

**Minneapolis-St. Paul TGA Application for 2012 Ryan White HIV/AIDS
Treatment Modernization Act Part A Funding**

PROJECT NARRATIVE

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x. Program Narrative

1) Demonstrated Need

1) A. HIV/AIDS Epidemiology.

(1) AIDS and HIV incidence and prevalence data for the Minneapolis–St. Paul TGA are presented in **Attachment 3**. The Minnesota Department of Health (MDH) and the State of Wisconsin’s HIV/AIDS Reporting Systems (eHARS) collect names-based AIDS and HIV infection data through a passive and active surveillance system. MDH data also include country of birth, which assists in understanding how the epidemic is emerging among African-born and Latino people living with HIV/AIDS (PLWH).

(2)(a) **Demographic Characteristics.** The Minneapolis-St. Paul Transitional Grant Area (TGA) comprises eleven Minnesota counties and two Wisconsin counties with a total population of 3,296,046. According to data from the two states’ eHARS, as of December 31, 2010 there were 3,187 individuals living with HIV (non AIDS) in the TGA, a 4.4% increase over 2009. An additional 2,757 individuals were living in the TGA with AIDS. Included in these were 497 new cases reported from 2008 through 2010. The TGA had fewer new infections in 2010 than in 2009, with a 9% increase, but still saw the second largest number of new infections since 1996. Of 6,814 Minnesotans living with HIV/AIDS, 87% live in the TGA. Pierce and St. Croix Counties in Wisconsin accounted for less than 1% of the TGA’s cases. The local epidemic continues to be centered in the Twin Cities of Minneapolis-St. Paul, with 55% of Minnesota’s PLWH. There has been a gradual shift to more cases in the suburban areas, which account for 31% of Minnesota’s HIV/AIDS prevalence. Of new infections in the TGA in 2010, 29% were among suburban dwellers.

(b) **Disproportionate Impact.** Men who have sex with men (MSM) is the group most affected by HIV in the TGA. MSM account for 58% of all HIV cases and 49% of AIDS cases diagnosed in 2008-2010. There was a 66% increase last year in the number of new HIV infections among MSM. Age is an important factor to determine trends; 16% of new infections in 2010 were among youth (age 13 – 24). Specifically among young men there has been acceleration from 18 cases in 2002 to 67 cases in 2010 (a 272% increase). Youth of color account for a disproportionate number of new HIV infections. Among young men, African Americans and Hispanics (each representing 3% of the population) accounted for 37% and 10% of new infections, respectively. Among 11 newly diagnosed young women, half were women of color; 75% of female PLWH in the TGA are women of color. Trends in the annual number of HIV infections diagnosed among females differ by racial and ethnic group. Women of color make up approximately 11% of Minnesota’s female population and accounted for 62% of the new infections among women. White women make up about 89% of the female population, but account for only 25% of those living with HIV/AIDS, while African American women represent 29% and African-born women 30%. Six percent are Hispanic. According to the 2010 MDH Epidemiological Profile, there were 1,363 African Americans (U.S. born) living with HIV/AIDS in the TGA in 2010—an increase of 3.5% over the previous year. Similarly, there were 777 African-born PLWH, compared to 751 in 2009. In the past three years, of the 189 blacks newly diagnosed with AIDS, 39% are African-born. Hispanics also make up a larger proportion of the local epidemic, with 8% (484) of living HIV/AIDS cases. At 5% of the population, they are disproportionately impacted, comprising 12% of new AIDS cases between 2008 and 2010. Fewer than 2% are American Indian/Alaska Native, or Asian.

Census data show a 600% increase in the number of African immigrants in Minnesota between 1990 and 2000. The Minnesota state demographer estimated 62,612 people living in

Minnesota were born in African countries. Prior to 2010, immigrants with HIV/AIDS were not permitted entry into the United States; through a special medical waiver program 188 HIV-positive African refugees arrived from 2000 to 2008. New HIV infections among African-born men and women have been documented each year since 1997. From 2008-2010, there were 73 newly diagnosed AIDS cases among African-born people living in the TGA, who at 13% of the local epidemic but make up less than 2% of the TGA's population. Overall, African-born individuals accounted for 10% of new AIDS cases in 2010.

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 6,592. IDUs comprise 13% of the Minnesota AIDS cases, 11% of all living HIV/AIDS cases and 8% of AIDS cases diagnosed in the TGA during the three-year period ending December 31, 2010. Among women, IDU is the second most common mode of transmission (after heterosexual contact) making up 15% of cases among women.

In 2010, 23% of new HIV infections in Minnesota were among youth; this is the second highest increase for this group (only 2009 was higher). MSM was the predominant mode of exposure among adolescent and young adult males, accounting for an estimated 96% of new HIV infections. While 99.5% of the TGA's living AIDS cases are adults over age 19, the TGA has 12 living AIDS cases in children or youth under the age of 19. There are 65 youth under 19 years of age living with HIV (not AIDS). There were two new cases of HIV infection in 2010 among children younger than 13 years.

The TGA includes several suburban, semi-rural and rural counties surrounding Minneapolis and St. Paul. Historically, most new HIV infections (including AIDS at first diagnosis) in Minnesota have occurred in the TGA. This trend continued in 2010 with 42% of new infections among residents of Minneapolis, 15% in St. Paul, 29% in the suburbs, and 15% outside the TGA. Of all new HIV cases in Minnesota, 30% were either AIDS at first diagnosis or progressed to AIDS within one year. Since 2000, the percentage of newly diagnosed persons progressing to AIDS within one year has remained at around 30%. However, this overall stability masks important differences by race and ethnicity. While the rate of new cases progressing to AIDS within one year among whites and African Americans is 30%, this percentage is significantly higher among Hispanics (47%) and African-born (35%). Most of the cases among Hispanics were among foreign-born individuals.

In its 2009 *Homelessness in Minnesota*, Wilder Research Center estimated that 9,654 individuals (of which 13% were unaccompanied youth) were homeless at some time in 2009. Two percent of respondents in metropolitan areas indicated that they have tested positive for HIV, and 91% of those indicated they had accessed medical treatment in the previous 12 months. Data from the Federal Bureau of Prisons and Minnesota Department of Corrections indicate that 16 HIV positive individuals were released from federal facilities in Minnesota during 2010, and 38 from state facilities. Information from the corrections departments of the TGA's two largest counties indicates that a total of 37 HIV-positive people were released during 2010; however, since the majority of them were identified as positive by self report during brief incarcerations (averaging six to seven days), the actual prevalence among this group may be much higher.

In summary, these data portray an expanding and evolving epidemic in the TGA, with MSM continuing to experience the greatest impact. Additional trends include the following:

- In 2010, the TGA had the second highest number of new HIV infections since 1996
- There was a 66% increase last year in the number of new HIV infections among MSM
- Communities of color comprise a disproportionate share of HIV/AIDS cases

- The number of positive women continues to increase, particularly black women
- Urban counties are more impacted, with 88% of HIV+ Minnesotans living in the TGA
- New HIV infections among young men are increasing; 95% of positive young men are MSM.

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

(c) Populations Underrepresented in HIV Primary Medical Care – Comparing the TGA's client-level data (CLD) with the epidemiological profile, it appears that whites and MSM are underrepresented in the Ryan White funded system of HIV primary medical care; however, the 2010 Ryan White CLD represents only a partial picture of the HIV system of primary medical care. Minnesotans have historically had access to health insurance through public programs or the purchase of health insurance for PLWH. This has reduced the need to use Ryan White Part A funds to directly support primary medical care and allowed funds to be used to create a comprehensive system of services that support access to medical care. To address disparities in access to HIV medical care, in 2010 the Planning Council allocated 30% 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 services to Latinos, with a resulting increase in this group's representation in utilization data. Thus for 2010, of those utilizing Ryan White-funded primary care, 13% were Latino and 31% were white. The largest group utilizing primary care was African American at 47%. Men and women accessed primary care at rates more reflective of the epidemic, with 70% men and 29% women seen in primary care. Early Intervention Services served 49% whites, 27% African American and African born, and 33% Hispanic individuals.

Since 2003, undocumented individuals, except pregnant women, are no longer eligible for publicly-funded Minnesota Healthcare Programs. In that same year, income eligibility guidelines for state-funded insurance for the working poor changed to 75% of FPL. These changes will continue to disproportionately impede the ability of African Americans, new immigrants, Latinos and Native Americans to access primary care.

(d) Estimated Level of Service Gaps – According to 2010 service utilization data, 3,427 unduplicated individuals living with HIV/AIDS, out of a possible 5,944 in the TGA (58%), received some type of service within the Ryan White Part A- and B-funded care system. Of the people in Ryan White services, 43% are white, 27% African American, 11% African born, 11% more than one race, 10% Hispanic, 2% American Indian, 1% Asian, 3% other, and 1% are of unknown race. Living HIV/AIDS cases in the TGA are 51% white, 36% African American or African-born, 8% Hispanic, 1.6% American Indian, and 1.6% Asian. Males comprise 78% of all cases living with HIV/AIDS in the TGA and account for 72% of the clients receiving services. Self identified MSM may be under-represented in the Ryan White system comprising only 49% of those utilizing a Part A or B funded service in 2010.

The Minnesota HIV Services Planning Council conducted a Needs Assessment Survey among PLWH in 2010 that asked whether participants had needed but not received HIV care and related core medical and support services in the previous 12 months. Two percent needed but did not receive HIV medical care although 13% didn't seek care until a year or more after diagnosis.

Fourteen percent needed dental care.. While 4% reported an unmet need for Mental Health treatment, 9% said they needed but did not get emotional support services. Emergency Financial Assistance (EFA) was needed but not received at a rate of 11% for utilities; 10% for food, and 11% for rent. Direct assistance needs were unmet at a rate of 10% for Food Vouchers; 6% Food Shelf; and 7% Transportation.

1) B. Impact of Co-morbidities on the Cost and Complexity of Providing Care

(1) The levels of comorbidities for the TGA population are presented in **Attachment 4**.

(2) PLWH who are uninsured, homeless, living in poverty, affected by substance use, have severe mental illness, have sexually transmitted infections (STIs) or other co-infections, or were recently incarcerated face additional challenges to access services because systems of care are not well integrated. Those born outside of the United States encounter additional linguistic and cultural barriers to care. As PLWH contend with these issues it may become difficult for them to access services, attain economic self-sufficiency and stable housing, and adhere to complex medical care and medication regimens. The grantee has collected quantitative data on HIV comorbidities, insurance status and poverty in the TGA from the Minnesota Department of Health (MDH), Wisconsin Department of Health Services, the U.S. Census Bureau, local and national reports, and service provider data. Although data are available for several comorbidities, their rates among PLWH are difficult to determine because other service systems often do not collect HIV related data. Linkages between systems of care are limited and PLWH 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 care and its costs for PLWH in the TGA. Data collected since 2009 through the TGA's improved client level data system provides detail about the following comorbidities among PLWH who access Ryan White funded services.

(a) Sexually Transmitted Infections (STIs). The MDH reports that although overall incidence rates for STIs in Minnesota are lower than those in many other areas of the United States, certain population subgroups in Minnesota have very high STI rates. Particularly affected are adolescents, young adults, and persons of color. In 2010 the number of reported bacterial STDs increased to 17,760 cases, representing an overall increase of 5% from the previous year. The change in incidence rates varied by disease, with chlamydia increasing by 6%, primary/secondary syphilis increasing by 110% and gonorrhea decreasing by 9%.

Since 2002, syphilis rates have fluctuated but remained elevated, with an increase from 83 in 2002 to 221 in 2010. MSM accounted for 89% of all cases among males in 2010. Racial disparities in STIs persist in Minnesota with communities of color having the highest rates. Adolescents and young adults (ages 15-24) accounted for 69% of chlamydia and 65% of gonorrhea cases reported in 2010. Sexually transmitted infection rates are likely higher among PLWH compared to the general population. Based on 2010 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 \$540 per patient. Antibiotic treatment costs range from \$8-\$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. About 10% of participants (58 of 567) in the 2010 Consumer Needs Assessment reported that they had been treated in the previous 12 months for an STI. This rate is consistent with reports from the MDH for 2010, which note that STI rates continue to be

highest in the city of Minneapolis and Twin Cities suburbs. Co-infection with an STI may add up to \$329,300 to the annual cost of care for PLWH in the TGA.

(b) Homelessness. According to *Homelessness in Minnesota* (Wilder Research Center, 2010) an estimated 6,565 homeless individuals lived in Minneapolis-St. Paul in 2009, including 591 unaccompanied youth. Two percent of homeless adults interviewed reported that they were HIV positive. Another 3% reported having a STI other than HIV. People of color are vastly overrepresented among the Twin Cities' homeless population, with 57% identified as African American and 8% American Indian. In 2010, Ryan White client-level data indicated that 11% of service recipients in the TGA were homeless at some time during the year or in unstable housing. According to *Homelessness in Minnesota*, mental illness and drug abuse are prevalent among homeless adults. The report estimates that 59% have a serious mental illness. Twenty-nine percent have a diagnosis of drug or alcohol abuse disorder. These additional comorbidities are significant barriers to entering and maintaining primary HIV medical care. Homeless patients are more likely to visit emergency rooms, are hospitalized more frequently, stay in the hospital for longer periods of time and have poorer health outcomes. Eighteen percent of respondents said they were not taking a needed medication, and 50% said they were not getting needed medical care due to financial issues. 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. Many homeless PLWH will require intensive assistance through Medical Case Management (MCM) to access mental health or substance use treatment, shelter and supportive social services before successful treatment for HIV is likely. Based on the TGA's unmet need estimate of 24% of PLWH (1,427), an estimated 11% rate of inadequate housing among the TGA's PLWH (157) and an average per capita annual MCM cost of \$1,344 in 2010, providing MCM services to those out of care could add an additional \$211,000 to the cost of care for homeless PLWH.

(c) Uninsured. According to the *2009 Minnesota Health Access Survey* (updated January 2011), the rate of uninsurance in 2009 was 9% for Minnesotans; applied to the population of the TGA that comes to 296,644 non-elderly uninsured. About 29% had health insurance coverage through a public program (including Medicare). People with the lowest family incomes—at 100% of FPL—had uninsurance rates of 18%, while those with incomes from 101-300% of FPG were uninsured at a rate of 15%. Members of minorities are more likely to be uninsured than whites. Statewide, 29% of Latinos, 16% of African Americans, and 19% of American Indians were uninsured in 2009, compared with 8% of whites. Minnesota has an array of public programs in which PLWH can enroll. Client level data show that in 2010, 21% of Ryan White program recipients were enrolled in Medicaid. Fourteen percent had Medicare coverage and another 10% were enrolled in other publicly-funded healthcare programs. Minnesota's Part B funded HIV/AIDS Insurance and ADAP Program provided assistance to 36% of Ryan White program participants in the TGA. Needs Assessment data from 2010 indicate that 29% of respondents had been uninsured for at least one 3-month period since their diagnosis.

In FY2010, \$932,935 in Part A and Part A MAI funds were expended on Primary Care and Early Intervention Services for 761 of the TGA's uninsured and under-insured PLWH. The average Part A expenditure per patient was \$1,226. All three Part A primary care providers are funded for Medical Case Management and one provider is funded to provide Benefits Counseling through its Part C grant. Most patients receiving Part A primary care are uninsured temporarily. Additional costs for MCM are incurred to keep them connected to care.

State Medicaid Program and Medicare. Minnesota's Medicaid program (MA) covers basic healthcare services as well as HIV medications. MA affords some of the most comprehensive benefits in the country, including an expansive drug formulary without limiting the number of prescriptions or dollar amounts per month. Recipients pay \$1-3 per prescription up to a maximum of \$7 per month. In response to changing needs, the Minnesota Legislature has changed income eligibility standards for MA to include single adults living at or below 75% of FPL and former recipients of the defunct General Assistance Medical Care program. In 2010, 13% of the TGA's population was enrolled in Medicaid (**see Attachment 4**). Client level utilization data show that 23% of PLWH in the TGA who accessed a Ryan White funded service in 2010 were Medicaid recipients, with estimated expenditures of \$20,125,639 or 71% of the cost of publicly funded HIV outpatient medical care. The average per-capita annual expenditure on outpatient care for a PLWH enrolled in MA in 2010 was \$16,941. In 2010, Medicare provided coverage for an estimated 15% of PLWH in the TGA and also for 14% of those who utilized Ryan White services. Ryan White Parts A and B provided wrap-around services to most of the TGA's Medicare recipients living with HIV. Minnesota's ADAP program provided support to cover the Medicare Part D "donut hole" coverage gap for 117 PLWH in the TGA in 2010. While filling few medical care gaps for Medicaid and Medicare recipients, Ryan White programs help clients access care. Medical Case Management, Benefits Counseling, Outreach, Transportation, Emergency Financial and Housing Assistance, Food & Nutrition, and other services allow people to access and remain in care. MCM is critical for Medicaid recipients. In FY2010, MCM outlays accounted for 43% of all Part A funds spent on services, supplementing a state appropriation for MCM services. Part A funds will account for 60% of the TGA's MCM budget in FY2011. This high priority service area is ranked fourth in the Planning Council's 2011-2012 prioritization.

(d) Persons Living at or below 300% of Federal Poverty Guidelines. Minnesota has fared somewhat better than the nation as a whole in regard to poverty and income. By applying poverty level data from the American Communities Survey to 2010 data from the U.S. Census Bureau, the number of persons living below 300% of poverty in the TGA is 1,149,019 or 35% of the population. The MDH Health Economics Program (2005) report estimates that 9% 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 most difficult for those who are not poor enough to qualify for Medicaid or other publicly funded healthcare programs. Participants in the 2010 Consumer Needs Assessment accessed Emergency Financial Assistance (EFA) to address barriers to HIV medical care as follows: 31% to pay utilities; 31% to pay for food; and 23% for housing to forestall eviction. A total of 51% accessed a food shelf in the previous twelve months. In FY2010, combined Part A and Part B expenditures on EFA (including housing support) reached \$470,335 and helped 1,112 PLWH avoid eviction and pay utility or medical bills.

(e) Trends in Services and Fiscal Resources as a Result of Municipal and State Budget Cuts. As a result of Minnesota's economic downturn and the associated decreases in income and property tax revenues, state budget decisions will impact a variety of clinical and non-clinical HIV services in 2012. Since Minnesota is one of the earlier states to adopt Medicaid expansion under the 2010 Affordable Care Act, direct funding for HIV clinical services has so far been spared from cuts, but the growth in both the epidemic and the number of PLWH utilizing Ryan White funded services in an atmosphere of flat funding presents a challenge to ensuring access to care. Following the elimination in 2010 of Minnesota's General Assistance Medical Care (GAMC) program, designed to be a safety net for the medically indigent who do not qualify for

Medicaid, more PLWH were moved onto Medical Assistance in July of 2011. Recent changes made by the Minnesota Legislature to Minnesota Care, the state's subsidized insurance program for working people who are uninsured, require single adults with incomes $\geq 200\%$ of FPL to purchase private insurance and apply for reimbursement. While a small number of PLWH will lose their Minnesota Care eligibility, it is likely they will need assistance in enrolling in private insurance and paying the premiums so they do not lose health coverage. Other recent changes still being studied for their potential impact on PLWH include a cap on Medicaid waiver programs that allow disabled individuals (including PLWH) to receive subsidized services for home and community-based health services and a reduction in a Mental Health services block grant that will affect residents of the TGA. Hennepin County Medical Center is the largest HIV medical care provider in Minnesota and also the state's safety net hospital. Its Positive Care Clinic provides HIV medical care through Ryan White and other funding for services beyond what MA covers. This program operated at a loss of almost \$2 million in 2010, while the Infectious Disease Clinic treating PLWH at Ramsey County's safety net hospital lost more than \$500,000. In addition, the city of Minneapolis reduced its contribution to the Neighborhood Healthcare Network for HIV counseling and testing by \$42,000 in 2010. The Part A grantee expended \$898,424 to provide Outpatient Ambulatory care services to 716 clients in FY2010.

(3) Formerly Incarcerated PLWH. According to the Federal Bureau of Prisons, 41 individuals living with HIV or AIDS were released in 2008-2010 from federal facilities in Minnesota. The majority (99%) were from the Federal Medical Center located in Rochester. According to the Minnesota Department of Corrections (MNDOC), 90 PLWH were released in 2008-2010 from state correctional facilities. The MNDOC began routine screening for HIV at its St. Cloud facility in October, 2007 and at the Shakopee facility in January, 2008. Shakopee houses all female residents and St. Cloud is where all males entering the correctional system begin their sentences. Routine HIV testing is not conducted within the corrections system at the local level. All TGA county correctional facilities have an initial health screening form completed by medical personnel during intake. 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. The Hennepin County Corrections nursing supervisor estimates that approximately 36 individuals living with HIV were incarcerated at the workhouse facility and released in 2010. The Ramsey County Corrections section manager said one PLWH incarcerated at its workhouse was released in 2010. 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+ individuals in local facilities is much higher, there is little incentive for a detainee to request testing or identify as HIV+ 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. MCM services would likely assist PLWH being released from incarceration in staying in or reconnecting to care. Estimating that a minimum of 171 PLWH are released from Federal, State and the TGA's two largest counties' facilities annually, providing MCM services to the formerly incarcerated may add \$214,776 to the cost of care.

1) C. Impact of Part A Funding Mechanisms

(1) Report on the Availability of Other Public Funding

(a) See **Attachment 5** for a summary of other public funding available for HIV services during FY2011 and other public funding anticipated to be available in FY2012.

(2) Coordination of Services and Funding Streams

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

i) Medicaid. So that priority setting and resource allocation consider Medicaid and other state-funded healthcare programs, the grantee and Planning Council ensure that: 1) The Minnesota Department of Human Services (DHS), the Part B grantee and agency responsible for Medicaid and all other state-funded healthcare programs, is a party to the Intergovernmental Agreement (**Attachment 2**). DHS has two seats on the Council: one from the state Medicaid office and one from the Part B grantee office; 2) Staff from DHS sit on the Planning & Priorities and Needs Assessment committees, which are responsible for priority setting, long-range planning, resource allocation and standards development; 3) The Parts A and B grantees monitor program usage and identify emerging issues related to the coverage of healthcare services and medications; 4) DHS staff determine eligibility of PLWH who may qualify for state-sponsored insurance and 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 DHS on the number of PLWH enrolled in all Minnesota Healthcare Programs (MHCP), including Medicaid, and spending on HIV outpatient medical care, dental care, mental health and chemical dependency treatment services and home and community-based support services.

ii) Medicare. In 2010, 482 PLWH in the TGA who received Ryan White Part A and B funded services (14%) were enrolled in Medicare. Through ADAP and the HIV Insurance Program, Minnesota's Part B grantee provides additional assistance to PLWH with incomes at 150-300% FPL who are enrolled in Medicare Part D. A state appropriation provides support for the HIV Insurance Program. For FY2011, the Planning Council allocated \$109,000 in Part B funds to provide benefits counseling (non-Medical Case Management) to help PLWH identify the most comprehensive private and public healthcare programs to ensure continued access to affordable treatment. This helps PLWH who are Medicare eligible to enroll in the Part D prescription drug plans and "extra-help" programs. DHS provides the Council with information on the number of PLWH on Medicare who are also enrolled in ADAP and the HIV Insurance Program. In 2010, DHS provided 117 PLWH on Medicare with assistance to alleviate the prohibitive out-of-pocket cost of the Medicare Part D "donut hole."

iii) Children's Health Insurance Program (CHIP). The number of children aged 19 or younger living with HIV/AIDS in the TGA as of December 31, 2010 remains relatively small at 76 (1% of prevalence). Most low-income children with HIV can get coverage under Medicaid or MinnesotaCare (the state's CHIP). Because of this, few children access Ryan White funded insurance or drug programs. A representative from DHS sits on the Planning Council and provides information about MinnesotaCare and other DHS programs to reduce duplication of services.

iv) Veterans Affairs Programs. The Veterans Administration Medical Center in the TGA has an HIV specialty clinic that currently provides care to 153 patients. Veterans have access to the same comprehensive drug formulary as Medicaid offers and most veterans with HIV receive comprehensive services through the VA system. Veterans use other Ryan White funded services that are not part of VA benefits, including medical case management, health education, food bank/home delivered meals and medical transportation services.

v) Housing Opportunities for Persons with HIV/AIDS (HOPWA). 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 Planning Council member and the Council Coordinator participate in the Minnesota HIV Housing Coalition. The co-chair of the Housing Coalition presented an update

on HOPWA funded services at the Planning Council's June 2010 meeting as part of the informational sessions to prepare the Council for prioritization for fiscal years 2011 and 2012. The Council received a HOPWA update at its September 2011 meeting. The TGA's largest AIDS service organization is a subrecipient of state formula HOPWA funds and also has a Part A contract to provide rental assistance through its emergency financial assistance program. The grantee works closely with this agency to coordinate Part A, Part B, and HOPWA funds.

vi) CDC Prevention. The grantee and Planning Council have a long history of coordination with the CDC grantee (MDH). 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 improve coordination between care and prevention. The plan culminated in the expansion of 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 prevention, care and the TGA's EIIHA effort.

Minnesota's State AIDS Director is a member of the Planning Council and provides a monthly update on CDC and state-funded HIV prevention funding and programming at Council meetings.

vii) Services for Women & Children. Thirty-five percent of women and children (<13 years) living with HIV are enrolled in Medicaid or another Minnesota Healthcare Program. Food support services and substance use treatment for pregnant women are considered in the planning process in several ways. First, a Women & Families service provider network, convened by West Side Community Health Services (WSCHS) in St. Paul, meets regularly to coordinate HIV service needs of women and children. WSCHS also receives Part A funding to deliver Medical Case Management, culturally appropriate Primary Care, Mental Health and Health Education/Risk Reduction services. Second, WSCHS's HIV health educator is a member of the Planning Council's Community Voice Committee. Staff from state and local agencies administering programs such as WIC and substance use treatment programs participate in the Planning Council or its committees. Finally, providers of services for women and children also contributed to the 2009 Statewide Coordinated Statement of Need.

viii) 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.

ix) Local, State, and Federal Public Health Programs. The Part A grantee office is colocated with the Hennepin County Public Health Clinic, which is the largest local public health agency in Minnesota, serving 35% of the TGA's population. In 2010, the clinic diagnosed 52% of new HIV infections identified in the TGA and provided STD testing and treatment through 11,230 patient visits. Part A funds the County's Public Health Clinic for Early Intervention, Outreach, Health Education/Risk Reduction and Mental Health Services. As a result, Part A funding is closely coordinated with the state's largest CDC-funded HIV counseling, testing and referral provider. The Public Health Clinic also receives both CDC and state funding for HIV and syphilis prevention targeting MSM. The Part A grantee coordinator is a member of the Minneapolis Public Health Advisory Committee and meets with Minnesota's STD and AIDS Director from the MDH monthly to coordinate local and state prevention and care funding and programming.

x) Federal, State and Local Funds for Substance Abuse and Mental Health Treatment. The DHS also administers state and federally funded substance use services and provides key information for the Council about how substance use treatment services are funded and utilized by PLWH enrolled in Medicaid and other publicly funded healthcare programs. In general, treatment on demand is available for low income PLWH. Treatment services are paid for through the state's Consolidated Treatment Fund supported through a Substance Abuse and Mental Health Services Administration Block Grant. The Council's FY2011 allocations include \$139,500 in 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 substance use treatment funded through other public sources and ensure that a continuum of care exists for PLWH who are substance users. In addition to DHS's oversight of substance use treatment services, its staff participates in the planning, priority setting and allocations processes. The DHS also provides training for substance use treatment centers on appropriate care and resources for PLWH.

xi) Other Ryan White Program Funding. Representatives from all Parts of the Ryan White Program participate in HIV services planning to ensure coordination of federal dollars. The Part A grantee, DHS (the Part B grantee) and MDH (the CDC Prevention grantee) meet quarterly to coordinate budgets and spending and plan for efficient disbursement of federal and state dollars. Minnesota has two Part C programs, Hennepin County Medical Center (HCMC) and the Rural AIDS Action Network. 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 first Intergovernmental Agreement in 1995 established the Planning Council as a joint Parts A and B planning body, thus Part A and B services and funding are prioritized and allocated together. This ensures that funds are allocated efficiently and effectively, and resources are maximized for core medical and supportive services. The planning process has worked well to meet the needs of PLWH since the TGA has always been the epicenter of Minnesota's HIV epidemic, with 86% of the state's PLWH. Many PLWH in greater Minnesota travel to 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 the State HIV insurance continuation program.

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 principles 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. Reimbursement methods and standards for service delivery are uniform across providers regardless of which government agency manages contracts. The principles prevent duplication of state and local funding of HIV services.

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. Part A MAI funds allocated to Outreach services and ADAP MAI funds are used to connect African American and African-born PLWH who know their status. Further coordination with other Ryan White programs comes from the involvement of the Part B, C and F (MATEC) grantees in planning activities. Part C supports a collaboration of Hennepin County Medical Center in Minneapolis and Health Partners Specialty Clinics in St. Paul. Representatives from Part C sit on the Planning Council. Staff from West Side Community Health Services, which received Part D funding until 2011 and is

currently a Part A contractor, are a voice for the needs of Latino PLWH. A representative from West Side sits on the Council. 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 Quality Management Advisory Committee (QMAC). The Planning Council regularly considers the TGA's Part C resources in allocating funds to prioritized services as the Council's Part C representative shares information about its program and funding. The coordinator of the Midwest AIDS Training and Education Center (MATEC) is also a member of the QMAC. Both Part A and Part B grantee directors attend the annual regional AIDS Training and Education Center Policy Training and Advisory Council.

1) D. Assessment of Emerging Populations with Special Needs

(I) The HIV epidemic in Minnesota is driven by sexual exposure, primarily among MSM, the largest percent of those living with HIV/AIDS (59%) and new cases (49%) in 2010. Among females, heterosexual contact is estimated to account for 83% of prevalent HIV infections as of 2010. Racial and ethnic minorities are affected disproportionately, especially African Americans who are over-represented in every risk group. The number of African-born PLWH continues to increase. New cases among Latino men amounted to 204 for 2004-2010, with 29 new infections in 2010 alone. The changing epidemic, in combination with the significant presence of comorbidities and flat funding for healthcare, exacerbate 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. There are service delivery challenges for all of these populations. The following table provides estimates of these six populations in the TGA along with HIV and AIDS prevalence:

2010 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		16	134	150
25 – 49 years		913	1,218	2,131
50 years and older		611*	520	1,131
Men of color who have sex with men (includes MSM/IDU) by race/ethnicity:	7,379 [†]			
Black/African American		283	314	597
Latino		137	126	263
Asian		16	25	41
American Indian		23	19	42
Other		13	27	40
Women of color (≥ 13 years)	154,174	455	546	1,001
Latinos/Latinas	99,121	269	211	480
African Americans	157,962	650	708	1,358
African-born Immigrants	35,000 – 50,000	375	402	777
3,296,046 U.S. Census Bureau Estimates of TGA Population (2010).				
* Excludes 2 MSM cases missing age information.				
[#] Estimates by age category not available. [†] Estimates by race/ethnic category not available.				

Each population presents unique challenges and has its own service gaps. Data sources used to estimate the costs of services for emerging populations include: 2010 client level service utilization data; 2010 HIV/AIDS prevalence data (Minnesota Department of Health and Wisconsin Department of Health Services); and FY2010 Part A and Part B base (not ADAP) expenditures on medical and support services.

Men Who Have Sex with Men (MSM). (a) Unique Challenges: Hennepin County's 2010 Survey of the Health of All the Population and the Environment (SHAPE 2010) estimates the number of respondents who identified as gay or bisexual at 9%, compared to the CDC estimate that 4% of the U.S. male population has sex with men. The county epidemiologist estimates that from 3 to 7% of MSM in the TGA have HIV infection. For Hennepin County alone, the estimate is between 6 and 14%. With the next highest prevalence among demographic groups at 2% for African born (statewide), the continued impact on MSM is clear. The number of HIV+ people in this group encompasses 54% of all PLWH in the TGA. Those who are not open about their same-sex activities remain difficult to reach. Issues related to mental health and substance use are probable contributing factors for MSM who fail to learn of their HIV status or who know their status and do not connect to care. A total of 349 men who identified as gay or bisexual participated in the Minnesota HIV Services Planning Council's 2010 Needs Assessment. Of those, 53% said they had been diagnosed with mental health issues, and 30% with substance abuse or dependency. Three percent of respondents said they needed, but did not get, mental health services in the prior year. Young MSM, particularly those who are homeless or engage in sex work or heavy drug use, are often difficult to bring into the service delivery system. New infections among young men in Minnesota are increasing. MSM was the predominant mode of HIV exposure among adolescent and young adult males, with an estimated 96% of the new HIV infections diagnosed between 2008 and 2010. New infections among young MSM increased by 83% in 2008-2009. In 2010, new cases dropped to 67, but still remained above the 2008 count of 44 cases. Since 2001, the number of cases among young males has increased by more than 300%.

(b) Service Gaps: Sixty percent of men who identified as gay or bisexual in the 2010 Needs Assessment survey stated they had received a Ryan White funded service in the prior year and 96% said they had received HIV medical care. While this is favorable compared to the MDH 2010 Unmet Need estimate of 24% in the TGA, it is important to note that survey outreach was most successful among clients of agencies in the local continuum of care. Of 54 MSM who specified a barrier to accessing medical care in the Needs Assessment survey, 19% said they did not know where to go to get care. Service gaps also exist for this population in paying for HIV prescriptions, health insurance assistance, and Emergency Financial Assistance to prevent utility shutoff or eviction. Ryan White utilization data show a total of 1,494 MSM/IDU of all races in the TGA that used funded services in 2010 (44% of MSM living with HIV/AIDS in the TGA).

(c) Estimated Costs: Using service utilization data from the TGA's client-level database and end of year expenditure reports, the estimated cost of providing Part A and B base (not including ADAP) funded services to all MSM (including men of color) in 2010 is \$3,972,151. The estimated cost for Part A funded services alone was \$2,935,669.

Men of Color Who Have Sex with Men (MCSM) (a) Unique Challenges: MCSM make up a growing proportion of new HIV infections among MSM in the TGA. Of the new HIV infections from 2008-2010, MSM accounted for an estimated 96% of cases among white, 93% among Hispanic, 83% among African American, and 17% of cases among African-born males. The latter three also had the most cases with unspecified risk, which due to social stigma, are likely unclassified MSM cases. MCSM are disproportionately represented when taking race-specific

population size into account. African American males comprise only 4% of the state's male population but in 2010, 27% of the new male cases were African American or African born. Using the CDC estimate that 4% of American males are MSM, 15% of African American MSM in the TGA are living with HIV. Hispanic males make up 3% of the male population yet 11% of the new male cases. Together, MCSM made up 29% of MSM living with HIV/AIDS in Minnesota in 2010. As noted in the MDH 2010 Epidemiological Profile, race is not considered a biological reason for disparities in HIV prevalence among persons of color but can be considered a marker for other personal and social characteristics that put a person at greater risk. These characteristics may include lower socioeconomic status, less education, stigma of same-sex 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 people of color. While the median household income for whites in Minnesota is \$57,979, it is less than half that (\$26,930) for African Americans. The income disparity is even greater in the TGA.

(b) Service Gaps. In the 2010 Needs Assessment Survey 2% of non-white MSM reported needing but not getting Medical Case Management services. Three culturally specific HIV service organizations in the TGA that target African Americans reported serving a combined total of only 45 MSM (19% of all of their clients), in 2010. Given their representation in the epidemic, these low numbers may indicate strong stigma toward same-gender sexual behavior among communities of color, which may be a significant barrier to care. One hundred thirty-nine men of color who identified as gay or bisexual participated in the 2010 Needs Assessment survey. Of those, 8% said they had not seen a healthcare professional for HIV care in the previous year. Six percent of MCSM said they needed but did not get transportation to medical appointments; 8% needed but did not get Emergency Financial Assistance (EFA) to assist with housing costs or pay for food, and 9% did not get needed EFA to prevent shutoff of utilities.

(c) Estimated Costs: Part A and B base funded services for all MCSM in the TGA in 2010 cost an estimated \$1,649,601. The estimated cost for Part A funded services alone was \$1,219,159.

Women of Color. (a) Unique Challenges: In 2010 there were 1,330 women living with HIV/AIDS, with 99% aged 13 or older. Seventy-five percent were women of color. Trends in the annual number of HIV infections diagnosed among females differ by racial and ethnic group. In 2010, women of color accounted for 70% of new infections among females, with African American and African born women accounting for 88% of those infections. There were 20 new cases among African-born females reported in 2010, while 30% of the 1,571 women living with HIV/AIDS in Minnesota were African born. Of those, 97% identified heterosexual contact as the mode of exposure. Another 29% of female PLWH were African American, while 27% were white. The annual number of new infections diagnosed among Hispanic, American Indian, and Asian females continues to be quite small. For 15 years the number of births to HIV-infected women increased steadily from 14 in 1996 to 71 in 2009. However, the number of births decreased to 46 in 2010. During the same time period the rate of transmission has decreased from 15% between 1994 and 1996 to 1.0% in the past three years, the expected rate of transmission when both mother and child receive preventive anti-retroviral treatment. Only two cases of perinatally acquired HIV infection were diagnosed between 2008 and 2010, but the growth in births to HIV+ women in the last ten years shows a need for health education and risk reduction.

People for whom English is a second language who are also dealing with cultural differences can be challenged to access most social services, including those specific to HIV/AIDS, without a case manager. African-born women may experience additional shame and stigma associated with an HIV diagnosis, while they face cultural expectations about having children. Because of

inadequate knowledge and the fear that they may not have children if they are known to be 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 proven 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 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 because of their HIV status. Legal services that help women with immigration and plan for guardianship of children are also important.

(b) Service Gaps: The Planning Council's 2010 Needs Assessment included 108 women of color. Fifty-four percent of them said they had received a Ryan White-funded service in the previous year, while 85% had accessed HIV medical care. Forty-eight percent had a history of mental illness, with 35% saying they had received mental health services in the previous year while 5% said they needed but did not get mental health care. Twenty percent said they had been told they had a substance abuse problem. An annual income of less than \$17,171 (125% of FPG) was reported by 86% of participants. Ten percent of women of color reported that there were two or more days in the past 30 days when they had little or nothing to eat. Fifty-four percent reported receiving disability support, 51% had accessed a food shelf in the previous year, 28% described their housing situation as unstable, and 31% had received Emergency Financial Assistance. The picture that emerges from these data is that women of color who live in poverty receive some supports that do not entirely address the barriers to accessing HIV medical care.

(c) Estimated Costs: Part A and B base funded services for women of color in 2010 cost an estimated \$1,653,970. The estimated cost for Part A funded services alone was \$1,222,388.

Latinos. (a) Unique Challenges: The Latino population in the TGA grew from 99,740 in 2000 to 181,177 in 2009—an 82% increase. It is also a young population with a median age of 22, compared to 37 for the general population. Among all the racial and ethnic groups in the U.S., Latinos experience a very high poverty rate (22%). Sixty-five percent of Hispanic Minnesotans speak only Spanish at home. Accompanying these socioeconomic issues is persistently inadequate access to health services and poorer health status and health outcomes compared to other groups. An estimated 31% of Hispanic Minnesotans currently do not have health insurance, according to the Pew Hispanic Center. Surveillance data from 2010 indicate 484 Latinos were living with HIV/AIDS in the TGA. This represents 8% of the total prevalence for the fourth consecutive reporting period. Fifty-nine new AIDS cases were diagnosed among Latinos in 2008-2010 in the TGA. Latinos are also the most likely demographic group to enter care late; 47% progress to AIDS within a year of HIV diagnosis.

(b) Service Gaps: Since 2003, undocumented immigrants, many born in Latin America, are no longer eligible for publicly funded health programs in Minnesota. In Hennepin County's 2006 SHAPE study, 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 county adults. Almost one-fourth of Latino adults who needed medical care delayed or did not receive it. 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. In

the 2010 Needs Assessment, 62 of 567 HIV-infected respondents identified themselves as Latino. Of these 35% were inadequately housed, 68% had an income of less than \$17,171, and 34% 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 healthcare and support services are located, affordable housing, accessible transportation, and language-appropriate services are essential HIV/AIDS services for Latinos.

(c) Estimated Costs: Part A and Part B funded services for Latinos living with HIV in 2010 cost an estimated \$734,127. The estimated cost for Part A funded services alone was \$542,566.

African Americans (a) Unique Challenges: In its September 2010 *HIV Among African Americans* the CDC states that African Americans face the most severe burden of HIV in the United States, with blacks accounting for almost half (46%) of PLWH at the end of 2007. It also describes 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. Census estimates show African Americans as the second largest racial or ethnic group (behind whites) in Minnesota, comprising 5.2% of the total population. U.S.-born African Americans comprise 19% of men and 29% of women living with HIV/AIDS in Minnesota. The MDH reports that in 2008-2010, 23% of new HIV infections were among US-born African Americans. MSM or MSM/IDU accounted for 86% of new infections among African American males from 2008 to 2010. African American women represent 29% of women living with HIV/AIDS in Minnesota.

(b) Service Gaps: Of 178 U.S.-born African Americans completing the 2010 Needs Assessment, 11% said they had not seen a health professional for HIV medical care in the prior year. Thirty-five percent had experienced being inadequately housed and 11% had gone without medical care or prescriptions for HIV in the previous six months because they couldn't afford them. Ten percent of people who did not see a dentist said they needed to do so, and 32% had waited more than a month to get a dental appointment. Of those who did not get transportation assistance to attend medical appointments, 8% said they needed it.

(c) Estimated Costs: Part A and B base-funded services for African Americans in 2010 cost an estimated \$2,058,177. The estimated cost for Part A funded services alone was \$1,521,122.

African born Refugees/Immigrants. (a) Unique Challenges: The U.S. Census estimates that there are 63,982 African-born persons living in Minnesota. The total cases of HIV/AIDS among African-born in the TGA for 2010 is 777. Of new HIV infections in 2010, African-born persons accounted for 10% of cases, but represented 1% of the state's population. African-born women had a new infection rate second only to non-Hispanic whites among other female groups; 20 out of 68 cases. African-born men accounted for 13 new cases (4%) in 2010.

(b) Service Gaps: According to the 2010 Consumer Needs Assessment, African-born PLWH tend to delay seeking care. While 25% of those born in the U.S. waited four months or longer to seek care after diagnosis, 38% of African-born waited that long. Hennepin County's SHAPE 2006 study reported that 10% of African-born respondents were uninsured for the entire year preceding the study compared to 3.4% of all adults. Of African born individuals needing medical care, 20% reported that there was a time in the previous year when they did not get the care they needed. Concern about cost or not having health insurance were the most common reasons.

(c) Estimated Costs: 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 2010 was \$806,229. The estimated cost for Part A funded services alone was \$595,854.

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 FY2010 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 2010	Expected to Utilize Part A & B base Funded Services	Estimated Annual Cost of Providing Services for those Out of Care (Part A & B Base)
MSM/MSM IDU - All	810	53%	427	\$732,913
Women of Color	226	73%	164	\$281,431
Latinos	120	70%	84	\$144,026
Black/African American (U.S. born)	318	69%	219	\$376,217
Black/African-born	199	47%	94	\$160,367
Total (not unduplicated)	1,673	52%	870	\$1,491,633
Total Unduplicated	1,407	55%	773	\$1,324,560

The average per-client cost of Ryan White Part A and B base funded services in fiscal year 2010 was \$1,715. 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 FY2010.

1) E. Unique Service Delivery Challenges

The demographics of the epidemic in the TGA present a significant challenge to successfully engaging people living with HIV in care. Since 2000, approximately one third of all new HIV infections in Minnesota have either been AIDS at first diagnosis, or have progressed to AIDS within one year. As with other characteristics of the epidemic, the proportion of late testers varies by demographic group. From 2000 to 2010, the rate of Hispanics (47%) and African-born (35%) testing late was higher than that among American Indians (32%), Asian/Pacific-Islanders (33%), Whites (29%) and African Americans (30%). The percentage of late testers is significantly higher among foreign-born cases compared to others, with 48% in 2010 compared to 26% of U.S.-born cases. Some consumers from within these groups face considerable cultural and linguistic barriers to accessing HIV medical care and lack the knowledge and confidence to navigate the system of care and services. In order to reach people with health education messages that address stigma and promote health literacy, particularly Latinos, African Americans and African-born PLWH, the Planning Council allocated \$86,700 for Health Education/Risk Reduction activities in FY2011, of which \$17,700 targets Spanish-speaking individuals.

An additional barrier to care for African-born immigrants who do not speak English well is obtaining interpreter services that they trust. Clients of a community-based organization that primarily serves African-born clients had difficulty obtaining interpreter services consistently during primary care visits. A Part A contract manager 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 to avoid going to the largest outpatient HIV clinic in Minneapolis. While the clinic is a part of a large medical center that provides no-cost interpreters of multiple African languages, interpreters are used throughout the medical center, 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 needs to their caregivers and not receiving accurate information about their health or treatment instructions. Subsequently, the contract manager worked with the

medical center to implement a plan to use interpreters telephonically through the AT&T Language Line. The agency's clients reported that they felt more comfortable navigating their clinic appointments independently with less concern of their status being disclosed.

Increasing costs of care along with increasing socioeconomic stress on low income PLWH 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 medical care for PLWH, Minnesota has historically been fortunate to provide extensive access to healthcare through state and federally funded programs such as Medicaid, Minnesota Care and a high risk insurance pool. Several clinics and hospitals 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 many clients were able to access clinical services through their health insurance, the number served through Ryan White funded programs has historically been rather low. However, Minnesota's system of healthcare access is changing. Rising costs and reductions in public spending on healthcare 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 Healthcare Programs since 2003 along with tighter eligibility restrictions and higher out-of-pocket costs continue to increase the burden on the Ryan White program. In 2010, the elimination of General Assistance Medical Care (GAMC) from the state budget, which provided basic medical coverage to the medically indigent (5% of PLWH in the TGA), created an additional burden of uncompensated care for the state's largest HIV/AIDS specialty clinic at Hennepin County Medical Center (HCMC), which receives both Part A and Part C funding. While PLWH formerly covered through GAMC have now been enrolled in Medical Assistance under the state's Medicaid Expansion through the Affordable Care Act, HCMC provided HIV clinical services in 2010 at an operating loss of almost \$2 million. The erosion of a formerly robust system of publicly funded healthcare means that more low income PLWH will need to rely on the Ryan White Program for their primary care. In 2008 and again in 2011 the state cut \$2.4 million in state appropriations for the HIV Insurance Program and Medical Case Management (MCM) due to a budget deficit and tapped into the State's ADAP rebate reserve to fill the funding gap. The Part B grantee's latest ADAP forecast takes into account borrowing that the state has done from funds it budgeted for case management and insurance premium support for PLWH in the last two biennia. The Part B grantee has used drug rebate funds to cover this borrowing while the state repays the funds. As long as the repayment continues, the ADAP forecast is for adequate funding; if there is a default, a shortfall of funds may occur by July 1, 2013.

In the past five years the number of clients seen by the Part A funded Primary Care programs increased by 397%, from 144 clients in 2004 to 716 clients in 2010. Due to the rise in healthcare costs, including the Medicare Part D "donut hole" for recipients whose incomes are too high to qualify for extra help, PLWH in the TGA more frequently face prohibitive out-of-pocket costs. At the same time, hospitals and clinics are reducing the amount of charitable care they provide. In response to the increasing cost barriers to care, the Planning Council increased Part A allocations for Outpatient/Ambulatory medical services by 396% from 2005 to 2010. Services funded by Part A that help bring people into primary care, such as Outreach and MCM, are not reimbursable through insurance programs. The Part A allocation for MCM has increased from \$1,710,100 in 2008 to \$1,977,410 for FY2011.

These economic phenomena along with a harder-to-serve population of PLWH are increasing the cost of HIV services. Part A funds are needed to provide quality care for those struggling

with multiple diagnoses and difficult socioeconomic circumstances. The Planning Council’s 2010 Consumer Needs Assessment found that 14% of 494 participants said they had to go without medical care or prescriptions for HIV because they could not pay for them. 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 2010, among the Ryan White supportive service categories, Medical Transportation (Part B) was the most utilized, with 1,240 clients (36%) accessing transportation services. Food & Nutrition was the next most utilized service with 1,137 clients (33% of total clients). The next most used support services were Emergency Financial Assistance and Health Education/Risk Reduction with 962 and 383 clients, respectively.

Based on the expanding epidemic in the TGA, Ryan White service utilization, the costs of care in 2011 and of maintaining the Comprehensive Plan goal of reducing Unmet Need to 25%, the grantee estimates that the TGA would need an increase of \$1,324,560 in Part A funding in FY2012 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

(1) The Minneapolis-St. Paul TGA did not experience a decline in Ryan White formula funding in Fiscal Year 2011. Formula funding increased from \$3,712,983 in 2010 to \$3,848,611 (not including MAI) in 2011; a 3.7 % increase.

1) G. Unmet Need

(1) **Unmet Need Framework:** The Unmet Need Estimate for FY2011 is found in **Attachment 6**.

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

(3) Unmet Need Trends Table

Percent of Unmet Need CY2008, 2009, & 2010 Minneapolis - St. Paul TGA						
Calendar Year	People Living with AIDS and not receiving HIV medical services		People Living with HIV (non-AIDS and not receiving HIV medical services)		Total People Living with HIV (AIDS and non-AIDS) and not receiving HIV medical services	Percent Unmet Need
2008	844	35%	1,519	50%	2,143	43%
2009	945	35%	1,543	51%	2,488	43%
2010	452	16%	2,201	31%	2,653	24%

Unmet need for HIV medical care in the TGA appears to have dropped dramatically in 2010 after remaining constant in 2008 and 2009 for both people living with AIDS and HIV (non-AIDS). However, it is important to note that the MDH, in its description of the method used to calculate unmet need, counted as “in-care” clients of the two largest hospital-based clinics in Minnesota who are in eHARS but may not have had a CD4 or viral load reported during 2010. As noted, this discrepancy in data reporting has been addressed by a Minnesota reporting rule change, effective June 2011, that requires all CD4 and viral load tests and results to be reported to eHARS, regardless of whether they are initial diagnostic results or performed as part of ongoing care. During the two prior years, the MDH completed an intensive project of comparing individual patient’s medical records at the two non-reporting clinics to eHARS data. The review resulted in 25 patients of one clinic being identified as receiving HIV medical care but not having been reported to the MDH, most likely as a result of moving to Minnesota following diagnosis in another state. This project helped support the need for the reporting rule change that took effect in June of 2011. It is expected that as new CD4 count and viral load data are reported by the two largest clinics the 2011 Unmet Need Estimate will revert to a level closer to previous years. The 2010 Needs Assessment found 12% of respondents reported they had to go without healthcare because money was needed for food, clothing, or housing. Since the majority (60%) of respondents was receiving services within the Ryan White system, the rate of PLWH with unmet medical care needs for financial reasons is expected to be higher in the improved estimate.

The Minnesota HIV Services Planning Council allocated \$865,800 for HIV Primary Care and Culturally Appropriate Primary Care in FY2010, which likely contributed to the actual unmet need remaining level or slightly improving in 2010. During the same period, the Part A grantee reaffirmed its primary quality improvement goal to increase the number of those who are aware they are HIV positive who attend an HIV medical appointment every six months. All Part A funded Ryan White providers are expected to include this goal in their annual quality improvement plans until they assess 90% or more of their clients as current in HIV medical care.

(4) Planning and Decision Making to Address Unmet Need. The grantee presented unmet need data to the Planning Council prior to its prioritization and allocations process for the 2011-2012 biennium. The Council considered utilization patterns of populations of PLWH that received Ryan White funded care to better understand how to address unmet need. As a result, the grantee will fund programs based on the priorities and allocations to promote retention of those previously connected to care but who have not had an appointment in the past six months, and to provide Outreach services that will utilize newly revised standards to increase their impact.

(a) Determination of Demographics. Information on PLWH who know their status and are not in care is estimated by subtracting the number of people who are in care in each demographic category from incidence and prevalence data. Demographic information about those who are in care is available, although incomplete. The MDH uses surveillance data, lab reports of CD4 counts and viral loads for people known to be living with HIV submitted by commercial laboratories and most Minnesota medical centers. While the Unmet Need Framework does not factor in client location in developing the estimate, the MDH collects county of residence and ZIP code data for use in its annual HIV Prevalence & Mortality Report. These data sets are combined with the locations of Ryan White-funded care and services providers to map the availability of services compared to populations of PLWH (see the TGA Providers/Prevalence Map in **Attachment 12**). With the institution of the state reporting rule change in June 2011 that requires all CD4 and viral load tests to be reported to eHARS, MDH will be able to refine its ability to

geo-map PLWH by their in-care status within the next two years. The available demographic information on those in care during the specified time period are summarized below:

Demographic Characteristics of PLWH In-care, Mpls-St. Paul TGA January 1 – December 31, 2010 (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	2,308	3,055	24%
Black – U.S. Born	1,040	1,363	24%
Black - African Born	578	777	26%
Hispanic/Latino	360	484	26%
American Indian	78	95	18%
Asian	70	94	26%
Multiple/Unknown	56	66	17%
TOTAL	4,490	5,944	24%
Male	3,472	4,614	25%
Female	1,018	1,330	23%
TOTAL	4,490	5,944	24%

The demographic data indicate the following:

- African-born individuals, already a disproportionately large population within prevalence estimates, were also out of care most often, at 26%. African-born PLWH reside in the core cities and first ring suburbs.
- Latinos were also out of care at an estimated rate of 26% in 2010. This group has a large population in St. Paul and a growing one in Minneapolis.
- Both Latino and African-born populations are disproportionately represented among late testers (those who progress to AIDS within one year of HIV diagnosis). In 2010, 48% of foreign-born individuals who tested positive for HIV were diagnosed with AIDS within a year.
- While 26% of Asians were also out of care, as a group they represent one of the smallest subsets of PLWH in the TGA, so this rate is viewed with caution.
- While men, at 25%, are just a little more likely to be out of care than women (23%), their much greater proportion in the prevalence of PLWH demonstrates there are still unacceptably high rates of unmet need among men living with HIV. Limited information on exposure category among those who know their status indicates that men who have sex with men (MSM) may be somewhat less likely to be in care compared to the overall population of those who know their status. Gay and bisexual men generally reside in Minneapolis and St. Paul and the inner suburbs.
- The proportions of white and African American PLWH who were out of care in 2010 were the same at 24%. African American populations are most heavily represented in the cities of Minneapolis and St. Paul and their first-ring suburbs.
- American Indians, as a group, were the most likely to be in care (18% out of care) compared to the total population of those in the TGA who know their status. Because of overall low numbers, this data must be viewed with caution. In the TGA, the American Indian population is concentrated in Minneapolis.

(b) Five-year Trends. As the shared client-level data collection system of the Part A and Part B grantees in Minnesota, and administered by MDH, was implemented, improved data demonstrated a more accurate, though higher, percentage of PLWH who were not current in HIV care for four of the past five years. The additional improvement in data collection that is expected in response to the Minnesota reporting rule change should demonstrate a more accurate, but more gradual, improvement in the number of PLWH in care than this year’s estimate represents.

(c) Assessment of Service Needs, Gaps and Barriers for People Not in Care. The Planning Council's 2010 Consumer Needs Assessment Survey's 494 participants are all PLWH in Minnesota. While they are primarily recipients of Ryan White services (60%), their responses help develop understanding of the issues faced by those who are not in care. Twenty-two percent of survey respondents said they had not received outpatient HIV medical care in the previous twelve months. Of those who said they did not access care, 90% said they did not need it, demonstrating a need for increased health education among those who do access services. Of those who had received care, 11% said they had difficulties in accessing it. Transportation problems were most frequently cited as the reason, with 7% of those who did not get assistance stating they had needed it. Stigma and poverty present greater barriers among affected populations of color. While 96% of respondents who identify as MSM saw a healthcare provider for their HIV-related medical care in the last year, among MSM of color, the response declined to 92%. The most frequently cited unmet need in the survey was for dental care, with 31% saying they had to wait more than a month to get a routine dental appointment; 14% who didn't see a dentist needed to do so. Twenty-two percent had been turned away from a pharmacy because they were unable to pay for medications; 12% said they had gone without medical care or prescriptions in the previous 12 months because they were unable to pay for them; 10% said they did not currently have health insurance. Forty-nine percent acknowledged a mental illness or substance abuse diagnosis; 11% rated how their mental health needs were being met as fair, poor, or not at all. Fourteen percent said that in the past month, they had had little or nothing to eat for two days. Together, these responses demonstrate the challenges and barriers to accessing routine HIV medical care related to behavioral health comorbidities and poverty.

In 2008 a "Path to Care" study, involving a survey and interviews with 56 PLWH (17 newly diagnosed), provided additional information on the needs of the newly diagnosed and those who drop out of care. Participants in the Path to Care Study reported that depression and drug or alcohol use were among the top four reasons why they either dropped out of or delayed care. Findings indicated that while coverage for mental health services is available to low-income Minnesotans, there is pressure on the state's mental health system due to large patient-to-provider ratios, making it difficult to get timely services.

(d) Efforts to Assist Out-of-Care Individuals to access Primary Care. Medical care retention and Outreach services will continue to be funded to help more HIV+ individuals who have left care or not yet found a medical home to access care. Also planned are increased levels of Mental Health services and culturally appropriate Mental Health Access services, as well as Outpatient Substance Abuse assessments and treatments to address behavioral health barriers to accessing HIV medical care. Health Education/Risk Reduction programs tailored to meet the needs of several populations that are disproportionately represented among those out of care (MSM, women of color, African-born individuals) will receive continued funding.

The grantee and the Planning Council, in collaboration with Minnesota's Parts B and C grantees and the MDH (CDC prevention grantee), are employing a multi-pronged approach to finding PLWH who are not in care and getting them into primary care. Components of the 2009 - 2011 comprehensive plan designed to address the results of the Unmet Need Framework include: 1.) Medical Care Retention (\$66,600 as part of Medical Case Management/Treatment Adherence in FY2011) – is a focused intervention designed to identify patients of HIV primary care clinics who are not currently in care and facilitate a return to care. Two TGA providers identify clinic patients who have missed appointments and work with them to help them 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 in 2012.

2.) Outreach (\$149,400 Part A and \$50,000 Part A MAI in FY2011) - 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 know their status. Outreach targets injection drug users, other substance abusers, African Americans, African immigrants, and MSM. The Planning Council allocation for Outreach will be sustained in FY2012.

3.) Mental Health Services (\$332,800 in FY2011 including \$135,200 Culturally Appropriate Mental Health Access) and Health Education/Risk Reduction (\$86,700 in FY2011) – African American AIDS Task Force (AAATF) conducts mental health groups for African American men and women who are HIV-positive. 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, self-care, harm reduction, HIV medical care and community resources. The \$419,500 in combined funding for these services in FY2011 also supports three other programs targeting Latinos, the African-born, MSM and injection drug and other substance users that include a health education component.

4.) Substance Abuse Treatment/Outpatient Services (\$139,500 in FY2011) –Two funded programs in this service area 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 2012 will sustain these programs.

5.) Quality Improvement Programs - A key component of the grantee’s quality management program requires that all Part A funded providers assess whether or not their clients have received primary medical care 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. Providers are also expected to follow up on the referral to see if they entered care and if additional assistance is needed. 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.

2) Early Identification of Individuals with HIV/AIDS (EIIHA)

2) A. Strategy

(1) Identifying Individuals who are Unaware of their HIV Status.

(a) Beginning in April 2010, the Part A grantee along with Minnesota’s Part B (DHS) and CDC HIV prevention (MDH) grantees have collaborated with an EIIHA workgroup to develop recommendations for a coordinated strategy to identify, diagnose and link the HIV unaware with care. The workgroup comprises stakeholders including HIV care, prevention and testing providers, representatives from all Ryan White grantees (Parts A, B, C, D and F), consumers and providers from outside the Ryan White funded care system. The workgroup’s recommendations were presented to the Minnesota HIV Services Planning Council as it set its priorities and allocations for 2011 and 2012. The Planning Council is using the workgroup recommendations

to guide its update of the comprehensive plan in 2012 to ensure early identification and treatment of PLWH who are unaware of their status. The Part A grantee established its goals based on the EIIHA workgroup's recommendations. They were developed to be consistent with the National HIV/AIDS (NHAS) goals to 1) reduce the number of people who become infected with HIV, 2) increase access to care and optimize health outcomes for people living with HIV, and 3) reduce HIV-related health disparities as described under each goal:

Goal 1. Increase opportunities for testing and diagnosis of HIV among the following targeted populations in the TGA: 1) those testing for STIs; 2) Men who have sex with men (MSM); 3) Disproportionately affected communities of color: African American, African-born and Latino.

i) NHAS goals. This strategy will help to reduce the number of people who become infected with HIV because HIV testing standards also provide for those tested to receive a risk assessment, counseling and education to help them identify and reduce their risks for HIV exposure. Those who test positive are assisted to make a rapid connection to HIV medical care; any barriers are assessed and addressed as part of the Ryan White funded services that provide testing. By targeting populations for testing and connection to care that are disproportionately represented in the local epidemic, compared to their ratios within Minnesota's population demographics, this goal addresses HIV-related health disparities.

ii) Making individuals aware of their HIV status. In addition to the importance of testing among the targeted populations for this goal, the specific plans that support it include strategies to promote participants receiving test results.

Goal 2. Increase testing among partners and social networks of PLWH who receive Ryan White funded services. Based on the understanding that PLWH who receive care and services are well positioned to know people in the community who may be at risk of infection, a peer outreach model can also address barriers to testing grounded in stigma and fear of disclosure. Partners and social networks to be addressed include: a) Newly diagnosed PLWH; b) Individuals diagnosed with AIDS within one year of testing; c) Populations with high coinfection rates (i.e., those with syphilis or Hepatitis C); d) High-risk and comorbid populations (e.g., substance abusers, incarcerated, homeless and those with mental health issues).

i) NHAS goals. This strategy will help to reduce the number of new HIV infections because it simultaneously reduces stigma and promotes communication among at-risk peers of the importance of becoming aware of one's status and of resources in the community to help reduce risk.

ii) Making individuals aware of their HIV status. In addition to the importance of testing among the populations targeted for this goal, the specific plans that support it include initiatives to promote participants receiving their test results by employing rapid testing and providing referral and follow-up regardless of result.

Goal 3. Provide rapid access to HIV counseling, testing, referral and linkage to care through Outreach services at the time an individual's assessment identifies a risk of being infected. The grantee will complete implementation of Outreach standards updated in FY2011 for all funded Outreach providers, including the requirement to develop formal and functional relationships with testing sites and early intervention programs. The standards are predicted to increase the number of individuals who are either unaware they are HIV positive or HIV positive and aware of their status but out of care who are reached and assisted to connect with HIV medical care. Based on HRSA's decision to allow Ryan White-funded Outreach programs to provide HIV testing, the grantee will incorporate a testing component into its Outreach programs in FY2012 that is designed to coordinate with, but not supplant, CDC funded testing programs in the TGA.

i) NHAS goals. Individuals who are linked to HIV medical care through Outreach are less likely to engage in risk behaviors that may lead to others being infected; consistent treatment adherence by those linked to care reduces infection risk by reducing viral loads. The goal of Outreach is to address barriers to care so that PLWH may have better access and improved health outcomes. The populations targeted by Outreach include African Americans, African-born, substance users and MSM, all of which are disproportionately affected by the epidemic. These services are planned to address those disparities.

ii) Making individuals aware of their HIV status. Outreach efforts will yield contacts with people who are unaware of their status but at risk as well as with those who are aware of being positive and out of care. The unaware will be linked to testing, and receive their results as well as post-test counseling, referral and follow-up.

Goal 4. Create a seamless system where unaware individuals can flow from testing to diagnosis to care with minimal steps and barriers through Early Intervention Services and Outreach providers developing formal and functional relationships with Points of Entry outside the Ryan White system as well as with primary care and medical case management programs.

i) NHAS goals. By facilitating referrals to the HIV testing and care continuum by providers of services for people at increased risk of HIV, including substance use counseling, mental health, corrections, and other health services, this goal promotes greater awareness of the local epidemic and facilitates counseling, testing and referral to reduce new infections. Points of Entry (POE) relationships with Ryan White funded services will increase access to care and improve health outcomes by providing accessible resources for POE providers to use in referring their clients to care and services. HIV-related health disparities will be addressed by increasing the capacity of the healthcare and social service system in the TGA to recognize clients at risk of HIV infection and facilitating their referral access to Ryan White services.

Goal 5. Provide all newly diagnosed clients through Outreach and EIS programs with education focused on increasing their competencies in navigating the healthcare system.

i) NHAS goals. Newly diagnosed individuals who feel confident in navigating the HIV healthcare system are more likely to link to an HIV medical provider and comply with treatment, thus reducing their incidence of engaging in risky behaviors while lowering viral load, both of which will reduce new infections. Continuous access to HIV care and optimal health outcomes result from health education efforts that reduce individuals' barriers to care. Health disparities resulting from low health literacy are also addressed.

ii) Making individuals aware of their HIV status. This strategy is designed to increase awareness of HIV status beyond delivery of a test result to include understanding of how to remain healthy with HIV by accessing and utilizing a healthcare system that can best address the needs of each newly diagnosed individual.

(b) The Part A grantee is working in partnership with Hennepin County Public Health clinics to increase routine HIV testing for: patients presenting for STI tests; MSM outreach programs; Healthcare for the Homeless clinics; and the County's refugee health clinic. In the past year these clinics increased promotion of HIV testing in the county's correctional facilities. The grantee is also coordinating with a community-based organization it funds to provide Medical Case Management, Mental Health Access, Outreach and several support services to coordinate with its two CDC-funded testing programs. These programs are expanding HIV testing efforts, and increasing outreach to young gay and bisexual men, specifically those with substance use issues.

(c) In its current RFP process (during third quarter FY2011), the grantee requires each proposal to describe protocols, processes and outcomes measures for 1) assessing each client's linkage to

HIV medical care; and 2) maintaining active referral relationships with HIV testing sites, primary HIV medical care providers, and Medical Case Management programs. In addition, Early Intervention Services and Outreach proposals must address how they will facilitate access to HIV testing for partners and social networks of HIV+ clients. Scoring of these proposal sections will be weighted to ensure that contracts to provide Ryan White funded services are awarded to those best prepared to support EIIHA strategies.

(d) The Planning Council ranked ADAP Treatments number one in its 2011-2012 prioritization and allocation process. The grantee works in close partnership with the Planning Council and Part B grantee to be regularly apprised of the ongoing availability of ADAP resources, insurance coverage, the impact of implementation of healthcare reform and reports from the major HIV primary care providers of the amount of uncompensated HIV medical care (including prescriptions) provided. As newly diagnosed individuals enter the Ryan White care system, impacts on ADAP availability will be closely monitored and, as necessary, recommendations will be made to the Planning Council for continuing allocations to meet this priority.

(e) The Part A grantee's strategy emphasizes partnering with public health clinics to explore increased opportunities to test those disproportionately represented in the local epidemic. One example is Hennepin County Public Health's Refugee Clinic, which provides screening, physical exams and treatment of tuberculosis and STIs, and referral to primary care for immigrants fleeing other countries, many from African nations. Minnesota has experienced a steady increase in the number of African-born PLWH, representing 13% of the epidemic in 2010. Other groups targeted to address disparities include African Americans and Latinos, both of which are also disproportionately represented. The Part A MAI program funds outreach, medical case management and culturally appropriate primary care targeting African Americans and Latinos.

(f) Challenges to increasing routine testing in non-HIV healthcare settings include the perception in Emergency Departments and primary care clinics that clinicians there do not have the skills or resources to provide HIV tests and post-test counseling. Even in public health STI clinics, testing protocols may be unclear or inconsistent. Clinicians treating patients who are known or suspected to be coinfecting with syphilis or hepatitis C may view time, cost, or their lack of specific training in HIV screening and counseling as reasons to refer to community HIV test sites instead of completing the screen during their contact with the patient. However, the CDC says in its "Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings" that referrals by mainstream medical clinics to confidential HIV testing sites in the community have proven ineffective because of poor compliance by patients.

Challenges to the plan to increase testing among men who have sex with men (MSM) include misinformation and denial—particularly among young men—about their level of risk for HIV infection. Additionally, the CDC cites the low number of clinicians who discuss sexual activity and provide HIV screening and risk information to adolescent males who receive healthcare services as a factor leading to failure to screen early for HIV in these patients. Men who live in poverty or who are affected by comorbidities such as poverty, substance use and incarceration face additional barriers to accessing routine HIV testing. Many MSM who have not integrated their sexual orientation into their identity experience stigma around same-gender sexual activity resulting in denial of risk and fear of identity disclosure. Homophobia-associated stigma may be more pronounced among black and Latino MSM. Low testing rates among Asian and Native American MSM and male to female transgender individuals may indicate lack of recognition or denial of risk and lack of support from both their ethnic communities and the gay community.

Members of disproportionately affected communities of color, who are also disproportionately affected by issues of poverty, may have fewer contacts with routine or preventive health-care providers, making it more difficult to encourage routine testing. Within some cultures there is greater level of stigma associated with HIV than in general, which may contribute to a reluctance to be tested. Lack of trust in the healthcare system or varying cultural beliefs about health can also be a barrier to HIV testing among both American and foreign-born people of color.

The primary challenges in reaching partners and social networks of people newly diagnosed with HIV lie in their reluctance to disclose the names and contact information of partners due to fear of stigma at a time when they are still adjusting to the news of their positive result. The increased availability of anonymous sexual contacts through social media also may increase the number of newly-diagnosed individuals who do not have contact information for their partners. Factors such as stigma, denial, cultural beliefs about healthcare, poor understanding of risk, and comorbidities such as mental illness and substance abuse that lead individuals to not be tested until later in the course of their disease may also apply to their contacts and social networks.

Populations with high rates of comorbidity, including the chronically homeless, substance users, the incarcerated, and those with mental health issues, due to a high number of unmet basic needs for housing, food, and transportation, contribute to HIV screening receiving a low priority among the clients themselves and those providing them with healthcare and other services. Inadequate insurance among these populations also severely restricts access to preventive care.

A major challenge to increasing routine HIV testing is that people seen as having moderate or low risk of HIV infection and their primary healthcare providers may have the perception that they are at no risk, or may never consider HIV at all during clinical contacts, leading to failure to include routine HIV screening in their primary care visits.

(g) The Ryan White Program's role in facilitating routine HIV testing within the EMA/TGA is to actively partner with the MDH and other CDC funded testing initiatives (including two projects of the Minnesota AIDS Project that target young MSM and those affected by substance use). Through active participation in coordinating the local continuum of prevention, testing, education and HIV medical care and services, the Ryan White Program will use allocated EIS and Outreach resources to address identified gaps in routine HIV testing among target populations not already being tested through funding from MDH, insurance or other sources. The grantee will continue to advocate for increased testing at public health and STI clinics and disseminate aggregate results of the demographics of people tested and the number found to be positive, to demonstrate lost opportunities for testing among people who were actively receiving healthcare. The grantee will continue its project to seek partnerships with HMOs that provide healthcare services to Minnesota Healthcare Program recipients to develop and implement quality improvement projects around routine HIV testing.

(h) The grantee has active planning partnerships and contractual relationships with Minnesota's three Part C grantees, all of which also have Part A and/or Part B funded programs managed by the Part A grantee. The grantee will continue to promote and facilitate coordination of EIIHA activities and communications with the Part C program through the EIIHA Work Group, which includes two of the Part C grantees, and coordinating activities of the Planning Council, on which the Part C grantees sit. Part A will disseminate its EIIHA Plan and results and request the Part C providers' plans and outcomes and continue to look for opportunities to coordinate efforts and share resources to identify unaware individuals and connect them to care and services.

(2) See EIIHA Matrix 1.2 in **Attachment 9**.

2) B. Plan

(1) Barriers to awareness of HIV status

T1. Individuals Not Post-Test counseled

(a) Priority Needs: The overall incidence of people who did not receive their HIV test results from publicly funded testing sites in 2009-2010 was 6% overall and 7% for those who tested positive. Universal use of rapid testing has kept the no-return rate low. Providers report that the most frequent reason for clients not receiving results is that some leave the test site during the wait time for a rapid test result, either leaving without informing clinic staff or failing to return for their results. While some are later reached by telephone or a home visit by clinic staff or a disease investigator, some do not provide accurate contact information and are lost to follow-up. Fear of HIV and loss of emotional and economic support from family and friends as a result of disclosure may obstruct awareness of HIV status for this group. This is likely to be more significant for young people who are economically dependent and those experiencing domestic and sexual abuse. (b) Cultural Challenges: Fear of disclosure, stigma, poor knowledge about HIV, emotional distress, and lack of previous connection to a healthcare provider may contribute to an individual's decision not to wait or return for their test results. These problems are most prominent among members of disproportionately affected cultures; in the TGA, this includes African-born and African American clients.

T2. Individuals Who Receive Preliminary Positive Results Only

(a) Priority Needs: Members of this target group are most likely to be “anonymous” testers who are unwilling to provide accurate contact information based on fear of disclosure. The ability to follow up with these individuals who do not return for their appointment for a confirmatory test is extremely limited unless their desire to remain healthy and address risky behaviors becomes a higher priority than their need to remain anonymous. Clients who are also challenged by mental health or substance use issues are less able to cope with a positive preliminary result and may revert to dysfunctional behaviors that intensifies their denial leading to failure to keep subsequent appointments for confirmatory tests. Meeting their emotional and basic needs is likely to be a higher priority than knowing their HIV status.

(b) Cultural Challenges: Clients with little connection to the healthcare system—often, people affected by poverty who do not have a relationship with a primary healthcare provider but only seek urgent or emergent care when ill—may have insufficient trust of the system or motivation to return for their results or provide accurate contact information. Individuals who receive preliminary positive results only may also face the same cultural challenges as those who do not receive post-test counseling including HIV stigma as well as same-sex sexual orientation stigma. These stigmata may be greater for those born outside the U.S. and American born African Americans, Latinos and individuals from other communities of color.

T3. Moderate and Low Risk Individuals

(a) Priority Needs: People at moderate to low risk of HIV infection likely believe that HIV “can't happen to me”, so the desire to become aware of their status is not a priority even if they are connected to a healthcare provider. Opportunities for testing this group are few unless individuals are pregnant or receive care at a provider that has implemented routine testing.

(b) Cultural Challenges: Healthcare providers as well as patients may not recognize that people of any age who are sexually active may be at risk. This may be compounded by the stereotyping of middle-aged and older patients as being less sexually active. Truly routine, opt-out HIV testing is still not the norm in preventive primary care.

T4. People Testing for STIs at Public Health Clinics

(a) Priority Needs: People in the TGA who utilize public health clinics for STI testing and treatment are disproportionately from disenfranchised populations including those whose incomes may be too low to access preventive healthcare, African Americans, people born outside the U.S. and MSM. If presenting with symptoms or suspicion of being exposed to an STI other than HIV, both emotional and physical relief from their exposure and/or symptoms likely take priority over learning one's HIV status. While the majority of people presenting for STI testing at the TGA's public health clinics are also tested for HIV, one ongoing challenge is to ensure that truly routine (not solely risk-based) testing is promoted for every individual presenting for STI testing.

(b) Cultural Challenges: Members of populations that are disproportionately affected by HIV may be more open to testing for STIs, but due to stigma and lack of access to accurate information about HIV transmission risk, refuse HIV testing. Receiving an HIV test may reveal sexual behaviors they are uncomfortable disclosing because they are taboo in their communities.

T5. Young MSM

(a) Priority Needs: Young MSM, particularly those who depend on their parents to meet their basic needs, may not get tested for fear that disclosure of their HIV status or sexual orientation may result in rejection and loss of economic support. Additional barriers to becoming aware of their status include a developmentally related sense of invulnerability resulting in a denial of risk for HIV and the belief that antiretroviral therapy is a simple solution if they become infected. An important challenge for providers lies in informing young men who live with their parents of HIV test results. If they do not receive their results at the point of testing, Disease Investigation workers may face difficulties in contacting young clients without inadvertently disclosing their status or risk profile. No local or state legislation or policies are in place that obstruct awareness of HIV status for this or any other target group.

(b) Cultural Challenges: The CDC cites the low number of clinicians who discuss sexual activity and provide HIV screening and risk information to adolescent males as a factor leading to failure to screen early for HIV in their patients. According to "Treating Adolescents with HIV: Tools for Building Skills in Cultural Competence, Clinical Care, and Support (hivcareforyouth.com)," a web-based training developed by HRSA/HAB in collaboration with a diverse group of adolescent HIV specialists, "it is not unusual for HIV infected youth to believe that they will never be able to have sex...if they were to disclose their status."

T6. MSM Aged 29 and older

(a) Priority Needs: Mature men who are affected by comorbidities such as poverty and incarceration face additional barriers to accessing routine HIV testing that obstruct awareness of HIV status. Many MSM who have not integrated their sexual orientation into their identity experience stigma around same-gender sexual activity resulting in denial of risk and fear of identity disclosure. In addition, higher rates of substance abuse among MSM may obstruct healthy behavior seeking including annual HIV screening.

(b) Cultural Challenges: Low testing rates among Asian and Native American MSM, and among male-to-female transgendered individuals demonstrate the lack of recognition or denial of risk and lack of support from both their ethnic communities and the gay community. Sexual orientation stigma and provider competency in providing relevant healthcare to MSM is a significant factor in health seeking behavior for this target group.

T7. African American Women

(a) Priority Needs: The challenges for African American women are present most often for those who live in poverty, with concomitant issues of housing instability, increased incidence of partner abuse and limited access to consistent means of communication. Except for women who

are tested during pregnancy (routine HIV testing during prenatal care has become widespread in Minnesota), African American women living in poverty who access the healthcare system may do so only when ill or injured, and more often through emergency departments than at primary care clinics. There is a need to increase routine HIV testing in these settings to overcome social and economic priority needs that obstruct awareness of HIV status.

(b) Cultural Challenges: The Minnesota Department of Health, in its 2010 STD Surveillance Report, notes that racial disparities in sexually transmitted infections persist in Minnesota. Black females represent 27% of the 2010 chlamydia rate in Minnesota, though the overall African American population of Minnesota is just 5%, which demonstrates the continued presence of risk of HIV infection among African American women.

T8. African American MSM

(a) Priority Needs: For this population, which is also disproportionately affected by issues of poverty and perhaps same-sex sexual orientation stigma, the priority of maintaining psychosocial and economic support from the community often trumps awareness of HIV status as a priority. Members of this target group are more likely to have fewer contacts with routine or preventive healthcare providers, making it more difficult to encourage routine testing.

(b) Cultural Challenges: Fear of stigma associated with an even more pronounced level of homophobia within the African American community contributes to a greater sense of stigma and denial among African American MSM who do not identify as gay or bisexual.

T9. African-born Individuals

(a) Priority Needs: Various estimates put the number of African immigrants in Minnesota between 70,000 and 80,000. This is more than a tenfold increase since 1990. Within several of the immigrant African cultures there is an even greater level of stigma associated with HIV than in the community at large, which may compromise clients' willingness to be tested or to follow through with post-test counseling for fear of loss of emotional and economic support from family and the community.

(b) Cultural Challenges: Lack of trust in the healthcare system or varying cultural beliefs about health can also be a barrier to HIV testing among African immigrants.

T10. Individuals Newly Diagnosed HIV+

(a) Priority Needs: The primary challenges in reaching partners and social networks of people newly diagnosed with HIV lie in their reluctance to disclose the names and contact information of partners due to fear of stigma at a time when they are still adjusting to the news of their positive result. The increased availability of anonymous sexual contacts through social media also increases the number of newly-diagnosed individuals who do not have contact information for their partners.

(b) Cultural Challenges: Mistrust of disease investigator discretion may be a barrier for newly diagnosed individuals, who may have no prior connection to either primary healthcare or the public health system.

T11. Late Testers

(a) Priority Needs: Defined as people who are diagnosed with AIDS at the same time they test positive for HIV or within one year after testing positive, late testers may experience barriers related to stigma, denial, cultural beliefs about healthcare, poor understanding of risk, and comorbidities such as mental illness and substance abuse that lead individuals to not be tested until later in the course of their disease. Meeting social and basic needs such as maintaining family ties and social networks and having stable housing, employment and nutrition are priorities that supersede seeking preventive healthcare and HIV status awareness. For those born

outside the U.S. remaining in the country (fear of deportation) for economic reasons is also a priority that may obstruct awareness of HIV status. Their contacts and social networks may also be affected by these barriers to testing and learning of their status.

(b) Cultural Challenges: Late testers are more likely to be foreign-born, according to the MDH. In 2010, 48% of foreign-born cases were late testers compared to 26% of US-born cases. For this group, fear of disclosure due to stigma is a significant barrier to not only following through on post-test counseling and confirmatory testing but also to reaching partners for testing. Linguistic and other cultural barriers such as fatalism may also pose challenges to learning their status.

T12. High Coinfection Groups

(a) Priority Needs: Populations known to be frequently coinfecting with HIV as well as syphilis or hepatitis C may prioritize treating their current infection and meeting basic needs over learning their HIV status. Knowing that they are also infected with HIV may be one more piece of bad news that they emotionally can't handle. For those who are actively injecting drugs, scoring their next "hit" or finding a place to "crash" may be top priority. Members of this target group may not have received an HIV test because clinicians treating these patients may view time, cost, or their lack of specific training in HIV screening and counseling as reasons to refer to community HIV test sites instead of completing the screen during their contact with the patient. However, the CDC says such referrals have proven ineffective because of poor compliance.

(b) Cultural Challenges: One challenge is to ensure that testing sites have the knowledge and capacity to provide cultural, linguistic, and LGBT-competent counseling, testing and referrals particularly for MSM, African Americans, those born outside the United States (Africans and Latinos) and injection drug users. This challenge may be more difficult to surmount for those private clinics outside the system of STI and HIV care. Testing sites will also need to have the tools to connect clients to services that can address the needs of those dealing with substance abuse, emotional distress and mental illness.

T13. Comorbid Groups

(a) Priority Needs: For individuals who experience comorbidities such as chemical dependency, mental illness, homelessness and poverty, learning of one's HIV status is unlikely to be a priority until their basic needs and other conditions are addressed.

(b) Cultural Challenges: For those with significant comorbidities who test, transience and instability may make it more difficult to follow through with confirmatory testing, partner services provided by disease investigators, and staying connected to outreach workers who can assist with reconnecting with Early Intervention Services.

(2) Activities to address barriers that obstruct awareness of HIV status.

T1. Individuals not post-test counseled

(a) Priority Needs: Obtain an assessment from the MDH of the projected level of continued improvement (above 91% reported in 2009; increased to 95% in 2010) of clients who receive post-test counseling and related education needs of providers to meet improvement goal.

Implementation: FY2011; ongoing. Responsible: HIV CTR Coordinator, MDH.

(b) Cultural Challenges: Educate providers of HIV testing services on the best practices to promote client participation in post-test counseling with a focus on addressing cultural factors, such as fear of disclosure, stigma, poor knowledge about HIV, emotional distress, or lack of previous connection to a healthcare provider. Implementation: FY2012. Responsible: HIV CTR Coordinator, MDH.

T2. Individuals who receive preliminary positive result only

(a) Priority Needs: Develop and distribute to HIV test sites a protocol for immediate connection to Early Intervention Services (EIS) or HIV primary care any individual whose rapid test is positive and who is deemed as being at risk of not remaining at or returning for a confirmatory test. Implementation: initiated FY2011; ongoing. Responsible: HIV CTR Coordinator, MDH.

(b) Cultural Challenges: Ensure, through annual site visits and reviews of compliance with Universal Standards that address culturally specific needs, that EIS and primary care sites to which clients are referred when testing positive will address client barriers based on cultural needs. Implementation: initiated FY2011; ongoing. Responsible: Part A services coordinator, contract manager, CQM coordinator.

T3. Moderate and Low Risk Individuals

(a) Priority Needs: Work with the Minnesota Midwest AIDS Training and Education Center (MATEC) to educate providers of primary medical care on the importance of routinely testing adults and adolescents for HIV, emphasizing the CDC recommendations for screening of patients who have not been tested in the previous 12 months. Implementation: initiated FY2011; ongoing. Responsible: Part A CQM coordinator, MATEC coordinator.

(b) Cultural Challenges: Develop and deliver education to providers that includes components to enhance cultural competence on best practices to address barriers to informing moderate- and low-risk individuals of their HIV test results. Implementation: initiated FY2011; ongoing. Responsible: Part A CQM coordinator, MATEC coordinator.

T4. People tested for STIs at Public Health Clinics

(a) Priority Needs: Provide funds, training, and tracking mechanisms as needed to increase the percentage of individuals receiving STI testing at the Hennepin County (HC) Public Health clinics who also receive routine opt-out HIV tests. Implementation: started in FY2010; ongoing. Responsible: Part A Services Coordinator, Public Health Clinic manager.

(b) Cultural Challenges: Educate providers at the public health clinic on the best practices to promote client participation in post-test counseling with a focus on addressing cultural factors, such as fear of disclosure, stigma, poor knowledge about HIV, emotional distress, or lack of previous connection to a healthcare provider. Implementation: FY2012. Responsible: HIV CTR Coordinator, MDH; Hennepin County Public Health Clinic manager.

T5. Young MSM

(a) Priority Needs: Part A funded Outreach and Health Education/Risk Reduction programs targeting YMSM develop and implement partner testing campaigns including using peer recruiters. Implementation: initiated FY2011; ongoing. Responsible: Part A contract managers, designated providers

(b) Cultural Challenges: Educate funded providers on the best practices to promote client participation in post-test counseling with a focus on addressing cultural factors, such as fear of disclosure, HIV and same-sex sexual behavior stigma, poor knowledge about HIV, emotional distress, or lack of previous connection to a healthcare provider. Implementation: initiated FY2011; ongoing. Responsible: Part A Services Coordinator.

T6. MSM Aged 29 and older

(a) Priority Needs: Provide funds, training, and tracking mechanisms as needed to increase the percentage of individuals who identify as MSM at the HC Public Health clinics who also receive routine opt-out HIV tests. Implementation: started in FY2010; ongoing. Responsible: Part A Services Coordinator, Public Health Clinic manager.

(b) Cultural Challenges: Educate providers at the public health clinic on the best practices to promote client participation in post-test counseling with a focus on addressing cultural factors,

such as fear of disclosure, stigma, poor knowledge about HIV, emotional distress, or lack of previous connection to a healthcare provider. Implementation: FY2012. Responsible: HIV CTR Coordinator, MDH; HC Public Health Clinic manager.

T7. African American Women

(a) Priority Needs: Part A Minority AIDS Initiative Outreach program will develop and implement a partner testing campaign and establish a formal referral relationship with the Hennepin County Public Health Clinic for referrals for confirmatory testing and Early Intervention services. Implementation: initiated FY2011; ongoing. Responsible: Part A contract manager, designated MAI provider.

(b) Cultural Challenges: Develop and deliver education to providers on culturally appropriate practices to address stigma and reduce barriers to accessing testing and healthcare services for African American, African-born, and Latino clients. Implementation: initiated FY2011; ongoing. Responsible: Part A clinical quality coordinator.

T8. African American MSM

(a) Priority Needs: Part A Minority AIDS Initiative Outreach program will develop and implement a partner testing campaign and establish a formal referral relationship with the Hennepin County Public Health Clinic for referrals for confirmatory testing and Early Intervention services. Implementation: initiated FY2011; ongoing. Responsible: Part A contract manager, designated MAI provider.

(b) Cultural Challenges: Develop and deliver education to providers on culturally appropriate practices to address same-sex sexual behavior stigma and reduce barriers to accessing testing and healthcare services for African American, African-born, and Latino clients. Implementation: initiated FY2011; ongoing. Responsible: Part A Clinical Quality Coordinator, HIV Services Planner.

T9. African-born Individuals

(a) Priority Needs: Routine HIV testing protocol is included in the refugee screening program at Hennepin County's Public Health Clinic. Implementation: initiated FY2011; ongoing. Responsible: HC Public Health Clinic manager.

(b) Cultural Challenges: Develop and deliver education to providers on culturally appropriate practices to address stigma and reduce barriers to accessing testing and healthcare services for African American, African-born, and Latino clients. Implementation: initiated FY2011; ongoing. Responsible: Part A clinical quality coordinator, HIV Services Planner.

T10. Individuals Newly Diagnosed HIV+

(a) Priority Needs: Develop peer outreach programs to provide peer support to individuals newly diagnosed with HIV and promote testing among their partners and social networks. Implementation: initiated FY2011; ongoing. Responsible: Part A Services Planner, part A Contract Manager.

(b) Cultural Challenges: Develop and deliver education to providers on culturally appropriate practices to address stigma and reduce barriers to accessing testing and healthcare services for African American, African-born, and Latino clients. Implementation: initiated FY2011; ongoing. Responsible: Part A Clinical Quality Coordinator, HIV Services Planner.

T11. Late Testers

(a) Priority Needs: Develop an intensive Disease Investigation/Partner Services approach to late testers that utilizes motivational interviewing to identify barriers to testing and facilitates partner contacts to offer testing. Implementation: FY2012. Responsible: MDH Partner Services supervisor, Hennepin County Disease Investigator.

(b) Cultural Challenges: Educate providers of HIV testing services on the best practices to promote client participation in post-test counseling with a focus on addressing linguistic and cultural factors, such as fear of disclosure, stigma, poor knowledge about HIV, emotional distress, or lack of previous connection to a healthcare provider. Implementation: FY2012. Responsible: MDH HIV CTR Coordinator.

T12. High Coinfection Groups

(a) Priority Needs: Develop an intensive Disease Investigation/Partner Services approach to PLWH who are co-infected with syphilis or Hepatitis C that utilizes motivational interviewing to identify barriers to testing and to facilitate partner contacts to offer testing. Implementation: started in FY2010; ongoing. Responsible: Part A Services Coordinator, HC Public Health Clinic manager.

(b) Cultural Challenges: Educate providers of HIV testing services on the best practices to promote client participation in post-test counseling and Disease Investigation/Partner Services with a focus on addressing cultural factors, such as fear of disclosure, stigma, poor knowledge about HIV, emotional distress, or lack of previous connection to a healthcare provider. Implementation: FY2012. Responsible: HIV CTR Coordinator, MDH

T13. Comorbid Groups

(a) Priority Needs: Incorporate outreach activities into Early Intervention Services provided by HC Public Health Clinic to increase partner testing offered at healthcare for the homeless clinics, substance abuse treatment facilities, and Hennepin County correctional facilities. Implementation: initiated FY2011; ongoing. Responsible: Part A contract manager; HC Public Health Clinic manager.

(b) Cultural Challenges: Educate providers of HIV testing services on the best practices to promote client participation in post-test counseling with a focus on addressing cultural factors, such as fear of disclosure, stigma, poor knowledge about HIV, emotional distress, or lack of previous connection to a healthcare provider. Implementation: FY2012. Responsible: Part A Services Coordinator; HC Public Health Clinic manager.

(3) Actions Taken to Facilitate HIV Testing in the TGA.

(a) The grantee coordinates testing efforts with the MDH, other CDC funded testing initiatives (including two projects of the Minnesota AIDS Project that target young MSM and those affected by substance use) and, the Minnesota Department of Human Services (Minnesota's Part B grantee). The grantee, based on allocations by the Planning Council, has funded and partnered with the Hennepin County Public Health Clinic (the state's largest HIV testing site) to identify opportunities for additional HIV testing activities. The EIIHA workgroup developed an activity matrix to assess how the HIV provider community is addressing its recommendations to the Planning Council to increase testing.

(b) The grantee has worked with the Hennepin County Public Health Clinic, the funded Early Intervention Services (EIS) provider, to address identified gaps in routine HIV testing among target populations not already being tested through funding from MDH, insurance or other sources. Three Ryan White funded programs of the clinic work to: a) identify, recruit and train peer educators/testing recruiters who will promote HIV testing among YMSM; b) pilot a project to offer EIS services on the same day to clients with a positive rapid test, including blood draws for a confirmatory test, CD4 count and viral load testing in addition to assessment of insurance coverage and need for additional services; c) pilot a "concierge" project aimed at connecting clients newly tested positive who are insured to an HIV specialty clinic for an appointment within 48 hours of their diagnosis. The concierge will offer emotional support and brief services

to address any identified barriers to connecting to HIV care. Peer navigators will assist clients in connecting with medical and supportive services.

(4) Identifying, Informing, Referring and Linking

(a) Identifying individuals unaware of their HIV status

- i) Activities essential for identifying PLWH who are unaware of their status. These activities focus on working in coordination with the MDH to identify the populations most likely to be affected by HIV but unaware of their status. In Minnesota, epidemiological data indicate that men who have sex with men continue to represent 54% of the prevalence, so activities that focus on connecting with MSM and encouraging them to be tested are a major focus. These include peer outreach to young MSM, promotion of routine HIV testing for all patients tested for STIs at the Hennepin County Public Health Clinic, and increased testing by the Healthcare for the Homeless program. Disproportionately represented communities in the epidemic, particularly African American women and African born and Latino immigrants, are the focus of activities to improve the effectiveness of Outreach programs to members of those communities who are aware of their HIV+ status but out of care, and to promote testing of their partners and social networks. Additional programs focus on increased HIV testing in the Public Health Clinic's Refugee clinic and a project to promote routine testing among adult publicly-funded Minnesota Healthcare Program recipients who are not receiving routine testing as part of prenatal care.
- a. The grantee has implemented, in FY2011, the following ongoing projects: YMSM Peer Outreach, increased testing by Healthcare for the Homeless and the Public Health Clinic Refugee program.
- b. Proposed activities that are in the research and baseline data collection stage include:
- i. Increased routine HIV testing for patients tested for STIs. Implementation: FY2012; Responsible: Public Health Clinic Manager; Part A CQM coordinator.
 - ii. Testing of partners and social networks of Outreach clients. Implementation FY2012; Responsible: Part A HIV Services Planner.
 - iii. Increased routine testing of Minnesota Healthcare Program adult recipients. Implementation: FY2012; Responsible: Part A CQM coordinator.
- ii) Coordination with Part B. The Part A and B grantees are working collaboratively on a Service Analysis Process (SAP) for Outreach services (provided by five contracted agencies, with funding coming from Part A, Part A MAI, ADAP MAI and state dollars). In FY2011, the grantees adopted updated standards for Outreach services developed during this process, and cooperated in gap analysis, training, and establishment of quality improvement goals for contracted Outreach providers. The Part A Services Planner serves on a steering committee that advises the Part B grantee's "Peer-to-Peer" project to engage consumers and help link other PLWH into care as needs arise for newly diagnosed people in the TGA. This Part B/ADAP MAI funded project was inspired by training provided by Mosaica, part of HRSA's *Project Consumer Linc*.
- iii) Coordination with prevention and disease control without supplanting funds. The Minnesota Department of Health has a position on the Planning Council (currently filled by Minnesota's State STD and AIDS Director) to facilitate understanding of programs and outcomes between prevention and Ryan White care services. The MDH also reports to the Part A grantee and Planning Council routinely on changes in the state's HIV epidemiological data. The grantees, Planning Council and MDH work together monthly to coordinate prevention and care efforts. Participation of MDH staff in the EIIHA workgroup and data from e-HARS, and MDH's Testing and Disease Intervention/Partner Services databases informed the selection of the target populations for the grantee's EIIHA efforts. The Government HIV Administrative Team (MDH,

DHS and Hennepin County) hold quarterly meetings to coordinate all state and local Ryan White and funded care programs with CDC and state funded CTR and HIV prevention programs to ensure efficient use of resources and consistent policies. The MDH's HIV epidemiologist and CTR coordinator also send data on the results of CDC and state funded testing programs to the Part A CQM Coordinator annually.

(b) Informing individuals of their HIV status

i) Activities essential for informing unaware individuals of their status. These activities focus on identifying and promoting best practices to facilitate client participation in post-test counseling aimed at informing them of their status, providing emotional support, initiating HIV medical care, and addressing barriers to connecting to care.

a. The grantee has implemented, in FY2011, a project to provide immediate CD4 and viral load testing and other initial HIV medical services to clients of the Hennepin County Public Health Clinic during the same appointment when positive rapid test results are obtained.

b. Proposed activities that are in the research and baseline data collection stage include:

i. Obtain an assessment from the MDH of the projected level of improvement (above 95% reported in 2010) of clients who receive post-test counseling and related education needs of providers to meet that improvement goal. Implementation: FY2012; Responsible: HIV CTR Coordinator, MDH.

ii. Develop and deliver education to providers on culturally appropriate practices to address stigma and reduce barriers when informing African American, African-born, and Latino clients of results. Implementation: FY2012; Responsible: Part A HIV Services Planner.

iii. Develop and deliver education to testing sites and Early Intervention providers on motivational interviewing techniques that effectively engage individuals who have not been regularly engaged in primary healthcare and/or have co-occurring conditions in following through on testing and learning their HIV status. Implementation: FY2012; Responsible: Part A HIV Services Planner.

ii) Coordination with Part B. The Minnesota DHS began funding the CareLink program in 2008 to enhance the MDH's Disease Investigation/Partner Services beyond its usual scope of identifying and notifying partners of newly diagnosed PLWH. In addition to notification, testing and referral services, this program works with newly diagnosed PLWH. The program refers them to Part A funded HIV primary medical care and follows up with PLWH and their identified partners to promote testing and linkage to care. Together with the Planning Council, the Part A grantee considers the number of people served by this program and outcomes when coordinating planning for Early Intervention Services, Outreach and Medical Case Management.

iii) Coordination with prevention and disease control without supplanting funds. The Part A grantee is co-located with the Hennepin County Public Health Clinic and funds its Early Intervention, Outreach, Health Education/Risk Reduction and Mental Health Access services. This clinic, which is the MDH/CDC funded test site that diagnosed 45% of new HIV cases in the state in 2010, has a Disease Investigation/Partner Services position funded by MDH. In the past year, this position has increased partner outreach and testing services, provides follow-up post-test counseling with individuals who either do not return for results or for a confirmatory test and provides referral and linkage services to the newly diagnosed.

(c) Referring to Medical Care and Services

i) Activities essential for referring individuals recently informed of HIV+ status to medical care. These activities focus on expanding the referral capacity and skills and relationships of Disease Investigators/Partner Services providers and Public Health Clinic staff who test clients for STIs

including HIV and provide healthcare for the homeless and refugee health screenings. As a result of these activities, in addition to successfully informing clients newly tested HIV+ of their status, they more effectively refer clients to HIV medical care that will meet their unique needs and circumstances.

a. The grantee has implemented two ongoing programs at the Hennepin County Public Health Clinic in FY2011 with a strong referral component: the Fast Track pilot and Concierge programs. Each program includes a protocol to identify the health insurance status of clients who test positive, and if they have coverage for private clinic care, to identify and address any barriers, with the goal of connecting clients to an appointment within 48 hours of the initial test result. This will include, for Fast Track clients, performing initial CD4, viral load, and CBC blood draws and assisting the client to provide releases of information so that test results may be conveyed to their HIV primary medical care providers. Clients receiving concierge services are assessed for barriers due to transportation, stigma, or emotional support needs and receive brief services to address these barriers and assist clients to follow up with referrals.

b. Proposed activities that are in the research and baseline data collection stage include:

i. Develop and distribute to HIV test sites a protocol for immediate referral to Ryan White-funded Early Intervention Services or HIV primary care any individual whose rapid test is positive and who is deemed as being at risk of not remaining at or returning to the test site for a confirmatory test. Implementation: FY2012; Responsible: HIV CTR Coordinator, MDH.

ii. Develop a reporting protocol to track the number of individuals who present for STI testing, identify as MSM or receive medical care at healthcare for the homeless clinics and refugee health screening at the Hennepin County Public Health clinics who also test positive for HIV that are referred for HIV medical care. Implementation: FY2012 Responsible: Part A Contract Managers, HC Public Health Clinics Manager.

iii. Develop and deliver education to providers on culturally and linguistically appropriate referral resources to use when referring African American, African-born, and Latino clients who test positive for HIV to medical care. Implementation: FY2012; Responsible: Part A HIV Service Planner.

iv. Develop and distribute to HIV testing and Early Intervention sites current referral information on Outreach, Medical Case Management, other core medical and supportive services that can address substance abuse and mental health needs and help meet basic needs. Implementation: FY2012; Responsible: Part A HIV Services Coordinator.

ii) Coordination with Part B. As part of the collaborative Outreach Service Analysis, the Part A and B grantees studied how referrals to HIV medical care are made for the newly diagnosed. The collaborative has recommended improvements to the updated standards based on their service analysis findings. Part B funds Minnesota's centralized Referral for Healthcare and Supportive Services which is routinely utilized by both consumers and Part A funded outreach workers and medical case managers. As implementation of the revised Outreach standards continues and moves into the evaluation phase in FY2012, the grantee will continue to collaborate with Part B on designing and implementing improvements to the referral network and protocols, and devise baseline measures for quality improvement initiatives.

iii) Coordination with prevention and disease control without supplanting funds. The MDH makes available to the Part A grantee its annual data on the number of people each year who test positive through CDC and state funded testing programs, are informed of their results, and referred to care. The grantee will compare these data to Ryan White client level data and engage in joint planning with the MDH to improve referrals. The Part A and B grantees and MDH

collaborate on convening two “All HIV Care and Prevention Provider Meetings” each year. A goal of these meetings is to strengthen prevention and care provider capacity and to facilitate cross-provider collaboration, creating a seamless continuum of prevention and care. Structured networking activities lead to both informal and formal referral relationships between CDC-funded prevention/testing programs and HIV care Outreach, Early Intervention, Outpatient/Ambulatory Medical Care and Medical Case Management programs.

(d) Linking to Medical Care

i) Activities essential to ensuring access to HIV medical care regardless of system entry point.

The Ryan White Program has created a continuum of care in the Minneapolis-St. Paul TGA that includes a robust system for linking people living with HIV who are aware of their status to quality medical care and the supportive services needed to help them enter and stay connected to care. Since 2007 increased allocations have eliminated waiting lists for Medical Case Management Services (MCM), helped mitigate economic barriers to accessing quality HIV medical care and improved access to substance use treatment and mental health services. Activities essential to ensuring access to care focus on strengthening the network of referral relationships among Points of Entry (POE) agencies, test sites and the Ryan White funded services most likely to be involved in identifying HIV+ people unaware of their status, promoting testing, and facilitating their connection to care: Outreach, Early Intervention Services, HIV Primary Care, and MCM.

a. The grantee developed an improved POE process for all Outreach services in FY2011, including training on the distinction between community points of entry and Ryan White care and services providers and the HRSA/HAB list of suggested POE sites; followed up during site visits on contractual expectations that formal POE relationships are documented, and initiated monitoring, technical assistance, and quality improvement planning to support effective Outreach activities following implementation of updated Outreach services standards.

b. Proposed activities that are in the research and baseline data collection stage include:

i. Develop a standard for reciprocal referral agreements among all Early Intervention Services, Medical Case Management, Outreach and the MDH’s five funded HIV test sites.

Implementation: FY2012; Responsible: Part A HIV Services Coordinator and Contract Managers.

ii. Develop a standard for reciprocal referral agreements among all Early Intervention Services, Medical Case Management, Outreach and HIV specialty clinics within the TGA.

Implementation: FY2012; Responsible: Part A Contract Managers.

iii. Promote a goal to increase to 100% the number of persons testing positive for HIV who are referred to a CareLink specialist at MDH or the Disease Investigation/Partner Notification specialist at Hennepin County Public Health for assistance to connect to care. Implementation: March 1, 2012. Responsible: MDH Disease Investigation/Partner Notification division and HC Public Health Clinic manager.

ii) **Coordination with Part B.** The Part A and B grantees have established a shared planning process through the Planning Council. Both grantees have collected data from all contracted providers since 2005 about the number of clients referred to HIV medical care, whether they have been seen in the prior six months, and the number of referred clients who received follow-up to confirm linkage to care. The grantees will continue to examine this data and discuss strategies with the Planning Council to improve access and retention in care. The Part A grantee also works closely with the Part B ADAP and HIV insurance programs to ensure that Part A funded Outreach, Early Intervention and Medical Case Management providers are trained to

assist the newly diagnosed in accessing Part B-funded medical care reimbursement mechanisms so inability to pay does not become a barrier that delays care.

iii) Coordination with prevention and disease control without supplanting funds. The MDH amended the Minnesota Communicable Disease Reporting Rule, effective July 1, 2011, to require all laboratories to report to MDH the results of all CD4+ lymphocyte counts and percents and the results of all HIV viral detection laboratory tests. This change will allow the grantee and MDH to work together to improve data about individuals who have been informed of HIV positive results who are not consistently linked to care. These data will inform planning and quality improvement efforts. In addition, the MDH, which administers both e-HARS and the Part A and B grantees' Minnesota CAREWare client-level database, received a grant in 2011 from the CDC to develop the protocols and program CAREWare to be able to upload CD4 counts and viral load values from e-HARS into CAREWare so these clinical indicators are reported for all consenting Ryan White clients. This will enable improved tracking of linkage to and retention in HIV medical care for Ryan White clients receiving Early Intervention, Outreach and Medical Case Management services.

iv) Post-referral activities to verify medical care by a Ryan White-funded program was accessed. The Part A and B grantees in Minnesota collaborate with the MDH on a Ryan White Client Level Data system to collect and report both HRSA/HAB required client level data and quality measures and outcomes data related to Ryan White services.

a. Providers are required to enter the date of each client's HIV diagnosis when reporting service utilization. Every six months, all providers must complete a custom form in the database to document for all clients whether they received HIV medical care in the previous six months, if they were referred if not current in care, and whether this referral was followed up to confirm that clients accessed care. These data points have been collected by the grantee for all contracted providers since FY2005.

b. Proposed activities that are in the research and baseline data collection stage include: The grantee is contracting with the developer of CAREWare, its client level data collection system, to make programming changes that will allow assessments of clients' HIV medical care, referral and follow-up status to be done on a per-provider and programmatic basis. This will allow for quality improvement planning targeting providers who need to increase their capacity for post-referral follow-ups. Implementation: FY2011 (ongoing); Responsible: Part A Data & Outcomes Coordinator and Clinical Quality Management Coordinator.

v) Post-referral activities to verify medical care by a private HIV medical provider was accessed

a. The Part A grantee currently has contractual arrangements with three large HIV clinics in the TGA to provide Outpatient/Ambulatory Medical Care, Medical Case Management and other core and supportive services. Two of these programs have co-located medical case managers at two other large private clinics providing primary medical care. The Hennepin County Public Health Clinic's concierge program also has formal agreements with five private HIV clinics in the metropolitan Twin Cities area designed to make appointments on short notice for newly diagnosed individuals who have insurance.

b. Proposed activities that are in the research and baseline data collection stage include:

i. Collaborate with Part B's Peer-to-Peer program in its effort to strengthen relationships with private HIV care providers to verify that individuals referred into private care have accessed care by developing similar agreements to those the Public Health Clinic uses. Implementation: FY2012; Responsibility: Part B Program Director.

vi) Efforts to address legal barriers to routine testing. Minnesota has no state or local laws that present legal barriers to routine testing for the majority of the population. The most significant legal barrier relates to people who are incarcerated for relatively brief times in the county jails. While an initial medical screening is completed by medical personnel during the intake process, and individuals are asked whether they have a communicable disease (including HIV infection), the correctional facilities are not required to complete a medical evaluation (including any screenings or tests) more quickly than within the first 14 days of incarceration. Since the average length of stay in county jails is 4-5 days, most people leave the system before they have an opportunity to be screened for HIV. Both of the public health clinics of Minnesota's two largest urban counties (Hennepin and Ramsey), provide HIV testing in the county jails for individuals who request it. The grantee will continue to partner with the MDH and Hennepin County Public Health & Clinical Services to advocate for routine opt-out testing at intake for people entering the county correctional system.

2) C. Data

(1) Estimated number of PLWH who were unaware of their status as of 12/31/09 in the TGA: 1,531. This estimate was arrived at using the Estimated Back Calculation Methodology based on the national proportion of undiagnosed of 21% and the 2009 HIV/AIDS prevalence in the TGA of 5,759 thus $(.21/.79) \times 5,759 = 1,531$.

(2) Coordination of data collection and sharing with Part B: The Part A and B grantees, in partnership with the MDH, have an established collaborative that administers a shared client-level database for all Part A and B funded services in Minnesota. Because the MDH also provides HIV surveillance for the state and maintains it via its eHARS database, the collaborative meets every other month to explore ways to coordinate the two databases to improve linkage to care for all PLWH in Minnesota.

(3) Coordination with Disease Control and Prevention/Intervention of Testing and Awareness Data. Minnesota's shared Ryan White Client Level Database for Part A and B services is administered by the MDH. This arrangement allows for coordination among the grantees and MDH of data about PLWH accessing Ryan White funded services. Because both systems are names based, it has allowed the MDH STD/HIV Division to identify individuals receiving Ryan White services who are not in the eHARS database and contact their medical providers to correct reporting oversights. The grantee and MDH are exploring additional opportunities to coordinate these databases to improve unmet need estimates and are considering methods to determine community viral loads. The MDH received CDC funding in 2011 for one project to support this goal. It is developing a programming link to upload CD4 and viral load test data from its eHARS data system into Minnesota CAREWare. One benefit of this project will be the ability to demonstrate the impact on viral load on the population of PLWH who receive Ryan White-funded care and services compared to community viral load estimates.

(a) HIV Testing & Awareness Data. See **Attachment 10**.

3) Access to HIV/AIDS Care and the Plan for FY2012

3) A. FY2012 Implementation Plan Table. Attachment 7 presents four core medical services included in the TGA's FY2012 Implementation Plan in order of Planning Council priority: Outpatient/Ambulatory Medical Care (Priority # 1); Medical Case Management (#3); Mental Health Services (#7); and Substance Abuse Treatment Services/Outpatient (#11). The two supportive service categories presented in the plan are Food Bank/Home Delivered Meals (#4) and Emergency Financial Assistance (#8). The Planning Council assigned allocations to these

areas in September of 2011 according to needs assessments conducted in 2008-2010 and expenditure data from 2009 and 2010. The amount for the six service areas combined comprises 89% of the Part A budget for services.

3) B. Implementation Plan Narrative

The TGA's established continuum of HIV/AIDS care and access services has multiple points of entry for those who are newly diagnosed or PLWH who need to be connected to care. A statewide telephone referral service provides confidential information about HIV and connects callers to resources. The MDH funds HIV testing sites in clinical and community settings that refer newly-diagnosed individuals into the HIV care system. The TGA contracts with a provider of Early Intervention Services based in Hennepin County's public-health clinic to provide medical care, laboratory testing, and assistance to connect to ongoing primary care and support services. Three Outreach providers (one MAI funded to focus on providing services to African American and African-born PLWH) plan activities to identify HIV+ individuals who know their status but are not in care, assisting them to overcome barriers to 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); Treatment Adherence through three providers; Mental Health services at three clinic-based and four community-based agencies; one Home & Community-based health services provider; Medical Nutritional Therapy; and four clinic-based providers of Medical Case Management (MCM) services. One community-based provider receives Part A MAI funds to provide MCM services to African American PLWH. Part B and State funds support MCM programs at five community based organizations that target services to African-born individuals, African Americans, American Indians, youth and MSM. The Minnesota Department of Human Services administers the State's Part B funded ADAP and State funded HIV Insurance Program which are forecast to meet the needs of eligible PLWH through June 2015. Oral Healthcare for the TGA's uninsured and underinsured PLWH is funded through a combination of Ryan White Part A and B funds. Substance Abuse Treatment services are accessed through Minnesota's publicly funded healthcare programs and through the state's Consolidated Treatment Fund which is available for those with incomes up to 215% of FPL. Since FY2009, Part A has funded Rule 25 assessors embedded in two large case management programs to facilitate access to publicly-funded substance use treatment. The funded Mental Health Access programs that focus on African American, African-born, Latino populations and MSM provide entry level Mental Health services. Support services that 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. 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.

(1) The Planning Council relied on the results of the following needs assessments to prioritize services for fiscal years 2011 and 2012, allocate funds to services for FY2012, and formulate the goals for the 2009-2011 Comprehensive Plan: 1) Oral Health and Behavioral Health Services Assessment and Path to Care Study (2008); 2) 2010 Consumer Needs Assessment Survey; and 3) Unmet Needs Estimates, 2008 – 2010.

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

2012. The results of the needs assessments, along with the most recent Unmet Need estimate (**see Attachment 6**), identified the following strategies to meet the healthcare and social service needs of PLWH in the TGA: a) Continue to ensure access to publicly funded healthcare coverage; b) Increase access to the primary healthcare system; c) Ensure that PLWH have their basic needs met including housing, nutrition and medical transportation; d) Improve access to behavioral health services (mental health and substance abuse treatment); e) Enhance awareness of existing HIV services; and f) Mitigate cultural and linguistic barriers to care.

The Planning Council's priorities closely match consumer rankings in the 2010 Consumer Needs Assessment, with five of the seven top-ranked service areas in the Planning Council Priorities for 2011-2012 within one or two places of consumers' priorities. ADAP, Health Insurance Premium assistance, Food Bank/Home Delivered Meals, Oral Healthcare, and Mental Health services appeared in both groups' top seven services. While Outpatient/Ambulatory Medical Care and Medical Case Management were not as highly ranked by consumers as the Planning Council, the majority of consumers participating in the survey said they were receiving these services and were thus seen as unlikely to identify them as a need. With an estimated 24% of PLWH in the TGA not current in care according to the Unmet Need estimate as new HIV cases increase and public funds for healthcare remain flat, the Council continued to prioritize these two core medical services to ensure access. Other objectives in the plan, including Mental Health services, Outpatient Substance Abuse treatment, Food Bank/Home Delivered Meals, and Outreach, focus on facilitating access to complete healthcare, addressing comorbidities that complicate access to HIV medical care and mitigating health-related consequences of poverty.

(2) Since the Planning Council also serves as the planning body for Part B, the AIDS Drug Assistance Program (ADAP) is included as a core medical service funded solely by Part B in the statewide plan. Although ranked tenth in priority, the Planning Council did not allocate Part A funds for the ADAP. The anticipated ADAP award and the forecast for drug rebate revenue are deemed adequate to meet the ADAP needs of Minnesota's PLWH in 2012. Continued solvency of Minnesota's ADAP precludes allocating funds for a Local AIDS Pharmacy Assistance Program. Also, home healthcare and hospice are covered through Minnesota Healthcare programs and private insurance, and thus are not allocated Ryan White funding.

(3) Medical Case Management (MCM) is an important key to entry into the continuum of care in the TGA. MCM facilitates initiation and continuation of primary medical care, assistance to access health insurance, treatment adherence counseling, basic behavioral health assessments, and HIV risk reduction interventions, as well as addressing the individual basic needs of PLWH. Service plans include regular reassessment of all cultural and socioeconomic factors that can interrupt HIV primary medical care. The 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 multilingual 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 MCM in FY2012 is \$2,054,700 to continue to ensure that this critical service is available to all eligible PLWH in the TGA.

The objective of Culturally Appropriate Primary Care is to provide multidisciplinary healthcare services for Spanish-speaking PLWH and is supported with Part A and MAI funding, to provide healthcare services for 61 Spanish-speaking PLWH. It is of particular importance among undocumented immigrant PLWH who are ineligible for Minnesota's publicly-funded

health programs. High levels of poverty among the TGA's populations of color, particularly African-born and Spanish-speaking immigrants, which combined with a shortage of adequate numbers of mental health practitioners, contribute to unmet need for Mental Health services. The Plan objective to provide individual and group mental health services helps address that need. Through an African specific agency, mental health groups address stigma, isolation and fear of HIV for African-born PLWH. 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 (MCM), Mental Health, Primary Medical Care, Food Bank/Home Delivered Meals, Emergency Financial Assistance, Medical Transportation and Linguistics services.

(4) The continuum of access services, especially MCM, addresses the needs of emerging populations by placing an emphasis on services that are culturally appropriate and diminish barriers to care. These populations include men who have sex with men 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. Two Outreach service providers focus their activities on connecting African Americans and MSM to primary care, MCM and supportive services that address barriers to accessing and maintaining medical care. 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 necessary for effective long-term treatment of HIV. Among these, the Food Bank/Home Delivered Meals program is funded to provide nutritional services that maximize the benefits of primary medical care. Fiscal year 2012 objectives for this program are met through provision of home-delivered meals, emergency food shelf services, congregate meals, and emergency food vouchers. 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 Onsite Meals provider also provides a Food Shelf, receives state funds for MCM and is often a referral point of entry into primary care. Part A began funding Medical Nutritional Therapy in 2009 through registered dietitian services at two major HIV medical centers to assess the needs of and assist clients enrolled in the Part B nutritional supplement program. Food Bank & Home Delivered Meals programs help to address needs for adequate nutrition and reduce the forced choice between medical care and paying for food.

As unemployment rises and employer-sponsored healthcare benefits shrink, more PLWH in each of the TGA's emerging populations apply for Emergency Financial Assistance (EFA). Priority is given to applications for assistance to prevent 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 to maintain regular HIV medical care. The \$237,000 allocated for EFA in FY2012 will result in up to \$390 in assistance for 1,053 clients. The objective of Emergency Housing Assistance (incorporated into the EFA program) is to provide direct financial assistance to mitigate homelessness. Additional supportive services included in the complete plan to promote access to and maintenance of primary care include: Health Education/Risk Reduction; Outreach services that target people who know their status and are not currently in care, including an MAI funded program that targets African Americans.

(5) Early Intervention services will provide 61 newly tested individuals in FY2012 with healthcare exams, preliminary lab work and referrals to support entry into care. Several objectives are aimed at assisting PLWH with maintaining access to care. Primary care will be provided for a total of 573 PLWH in the TGA. An additional 61 individuals will receive Culturally Appropriate Primary Care funded through Part A MAI. Since these funds must be used as a last resort, they provide a critical safety net for the uninsured to enter the primary care

system. Medical Case Management will be provided to 1,190 PLWH to assess needs for and facilitate access to HIV primary medical care. An additional 64 African American clients will receive MCM services funded by MAI. Medication adherence counseling will be provided to 757 PLWH, to include assessment, counseling, education, tools and follow-up services provided through HIV clinics at two large medical centers in Minneapolis. A total of 24 individuals who are physically challenged by the effects of HIV or comorbid conditions will be provided with homemaking services that contribute to their ability to function independently. As a core medical service, \$120,400 in Oral Health services will help to address the disparity in access to optimal oral healthcare 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.

(6) Because the vast majority of PLWH in the TGA reside in Hennepin and Ramsey counties (83%), 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 12**). Medical Transportation services are provided using Part B funds and include a cooperative process for PLWH to obtain rides, bus cards or taxi vouchers to medical appointments. The Part A grantee facilitates an annual meeting where contracted transportation providers plan together to make services available in all sectors of the TGA while avoiding duplication. A Culturally Appropriate Primary Care program is located in 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.

(7) Applicants to become Part A service providers must address the following: a) How their programs 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; b) Plans to involve members of the target population in program development and evaluation; and c) Agency plans to maintain program staff that reflects the target population by at least 50%. In addition, during annual site visits, the grantee's contract managers and quality coordinator assess each agency's ability to provide culturally appropriate services and cover free access to interpreter services which receives a combined Parts A and B allocation of \$15,000.

(8) The TGA's complete 2012 Implementation Plan addresses the Healthy People 2020 goal for HIV: "Prevent human immunodeficiency virus (HIV) infection and its related illness and death." Activities planned for 2012 will focus particularly on the following: **HIV-9** Increase the proportion of new HIV infections diagnosed before progression to AIDS; **HIV-10** Increase the proportion of HIV-infected adolescents and adults who receive HIV care and treatment consistent with current standards; **HIV-12** Reduce deaths from HIV infection; **HIV-11** Increase the proportion of persons surviving more than 3 years after an AIDS diagnosis. The 2012 Implementation Plan addresses additional Healthy People 2020 goals by promoting routine testing, providing outreach to partners and social networks of PLWH, and bringing PLWH who know their status into care, thus reducing transmission and disease progression. These additional goals addressed by the Plan include: **HIV-4** Reduce the number of new AIDS cases among adolescents and adults; **HIV-6** Reduce the number of new AIDS cases among adolescent and adult men who have sex with men; **HIV-13** Increase the proportion of persons living with HIV who know their serostatus.

(9) Meeting the service needs of Women, Infants, Children and Youth (WICY) 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 22% of living HIV/AIDS cases, while Youth (age 13-19) make up 1%, and Infants and Children (age <13) make up less than half of 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 were granted joint WICY waivers for 2003 through 2011. Despite the waivers, the grantee and Planning Council make every effort to ensure that Part A and B resources for WICY are proportionate to their representation in the epidemic. Women are generally overrepresented in Ryan White funded services in the TGA; for example, in 2010, 29% of those accessing Case Management services and Primary Care were women. Emergency Financial and Housing Assistance, Food Shelf, Food Vouchers, Onsite and Home-Delivered Meals address additional barriers to care by meeting women and children's basic needs.

(10) The Planning Council approved an MAI plan for 2012 that includes allocations for Culturally Appropriate Primary Care (\$145,700), Medical Case Management (\$75,500) and Outreach (\$50,000). While each of these services is broadly addressed in the 2012 Implementation Plan, the addition of targeted MAI funds that are used to provide culturally specific services will increase the number of disproportionately represented minorities who access care and improve their outcomes by addressing barriers unique to each culture.

(11) Unmet need data were used by the Planning Council in setting priorities and allocations for 2012. Its Needs Assessment & Evaluation and Planning & Priorities committees reviewed the 2009 MDH report on the estimate of the number of PLWH who were out of care. The report indicates that 43% of people living with HIV in the TGA did not receive primary medical care. It included unmet need estimates by gender, race and ethnicity. The Council used this as one source of information to prioritize services and allocate resources to service areas that connect people to care (Outreach, Early Intervention Services, MCM, Outpatient/Ambulatory Medical Care). In addition, the 2010 Needs Assessment asked a series of questions related to unmet need. Respondents who indicated they had needed but not received each of the funded services were asked what barriers they experienced. These data were provided to the Council in service area review summaries.

(12) The Council provides joint planning for the Part A and Part B grantees. Each year, prior to allocations, the Part B grantee provides an ADAP forecast that addresses the solvency of the ADAP program in the state and the need for medications in the Part A TGA and the entire State. Because the most recent ADAP forecast indicated solvency for the ADAP program through FY2015, the Council did not allocate any resources to the provision of medications.

(13) Council members and support staff served on the EIIHA workgroup convened by the Part A and B grantees, the MDH, and the Council to address EIIHA requirements. The work group made recommendations of strategies to identify persons unaware of their HIV status and help them get into care. Recommendations from this workgroup were presented to the Council during the prioritization and allocations processes. The allocations approved by the Council in September 2011 for FY 2012 included allocations to Early Intervention Services, Outreach, and Outpatient/Ambulatory Medical Care targeting all of the populations identified by the EIIHA workgroup.

4). Grantee Administration

4) A. Program Organization

(1) Administration of Part A Funds. The Part A grantee organizational chart and staffing plan are presented as **Attachment 1**. The Chief Elected Officer, the Chair of the Hennepin County Board of Commissioners, designates the Public Health & Clinical Services (PHCS) 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 PHCS' Public Health Protection Sr. Administrative Manager. In addition to the RWP Supervisor, the grantee administrative team includes: an HIV Services Planner; two Contract Managers from the HSPHD's centralized Contract Administration area; 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 2.5 FTE administrative staff and 2.1 FTE Clinical Quality Management staff (see **Budget Narrative Attachment** and **Attachment 1B** 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 hiring procedures.

A Memorandum of Understanding between the Planning Council and Part A grantee sets their agreed-upon roles and responsibilities and establishes the staffing structure for the Council. Council staff includes the Council Coordinator and Administrative Specialist. The Part A grant supports 1.5 FTE Council staff (*see Budget Narrative Attachment for detail*) which is supervised by the Ryan White Program Supervisor.

(2) Process and Mechanism for Distinguishing Client Funding Streams. Client-level data entry is the primary mechanism by which the different funding streams (Parts A, B, C and state) are distinguished for each unique client. The Minnesota CAREWare centralized application serves as the joint Part A and Minnesota Part B client-level database. All Part A, B and C and state funded Minnesota providers enter their required client-level data into Minnesota CAREWare. Contracts in CAREWare are set up to distinguish between funding streams including Parts A, B, C, Part A MAI, ADAP MAI and state funded HIV services. When providers enter client-level service data into CAREWare, they are required to select the contract which indicates the source of funding for the service. For each distinct CAREWare service unit entered, only one source of funding can be selected so providers must assign each unique client to a single source of funding for each specific service delivered. Grantee contract management staff generates service unit reports from CAREWare that monitor provider assignment of funding sources to ensure that each client service is reimbursed through only one source.

4) B. Grantee Accountability

(1)(a) Steps taken by the grantee in 2011 to implement the National Monitoring Standards.

Grantee administrative staff conducted a comparison analysis of the National Monitoring Standards (NMS) with the existing local Part A *Universal Standards for Ryan White Providers* and programmatic and fiscal monitoring practices. The goal was to identify areas to improve in order to better meet NMS. Grantee program staff shared the NMS with all contracted providers to help identify their needs in meeting the NMS. As a result, provider contract language has been revised to better capture NMS requirements. Contract managers have subsequently provided technical assistance on how to obtain indirect cost plan approval. Contract budget line items for rent are now considered administrative costs. Each spring the grantee site visit team reviews and revises the Part A site visit protocol based on any changes in HRSA requirements and an evaluation of the previous year's site visit results.

(b) Process to separately track formula, supplemental, MAI, and carryover funds. Because of the penalties for unobligated formula funds established by the Ryan White Act, budget allocations for administration, clinical quality management and services are each divided based on the proportion of the grant award that is formula and supplemental.

Carryover funds are obligated separately in provider contracts and expenditures are tracked accordingly. A separate MAI administration and clinical quality management budget is developed and MAI funds for services are obligated separately in MAI subrecipient contracts. At the end of the fiscal year, once all subrecipient invoice payment have been disbursed, the amounts of unobligated funds for administration, clinical quality management and services are multiplied by the proportion of the award that is comprised of formula and supplemental funds to determine the amounts of unobligated formula and supplemental dollars.

Data systems utilized to track expenditures include a Ryan White Program (RWP) master financial management and contractor invoice Microsoft Excel workbook that is maintained by the grantee office. Hennepin County Office of Budget and Finance currently uses Apex (PeopleSoft) for its accounting system. Separate cost centers are assigned to Part A administration and contracted services, Planning Council and Clinical Quality Management.

(c) Process used to ensure timely monitoring and redistribution of unexpended funds. The Planning Council's allocations process is designed to avoid unobligated balances. At the meeting to allocate funds for FY2011, the Council assumed that the Part A award would be the same as in FY2010. This enabled the grantee to obligate all funds allocated to services in provider contracts by the beginning of the fiscal year. Once the award notice was received the Council made allocation adjustments based on the award increase. The final FY 2011 award noticed wasn't received until September 1st and the Council made final allocations at the September 13th meeting. Provider contracts were adjusted through ministerial adjustments to increase funding of designated services effective November 1, 2011, thus obligating 100% of funds for services. For FY2011, the grantee assumed that support for administration, planning and quality management would also be the same as in FY2010 and obligated funds in FY2011 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 quality management program are assigned separate cost centers in the County's financial management system to separately track expenditures ensuring that administrative and quality management caps are not exceeded.

All service contracts include a reallocation policy. If more than 40% of a contractor's program budget isn't expended by the end of the first half of the fiscal year, budgets can be reduced and funds allocated to other providers. RWP staff review spending and take into account expected temporal trends in expenditures before identifying opportunities for fund reallocation. If other programs within a prioritized service area can utilize funds, the grantee amends provider contracts to redistribute them. If utilization patterns or cost increases do not indicate a need for redistribution of funds within a service area, the Council reallocates funds to another prioritized service area. Contract managers then amend contracts to deliver the expanded services.

(d) Fiscal and program monitoring. Subrecipient program budgets are negotiated according to HRSA and Hennepin County guidelines. Budgets reflect HRSA line items for ease of reporting and satisfying conditions of award. If a subrecipient fiscal or programmatic problem is identified, RWP staff meets with the contractor to discuss solutions and determine if technical assistance is needed which may be provided by RWP staff or an outside consultant. Invoices are not approved for payment if an agency has outstanding fiscal issues. Invoice audits are also conducted to ensure that documentation properly supports all units billed. The Contract Administration audit staff conducts comprehensive fiscal audits of at least two subrecipients annually.

To improve contractor accountability and better assess cost effectiveness of services, the grantee continues to phase in unit rate contracting. The grantee procures Primary Care, Medical

Case Management, Oral Health Care, Substance Abuse Treatment/Outpatient, Home and Community-Based Health Services, Food Shelf/Home Delivered Meals and Emergency Financial Assistance on a unit rate basis. Most contractors submit invoices for expenditures monthly. A few large 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 and a description of client needs that are unmet. 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.

(e) Frequency of 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 assess compliance with contractual goals and objectives and soundness of fiscal management; document charting practices and compliance with client eligibility determination requirements; ensure that RWP 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 and HRSA's program and fiscal monitoring standards. The site visit format also allows the team to evaluate organizational structure, personnel management capacity; compliance with client utilization and outcomes data reporting; and assess emergent needs of PLWH/A and technical assistance needs of providers. The site visit team comprises the grantee's Services Planner, Contract Manager and Clinical Quality Management (CQM) Coordinator. Prior to the site visit, the RWP contract manager reviews: the contractor's most recent financial statement and audits, including A-133 single audits if applicable; 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. The CQM Coordinator reviews client charts to assess compliance with the TGA's Universal Standards for service delivery.

(f) Process for corrective actions related to fiscal or programmatic concerns. Following each site visit; a report summarizing findings and any indicated corrective action is sent to the contractor. 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 concerns. The Services Planner assists the Contract Manager 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 follows up to assess progress toward meeting the plan's goals.

(g) Number and Percentage of Contractors that Received a Site Visit in FY2011. Grantee staff conducted annual site visits at all 13 (100%) Part A contracted agencies.

(h) Improper charges, other findings and a Summary of Corrective Actions in FY 2011.

There were no findings or corrective actions from the nine comprehensive fiscal audits. From the annual site visits of all 13 providers, one agency received corrective action for not meeting documentation standards for informed consent, Bill of Rights, care status, financial eligibility and release of information. Another agency received corrective action for not meeting screening requirements for Mental Health Services and documentation requirements for Outreach. A third provider was late in submitting client level data. The audit summary letter highlighted these corrective actions. Technical assistance was provided to improve documentation, reporting, and meeting programmatic standards for these providers. The providers were required to and sub-

mitted an approved plan to address the corrective actions on October 7, 2011. Monitoring of corrective action plans will continue through FY 2011.

(i) Contractors That Received Technical Assistance (TA) in FY2011. All 13 (100%) Part A contractors received TA and/or training in FY2011. Technical assistance was provided by the grantee's TA consultants Community Consulting Group, and the National Office of Minority Health Resource Center. Contract Managers and the CQM Coordinator provided TA in the following areas: tracking expenditures; transportation collaboration; program promotion; grant writing and engaging African clients in culturally competent dialogue on sexual health.

(j) Contractor compliance with the audit requirement in OMB Circular A-133. Prior to site visits, providers are required to submit copies of their most recent annual audit including their A-133 single audit if they receive at least \$500,000 in federal funds. Contract managers review all audits and financial statements to assess sub-recipient fiscal stability and compliance with the Single Audit Act/OMB Circular A-133 requirements. In FY2011, all seven contractors receiving \$500,000 or more in federal funds complied with the A-133 audit requirements.

(k) Findings and response to OMB-Circular A-133 findings. No findings were identified.

(l) Process of receiving invoices from contractors/subcontractors. Contractors submit invoices on a monthly or quarterly basis. Only large health care institutions submit invoices quarterly. The grantee uses a standard electronic invoice form, which reflects contracted budget line items, to assist providers in managing their budgets. Contractors are expected to submit invoices to Accounts Payable by the 15th of the month following the period during which services were provided. Final invoices for the fiscal year are due by April 15.

(m) Process of payment made to contractors/subcontractors. Invoices and unit tracking spreadsheets are reviewed by the RWP Contract Manager for accuracy and compared to the program budget, entered in the RWP financial management invoice workbook and submitted to the Financial Analysis and 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 works 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 APEX reports is reconciled with the invoice amount and entered into the financial management workbook.

(n) Compliance with Federal Funding Accountability Transparency Act (FFATA). In July 2011, the Ryan White Program Supervisor inquired about FFATA's applicability to Ryan White Program grants and was informed by the TGA's HRSA Project Officer that Ryan White grants are not subject yet to the FFATA but may be in 2012.

(2) Fiscal Staff Accountability

(a) i) Program staff play the lead role with assistance from analysts in the County's Financial Analysis and Accounting Area (*see Attachment 1C*) to provide fiscal oversight of the Part A grant. Contract managers monitor spending through invoice review and entry into the RWP financial workbook before they are approved for payment. Support staff reconciles payments to contractors with invoice amounts monthly and enter all Administrative and Quality Management expenditures in the RWP financial workbook. The RWP Supervisor completes Part A budgets, monitors overall spending, presents quarterly expenditure reports to the Planning Council and works with the Financial Analysts to prepare grant Federal Financial Reports (FFR) and HRSA PMS disbursement reports submitted for grant payment draw downs. Contract Administration audit staff conducts comprehensive fiscal audits of Ryan White Part A subrecipients.

- ii) The RWP Supervisor meets with the financial analysts to resolve any contract payment problems or discrepancies discovered during the invoice/payment reconciliation process. The Program Supervisor also meets with fiscal staff prior to submission of the final FFR to reconcile any discrepancies between the Ryan White financial workbook and the County's payment system.
- iii) See **Attachment 1C** for an organizational chart of fiscal staff.

4) C. Third Party Reimbursement

(1) (a) 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. The grantee's instrument for primary care provider site visits assesses whether processes are in place to ensure that all third-party funding sources, including Medicaid, have been exhausted prior to the utilization of RWP funds. The Quality Coordinator reviews a statistical sample of client charts to verify client insurance status and that Ryan White eligibility was determined. To ensure that all Medicaid-eligible providers are certified, the grantee's Contract Managers check with the Department of Human Services to verify that each of the primary care providers receiving RWP funds has an active Medicaid provider number (all did in 2011). All RWP provider contracts contain the following language: *"Third party payments must be exhausted prior to accessing Ryan White grant dollars. The provider must ensure that Ryan White program funds remain the payer of last resort."*

(b) 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, or the HIV Insurance Program; and other public programs. Contractors are required to report these items using the Ryan White Part A and B grantees' centralized database in January and July. Insurance information is also documented in client charts. 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, some Mental Health services, Health Education/Risk Reduction sessions, or legal services.

(c) The Part A grantee does not generate any program income. Since no Part A funds are allocated to Minnesota's ADAP or a Pharmacy Assistance Program, no rebates are received.

4) D. Administrative Assessment

(a) The Planning Council's most recent evaluation of the administration of the Part A grant, completed October 21, 2011, used six measurement objectives. The Planning Council's assessment of the efficiency administrative mechanism is summarized as follows:

Minnesota HIV Services Planning Council Assessment of the Administrative Mechanism Part A Fiscal Year 2011 (N=21)		
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.	21	0
2. Implementation of a process to monitor spending and reallocate funds which aims to limit the amount of combined unspent Part A and B funds to not more than 10% at the end of the fiscal year (2010).	21	0
3. Determination of non-competitive funding was based on established criteria: provider selected through past RFP; record of quality service delivery; demonstrated HIV competency; established infrastructure; cost effective; and continuity of client care.	19	0
4. Redistribution of funds within a service category was based on the following: provider ability to utilize additional funds; provider capacity; impact on unmet need; sustainability of service after redistribution of funds; and specific Council directives.	19	0
5. Per service area/activity, sufficient number of providers is based on: number of contracts that can be administered; amount of funding allocated for each prioritized service area/activity; allocation requirements for populations with special needs; availability of qualified providers.	20	0
6. Award per service area/activity complies with Planning Council prioritization (2010) and allocation amounts set by Planning Council in August 2010 and subsequent reallocations.	20	0

Seventy percent of Planning Council members returned the evaluation instrument; however, two respondents did not evaluate measurement objectives 3 and 4, and one did not evaluate objectives 5 and 6. All respondents indicated that all objectives were met.

(b) No corrective action was recommended.

(c) No deficiencies per se were noted. One member commented "not enough justifications provided" on objective 3. The grantee is currently conducting a competitive request for proposals process that will select most providers to be funded in FY 2012.

5) Planning and Resource Allocation

5) A. Letter of Assurance from Planning Council Chairs - See **Attachment 2** for the Letter of Assurance from the Minnesota HIV Services Planning Council co-chairs.

5) B. Description of Priority Setting and Resource Allocation Processes

The Planning Council completed its biennial prioritization process for Fiscal Years 2011-12 in August 2010. The Council prioritizes services and allocates funds for both the Minneapolis-St. Paul TGA and Minnesota Part B. In 2010, the Planning & Priorities Committee refined the prioritization process based on feedback from past processes. It also reviewed the HRSA allowable services eligible for funding and selected those to be funded with Minority AIDS Initiative (MAI) funds. The full Council approved the list of services to be prioritized and the MAI services to be funded. The Needs Assessment & Evaluation Committee reviewed data from a variety of sources, studies, and surveys to create Service Area Review Summaries. Council members received a summary for each service category. Priorities were determined by each member using a grid on which they compared each service individually to all of the others indicating which one they considered more important based on the data. Members completed the form individually or in a session with Council staff to answer questions about the services and/or the process. The paired comparison analysis mechanism resulted in each service area receiving a score from each member. Aggregate scores provided the final prioritized list of services.

The Planning & Priorities Committee proposed values and guidelines for the Council to make allocation decisions. The Council approved the values that demonstrate the importance of data-based decision making and consideration of the needs and input of PLWH. At its September 2011 meeting, allocations for FY2012 were presented and approved. The Council will consider allocation adjustments when FY2012 Notices of Grant Awards are received.

(a) How the needs of those not in care were considered. The Needs Assessment & Evaluation Committee compared demographic patterns of client utilization of services with epidemiological data, the unmet need estimate, expenditure reports, and demographic breakout reports for African Americans, Latinos and African-born PLWH from needs assessments conducted from 2006 to 2010, the Systems Assessment (2007), and the Path To Care Study (2008) in determining categories to be funded. The Path To Care Study indicated that 25% of the respondents did not have their first visit with a doctor until one to six months after diagnosis and 12% reported that it was a year or longer before they saw a doctor after initial diagnosis. Those who indicated that they faced challenges connecting to care after diagnosis listed the following challenges: (1) depression [35%], (2) fear of disclosure [30%], (3) continued or increased drug and alcohol use to cope [27%], and (4) poor experience with a person or the service provided at the diagnosis site [32%]. The 2010 Consumer Needs Assessment provided similar data, indicating that 16% of all respondents in that survey (n=329) waited a year or longer to access HIV primary medical care.

Data from the 2010 Consumer Needs Assessment included responses from individuals who were not in care at the time they completed the survey. This web-based assessment was launched in March 1, 2010 to increase the number of PLWH represented. Of the 329 respondents who had completed the survey when the data was presented to the Council for prioritization, 17% indicated that they had not visited with a doctor, nurse or physician assistant in the past 12 months to take care of their HIV. The barriers to care for those who had not received medical care in the past year included lack of transportation, inability to find a physician they liked, and multiple service locations. In the same study, 7% of all respondents indicated that they had been denied medical care for HIV disease because they could not pay for it.

(b) How the needs of those persons unaware of their HIV status were considered. Data from the Path To Care Study that was reviewed by the Needs Assessment & Evaluation Committee revealed that 56% of study participants either delayed or discontinued care at some time before reestablishing HIV care. The goals of the study were to (1) describe where PLWH are diagnosed and their testing experience, (2) identify where the path to care begins for people living with HIV in Minnesota, (3) define what the “path to care” should lead to for people living with HIV, (4) describe what assistance PLWH need to get connected to care after initial diagnosis. This was considered a good indicator of the initial service needs of persons who recently become aware of their status. The study noted several *Implications for Allocation of Ryan White Resources in Minnesota*: Allocate resources in a way that (1) helps people live with HIV as a chronic condition by assuring access to a trusted medical provider, the service of a case manager to navigate the health care system and patient access to information and support for self-care management and advocacy, including information and support from peers; (2) develops the capacity of individuals and groups of PLWH to reach out and provide information and support to those who have delayed HIV care; (3) sustains “beacon services” that provide visible and accessible entry points, and (4) facilitates and coordinates access to alcohol or drug treatment or mental health services, to address situational and chronic mental illness.

Council members and support staff served on the EIIHA Workgroup convened by the Part A and B Grantees, the MDH, and the Council to formulate recommendations to identify persons

unaware of their HIV status and get them into care. Recommendations from this workgroup were presented to the Council during the prioritization and allocations processes. The allocations approved by the Council in August 2010 included allocations to Early Intervention Services, Outreach, and Outpatient/Ambulatory Medical Care.

(c) How the needs of historically underserved populations were considered. The Needs Assessment & Evaluation Committee compared demographic patterns of client service utilization with epidemiological data, the unmet need estimate, expenditures on culturally appropriate services, and demographic breakout reports for African Americans, Latinos and African-born PLWH from needs assessments including the Systems Assessment (2007), and the Path To Care Study in determining service categories to fund that address the needs of the underserved.

The Council allocated \$145,700 of Part A MAI in FY2012 for Culturally Appropriate Outpatient/Ambulatory Medical Care to assist under-represented communities with accessing and adhering to HIV primary medical care. This currently funded program helps increase the number of Latinos living with HIV/AIDS who access health care, and has helped to reduce disparities in access to care. Past studies have shown high rates of uninsured individuals among Latinos, which is a barrier to care. Latinos in Minnesota are also more likely to have AIDS at first diagnosis than other racial/ethnic populations. Providing accessible, affordable primary health care that is considerate of culture, language and immigration status has helped to address this disparity. Additional allocations to Medical Case Management (MCM) and Outreach will help to increase access and reduce disparities for communities of color.

(d) How PLWH were involved in the priority setting and allocation process and how their priorities are considered. All of the populations identified as having severe need are represented on the Council, including four (4) African immigrants. The Council is currently composed of 30 members, 13 (43%) of whom identify as living with HIV disease.

The Council's Community Voice Committee (CVC) meets monthly and includes HIV-positive Council members as well as HIV-positive community members. The CVC provides perspective on emerging service needs and problems associated with the current service delivery system. Most importantly, the group provides the Council with key insights into issues associated with living with HIV/AIDS. During the 2010 biennial prioritization process, the list of service categories and associated activities developed by the Planning and Priorities Committee were reviewed by the CVC for consumer input before forwarding them to 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 participate in both needs assessments and consumer surveys. In August 2008, the Council co-sponsored a community forum to solicit consumer input into the availability of services and gaps and barriers that might exist. Thirty-six consumers participated and 53 completed the survey associated with the event. The 2010 needs assessment contained responses from 329 consumers at the time of prioritization and 502 consumers before the survey closed, providing direct feedback about barriers to care and gaps in services from affected communities. Time is also allotted at the beginning of each Council meeting for community members to discuss service needs.

(e) How data were used in the priority setting and allocation process to increase access to core medical services and reduce disparities in access to the continuum of HIV/AIDS care. For the priority setting and allocation processes, the Council reviewed and considered epidemiological data, the unmet need estimate, service utilization data, needs assessments and

other qualitative data including quarterly and annual grantee expenditure reports, the Oral Health & Behavioral Health Services Assessment, and the Path to Care Study.

Each spring a MDH epidemiologist presents the Minnesota HIV epidemiological profile to the Council, which examines changes and trends in the epidemic from the previous two years, changes in demographics, emerging populations, 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. Second, the data are used to determine how resources should be used to address disparities and fill gaps in service delivery. In addition, service utilization data from the Minnesota CAREWare database are presented by grantee staff and include an analysis of utilization of each funded service area by population.

Needs assessment data from 329 surveys completed from March to July 2010 were used to inform the Council on the service needs of PLWH. This data revealed how many respondents who had not accessed a particular service area had needed it in the previous year. The data also included reasons consumers had been unable to access those services, revealing barriers to care and gaps in the service delivery system that were then considered in the allocations process.

The Council used data in multiple ways to establish priorities and allocations for core medical and support services. Increased rates of HIV infection as evidenced in annual epidemiological updates means more people may need assistance to access and maintain health care. To address an influx of new consumers, the Council reduced allocations to previously under-utilized service areas and increased those for two core medical services for FY2011: Outpatient/Ambulatory Medical Care including Culturally Appropriate Primary Care targeting Latinos, and MCM. In addition, the Council sustained funding to three other core medical services—Mental Health Services, Home and Community-Based Health Services and Substance Abuse Services (Outpatient). For FY2012 the Council allocated 77% of Part A funds to core medical services.

(f) How changes and trends in HIV/AIDS epidemiology were used in the priority setting and allocation processes. 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. The Planning and Priorities Committee reviewed the list of services to be supported with MAI funds in FY2011 and determined that they should include Culturally Appropriate Primary Care, 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 provided resources for this activity since 2005. MAI funding for Outreach supports case finding and coordination of entry into care for African American and African-born PLWH.

Epidemiological data showed that new HIV infections among MSM increased by 47% between January 1, 2007 and December 31, 2009. During 2010, new infections decreased from 2009 but remained higher than 2007 and 2008. In an effort to address this trend, the Council has sustained FY2011 allocations to several service areas including Early Intervention Services, Mental Health Services and HERR Services that target MSM.

(g) How the Planning Council used cost data to make funding allocation decisions. To help determine service area allocation levels, 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. MCM, including treatment adherence counseling, Food Bank/Home Delivered Meals, Home and Community-based Health Services and Substance Abuse Services (Outpatient) are all procured on a unit rate basis. These data are used to estimate unit and per-client costs. The grantee provides an expenditure report by service area quarterly.

(h) How unmet need data were used by the Planning Council in making priority and allocation decisions. In setting priorities and allocations for FY2011 and 2012, the Needs Assessment and Evaluation and Planning and Priorities Committees reviewed the 2009 MDH report on the estimate of the number of PLWH who were out of care. The report indicates that 43% of PLWH in the TGA did not receive the specified primary medical care. It included unmet need estimates by gender, race and ethnicity. The Council used this as one source of information to prioritize services and allocate resources to service areas that connect people to care (Outreach, Early Intervention Services, MCM, Outpatient/Ambulatory Medical Care). In addition, the 2010 Needs Assessment asked questions related to unmet need. The web-based survey asked respondents if they had accessed a service area in the past year. If the respondent said they had not, they were asked if they had needed that particular service. Those who had were then asked what barriers or problems they experienced in accessing the service. These data were provided to the Council in service area review summaries emphasizing service areas that indicated significant barriers and specific populations that may have had difficulty in access.

(i) How the Planning Council's process will prospectively address any funding increases or decreases in the Part A Award. Based on the history of the TGA's award amounts, the Council planned for the possibility of both an increase and a decrease in the award when it approved the prioritization and allocations processes for FY2011-12. The Planning & Priorities Committee recommended planning for allocations based on flat funding with contingencies for an increase or decrease in the award. If funding is decreased, allocations for service areas that were not fully expended in 2010 will be automatically reduced by the unspent amount. Then all service areas will be examined to maintain the 75% core medical expenditure requirement and then all service areas would be reduced proportionately. If funding is increased, the Council voted in August 2010 to consider first any needs in Outpatient/Ambulatory Medical Care and Emergency Financial Assistance. Then allocations will be increased proportionately with an emphasis on continuing to ensure that all core medical services are available to eligible PLWH residing in the TGA and that the 75% core medical service expenditure requirement is met.

(j) How MAI funding was considered during the planning process to enhance services to minority populations. In evaluating the need to eliminate gaps and barriers in services for disproportionately impacted and underserved populations, the Council considered data from the 2010 Needs Assessment. The data indicated that in the past 12 months, of those African American respondents who had not accessed MCM services, 4% needed to access the service but were unable to do so due to various barriers. Likewise, 22% of the Latino respondents indicated that they needed primary medical care in the past 12 months but were unable to access the service compared to 10% of non-Latino respondents. The number of Latino consumers accessing medical care at the clinic receiving MAI funding has steadily increased since funding was first made available. Based on the data, the Planning & Priorities Committee determined that it was important to sustain the service areas that previously received MAI funding: Outpatient/Ambulatory Medical Care, MCM and Outreach. Based on a projection of flat MAI funding in 2012, the Council directed the grantee to allocate \$145,700 to Outpatient/Ambulatory Medical Care targeting Latinos, \$75,500 to MCM targeting African Americans and African-born individuals, and \$50,000 to Outreach targeting African Americans and African-born individuals.

(k) Data on Persons Unaware of HIV Status used in Prioritization & Allocations. Data from the Path To Care Study was reviewed by the Needs Assessment & Evaluation Committee. Access and connection to the health system were most important factors helping those newly diagnosed get connected to HIV care. Survey responses indicated the most helpful services

offered and made available at initial diagnosis were (1) finding a doctor, (2) connecting to an AIDS service organization for services and support, (3) receiving help to prevent infecting others, (4) receiving drugs to treat HIV infection; and (5) meeting with a counselor, therapist or psychiatrist. Similarly, responses from the interview process pointed to the role services from health professionals played in helping people get connected to care. The most helpful services offered at initial diagnosis were (1) connecting to an AIDS service organization, (2) having access to a comprehensive and coordinated medical and social service support system at the diagnosis site, (3) receiving information and referral tools, (4) having a support network, (5) getting connected to a case manager and a trusted doctor. The Path to Care Study drew upon interviews with staff from the diagnosis sites that consistently report the largest number of new HIV cases annually and a site that provides screening, testing and diagnosis services to Latinos. Interviews with representatives from four Ryan White funded service providers, a Part F grantee, and a discussion with the Council also informed the study.

Council members and support staff served on the EIIHA workgroup that was formed to recommend ways to identify persons unaware of their HIV status and link them to care. Among the data sources reviewed by the workgroup were the CDC estimate of persons unaware of their HIV status, MDH data on all publically funded test sites, and disease investigation data on risk factors. The recommendations from this workgroup were presented to the Council during the prioritization and allocations processes.

6) Budget and Maintenance of Effort (MOE)

6) A. Budget – See Budget Information Form SF 424A and Budget Narrative Attachment.

6) B. Maintenance of Effort

(1) Maintenance of Effort (MOE) Table. The following Part A Maintenance of Effort (MOE) Summary Report details FY 2009 and 2010 HIV-related expenditures by local governments within the Minneapolis-St. Paul Transitional Grant Area (TGA):

Item No.	Item Description	Agency/Department/Other Government Unit	FY 2009	FY 2010
1	Early Intervention Services	City of Minneapolis Department of Health and Family Support	\$ 116,992	\$ 54,997
2	Early Intervention Services	St. Paul - Ramsey Public Health Department	\$ 150,078	\$107,564
3	Early Intervention Services	Hennepin County Human Services and Public Health	\$ 2,992	\$ 90,920
4	Housing Services	Hennepin County Human Services and Public Health	\$ 63,191	\$164,086
Total			\$ 483,183	\$ 417,567

(2) MOE Methodology. As shown in the MOE table, there are three jurisdictions that contribute to the TGA’s maintenance of effort. These MOE contributors were established by the TGA’s Intergovernmental Agreement in 1999. In FY2009, the MOE components were revised to comply with the reauthorized Ryan White Act and to contain only HRSA fundable service categories. Each August, financial staff from the three entities complete a MOE summary report that lists expenditures on Ryan White services for the most recent fiscal years and an accompanying letter that certifies that the summary report accurately reflects resources dedicated to HIV services for the period indicated within the constraints of available data. Expenditure data from the three jurisdictions are totaled to determine changes in overall MOE outlays.

7) Clinical Quality Management

7) A. Description of Clinical Quality Management Program

(1) Clinical Quality Management Structure, Vision, Mission and Goals.

(a) In support of its vision that contracted services will provide high quality care for PLWH and its mission to assure that PLWH in the TGA have access to, understand, and receive care that meets US Department of Health and Human Services (DHHS) treatment guidelines and standards of care, the TGA's clinical quality management (CQM) program has a goal that contracted providers will develop expertise in maintaining quality improvement programs that meet the unique needs of their agencies, staff and clients for timely, efficient, and effective services that facilitate PLWH receiving HIV medical care.

i) The CQM program's purpose is to facilitate the delivery of high quality care and services by contracted providers who are supported in their mission of providing care for PLWH. The CQM program's annual quality goals for FY2012 include 1) Increase the proportion of PLWH in the TGA who know their status and are in care; 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; 3) Support contracted providers' quality improvement efforts and adherence to the TGA's "Universal Monitoring Standards for Funded Programs" and the HRSA/HAB Monitoring Standards through training, technical assistance, and site visits; 4) Engage consumers of Ryan White services in learning about standards for HIV care and self advocacy for obtaining highest quality care and services; 5) Develop strategies in partnership with the Minnesota Departments of Health and Human Services to increase the number of PLWH that are unaware of their status who become aware and connected to HIV care; 6) Use the HAB performance measures and client level data to develop a system-level assessment of the status of clinical quality of care and services in the TGA that will inform quality program planning.

ii) **Roles of Clinical Quality Management Staff and Committee.** The TGA has a full-time Clinical Quality Management (CQM) coordinator who evaluates annual quality work plans from each contracted service provider as well as semi-annual quality improvement progress reports. The coordinator communicates with providers about how progress toward their goals integrates with the Part A system-wide quality goals and efforts. In collaboration with the TGA's contract managers, the coordinator performs annual site visits and reviews a sample of client records for compliance with Universal Monitoring Standards and contract goals. The coordinator provides training and technical assistance for providers on best practice standards. CQM activities are coordinated across Ryan White Parts to develop strategies that ensure HIV care is provided in accordance with DHHS guidelines. The coordinator acts as a liaison among the grantee, Planning Council, provider agencies, outcomes evaluation staff, capacity development consultants, quality coordinators from other Ryan White Parts, MDH epidemiologists, and the Quality Management Advisory Committee. The grantee's Outcomes and Data coordinator assesses the completeness and validity of the various data sets, including client level data and outcomes evaluation data, collected by the grantee and providers and recommends ways to both improve data collection and coordination and incorporate findings into CQM activities.

The TGA's CQM plan and work are guided by the Quality Management Advisory Committee (QMAC), which includes representatives from Ryan White Parts A, B, C, and F in Minnesota, the Planning Council, the Part A Outcomes and data coordinator, HIV service providers, the MDH, and consumers. The QMAC, which meets bimonthly, has developed and revises the TGA's "Universal Monitoring Standards," incorporating HRSA's Universal Monitoring Standards in its 2011 revision. Activities and progress in quality improvement are reported at each meeting. Aggregate information about site visit findings is reviewed by the QMAC annually. The committee ensures that the consumer's voice is represented in all quality program decisions and goals. The CQM coordinator seeks consultation from committee members as needed to en-

sure 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.

iii) The Part A grantee budgets up to 5% of its overall annual budget to Quality Management activities, which are assigned to a total of 2.0 FTEs (See **Attachment 1**).

iv) The CQM program contracts with the server host who maintains the Minnesota CAREWare system's secure central server, where client level data are collected. In FY2011, the CQM program contracted with the CAREWare developer to make programming changes to allow collection and analysis of quality data related to assessment of clients' in-care status, referrals and follow-up for clients out of care on a per-provider and programmatic level.

(b) Established Quality Management Program.

i) 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.

ii) All Part A contracted service providers collect and submit data semi-annually through a Client Level Data System on the following indicators: a) Number and percent of program participants who are current in care (using the HAB Performance measure for Medical Visits); b) Number and percent of participants who are not current with care and are successfully referred to receive care; c) Number and percent of program participants who initiate and/or maintain health insurance; d) Race, ethnicity, and country of origin of HIV services participants.

iii) Additional clinical measures for funded Outpatient/Ambulatory Medical Care sites: a) HAB performance measure results for CD4 counts, PCP Prophylaxis, HAART and ARV Therapy for pregnant women by three Primary Care clinics; b) Viral load test results for patients of two Medication Adherence programs and three Primary Care clinics; c) Initial CD4 counts (health status indicator) at one Early Intervention clinic; d) Annual number of pelvic exams and Pap screening tests completed for women patients of three Primary Medical Care providers.

Medical Case Management (MCM) providers also measure and report on the: Outcomes of HAB performance measures for Medical Visits and Care Plan; Frequency with which case managed clients keep HIV medical appointments; Number and types of barriers to remaining current in care addressed by case managers; Number of participants in target groups; Need for treatment adherence support; Need for dental, mental health, and substance use treatment services.

iv) The annual CQM Plan is disseminated to the Planning Council and contracted providers, several weeks ahead of the April 1 due date for each provider's individual QI annual work plan.

Providers are encouraged to set individual goals that support one or more of the Part A Annual CQM Goals. 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 required semi-annual Quality Progress Reports and evaluated at the end of each contract year by comparing their reported results to Client Level Data, quarterly utilization and spending reports, and the Part A Annual Goals.

v) Two providers receive MAI funds to provide Culturally Appropriate Primary Care to Latinos and MCM and Outreach to African American PLWH. They collect data on HIV medical care status, referral outcomes, CD4 count and viral load, Pap tests, needs for mental health, substance

abuse treatment, and treatment adherence support as well as data on the race, gender, ethnic background and country of origin of each client served. These data are compared to the aggregate of QI and outcomes data for the Part A CQM program as a whole and analyzed for trends and opportunities for improvement in quality of services for PLWH who are members of the targeted minority groups.

vi) Outcomes Evaluation reports are completed for each service area, with providers receiving their individual detailed results. Outcomes for entire service areas are made available to the providers within that service area and to the Planning Council. These inform individual providers' annual quality work plans, the QMAC's annual evaluation of the TGA's quality program, and the Service Area Reviews utilized by the Planning Council in its biennial prioritization process. Primary care providers' reports on outcomes of clinical measures are used to set CQM goals to improve care. The CQM coordinator and grantee consider these outcomes in evaluating how well providers meet contractual requirements for their annual QI plans. The Planning Council receives an annual report on CQM progress.

7) B. Description of Data Collection and Results

(1) All client level data (CLD) elements required for the RSR are submitted by 100% of Part A funded providers into a shared Part A and Part B database that is administered by the MDH.

(2) The Minnesota Ryan White Management Information System is Minnesota CAREWare, a shared database for Part A and B CLD collection and reporting. Housed on a secure, dedicated central server, data are available to providers in their individual domains and to grantees in aggregate formats. Reporting responsibilities are maintained by each grantee for planning, policy and grant development. Providers receive training and regular updates about CLD requirements and ways to use data to monitor their performance on HAB Performance Measures, and how to incorporate them into their annual QI work plans. The grantee uses the data to assess its progress on meeting annual quality goals as it completes its annual evaluation of the Part A QI Plan.

(3) 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 by either electronic spreadsheet or scannable forms. All submitted data were transferred into the central database. Since October of 2009, providers have directly entered and updated client utilization data as services are provided. In January and July, providers are required to update and submit data on client eligibility, insurance status, clinical outcomes, and HIV medical care status, including referral and follow-up information for those not current in care. The RSR for Parts A and B is generated from the database and submitted by the system administrator at MDH.

(4) Data collected in support of CQM goals and 2010 results are as follows:

Performance Measure	2009 Part A clients: N=2,763	2010 assessed clients: N=3,500	Part A FY2012 QI Plan in response to measure
Medical Visits			
Clients who saw a HIV medical provider in the last six months	2,237 (81%)	3,207 (92%)	Improve to 95% in FY2012
Clients who did <u>not</u> see a provider in the last six months	110 (4%)	127 (4%)	Decrease to 2% in FY2012
Clients who did not know, agency didn't know, or left blank medical care status	411 (15%)	166 (5%)	Decrease to < 5% in FY2012
Out of care clients who were referred to care	39 (35%)	34 (27%)	Increase to 75% in FY 2012
Referred clients who received follow-up	6 (15%)	5 (15%)	Increase to 50% in FY 2012

Outpatient/Ambulatory Medical Care CD4 counts PCP Prophylaxis, HAART ARV Therapy for pregnant women		Data entered into Minnesota CAREWare beginning FY2011; data analysis pending	Set improvement goals for FY2012 following data analysis
MCM Outcomes Acuity scale Status of comorbidities Assessment of ongoing MCM needs		Data entered into Minnesota CAREWare beginning in 2010; data analysis pending	Set QI goals for FY2012 following data analysis

(5) The Planning Council uses results of the CQM program in its biannual priority setting process. The coordinator reports on quality improvement progress to the Needs Assessment & Evaluation committee, which compiles all data into understandable formats for Council members to use in prioritizing services and allocating both Part A and Part B funds. Outcomes Evaluation results are incorporated into service area reviews and made available to the Planning Council in advance of prioritization and allocation. The CQM program’s system-wide effort to measure progress in getting PLWH who are aware of their status into care helps the Planning Council 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 in HIV medical care soon after diagnosis; and 2) Ensure a continuum of services, including culturally appropriate services and geographic parity, to engage PLWH in care soon after diagnosis and to maintain their adherence to medical care.

(6) The Part A CQM Program’s primary goal is to increase the number of PLWH in the TGA who access and maintain care that meets DHHS guidelines for HIV treatment. 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 overall client in-care percentage shows less than optimal results are required 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 providers to achieve their initial goals and develop quality improvement interventions based upon CLD data and service-specific outcome measures. The CQM coordinator and contract managers implemented a service analysis process to assess the effectiveness of each service area that identifies goals and related objectives, develops process and outcomes measures, rates how well measures match program goals and objectives, analyzes how costs vary among providers, and determines more effective models of delivery. The process uses data to determine its effectiveness and gap analysis for the service area and recommends outcomes measures and QI goals for the service area. Service analysis projects were completed in FY2011 for Outreach; Primary Care will be the next service area for analysis in FY2012.