St. Paul Transitional Grant Area (TGA) comprises eleven Minnesota counties and two Wisconsin counties with a total population of 3,287,531. According to data from the Minnesota Department of Health (MDH) and the Wisconsin Department of Health Services eHARS, as of December 31, 2008 there were 3,017 individuals living with HIV (non AIDS) in the TGA, a 4.4% increase over 2007. An additional 2,280 individuals were living in the TGA with an AIDS diagnosis—an increase of nearly seven percent from the previous year; included in these were 291 new AIDS cases reported from January 1, 2007 to December 31, 2008—a one percent increase from the previous two-year reporting period. Of 6,220 Minnesotans living with HIV/AIDS, 87% (5,440) live in the TGA. Pierce and St. Croix Counties in Wisconsin accounted for just one percent (59) of the TGA’s cases. The local HIV/AIDS epidemic continues to be centered in the Twin Cities of Minneapolis-St. Paul, with 63% of Minnesota’s PLWH/A. There has been a gradual shift to more cases in the suburban areas, which account for 35% of Minnesota’s HIV/AIDS prevalence. Of new infections in the TGA in 2008, 36% were among suburban dwellers.

Men who have sex with men (MSM) continue to be the group most affected by the HIV epidemic in the TGA. MSM account for 52% of living HIV/AIDS cases and 41% of AIDS cases diagnosed over the two-year period ending December 31, 2008. As the predominant mode of exposure for all living HIV/AIDS cases in the TGA, MSM accounted for 52% of new HIV/AIDS infections in 2007-2008. Age is an important factor to determine trends; looking at new HIV infections reported to the MDH among youth (ages 13-24), in 2008 18% of new infections were among this age group. Specifically among young men there has been a steady increase from 18 cases in 2002 to 42 cases in 2008 (a 133% increase). As with the adult cohort, persons of color account for a disproportionate number of new HIV infections among adolescents and young adults. Among young men, African Americans and Hispanics (each representing three percent of the population) accounted for 31% and 9% of new infections, respectively. African-born individuals, while estimated to be one percent of the general population, were four percent of new HIV cases. Among 51 newly diagnosed young women, African Americans were at 41%, African-born at 14%, and Hispanics at four percent of the new infections diagnosed during the same time period.

Women of color continue to be a growing proportion of the epidemic. Women comprise 23% of the PLWH/A in the TGA, and there was a greater than six percent increase in the number of women living with HIV/AIDS in 2008. Trends in the annual number of HIV infections diagnosed among females differ by racial and ethnic group. Men and women of color overall are disproportionately affected by HIV/AIDS, but in Minnesota this disparity is most apparent among women. White women make up approximately 90% of the female population, but they account for only 28% of the women living with HIV/AIDS, while African American and African-born

women each represent 30% of infected women and another six percent are Hispanic. Women of color make up approximately 11% of Minnesota's female population and accounted for 67% of the new infections among women.

According to the 2008 MDH Epidemiological Profile, there were 1,256 African Americans (U.S. born) living with HIV/AIDS in the TGA as of December 31, 2008—an increase of four percent over the previous year. Similarly, there were 722 African-born PLWH/A, compared to 692 in 2007 (a four percent increase). In the period ending December 31, 2008, of the 119 black people newly diagnosed with AIDS, 43% are African-born. Hispanics also make up a larger proportion of the local epidemic, accounting for eight percent (412) of living HIV/AIDS cases in 2008. Of those living with HIV/AIDS in the TGA, two percent (89) are American Indian/Alaska Native, and one percent (76) are Asian.

According to the 2000 Census, whites make up about 86% of the state population, but they represent 53% of all new HIV/AIDS infections in 2007. While populations of color make up 11% of the state's population, they comprise 45% of new HIV infections in Minnesota. This disproportionate impact, particularly on the black community, is consistent with trends seen nationwide, and is especially disconcerting since blacks comprise only about eight percent of the population in the TGA. Hispanics too are disproportionately impacted by HIV compared to their representation in the TGA, comprising 10% of new AIDS cases between 2007 and 2008, yet making up just three percent of the general population.

The number of African immigrants in Minnesota continues to grow. Census data show a 600% increase in the number of African immigrants in Minnesota between 1990 and 2000. The Minnesota State Demographer estimated that there were 62,612 people living in Minnesota who were born in African countries. Somalia, Ethiopia, and Liberia are the most common countries of origin although nearly every African country is represented in Minnesota, which became one of six sites in the U.S. to receive HIV-positive refugees in 2000. Typically immigrants, with HIV/AIDS are not permitted entry into the United States, but through the special medical waiver program 188 HIV-positive African refugees arrived between 2000 and 2008, with 120 first settling in Hennepin County. Increases in the number of HIV infections among African-born men and women have been documented each year since the late 1990s. For the most recent two-year period, there were 51 newly diagnosed AIDS cases among African-born people living in the TGA, who now account for a startling 13% of the local epidemic but account for less than two percent of the TGA's population. Overall, African-born individuals accounted for 18% of new AIDS cases in 2008.

Data on injection drug use are limited in Minnesota and are based on admissions to treatment programs and emergency room visits. The estimated number of injectable drug users (IDUs) in the TGA is 6,214. IDUs comprise seven percent of the living AIDS cases, six percent of living HIV cases and five percent of AIDS cases diagnosed in the TGA during the two-year period ending December 31, 2008. Injection drug use was an associated risk factor (either IDU alone or MSM/IDU) for 11% (630 of 5,499) of those living with HIV/AIDS in the TGA at the end of 2008. Among women, IDU is the second most common mode of transmission (after heterosexual contact) making up five percent of cases among women in 2008. Intravenous drug use is estimated to account for seven percent of HIV cases among African-American women in Minnesota, and 16% among white women.

Consistent with national data, the vast majority (99.5%) of the TGA's living AIDS cases are adults over age 19. As of December 31, 2008, the TGA had 12 living AIDS cases in children or youth under the age of 19. Two new AIDS cases under age 19 were reported during the reporting

period and there are 51 youth under 19 years of age living with HIV (not AIDS) in the TGA. This age group accounts for two percent of all living HIV cases in the TGA. There were no new cases of AIDS in 2008 among children younger than 13 years. The higher number of youth living with HIV versus AIDS may reflect not only the national trend of a decrease in HIV transmission from infected mothers at birth, but an increase in unsafe sexual practices among gay male youth and adolescents in general. In 2008, 18% of the 326 new HIV infections were among young men (age 13-24).

The TGA includes several suburban, semi-rural and rural counties surrounding the core cities of Minneapolis and St. Paul. Historically, about 90% of new HIV infections (including AIDS at first diagnosis) in Minnesota have occurred in the TGA. This trend continued in 2008 with 44% of new infections among residents of Minneapolis, 9% in St. Paul, 36% in the surrounding suburbs, and 12% outside the TGA. Since 2000, approximately one third of all new HIV infection cases diagnosed in Minnesota have either been AIDS at first diagnosis, or have progressed to AIDS within one year of initial HIV diagnosis. The proportion of late testers varies by demographic characteristics. The most significant differences occur by race/ethnicity, with the proportion of late testers between 2000 and 2008 among Hispanics (47%) and African-born (42%) being higher than that among whites (29%) and African Americans (29%). Differences by age, as expected, show the percentage of late testers increasing with age at time of diagnosis. In 2008, 17% of those diagnosed between the ages of 13 and 24 were late testers compared to 44% of those 45 years and older. In 2008, 39% of foreign-born cases were late testers compared to 29% of US-born cases.

In its March 2007 *Overview of Homelessness in Minnesota*, Wilder Research Center estimated that 7,713 individuals (of which 206 were unaccompanied youth) were homeless at some time during 2006. Based on interviews with 3,800 homeless adults, the study estimates that two percent are living with HIV, which is 12 times the HIV prevalence rate in the TGA's general population. Data from the Federal Bureau of Prisons and Minnesota Department of Corrections indicate that among individuals discharged in 2008 from detention, 14 from federal facilities and 29 from state facilities were positive for HIV. Information from the correctional facilities of the TGA's two largest counties indicates that a total of 247 HIV-positive people were released during 2006-2008; however, since the majority of them were identified as HIV-positive by self report during brief lengths of incarceration (averaging six to seven days), the actual prevalence among this group is probably much higher.

In summary, these data portray an evolving epidemic in the Minneapolis-St. Paul TGA, with men who have sex with men continuing to experience the greatest impact. Additional trends that have emerged nationally also appear in the TGA, including:

- Communities of color comprise an increasingly disproportionate share of HIV and AIDS cases
- African-born persons living with HIV/AIDS account for 13% of all cases in the TGA but less than two percent of the TGA's population
- The number of women living with HIV/AIDS continues to increase, particularly African American and African-born women of childbearing age
- The TGA's urban counties continue to be disproportionately impacted with 85% of the PLWH/A in the TGA living in Hennepin or Ramsey county
- New HIV infections among young men are increasing in the TGA; the mode of exposure for 98% of new infections among young men is MSM or MSM/IDU

These trends have a significant impact on the cost and complexity of service delivery in the Minneapolis-St. Paul TGA. The urban area has a strong network of HIV service providers; however, many of these organizations have not traditionally targeted outreach activities to young MSM, women, communities of color, and immigrant communities. As the HIV/AIDS epidemic expands to include greater numbers from these communities, the number of individuals with complex issues involving substance use, mental illness, unstable housing, low socioeconomic status, language or cultural barriers and stigma continues to increase. These cofactors make it even more difficult for these populations to access or maintain health insurance and employment, or to adhere to complex medication regimens.

Populations Underrepresented in HIV Primary Medical Care – The 2008 Ryan White services utilization data represent only a partial picture of the HIV/AIDS system of primary medical care. In many states, Ryan White funds are primarily used to pay for medical care for PLWH/A. Minnesota has historically been fortunate to provide extensive access to health insurance through public programs or the purchase of health insurance for PLWH/A. This has reduced the need to use Ryan White Part A and Part B funds to directly support primary medical care and allowed the dollars to be used to create a comprehensive system of services that support access and adherence to medical care. To address disparities in access to care in 2008, the Planning Council allocated 26% of Part A funds for ambulatory medical care to culturally specific primary care. Minority AIDS Initiative (MAI) funds support a primary care program that provides bilingual medical services to Latinos, with a resulting increase in this group's representation in utilization data. Thus for 2008, of those utilizing Ryan White-funded primary care, 17% were Latino, and 22% were white. The largest group utilizing primary care was African American at 42%. The remaining primary care users were American Indian (1.4%), Asian (0.5%), more than one race (3.2%), and those for whom race was reported "unknown" (9%). Men and women accessed primary care at rates more reflective of the epidemic, with 64% men and 35% women seen in primary care. While 35% who utilized Part A-funded primary care services identified "other" as their country of birth (not United States), for 32% this item was listed as "unknown." Early Intervention Services (primary care for newly diagnosed) served 62% whites, 24% African American and African born, and eight percent Latino individuals.

Since 2003, undocumented individuals with the exception of pregnant women are no longer eligible for publicly-funded Minnesota Health Care Programs. In that same year, the income eligibility guidelines for state-funded insurance for the working poor changed from 175% to 75% of the federal poverty level. These changes in publicly-funded health care programs will continue to disproportionately impede the ability of African Americans, new immigrants, Latinos and Native Americans to access primary care.

Estimated Level of Service Gaps – According to 2008 service utilization data, 3,700 unduplicated individuals living with HIV/AIDS, out of a possible 5,499 in the TGA (67%), received some type of service within the Ryan White Part A- and B-funded care system. Of the people in Ryan White services, 40% are white, 38% are African American or African born, four percent are more than one race, nine percent are Hispanic, two percent are American Indian, one percent are Asian, one percent other, and four percent are of unknown race. Living HIV/AIDS cases in the TGA are 52% white, 36% African American or African-born, eight percent Hispanic, two percent American Indian, one percent Asian, and one percent multi-race or unknown. Males comprise 77% of all cases living with HIV/AIDS in the TGA and account for 71% of the clients receiving services.

The grantee's Outcomes Evaluation/Client Level Reporting System data on Medical Case Management for 2008 obtained information from 1,372 clients and their case managers about their medical needs in the previous six months. It found that 35% of clients needed assistance with adhering to medication regimens, 23% needed help to access or maintain medical care, 19% needed help to get mental health services, and 11% identified a need for substance abuse services. In other service needs, 32% needed Emergency Financial Assistance, and 19% needed Housing Assistance.

1.b. Impact of Comorbidities on the Cost and Complexity of Providing Care

The levels of comorbidities, poverty and lack of insurance for the Minneapolis – St. Paul Transitional Grant Area's (TGA) population are presented in **Attachment 4**.

People who are living with HIV and AIDS (PLWH/A) who are uninsured, homeless, living in poverty, chemically dependent, have severe mental illness, have sexually transmitted diseases (STIs) or other co-infections, or were recently incarcerated face additional challenges to access services because systems of care are not well integrated, costs are higher and services may not be adequately reimbursed by third-party payers. In addition, those who were born outside of the United States encounter linguistic and cultural barriers to care. As PLWH/A contend with these issues it may become difficult for them to access or maintain health insurance, attain economic self-sufficiency and stable housing, and adhere to complex medical care and medication regimens. Physicians and case managers spend time trying to assist people with these issues that must be addressed if treatment is to be successful. Often, there is no compensation for additional services needed to provide quality care for those struggling with multiple diagnoses and stressful socioeconomic circumstances.

The grantee has collected quantitative data on HIV comorbidities, insurance status and poverty in the TGA from the Minnesota Department of Health, Wisconsin Department of Health Services, the U.S. Census Bureau, local and national reports, needs assessments, and service provider data. Although data are available for several comorbidities, their rates among PLWH/A are difficult to determine because other service systems often do not collect HIV related data. Linkages between systems of care are limited and PLWH/A may remain undiagnosed or untreated for other conditions. In addition to the sources listed above, data from the Minnesota Department of Human Services (DHS), unit costs from HIV primary care clinics and testing sites, and client utilization and service expenditure data are used to provide a more detailed picture of the impact of comorbidities on access to primary medical care and the cost of care for those living with HIV/AIDS in the TGA. In the future, data collected beginning in January of 2009 through the TGA's improved client level data system will provide more detail about the following comorbidities among PLWH/A who access services funded by the Ryan White Program.

Sexually Transmitted Infections (STI)– The Minnesota Department of Health (MDH) reports that although overall incidence rates for STDs in Minnesota are lower than those in many other areas of the United States, certain population subgroups in Minnesota have very high STI rates. Specifically, STIs disproportionately affect adolescents, young adults, and persons of color. In 2008 the number of reported bacterial STIs reached their highest level ever with 17,650 cases reported. This represents an overall increase of 3.5% from the previous year and is part of a continued trend observed over the past ten years. The change in incidence rates varied by disease, with chlamydia increasing by 7%, primary/secondary syphilis doubling, and gonorrhea decreasing by 12%. Minnesota has seen a resurgence of syphilis since 2002, with men who have sex with men (MSM) being especially impacted. Primary/secondary syphilis cases among MSM, who comprised 89% of male cases in 2008, increased by 87%. Racial disparities in STIs con-

tinue to persist in Minnesota with communities of color having the highest rates. Since 1996 the incidence of chlamydia has more than doubled to 292 per 100,000 in 2008, while gonorrhea increased from 56 to 62 per 100,000. Primary/secondary syphilis increased by 35% among males (95% of whom were MSM), while cases among women remained low. Adolescents and young adults (ages 15-24) accounted for 69% of chlamydia and 59% of gonorrhea cases reported in 2008. Sexually transmitted disease infection rates are likely higher among PLWH/A compared to the general population. Based on 2008 unit costs for laboratory tests and treatment from the TGA's largest HIV and STI testing clinic, the cost of screening for chlamydia, gonorrhea and syphilis averages \$371 per patient. Antibiotic treatment costs range from \$8.25–\$51. Treatment for co-infections can be as much as \$89. Costs are even higher for treatment of sexually transmitted infections in later stages. One latent case of syphilis can cost \$716 which includes comprehensive treatment and follow-up. Using the reported diagnosis of sexually transmitted disease infections from the 2003 Needs Assessment to estimate STI prevalence in the TGA's population of PLWH/A (18%), co-infection with an STI may add up to \$367,200 to the annual cost of care for PLWH/A in the TGA depending on the STI, how early it is treated, and frequency of infection.

Homelessness – According to *Overview of Homelessness in Minnesota* there were an estimated 7,713 homeless individuals living in the Minneapolis-St. Paul TGA, including an estimated 206 unaccompanied youth. This study said that two percent of the 3,800 homeless adults interviewed reported that they were HIV positive. Another two percent reported having a STI other than HIV. People of color are vastly overrepresented in the population of homeless persons in Minneapolis and St. Paul. In the general population 65% are Caucasian, 18% are African American, eight percent are Latino, and two percent are American Indian; among the homeless, 57% are African American, and eight percent are American Indian. In 2008, Ryan White client-level data indicated that nine percent (215 of 2,436) of all Part A and B service recipients whose living situation was known were homeless at some time during the year or in unstable housing. Three percent of clients receiving Medical Case Management services were homeless during both reporting periods in 2008 and another nine percent were in unstable housing.

According to *Overview of Homelessness*, mental illness and drug abuse are prevalent among homeless adults. The report estimates that 52% have a serious mental illness. Forty-eight percent of homeless men and 28% of homeless women had been in inpatient treatment for chemical dependency. These additional comorbidities are significant barriers to entering and maintaining primary HIV medical care. Homeless patients are more likely to visit the emergency room, are hospitalized more frequently, stay in the hospital for longer periods of time and have poorer health outcomes. Among those who had received care at an emergency room in the previous six months, 25% said that they were released with instructions they couldn't follow because they were homeless. For those living with HIV, adherence to antiretroviral treatment is likely to be a significant challenge. All of these factors, complicated by inadequate resources to provide stable housing, will significantly increase the cost of care for homeless PLWH/A. Based on the annual average assistance per recipient of HOPWA rental subsidies of \$6,996 in 2007, providing subsidies to the estimated number of homeless and inadequately housed PLWH/A in the TGA would cost an additional \$1,504,140 annually. Many homeless PLWH/A will require intensive assistance through Medical Case Management to access mental health or chemical dependency treatment, shelter and supportive social services before successful treatment for HIV is likely. Based on the TGA's unmet need estimate of 39% of PLWH/A (N=2,143), an estimated nine percent rate of homelessness or unstable housing among the TGA's PLWH/A and an average per capita

annual MCM cost of \$1,473 in 2008, providing MCM services to those out of care could add an additional \$284,100 to the cost of care for this population.

Uninsured –According to the U.S. Census Bureau’s 2008 *American Community Survey*, the rate of uninsurance was 8.4% for the population of the TGA, or 270,987 people. About 20% had health insurance coverage through a public program (including Medicare). People with the lowest family incomes—at 100% of Federal Poverty Guidelines (FPG)—had uninsurance rates of 18% or higher, while those with incomes from 101-300% of FPG were uninsured at a rate of 12.6%. People of racial and ethnic minorities are more likely to go without health insurance than whites. In Hennepin County, 52% of Latinos, 40% of African Americans, and 32% of other ethnic minorities were uninsured in 2008, compared with 21% of whites. Despite the fact that people of color are far more likely to be uninsured, white Minnesotans made up the largest category (70%) of people without health insurance. Minnesota has an array of public programs in which HIV-infected Minnesotans can enroll. Client level service utilization data show that in 2008, 27% of Ryan White program recipients were enrolled in the Minnesota Medical Assistance Program (Medicaid). Eighteen percent had Medicare coverage and another 15% of Ryan White clients were enrolled in other publicly-funded health care programs, including General Assistance Medical Care, MinnesotaCare (a subsidized insurance program for the working poor), and the state’s supplemental program for qualified Medicare recipients. Minnesota’s Part B funded HIV/AIDS Insurance and ADAP Program provided assistance to 781 individuals or 25% of the PLWH/A in the TGA receiving Ryan White services. Overall 12% were known to be uninsured, and the insurance status of eight percent was unknown.

In FY2008, \$741,254 in Part A funds were expended on Primary Care and Early Intervention Services for 513 of the TGA’s uninsured and under-insured PLWH/A. With an average annual expenditure per patient of \$1,445 and assuming that the percentage of uninsured PLWH/A is 12% based on client level data, the cost of providing primary care to all of the TGA’s uninsured PLWH/A, including those out of care, would approach \$953,500 annually.

State Medicaid Program and Medicare – Minnesota’s Medicaid program, Medical Assistance (MA), covers basic health care services as well as HIV medications. MA affords some of the most comprehensive benefits in the country, and includes an expansive drug formulary, while not limiting the number of prescriptions or dollar amounts per month. Recipients pay \$1-3 per prescription up to a maximum of \$12 per month.

In response to budget deficits, the Minnesota Legislature has reduced income eligibility standards for MA and imposed prescription co-payments of up to \$12. These changes impacted primarily pregnant women and single adults. In 2008, nine percent of the TGA’s population was enrolled in Medicaid (**see Attachment 4**). Client level utilization data show that 28% of PLWH/A in the TGA who accessed a Ryan White funded service in 2008 were enrolled in Medicaid. Estimated Medicaid expenditures for calendar year 2008 accounted for \$15,184,500 of the cost of publicly funded HIV outpatient medical care, including pharmacy, in the TGA. The average per-capita annual expenditure on outpatient healthcare for a PLWH/A enrolled in MA in this time period was \$14,489.

While filling few health care gaps for Medicaid recipients, Ryan White programs help meet access and support service needs. These include Medical Case Management, Benefits Counseling, Outreach, Transportation, Emergency Financial and Housing Assistance, Food and Nutrition, Legal Assistance and other services that allow people to access and remain in care. Medical Case Management is critical for MA recipients and providers are educated about the importance of Ryan White funds as the payer of last resort. In fiscal year 2008, HIV case management out-

lays accounted for 40% of all Part A funds spent on services, supplementing a state appropriation and a Medicaid allocation to support case management services for PLWH/A. Part A funds will account for 55% of Minnesota's annual HIV Medical Case Management budget in FY2010. This is a high priority service area, ranked second in the Planning Council's 2009-2010 joint Part A and B prioritization process, and allocated 42% of 2010 planned Part A spending.

Persons Living at or below 300 percent of Federal Poverty Guidelines – Minnesota has fared somewhat better than the nation as a whole in regard to poverty and income. In 2000, an estimated eight percent of Minnesotans were living at or below the poverty level compared to 13% nationwide, while the per-capita income in the TGA was \$26,219. Although these aggregate numbers are favorable, they misrepresent the disproportionate impact poverty has on persons of color in Minnesota. The MDH Health Economics Program (2005) report estimates that nine percent of all Minnesotans were living at or below the poverty level but 29% of African Americans, 25% of American Indians, 19% of Asians and 38% of Hispanics lived in poverty. Access to health insurance is becoming exceedingly difficult for those who are not poor enough to qualify for Medicaid or other state-funded health care programs. The most recent Census figures (2008) report the number of persons living below 300% of poverty in the TGA at 1,000,722 or 31% of the population.

Outcomes Evaluation for 2008 for Medical Case Management shows that 34% of 1,372 case-managed clients received help to obtain Emergency Financial assistance and four percent identified this as a need that was not met. Emergency Housing assistance was a need case managers helped clients to obtain for 19% of all case-managed clients, while 27% who identified this as a need did not receive this assistance. In the same time period, 9% of case-managed clients needed help to access an emergency food shelf and 18% needed help to obtain vouchers for food. In FY2008, combined Part A and Part B expenditures on Emergency Financial and Housing Assistance reached \$480,832 and helped 1,264 PLWH/A avoid eviction, pay utility and/or medical bills.

Trends in Services and Fiscal Resources as a Result of State Budget Cuts – As a result of Minnesota's economic downturn and the associated decreases in income and property tax revenues, state budget cuts will impact a diverse variety of clinical and non-clinical HIV services in the 2010 and 2011 biennium. The single greatest known impact to date is the planned elimination of Minnesota's General Assistance Medical Care (GAMC) program. Established by the Minnesota Legislature in 1975, the program is designed to be a safety net for the medically indigent, with eligibility limited to low-income adults, ages 21-64, who have no dependent children under age 18 and who do not qualify for federal health care programs. To qualify, an individual must be ineligible for Medical Assistance, have lived in Minnesota for at least 30 days and intend to stay, and be a U.S. citizen or non-citizen lawfully residing in the U.S. In fiscal year 2007, an average of 33,824 persons were eligible to receive GAMC services each month—many of them homeless, mentally ill, or dealing with addiction issues. To receive full medical benefits, a single individual must be at or below 75% of FPL (a monthly income limit of \$677) and own no more than \$1,000 in assets; to receive hospitalization-only benefits, a single individual qualifies with a monthly income up to \$1,580 (75–150% of FPL) with an asset limit of \$10,000. In May of 2009, Minnesota's governor announced his plan to use line-item veto authority to eliminate all funding for GAMC—a total of \$381 million—beginning in March of 2010. The safety-net hospitals that provide treatment to low-income individuals—primarily Hennepin County Medical Center (HCMC) in Minneapolis and Regions Medical Center in St. Paul—are major providers of outpatient care to PLWH/A. Even with Ryan White and GAMC funding, HCMC's Positive Care

Clinic, which provides Primary Medical Care, Medical Case Management, Medication Adherence, Mental Health Services and Medical Nutrition Therapy for 992 individual clients, asked its parent institution to absorb \$1.98 million in 2008 for uncompensated care of HIV positive patients. The medical center as a whole will lose all of the \$45 million in reimbursements it received in 2008 for GAMC recipients when the program ends. Most of the Positive Care Clinic's 210 patients classified as insured by "other public programs" have been covered by GAMC. Overall in the TGA, there were 18,392 individuals who were covered by GAMC for at least a part of 2008, and 233 PLWH/A in the TGA were covered by this program at a cost of \$2,338,707. Unless the Minnesota Legislature is able to pass a bill and obtain the governor's signature to restore this program, it is predicted that the majority of PLWH/A now covered by GAMC will need to have their care funded by Ryan White programs beginning in March of 2010. The Minnesota Department of Human Services anticipates that ADAP expenditures may increase by up to \$1,200,000 due to the elimination of GAMC. At an average per patient cost of \$1,343 for Part A funded primary care in 2008, the TGA would need an additional \$333,900 in funds allocated to Outpatient/Ambulatory Medical Care to fill the gap.

Formerly Incarcerated PLWH/A – According to the Federal Bureau of Prisons, 40 individuals living with HIV or AIDS were released in 2006-2008 from federal facilities in Minnesota. All of the 40 individuals released were male. The majority (98%) of PLWH/A released in 2006-2008 were from the Federal Medical Center located in Rochester, Minnesota. According to the Minnesota Department of Corrections, 81 PLWH/A were released in 2006-2008 from state correctional facilities in Minnesota. The Minnesota Department of Corrections began routine screening for HIV at the St. Cloud facility in October, 2007 and at the Shakopee facility in January, 2008. Shakopee houses all female residents and St. Cloud serves as the central prison where all males entering the correctional system begin their sentences. Routine HIV testing is not conducted within the penal system at the local level. All TGA county correctional facilities have an initial medical screening form completed by medical personnel during an individual's intake process. Individuals are asked whether they have a communicable disease including HIV infection. For those who disclose their positive status, care and medication are continued through the institution's medical clinic. However, TGA counties do not compile self-disclosed HIV status in aggregate form. According to the Hennepin County Corrections nursing supervisor, it is estimated that approximately 144 individuals living with HIV were incarcerated at the workhouse facility and released in 2006-2008. According to the Ramsey County Corrections section manager, there were approximately 36 individuals living with HIV incarcerated at the workhouse facility who were released in 2006-2008. Estimating HIV-positive individuals detained in the county jails is difficult since an average length of stay is only six to seven days. While it is believed that the actual number of HIV-positive individuals in local facilities is much higher, there is little incentive for a detainee to request testing or identify as HIV positive due to potential stigma and the transitory nature of their detainment. During intake, HIV status is revealed when an individual indicates taking HIV related medication; a direct question about HIV status is not asked. According to the Hennepin County Adult Detention Center, there were approximately 37 individuals with HIV released in the last three years out of 40,698 detainees booked within the facility each year. According to the Ramsey County Adult Detention Center, there were approximately 30 individuals with HIV released in the last 3 years out of approximately 27,000 detainees booked each year. Medical Case Management services would likely assist PLWH/A being released from incarceration in staying in or reconnecting to care. Estimating that a minimum of 83 PLWH/A are

released from the TGA's largest two counties' facilities annually, providing MCM services to the formerly incarcerated may add \$122,259 to the cost of care.

Tuberculosis (TB)—In 2007 for the first time since national TB surveillance began the TB incidence rate in Minnesota exceeded the national rate. In 2008, the number of TB cases decreased 11% to 211 cases. There were zero cases of TB reported for the two TGA counties of western Wisconsin. The majority of people with TB disease in Minnesota live in the Twin Cities metropolitan area. During the last two decades, the most distinguishing characteristic of the epidemiology of TB in Minnesota has been the consistently high percentage of cases among persons born outside the United States. This reflects the unique and changing demographics of immigrant populations arriving in the state, particularly persons from regions of the world where TB is common. The percentage of Minnesota's TB cases occurring among foreign-born individuals has exceeded 80% for all but one of the years 2000-2007, peaking at 87% in 2005, and while decreasing in 2008, still amounting to 73%. This decrease reflects the significant decline in primary refugee arrivals to Minnesota in recent years and the occurrence of three TB outbreaks among other high-risk populations in Minnesota in 2008. Other less frequent risk factors among TB patients reported in Minnesota during 2008 included HIV infection (5%), other medical conditions known to be associated with an increased risk for progression to active TB (11%), substance abuse (10%), homelessness (5%), and incarceration (2%). In 2008 there were 166 cases of active TB identified within the TGA's thirteen counties, five percent of which (8) are estimated to be coinfecting with HIV. Hennepin County's Public Health Clinic currently provides directly observed therapy for six TB/HIV co-infected individuals. Costs for managing co-infection with TB are based on estimates for a full course of the four-drug regimen recommended by the CDC. An uncomplicated course, for medications only, would average \$1,310 per patient, costing a total of \$10,480 for the 8 cases in the TGA.

Hepatitis C (HCV)—Based upon national estimates, approximately 40,000 to 60,000 Minnesotans are estimated to be chronically infected with HCV. The Minnesota Department of Health (MDH) estimates there were 19,918 people chronically infected with HCV living in the Minnesota TGA counties in 2008. There was a total of 22 cases in the two Wisconsin counties of the TGA reported by the Wisconsin Department of Health Services in 2008. MDH reports that in 2008 there were 507 HIV and HCV co-infected individuals living in the TGA. In co-infected persons HCV progresses faster, leading to serious liver disease. HCV is also exacerbated by the continued use of alcohol or drugs and medications used in antiretroviral therapy for PLWH/A. Hepatitis C Virus helps account for the 50% of deaths from liver disease among those with HIV. HCV treatment is costly, long in duration and has debilitating side effects including depression. Treatment is contraindicated for persons currently abusing substances or suffering from mental illness. In addition, treatment is only successful for about 40-50% of patients. The Hennepin County Medical Center Infectious Disease Clinic reports that ongoing follow-up clinical care for HCV for a patient co-infected with HIV increases by more than \$3,000 per year. This includes the cost of more frequent visits with an Infectious Disease physician and more lab tests. For those patients who are able to adhere to medication treatment and are receiving antiviral treatment for HCV, the cost increases to more than \$40,000 for 48 weeks of treatment. Using the HIV/HCV co-infection data reported for 2008, the estimated additional cost of follow up clinical care including HCV treatment would be \$20,280,000 for the TGA's estimated 507 co-infected PLWH/A.

Injection Drug Use (IDU) and Other Substance Abuse—The Minnesota Department of Human Services (DHS) estimates that the number of intravenous drug users (IDUs) in the general popu-

lation of the TGA in 2008 was 6,214. The HIV/AIDS Epidemiology profile identifies 345 individuals in the prevalence data who are IDUs and another 285 men who have sex with men who are also IDUs. Estimates of HIV among alcoholics and non-injecting drug addicts range from three percent to more than 33%. Alcohol and other substance use are likely to be significant barriers to accessing care. Outcomes evaluation data (2008) collected from and about clients receiving HIV Medical Case Management services through Ryan White illuminate the problem posed by substance abuse. These data indicate that 21% of clients have substance abuse issues that impact their ability to adhere to medication regimens, and 15% have substance abuse issues that impact their ability to access HIV medical care.

In the “2008 Oral Health and Behavioral Health Services Assessment” completed for the Minnesota HIV Services Planning Council by Bob Tracy Consulting, the following key observations were made about chemical health issues: HIV service providers who participated in service assessment interviews agreed that substance abuse impacted their clients’ ability to adhere to treatment regimens and suggested that based on their experiences the impact was even greater than the rate reported in Medical Case Management outcomes evaluation data. In addition, timely access to a “Rule 25” assessment, which is required in Minnesota in order to access publicly-funded substance abuse treatment, is a critical step in the path to receiving treatment. However, providers interviewed for the study said the lack of availability of a qualified assessor soon after a client agrees to participate in the assessment is a barrier to linking clients to chemical health treatment. Finally, they cited limited access to treatment providers that have the capacity to address the needs of PLWH/A as an additional barrier.

The Minnesota Department of Human Services (DHS) reported that in calendar year 2008, 236 PLWH/A in the TGA who were enrolled in a Minnesota Health Care Program received substance abuse treatment. This represents 12% of the PLWH/A who were enrolled in a MHCP. Data from the DHS-administered Consolidated Treatment Fund for chemical dependency show that in 2008, \$2,255,940 was expended on chemical dependency treatment for PLWH/A in the TGA who were enrolled in a MHCP with the average cost of treatment at \$9,559 per recipient. Costs will vary based on whether an individual is placed in an outpatient or inpatient program and whether or not a recipient completes treatment. If up to 12% of PLWH/A who are out of care are chemically dependent, treatment for those out of care would add an additional \$2,456,663 to the cost of HIV care in the TGA.

Mental Illness – The DHS estimates that there are 125,554 persons with serious mental illness or serious and persistent mental illness (SMI/SPMI) living in the state. According to the DHS, in calendar year 2008, 869 of the people living with HIV who were enrolled in a Minnesota Health Care Program accessed some form of mental health therapy. The total expenditure for mental health services for PLWH/A in the TGA on a publicly funded health care program in 2008 was \$1,715,345, costing \$1,973 per recipient. While access to treatment is available to low-income Minnesotans, the “2008 Oral Health and Behavioral Health Services Assessment” found that navigating the mental health care system and finding an HIV-capable provider are complicated by numerous factors. First, consumer knowledge about differences in types of mental health care and providers is limited [e.g. mental health care versus emotional support, or a counselor versus a therapist]. This can limit their abilities to be self care advocates. There are challenges finding providers they trust, particularly those who have experience that supports clients’ ability to incorporate HIV-related needs into their mental health plan of care and sensitivity to populations affected by HIV. The pool of HIV-ready providers to choose from is limited. Providers and consumers indicate they have experienced a wide range of professional capacity within programs

providing group support or counseling specifically for people living with HIV. There are significant barriers to getting timely psychiatric care due to an overall shortage of psychiatric care providers in Minnesota. The consequence is that to gain access to psychiatric services at the time when they are needed can be difficult, and in some cases, it places HIV health care providers in the position of having to prescribe and manage both psychotropic medications and HIV-related medications without the desired level of consultation with a psychiatrist or psychiatric nurse practitioner. Finally, HIV care and services providers' skills are put to the test when working with and negotiating the needs of clients with mental disorders. Providers perceive an increase in the number of clients in their care who experience more serious mental disorders, or are finding clients with these higher needs are requiring more time and skill. They also note the specialized nature of mental health screening and assessment processes, unique funding structures for reimbursing care and significant changes in how services are structured. In short, the mental health care system has unique features that are beyond the routine experiences of HIV medical case managers. Based on the per-client cost of mental health services for PLWH/A enrolled in a Minnesota Health Care Plan, meeting this need would add an additional \$1,714,537 to the cost of care for those PLWH/A who also have mental illness.

1.c. Impact of Part A Funding: Funding Mechanisms and the Impact of the Decline in Ryan White Formula Funding

i) Report on the Availability of Other Public Funding

See **Attachment 5** for a summary of other public funding anticipated to be available for HIV services during the FY2010 budget period.

ii) Coordination of Services and Funding Streams

In planning the continuum of prevention and care and prioritizing and allocating Part A funds, services funded by other sources are considered in the following ways:

Medicaid—To ensure that priority setting and resource allocation consider Medicaid as well as other state-funded health care programs, the grantee and the Planning Council have taken the following steps: 1) The Minnesota Department of Human Services (DHS), the state Part B grantee and agency responsible for Medicaid and all other state-funded health care programs, is a party to the Intergovernmental Agreement (IGA) (**Attachment 2a**) and has two seats on the Council including staff representing the state Medicaid office and from the Part B grantee office; 2) Staff from the DHS sit on the Planning and Priorities and Needs Assessment committees, which are responsible for priority setting, long-range planning, resource allocation and standards development; 3) The Part A and Part B grantees monitor program usage and identify emerging issues related to the coverage of health care services and medications; 4) DHS staff determine eligibility for all persons living with HIV who may qualify for state sponsored insurance programs as well as Ryan White funded programs such as ADAP to ensure the Ryan White program is the payer of last resort; and 5) The grantee and Planning Council receive an annual report from the DHS on the number of people living with HIV/AIDS enrolled in all Minnesota Health Care Programs (MHCP), including Medicaid, and all MHCP expenditures on HIV outpatient medical care, dental care, mental health and chemical dependency treatment services and home and community-based support.

Medicare—As of December 31, 2008, 534 PLWH/A in the TGA who received Ryan White Part A and B funded services (17%) were enrolled in Medicare. Prior to the implementation of Medicare Part D on January 1, 2006, Planning Council members participated in a Medicare work-group, convened by the DHS, to develop strategies to address the impact of Medicare Part D on access to medications and primary care. Minnesota's Part B grantee currently provides additional

assistance to PLWH/A with incomes between 150 and 300% of federal poverty guidelines who are enrolled in Medicare Part D through ADAP and the HIV Insurance Program. In addition to ADAP funds, a state appropriation provides support for the HIV Insurance Program. For FY2009, the Planning Council allocated \$178,600 in Part B funds to provide benefits counseling (non-Medical Case Management) to assist PLWH/A in identifying the most comprehensive and cost-effective private and public health care programs to ensure continued access to affordable treatment. This helps PLWH/A who are Medicare eligible to enroll in the Part D prescription drug plans and “extra-help” programs. The DHS periodically provides the Planning Council with information on the number of PLWH/A on Medicare who are also enrolled in ADAP and the HIV Insurance Program. As of December 31, 2009, 32 PLWHA on Medicare were receiving assistance from the DHS HIV/AIDS Program to alleviate the prohibitive out-of-pocket cost burden of the Medicare Part D “doughnut hole.”

State Children’s Health Insurance Program—Fortunately, the number of children aged 19 or younger living with HIV/AIDS in the TGA as of December 31, 2008 remains relatively small at 63 (1% of prevalence). The State has a small health insurance program for children with disabilities. Most low-income children with disabilities can get coverage under Medicaid or MinnesotaCare. Because of this coverage, few children access Ryan White funded insurance or drug programs. A representative from DHS, which administers the children’s health insurance program, sits on the Planning Council and provides information about this and other DHS programs in order to reduce duplication of services.

Veterans Affairs Programs—The TGA is home to a Veterans Administration Medical Center with an HIV specialty clinic that currently provides care to 151 patients. Veterans are offered the same comprehensive drug formulary as Medicaid offers and most veterans with HIV receive comprehensive services through the VA system. Veterans may use other Ryan White funded services that are not part of the veterans’ benefits, including medical case management, psychosocial support, health education, meals and nutritional services.

HOPWA (Housing Opportunities for Persons with HIV/AIDS)—The Minnesota Housing Finance Agency (MHFA) and the City of Minneapolis receive HOPWA formula funding. The Minneapolis program provides rental subsidies and the MHFA program provides both rental and mortgage assistance. A member of the Planning Council and the Council Coordinator participate in the Minnesota HIV Housing Coalition. The Council’s Planning and Priorities Committee consider HOPWA funded programs in the planning process. A leading member of the Minnesota HIV Housing Coalition presented an update on HOPWA funded services in Minnesota at the Planning Council’s May 2008 meeting as part of the informational sessions for Council members leading up to the 2008 biennial prioritization. The TGA’s largest AIDS service organization is a sub-recipient of state formula HOPWA funds and also has a Part A contract to provide rental assistance through its emergency financial assistance program. Its Transitional Housing Program coordinator chairs the Minnesota HIV Housing Coalition. The grantee works closely with this agency to coordinate Part A and Part B funds allocated for emergency financial assistance with their HOPWA funds.

CDC Prevention Program—The grantee and Planning Council have a long history of coordination with the Minnesota Department of Health (MDH), the CDC grantee. In FY 2002, the Planning Council and the Community Cooperative Council on HIV/AIDS Prevention (CCCHAP) developed a plan that identified where care and prevention intersect, formulated strategies to maximize resources and improved coordination between care and prevention. The Planning Council also worked with CCCHAP in 2003 and 2004 to expand the HIV continuum of care to

include prevention. As a result, improved awareness of the full spectrum of HIV service needs has assisted in effective planning for both prevention and care. The staff member from the MDH HIV and STI Prevention Section that coordinates the State's HIV prevention community planning process is a member of the Planning Council. Minnesota's State AIDS Director regularly attends Planning Council meetings and provides information on CDC and State funded HIV prevention funding and programming.

Services for Women & Children – The majority of women and children living with HIV are enrolled in Medicaid or another Minnesota Health Care Program, with 87% of women and 73% of infants and children receiving their care through one of these programs in 2008. Services such as Women, Infants and Children and substance abuse treatment programs for pregnant women are considered in the planning process in several ways. First, a Women and Families service provider network, which is convened by the Part D grantee–West Side Community Health Services in St. Paul–meets regularly to coordinate the HIV service needs of women and children. The Part A grantee's capacity development consultants, Community Consulting Group, have provided technical assistance to help sustain the Women and Families Network since 2003. West Side Community Health Services also receives Part A funding to deliver Medical Case Management, culturally appropriate Primary Care, Mental Health and Health Education and Risk Reduction services. Second, West Side's Part D grantee coordinator is a member of the Planning Council and its Planning and Priorities Committee. Staff from state and local agencies administering programs such as WIC and substance use treatment programs also sit on the Planning Council or participate on its committees. Finally, providers of services for women and children also contributed to the 2009 Statewide Coordinated Statement of Need.

Other State & Local Social Service Programs–Other social service programs are considered during the planning and priority setting process in ways similar to those described above. The Minnesota DHS HIV/AIDS program is situated in the department's Disabilities Services Division. The DHS HIV/AIDS director apprises the Council of other state funded programs for persons with disabilities such as Minnesota's "Pathways to Employment" program and the state's Medicaid waiver community support programs. Administrators of other state and local support programs, such as targeted case management, participate in the Planning Council and its committees as well as in formulating the Statewide Coordinated Statement of Need.

Federal, State and Local Funds for Substance Abuse and Mental Health Treatment Services–The DHS also administers substance use services and provides key information for the Council about how substance use treatment services are funded and utilization of mental health services by PLWH/A who are enrolled in Medicaid and other publicly funded health care programs. In keeping with the goals of the 2006–2008 Comprehensive Plan, the Planning Council and grantee conducted a mental health and substance use treatment systems assessment in FY2007. In general, treatment on demand is available for persons living with HIV, especially those who are low-income. Treatment services are paid for either through the State's Consolidated Treatment Fund supported through a Substance Abuse and Mental Health Services Administration Block Grant or through a client's health insurance. The Council's FY2009 allocations include Part A funding for chemical health assessment, treatment placement, short term counseling and follow up at the TGA's largest HIV specialty clinic and largest AIDS service organization. These new programs facilitate access to chemical dependency treatment funded through other public sources. The Council also allocated Part B funding to develop the capacity of chemical dependency treatment programs that receive public funding to deliver HIV competent services.

Several steps have been taken to avoid duplication of services and ensure that a continuum of care exists for PLWH/A who are substance users. First, as mentioned above, DHS oversees all substance use treatment services and staff participates in the planning, priority setting and allocations processes. Secondly, the DHS regularly conducts training for case managers that focuses on how to help clients access Minnesota's Rule 25 chemical assessment and treatment placement process and available substance use treatment options for PLWH/A.

Other Ryan White Funding—Representatives from all Parts of the Ryan White Act participate in HIV services planning, as well as share information to ensure coordination of federal dollars. The Government HIV Administration Team (GHAT) —Hennepin County Human Services and Public Health Department (Part A grantee), Minnesota Department of Human Services (Part B grantee) and Minnesota Department of Health (CDC Prevention grantee)—meets bimonthly to coordinate budgets and spending and to plan for the most efficient disbursement of federal and state dollars. A periodic All-Parts meeting is hosted by the Department of Human Services (DHS) and attended by representatives from all parts of the Ryan White Act, including Part F. Minnesota has two Part C programs, Hennepin County Medical Center (HCMC) and the Rural AIDS Action Network, and one Part D program, West Side Community Health Services. Part F is represented by the Minnesota AIDS Education and Training Center at the University of Minnesota, and a dental reimbursement program at HCMC.

The Part A and B grantees work together with the Minnesota HIV Services Planning Council to support a joint Part A and Part B prioritization and allocation process. The Part A Intergovernmental Agreement established the Planning Council as a joint Part A and Part B planning body in 1995. This close relationship ensures that Part A and B base funds are allocated efficiently and effectively, and those resources are maximized for Primary Care, Medical Case Management, drug assistance, insurance continuation and other health care and supportive services. This joint planning process has worked well since the Minneapolis-St. Paul TGA has always been the epicenter of Minnesota's HIV/AIDS epidemic with 88% of the state's PLWH/A residing in the TGA. Furthermore, many PLWH/A in greater Minnesota travel to the major HIV specialty clinics in the TGA for their primary medical care. Some services prioritized by the Planning Council are not allocated either Part A or Part B base dollars because funding for those services is available through other programs, such as State HIV insurance reimbursement program which is administered jointly with ADAP funds.

The Part B grantee also administers \$1.2 million in state HIV case management funds. In August 2008, the Part A and B grantee managers formalized a set of principals to ensure coordinated administration of Part A, B and state appropriations for HIV services. The "Principles of Coordinated Government Administration of HIV Service Delivery" serve as a framework for administrative decision-making to ensure that service procurement and contract administration are well coordinated and efficient and reimbursement methods for service delivery are uniform across providers regardless of which government agency manages contracts. The "Principles" are also designed to prevent duplication of state and local funding of HIV services and promote the development of uniform standards for sub-recipient monitoring.

Both the Part A Minority AIDS Initiative (MAI) and the Part B ADAP MAI are incorporated into the Planning Council's prioritization and allocations process. The portion of Part A MAI funds allocated to Outreach services and ADAP MAI funds are used to connect African American and African-born PLWHA who know their status to care. To assure coordination of MAI outreach funding, the Part B grantee passes its ADAP MAI funds through the Part A grantee which are then disbursed through a contract with a single provider, the African American AIDS

Task Force (AAATF), which also receives Part A MAI funding for Medical Case Management and Part B funds for Medical Transportation. The remainder of Part A MAI funds supports a Culturally Appropriate Primary Care program that targets Latinos.

Further coordination with other Ryan White programs is demonstrated by the involvement of the Part C and D grantees in planning and quality management activities. Part C supports a collaborative effort between Hennepin County Medical Center in Minneapolis and Health Partners Specialty Clinics in St. Paul. Representatives from the Part C program sit on both the Planning Council and the grantee's Quality Management Advisory Committee (QMAC). In addition, West Side Community Health Services receives Part D funding. Also a current Part A contractor, West Side has been a voice for the needs of Latinos living with HIV. A representative from West Side also sits on the Council and QMAC. Finally, a representative from the Rural AIDS Action Network, a Part C grantee that serves non-urban counties of the TGA and Greater Minnesota, sits on the QMAC. The Planning Council regularly considers the TGA's Part C and D resources in allocating funds to prioritized services as the Council's Part C and D representatives share information about their program activities and funding levels. The coordinator of the Midwest AIDS Training and Education Center (MATEC) is a member of the QMAC and participates in the All-Parts meetings. The MATEC coordinator worked with the Part A and Part B grantees on a consumer health literacy project that was piloted with funds carried forward in 2005 and continues in 2009. Both Part A and Part B grantees send representatives to the regional AIDS Training and Education Center Policy Training and Advisory Council held annually in Chicago.

1.d. Assessment of Emerging Populations with Special Needs—

The epidemic in Minnesota is driven by sexual exposure, primarily among men who have sex with men (MSM), who represented the largest percent of those living with HIV/AIDS (57%) and new cases (48%) in 2008. Among females, heterosexual contact is estimated to account for 84% of prevalent HIV infections as of 2008. New cases among Latino males increased from 12 in 1990 to 137 for 2004-2008, with 25 new infections in 2008 alone.

The HIV epidemic in Minnesota affects racial and ethnic minorities disproportionately, especially African Americans, who are over-represented in every risk group. Additionally, the emerging epidemic among African-born persons continues to increase at a rapid rate. The changing epidemic, in combination with the significant presence of comorbidities and reductions in public funding for health care services, exacerbates the needs of the following six populations: men who have sex with men (MSM [including MSM/IDU]), men of color who have sex with men (MCSM), women of color, African Americans, Latinos and African-born immigrants. Service delivery challenges exist for all of these populations. The following table provides estimates of these six populations in the TGA along with HIV and AIDS prevalence:

2008 EMERGING POPULATIONS WITH SPECIAL NEEDS ESTIMATES FOR MPLS-ST.PAUL TGA (Source: Minnesota Dept. of Health)				
Population with special needs.	Estimated # of persons in TGA	Estimated # of persons living with AIDS	Estimated # of persons living with HIV (not AIDS)	Estimated # of persons living with HIV (including AIDS)
*Men who have sex with men (includes MSM/IDU) by age:	51,477			
13 – 24 years		12	85	97
25 – 49 years		541	867	1,408
50 years and older		825	763	1,588
*Men of color who have sex with men (includes MSM/IDU)	7,379	395	418	813
Women of color (≥ 13 years)	154,174	383	548	943
*Latinos/Latinas	99,121	220	192	412
*African Americans	157,962	558	698	1,256
*African-born Immigrants	35,000 – 50,000	327	395	722
*These groups are not unduplicated in this table.				
3,229,878 MN/WI State Demographer Estimates of TGA Population (2008).				

This narrative addresses unique challenges that each population presents to the service delivery system, service gaps, and estimated costs associated with delivering services to each of these populations. Data sources used to estimate the costs of services for emerging populations with special needs include: 2008 client level service utilization data; 2008 HIV/AIDS prevalence data (Minnesota Department of Health HIV/AIDS Reporting System, Wisconsin Department of Health Services); and fiscal year 2008 Part A and Part B base (not ADAP) expenditures on medical and support services.

Men Who Have Sex with Men (MSM)—The number of people living with HIV in this group has increased to now represent fully 57% of all PLWH/A in the TGA. Access, cost, and attitude barriers were the top reasons identified by MSM for not accessing services in a 2003 Needs Assessment study performed for the TGA by Calabash: Learning, Evaluation and Research. These barriers range from not knowing where to go for help, to transportation problems, to not having insurance. Those who are not open about their same-sex activities or do not identify as gay or bisexual are difficult to reach. Young MSM, particularly those who are homeless, engage in sex work or heavy drug use, are often difficult to bring into the service delivery system. Reflecting the national trend, new infections among young men in Minnesota are increasing. Over the past four years the annual number of new infections among young men increased steadily from 18 cases in 2002 to 42 cases in 2008, a more than 133% increase. Alarming, new infections among MSM in the first half of 2009 increased by 25% compared to the same period in 2008. Further, the recent increase in syphilis cases in Minnesota among HIV-infected MSM indicates a need for continued health education and risk reduction interventions.

The 2003 Needs Assessment also highlights service delivery challenges unique to MSM. They were less likely to have used case management services; more likely to have multiple sex partners, and more likely to have exchanged money or drugs for sex. Client level data from 2008 show that only 47% of those receiving Medical Case Management services were MSM, significantly below their representation in the epidemic. This population most often cited transportation

as a barrier to medical care. Service gaps also exist for this population in affordable housing, substance abuse treatment, health insurance, employment, and transmission prevention services. Ryan White utilization data show a total of 1,911 MSM and MSM/IDU of all races in the TGA that used funded services in 2008 (55% of MSM living with HIV/AIDS in the TGA). Although the TGA has a smaller ratio of MSM who are Intravenous Drug Users than the national average, it is of concern that the number of MSM/IDU who are out of care continued to be unacceptably high in 2008 at 57% of those in the eHARS dataset. Unmet need demographic data indicate that up to 42% of MSM (including MSM/IDU) of all races may be out of care.

Using service utilization data from the TGA's Client Level Database and Part A and Part B end of year expenditure reports, the estimated cost of providing Part A and B base (not including ADAP) funded services to all MSM living with HIV/AIDS (White men and men of color) in 2008 was \$2,303,900. The estimated cost for Part A funded services alone was \$2,158,100.

Men of Color Who Have Sex With Men (MCSM)—MCSM make up a growing proportion of new HIV infections among MSM in the TGA. From 2007 through 2008, MSM or MSM/IDU was the risk category identified for 63% of men of color living with HIV and 68% of new infections among men of color were identified as MSM. MCSM are disproportionately represented when taking race-specific population size into account. African American males only comprised four percent of the State's male population in 2000. In 2008, 22% of the 238 new male cases were African American or African born. Similarly Hispanic males make up three percent of the male population yet 11% of the 238 new male cases. This disproportional impact is even greater among young (13–24 years of age) MSM. Persons of color accounted for a disproportionate number of new HIV infections among adolescents and young adults in 2008; among young men, whites accounted for 49% of new HIV infections diagnosed between 2006 and 2008, African Americans accounted for 31%, Hispanics 9%, and African-born 4% of the cases.

As noted in the MDH 2007 Epidemiological profile, race, while not considered a biological reason for disparities in the occurrence of HIV experienced by persons of color, can be considered a marker for other personal and social characteristics that put a person at greater risk for HIV exposure. These characteristics may include lower socioeconomic status, less education, stigma of same-gender sexual behavior, less access to culturally and linguistically appropriate services and greater prevalence of drug use. There are great disparities in income between whites and communities of color. While the per-capita income for whites in Minnesota is \$34,353, it is about half that (\$17,126) for people of color. The disparity is even greater in the TGA. In the Consumer Needs Assessment Survey (2006), non-white MSM were more likely than white MSM to report needing but not getting case management in the six months before the survey.

National data support concern about increasing rates of HIV infection among gay and bisexual African Americans. A CDC fact sheet updated in August of 2009 cites a study of MSM in five cities that found 46% of black MSM were HIV positive and 67% of them were unaware of their infection. Four culturally specific community-based organizations in the TGA that target African Americans in providing HIV services reported serving a combined total of only 109 MSM, including IDU (36% of all of their clients), in 2008. Given their representation in the epidemic, these low numbers may be indicative of the strong stigma toward same-gender sexual behavior that persists in communities of color, which may be a significant barrier to care. Service gaps that exist for MCSM include accessing HIV medical care due to community stigma; affordable housing; maintaining access to health insurance, health education and risk reduction; culturally appropriate substance abuse services; and mental health services.

As mentioned above, the estimated cost of providing Part A and B services to all MSM living with HIV/AIDS (White men and men of color) in 2008 was \$2,303,900. Since 26% of the TGA's MSM living with HIV are men of color, a rough estimate of the cost of Part A and Part B base funded services for this population in 2008 was \$599,000. The estimated cost for Part A funded services alone was \$561,100.

Women of Color – The number and proportion of cases of HIV/AIDS among females in Minnesota continues to increase. In 2008 there were 1,258 women living with HIV/AIDS, with 98% aged 13 or older. Seventy-one percent were women of color. Trends in the annual number of HIV infections diagnosed among females differ by racial and ethnic group. In the beginning of the epidemic, white women accounted for a majority of newly diagnosed cases among females. Since 1991, the number of new infections among women of color has exceeded the number among white women. In 2008, women of color accounted for 67 % of new infections among females, with African American and African born women accounting for 58 % of those infections. Since 2000, the annual number of new infections diagnosed among African American females had been stable at around 20 cases per year, but 27 new cases were diagnosed in 2008. Cases among African-born females have risen sharply, from three cases in 1996 to a high of 41 cases in 2002. However since 2002, the number of new HIV infections began to steadily decline, with 24 cases reported in 2008. The annual number of new infections diagnosed among Hispanic, American Indian, and Asian females continues to be quite small. Between 2003 and 2007 the number of births to HIV-positive women in Minnesota increased from 47 to 61, a 30% increase; in 2008 there were 50 births to positive mothers. During that same time period the rate of perinatal transmission was 1.2 percent, the expected rate of transmission when both mother and child receive preventive antiretroviral treatment. Only six cases of pediatric HIV infection have been diagnosed between 2003 and 2008. While it is fortunate that the rate of perinatal transmission has remained low in the state, the growth in births to HIV positive women during the last ten years suggests a need for health education and risk reduction in this population. One of the most significant changes in Minnesota is the rapid increase in the number and proportion of women born in Africa now living in and diagnosed with HIV in Minnesota. In 2008, 30% of the 1,449 women living with HIV/AIDS in Minnesota were African born, and of those, 96% identified heterosexual contact as the mode of exposure. Another 30% of female PLWH/A were African American, while 28% were white.

For persons for whom English is a second language and who are dealing with cultural differences, it can be complicated to access most social services, including those specific to HIV/AIDS, without a case manager. Especially for African-born women, there exists a great deal of shame and stigma associated with an HIV diagnosis. African-born women face cultural expectations about having children and may be looked down upon if they do not. Because of inadequate knowledge and the fear that they may not have children if they are known to be HIV-infected, African-born women may be reluctant to get tested for HIV until after they become pregnant. Although interventions to prevent transmission of HIV from the mother to the infant are highly accepted and highly effective, learning of one's HIV status during pregnancy is often particularly difficult. Many women struggle with disclosure to sexual partners for fear of abandonment or violence. Without community support, these women are especially vulnerable and have significant needs for culturally, linguistically and gender appropriate services. The special needs of women reflect the issues that make their access to HIV care difficult. For example, because women are likely to be primary caregivers of children and other family members also infected with HIV, services that provide care for children or family members while these women

access HIV/AIDS care are essential. Additionally, foreign-born women may avoid accessing HIV services due to fears that immigration authorities may remove their children from them because of their HIV status. Legal services that help women with immigration and plan for guardianship of children are also important. While the 2006 Consumer Needs Assessment Survey (CNAS) found that compared to men, women were significantly more likely to be enrolled in one of Minnesota's publicly funded health insurance programs, 38% of those program recipients were paying more for co-payments, deductibles, and cost shares. An analysis of needs specific to childbearing women was compiled from the 2003 Needs Assessment. Out of the 57 women, 71% were women of color; 44% being African American and African-born. The average monthly income for this group was \$786, substantially below the median of all those surveyed. These women were more likely to report that there were two or more days in the past 30 days where they had nothing to eat. They were less likely to report that they have an HIV physician and to be currently taking antiretroviral medication. In addition, 61% reported having been homeless in the past and 32% indicated that their HIV has made it more difficult to find housing. Affordable housing and lack of child care ranked the highest as service gaps for women and a lack of transportation or too great a distance to travel was a barrier to accessing medical care.

Based on an unduplicated total of 791 women of color utilizing Ryan White services in the TGA, the estimated cost of providing Part A and B base funded services to women of color in 2008 was \$1,078,100. The estimated cost for Part A funded services alone was \$1,010,000.

Latinos— The Latino population in the TGA grew from 99,740 in 2000 to 152,645 in 2008—a 53% increase. It is also a young population with 47% between 20 and 44 years of age, compared to 36% of the general population being in this age bracket. Among all the racial and ethnic groups in the U.S., Latinos experience a very high poverty rate (21%), and low education levels, with 43% of adults lacking high school diplomas. Thirty-eight percent of adults are not able to speak English well. Accompanying these socioeconomic issues is persistently inadequate access to health services and poorer health status and health outcomes compared to other groups. An estimated 32% of Latino adults currently do not have health insurance in Hennepin County, according to the *Survey of the Health of Adults, the Population and the Environment* (SHAPE) conducted in 2006. Beginning in 2003, undocumented immigrants, many of whom were born in Latin American countries, were no longer eligible for publicly funded health programs in Minnesota. Only 62% of Latino adults report they usually go to a doctor's office or clinic when they are sick, as compared to 85% for all Hennepin County adults. Almost one-fourth of Latino adults who needed medical care delayed or did not receive it because of lack of insurance, cost, or dislike or distrust of medical providers. Not seeking help for mental health issues was reported by more than one fourth of Latino adults as compared to 19% for all adults in the county. Almost half (48%) of those in need of mental health care delayed or did not seek care, primarily due to lack of insurance or cost, being unaware of where to get services, or dislike or distrust of service providers. Surveillance data from 2008 indicate 412 Latinos were living with HIV/AIDS in the TGA. This represents eight percent of the total prevalence for the second consecutive reporting period. Twenty-nine new AIDS cases were diagnosed among Latinos in 2007-2008 in the TGA. In the 2006 CNAS, 35 of 379 HIV-infected respondents identified themselves as Latino. Of these 26% were homeless, 31% were unemployed, and 51% had been diagnosed with AIDS. As this community is disproportionately affected by poverty, lack of community resources, and cultural and language barriers, the HIV continuum of care must be responsive to the complex set of needs faced by Latinos. Health insurance, understanding where health care and support services are lo-

cated, affordable housing, accessible transportation, and language-appropriate services are essential HIV/AIDS services for Latinos.

The estimated cost of providing Part A and Part B funded services for Latinos living with HIV in 2007 was \$449,800. The estimated cost for Part A funded services alone was \$421,400.

African Americans—United States health disparities for African Americans living with HIV continue to be out of proportion with their numbers in the overall population. The CDC shows HIV-related disease as the leading cause of death among African American women ages 25-44. There is a direct relationship between higher AIDS rates and lower income levels, as almost one in four African-Americans lives in poverty. The 2008 U.S. Census Estimate shows that African Americans are the second largest racial or ethnic group (behind whites) in Minnesota, comprising 4.6% of the total population. U.S.-born African Americans account for 19% of men and 30% of women living with HIV/AIDS in Minnesota, a disturbing disparity when compared to their representation in the general population. The MDH reports that in 2008, 21% of new HIV infections were among US-born African Americans. African American PLWH/A are younger than the general population of PLWH/A. MSM or MSM/IDU accounted for 68% of new infections among African American males from 2004 to 2008. African American women represent 30% of women living with HIV/AIDS in Minnesota.

The 2003 Needs Assessment interviewed 92 U.S.-born African Americans. Seventy-six percent had experienced being homeless and 77% indicated barriers to affordable housing. Seventy percent were recommended to be on medications and only 49% were on antiretroviral medications. Forty percent had transportation barriers and 19% indicated financial issues as barriers to getting or maintaining HIV medical care. Transportation and mental health rated high as needs that were not met. Some service gaps identified for African Americans include information about HIV services, health education and risk reduction services, and transportation.

Based on service utilization and expenditure data, the estimated cost of providing Part A and B base funded services to African Americans in 2008 was \$1,497,900. The estimated cost for Part A funded services alone was \$1,403,400.

African born Refugees/Immigrants –The U.S. Census estimates that there were 63,612 African-born persons living in Minnesota. However, many believe this to be an underestimate of the true African population in Minnesota, with some community members estimating that number at close to 100,000. Minnesota's African immigrants come from more than 25 countries, primarily Somalia and Ethiopia. Hennepin County's SHAPE 2006 study reported about one in five African born immigrants speak English "less than well," compared to 3.2% of all adults in Hennepin county. Nearly 10% were uninsured for the entire year preceding the study compared to 3.4% of all adults in the county. Of African born individuals needing medical care, 20% reported that there was a time in the previous year when they needed medical care but delayed or did not get the care they needed. Concern about cost or not having health insurance were the most common reasons. Sixty percent of African born reported that they had worried "often" that food would run out before they have enough money to buy more; this compares to 2.4% of all adults in the county. African-born people were also approximately three times more likely than all adults to report they missed a mortgage or rent payment because they did not have enough money.

The total cases of HIV/AIDS among African-born in the TGA for 2008 is 722. Of new HIV infections diagnosed in 2008, African-born persons accounted for 17% of cases, but represented less than one percent of the state's population. African-born women had the third highest new infection rate among other female groups; 24 out of 88 cases in 2008. African-born men, by contrast, accounted for 13 new cases (5%) in 2008. Compared to the general population of PLWH/A

in the TGA, African-born persons are underrepresented in Ryan White Part A and B funded services. Ryan White services were provided to 386 of 722 (53%) of African-born persons in MDH surveillance data in 2007. By comparison 67% of the TGA's PLWH/A who know their status utilized Ryan White funded services in 2008.

The Twin Cities Care Services and Assessment Demonstration Project conducted in 2006 and funded by Ryan White Part F (SPNS) illuminated the needs of the African-born PLWH/A in the TGA and identified a number of service gaps. African PLWH/A who were in care knew about medical services, case management, housing, and food services but needed more information on other services available; however, African PLWH/A who were out of care or newly diagnosed were not aware of services other than medical care. All service providers identified the lack of coordinated entry into the HIV continuum of care from refugee resettlement agencies as a barrier. Understanding eligibility requirements for services is also a barrier. African PLWH/A identified lack of transportation and employment as their most critical needs. Accessibility, defined as transportation, flexible clinic hours and appointments were identified as needs by all Africans interviewed. Cultural competency issues identified by Africans in care were lack of language interpreters, lack of employment assistance and need for more patience from service providers. Africans out of care were concerned about privacy, life after diagnosis, discrimination, provider communication styles and gender and ethnicity of service providers. Africans in care wanted more information on medications, HIV and services. Those out of care or newly diagnosed wanted more information on HIV and life after diagnosis and understanding of the qualifications of service providers.

Based on expenditure and service utilization data, the estimated cost of providing Part A and Part B funded services for Africans living with HIV in 2008 was \$512,500. The estimated cost for Part A funded services alone was \$480,200.

Costs of Addressing Unmet Need Among Emerging Populations—Demographic information from the unmet need estimate along with service utilization and Part A and Part B base expenditures in FY2008 provide an estimate of the costs of providing care to those out of care from populations with emerging needs: The following table shows these cost estimates:

Population with Special Needs	Number out of care	Percentage of Population Utilizing Services in 2008	Expected to Utilize Part A & B base Funded Services	Estimated Annual Cost of Providing Services for those Out of Care
MSM/MSM IDU - All	1,295	55%	708	\$ 964,677
Women of Color	358	84%	300	\$409,146
Latinos	169	80%	135	\$184,548
Black/African American (U.S. born)	550	88%	481	\$656,109
Black/African-born	271	52%	141	\$192,409
Total (not unduplicated)	2,643	59%	1,565	\$2,133,169
Total Unduplicated HIV+ Aware	2,143	67%	1,442	\$1,965,827

The average per client cost of Ryan White Part A and B base funded services in fiscal year 2008 was \$1,363. The number expected to utilize services is the unmet need estimate multiplied by the proportion of the population with special needs living with HIV in the TGA that utilized Part A and Part B base funded services in FY2008.

1.e. Unique Service Delivery Challenges

The demographics of the epidemic in the TGA present a significant challenge in successfully engaging people living with HIV in care earlier. Since 2000, approximately one third of all new HIV infection cases diagnosed in Minnesota have either been AIDS at first diagnosis, or have progressed to an AIDS diagnosis within one year of initial diagnosis with HIV (non-AIDS) infection. As with other characteristics of the HIV epidemic in Minnesota, the proportion of late testers varies by demographic characteristics. The most significant differences occur by race/ethnicity, with the proportion of late testers between 2000 and 2008 among Hispanics (47%) and African-born (42%) being higher than that among Whites (29%) and African Americans (29%). Some consumers from within these groups lack the knowledge and confidence to navigate the system of HIV care and support services effectively. In order to reach people with health education messages that address stigma and promote health literacy, particularly Latinos, African Americans and African-born PLWH/A, two groups within the TGA who face considerable cultural and linguistic barriers to accessing HIV medical care, in 2007 and 2008 the grantee used funds allocated by the Planning Council for Health Education activities to partner with Twin Cities Public Television(TPT) to produce two programs and related DVDs targeting these populations. They were: *Getting Right With AIDS* (targeting African Americans) and *Kuwu Nguvu: Living Well With AIDS* (promoting HIV care for African-born PLWH/A). These programs were a follow-up to the earlier *SIDA Sin Miedo* program that targeted Spanish-speaking people living with HIV. While each program has been broadcast multiple times on TPT's community channels, their greater impact has been felt by making DVDs available to providers of care and services, who make them available for clients to watch at their agencies and distribute copies to clients of the targeted groups. To date, 927 copies of *SIDA Sin Miedo*, 1,109 copies of *Getting Right With AIDS* and 998 copies of *Kuwu Nguvu* have been distributed to consumers, providers, and community based agencies. In a follow-up evaluation with recipients of the *SIDA Sin Miedo* DVD, 83% said it was a useful tool for providing information about HIV to Spanish-speakers in Minnesota. Evaluations of the impact of the two newer DVDs are planned for 2010.

An additional barrier to accessing and remaining in care for African-born immigrants who do not speak English well (28% nationwide according to the 2006 *American Community Survey*), is obtaining interpreter services that they trust. Members of a Mental Health Support group provided by a community-based organization that primarily serves African-born clients asked the agency to help them communicate their concerns to the Part A grantee about obtaining interpreter services consistently when they go for primary care visits. A program contract manager visited the group and was informed that stigma in the community and fear of disclosure by interpreters with whom they may be acquainted was causing some African-born PLWH/A to avoid HIV medical visits at the largest outpatient clinic in Minneapolis. While the medical center of which the clinic is a part provides no-cost interpreters of multiple African languages, they are used throughout this large hospital and its dozens of clinics, and attempts to match individuals to a particular interpreter with whom they feel comfortable resulted in long waits, missed appointments, and some individuals foregoing interpretation altogether. This resulted in clients not communicating their status and needs to their caregiver and not receiving accurate information about their own health or treatment instructions. The Part A program manager communicated these concerns to the medical center, and they agreed on and implemented a plan to facilitate the use of interpreters telephonically through the AT&T Language Line. The grantee expects increased use of the \$8,000 in Part A funds allocated for Linguistic Services as a result of this

project, and plans to follow up in 2010 with African born community members to measure its impact.

Increasing costs of care along with increasing socio-economic stress on low income PLWH/A create a significant challenge in maintaining the TGA's comprehensive continuum of care. While Ryan White funds in many states are primarily used to pay for primary medical care for people living with HIV/AIDS, Minnesota has historically been fortunate to provide extensive access to health care through state and federally funded programs such as Medicaid, Minnesota Care and a high risk insurance pool. Additionally, several clinics and hospitals throughout Minnesota have had a tradition of providing extensive charitable care for HIV/AIDS. Until recently this reduced the need to use Ryan White Part A and B funds to support primary medical care, and allowed the dollars to be used to create a comprehensive system of support services. Because of the high rate of clients in the service system who are able to access health care-related services through their health insurance, the number of clients served through these types of Ryan White Act funded programs has historically been rather low. However, Minnesota's system of health care access is changing. Rising health care costs and reductions in public spending on health care for the poor add significantly to the challenge of providing a continuum of services for people living with HIV and decreasing unmet need. Cuts in funding for Minnesota Health Care Programs beginning in 2003 along with tighter eligibility restrictions and higher out-of-pocket costs continue to increase the burden on Ryan White funded services. When it became apparent in 2004 that Minnesota's ADAP award, along with a \$1.15 million state appropriation for the HIV Insurance Program, would no longer provide sufficient revenue to purchase medications and insurance premiums for all eligible ADAP and insurance program recipients, the Minnesota Department of Human Services (DHS), the Part B grantee, implemented cost-sharing measures for ADAP recipients whose incomes fell between 100% and 300% of federal poverty level. Although the cost-sharing requirement was suspended in December 2007 due to an increase in Minnesota's ADAP award, the Part B grantee's latest ADAP forecast indicates that another shortfall may occur in FY2010 or 2011. In addition, the State cut the \$2.4 million in state appropriations for the HIV Insurance Program and Medical Case Management in FY2008 due to a budget deficit and tapped into the State's ADAP rebate reserve to fill the funding gap.

In the past two years the number of clients seen by the Part A funded Primary Care programs increased by 284%, from 144 clients in 2004 to 553 clients in 2008. Due to the rise in health care costs, including the Medicare Part D "doughnut hole" for recipients whose incomes are too high to qualify for extra help, PLWH/A in the TGA more frequently face prohibitive out-of-pocket costs and hospitals and clinics are cutting back on the amount of charitable care provided. In response to the increasing cost barriers to care, the Minnesota HIV Services Planning Council increased Part A allocations to Outpatient/Ambulatory medical services by 162% from 2005 to 2009. Compounding the challenge created by increasing costs of medical care, many of the services funded by Part A in the TGA that help bring people into or maintain primary health care, such as Outreach and Medical Case Management, are not reimbursable through private or public insurance programs. To continue its elimination of waiting lists Medical Case Management in the TGA, the Part A allocation for MCM increased from \$1,421,900 in 2008 to \$1,477,100 in FY2009.

These economic phenomena along with a harder-to-serve population of PLWH/A are increasing the cost of HIV service provision. Part A funds are increasingly needed to provide quality care for those struggling with multiple diagnoses and difficult socioeconomic circumstances. Recent consumer needs assessments conducted in 2005 and 2006 together with increased utiliza-

tion of Part A funded support services indicate that more PLWH/A are faced with the choice between paying for medical care or meeting basic needs. Part A allocations to support services such as Food Shelf, Home Delivered Meals, Emergency Financial and Housing Assistance and Medical Transportation are essential to maintaining access to medical care by mitigating economic barriers. In 2008, among Ryan White funded supportive service categories, Transportation was the most utilized, with 1,502 clients (41% of total Part A clients) accessing transportation services. Food & Nutrition was the next most utilized service with 1,312 clients (35% of total clients). The next most used support services were Emergency Financial Assistance and Health Insurance Assistance, with 778 and 703 clients, respectively.

Based on the expanding epidemic in the TGA (number of new infections), the cost of care in 2008, Ryan White service utilization and the Comprehensive Plan goal of reducing Unmet Need to 25%, the grantee estimates that the TGA would need an additional \$1,238,824 in Part A funding in FY2010 to keep up with the anticipated need for services to ensure access to care.

1.f. Impact of a Decline in Ryan White Formula Funding

The Minneapolis-St. Paul TGA did not experience a decline in Ryan White formula funding in Fiscal Year 2009. Formula funding increased from \$3,073,368 in 2008 to \$3,557,795 in 2009. Since 2007, the TGA's formula funding has increased by \$594,417.

1.g. Unmet Need

Unmet Need Estimate: The unmet need estimate for Minnesota, using the Framework developed by HRSA and the University of California, San Francisco, and revised in September 2009 is found in **Attachment 6**.

Estimation Methods - Population estimates for PLWH/A were computed using MDH eHARS data for the Minneapolis-St. Paul TGA. HIV infection is a reportable condition in Minnesota and the estimates reflect those living with HIV (non-AIDS) and those living with AIDS who know their status. Two counties in the TGA are in Wisconsin (Pierce and St. Croix); their data were separately calculated by the Wisconsin Department of Health Services and then combined with the MDH Framework to present a complete picture for the TGA. Reporting rules in Minnesota and Wisconsin do not explicitly require labs to report viral loads and CD4 counts to the State every time these tests are performed. Despite this barrier, MDH receives regular updates of viral loads and CD4 counts from most clinical systems. The above limitations are addressed by using aggregate clinic data to supplement eHARS data. These cases are not counted where a non-reporting clinic is listed as the primary care clinic, even when a CD4 or viral load was reported in 2008. Because they are included in the aggregate numbers provided by the clinics, they are thus not counted twice. However, eHARS data that are provided by these clinics are used to estimate the percentage of individuals who reside in the TGA and those who have AIDS vs. HIV/non-AIDS. Thus, by applying the above percentages to the aggregate numbers provided by non-reporting clinics, unmet need is calculated for both reporting and non-reporting clinics. See the Unmet Need Framework in **Attachment 6**.

Minnesota's Part A, B, C, and D grantees rely on the MDH for Minnesota's unmet need estimates. The Part A and B grantees work closely with MDH to improve this methodology. The Part C-funded clinics in the TGA, HCMC in Minneapolis and HealthPartners in St. Paul, report CD4 counts and viral loads to MDH either through eHARS or through aggregate clinic data for the specified recent time period. The TGA's Part D funded clinic, West Side Community Health Services, reports CD4 counts and viral loads through eHARS.

Assessment of unmet need - Demographic information on those in care is available, although incomplete. The eHARS data and aggregate patient data from HCMC include information on gender. The available demographic information on those in care during the specified time period are summarized below:

Demographic Characteristics of PLWH/A In-care, Mpls-St.Paul TGA January 1 – December 31, 2008 (Source: Minnesota Dept. of Health)			
Race/Ethnicity and Gender *	In-care (AIDS & HIV not AIDS)	Surveillance Total (AIDS & HIV not AIDS)	% Out of Care
White	1,568	2,841	45%
Black – U.S. Born	706	1,256	44%
Black - African Born	451	722	38%
Hispanic/Latino	243	412	41%
American Indian	47	89	47%
Asian	48	76	37%
Multiple/Unknown	29	44	34%
TOTAL	3092	5440	43%
Male	2,294	4,191	45%
Female	798	1,249	36%
TOTAL	3092	5440	43%

* Does not include individuals of multiple races or unknown race.

The demographic data indicate the following:

- American Indians, as a group, were the least likely to be in care (47% out of care), having greater unmet need compared to the population of those in the TGA who know their status.
- The proportions of Whites, African Americans, and Latinos out of care in 2008 were similar: 45%, 44% and 41% respectively.
- African-born blacks and Asians were about as likely to be in care as the overall population of those who know their status, with 38% and 37% respectively out of care in 2008.
- From 2000-2008, 39% of foreign-born individuals who tested positive for HIV were diagnosed with AIDS within one year of testing. In the overall population of newly diagnosed individuals, 31% progressed to AIDS within the first year.
- Women, compared to men, are consistently more likely to be in care (63% compared to 55%).
- Limited information on exposure category among those who know their status and are not in care indicate that men who have sex with men (MSM) may be slightly less likely to be in care (58%) compared to the overall population of those who know their status (61%).

Clients of Minnesota agencies receiving Ryan White funds were recruited to participate in a Part A-funded survey during April and May of 2006 with a focus on utilization and financing of HIV services. Surveys were completed by 379 respondents spread across 13 agencies (42% clinical and 58% non-clinical). The instrument focused on indicators of access and unmet need, including public or commercial insurance coverage, sources and frequency of HIV medical care, sources of dental care, patterns of use of HIV medications, whether medical care or essentials of living were foregone due to inability to pay both, and what specific service types were needed but not received. The data from this needs assessment indicate the following regarding unmet need: 1.) Thirteen percent of respondents reported that they had to go without health care be-

cause money was needed for food, clothing, or housing. Conversely, 18% of respondents reported that they had to go without essentials of daily living because the money was needed for health care or medication. 2.) Expansion of cost-share arrangements for programs like Medicaid or ADAP and the HIV Insurance Program or discontinuation of publicly insured programs were seen as likely to negatively impact HIV-positive Minnesota residents.

In addition to the consumer survey discussed above, the Planning Council's Needs Assessment & Evaluation Committee completed a two-phase systems assessment to identify gaps and barriers to care. A follow up "Path to Care" study, involving a survey and interviews with 56 PLWH/A (17 newly diagnosed) conducted by Bob Tracy Consulting, provided additional information on the needs of the newly diagnosed and those who drop out of care. The goal of the first phase of the systems assessment identified service sectors of the TGA's care system that are the most difficult to access or are not meeting the needs of PLWH/A. In 2006, the needs assessment consultant, Community Consulting Group, conducted focus groups and an online survey with case managers, client advocates, outreach providers and key informants in the mental health field to gather qualitative data on system gaps and barriers. The provider focus group and survey questions were informed by the results a client survey conducted in April and May 2006.

Results from the first phase of the systems assessment indicated that gaps or capacity limitations of the HIV case management, chemical dependency and mental health sectors may pose barriers to accessing care, particularly for those PLWH/A experiencing co-morbidities. The second phase of the systems assessment was completed in late FY2007 by Bob Tracy Consulting and focused on those services identified in the first phase that are the most difficult to access and seem to have the least capacity to meet the needs of PLWH/A—mental health, substance abuse, and dental services, as well as prevention services for people who are HIV positive and aware of their status. Findings indicated that while coverage for mental health services is available to low-income Minnesotans, there is a pressure on the overall mental health system due to large patient-to-provider ratios, making it difficult to get timely services. In addition, it is challenging to find mental health providers who are knowledgeable about HIV and providers of HIV care and services are seeing an increase in the numbers of their clients who display signs of more serious mental distress and disorders. Participants in the "Path to Care Study" completed in 2008 reported that depression and drug or alcohol use were among the top four reasons why they either dropped out of or delayed care. Finally, HIV case managers participating in the 2006 Minnesotans Living with HIV Survey reported that 13% of their clients demonstrated problems adhering to care plans because of alcohol or drug use. While funding is accessible through public health care programs, they are accessed exclusively through Rule 25 assessors, who may not always be available at the time a client exhibits readiness to enter the substance abuse services system.

"Path to Care" study participants said that the following were most helpful in connecting to care after diagnosis: finding a likeable and trusted doctor; being diagnosed at a site that offered medical services and helped coordinate care; being connected to a helpful case manager; having housing, food, financial and legal needs met; and arranging for health care and treatment coverage. Those who had delayed or stopped care indicated that finding a doctor they liked, stopping using drugs or alcohol and getting mental health support helped them reconnect to care.

The grantee and the Minnesota HIV Services Planning Council, in collaboration with Minnesota's Parts B, C, and D grantees and the MDH (CDC prevention grantee), are employing a multi-pronged approach to finding PLWH/A who are not in care and getting them into primary care. Components of the 2009—2011 comprehensive plan designed to reduce unmet need include:

1.) Medical Care Retention (\$66,600 as part of Medical Case Management/Treatment Adherence in FY2009) – 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 HIV primary care. Two TGA primary care providers identify clinic patients who have missed appointments and work with them to help return to care. Medical case managers assess factors that keep patients from attending appointments and help them connect to other services, such as transportation, that can mitigate barriers to care. Medical Care Retention will continue to be funded as a service activity under Medical Case Management/Treatment Adherence in 2010.

2.) Outreach (\$149,900 Part A and \$50,000 MAI in FY2009) - Three community-based organizations are funded to identify people who know their status and are not in care and 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 men who have sex with men. The Planning Council allocation for Outreach will be sustained in FY2010.

3.) Mental Health Services (\$282,300 in FY2009 including \$134,000 Culturally Appropriate Mental Health Support) and Health Education/Risk Reduction (\$86,700 in FY2009) – African American AIDS Task Force (AAATF) conducts mental health groups for African American men and women who are HIV-positive in a south Minneapolis neighborhood. This service is provided by a group facilitator with oversight by a clinical consultant who is a licensed behavioral health practitioner. In addition to promoting mental health wellness, group topics include information about HIV disease, benefits of individual mental health therapy, good nutrition, smoking cessation, stress reduction, self-care, harm reduction, HIV medical care and services and community resources. In FY2008, AAATF provided mental health services for 25 clients. The \$369,000 in combined funding for these services in FY2009 also supports three other programs targeting Latinos, MSM and injection drug and other substance users that include a health education component.

4.) Substance Abuse Treatment/Outpatient Services (\$139,500 in FY2009) – Based on a new Planning Council allocation to this service area, the grantee established two programs in 2009 to provide “just-in-time” connection to chemical health treatment services. These programs, one housed at the TGA’s largest HIV primary care clinic and the other at the TGA’s largest AIDS service organization, provide the Rule 25 chemical health assessments required for placement in State funded treatment programs as well as short-term counseling, treatment placement facilitation, and peer relapse prevention and harm reduction support. The Council’s allocation plan for 2010 will sustain these programs.

5.) Quality Improvement Programs - A key component of the grantee’s quality management program requires that all Part A and Part B funded providers assess whether or not their clients have received primary medical services in the past six months. If they have not, providers are required to make referrals to medical care or other services that facilitate entry into care. For those clients who have been out of care, providers are also expected to follow up on the referral either with the client or provider to see if they entered care and if they need additional assistance. In 2009, all provider quality improvement goals focus on improving interventions that assess client utilization of care, referrals to care and follow up on referrals to care.

The TGA’s entire continuum of prevention and care is focused on the goal of easing entry into and maintaining people in care. The Planning Council, together with its Needs Assessment & Evaluation and Planning & Priorities committees, receive an annual presentation on the unmet

need estimate by a MDH epidemiologist. In 2009, the Planning & Priorities committee reviewed Unmet Need data as it completed work on the 2009—2011 Comprehensive Plan. The Unmet Need estimate based on eHARS and clinic data from 2007 was made available to the work group, in support of its goal to increase the percentage of HIV positive Minnesotans who receive HIV medical care.

2. Access to HIV/AIDS Care and the Plan for FY2010

2.a. The EMA's/TGA's Established Continuum of HIV/AIDS Care and Access to Care

The Minneapolis-St. Paul TGA's 2009 HIV care system has multiple points of entry for those who are newly diagnosed or have been living with HIV but need to become connected to care. One is a statewide telephone referral service that provides confidential information about HIV and connects callers to resources to assist them to access care. The Minnesota Department of Health (MDH) funds HIV testing sites in clinical and community settings that refer newly-diagnosed individuals into the HIV care system. The TGA contracts with two providers of Early Intervention Services based in the public-health clinics of the state's two most populous counties to provide newly diagnosed individuals with medical care, laboratory testing, and assistance to connect to ongoing primary care and support services. Three Outreach providers (one that is MAI funded to focus on providing services to African American and African-born PLWH/A) plan activities to identify individuals who are HIV positive and know their status but are not in care, assisting them to overcome barriers to become connected to HIV medical care.

The TGA's core medical service system comprises three Primary Care providers (one MAI funded to provide culturally appropriate care to Spanish-speaking PLWH/A); Treatment Adherence through two Medication Adherence providers; Mental Health services at one clinic-based and six community-based agencies; one Home and Community-Based Health Care provider; Medical Nutritional Therapy provided by dietitians at two large HIV specialty clinics; and four clinic-based providers of Medical Case Management services. One community-based provider receives Part A MAI funds to provide Medical Case Management services to African American PLWH/A. Part B also funds a Medical Case Management program at a community based organization that targets its services to African-born individuals and provides services in multiple African languages. Oral Health Care for the TGA's uninsured and underinsured PLWH/A are funded through a combination of Ryan White Part A and B base funds. Substance Abuse Treatment services can be accessed through Minnesota's publicly funded health care programs, as well as through the State's Consolidated Treatment Fund which is available to individuals with incomes of up to 215% of Federal Poverty Guidelines. Beginning in FY2009, Part A funds Rule 25 assessors embedded in two large case management programs to facilitate access to publicly-funded substance abuse treatment for clients when they demonstrate readiness to address chemical health issues. The community-based Mental Health programs that focus on African American, African-born, Latino populations and MSM are positioned at the entry to care end of the spectrum of Mental Health services. They focus on assisting clients, mostly through group interventions, to generate solutions and self advocate to obtain medical services and achieve an optimal level of living with HIV, and are positioned to recognize signs of need among clients for more involved mental health screening and provide referrals into ongoing clinical mental health services. Support services designed to address barriers to care are most often accessed through Medical Case Management. These include Health Education/Risk Reduction, Emergency Financial and Housing Assistance, Medical Transportation, Benefits Counseling and Legal Services, and HIV Insurance. Food and Nutrition Services, including Home Delivered Meals, On-Site Meals, Food Shelf and Food Vouchers help meet basic needs that are major barriers to accessing

regular HIV medical care. All services in the continuum of care are expected to demonstrate in their quarterly reports how they help remove barriers to HIV primary care by addressing issues of stigma, health literacy, and challenges to coping with HIV.

2.b. The FY2010 Implementation Plan

Attachment 7a presents the following four core medical service categories included in the TGA's complete FY2010 Implementation Plan in order of Planning Council allocation: Medical Case Management (#1, preceded by Part B-funded ADAP Treatments in the Council's combined Parts A and B priority rankings); Outpatient/Ambulatory Medical Care (Priority #2); Mental Health Services (Priority #9); and Home and Community-Based Health Services (#12). Two supportive service categories presented in the plan are Food Bank/Home Delivered Meals (#6) and Emergency Financial Assistance (#8). The Planning Council assigned allocations to these areas according to data from four Needs Assessments conducted between 2003 and 2008 and expenditure data from 2007 and 2008. The amount for the six service areas combined comprises 84% of the Part A budget for services.

2.c. Implementation Plan Narrative

Connections Among the Latest Needs Assessments, Comprehensive Plan, Service Priorities and the FY2010 Implementation Plan – The Planning Council relied on the results of the following needs assessments to formulate the goals for the 2009—2011 Comprehensive Plan, prioritize services for fiscal years 2009 and 2010, and allocate funds to services for FY2010:

- Oral Health and Behavioral Health Services Assessment and Path to Care Study (2008)
- 2006 Consumer Needs Assessment Survey (CNAS).
- Care System Assessment Demonstration Project (2006)
- Brief Survey (2004)
- Needs Assessment of HIV Positive Minnesotans (2003)

In addition, the Planning Council reviewed the results of the two most recent Unmet Need estimates. The barriers to care and gaps in medical and support services identified by the needs assessments informed the goals of the 2009—2011 Comprehensive Plan and the Implementation Plan for 2010. The results of the needs assessments, along with the most recent Unmet Need estimate (see **Attachment 6**), identified the following strategies to meet the health care and social service needs of PLWH/A in the TGA:

- Continue to ensure access to publicly funded health care coverage;
- Increase access to the primary health care system;
- Ensure that PLWH/A have their basic needs met including housing, nutrition and medical transportation;
- Improve access to behavioral health services (mental health and substance abuse treatment);
- Enhance awareness of existing HIV services; and
- Mitigate cultural and linguistic barriers to care.

Overall, the Planning Council's priorities closely match the top needs identified by consumers interviewed for the Needs Assessment of HIV Positive Minnesotans. Outpatient/ Ambulatory Medical care, Medical Case Management, Emergency Financial Assistance, ADAP, Transportation and housing assistance are included in the top six needs of those interviewed for the study. The top six funded service areas outlined in the 2010 Implementation Plan, which include Outpatient/Ambulatory Medical Care, Medical Case Management, and Emergency Financial Assistance, reflect these consumer identified needs. Other objectives in the plan, including Mental Health services, Food Bank/Home Delivered Meals, and Home and Community-Based

Health Services, focus on facilitating access to complete health care and mitigating health-related consequences of poverty.

The service goals of the Implementation Plan are also consistent with the findings from the Brief Survey (2004) and the recent (2006) Consumer Needs Assessment Survey (CNAS). In the Brief Survey, 33% of respondents reported having to pay more for health care to meet their basic needs in the previous six months. Thirty-eight percent reported having to pay more for medications and 21% reported having to pay more for housing. When asked to predict the impact on their lives of changes in public health care programs (such as prescription co-payments for Medicaid and cost-sharing for ADAP), 29% of respondents predicted a negative effect on their ability to get prescription medications and 23% predicted a negative effect on maintaining health insurance. Twenty-five percent of CNAS respondents reported needing but not being able to get housing or rental assistance in the six months prior to their interview. As an access service, Medical Case Management enhances knowledge of existing services for PLWH/A who need to connect to care but do not know what services are available, where they are offered or how to successfully navigate the complex system of health care reimbursement. Fifty-two percent of participants in the Needs Assessment of HIV Positive Minnesotans said that lack of knowledge about services was a barrier to care. The Care System Assessment Demonstration Project (CSAD) concluded that a lack of knowledge about the system and services available to assist in paying for medications was a significant barrier for Minnesota's population of Africans living with HIV/AIDS, who may not know how to access or navigate the system of HIV care.

Unmet need estimates using eHARS and clinic patient data from calendar years 2007 and 2008 indicate that American Indians, African Americans, and men who have sex with men (MSM) may be less likely to be in care. Fifteen percent of PLWH/A interviewed for the Needs Assessment of HIV Positive Minnesotans reported that cultural barriers impede access to needed services. The CSAD Project recommended increased funding for intensive case management services that are able to address cultural barriers to care encountered by African-born PLWH/A. The CSAD Project also identified a need for competent language interpretation services that are sensitive to HIV stigma among African communities and the intense fear of unwanted disclosure of HIV status to community members. Although not listed as one of the top-funded support services in the Implementation Plan, linguistic services for this group were improved in 2009 and remain a component of the complete plan for 2010.

The plan for 2010 is congruent with the overarching goals and more specific objectives of the 2009 - 2011 Comprehensive Plan, which was revised by the Planning Council in 2009. The Comprehensive Plan goals, objectives and activities were derived from the key findings of the needs assessments and unmet need estimates. Each of the goals under the six service priority areas listed in **Attachment 7** is based on corresponding goals and objectives from the Comprehensive Plan. Five of the six service areas (all except Home and Community-based Health Services) included rank within the top ten (out of 24) service categories prioritized for 2009 – 2010 by the Planning Council. Many of the Plan's objectives, including the provision of Mental Health, Food Bank, and Emergency Financial Assistance, are designed to address the complex issues and additional costs associated with delivering care to the TGA's PLWH/A affected by the comorbidities of poverty, homelessness, and mental illness.

Core Services Not Prioritized in the Part A Plan – Since the Minnesota HIV Services Planning Council also serves as the planning body for Part B, Health Insurance Premium and AIDS Pharmaceutical assistance are included as core medical service priorities funded solely by Part B in the statewide plan for HIV services. Although ranked fourth and sixth in priority respectively

in the statewide plan, the Planning Council did not allocate Part A or B funds for either program since the anticipated ADAP award, the state appropriation for HIV insurance continuation, and the Department of Human Services' forecast of approximately \$2,246,000 in drug rebate revenue along with Medicaid, Medicare and other Minnesota Health Care Programs are deemed adequate to meet the needs of Minnesota's PLWH/A in 2010. Also, home health care and hospice services are covered through Minnesota Health Care programs and private insurance, and thus are not allocated Ryan White funding.

Increased Access to the HIV Continuum of Care for Minority Communities – As an access service, Medical Case Management (medically focused comprehensive care coordination) is an important key to entry into the HIV Continuum of Care in the TGA. Medical Case Management (MCM) provides initiation and continuation of primary medical care, assistance to access health insurance coverage, treatment adherence counseling, behavioral health assessments, and HIV risk reduction interventions, as well as addressing the myriad of individual needs of PLWH/A. Service plans must include regular periodic reassessment of all cultural and socioeconomic factors that can interrupt HIV primary medical care. The overall MCM system in the Twin Cities includes five culturally specific agencies located in communities disproportionately impacted by HIV. Among three providers of MCM there are several multi-lingual African-born case managers serving the growing population of Africans living with HIV/AIDS; one provider agency's entire staff is bilingual in Spanish and English. All providers are assessed during annual site visits for their ability to facilitate access to no-cost interpreter services for clients who require them. The Part A allocation for Medical Case Management was increased by eight percent from \$1,775,500 in FY2009 to \$1,854,800 for FY2010 to ensure that this critical service is available to all eligible PLWH/A in the TGA.

The objective of Culturally Appropriate Primary Care, which is considerate of language, culture, country of origin and immigration status, is to provide multidisciplinary health care services for Spanish-speaking PLWH/A and is supported with Part A and MAI funding, to provide health care services for 120 Spanish-speaking PLWH/A in the TGA. Obtaining and paying for health insurance remains a critical strategy for PLWH/A to access health care. To ensure people continue their coverage is a top priority for the HIV Insurance Program (Part B funded) which pays eligible client cost-effective insurance premiums. It is of particular importance among undocumented immigrant PLWH/A who are ineligible for Minnesota's publicly-funded health programs. Data from interviews conducted for the 2004 Brief Survey and 2006 Consumer Needs Assessment Survey demonstrates a high level of poverty among the TGA's populations of color, particularly African-born and Spanish-speaking immigrants. The combination of stress related to living with HIV, particularly for people also affected by poverty, and the shortage in Minnesota of adequate numbers of mental health practitioners, contributed to the Outcomes Evaluation finding in 2008 that 27% of case managed clients were assessed in need of case management services because of mental illness, and 40% of those with a need for Mental Health services reported that need was unmet. Confidential mental health support is a key entry point for African individuals for whom the stigma of HIV is a major barrier to care. Through an African specific agency, mental health groups address isolation and fear of HIV for African-born men and women as well as provide information and referrals to needed services through health education and risk reduction programming available to group members. The Implementation Plan objective to provide individual and group mental health services will help address that need, especially for those among the emerging populations who are living in poverty. African-born and Spanish-speaking immigrants are among the TGA's identified emerging populations of special need and

as such are targeted for Medical Case Management, Primary Medical Care, Food Bank/Home Delivered Meals, Emergency Financial (and Housing) Assistance, Medical Transportation and Linguistics services.

Objectives that Address the Needs of Emerging Populations of Special Need –The continuum of access services, especially Medical Case Management, addresses the needs of special populations by placing an emphasis on services that are culturally appropriate and diminish barriers to care. These emerging populations include men who have sex with men as a cohort, and in particular men of color who have sex with men. Also included are all women of color, African Americans, African-born individuals, and Latinos.

The Ryan White Part A program provides wrap-around support services that bring people who know their status into medical care and are crucial for maintaining the continuity of care necessary for effective long-term treatment of HIV. Among these, the Food Bank/Home Delivered Meals program is funded in the belief that nutritional services are critical to maximizing the benefits of primary medical care. Fiscal year 2010 objectives for this program are met through provision of home-delivered meals, emergency food shelf services, congregate meals, and emergency food vouchers for low income PLWH/A. Home-Delivered Meals are often the key in supporting patients to maintain good health and nutrition, enabling them to remain independent in their homes. The complexity of pharmaceutical regimens requires extensive coordination with each client's eating patterns and the Part A-funded food and nutritional services remain an important priority. The On-Site Meals provider also provides a Food Shelf and is often a referral point of entry into primary care. Part A began funding Medical Nutritional Therapy in 2009 by funding registered dietician services housed at a community based organization and a major medical center to assess the needs of and assist clients enrolled in the Minnesota Department of Human Services HIV/AIDS enteral nutritional supplement program. The Food Bank and Home Delivered Meals programs help to address needs for adequate nutrition of the identified populations and reduce the need to choose between accessing medical care and paying for food.

As unemployment rises and employer-sponsored healthcare benefits shrink, an increasing number of PLWH/A in each of the emerging populations in the TGA continue to apply for Emergency Financial Assistance (EFA). Priority is given to applications for assistance to prevent or forestall eviction or shutoff of utilities in order to enable clients to retain their housing, as maintenance of basic needs for food, shelter, and transportation are seen as key to assisting PLWH/A to maintain regular HIV medical care. The \$135,600 allocated for EFA in FY2008 resulted in an average of \$252 in assistance for the 537 participating clients. The objective of Emergency Housing Assistance (incorporated into the EFA program) is to provide direct financial assistance for PLWH/A to mitigate homelessness. This assistance subsidizes rent or moving expenses and is coordinated through the centralized EFA program. Applicants for emergency housing assistance grants are also referred to housing programs, including HOPWA funded subsidies and transitional programs, that can help identify resources that can provide long term solutions to maintaining stable housing. The FY2008 allocation of \$303,979 for this program was distributed to 615 applicants, with an average assistance award of \$494. Additional supportive services included in the complete plan to promote access to and maintenance of primary care include: Health Education/Risk Reduction activities; and Outreach services that target people who know their status and are not currently in care, and are provided by Hennepin County's public health clinic and a large community-based multi-service organization dedicated to providing information, referral, and resources to PLWH/A. An additional Outreach provider, funded with MAI dollars, targets African Americans living with HIV.

Objectives to Ensure Engagement in Primary Medical Care and Treatment Adherence –

Early Intervention services will provide 36 newly tested individuals in FY2010 with primary health care exams, preliminary lab work and the necessary referrals to support entry or re-entry into care. Several objectives are aimed at assisting PLWH/A with maintaining access to care. Primary care will be provided for a total of 283 PLWH/A in the TGA. An additional 128 individuals will receive Culturally Appropriate Primary Care funded through the TGA's Minority AIDS Initiative (MAI). Since these funds must be used as a last resort, they provide a critical safety net for persons with no source of health care coverage to enter the primary care system and receive quality medical care. Medical Case Management will be provided to 1,358 PLWH/A to assess needs for and facilitate access to HIV primary medical care. An additional 46 African American clients will receive MCM services funded by MAI. Service plans address barriers that may impact maintaining medical care and treatment. Medication adherence counseling will be provided to 948 PLWH/A with medication adherence assessment, counseling, education, tools and follow-up services provided through HIV clinics at two large medical centers in Minneapolis. A total of 31 individuals who are physically challenged by the effects of HIV or comorbid conditions will be provided with paraprofessional home health care through homemaking services that contribute to their ability to remain in their homes and function independently. A total of \$151,400 will allow for weekly homemaking visits of two to three hours to assist each program participant. As a core medical service, \$118,000 in Oral Health services will help to address the disparity in access to optimal oral health care experienced by low income people of color who were found in the 2008 Service Assessment to be less likely to have a usual source of dental care and more likely to experience barriers presented by low Medicaid reimbursement rates that cause dental practitioners to limit the number of publicly funded patients they see.

Promoting Parity of Services – Because the vast majority of PLWH/A in the TGA reside in Hennepin and Ramsey counties (84%), most of the services that are funded in the TGA are located in Minneapolis and St. Paul (see Map of HIV Service Providers in **Attachment 10**).

Medical Transportation services are provided with Part B funds and include a cooperative process for PLWH/A to obtain rides, bus cards or taxi vouchers for available public transportation to medical appointments. While all Ryan White Part A-funded vendors are required to provide services for the entire TGA, the contracted transportation providers plan together to make sure services are available in all sectors of the TGA (and state) and to avoid duplication. A Culturally Appropriate Primary Care program is currently funded and located on the West Side of St. Paul in one of the largest Latino neighborhoods in the TGA. Medical Case Management programs are also located throughout the community and several of them serve specific populations, including African Americans, African-born and Latinos.

Assuring Culturally and Linguistically Specific Service Provision – When submitting a proposal to become a Part A service provider, applicants must address the following: 1) How their program will target a clearly defined population that is underserved and/or over-represented in the epidemic, and that at least 60% of its clientele is part of the defined population; 2) Plans to involve members of the target population in program development and evaluation; and 3) Agency plans to maintain a program staff that reflects the target population by at least 50%. In addition, during annual site visits, the grantee's program contract managers and quality coordinator assess each agency's current provisions to provide culturally appropriate services and compliance with the Universal Standard covering free access to interpreter services.

Healthy People 2010 Initiative and the 2010 Implementation Plan - The TGA's 2010 Implementation Plan will work toward achieving Healthy People 2010 Goal 13 by preventing HIV in-

fection and its related illness and death. Although the goals and objectives of the 2010 plan address the majority of the objectives under Healthy People 2010 Goal 13, the activities planned for 2009 will focus primarily on the following goals:

- 13-13. Increase the proportion of HIV-infected adolescents and adults who receive treatment and prophylaxis consistent with Department of Health and Human Services treatment guidelines
- 13-14. Reduce deaths from HIV infection
- 13-15. Increase years of life of an HIV-infected individual by extending the interval of time between an initial diagnosis of HIV infection and AIDS diagnosis
- 13-16. Increase years of life of an HIV-infected person by extending the interval of time between an AIDS diagnosis and death.

The 2008 Implementation Plan secondarily addresses additional Healthy People 2010 goals by bringing PLWH/A who know their status into care, thus reducing transmission and disease progression. These additional goals addressed by the Plan include:

- 13-1. Reduce AIDS among adolescents and adults
- 13-2. Reduce the number of new AIDS cases among adolescent and adult men who have sex with men
- 13-3. Reduce the number of new AIDS cases among females and males who inject drugs
- 13-4. Reduce the number of new AIDS cases among adolescent and adult men who have sex with men and inject drugs.

Ensuring Resource Allocations for WICY – Meeting the service needs of Women, Infants, Children and Youth (WICY) who are living with HIV/AIDS continues to be a priority for the TGA. Infants, children and youth, however, make up a relatively small proportion of the TGA’s epidemic. Women account for 23% of all living HIV/AIDS cases, while Youth (age 13-19) make up less than one percent, and Infants and Children (age <13) also make up less than one percent. Given these small numbers, the TGA and Planning Council have requested data to assure that spending by the state’s Medicaid and Children’s Health Insurance Programs, as well as other federal and state spending, occurs in proportion to how these populations appear in the local epidemic. As such, the TGA along with the Part B grantee applied for and were granted joint WICY waivers for 2003 through 2009. Despite the waivers, the grantee and Planning Council make every effort to ensure that Part A and B resources for WICY with HIV/AIDS are proportionate to their representation in the overall epidemic. Women are generally overrepresented in Ryan White funded services in the TGA; for example, in 2008, 32% of those accessing Case Management services and 35% of those accessing Primary Care were women. Women face additional barriers to care in meeting basic needs for themselves and their children, and services which address these barriers include Benefits Counseling, Emergency Financial and Housing Assistance, Food Shelf, Food Vouchers, On-Site and Home-Delivered Meals.

Minority AIDS Initiative (MAI) – The Minneapolis-St. Paul TGA’s MAI plan for 2009 includes allocations for Culturally Appropriate Primary Care (\$161,900), Medical Case Management (\$51,000) and Outreach (\$50,000). The objective of Culturally Appropriate Primary Care, which is considerate of language, culture, country of origin and immigration status, is to provide multidisciplinary health care services for 128 Spanish speaking PLWH/A. This program will serve 31% of PLWH/A identified as Hispanic in the TGA. MAI-supported Medical Case Management services target African Americans and provide assistance in applying for publicly funded health care programs, accessing primary medical care, treatment adherence services and support services that meet psychosocial and basic needs. The FY2009 MAI plan provides for

Outreach activities that target communities where HIV is increasing, including the African American and African-born communities. The objective of Outreach services is to successfully provide information, support and referrals to PLWH/A in order to increase access to HIV care services for individuals not currently in care. Needs assessment data document lack of knowledge of services as the major barrier to care for all special needs populations. Outreach activities establish the relationship for trust building, which begins the communication that is often the first step in connecting to care.

3. Grantee Administration

3.a. Program Organization

The Minneapolis-St. Paul Transitional Grant Area (TGA) Part A grantee organizational chart and staffing plan are presented in **Attachment 1**. The Chief Elected Officer, the Chair of the Hennepin County Board of Commissioners, designates the Public Health Protection (PHP) service area of the Hennepin County Human Services and Public Health Department (HSPHD) as the unit that administers the TGA's Part A grant. The Ryan White Program (RWP) Supervisor oversees the daily operations of grant administration and reports to the PHP Human Services Area Manager. The RWP Supervisor is the lead Part A grantee liaison between Hennepin County and stakeholders involved in the planning, delivery and receipt of Part A funded services including: Part B (Minnesota Department of Human Services), C, D and F grantees; the Minnesota Department of Health–Minnesota's CDC HIV prevention grantee; Part A and B funded community and clinic-based providers; recipients of Ryan White funded services; and other interested community members. In addition to the RWP Supervisor, the grantee administrative team includes: two Program Contract Managers; a Contract Analyst from the HSPHD's centralized Contract Administration division; a Quality Management Coordinator; an Outcomes Evaluation and Data Coordinator and program support staff. The administrative team procures services, manages provider contracts, provides fiscal and program monitoring and oversight, prepares annual grant applications, conditions of award and grant reports, and takes the lead on quality improvement and evaluation. The Part A grant supports 2.2 FTE administrative staff and 2.1 FTE Clinical Quality Management staff (see **Budget Narrative Attachment** for detail). There are currently no grantee staff vacancies. Should a vacancy occur, the RWP Supervisor will hire new staff using the County's Human Resources open competitive, lateral transfer or promotional hiring procedures.

A Memorandum of Understanding between the Planning Council and Part A grantee sets agreed-upon roles and responsibilities of the grantee and Planning Council and establishes the staffing structure for the Council. Planning Council staff includes the Council Coordinator and Administrative Specialist. The Council Coordinator, the lead member of the Council support team, ensures that the Planning Council has information, tools and support to meet its mandated responsibilities. The Administrative Specialist receives work direction from the Council Coordinator and is supervised by an Administrative Services Supervisor in the HSPHD's Administrative Services Area. The Part A grant supports 1.5 FTE Council staff (see **Budget Narrative Attachment** for detail).

3.b. Grantee Accountability

Process for Tracking Formula, Supplemental, Unobligated and Carry over Funds–For FY2009, the Minneapolis–St. Paul TGA received \$3,557,795 in formula and \$1,529,213 in supplemental funding. Overall, Part A funding increased by \$697,491 (15.9%) compared to FY2008. Because of the penalties for unobligated formula funds established by the Ryan White HIV/AIDS Treatment Modernization Act, formula funds for HIV services and administrative

support, including Planning Council activities, and clinical quality management are disbursed and spent down before supplemental and carry over funds are used to meet program costs. As a result, 100% of FY2008 formula funds were expended by December 31, 2008. By the end of FY2008, 93% of supplemental funds were spent resulting in overall Part A spending of 98%. No funds were carried forward from FY2007 into 2008. Since formula funds were fully spent in FY2008, the grantee is ineligible to carry forward unspent funds into FY2009. The grantee will continue to spend down formula funds first in fiscal years 2009 and 2010 in order to avoid any penalties for unobligated balances.

The Planning Council's allocations process is designed to avoid unobligated balances. At the August 2008 meeting to allocate funds for FY2009, the Planning Council assumed that the Part A award would be the same as the FY2008 award. This enables the grantee to obligate all funds allocated to services in provider contracts by the beginning of the fiscal year. Adjustments can be made through contract amendments once the actual award is received. The Part A grantee obligated 96% of funds allocated by the Planning Council for FY2009 HIV services in provider contracts by March 1, 2009. Once the award notice was received the Planning Council made allocation adjustments on May 12, 2009 based on the award increase. Provider contracts were adjusted to increase funding of designated services by July 1, 2009, thus obligating 100% of funds for services. For FY2009, the grantee assumed that support for administration and planning and clinical quality management would also be the same as in FY2008 and obligated funds in FY2009 budgets accordingly. Small budget adjustments for administration and quality management were made based on the actual award amount. Budgets and expenditures for HIV services, administration, Planning Council support and the grantees' clinical quality management program are assigned separate cost centers in Hennepin County's financial management system. This facilitates separate tracking of expenditures to ensure that administrative and quality management caps are not exceeded.

The process used to ensure timely redistribution of unexpended funds – All service contracts include a reallocation policy and procedure. If 40% or less of a contractor's program budget is expended by the end of the first six months of the fiscal year, program budgets can be reduced accordingly and funds allocated to other providers. Once August invoices are received, Ryan White Program staff review contractor spending and take into account expected temporal trends in expenditures before identifying opportunities for reallocation of funds. If additional funds can be utilized by other programs within a prioritized service area, the grantee will amend provider contracts to redistribute the funds accordingly. If utilization patterns or cost increases do not indicate a need for redistribution of funds within a service area, the grantee will submit a proposal to the Planning Council for reallocation of unspent funds to another prioritized service area. Once approved, the grantee amends contracts to appropriate providers to deliver services based on the Council's reallocation plan. The process for reallocating funds was extremely successful in avoiding under spending by the end of FY2008 given that the overall Part A award increased by 4.4%.

Fiscal and Program Monitoring - In general, most contractors providing Ryan White Program (RWP) Part A funded services have done so for several years and are familiar with the RWP fiscal management requirements. Contract managers work closely with newly funded contractors to ensure that sound fiscal management practices are developed and implemented. The grantee makes attempts to minimize fiscal concerns in advance of contract execution. Program budgets are negotiated according to HRSA and Hennepin County guidelines. Budget line items reflect HRSA line items for ease of reporting and satisfying conditions of award. Should a fiscal prob-

lem be identified, RWP staff meets with the contractor to discuss the issue and determine the need for technical assistance, which may be provided by RWP staff, through HRSA communicated opportunities, the CAEAR Foundation, or local providers. Invoices are not approved for payment if an agency has outstanding fiscal issues. The grantee may also involve HSPHD Contract Administration financial staff at an annual site visit or in a separate meeting with a contractor to address fiscal management concerns.

To improve contractor accountability and better assess cost effectiveness of services, the grantee continues to phase in unit rate contracting. Medical Case Management (MCM) providers are now reimbursed based on hourly unit rates for work on behalf of individual clients. Unit rates for MCM were developed jointly with the Minnesota Department of Human Services—the Part B grantee—to ensure uniform rates regardless of funding source. The grantee began procuring Treatment Adherence services, Primary Care, and Food Shelf/Home Delivered Meals and Home and Community-Based Health Services on a unit rate basis in 2003, 2004 and 2006, respectively.

Most contractors submit invoices for expenditures monthly. A few larger health care organizations submit invoices quarterly. Contractors are also required to submit quarterly narrative progress reports. Progress reports include information on the numbers of clients served; units of service provided; case studies; relevant staffing changes or administrative issues; a description of client needs that are unmet; and a list of trainings attended by staff. Contractors receive a quarterly summary on numbers of clients served and units of service provided so they can monitor their spending and progress toward achieving process goals stipulated in their contracts.

Fiscal and Programmatic Monitoring Site Visits—Contractors receive site visits at least once during the annual Part A contract period as specified in their contract. Combining fiscal and programmatic components, they are an opportunity to assess compliance with contractual goals and objectives and soundness of fiscal management; document charting practices and compliance with client eligibility determination requirements; ensure that Ryan White Program funds are the payer of last resort; review progress toward quality improvement goals; and assess adherence to the grantee’s Universal Standards for service delivery. The site visit format also allows the contract manager to evaluate organizational structure, personnel management capacity and compliance with client utilization and outcomes data reporting. The updated FY2009 site visit instrument improves the efficiency of site visits, assesses emergent needs in populations served and assesses technical assistance needs. The site visit team comprises the grantee’s Program Contract Manager, Quality Management (QM) Coordinator and a Contract Analyst from HSPHD’s Contracts Administration service area. Prior to the site visit, Ryan White Program (RWP) contract administration staff reviews: the contractor’s most recent financial statement and audits, including A-133 single audits if applicable; certificates of insurance; internal financial controls including policies and procedures for separating RWP dollars from other funding sources and monitoring of third party reimbursement; tracking of RWP-funded staff time and effort; quarterly reports; spending to date and client level utilization and outcomes data reporting compliance. The QM Coordinator reviews client charts to assess compliance with the TGA’s Universal Standards for service delivery. In addition to annual site visits, invoice audits are also conducted to ensure that providers’ documentation properly supports all units billed. Since unit rate reimbursement for Medical Case Management (MCM) services was implemented in FY2008, all five MCM providers have received invoice audits.

Process for Corrective Actions Related to Fiscal or Programmatic Concerns—Following each site visit; a report that summarizes findings and any indicated corrective action is mailed to the contractor. In addition, any contract file documents not obtained prior to or during the site

visit will be required to be submitted by a set date. If a programmatic concern is identified, the contract manager meets with the agency to develop a corrective action plan and communicates in writing expectations for meeting the plan goals. The corrective action plan must be agreed upon within 30 days of identifying any concerns. The QM Coordinator assists the Program Contract Manager and Contract Analyst in assessing TA needs and identifying appropriate interventions if needed. By the end of the quarter following the identification of the problem, the contract manager will follow up with the agency to assess progress towards meeting the plan's goals. In FY2008, grantee staff was able to address programmatic concerns with contractors through correspondence, face-to-face meetings, mutually agreed upon plans of action, and the provision of technical assistance.

Number and Percentage of Contractors that Received a Site Visit in FY2009—Grantee staff conducted annual programmatic site visits at all 13 (100%) Part A contracted agencies from June through August 2009.

Improper charges, other findings and a Summary of Corrective Actions in FY 2009 - Minor improper charges were found following a financial audit of one agency that provides Medical Case Management, Mental Health and Outreach services. Expenditures for a monthly transportation allowance for the Executive Director had been included in invoices for employee travel. The Contract Analyst sent a letter to the agency's Program and Executive Director that such charges are not allowed. Subsequent billing did not include these expenditures. From the annual site visits of all 13 providers, 6 had one or more of the following corrective actions: to increase documentation that clients received a Confidentiality Notice (three providers); to increase documentation of signed consent to receive service forms (three providers); to collect client financial eligibility every 6 months (three providers); to improve the documentation of client care status (three providers); increase documentation that the client received a copy of Bill of Rights (two providers); to improve documentation of client HIV status (one provider); and improve outcomes data collection (one provider). Unless otherwise specified, corrections will be monitored for improvement during 2010 site visits.

Contractors That Received Technical Assistance (TA) in FY2009 - All 13 (100%) Part A contractors have received technical assistance (TA) and/or training in FY2009. Seven of the contractors are clinic-based and six are community-based organizations. Technical assistance was provided by the grantee's TA consultants, Community Consulting Group (CCG), the Contract Managers and the QM Coordinator in the following areas: interpretation services; transportation collaboration; medical case management standards; personnel management; developing inter-agency collaboratives; engaging clients in culturally competent dialogue about chemical, mental, and sexual health; and developing a quality management work plan. In 2009, the grantee continues to develop online training modules accessible through the Minnesota HIV Services Planning Council website. Training modules developed to date include: Building Alliances I & II; Grant Writing; Medical Case Management (MCM) Unit Rate Contracting; MCM Standards; and Preparing Your Program for Unit Rate Reimbursement. In fall of 2008, the Part A grantee collaborated with the Part B, C and D grantees in a national project by Positive Outcomes, Inc to develop a Medical Case Management training curriculum. Minnesota was a curriculum test site.

Contractors compliance with the audit requirement in OMB Circular A-133. - Prior to site visits, all providers are required to submit copies of their most recent annual audit. In 2005, contract language was added that requires all Part A providers to submit biannual programmatic revenue and expenditure reports to the grantee. Contract Administration staff review the financial statements to assess sub-recipient fiscal stability. For agencies with budgets of \$500,000 or

greater, audits are reviewed by Hennepin County's Contract Administration staff to assess compliance with the Single Audit Act/OMB Circular A-133. In FY2009, all eight contractors receiving \$500,000 or more in federal funds complied with the A-133 audit requirements. No findings were identified.

Process of receiving invoices from contractors/subcontractors. - Contractors submit invoices on either a monthly or quarterly basis. Only large providers, such as health care institutions, submit invoices quarterly. The grantee has developed a standard electronic invoice form, which reflects contracted budget line items, to assist providers in managing their budgets. Units of service provided are also reported on the invoice form along with a unit tracking spreadsheet. Contractors are expected to submit invoices to their respective RWP Contract Manager by the 15th of the month following the period during which services were provided and final invoices for the fiscal year are due by April 15.

Process of payment made to contractors/subcontractors. Invoices and tracking spreadsheets are reviewed by the RWP Contract Manager for accuracy and compared to the program budget, entered in a financial management tracking workbook, approved by the RWP Supervisor and submitted to the Financial & Accounting area (*see Attachment 1C*) for payment. If invoices are inaccurate or show overspending of 10% or more on a line item, the Contract Manager will work with the agency to mitigate the problem. Any shift in budget line item amounts must be requested in writing and approved by the RWP Supervisor. Once payment is made, the payment amount from Hennepin County's monthly cost center financial reports is reconciled with the invoice amount and entered into the financial tracking workbook. Contractors receive a quarterly expenditure summary from grantee staff to assist in budget management. If invoices are late, corrective action is communicated through the quarterly summary.

3.b.1. Fiscal Staff Accountability

Hennepin County's Human Services and Public Health Department's Financial Analysis and Accounting service area provides fiscal staff support for the Ryan White Program (RWP). An organizational chart for fiscal staff is presented as **Attachment 1C**.

Role and responsibility of program and fiscal staff - Two accountants in the Accounting Unit and a pool of support staff in the Accounts Payable Unit work directly with (RWP) staff. The RWP Supervisor and Contract Managers maintain a master financial tracking workbook that logs all sub recipient invoices and payments as well as administration and quality management expenditures. Contract Managers check invoices against contract budgets, enter invoice expenditure amounts into the workbook and approve the payment if year-to-date spending is in line with program contract budgets. After review and approval by the RWP Supervisor, invoices are forwarded to Accounts Payable staff for payment. Once payment appears in the County's financial management ledger, RWP support staff enters the payment amount in the invoice workbook to reconcile the amounts. One Accountant (Hutterer) in the Accounting Unit prepares and submits the Financial Status Report (FSR). The other Accountant (Ranfelt) prepares and submits the PSC 272 to report quarterly disbursements to HRSA for expenditure draw downs. The Accountants also provide Hennepin County's external auditor documentation for the payment selections for the A-133 single audit of RWP funds received by the County.

Coordination of program and fiscal staff. - The Accountant who submits the FSR works with the RWP Supervisor to reconcile invoice amounts logged in the invoice workbook with year-to-date financial management payment reports following the close of the fiscal year. This process ensures accurate reporting of formula and supplemental unobligated balances on the final FSR. The Accountant who prepares the PSC 272 disbursement report coordinates with the RWP Su-

pervisor and the Accountant who submits the FSR to ensure that the first PSC 272 report prepared after submission of the final FSR accurately reports disbursements based on fiscal year grant expenditures. The RWP Supervisor, Accountants and the Sr. Administrative Manager in the Accounting Unit meet as needed to resolve any fiscal reporting issues, ensure accurate expenditure tracking and reporting, and to maintain continuity of fiscal support to the RW Program.

3.c. Third Party Reimbursement

To ensure that Ryan White Program (RWP) funds are the payer of last resort, contractors are asked at each site visit to demonstrate how they determine Ryan White eligibility and track other sources of reimbursement. Upon intake and every six months, all clients are asked about health insurance status including: private insurance; enrollment in Medicare; Medicaid; veteran's health care benefits; ADAP; the HIV Insurance Program and other public programs. Contractors are required to report these items using the Ryan White Part A and B Client Level Reporting System (CLRS) in January and July each year. All Part A primary care providers have onsite caseworkers, including Medicaid enrollment workers, social workers, case managers, and benefits counselors, that review client eligibility for third party reimbursement. Many agencies ask about changes in insurance status at each appointment or as part of the billing requirement; however, many of the TGA's Part A funded programs cannot bill third parties for services such as food bank/home delivered meals, most HIV medical case management (unless Medicaid enrolled clients qualify for a waived program), support groups, health education and risk reduction sessions, benefits counseling or legal services. Other criteria for Ryan White eligibility such as HIV status and income are captured on intake forms and documented by each agency in client files and through the Client Level Data System.

To ensure that all Medicaid-eligible providers are Medicaid certified, the grantee's contract managers check with the Department of Human Services' online MMIS system to verify that each of the primary care providers receiving Ryan White funding has an active Medicaid provider number. In 2008, all primary care providers had an active Medicaid provider number. The grantee's instrument used for primary care provider site visits assesses whether processes are in place to ensure that all third-party funding sources, such as Minnesota Health Care Programs, have been exhausted prior to the utilization of RWP funds. Since March 1, 2006, only Medicaid certified mental health providers are eligible to provide Part A or Part B funded mental health therapy. Provider contracts specify that in order to receive Part A funded services "*clients must not have access to other sources of reimbursement for services.*" In addition, contracts contain the following language: "*The provider agrees that every reasonable effort will be made to collect from third-party payment sources and/or government agencies, which are either authorized or under legal obligation to make such payments.*"

3. d. Administrative Assessment

The Planning Council's most recent evaluation of the administration of the Part A grant, completed September 8, 2009, determined five outcomes using six measurement objectives to assess the efficiency of the administrative mechanism. The outcomes are:

- The awards to service providers were completed in a timely manner
- The awards to service providers were given out according to established criteria
- Appropriate justification was made for service area/activity sole source contracts for services not included in the Request for Proposal process
- The grantee received sufficient proposals for all categories solicited

- The awarding of funds matched the service areas/activities established in the allocations completed by the Planning Council in fiscal year 2008

Planning Council assessment of achievement of the six objectives is summarized as follows:

Minnesota HIV Services Planning Council Assessment of the Administrative Mechanism Part A Fiscal Year 2009 (N=23)		
Objective	Met	Unmet
1. Implementation of a process which utilizes the Planning Council's priority and allocation decisions as a basis for securing services; 75% of newly awarded funds are initially obligated within 90 days of the grant award, and 100% of such funds are initially obligated within 120 days of the grant award.	23	0
2. Implementation of a process to monitor spending and reallocate funds which aims to limit the amount of combined unspent Part A and Part B funds to not more than 10% at the end of the fiscal year (2008).	23	0
3. Service areas/activities are funded by a Request for Proposals process using established criteria.	23	0
4. Appropriate justification was made for service areas/activities sole source contracts for services not included in the Request for Proposal (RFP) process	23	0
5. Per service area/activity, a sufficient number of requests for funding is based on the number of contracts to be awarded.	23	1
6. Award per service area/activity complies with Planning Council prioritization (2008) and allocation amounts set by Planning Council in 2007 and 2008.	23	0

Twenty-three of 26 Planning Council members (86%) completed the evaluation. All respondents indicated that the objectives were met. Of the eleven comments from the completed instruments, three suggested improving the diversity of the proposal review committee that recommends agencies for funding by including more people living with HIV, men and African American/African-born reviewers. Although no corrective action was recommended, the grantee plans to broaden the call for volunteers to serve on the next proposal review committee by contacting a wider variety of organizations and individuals to recommend reviewers.

4. Planning and Resource Allocation

4)a.1. Letter of Assurance from Planning Council Chair(s) – See **Attachment 2c** for the Letter of Assurance from the Minnesota HIV Services Planning Council co-chairs.

4)a.2. Description of Priority Setting and Resource Allocation Processes

The Minnesota HIV Services Planning Council (Council) completed its biennial prioritization process for Fiscal Years 2009 and 2010 in August 2008. The Council prioritizes services and allocates funds for both the Minneapolis-St. Paul TGA's Part A award and Minnesota's Part B base award. During 2008, the Council refined the prioritization process based on feedback from the previous processes completed in 2004 and 2006. The Planning and Priorities Committee reviewed a revised list of services and activities eligible for funding. The committee also selected services to be funded with Minority AIDS Initiative (MAI) dollars. To ensure that the needs of those not in care and those from historically underserved and emerging populations were considered, the Planning and Priorities Committee compared demographic patterns of client utilization of services with epidemiological data, expenditures on culturally appropriate service activities, and demographic breakout reports from the needs assessments conducted in 2003, 2004 and 2006 for African Americans, Latinos and African-born PLWH/A, the Systems Assessment (2007), the Path To Care Study (2008), and the Twin Cities Care System Assessment Demonstration (CSAD) Project (2006) in determining categories to be funded by the TGA's Part A award. Once the full Council approved the list, Council staff revised a grid of service categories

on which members conducted a paired comparison analysis of one service to another as they worked their way through the list of eligible services. A second paired comparison analysis process was used to rank service activities within the categories and the MAI selected activities, providing a clearer and more compelling picture of the Council's priorities. Members were given the option to complete the form individually, or to attend an open house session where Council staff was available to answer members' questions about the service areas or the process. The paired comparison analysis mechanism resulted in each service area and activity receiving a score from each Council member. Scores from all Council members are then totaled, creating a ranked priority order for service areas and activities within those areas.

Priorities are established for a two-year period.

The Planning and Priorities Committee reviewed a set of values to guide the Council in its allocations decision making process which included: majority rules, individuals vote; equity; data-based; culturally competent; based on consumer and system needs; efficient use of resources; and flexible and responsive to system changes. The agreed-upon values demonstrate the premium placed on data-based decision making, as well as consideration of the needs and input of consumers of services and people living with and affected by HIV/AIDS. At the August 2009 Planning & Priorities Committee meeting and the September 2009 Council meeting, allocations for FY2010 were approved with the assumption of flat funding. The Council will then approve a final allocations proposal once all awards are received by the Parts A and B grantees.

Involvement of People Living with HIV—The Council strives to ensure representation by all communities impacted by HIV/AIDS. Currently, all of the populations identified as having a severe need are represented on the Council, including three African immigrants. The Council's Community Voice Committee (CVC) meets monthly and includes HIV-positive community members as well as Council members. The CVC provides perspective on emerging service needs and problems associated with the current service delivery network. Most importantly, the group provides the Council with key insights into issues associated with living with HIV/AIDS. During the most recent biennial prioritization process, the list of service categories and associated activities developed by the Planning and Priorities Committee, as well as the list of service activities selected for MAI funding, were reviewed with the CVC for consumer input before forwarding them for consideration by the full Council. People living with HIV/AIDS populate all Council committees, where they provide input on services and allocations as well as data collection and analysis.

In addition to serving on the Council and its respective committees, PLWH/A are consistently involved in the priority setting and allocations processes. First, PLWH/A participate in both needs assessments and consumer surveys. Three hundred seventy-nine consumers participated in the Consumer Needs Assessment completed in 2006. The assessment included one-to-one surveys conducted by case managers, care advocates and outreach workers from 13 agencies. The surveys provide an avenue by which the Planning Council gets direct feedback information about barriers to care and gaps in services from affected communities. Second, time is allotted at the beginning of each Council meeting for community members to come and discuss service needs. Finally, the Council is currently composed of 27 members, 12 (44%) of whom identify as living with HIV disease. In August 2008, the Council co-sponsored a community forum to solicit consumer input into the availability of services and any gaps and barriers that might exist. Thirty-six consumers participated in the breakout session and a total of 53 consumers completed the survey associated with the event.

Use of Data in the Prioritization and Allocation Processes to Increase Access to Core Medical Services and Reduce Disparities

Preparation for priority setting spanned an entire year. Several data resources were presented to the Council for review and consideration. For the FY2009/2010 priority setting and 2010 allocation processes, the Council considered epidemiological data, the unmet need estimate, outcomes evaluation results, service utilization data, needs assessments and other qualitative data including a consumer survey conducted in 2006 and the Care System Assessment Demonstration Project—funded through the Ryan White Special Projects of National Significance, and quarterly and annual grantee expenditure reports.

In June 2008, a Minnesota Department of Health (MDH) epidemiologist presented the Minnesota HIV epidemiological profile to the Needs Assessment and Evaluation Committee and the full Council. The Council examined epidemiological changes and trends over the previous two year period, changes in demographics of HIV/AIDS cases, information on populations with emerging and special needs, such as the African-born population, and estimates of unmet need. Epidemiological data are used in the allocation process in two key ways. First, consideration is given to service area allocations based upon increased prevalence over the previous year. Second, the data are used to determine if new service areas or activities should be considered to fill gaps in service delivery. A similar update was provided in June 2009 on the 2008 epidemiological profile prior to approval of the 2010 allocations.

Outcomes data were also considered in the FY2009/2010 priority setting process. Outcomes evaluation results are presented in a report format called Service Area Reviews (SARs), which integrate information about epidemiology, service utilization, outcomes, needs assessment and consumer satisfaction data for each service area. Outcomes data provide the Council with a sense of the impact of a service as well as the ability of the service to meet its intended goals. For example, outcomes data for Part A funded Primary Care services documented that CD4 and viral load results continue to improve over time. This outcomes data supported the Council's decision to increase Primary Care allocations by \$40,000 in FY2006, \$225,600 in FY2007, by an additional 29% to \$620,100 in FY2008, and by \$120,006 in FY2009.

Service utilization data are presented by MDH and include an analysis of under- or over-utilization of each funded service area by population. This analysis is also used with the grantee's year-end expenditure report to calculate per-client costs for each of the funded services. Because the Council initially allocated funds based on an assumption of flat funding, utilization data had a direct impact on the priority setting and resource allocations process. Due to increased prevalence in the TGA, the Council agreed to increase by two percent allocations to services funded in the previous fiscal year. This meant lower prioritized services which had been previously funded might suffer because of the increased allocations for higher ranked services, although this was not the case in FY2009 due to an increase in the TGA's Part A award. The increase and attention to service areas that were under-utilized in 2008 allowed the Council to allocate funding to lower prioritized service areas such as Legal Services and Linguistic services which may have lost funding otherwise.

Qualitative data play a key role in integrating the perspectives of PLWH/A into the priority setting and allocation process. The Council collects these data in many ways, including focus groups, public forums, needs assessments, consumer satisfaction surveys, and community participation on Council committees. Other qualitative data considered by the Council were presented by the Twin Cities Care System Assessment Demonstration (CSAD) Project. The CSAD data included an assessment of system and individual barriers experienced by African-born PLWH/A. The Minneapolis-St. Paul TGA was one of three in the nation that participated in this

study. The Council received a final report on the CSAD findings and plan of action at the June 2006 meeting.

Needs Assessment data from FY 2006 were used extensively during the most recent priority setting and allocations processes. Highlights from surveys conducted on one-to-one basis with 379 PLWH/A include the following: respondents reported a mean monthly income of \$911 during the previous twelve months (a decline from the Brief Survey conducted in 2004); less than one-quarter (21%) of respondents reported enrollment in private health insurance or a health maintenance organization while six percent were uninsured; five percent reported not accessing HIV medications in the past six months because they could not pay; 13% reported not seeking healthcare in the past 12 months because of concerns about how to pay for it.

The Council used data in multiple ways to establish priorities and allocations for core medical and support services. First, increased rates of HIV infection as evidenced in annual epidemiological updates means more people may need assistance in accessing and maintaining health care. As the Council monitors quarterly expenditures, service areas and activities that are under utilized allow the Council to reallocate funds to service areas such as Primary Care that are seeing this influx of new consumers. Second, outcomes data on Medication Adherence demonstrated that persons participating in an adherence program had fewer missed doses and showed improved clinical outcomes and the Council voted to sustain funding for this important program in 2010. Third, Inreach—a treatment adherence intervention—was piloted as a new service activity after the unmet need estimate conducted in 2004 showed 41% of PLWH/A were not in care and information from clinics indicated a high rate of missed appointments. This medical care retention activity is based in medical clinics where the primary purpose is reconnecting with people not in care or who have lapsed from care. As the number of consumers in care has increased, the Council has continued to allocate funds to this service activity which has shown success in reducing barriers to attending medical appointments.

In an effort to increase access and reduce disparities, the Council increased or sustained allocations to two core medical services—Outpatient/Ambulatory Medical Care including Culturally Appropriate Primary Care targeting Latinos and Medical Case Management for the sixth consecutive year. In addition, the Council increased or sustained funding to three other core medical areas—Mental Health Services, Home and Community-Based health Services and Substance Abuse Services (Outpatient) for FY2010. The Council's allocation plan for FY2010 has 76% of the Part A funds allocated to core medical services.

In addition, \$174,600 of Part A MAI and Part A funds was allocated in FY2010 for Culturally Appropriate Outpatient/Ambulatory Medical Care to assist under-represented communities with accessing and adhering to HIV primary medical care. This represents a 91% increase in funding for this service area over a four-year period. The program currently funded through the TGA's Minority AIDS Initiative to provide this service has helped increase the numbers of Latinos living with HIV/AIDS who access as well as maintain their health care and has helped to reduce disparities in access to care. Past studies have shown high rates of uninsured individuals among this population, which is a barrier to care. Latinos in Minnesota are also more likely to have AIDS at first diagnosis. Providing accessible, affordable, culturally appropriate primary health care that is considerate of culture, language and status in the TGA has helped to address this disparity. The additional allocation of Part A funds will help to increase access and reduce disparities for communities of color.

Part A funds were not allocated for the purchase of medications. Twenty-six percent of the TGA's PLWH/A access medications through state-funded health care programs (Medicaid, Min-

nesota Care and General Assistance Medical Care). Minnesota's ADAP award is supplemented by rebate dollars and provides medications for 18% of PLWH/A in the TGA. The State of Minnesota also provides an annual appropriation of \$1.2 million for the HIV Insurance Program, which will purchase high-risk insurance pool policies for a projected 67% of its enrollees in 2009. The Council's plan for FY2010 includes \$16,000 in Health Insurance Premium Assistance to help mitigate a new gap in coverage created by elimination of the State's General Assistance Medical Care program in 2010 due to cuts. Enrollees in this program have an income at or below 75% of the federal poverty guidelines and will be transitioned to a State funded program that will require payment of a small premium. This assistance program will help pay the premium and prevent 200 very low income single adults living with HIV from losing health coverage.

Use of Changes and Trends In Epidemiological Data on Priority Setting and Allocations –

As the epidemic in the TGA has shifted, greater emphasis has been placed on services to communities of color and women, especially African-born immigrants. As part of the biennial prioritization process conducted in 2008, the Planning and Priorities Committee revised the list of services to be supported with MAI funds to include Culturally Appropriate Primary Care, Medical Case Management (MCM), and Outreach. The Council allocated funds to continue funding Culturally Appropriate Primary Care that targets Latinos. Allocating MAI funds for MCM, targeted for African Americans, has increased resources for this activity every year since 2005. MAI funding for Outreach supports case finding and coordination of entry into care for African American and African-born PLWH/A who are aware of their status and not in care. Trends in new infections among African-born and the associated increase in prevalence in this population resulted in the Council allocating carry over funds in 2004 for an Emotional Support/Health Education Risk Reduction (HERR) program for African-born PLWH/A. Since then, allocations for Mental Health services have increased and allocations for HERR have been sustained for programs targeting this population which helps participants gain knowledge of HIV services and improve their HIV related health literacy. These programs have been instrumental in addressing the intense HIV stigma many African PLWH/A experience, which can be a significant barrier to care. Epidemiological data show that new HIV infections among MSM increased by 11% between January 1, 2007 and December 31, 2008. During the first six months of 2009, new infections have increased by 25% compared to the same period in 2008. In an effort to reverse this trend, the Council has sustained or increased FY2009 allocations to several service areas including Early Intervention Services, Outreach, Mental Health Services and HERR Services including culturally specific services in communities of color.

Use of Cost Data in Making Funding Allocation Decisions – Council members were provided with client capacity data based on provider contractual goals, along with client utilization data, units of service provided and expenditures for each service activity. These three sources are used to estimate unit and per-client costs. Expenditure data are provided quarterly by the grantee.

Provider capacity and client service utilization data are provided annually. Prior to the all-day allocations meeting for FY2009 funding, the Council received a table with these three elements for all of the services funded in 2008. Comparing unit costs and costs per client for some service areas has been difficult since the types of services and how they are delivered can vary considerably from one provider to another. As the Part A grantee continues to procure more services through unit-rate contracting, the Council will receive more accurate unit cost information.

How Unmet Need Data were used in making priority and allocation decisions–In setting priorities and determining allocations for FY2009/2010, the Needs Assessment and Evaluation and Planning and Priorities Committees reviewed the MDH report on the estimate of the number of

PLWH/A who were out of care. In response to the first unmet need estimate conducted in 2003, the Council allocated carryover funds in FY2004 to pilot an “inreach” project—a treatment adherence intervention. The Inreach pilot was conducted by the TGA’s largest HIV primary care clinic to find and follow up with PLWH/A who had missed appointments or were missing from care. After successful implementation of the pilot which brought 33 patients back into care, the Council has included Inreach on the service activity list for prioritization and allocated funds for Inreach for FY2005 through 2010. In FY2009, the Council again allocated MAI funds for Outreach to find cases of PLWH/A who know their status and are not in care. The MAI-funded Outreach program targets African Americans. In FY2009, the Council felt strongly about continuation of this service activity and allocated resources to continue a service which also targets men who have sex with men and substance abusers. In addition, MAI funds were earmarked for culturally appropriate primary care in 2009 and 2010. In 2008, the MAI funded clinic provided care for 31% of all Latinos living with HIV in the TGA.

How the Planning Council Process Addresses Changes in the Part A Award—Since becoming an EMA (now TGA), the Minneapolis – St. Paul Part A/Title I award has both declined and increased. The award decreased by five percent between 2003 and 2004 and by 2.7 percent between 2004 and 2005. The award increased slightly by 1.1 percent between FY2005 and 2006. Since a significant increase in 2007, the award has continued to increase. Although less than six percent of the TGA’s total award, the MAI portion of the award has also increased modestly each year since 2003. Based on these patterns, the Council anticipated the possibility of both an increased and a decreased award when it designed the prioritization and allocations process used for FY2009 and 2010. The Planning & Priorities Committee recommended planning for allocations based on flat funding with contingencies for increased and decreased funding amounts. If funding is decreased, allocations will be first decreased in lower prioritized support service areas proportionately and then the lower prioritized core medical services if necessary. If funding is increased, allocations will be increased proportionately with an emphasis on continuing to ensure that all core medical services are available to eligible PLWH/A residing in the TGA and that the 75% expenditure requirement for core medical services is achieved.

4.c. Funding for Core Medical Services - Attachment 7b shows Planned Allocations for services in FY2010 that meet the 75% core medical service expenditure requirement.

5. Budget and Maintenance of Effort (MOE)

5.a. Budget – See *Budget Information for Non-Construction Programs (Form 5161-1, SF 424A) and Budget Narrative Attachment.*

5.b. Maintenance of Effort

Core medical service and support service budget elements that will be used to document Maintenance of Effort:

The core medical service and supportive service that will be used to document Maintenance of Effort (MOE) beginning in FY2008 are Early Intervention Services and Housing Services. These service categories are based on local funding for HIV services that are fundable under the Ryan White HIV/AIDS Treatment Act as defined by the Secretary of the Department of Health and Human Services. These funds are provided by the three jurisdictions in the Minneapolis-St. Paul TGA that have 10% or more of the known living HIV/AIDS cases in the TGA. These jurisdictions are Hennepin County, the City of St. Paul and Ramsey County.

Tracking system used to document MOE elements. In October 2009, the Ryan White Program (RWP) Supervisor met with Hennepin County Human Service and Public Health Department's Sr. Administrative Accounting Manager to assess expenditures for services previously reported for the TGA's MOE as to their eligibility under section 2604 of the Ryan White Act as reauthorized in 2006. In addition, RWP staff contacted financial analysts for the City of Minneapolis and the St. Paul/ Ramsey Public Health Department to obtain additional detail about the services being funded that were previously included as elements in the TGA's MOE reports. The services funded by the City of Minneapolis were primarily for public school-based STI and HIV prevention programs which are not eligible to be funded under the Ryan White Act. These elements will no longer be reported as part of the TGA's Maintenance of Effort. The local government departments to report eligible HIV-related expenditures beginning with fiscal year 2008 will be the Hennepin County Human Services and Public Health Department and the City of St. Paul/Ramsey County Public Health Department.

Grantee staff will continue to use the methodology that was revised in FY2003 to document and track the Part A TGA's MOE from year to year. Documents sent to the departments reporting their MOE expenditures will be updated to describe the new MOE requirements included in the MOE Reporting Guidance issued by HRSA in August 2009 and to confirm that elements are eligible under the most recent authorization of the Ryan White Act. Already identified fiscal staff in Hennepin County's Human Services and Public Health Department's Financial Analysis and Accounting service area and the manager of St. Paul/Ramsey County Department of Public Health's Room 111 (STI/HIV clinic) will receive the materials and forms to complete, including: a cover letter requesting a report of MOE expenditures for the most recent two years; description of the MOE monitoring process; MOE expenditure reporting worksheet that includes the unit of government and department reporting, expenditures for the most recent and next most recent years, a description of the services funded and whether expenditure amounts were actual or estimated with a description of the basis used to estimate expenditures where applicable; and MOE signature document that affirms the expenditure report accurately reflects resources dedicated to eligible HIV services at the referenced governmental unit for the period indicated.

Following receipt of the completed expenditure reporting worksheet and signature documents, grantee staff will enter the MOE data into an expenditure reporting form modeled after the sample included in the August 2009 guidance issued by HRSA.

6. Clinical Quality Management

6.a. Description of Clinical Quality Management Program

Clinical Quality Management Structure, Vision, Mission and Goals –

Vision: The TGA's contracted service providers will deliver high quality care and services and be supported in their mission of providing care for people living with HIV/AIDS (PLWH/A).

Mission: To assure that PLWH/A in the Minneapolis-St. Paul TGA have access to, understand, and receive care that meets Department of Health and Human Services (DHHS) standards.

Overall Goal– Each contracted provider agency will develop expertise in maintaining a quality improvement program that meets the unique needs of the agency, its staff and its clients for timely, efficient, and effective services that ultimately facilitate PLWH/A to initiate and continue in HIV primary care.

Annual Quality Goals (AQGs) for FY2010–

AQG 1: Increase the proportion of people living with HIV/AIDS in the TGA who know their status and are in care.

AQG 2: Support the Minnesota HIV Planning Council's priority setting process through needs assessment analysis and reporting, service area reviews, and Quality Improvement project results.

AQG 3: Support contracted providers' quality improvement efforts and adherence to the TGA's "Universal Standards for Funded Programs" through training, technical assistance, and site visit activities.

AQG 4: Engage consumers of Ryan White services in learning about standards for HIV care and self advocacy for obtaining highest quality care and services.

AQG 5: Identify and implement strategies to decrease the number of people newly diagnosed with HIV who advance to AIDS within one year.

Roles of Clinical Quality Management Staff Members and Committee - The TGA has a full-time Clinical Quality Management (CQM) coordinator responsible for obtaining and evaluating annual quality work plans from each contracted service provider as well as semi-annual quality improvement progress reports. The coordinator communicates with providers about progress toward their goals and how it integrates with the Part A system-wide quality goals and efforts. In collaboration with the grantee program contract managers, the coordinator performs annual site visits and reviews a statistical sample of client records for compliance with Universal Standards and contract goals. The coordinator works with providers to promote the implementation of best practice standards, and provides training and technical assistance for providers toward that end. CQM activities are coordinated as a collaborative effort across Ryan White Parts to develop strategies that ensure HIV care is provided in accordance with DHHS guidelines. The CQM Coordinator acts as a liaison among the grantee, Planning Council, contracted provider agencies, outcomes evaluation staff, needs assessment and capacity development consultants, quality coordinators from other Ryan White Parts, Minnesota Department of Health (MDH) epidemiologists, and the Quality Management Advisory Committee.

The TGA's CQM plan and work are guided by the Quality Management Advisory Committee (QMAC), which is made up of representatives from Ryan White Parts A, B, C, D and F in Minnesota, the MN HIV Services Planning Council, the Part A outcomes evaluation and data coordinator, HIV service providers, the MDH, and community consumers. The QMAC, which meets bimonthly, has developed and revises the TGA's "Universal Standards for Funded Programs." Activities and progress in quality improvement are reported at each meeting. Aggregate information about site visit findings (including client chart audits for compliance with Universal Standards) and contracted providers' progress toward meeting quality improvement goals are reviewed by the QMAC annually. The CQM coordinator seeks consultation from committee members as needed to ensure timely completion of work plan objectives. The Ryan White Program Coordinator provides oversight and approval of the Part A annual quality work plan and its integration into the overall Part A program; serves as a member of the QMAC and provides expertise on the Ryan White Program; and supervises the CQM and Outcomes and Data coordinators. The Part A grantee budgets up to five percent of its overall annual budget to Quality Management activities.

Established Quality Management Program -

Internal CQM Program Assessments and Activities to Assess Quality of Services—The QMAC reviews and approves the Part A grantee's annual CQM Work Plan and conducts an annual quality program assessment using the "Checklist for the Review of an HIV-Specific Quality Management Plan" developed by the National Quality Center. This tool enables the annual

evaluation of the Part A program, covering 11 domains that include overall quality goals, program structure, performance measurement planning, capacity building, and evaluation.

Indicators Monitored for Outpatient Health Services and Medical Case Management—Each Part A contracted service provider in all service categories collects and submits data semi-annually through a Client Level Data System on the following indicators:

- Number and percent of program participants who are current in care (have received HIV medical care in the previous six months)
- Number and percent of participants who are not current with care and are successfully referred to receive care
- Number and percent of program participants who initiate and/or maintain health insurance coverage
- Race, ethnicity, and country of origin of HIV services participants

Medical Case Management providers also measure and report on the:

- Number of program participants in target groups: those who are homeless or in unstable housing, and those with chemical dependency or current chemical abuse issues
- Frequency with which case managed clients keep HIV medical appointments
- Need for treatment adherence support
- Need for dental, mental health, and substance abuse treatment services
- Number and types of barriers to remaining current in care addressed by case manager

Clinical measures for the funded Outpatient/Ambulatory Medical Care sites are as follows:

- CD4 counts and viral load test results reported over time for patients of two Medication Adherence programs and three Primary Care clinics
- Initial CD4 counts (health status indicator) at two Short Term Intervention clinics
- Annual number of pelvic exams and Pap screening tests completed for women patients of three Primary Medical Care providers
- Annual number of pregnant women receiving HIV medical care, and number of those who were prescribed antiretroviral medications, at three Primary Medical Care providers.

Process to Implement, Monitor, and Evaluate the QM Plan—The annual Part A QM Plan is disseminated to the Planning Council and contracted providers each year, several weeks ahead of the April 1 due date for each provider's individual Quality Improvement (QI) annual work plan. Providers are encouraged to pay particular attention to the Part A Annual Quality Goals and to set individual goals that are in support of one or more of them. The CQM coordinator evaluates each provider's annual plan and provides feedback on its relevance to overall Part A goals, feasibility, and appropriateness of planned indicators and measurements. Training and technical assistance are provided to agencies that request them. Providers' quality plans are monitored through semi-annual Quality Progress Reports that are contractually required and evaluated at the end of each contract year by comparing their reported results to Client Level Data reports, quarterly utilization and spending reports, and the Part A Annual Goals.

Activities and Plans Using Data to Demonstrate Clinical Health Outcomes—Outcomes Evaluation reports are completed on a periodicity schedule specific to each service area. Each provider agency receives its own individual results in full detail; aggregated results showing outcomes for entire service areas are made available to the providers within that service area and to the Planning Council; the Part A grantee is copied on all reports. These data are used to inform individual providers' annual quality work plans, the QMAC's annual evaluation of the TGA's quality program, and the Service Area Reviews (SARs) utilized by the Planning Council in its biennial prioritization process.

6. b. Description of Data Collection and Results

Preparation for Client Level Data Reporting—Improvement of the system-wide provider data collection and reporting system is an ongoing quality improvement project of the grantee. To analyze its current data collection process and plan for the new client level data (CLD) reporting requirements, the Part A grantee formed a Data Improvement Project Work Group together with the Minnesota Department of Human Services (the Part B grantee) and the Minnesota Department of Health (the data collection system administrator). The work group's goal was to create a data management solution utilizing a shared central database for accurate, efficient, and effective data collection and reporting. In September 2008, the Part A grantee was awarded a Special Projects of National Significance (SPNS) grant for CLD capacity building. As part of the application process for that grant, the grantee assessed each contracted provider's readiness to begin electronically submitting the required CLD elements starting in 2009, and developed a plan to assist providers to address readiness gaps in hardware, software, and staff training for data collection and reporting. Centralization of Ryan White Parts A and B data will allow all stakeholders, including providers and grantees, access to their own information in a unified and accurate manner. Additionally, federal reporting responsibilities will be maintained at each partner agency and each will be able to independently utilize their own data for planning, policy and grant development. Contracted providers attended several training sessions and have received regular newsletter updates about CLD requirements and specific ways that they will be able to use the collected data to monitor their performance on the first two groups of HAB HIV core clinical measures, and how to incorporate these measures into their annual QI work plans. The grantee will use the collected data to assess its progress on meeting its annual quality goals, in collaboration with the QMAC as it completes its annual evaluation of the Part A QI Plan.

Process for Collecting and Reporting Client Level Data—In July of 2009, providers reported all of the elements to meet HRSA's new Client Level Data (CLD) requirements collected since January 1, 2009. Those who had previously been submitting that data via spreadsheets continued to do so, and those who had been completing hard-copy bubble sheets were required to submit those, with new client level elements incorporated. All submitted data was transferred or scanned into the shared CAREWare database on the project's secure central server. Beginning on October 15, 2009, providers have direct access to their individual domains on the server, and will now directly enter and update client level information as it is obtained. In the case of five providers that had previously made major investments in other electronic data systems, technical assistance was provided to enable them to format data from their existing systems for upload to the central server. In either case, providers are required by the 15th of each month to submit all service data for the previous month. On a semi-annual basis, they are required to update and submit updated eligibility information and, in the case of Outpatient/Ambulatory providers and Medical Case Management programs, required clinical data. The Ryan White Service Report for Parts A and B will be generated from the central CAREWare database.

Data Collected—Data related to the TGA's established performance measures are collected as follows:

- All contracted providers submit data for the previous six months on all Ryan White program service recipients in July and January to the CLD system, including HIV/AIDS status; exposure category; age, race, ethnicity, country of birth, and county of residence; health insurance status and coverage type; HIV outpatient/ambulatory care visits and number and percent of referrals and follow-ups for those out of care; type and number of services provided; and financial eligibility for Ryan White services.

- Medical Case Management (MCM) Outcomes forms are completed by case managers with input from their clients and have been submitted twice annually since 2000. Custom tabs in the Minnesota version of CAREWare have been designed to include MCM Outcomes data with the HRSA-required CLD fields. Data collected on these forms include acuity scale (episodic, maintenance, or intensive case management required); issues that contribute to eligibility and need for case management services; status of client needs related to medical care, including assistance to obtain HIV medications and health insurance; treatment adherence issues; access to coverage for co-occurring conditions; access to HIV medical care, dental care, mental health or substance use services; issues related to participation in clinical trials; other client needs that impact participation in HIV medical care, including need for culturally appropriate services, food and nutrition, medical transportation, health education, home health services, and emergency financial and housing assistance.
- Clinical data are collected through the Outcomes Evaluation program at funded Outpatient/Ambulatory Medical Care sites as follows: CD4 levels and viral loads are continuously collected at three Primary Care providers, two clinics providing Medication Adherence services, and two Early Intervention Services providers. All findings are reported semi-annually as part of Ryan White Service Reports. The Primary Care providers, which are also Part C or D grantees, also report on antiretroviral medication status, screenings for TB, sexually transmitted infections, Hepatitis B and C, substance use and mental health issues, Pap smears, pregnancy status, prenatal care, and prescription of antiretrovirals for vertical transmission prevention.

Data Collection Results—Comparative CLRS results for calendar years 2006-2008 are shown below for the key measures of accessing care in the previous six months and being referred if not current in care:

Client Level Reporting System Quality Indicators 2006-2008 Findings									
Program	Number of CLD Cases			Accessed Care			Out of Care and Referred		
	2006	2007	2008	2006	2007	2008	2006	2007	2008
Medical Case Management	1856	1556	2087	65%	89%	89%	19%	19%	16.3%
Outreach	165	107	106	70%	84%	83%	25%	67%	46.0%
Education/Self Advocacy	508	369	274	58%	83%	85%	6%	15%	21%

This table does not reflect a quality improvement initiative undertaken by the TGA just prior to the July, 2006 report. To address the unacceptably large number of clients whose care status was reported as “unknown” on the 2005 CLRS reports, training and technical assistance were provided to all reporting agencies. The resulting decrease in “unknown” reports coincided with an increase in “no” responses to the question “Has the client received HIV medical care in the past six months?” This created a larger denominator for the pool of clients to be referred to care. Since these results were shared with case management providers, they have increased their efforts to assess and assist clients to keep medical appointments, resulting in an increase in the percent of clients who had accessed care in the 2007 reporting periods that was maintained in 2008. Primary Care outcomes for patients at two clinics show a change in mean CD4 count from 326 at baseline to 353 among patients with three reported CD4 counts, and a change in mean viral load counts from 48,238 at baseline to 17,316 for patients with three reported viral loads.

How Data Are Used to Improve or Change Service Delivery—The Planning Council uses reported results of the TGA’s CQM program in its biannual priority setting process. The CQM coordinator regularly reports on quality improvement progress to the Council’s Needs Assessment and Evaluation committee. This committee is responsible for compiling all data into understandable formats for Council members to use in prioritizing services and allocating both Part A and

Part B base award funds. Outcomes Evaluation results are summarized as 31 service area reviews and made available to the Planning Council in advance of its prioritization and allocation process. The CQM program's system-wide effort to measure progress in getting PLWH/A who are aware of their status into care helps the Planning Council to focus its priorities and allocations on addressing unmet need. This is reflected in the two overarching goals in the 2009–2011 Comprehensive Plan: 1) Increase the percentage of Minnesotans living with HIV/AIDS who receive quality HIV medical care and to engage PLWH/A in HIV medical care soon after diagnosis; and 2) Ensure a continuum of service, including culturally appropriate services and geographic parity, to engage PLWH/A in HIV medical care soon after diagnosis and to maintain their engagement and adherence to medical care over time.

Quality Improvement Projects– The Part A Clinical Quality Program's overarching goal is to increase the number of people living with HIV/AIDS in the TGA who access and maintain HIV medical care that meets DHHS guidelines for the treatment of HIV. All agencies providing Ryan White-funded services are required to document how they assessed their clients' current care status, defined as whether they have had an HIV medical visit in the previous six months, and provided referrals and follow-up to those who are not current. Providers whose CLD findings show less than optimal participation in care are strongly encouraged to focus their QI work plans on improving this measure. Expectations are that Primary Care and Medical Case Management providers will have higher rates of clients who are current in care than those who provide brief transactional services such as Emergency Financial Assistance or Food services, so there is no single benchmark for the spectrum of service providers. The CQM coordinator works with contracted providers to achieve their initial goals and develop and implement quality improvement interventions based upon CLD data and service-specific outcome measures.

The CQM coordinator is the project leader on the Data Improvement Project, a cooperative effort with the Part B grantee and the Minnesota Department of Health STI and HIV Section with the goal to improve client level data collection, analysis and reporting. The grantee's CQM coordinator and program contract managers have designed and implemented a process to evaluate each service area, incorporating HRSA guidance and national benchmarks to define each service area, identify service goals and related objectives, develop process and outcomes measures including utilization, a rating of how well measures match and support program goals and objectives, an understanding of how costs per client and per unit of service vary among contracted providers of that service, and determination of what additional measures need to be instituted. The process then uses the identified data sets to arrive at an effectiveness and gap analysis for the service area and concludes with recommendations, including those on how outcomes evaluations for the service area should be changed or added, and goals for quality improvement. The grantee has added a permanent Outcomes and Data coordinator position during FY2009, and an important focus of that position will be to assess the completeness and validity of the various data sets collected by the grantee and recommend ways to both improve data collection and coordination and to incorporate findings into quality improvement activities.