06 - 0015

Program Announcement 04012

HIV Prevention Projects: Interim Progress Report for 2005 and Continuing Application for 2006

Minnesota Department of Health
STD and HIV Section

September 21, 2005

Correction to MDH HIV Prevention Funding Application, pages ~~32–34~~ 27-29

B. Modifications to Health Education and Risk Reduction Grantees

This table summarizes the information requested for HERR grantees that had modifications to their contracts. From July 2004 through June 2005, fifteen agencies were funded through a competitive RFP process to implement health communication/public information activities targeting African communities. An additional three agencies were added for the time period of January 2005 through June 2005. These contracts were implemented in response to steadily increasing rates of new HIV infections among African-born individuals reported to the MDH in recent years. Health communication/ public information was chosen as the intervention based on needs assessment activities conducted in 2003 that indicated a need for greater community awareness of HIV in order to combat the very high levels of stigma and denial that exist in African communities, as well as to increase individual knowledge regarding HIV and risk reduction strategies.

A subset of these agencies was identified for continued funding from July 2005 through June 2006. The eleven agencies were selected based on the following criteria: programs target African communities with the highest incidence and prevalence (Ethiopian/Oromo, Kenyan, Cameroonian, Liberian, and Somali); programs satisfactorily met the requirements of the original grant agreement; and programs met the objectives of the original grant agreement. Grant managers' observations during site visits were also taken into consideration.

The funded agencies are required to submit narrative reports on their progress twice a year, and the contract manager conducts site visits with each agency to identify successes, challenges, and technical assistance needs.

All of the agencies are funded through state dollars. The itemized budgets and budget narratives are provided for all agencies in Attachment A (not included).

Agency and Period of Performance	Target Population	Interventions and # of Clients (6 month target)	Evidence Basis
African Assistance Program, Inc (AAP) 7710 Brooklyn Boulevard, Suite # 206 Brooklyn Park, MN 55428 July 1, 2005 – June 30, 2006	Liberian	*Health Communication/Public Info* – HIV/AIDS public service announcements (PSAs) on Cable TV most watched by the Liberian community (2,500 viewers) – HIV/AIDS educational TV programs targeting three Liberian tribes (2,500 viewers) – Collaborate with Project Lifeline to conduct HIV/AIDS presentations at Liberian places of worship, awareness training to Liberian clergy; host HIV/STD prevention and awareness events, reach youth through music and poetry	Needs assessment data

AGENCY AND PERIOD OF PERFORMANCE	TARGET POPULATION	INTERVENTIONS AND # OF CLIENTS (6 MONTH TARGET)	EVIDENCE BASIS
Kids Home International (KHI) 2700 Stevens Ave South Minneapolis, MN 55408 July 1, 2005 – June 30, 2006	Kenyan	*Health Communication/Public Info* – HC/PI presentation targeting youth (10 youth) – In collaboration with places of worship, conduct HC/PI presentations during services (203 people) – Conduct HC/PI presentations to different Kenyan cultural groups (190 people)	Needs assessment data
Mestawet Ethiopian Newspaper 1821 University Avenue West, Suite #318 Saint Paul, MN 55104 July 1, 2005 – June 30, 2006	Ethiopian	*Health Communication/Public Info* – HC/PI presentations at two Ethiopian places of worship (200 participants) – Newspaper HIV/AIDS fact sheets (7,500) – In collaboration with Abissinia Ethiopian TV and Ethiopian radio, regularly interview leaders on HIV/AIDS related topics. Also run HIV/AIDS PSAs on radio/TV (5,000 Ethiopian listeners/viewers)	Needs assessment data
Minnesota African Women's Association (MAWA) 1201 37th Avenue North Minneapolis, MN 55412 July 1, 2005 – June 30, 2006	Liberian	*Health Communication/Public Info* – HC/PI presentations to Liberian women in small groups at locations they congregate (100 participants) – Provide basic HIV education on African Cable TV targeting the Liberian community as a whole	Needs assessment data
Nyagetinge Umoja 2316 Fernside Lane Mound, MN 55364 July 1, 2005 – June 30, 2006	Kenyan	*Outreach* – HIV prevention education activities at social events, birthday parties, pre-wedding parties (225 people) *Health Communication/Public Info* – HC/PI presentations at places of worship and at Kenyan community forum (100 people) – Reach youth through music and poetry performed by peers (50 youth)	Needs assessment data
Oromo Community of Minnesota, Inc (OCM) 1505 South 5th Street Minneapolis, MN 55454 July 1, 2005 – June 30, 2006	Oromo	*Health Communication/Public Info* – Two HC/PI presentation targeting youth (28 youth) – Two HC/PI presentation targeting an existing Oromo women group that meets monthly (28 women) – Two HC/PI presentation targeting elders (25 elders) – Two HC/PI presentations at community events (300 people) – HIV/AIDS prevention education on Oromo TV and radio (3,500 listeners/viewers)	Needs assessment data

AGENCY AND PERIOD OF PERFORMANCE	TARGET POPULATION	INTERVENTIONS AND # OF CLIENTS (6 MONTH TARGET)	EVIDENCE BASIS
Project Valentine (PV) 2135 44th Avenue North Minneapolis, MN 55364 July 1, 2005 – June 30, 2006	Cameroonian	*Health Communication/Public Info* – Present HIV/AIDS education to large group in the form of drama, poetry and music (200 people)	Needs assessment data
Somali Community Resettlement Services, Inc (SCRS) 1903 S. Broadway Rochester MN 55904 July 1, 2005 – June 30, 2006	Somali	*Health Communication/Public Info* – HIV/AIDS PSAs on local Somali TV (7,500 viewers) – HC/PI for Somali youth group, women's group, and Somali community as a whole (103 people) – Conduct interviews on local Somali TV on HIV/AIDS epidemic among Africans (7,500 viewers)	Needs assessment data
Somali Health Project (SHP) 416 E Hennepin Avenue, Suite #109 Minneapolis, MN 55414 July 1, 2005 – June 30, 2006	Somali	*Health Communication/Public Info* – HC/PI presentations at Somali community gatherings, community center, Somali places of worship, etc. (240 people)	Needs assessment data
Sub-Saharan African Youth and Family Services in Minnesota (SAYFSM) 1885 University Ave West Saint Paul, MN 55104 July 1, 2005 – June 30, 2006	Oromo and Ethiopian	*Health Communication/Public Info* – HC/PI presentations in community and/or places of worship (150 participants) – Collaborative broadcasts (Oromo and Amharic radio and cable TV) to present and educate in the area of HIV/AIDS (5,500 listeners/viewers) – Collaborate with Wee Care Family Services Inc. to provide HIV/AIDS HC/PI presentations specific to youth, women, and men separately (60 participants)	Needs assessment data
Zyombi Project (ZP) 1351 23rd Street Minneapolis, MN 55404 July 1, 2005 – June 30, 2006	Cameroonian	*Health Communication/Public Info* – HC/PI presentations to community leaders (20 community leaders) – HC/PI presentations at traditional Cameroonian festivities, birthdays, weddings, etc. (100 people) – HC/PI presentations to three Cameroonian cultural groups (60 people)	Needs assessment data

Table of Contents

Proposed Budget for 2006

The following revised budget proposal reflects HIV Prevention Project funds requested in the amount of $3,269,160 for a twelve-month period to fund the continuation of Minnesota's HIV Prevention Program for the period of January 1, 2006 through December 31, 2006.

A. PERSONNEL **$1,292,035**

In addition to the positions listed below, the State of Minnesota contributes an estimated $523,000 annually in support of the personnel costs of the STD and HIV Section.

1. Health Program Manager Senior (K. Beardsley)
   0.15 FTE x 12 months

   This position is the Minnesota AIDS Director and oversees all HIV and STD prevention and control activities. This position provides direction, supervision, and coordination activities to all personnel listed below.

2. Health Program Representative, Principal (J. Ashley)
   0.15 FTE x 12 months

   This position is the Assistant Section Manager of the STD and HIV Section. Reporting directly to the AIDS Director, this position assists the AIDS Director in managing, supervising, and coordinating STD and HIV prevention activities of the MDH.

3. Health Program Representative, Principal (vacant)
   1.0 FTE x 12 months

   This position manages positions in the section that have section-wide responsibilities. Coordinates section-wide resources in a way that supports programmatic functions across the section.

4. Planner Principal (J. Hanson Pérez)
   0.55 FTE x 12 months

   This position coordinates HIV, STD and Viral Hepatitis planning and needs assessment activities for the STD and HIV Section.

5. Planner Principal (vacant)
   0.50 FTE x 12 months

   This person provides support for Minnesota's community planning efforts by staffing the Community Cooperative Council on HIV/AIDS Prevention (CCCHAP). This includes developing goals and a framework for an ongoing community-driven community planning process that researches and identifies HIV prevention resources, needs, and target populations at risk in Minnesota.

6. State Program Administrator, Intermediate (P. Naughton)
   1.0 FTE x 12 months

   The person provides contract monitoring related to the financial aspects of all section grant agreements and professional/technical contracts (including Annual Plan Agreements) between the STD and HIV Section and community based organizations providing STD/HIV prevention activities, HIV and STD testing, needs assessment and evaluation activities. This position will monitor compliance with standard activities related to grant agreements and contracts; i.e., reports, audits, materials review and provide technical assistance to section staff in selecting the appropriate mechanism for selection of a grantee or contractor and the appropriate contracting mechanism.

7. Health Educator III (R. Nelson)
   1.0 FTE x 12 months

   This position manages the Public Information section of the HIV Prevention Cooperative Agreement with CDC. Duties include all public education efforts, including implementation of mass media strategies. This person provides technical assistance to all city/county health departments, regarding HIV and STD educational materials, media and community education strategies. This person takes primary responsibility for developing systems to identify, select, and submit or develop materials for review to MDH epidemiology, program, and administrative staff. This person manages a system for disseminating and tracking usage of HIV and STD resources, and will access the services provided by the National AIDS Information Clearinghouse. This person represents the MDH in working with other agencies such as the American Red Cross, the Minnesota Department of Education, and the Minnesota AIDS Project in order to coordinate the statewide selection, development, and distribution of HIV/STD educational materials, to avoid duplication of services and ensure that information and resource gaps are identified. In addition, this position coordinates the maintenance and distribution of all media products, and the coordination of all Minnesota mass media activities with CDC's Prevention Marketing Initiative or other campaigns.

8. Health Program Manager, Senior (S. Schletty)
   Early Diagnosis and Intervention Unit
   0.50 FTE x 12 months

   This position manages the HIV and STD Partner Counseling and Referral Services (PCRS) and the HIV Counseling, Testing and Referral (CTR) programs of the STD and HIV Section. This position provides direction, supervision, and coordination to all personnel within these programs.

9. Health Program Supervisor (M. Babcock)
   Early Diagnosis and Intervention Unit
   1.0 FTE x 12 months

   This position supervises some of the Health Program Representatives, Senior who provide HIV and STD PCRS. This position oversees PCRS data collection and management to evaluate PCRS activities. This individual must have a thorough understanding of HIV infection and STD epidemiology, disease investigation and interviewing techniques, and the ability to effectively provide day-to-day guidance and direction to staff and to establish and maintain performance standards and appropriate record-keeping procedures.

10. Health Program Representative, Senior (G. Haff)
    Early Diagnosis and Intervention Unit
    0.50 FTE x 12 months

    This staff person conducts specialized investigations of complaints made to the MDH about persons with HIV infection who are alleged to have engaged in behaviors that placed others at risk of infection despite having been informed and counseled about how to prevent transmission. This investigator receives and assesses such complaints from health and human services professionals, public health officials, and citizens and then conducts legally sensitive investigations to independently verify reported information. The investigator also devises remedies to recommend to the Commissioner of Health to intervene when necessary; assists with the implementation of the remedy; and, monitors the compliance of the person who has received a Commissioner's or court order.

11. Health Program Representatives, Senior (S. Johnson)
    Early Diagnosis and Intervention Unit
    1.0 FTE x 12 months

12. Health Program Representatives, Senior (C. Stephens)
    Early Diagnosis and Intervention Unit
    1.0 FTE x 12 months

13. Health Program Representatives, Senior (Vacant)
    Early Diagnosis and Intervention Unit
    1.0 FTE x 12 months

14. Health Program Representatives, Senior (R. Easton)
    Early Diagnosis and Intervention Unit
    0.25 FTE x 12 months

15. Health Program Representative, Senior (J. Saavedra)
    Early Diagnosis and Intervention Unit
    0.25 FTE x 12 months

    The preceding five Health Program Representative Seniors provides PCRS to HIV/STD-infected persons reported to the MDH by physicians and medical laboratories and to their sexual and needle sharing partners. These individuals are responsible for PCRS for persons who reside in the seven-county Twin Cities metropolitan area. They have been trained about the clinical and epidemiological aspects of HIV infection and other STDs and have completed the CDC Introduction to STD Intervention course.

16. Health Program Representative, Senior (T. Heymans)
    Early Diagnosis and Intervention Unit
    0.25 FTE x 12 months

    This position provides HIV/STD PCRS for persons who reside in Greater Minnesota (the area of the state outside the seven-county Twin Cities metropolitan area). The position is based in St. Cloud, in the central part of the state. This staff person is responsible for interviewing and counseling all HIV and syphilis cases, providing disease intervention

activities for gonorrhea and chlamydia, and working with MDH Epidemiology Field Services (EFS) staff as necessary. This staff person plans and collaborates with the EFS staff to assure continuity of PCRS and technical assistance services related to HIV and other STDs. This staff person provides technical assistance for primary health care providers at the major STD clinics in Greater Minnesota in order to educate them about the disease intervention process and to build their capacity for partner counseling of patients treated for gonorrhea and chlamydia.

17. Health Program Representative, Senior (S. Gordon)
    Early Diagnosis and Intervention Unit
    1.00 FTE x 12 months

    This position is responsible for designing an operational program for the delivery of effective, efficient, cost-effective, and high quality HIV testing, counseling, and referral (CTR) services by grantee, contract, and other provider organizations. This position trains, provides technical assistance, and consults with personnel who directly provide MDH-funded CTR services, those responsible within their organizations for operational implementation and maintenance of MDH-funded CTR services, and their counterparts in settings not funded by the MDH where CTR services have been promoted. This position also evaluates individual MDH-funded CTR programs, and the CTR program as a whole, so that the level of achievement of program goals can be determined, funding and individual CTR program operations can be adjusted, and CDC reporting requirements are met. This position promotes the MDH CTR program so that support for and participation in the program are garnered from those at high risk for HIV infection, key stakeholders, and health care providers.

18. Office & Administration Specialist (C. Olson)
    Early Diagnosis and Intervention Unit
    1.0 FTE x 12 months

    This position provides records and other clerical support services for the Early Diagnosis and Intervention Unit. Services include processing and filing confidential disease investigation and partner notification records. This person has been trained to carry out these duties in a discreet and efficient manner while communicating with health professionals and the public.

19. Health Program Representative, Principal (G. Novotny)
    Health Education and Risk Reduction (HERR) Unit
    1.0 FTE x 12 months

    This person plans, manages, implements, and evaluates the activities of the Health Education and Risk Reduction (HERR) Unit. This person has the following responsibilities: (1) to ascertain needs and evaluate program goals and objectives; (2) to direct the implementation of the Health Education/Risk Reduction, Prevention with Positives and Capacity Building sections of the HIV Prevention Cooperative Agreement with CDC; and (3) to develop, administer, and review allocations of state funding to HIV prevention programs administered in communities throughout Minnesota.

20. Health Program Representative, Senior (K. Chinn)
Health Education and Risk Reduction Unit
1.0 FTE x 12 months

This person manages activities described within the Health Education/Risk Reduction and Prevention with Infected Persons sections of the HIV Prevention Cooperative Agreement. This person is responsible for managing, monitoring, and providing technical assistance to eight community based contract programs targeting high risk populations, including HIV positive persons, and for managing one technical assistance contract. This person develops the tri-annual Request for Proposals for HERR grants and manages the proposal review process.

21. Health Program Representative, Senior (J. Nyakundi)
Health Education and Risk Reduction Unit
1.0 FTE x 12 months

This person manages activities described within the Health Education/Risk Reduction section of the HIV Prevention Cooperative Agreement. This person is responsible for managing, monitoring and providing technical assistance to eleven community based contract programs targeting African communities and one contract program targeting MSM. This person also coordinates data collection from all HERR grantees.

22. Health Program Representative, Senior (R. Yaeger)
Health Education and Risk Reduction Unit
1.0 FTE x 12 months

This person manages activities described within the Health Education/Risk Reduction, Prevention with Infected Persons and Capacity Building sections of the HIV Prevention Cooperative Agreement. This person is responsible for managing, monitoring, and providing technical assistance to eight community based contract programs targeting high risk populations, including HIV positive persons, and one evaluation service contract. This person also has primary responsibility for assessing grantees' training and technical assistance needs; and for planning, coordinating and delivering training opportunities.

23. Health Program Representative, Intermediate (Vacant)
Health Education and Risk Reduction Unit
1.0 FTE x 12 months

This person is responsible for providing support for Minnesota's HERR and other prevention efforts among youth. Tasks include coordinating the Minnesota Youth Advisory Council on HIV/STD Prevention, including recruitment and training of Youth Council members, provision of logistical support for the Youth Council and working with the Youth Council to provide technical assistance and training to youth serving agencies in the community. The Youth Council exists to promote and support youth involvement in HIV/STD prevention activities. This person also manages five community based grant contracts targeting youth and one contract targeting IDUs.

24. Office Services Supervisor I (K. Regan)
Administrative Services Unit
1.0 FTE x 12 months

This position supervises the section's clerical staff. Tasks include managing section expenditures and purchases, section budget monitoring, and overseeing word processing of major grants, plans, and contracts. This person also provides office services and clerical support to the Early Diagnosis and Intervention Unit Manager and Health Threat Investigations. Tasks include the word processing of confidential correspondence to medical and legal professionals, record searches of files to facilitate disease intervention/partner notification activities, and ordering of materials.

25. Office & Administration Specialist, Senior (R. Dauffenbach-Kotrba)
Administrative Services Unit
1.0 FTE x 12 months

This position provides office services and clerical support related to disease intervention and evaluation program activities. This person is responsible for the word processing and preparation of grant applications, grants/contracts, surveys, assessment tools, grant proposals, progress reports, and correspondence.

26. Customer Service Specialist, Intermediate (N. Petschauer)
Administrative Services Unit
0.75 FTE x 12 months

This part-time position provides office services and clerical support to the entire STD and HIV Section including maintaining sufficient levels of resource materials, processing literature requests, filing catalogs and samples, assembling information packets and media kits, coordinating and processing large resource material mailings, conducting literature searches, word processing, and copying. This person is also responsible for scanning HARS case reports for the Epidemiology, Surveillance and Evaluation Unit.

27. Office & Administration Specialist, Senior (J. Barry)
Administrative Services Unit
0.75 FTE x 12 months

This position provides office services and clerical support to the entire STD and HIV Section including purchasing of supplies; processing invoices; word processing of contracts, grant applications, RFPs, media materials, reports, and correspondence; creation of slides, and handling all out of state travel arrangements.

28. Office and Administrative Specialist (A. Kotrba)
Administrative Services Unit
1.0 FTE x 12 months

This position provides general office services and clerical support to the STD and HIV Section and assists other section staff in the logistics of executing meetings.

29. Office & Administration Specialist, Senior (G. Griggs)
Administrative Services Unit
1.0 FTE x 12 months

This position provides logistical and advanced clerical support to the CCCHAP. Duties include providing meeting support, formatting and preparing planning documents, maintaining mailing lists, documenting meeting attendance, coordinating CCCHAP member recruitment efforts, coordinating CCCHAP member training, attending all CCCHAP meetings, taking minutes, generating reports, and providing staff support for one of the CCCHAP committees. This position is also responsible for coordinating logistics in support of community and professional trainings offered by the section.

30. Epidemiologist Supervisor (P. Carr)
Epidemiology, Surveillance and Evaluation Unit
0.50 FTE x 12 months

This position manages STD and HIV epidemiology activities of the section, providing direction, supervision and coordination for all personnel within the program. Program activities include ongoing surveillance of STDs and HIV, special surveillance and research projects, and evaluation activities for the section.

31. Epidemiologist Senior (T. Sides)
Epidemiology, Surveillance and Evaluation Unit
0.70 FTE x 12 months

This position coordinates and directs methodological aspects of HIV/AIDS surveillance, coordinates the section Data Planning Team, serves as the overall HIV/AIDS surveillance liaison with CDC, and coordinates the writing of HIV/AIDS surveillance grant proposals/ progress reports. This position also provides public and professional presentations on HIV/AIDS epidemiology, conducts direct epidemiological analyses and special investigations, collaborates on HIV/AIDS surveillance related research, and serves as a HIV Positive Refugee Relocation Project representative.

32. Information Technology Specialist II (T. Klein)
Information Technology Services Unit
0.50 FTE x 12 months

This staff person is responsible for system administration of the PEMS database. This person will provide training and technical support to grantees regarding submission of data, and will work with grantees to ensure accurate and timely reporting of data.

33. Information Technology Specialist II (K. Anderson)
Information Technology Services Unit
1.0 FTE x 12 months

This position coordinates the operation, management, and ongoing development of the HIV Testing System (HTS), and submits HTS data to the CDC on a quarterly and annual basis. The position is also responsible for developing and maintaining the STD and HIV Section's websites, including the website for the Community Cooperative Council on HIV/AIDS Prevention.

34. Information Technology Specialist IV (M. Nguyen)
Information Technology Services Unit
0.75 FTE x 12 months

This position designs computer programs to meet the needs of the STD and HIV Section. Duties include assistance in the development and implementation of an improved disease intervention database designed to assess and monitor disease intervention activities and outcomes, and assistance with data entry and analysis related to the HIV prevention program evaluation project. The person in this position develops computer screens for data entry, designs menu-driven programs to generate necessary reports, and assists in modifications of the system as requested to reflect changes in data needs or program directions.

B. FRINGE BENEFITS (Calculated at 30%) **$387,610**

C. TRAVEL **$34,500**

1. In-state Travel $15,500
Unmarked state cars for use by three full time Disease Intervention Specialists.

2. Out of State Travel $18,000
Travel expenses to send three individuals to three CDC, three-day conferences/meetings in Atlanta per year, including attendance at the national HIV Prevention Leadership Summit

3. Staff Mileage Reimbursement $1,000
Reimbursement at the current federal rate for staff to attend community planning, other STD and HIV Section-related meetings, and to conduct site visits

D. EQUIPMENT **$0**

E. SUPPLIES **$38,850**

1. OraSure Test Kits $8,850
1,500 OraSure test kits @ $5.90 per kit

2. Supplies for STD and HIV Section Staff $30,000
Includes items such as computer hardware and software, office supplies, office furniture, supplies for copier and printers.

F. CONTRACTUAL **$1,047,610**

Details about each contractor's location, period of performance, target population(s), funded intervention(s), and evidence basis is included in the Information on Contractors/Grantees section of this interim progress report

Counseling, Testing and Referral (CTR) Contracts $412,110

These programs provide counseling, testing and referral services to high risk individuals:

1. Hennepin County Human Services & Public Health Department (Red Door Clinic) $88,000
2. St. Paul Ramsey County Public Health Department (Room 111) $37,400
3. United Family Practice – North Memorial Hospital $48,500
4. Hennepin County Human Services & Public Health Department (funding to support joint prevention and care outreach and testing contracts administered by Hennepin County) $50,000
5. Minnesota AIDS Project (January – June, 2006) $10,000
6. Clinic-based CTR targeting Africans and Latinos to be identified through informal solicitation with funding starting January 1, 2006 $138,210
7. MDH Public Health Lab - Memorandum of Understanding (this memorandum of understanding provides for the cost of processing serum and OraSure tests conducted by grantees) $40,000

Community Based Prevention Grant Contracts $400,000

Community based prevention programs provide outreach, individual level, group level, prevention case management, and health education/public information interventions to priority target populations.

A total of $1,704,000 in state and federal funds will be used to support community based prevention grant contracts in 2006. Of this total amount, $1,304,000 is state funding. All continuing community based grant contracts for the time period of January 1, 2006 through June 30, 2006 will be funded through state dollars. $400,000 in federal funding will be used to support community based prevention grant contracts funded from July 1, 2006 through December 31, 2006, with the balance of those contracts supported by state funding.

Detailed information about all contractors funded January through June 2006 is included in the Information on Contractors/Grantees section of this interim progress report.

1. Prevention grantees will be identified through RFP process and will be funded with federal dollars starting July 1, 2006 $400,000

Service Contracts $62,500

1. Evaluation $37,500
   This contractor will provide evaluation training to all grantees and provide individual technical assistance to grantees regarding process and outcome monitoring evaluation plans and the development of evaluation tools. The contractor will be identified through a competitive process with funding to begin April 1, 2006.
   a) Contractor to be determined $37,500

2. Training/Technical Assistance $25,000
   This contractor will provide training and technical assistance to grantees related to organizational infrastructure and implementation of interventions. The contractor will be identified through a competitive process with funding to begin July 1, 2006.
   a) Contractor to be determined $25,000

Sole Source Contracts $173,000

1. Minnesota AIDS Project AIDSLine $131,000
   The AIDSLine provides information about HIV as well as referrals to testing, prevention, and care services.

2. Family Tree STD Hotline $42,000
   The STD Hotline provides information about STDs as well as referrals to testing and treatment.

G. CONSTRUCTION $0

H. OTHER $46,670

1. Community Planning $34,350
   Funds are needed to support community planning group member participation, including travel reimbursement, hotel expenses, American Sign Language interpreters, member stipends and day care reimbursement. Stipends are provided to individuals who must lose income by taking unpaid leave from work, or who have no other source of reimbursement for their time spent at community planning activities.

   Stipends $7,865
   $55/day x 13 members x 11 days = $7,865

   Food / Refreshments at all day meetings for 50 people) $3,400
   $425/day x 8 days = $3,400

   Per Diems for traveling members $1,900
   $28.78/day x 22 days x 3 members = $1,900

   Room Rental (when MDH space not available) $300

   ASL Interpreters $6,400
   $40/hour x 8 hrs/day x 8 days x 2 interpreters = $5,120
   $40/hour x 4 hrs/day x 4 days x 2 interpreter = $1,280

Mileage reimbursements 1,831 miles roundtrip x $.405/mile x 145 trips = 7,750	$7,750	
Cab Fare for CCCHAP Member	$75	
Hotel expenses for Greater Minnesota residents $90/night x 2 nights/mtg x 4 mtgs x 3 people = $2,160	$2,160	
Day Care Reimbursement 2 children x $50/day x 10 days x 2 people = $1,000 5 children x $50/day x 14 days x 1 person = $3,500	$4,500	

2. Youth Council — $320
   Food for meetings as incentives to Youth Council members.
   4 meetings x $80/meeting = $320

3. Other Operating Expenses — $12,000
   Includes copying, postage, equipment repair, employee development.

I. TOTAL DIRECT CHARGES — **$2,847,275**
(Total of personnel, fringe, travel, equipment, supplies, contractual, construction, other)

J. INDIRECT CHARGES — **$421,885**
(Calculated as 19.4% on all direct charges except equipment and costs in excess of $25,000 on each contract)

K. TOTAL — **$3,269,160**

Information on Contractors/Grantees

A. Health Education and Risk Reduction Grantees

The following table provides the information requested for existing Health Education and Risk Reduction (HERR) and Prevention with HIV Infected Persons programs that will continue through June 30, 2006. This table includes grantees, listed in alphabetical order, that are funded by the MDH. All agencies will be funded with state dollars for the first half of the year. Numbers of clients to be reached are six-month targets calculated as 50 percent of the clients proposed to be reached in 2005. HERR grantees for the time period of July 1, 2006 through December 31, 2008 will be identified in late 2005 through a competitive Request for Proposals (RFP) process.

Agency and Period of Performance	Target Population	Interventions and # of Clients (6 month target)	Evidence Basis
Access Works 11 West 15th Street Minneapolis, MN 55403 January 1, 2003 – June 30, 2006	Male and Female IDUs of All Races	*Individual Level and OraSure Testing* – Risk assessment, HIV/hepatitis risk reduction counseling related to substance use and sexual health, harm reduction. OraSure testing provided. Referrals to hepatitis A and B vaccinations and hepatitis C testing and treatment. – 75 persons *Group Level* – HIV/hepatitis educational group (series of 6 sessions over 6 months) providing risk and harm reduction information, as well as testing and treatment information for hepatitis C (HCV) infected and HIV/HCV co-infected individuals. – 30 persons – Weekly group for users providing info HIV and hepatitis education, risk reduction support, nutritional info, needle cleaning, and skills building and role plays – 6 persons *Prevention Case Management* – Risk assessment; counseling on harm reduction, sexual health and substance use; individual prevention plan; accompany to appointments – 8 persons	All interventions based on Stages of Change Model

AGENCY AND PERIOD OF PERFORMANCE	TARGET POPULATION	INTERVENTIONS AND # OF CLIENTS (6 MONTH TARGET)	EVIDENCE BASIS
Africa Solutions 310 East 38th Street Minneapolis, MN 55409 January 1, 2003 – June 30, 2006	Adult Heterosexual Women of All Races (African-born)	*Outreach* – Outreach in places Africans congregate – 1080 African adults *Health Communication/Public Info* – Presentations on HIV/STD and hepatitis risk reduction skills in service organizations and at community events – 60 African women and 13 male sexual partners *Other* – Community forum at which an HIV/STD specialist provides accurate and current information about HIV/STDs/hepatitis, and testing referrals – 25 African women and 5 male sexual partners	Health Belief Model Theory of Reasoned Action Social Learning Theory Diffusion of Innovation Empowerment Theory
The Aliveness Project 730 38th Street East Minneapolis, MN 55407 January 1, 2003 – June 30, 2006	HIV+ Adults	*Outreach* – Outreach at homes, coffee shops, street, public sex environments, community venues and on-site outreach with short prevention messages, information and safer sex and bleach kits – 350 HIV+ persons *Individual Level* – Staff and peer-led risk assessment and risk reduction counseling. May include sexual partners occasionally – 38 HIV+ persons *Group Level* – Educational group sessions (one for MSM, another for other HIV+ adults) with opportunity for peer modeling of risk reduction skills. May include sexual partners occasionally – 50 HIV+ persons *Health Communication/Public Info* – Presentations and brief on-site individual encounters to give out safer sex and bleach kits, and referrals – 750 persons	Stages of Change Theory of Reasoned Action and Social Cognitive Theory Behavioral Self-management and Assertion Skills *and* Small Group Lecture plus Skills Training (Compendium) INSPIRE Stages of Change

AGENCY AND PERIOD OF PERFORMANCE	TARGET POPULATION	INTERVENTIONS AND # OF CLIENTS (6 MONTH TARGET)	EVIDENCE BASIS
Breaking Free 770 University Ave West St. Paul, MN 55104 January 1, 2003 – June 30, 2006	Adult African American Heterosexual Women (prostituted)	*Outreach* – Outreach targeting prostituted women in areas of high prostitution, bars, hair salons – 450 persons *Health Communication/Public Info* – HIV/STD presentations at treatment centers, halfway houses, Johns school, shelters, churches, community centers, health fairs, community events. – 1750 persons	Evaluation of similar programs in MN and other states Evaluation of similar programs in MN and other states
Chicanos Latinos Unidos en Servicio (CLUES) 2700 East Lake Street Minneapolis, MN 55406 January 1, 2003 – June 30, 2006	MSM of Color (Latinos)	*Outreach and OraSure Testing* – Outreach and OraSure testing in night clubs, bars, restaurants, coffee shops, places of worship – 300 Latinos *Individual Level* – Risk assessment, risk reduction counseling about HIV/STDs, substance use, safer sex and building self esteem – 18 Latino men *Group Level* – Four group sessions focusing on HIV/STDs, substance use, safer sex, and self esteem – 15 Latino men	All interventions based on the following: Reasoned Action Health Belief Model Social Learning Theory Self-Management Models Stages of Change Model
The City, Inc. 1545 East Lake Street Minneapolis, MN 55407 January 1, 2003 – June 30, 2006	Young MSM (African American)	*Outreach* – Outreach in schools, buses/bus stops, concerts, fast food restaurants, schools, barber shops – 25 young African American men and transgender youth *Individual Level* – Risk assessment, skills building and practice, individual prevention plan – 8 young African American men and transgender youth	Health Belief Model Stages of Change Model
	Young African American Heterosexual Women	*Outreach* – Outreach at schools, hangouts, bus/bus stops, beauty shops, fast food restaurants, concerts, special events – 75 African American youth *Continued on next page*	Health Belief Model

AGENCY AND PERIOD OF PERFORMANCE	TARGET POPULATION	INTERVENTIONS AND # OF CLIENTS (6 MONTH TARGET)	EVIDENCE BASIS
The City, Inc. *continued* 1545 East Lake Street Minneapolis, MN 55407 January 1, 2003 – June 30, 2006	Young African American Heterosexual Women	*Individual Level* – Risk assessment, risk reduction counseling, skills building and practice, individual prevention plan, encourage testing – 8 African American youth *Group Level* – 3-session group led by staff and peer educators providing HIV/STD info, risk reduction, sexual violence, skills building – 15 African American youth *Health Communication/Public Info* – Educational presentations at City Inc, alternative schools, group homes, churches, "hang-out, condom house," special events, community events, community organizations, community radio – 500 African American youth	Stages of Change Model Empowerment Theory Social Learning Theory Diffusion of Innovation
Clinic 42 – Abbott Northwestern Hospital 2545 Chicago Ave S Minneapolis, MN 55404 January 1, 2003 – June 30, 2006	HIV+ Adults	*Individual Level* – Risk assessment, develop behavioral goals, identify supports and barriers – 63 HIV+ persons *Group Level* – Three groups targeting HIV+ MSM, HIV+ Heterosexuals, and HIV/HCV co-infected persons. Group discussion focuses on sexual health, dating and disclosure, sexual and mental/chemical health, body image, safer sex skills – 29 HIV+ persons *Prevention Case Management* – Risk assessment, behavior change counseling, individual prevention plan – 3 HIV+ persons *Health Communication/Public Info* – Coasters with STD information – Website with health information, resources, message board, live chats targeting HIV+ persons and/or negative sexual partners – 50 persons	CDC guidance on incorporating prevention into medical care Small Group Lecture plus Skills Training (Compendium) Empowerment Theory CDC prevention case management guidance Info from 2003 conference on interventions on the Internet

AGENCY AND PERIOD OF PERFORMANCE	TARGET POPULATION	INTERVENTIONS AND # OF CLIENTS (6 MONTH TARGET)	EVIDENCE BASIS
Face to Face Health and Counseling Service 1165 Arcade Street St. Paul, MN 55106 January 1, 2003 – June 30, 2006	Young MSM	*Individual Level & OraSure Testing* – Risk assessment, HIV education, risk reduction counseling, skills practice, psychosocial evaluation. OraSure testing at drop-in center – 10 young men *Group Level* – Support and educational group focusing on HIV education, risk reduction, safer sex negotiations, psychosocial evaluation – 13 young men *Health Communication/Public Info* – Health information booths at Gay Pride and Worlds AIDS Day – 225 youth *Other* – Presentations about issues affecting GLBT youth – 75 youth-serving providers	All interventions based on Harm Reduction Theory
	Young Heterosexual Women of All Races	*Individual Level & OraSure Testing* – Risk assessment, risk reduction counseling, skills practice, psychosocial evaluation. OraSure testing at drop-in center – 25 young women *Health Communication/Public Info* – Educational presentations on HIV and risk reduction at schools, other agencies, community health fairs, correctional facilities – Information on HIV, risk reduction at health fairs, community events – 375 youth	
The Family Tree, Inc 1619 Dayton Avenue St. Paul, MN 55014 January 1, 2006 – December 31, 2008	Individuals at risk of STD infection, individuals concerned about STDs	*Health Communication/Public Info* – Phone hotline that provides information about STDs (including HIV), and referral to appropriate services – Media campaign promoting hotline targeted at African Americans	

AGENCY AND PERIOD OF PERFORMANCE	TARGET POPULATION	INTERVENTIONS AND # OF CLIENTS (6 MONTH TARGET)	EVIDENCE BASIS
Hennepin County Red Door Clinic 525 Portland Ave S Minneapolis, MN 55415 January 1, 2003 – June 30, 2006	Adult MSM of All Races	*Outreach* – Outreach at public sex locations, bars, cafes, community events – 900 men *Individual Level, OraSure/OraQuick* – Risk assessment, risk reduction counseling, sexual negotiation, communication, maintenance of safer sex behavior, counseling and testing – 100 men *Group Level* – 8-session group on increasing condom use and decreasing internalized homophobia – 12 men – Monthly support group for married men who are also attracted to men – 48 men – Chemical/sexual health educational and skills building group for MSM in treatment programs – 60 men – Ongoing discussion group for sexually active gay/bi men on sexual health and other issues – 48 men – Ongoing discussion group for sexually active gay/bi men over age 55 on sexual health/other issues – 12 men *Prevention Case Management* – Risk assessment, behavior change counseling, individual prevention plan, testing – 3 men *Health Communication/Public Info* – Website with program and testing information; e-mail response and postings to chat rooms – 150 hits – Articles on HIV/STDs, sexual health, program information in gay press – 12,000 copies distributed – Presentations on HIV/STDs to HIV+ and high risk MSM – 60 men – Information, referral and recruitment into program at events – 750 men *Continued on next page*	Theory of Reasoned Action, Health Belief Model, Stages of Change Theory of Reasoned Action, Health Belief Model, Stages of Change Model Theory of Reasoned Action Health Belief Model Stages of Change Model Stages of Change Model, CDC PCM Guidance Public health research

AGENCY AND PERIOD OF PERFORMANCE	TARGET POPULATION	INTERVENTIONS AND # OF CLIENTS (6 MONTH TARGET)	EVIDENCE BASIS
Hennepin County Red Door Clinic *continued* 525 Portland Ave S Minneapolis, MN 55415 January 1, 2003 – June 30, 2006	Young African American Heterosexual Women	*Outreach* – Outreach at strip clubs that have primarily African American dancers and at sex businesses – 97 African American young women *Individual Level, OraSure/OraQuick* – Risk assessment, risk reduction counseling, information about HIV/STD testing, pre- and post-test counseling if test requested during Teen Clinic at Red Door – 29 young African American women and sexual partners *Group Level* – Group workshops and risk reduction skills building for youth in sex businesses, alternative schools, youth shelters, substance use programs – 98 young African American women *Health Communication/Public Info* – Distribute risk reduction information and supplies at health fairs, community events, parades – Website with information, e-mail response with information and referrals – 160 young African American women and their partners	Health Belief Model, Theory of Reasoned Action, Social Learning Theory Health Belief Model Theory of Reasoned Action Health Belief Model Social Learning Theory Diffusion of Innovation Social Learning Theory Health Belief Model
	Young Heterosexual Women of All Races	*Outreach* – Outreach at strip clubs, sex businesses – 160 young women *Individual Level, OraSure/OraQuick* – Risk assessment, risk reduction counseling, information about HIV/STD testing, pre- and post-test counseling if test requested during Teen Clinic at Red Door – 54 young women and sexual partners *Continued on next page*	Health Belief Model, Theory of Reasoned Action, Social Learning Theory Health Belief Model Theory of Reasoned Action

AGENCY AND PERIOD OF PERFORMANCE	TARGET POPULATION	INTERVENTIONS AND # OF CLIENTS (6 MONTH TARGET)	EVIDENCE BASIS
Hennepin County Red Door Clinic *continued* 525 Portland Ave S Minneapolis, MN 55415 January 1, 2003 – June 30, 2006	Young Heterosexual Women of All Races	*Group Level* – Group workshops and skills building for youth in sex businesses, alternative schools, youth shelters, substance use programs – 102 young women *Health Communication/Public Info* – Info, safer sex strategies at health fairs, community events, parades, etc – 200 young women and their partners – Website with information, e-mail information and referrals – 2500 hits – Staff training about HIV/STDs and hepatitis and how to work with young women regarding sexual health – 18 professionals at agencies, medical and educational institutions	Health Belief Model Social Learning Theory Diffusion of Innovation Social Learning Theory Health Belief Model
Indigenous Peoples Task Force (IPTF) 1433 Franklin Ave E Minneapolis, MN 55404 January 1, 2003 – June 30, 2006	MSM of Color (Native Americans)	*Outreach and OraSure Testing* – Outreach in public sex places, bars, street, community centers – 450 Native American men *Individual Level* – Risk assessment, risk reduction counseling, skills building – 8 Native American men *Health Communication/Public Info* – Presentations at Pow Wows on HIV/STD/hepatitis transmission and prevention – 500 Native Americans – Presentations at CBOs, health seminars, and when requested by tribal health organizations on HIV/STDs, gender identification and/or relationships in Native communities, abuse and racism – 25 Native Americans	Social Learning Theory, Diffusion of Innovation Health Belief Model Health Belief Model, Social Learning Theory Social Learning Theory Empowerment Theory

AGENCY AND PERIOD OF PERFORMANCE	TARGET POPULATION	INTERVENTIONS AND # OF CLIENTS (6 MONTH TARGET)	EVIDENCE BASIS
Leech Lake Band of Ojibwe 6530 US 2 NW Cass Lake, MN 56633 January 1, 2003 – June 30, 2006	Female IDUs of All Races (Native American)	*Individual Level* – Risk assessment, safer sex and safer drug use counseling – 13 Native American women *Health Communication/Public Info* – Educational presentations focused on HIV/STDs, safer sex and drug use at Pow Wows, traditional gatherings, health fairs and schools on or near reservation – 150 Native American persons	All interventions based on Health Belief Model
	Young IDUs (Native American)	*Individual Level* – Risk assessment, risk reduction counseling, HIV/STD/hepatitis info, adolescent health issues, healthy decision making – 13 young Native Americans *Health Communication/Public Info* – Educational presentations focused on HIV/STDs, safer sex and drug use at Pow Wows, traditional gatherings, health fairs and schools on or near the reservation – 150 Native American youth	
Minneapolis Urban League (MUL) 2100 Plymouth Avenue N Minneapolis, MN 55411 January 1, 2003 – June 30, 2006	MSM of Color (African American)	*Outreach and OraSure Testing* – Outreach and OraSure testing in bars, parks, neighborhoods, community events – 500 African American men *Individual Level* – Culturally specific risk assessment, risk reduction counseling – 15 African American men	Diffusion of Innovation Theory Harm Reduction Theory

AGENCY AND PERIOD OF PERFORMANCE	TARGET POPULATION	INTERVENTIONS AND # OF CLIENTS (6 MONTH TARGET)	EVIDENCE BASIS
Minnesota AIDS Project (MAP) 1400 Park Avenue S Minneapolis, MN 55404 January 1, 2003 – June 30, 2006	Adult MSM of All Races	*Outreach* – Outreach by volunteers at bars and public sex locations. Offer OraSure testing which is provided through ILI in a van at outreach site – 450 men – Outreach by volunteers and staff on Internet and in chat rooms – 150 men *Individual Level and OraSure* – Risk assessment, risk reduction counseling, individual prevention plan, counseling and testing – 163 persons, primarily men *Group Level* – Group intervention on sexual health, condom use, risk reduction. Leadership and skills training on providing prevention messages to peers and community – 43 men *Health Communication/Public Info* – Facilitated discussions on how HIV/STDs relate to reality for gay/bi men – 115 men – Print and web ads developed by program participants with prevention messages and promotion of programs – Environmental outreach including distribution of safer sex kits and health promotion messages - 17,000 persons	Mpowerment
	HIV+ MSM	*Individual Level* – Face to face risk assessment, individual prevention strategies, self care and health promotion – 4 newly diagnosed HIV+ men – Internet risk assessment, self care and health promotion – 5 newly diagnosed HIV+ men *Group Level* – Group training and discussions about risk reduction and self care. Leadership and skills training for core group members to provide prevention messages to peers and community. Some will be recruited to volunteer for HC/PI activities – 20 HIV+ men *Continued on next page*	Mpowerment Mpowerment

AGENCY AND PERIOD OF PERFORMANCE	TARGET POPULATION	INTERVENTIONS AND # OF CLIENTS (6 MONTH TARGET)	EVIDENCE BASIS
Minnesota AIDS Project (MAP) *continued* 1400 Park Avenue S Minneapolis, MN 55404 January 1, 2003 – June 30, 2006	HIV+ MSM	*Health Communication/Public Info* – Core group members provide health education/information informal outreach at Twin Cities Gay Men's Softball League games – 150 contacts – Core group members collaborate with another MAP program to conduct outreach at gay/bi bars –150 contacts – Core group members maintain regular Internet outreach hours in gay/bi chat rooms – 75 contacts	Mpowerment
	African American Male IDUs	*Outreach* – Outreach in van to street locations and fixed sites. Offer OraSure testing which is provided through ILI at outreach site – 60 persons	Stages of Change
		Individual Level and OraSure Testing – Risk assessment and harm reduction counseling, pre- and post-test counseling, OraSure testing, Rule 25 assessments – 93 persons	Stages of Change
		Health Communication/Public Info – Small group HIV/STD/hepatitis education and risk reduction presentations – 490 persons – Briefer outreach contacts – 510 persons	Stages of Change
	All target populations, as well as any individual or community in the state concerned about HIV (*Note:* The AIDSLine/Quick Connect is partially funded with Ryan White CARE Act dollars)	*Health Communication/Public Info* – Phone hotline (AIDSLine) and web site that provides information about HIV and referrals to testing, prevention and care services – 1100 phone and e-mail contacts – Quick Connect provides face-to-face information about services for HIV positive individuals – OraSure counseling and testing provided. Risk assessment to determine need for testing is done through phone calls to the AIDSLine	National and state surveys indicating a continuing need for basic HIV information

AGENCY AND PERIOD OF PERFORMANCE	TARGET POPULATION	INTERVENTIONS AND # OF CLIENTS (6 MONTH TARGET)	EVIDENCE BASIS
Neighborhood House 179 East Robie Street St. Paul, MN 55107 January 1, 2003 – June 30, 2006	Young Heterosexual Women of All Races (Latina)	*Individual Level* – Risk assessment, risk reduction counseling, individual prevention plan, accompany to appointments – 15 young Latina women *Group Level* – Small group discussions on HIV/STDs, risk reduction, family communication, cultural barriers, skills building held at Neighborhood House, in community settings, homes and schools – 25 young Latina women	Both interventions based on Social Learning Theory Social Inoculation Theory Cognitive Behavioral Theory
Pillsbury United Communities 3501 Chicago Ave S Minneapolis, MN 55407 January 1, 2003 – June 30, 2006	MSM of Color (primarily African American and Latino)	*Outreach* – Outreach in bars, streets, shelters, parks, events – 2400 persons *Individual Level* – Risk assessment, risk reduction counseling, individual prevention goals – 13 men *Group Level* – Men's brunch focused on sexual responsibility, condom use, relationships, HIV/STDs, spirituality, racism, coming out, etc. Chemical health classes offered during brunch four times during year – 133 men *Health Communication/Public Info* – Presentations on HIV/STD risk reduction at events, CBOs, schools, group homes and treatment centers – 800 men	Program evaluation data Health Belief Model Cognitive Behavioral Theory Health Belief Model
Program in Human Sexuality (PHS) University of Minnesota 1300 Second Street Minneapolis, MN 55454 January 1, 2003 – June 30, 1006	Adult MSM of All Races	*Group Level* – Man to Man Seminar on sexual health, condom use, risk reduction to 30 men – Our Sexual Health Seminar to 25 persons – All Gender Health Seminar to 20 persons	Sexual Health Model

AGENCY AND PERIOD OF PERFORMANCE	TARGET POPULATION	INTERVENTIONS AND # OF CLIENTS (6 MONTH TARGET)	EVIDENCE BASIS
Rural AIDS Action Network (RAAN) 970 Raymond Avenue St. Paul, MN 55114 (*Note:* office located in metro area, but services provided in Greater MN) January 1, 2003 – June 30, 2006	Adult MSM of All Races	*Individual Level* – Risk assessment, risk reduction counseling, mental and chemical health screening, safer sex kits – 15 men *Group Level* – 10-session peer led groups focused on homophobia, coming out in Greater MN, HIV/STD/hepatitis in rural areas, religion and GLBT community, safer sex and domestic violence – 8 men *Health Communication/Public Info* – HIV/STDs 101 presentations at rural network meetings and campus health fairs, and information at World AIDS Day and Pride events in Greater MN – 450 persons	All interventions based on Social Learning Theory Health Belief Model Theory of Reasoned Action
Turning Point, Inc. 1500 Golden Valley Road Minneapolis, MN 55411 January 1, 2003 – June 30, 2006	African American Male IDUs	*Outreach* – Outreach in shooting galleries, bars, shelters, substance use treatment centers, places where drug dealers congregate, etc. – 206 African American men *Individual Level* – Risk assessment, HIV/STD/hepatitis risk reduction and harm reduction counseling – 40 African American men *Group Level* – Group sessions at treatment center on condom use, cleaning needles, vein care, hepatitis C symptoms, harm reduction – 200 African American men	All interventions based on Harm Reduction Model
	African American Female IDUs	*Outreach* – Outreach in shooting galleries, bars, shelters, substance use treatment centers, places where drug dealers congregate – 94 African American women	

Continued on next page

AGENCY AND PERIOD OF PERFORMANCE	TARGET POPULATION	INTERVENTIONS AND # OF CLIENTS (6 MONTH TARGET)	EVIDENCE BASIS
Turning Point, Inc. *continued* 1500 Golden Valley Road Minneapolis, MN 55411 January 1, 2003 – June 30, 2006	African American Female IDUs	*Individual Level* – Risk assessment, risk reduction and harm reduction counseling – 15 African American women *Health Communication/Public Info* – Presentations on HIV/STD/hepatitis prevention, safer sex, condom use, safer injection information and harm reduction in treatment centers, shelters, community centers, etc. – Community outreach including safe sex and injection information at community events – 150 persons	All interventions based on Harm Reduction Model
Wake Up We're Affected (WUWA) 3149 35th Avenue South Minneapolis, MN 55406 January 1, 2003 – June 30, 2006	Adult African American Heterosexual Women	*Outreach* – Outreach by peer educators in bars and community events – 300 African American women *Health Communication/Public Info* – Presentations and lectures at community events to increase awareness of HIV/STDs and empower women to teach others – Forums in clubs, churches, community settings – 1650 African American women	Paulo Freire's Theory of Education Paulo Freire's Theory of Education
Youth and AIDS Projects (YAP) 428 Oak Grove Street Minneapolis, MN 55403 January 1, 2003 – June 30, 2006	Young MSM	*Outreach* – Outreach in bars, parks, beaches, restaurants, entertainment venues, and institutions (shelters, drop-in sites, correctional facilities, support groups) – 125 youth *Individual Level and OraSure Testing* – Risk assessment, risk reduction counseling, OraSure testing, monitoring change in knowledge and behavior – 25 young men *Group Level* – One peer education group session focused on safer sex, condom use, risk associated with sex and drug use, role plays – 18 young men *Continued on next page*	Social Learning Theory Health Belief Model Social Learning Theory Health Belief Model Social Learning Theory

AGENCY AND PERIOD OF PERFORMANCE	TARGET POPULATION	INTERVENTIONS AND # OF CLIENTS (6 MONTH TARGET)	EVIDENCE BASIS
Youth and AIDS Projects (YAP) *continued* 428 Oak Grove Street Minneapolis, MN 55403 January 1, 2003 – June 30, 2006	Young MSM	*Prevention Case Management/OraSure* – Risk assessment, behavior change counseling, individual prevention plan, OraSure testing – 25 young men *Health Communication/Public Info* – Information on HIV and risk reduction provided at community events and through educational presentations in bars, shelters, drop-in, recreation and counseling centers – 500 youth	CDC PCM Guidance Social Learning Theory

B. Modifications to Health Education and Risk Reduction Grantees

This table summarizes the information requested for HERR grantees that had modifications to their contracts. From July 2004 through June 2005, fifteen agencies were funded through a competitive RFP process to implement health communication/public information activities targeting African communities. An additional three agencies were added for the time period of January 2005 through June 2005. These contracts were implemented in response to steadily increasing rates of new HIV infections among African-born individuals reported to the MDH in recent years. Health communication/ public information was chosen as the intervention based on needs assessment activities conducted in 2003 that indicated a need for greater community awareness of HIV in order to combat the very high levels of stigma and denial that exist in African communities, as well as to increase individual knowledge regarding HIV and risk reduction strategies.

A subset of these agencies was identified for continued funding from July 2005 through June 2006. The eleven agencies were selected based on the following criteria: programs target African communities with the highest incidence and prevalence (Ethiopian/Oromo, Kenyan, Cameroonian, Liberian, and Somali); programs satisfactorily met the requirements of the original grant agreement; and programs met the objectives of the original grant agreement. Grant managers' observations during site visits were also taken into consideration.

The funded agencies are required to submit narrative reports on their progress twice a year, and the contract manager conducts site visits with each agency to identify successes, challenges, and technical assistance needs.

All of the agencies are funded through state dollars. The itemized budgets and budget narratives are provided for all agencies in Attachment A (not included).

Agency and Period of Performance	Target Population	Interventions and # of Clients (6 month target)	Evidence Basis
African Assistance Program, Inc (AAP) 7710 Brooklyn Boulevard, Suite # 206 Brooklyn Park, MN 55428 July 1, 2005 – June 30, 2006	Liberian	*Health Communication/Public Info* – HIV/AIDS public service announcements (PSAs) on Cable TV most watched by the Liberian community (5,000 viewers) – HIV/AIDS educational TV programs targeting three Liberian tribes (5,000 viewers) – Collaborate with Project Lifeline to conduct HIV/AIDS presentations at Liberian places of worship, awareness training to Liberian clergy; host HIV/STD prevention and awareness events, reach youth through music and poetry	Needs assessment data

AGENCY AND PERIOD OF PERFORMANCE	TARGET POPULATION	INTERVENTIONS AND # OF CLIENTS (6 MONTH TARGET)	EVIDENCE BASIS
Kids Home International (KHI) 2700 Stevens Ave South Minneapolis, MN 55408 July 1, 2005 – June 30, 2006	Kenyan	*Health Communication/Public Info* – HC/PI presentation targeting youth (20 youth) – In collaboration with places of worship, conduct HC/PI presentations during services (405 people) – Conduct HC/PI presentations to different Kenyan cultural groups (380 people)	Needs assessment data
Mestawet Ethiopian Newspaper 1821 University Avenue West, Suite #318 Saint Paul, MN 55104 July 1, 2005 – June 30, 2006	Ethiopian	*Health Communication/Public Info* – HC/PI presentations at two Ethiopian places of worship (200 participants) – Newspaper HIV/AIDS fact sheets (7,500) – In collaboration with Abissinia Ethiopian TV and Ethiopian radio, regularly interview leaders on HIV/AIDS related topics. Also run HIV/AIDS PSAs on radio/TV (5,000 Ethiopian listeners/viewers)	Needs assessment data
Minnesota African Women's Association (MAWA) 1201 37th Avenue North Minneapolis, MN 55412 July 1, 2005 – June 30, 2006	Liberian	*Health Communication/Public Info* – HC/PI presentations to Liberian women in small groups at locations they congregate (200 participants) – Provide basic HIV education on African Cable TV targeting the Liberian community as a whole	Needs assessment data
Nyagetinge Umoja 2316 Fernside Lane Mound, MN 55364 July 1, 2005 – June 30, 2006	Kenyan	*Outreach* – HIV prevention education activities at social events, birthday parties, pre-wedding parties (450 people) *Health Communication/Public Info* – HC/PI presentations at places of worship and at Kenyan community forum (200 people) – Reach youth through music and poetry performed by peers (100 youth)	Needs assessment data
Oromo Community of Minnesota, Inc (OCM) 1505 South 5th Street Minneapolis, MN 55454 July 1, 2005 – June 30, 2006	Oromo	*Health Communication/Public Info* – Two HC/PI presentation targeting youth (55 youth) – Two HC/PI presentation targeting an existing Oromo women group that meets monthly (55 women) – Two HC/PI presentation targeting elders (50 elders) – Two HC/PI presentations at community events (600 people) – HIV/AIDS prevention education on Oromo TV and radio (7,000 listeners/viewers)	Needs assessment data

AGENCY AND PERIOD OF PERFORMANCE	TARGET POPULATION	INTERVENTIONS AND # OF CLIENTS (6 MONTH TARGET)	EVIDENCE BASIS
Project Valentine (PV) 2135 44th Avenue North Minneapolis, MN 55364 July 1, 2005 – June 30, 2006	Cameroonian	*Health Communication/Public Info* – Present HIV/AIDS education to large group in the form of drama, poetry and music (200 people)	Needs assessment data
Somali Community Resettlement Services, Inc (SCRS) 1903 S. Broadway Rochester MN 55904 July 1, 2005 – June 30, 2006	Somali	*Health Communication/Public Info* – HIV/AIDS PSAs on local Somali TV (15,000 viewers) – HC/PI for Somali youth group, women's group, and Somali community as a whole (205 people) – Conduct interviews on local Somali TV on HIV/AIDS epidemic among Africans (15,000 viewers)	Needs assessment data
Somali Health Project (SHP) 416 E Hennepin Avenue, Suite #109 Minneapolis, MN 55414 July 1, 2005 – June 30, 2006	Somali	*Health Communication/Public Info* – HC/PI presentations at Somali community gatherings, community center, Somali places of worship, etc. (240 people)	Needs assessment data
Sub-Saharan African Youth and Family Services in Minnesota (SAYFSM) 1885 University Ave West Saint Paul, MN 55104 July 1, 2005 – June 30, 2006	Oromo and Ethiopian	*Health Communication/Public Info* – HC/PI presentations in community and/or places of worship (150 participants) – Collaborative broadcasts (Oromo and Amharic radio and cable TV) to present and educate in the area of HIV/AIDS (5,500 listeners/viewers) – Collaborate with Wee Care Family Services Inc. to provide HIV/AIDS HC/PI presentations specific to youth, women, and men separately (60 participants)	Needs assessment data
Zyombi Project (ZP) 1351 23rd Street Minneapolis, MN 55404 July 1, 2005 – June 30, 2006	Cameroonian	*Health Communication/Public Info* – HC/PI presentations to community leaders (40 community leaders) – HC/PI presentations at traditional Cameroonian festivities, birthdays, weddings, etc. (200 people) – HC/PI presentations to three Cameroonian cultural groups (120 people)	Needs assessment data

C. Counseling, Testing and Referral Grantees

The following table summarizes the requested information for the existing Counseling, Testing and Referral (CTR) grantees that will be funded through December 31, 2006. This table includes grantees that receive funding to support staff to provide CTR services. HERR grantees that have OraSure testing incorporated into their HERR contracts are not included here. Community based CTR grantees will be identified in late 2006 through the HERR RFP process and will be funded for the time period of July 1, 2006 through December 31, 2008. Clinic based sites serving Latinos and Africans will be identified in late 2005 through an informal solicitation process and will be funded for the time period of January through December 2006. All interested clinic based sites will compete in a separate RFP in late 2006 and will be funded for the time period of January 1, 2007 through December 31, 2009.

Agency and Period of Performance	Target Population	Interventions	Evidence Basis
Hennepin County Red Door Clinic 525 Portland Ave S Minneapolis, MN 55415 January 1, 2002 – December 31, 2006	At-risk Individuals	*Counseling, Testing and Referral* – Staff time to provide HIV counseling and testing in an STD clinic (OraQuick, OraSure and serum)	N/A
Minnesota AIDS Project (MAP) 1400 Park Avenue South Minneapolis, MN 55404 January 1, 2003 – June 30, 2006	At-risk Individuals	*Counseling, Testing and Referral* – Staff time to provide OraSure testing on-site, and during ILI interventions funded through the HERR grant	N/A
St. Paul-Ramsey County Public Health Room 111 555 Cedar Street St. Paul, MN 55101 January 1, 2002 – December 31, 2006	At-risk Individuals	*Counseling, Testing and Referral* – Staff time to provide HIV counseling and testing in an STD clinic (serum tests)	N/A
United Family Practice - North Memorial Hospital 1020 West Broadway Minneapolis, MN 55411 January 1, 2003 – December 31, 2006	At-risk Individuals (African Americans)	*Counseling, Testing and Referral* – Staff time to provide OraQuick and OraSure testing in the context of outreach services	N/A

D. Professional/Technical Assistance Contractors

Two professional/technical assistance contracts will be in place during part of 2006. One contractor will provide evaluation training to all grantees and individual technical assistance to grantees regarding process and outcome monitoring evaluation plans and the development of evaluation tools. The contractor will be identified through a competitive process with funding to begin April 1, 2006. The other contractor will provide training and technical assistance to grantees related to organizational infrastructure and implementation of interventions. The contractor will be identified through a competitive process with funding to begin July 1, 2006.

Community Planning

1. Summarize changes made to the Comprehensive HIV Prevention Plan between January 1 and June 30, 2005 and explain why they were made.

A number of changes were made to the Minnesota Comprehensive HIV Prevention Plan during the first half of 2005. The Community Cooperative Council on HIV/AIDS Prevention (CCCHAP), which is the statewide community planning group for Minnesota, conducted its prioritization process during March and April 2005. A new comprehensive plan for 2006 through 2008 was developed to reflect the priorities identified by the CCCHAP. In addition, the new plan includes the most recent data available for the epidemiological (epi) profile, needs assessment, and effective interventions sections of the plan. The resource inventory was updated to reflect currently funded programs and the chapter on collaboration and coordination was also updated to reflect current collaborative efforts. The CCCHAP did not conduct gap analysis during the first half of 2005, but the new plan contains the plan for gap analysis activities to be undertaken in 2006 and 2007.

2a. Describe major issues addressed during community planning group meetings between January 1 and June 30, 2005 and the outcomes of activities to address those issues.

Interpretation of the Results of the Target Population Prioritization Process

The CCCHAP meets as a full group four times a year and two meetings were held during the first half of 2005. The CCCHAP prioritized target populations at the first meeting, which was held in March 2005. The CCCHAP used the Academy for Educational Development (AED) prioritization process as previously described in the 2004 annual progress report. The CCCHAP spent most of their time in 2004 developing the process. The results of the prioritization process are as follows:

TARGET POPULATION	PRIORITIZATION SCORE
HIV Positive Persons	
HIV+ Men Who Have Sex with Men (MSM)	134.0
HIV+ Injecting Drug Users (IDU)	114.8
HIV+ High Risk Heterosexuals (HRH)	96.7
HIV+ Youth	83.9
HIV+ Greater Minnesotans	81.0
Men Who Have Sex with Men	
MSM of All Races	133.6
MSM of Color	123.0
Young MSM	92.2
High Risk Heterosexuals	
African HRH	130.6
African American HRH	93.7
Latino/a HRH	88.0
Native American HRH	84.6
Young HRH	73.6
White HRH	72.7
Injecting Drug Users	
MSM/IDU	114.0
IDU of All Races/All Genders	112.0

The major issue related to the prioritization process came up in relation to the final prioritization scores. As seen in the results, some of the scores were quite close, and the question was raised as to whether it was necessary to run an analysis of variance (ANOVA) test to see whether the differences in scores were based solely on chance or whether they were truly different. It was suggested that if there were target populations with scores that were not statistically significantly different, the CCCHAP could identify a factor (e.g., incident cases) to break the "tie" between those scores. Other members disagreed, feeling that a tie would occur only if two scores were exactly the same. After much discussion, the CCCHAP voted to accept the scores as tabulated. The priority ranking of the target populations was based on those scores within each population category.

Funding Allocation Principles

The CCCHAP is not responsible for allocating funds; this is the responsibility of the Minnesota Department of Health (MDH). After the target population prioritization process was completed, the MDH developed funding allocation principles (described in detail in the Health Education/Risk Reduction section of this document) for use in the upcoming Request for Proposals (RFP), which will be based on the results of the CCCHAP's prioritization process. In order to most effectively and efficiently prevent new HIV cases, the funding principles prioritize the funding of comprehensive programming in the target populations that received the highest scores from the CCCHAP within each of the population categories rather than funding smaller efforts within all of the prioritized target populations. Also, in order to reduce duplication of effort and address as many needs as possible, the MDH will consider other sources of state and federal HIV prevention funds when making funding decisions.

The application of these funding principles resulted in five target populations being eliminated from possible funding in the upcoming RFP. HIV Positive Youth, HIV Positive Greater Minnesotans, Asian/Pacific Islander HRH and White HRH were eliminated because of the lower scores they received in the prioritization process. Native American HRH were eliminated because there are substantial other federal funds coming into the state to address HIV prevention needs within this population.

At the April CCCHAP meeting, the MDH presented its proposed funding principles to the CCCHAP, discussed the impact of their application and asked them to come to consensus on any messages or concerns they wanted the MDH to consider in finalizing the principles. The CCCHAP arrived at consensus that the funding principles made sense overall. They also arrived at consensus on two concerns. One was that the elimination of some of the target populations makes it difficult to implement programs that target a broader audience, such as women across populations. There was also concern that considering other sources of funding may penalize organizations that are successful in receiving those funds and may also inappropriately assume that organizations with other funding are able to effectively reach the entire high risk population they are funded to serve. After considering input from the CCCHAP, as well as input received from currently funded grantees, the MDH maintained the funding principles as originally proposed.

Prioritization of Co-factors

In 2004, when the MDH and the CCCHAP were developing the prioritization process, the MDH proposed and the CCCHAP agreed to implement a different process for identifying interventions. The revised process resulted in the CCCHAP being responsible for identifying and prioritizing co-factors that most impact HIV risk within each target population instead of identifying a set of interventions for each target population. The original list of co-factors identified by the CCCHAP included: sexual networks, socioeconomic status, level of education, stigma, immigration, population mobility, gender power imbalance, domestic violence/sexual victimization, perceived risk, STDs, pregnancies, hepatitis B and C, substance use and mental health.

The process to identify and prioritize co-factors was conducted at the April 2005 CCCHAP meeting. Because it was a completely new process, there was some discussion and refinement of the process that occurred during the meeting. In the first step of the process, the CCCHAP developed a list of co-factors to be considered for each specific priority target population. Co-factors were only identified for the target populations that would be eligible for funding in the upcoming RFP. As the CCCHAP was developing the lists, they were asked to consider how each of the co-factors impacted HIV risk within that population and whether an HIV prevention program could feasibly address each co-factor. CCCHAP members also had the opportunity to add co-factors that were not originally included. CCCHAP members were then given 5 stickers ("dots") per target population, and they placed these next to the co-factors they felt most impacted HIV risk within each population, based on their experience and the information packets they received in advance of the meeting.

Once the "dots" exercise was completed, the results were presented in rank order by target population. The CCCHAP then considered each population individually and determined whether any of the co-factors could be grouped together for that population. Groupings of co-factors were based on whether the individual co-factors had a similar impact on HIV risk and if they could feasibly be addressed together by a prevention program. After they agreed on groupings, the CCCHAP determined how many co-factors or co-factor groupings should be included in the RFP for each population. This varied by population as the CCCHAP decided not to set a standard limit on the number of co-factors/co-factor groupings. The CCCHAP also decided that once the priority co-factors/co-factor groupings were identified, they would not be placed in any ranked order in the RFP.

As a result of the co-factor prioritization process, the responsibility of identifying interventions will now fall upon the organizations that apply for funding in the RFP process. These organizations, which have the expertise in serving their target populations, will take on full responsibility in the upcoming RFP for identifying the intervention(s) they plan to implement and for providing justification for the efficacy of their proposed programs in reaching the target population(s) they propose to serve and in addressing one to three of the co-factors/co-factor groupings identified for that target population(s). In addition, all agencies, regardless of target population, will be required to describe how they will address the two core HIV risk factors identified by the CCCHAP: 1) unprotected anal or vaginal sex with a person or persons of unknown or different serostatus; and 2) sharing of injection drug equipment and/or other instruments that puncture the skin.

Following are the co-factors and co-factor groupings that were identified as priorities for each of the target populations. Definitions of each of the co-factors and a description of their impact on HIV risk will be included in the RFP. Organizations proposing to address a co-factor grouping will be required to address each of the individual co-factors included in the grouping.

HIV+ MSM

- Sexual networks
- Stigma + Disclosure
- Access to health care + Active/untreated STDs + High viral load
- Mental health
- Substance use

HIV+ IDU

- Access to syringes + Substance use
- Access to health care + Active/untreated STDs + High viral load
- Mental health
- Sexual networks
- Stigma + Disclosure
- Survival sex

HIV+ HRH

- Language barriers + Cultural barriers + Stigma + Disclosure
- Access to health care + Active/untreated STDs + High viral load + Health literacy
- Substance use
- Mental health

MSM of All Races

- Language barriers + Cultural barriers + Religious/spiritual beliefs + Stigma + Disclosure
- Access to health care + Active/untreated STDs + Health literacy
- Sexual networks
- Substance use
- Sexual role power dynamics + Survival sex + Domestic violence/sexual victimization
- Mental health

MSM of Color

- Language barriers + Cultural barriers + Religious/spiritual beliefs + Stigma + Disclosure
- Access to health care + Active/untreated STDs + Health literacy
- Sexual networks
- Perception of risk
- Mental health
- Substance use

Young MSM

- Substance use + Access to syringes
- Access to health care + Active/untreated STDs + Health literacy
- Developmental issues + Perception of risk
- Survival Sex + Economic dependence + Sexual role power dynamics
- Population mobility + Homelessness
- Sexual networks + Social norms of risky behavior
- Mental health
- Stigma + Language barriers + Education system barriers to discussing safer sex and sexuality

African HRH

- Language barriers + Cultural barriers + Religious/spiritual beliefs + Stigma + Disclosure + Perception of risk
- Access to health care + Active/untreated STDs + Health literacy + Tuberculosis
- Gender power imbalance + Survival sex
- Sexual networks

African American HRH

- Access to health care + Active/untreated STDs + Health literacy
- Substance use
- Gender power imbalance + Survival sex + Domestic violence/sexual victimization
- Stigma + Religious/spiritual beliefs
- Perception of risk
- Homelessness

Latino/a HRH

- Language barriers + Cultural barriers + Religious/spiritual beliefs + Stigma
- Access to health care + Active/untreated STDs + Health literacy
- Fear of deportation + Homelessness + Population mobility + Sexual networks
- Gender power imbalance + Survival sex + Domestic violence/sexual victimization + Economic dependence

Young HRH

- Access to health care + Active/untreated STDs + Health literacy
- Education system barriers to discussing safer sex and sexuality
- Sexual networks
- Survival sex + Domestic violence/sexual victimization + Homelessness
- Perception of risk
- Substance use

MSM/IDU

- Substance use + Access to syringes
- Sexual networks + Social norms of risky behavior
- Access to health care + Active/untreated STDs + Health literacy
- Survival sex + Homelessness
- Mental health

IDU of All Races/All Genders

- Substance use + Access to syringes
- Access to health care + Active/untreated STDs + Health literacy + Fear of criminal prosecution/incarceration
- Survival sex + Homelessness
- Sexual networks + Social norms of risky behavior
- Mental health

2b. Has the jurisdiction considered combining the HIV prevention community planning group and other planning bodies, such as the Ryan White Title I Planning Council?

In 2001, an ad hoc committee was established to consider the possible merger of the CCCHAP and the Minnesota HIV Services Planning Council (Planning Council). The committee consisted of the co-chairs from each planning body, former members of each planning group, representatives from prevention and care service organizations, and staff from the MDH and the CARE Act Title I and II grantees (in Minnesota, the Planning Council prioritizes and allocates

both Title I and II funds). There have been no further discussions about merging the two bodies since that time.

2c. If yes, summarize the results of those considerations.

The ad hoc committee decided against merging the two planning groups. In truth, the prospect of such an undertaking seemed overwhelming. The work required for both prevention and care planning seemed like too much for one group to manage. The two groups were on very different schedules in terms of prioritization and the resulting contracting cycles. Additionally, the cultures of the two groups were very different. There was also fear that issues related to care would overshadow issues related to prevention. The ad hoc committee did develop a plan for how the two planning groups could coordinate in order to improve community participation in prevention and care planning, improve coordination of prevention and care services, and maximize the use of financial and human resources to support community planning. This plan has been used to varying degrees since then, with minimal activity occurring at the present time. The Governmental HIV Administrative Team (GHAT), which consists of representatives from the MDH and the Title I and II grantees, will review this plan at their next meeting in late September and discuss which, if any, activities can feasibly be maintained and which activities should be deleted.

3. What specific DEBI program models, if any, are listed in the Minnesota Comprehensive HIV Prevention Plan for priority target populations?

As a result of implementing the co-factor prioritization process as described in response to Question 2a, no interventions were specifically identified by the CCCHAP for priority target populations. However, the new *Minnesota Comprehensive HIV Prevention Plan 2006 - 2008* includes a chapter on effective interventions. This chapter describes evidence based interventions for all of the priority target populations. The chapter includes all of the DEBI programs, all of the interventions from the *Compendium of HIV Prevention Interventions with Evidence of Effectiveness* (Compendium), as well as other interventions that have been shown to be effective. The MDH does not require funded agencies to implement DEBI interventions. Organizations responding to the RFP will receive a copy of the effective interventions chapter, and will have the opportunity to attend an overview training on all of the DEBI interventions. However, organizations will also have the option of proposing innovative interventions with accompanying justification supporting their effectiveness with the target population(s) and co-factor(s).

4. What community planning issues do you plan to address between January and December 2006? Describe the actions you plan to take to address these issues, the outcomes you expect to achieve, and how you will determine whether outcomes are met.

New CCCHAP members will be elected in November 2005, with membership terms beginning in December. They will receive a new member orientation in January 2006, which is structured to familiarize them with the community planning process and their responsibilities as CCCHAP members. The expected outcome of this orientation is that new members will have acquired the basic knowledge needed for effective participation in the community planning process. Whether this outcome has been achieved will be determined by feedback gathered through an evaluation of the orientation, through evaluations at each CCCHAP meeting, as well as an overall evaluation of the planning process conducted at the last meeting of the year. In addition, members who leave are given an exit interview in which they are specifically asked whether they received enough training to do effectively do their job as a CCCHAP member.

The work of the CCCHAP in2006 will be focused on gap analysis. The CCCHAP will be asked to identify gaps in the following areas: emerging populations, needs assessment, Partner Counseling and Referral Services (PCRS), public information, evaluation, provider capacity and health department capacity. Gap analysis will continue in 2007, at which time the CCCHAP will focus on identifying gaps in emerging populations, needs assessment, Health Education/Risk Reduction (HERR) programming and Counseling, Testing and Referral (CTR) services.

The CCCHAP has defined emerging populations as populations that were not prioritized during the most recent prioritization process, but in which concerning trends have been noted since that time. In 2006, the CCCHAP will review HIV and STD surveillance data from 2005, as well as input from CCCHAP, the Planning Council, and prevention and care providers, to see if there are any non-prioritized populations that should be identified as emerging populations. If an emerging population(s) is identified, the next step is to review existing needs assessment data to see if more information is needed about the population(s). If this is the case, needs assessment is identified as an unmet need for the emerging population(s). If sufficient needs assessment data already exist for the emerging population(s), the CCCHAP will identify priority co-factors for the population(s). Addressing the priority co-factors for the emerging population(s) then becomes the unmet need.

In order to determine gaps in needs assessment data, the CCCHAP will review existing needs assessment and research data for each of the priority target populations and determine whether any further needs assessments are required for any of the populations. If needs assessment is identified as an unmet need for any of the populations, the CCCHAP will also be asked to identify specific gaps in information by population.

When considering gaps in the PCRS Program, the CCCHAP will review data related to specific outcomes of the program. For example, one outcome will be to look at how many HIV positive patients were contacted by PCRS staff, and of these, how many actually received PCRS. Another will be to look at how many partners were contacted, and of these, how many received PCRS. In addition, PCRS staff, with support from CCCHAP members, will conduct four community forums with consumers and providers to gather more qualitative input on the program. The CCCHAP will also review this information. The CCCHAP will use all of the information to identify any possible gaps in the PCRS Program.

The CCCHAP will identify gaps in public information by comparing the efforts that have been implemented to the priority target populations and co-factors. This process will help them identify gaps in target populations and co-factors being addressed and gaps in linguistically and culturally appropriate public information efforts. The CCCHAP will also compare how many news releases and public service announcements have been released by the MDH to how many have been utilized by the media in order to identify gaps in utilization of materials.

Evaluation gaps will be identified in two steps. The first is to review the data currently being collected by the MDH, the CCCHAP and grantees to ensure that it meets CDC's evaluation requirements. The second step will be to determine if there are additional evaluation needs and/or wishes beyond what is required.

Gaps in provider capacity will be identified by reviewing needs outlined in the capacity building plan developed by the MDH, as well as a summary of needs identified by grantees in progress reports and needs identified by grant managers through their interactions with grantees.

Finally, the CCCHAP will identify gaps in health department capacity through assessing the MDH's existing capacity to support community planning, the distribution of funds, HERR contract management, grantee training activities, evaluation, PCRS, CTR and public information programs. Specific input will be gathered about HERR contract management and community planning through surveys to be completed by grantees and CCCHAP members.

Once the CCCHAP has identified gaps in each of the areas mentioned above, the outcome of the process will be to have the CCCHAP rank the areas of unmet need in order of priority. Should additional funds become available, the MDH will consider the prioritized gaps identified by the CCCHAP when making decisions about how to use the funding. The MDH will know that the CCCHAP's outcomes have been met with the development of a prioritized list of specific unmet needs for each of the gap analysis areas.

Health Education and Risk Reduction

1. Describe methods used by the health department to monitor the performance of its grantees/funded providers.

The health department staff uses several methods to monitor the performance of grantees through a combination of tools and relationships. They include: 1) intervention work plans; 2) progress reports, both program monitoring and narrative reports; 3) outcome monitoring reports; 4) program site visits; 5) materials review; and 6) working relationships with these providers.

Intervention Work Plans

Grantees are required to submit an annual intervention work plan for the following year. In the intervention work plans, agencies are currently asked to describe the following information for each intervention by target population: a) staffing needs; b) scientific support for the intervention; c) justification for using the intervention with the target population; d) expected outcomes; e) process objectives; f) strategies to reach individuals from the target population; g) location/setting where the intervention will take place; h) schedule of activities; i) amount of time spent with individuals; j) educational content/messages that will be provided; k) content of materials that will be distributed; l) types and methods of referrals; and m) data collection methods. MDH grant managers review the intervention work plans and any recommended adjustments are made before implementation begins.

Progress Reports

Each program is required to complete semi-annual progress reports that include two parts: the program narrative report and the program monitoring report. The narrative report describes successes and challenges faced by the program as a whole for the given six-month period. The program monitoring report is quantitative and provides demographic information for each type of intervention being conducted by the grantee. Grant managers are responsible for reviewing the reports, following up with grantees with their questions and feedback, and approving the reports.

Outcome Monitoring Reports

Only grantees that have successfully planned, implemented and utilized process monitoring projects are eligible to conduct outcome monitoring evaluation projects. These projects require an evaluation plan, instrument development, instrument testing and approval, data collection, data analysis, and program recommendations.

Program Site Visits

Program site visits are conducted multiple times a year with each grantee. The MDH conducts these direct program implementation observations during outreach, group level interventions (GLI), and health communication/public information (HC/PI). These intervention observations allow for real time constructive feedback, with a follow-up written summary for program improvement.

Materials Review

Grantees are required to submit all HIV educational materials to the MDH for review and approval by the grant manager and the AIDS Material Review Panel (AMRP) prior to their use and dissemination. A schedule of review meetings is communicated at the beginning of each

calendar year. Grantees need to plan for use of their proposed materials according to this schedule.

Working Relationships

Grant managers maintain consistent telephone and e-mail contact with grantees to gather information regarding budget issues and questions, staff training needs or concerns, data collection questions, educational material development, referral and resources, and reporting. The relationships built over time with grantee staff and agency management facilitates these communications and facilitates overall effective performance monitoring.

2. **Major issues identified by the health department through contract monitoring activities between January and June 2005 to: a) help ensure that services target those most at risk, and b) help ensure that grantees implemented interventions with fidelity to intervention protocols and core elements.**

The grant managers identified and responded to the need to ensure that interventions are targeting persons at highest risk for transmitting or acquiring HIV as follows:

a. Grant managers provided training to new grantee staff on identifying high risk persons and the importance of strategic planning to reach these individuals with interventions.
b. Grant managers reviewed grantee intervention work plans and narrative reports to determine the degree to which high risk individuals were actually reached through intervention delivery. Contract managers provided constructive feedback that included an analysis of success in reaching these individuals.
c. Grant managers also conducted programmatic site visits to observe and assess the degree to which high risk individuals were being reached. Feedback was provided to the grantees.

The grant managers identified and responded to the need to ensure fidelity to intervention protocols and core elements as follows:

a. New grantee staff persons were trained on the required core elements of each intervention.
b. Contract managers reviewed and assessed submitted materials, including curricula and work plans, to identify whether intervention protocols and core elements were included in program planning and design.
c. Contract managers conducted programmatic site visits to observe whether interventions were being implemented with fidelity to protocols and core elements.

Other major issues identified in 2005 as affecting the targeting of high risk individuals and implementation of interventions included: grantee employee turnover, insufficient funding for grantees, inadequacy of culturally appropriate HIV/STD materials for diverse African communities residing in Minnesota, HIV stigma and literacy levels among some African refugee communities, restrictions on HIV prevention materials, and client data collection challenges.

a. To address the issue of employee turnover, the MDH has contracted the services of a consultant to work with the affected agencies on employee recruitment. This work will begin in the second half of 2005 and will include: a) an assessment of the individual needs of each agency; b) training on the use of behavioral interviewing, which is an interviewing skill to assist agencies in finding the best candidate for a position; and c) training on scenario interviewing, another interviewing skill.
b. The MDH Office of Minority and Multicultural Health (OMMH), in collaboration with the STD and HIV Section, has sponsored several capacity building trainings for CBOs, which

include but are not limited to grant writing, program evaluation, board member recruitment and agency strategic planning. Through these workshops, some agencies have applied for and received Minnesota foundations funds.

c. The inadequacy of culturally appropriate HIV/STD materials for diverse African communities residing in Minnesota may continue for some time. The problem is more complex than simple translation of the materials since the translation must also take into consideration cultural issues related to the discussion of HIV and sexuality. There are also numerous African dialects. Finally, many refugees who were forced out of their countries have low literacy levels in their own languages and rely primarily on oral and visual communication.

d. Grantees continue to express concern about recent state legislative attempts to increase restrictions on speech and the images and content of prevention materials. Grant managers work closely with grantees to assure materials meet the requirements in the CDC guidance.

e. The evaluation consultant, in collaboration with grant managers, is planning training and technical assistance for grantees in the development of data collection tools that are consistent with reporting requirements, as well as feasible for use during the intervention delivery.

3. Describe the following for any DEBI program models implemented between January and June 2005:

a. DEBI models that were adapted and tailored by funded providers.

The Minnesota AIDS Project (MAP) has adapted and tailored the Mpowerment model for two of its programs: the Pride Alive health education program targeting adult gay identified men; and the Prevention 4 Positives program targeting HIV positive gay identified adult men.

b. Implementation challenges experienced by grantees.

One implementation challenge for MAP was getting staff fully trained in the Mpowerment model. This included investing time and funds to send all staff who directly implement the projects for training at the University of California San Francisco. It also required an investment of time and effort to educate staff, board members, and MAP clients about the Mpowerment model, as well as to build support and conduct strategic planning for replicating this DEBI. Replicating the Mpowerment model was a radical departure from past programming.

c. Successes achieved from the DEBI.

To date, the replication of the Mpowerment model through the two MAP programs has exceeded expectations. This is especially true for their core group membership and their volunteer outreach team. The MAP semi-annual report for January through June 2005 states, "As the program has evolved, we've seen the participants take ownership of much of the decision-making process. The Core Group has fostered leadership and community building among the target population and continues to grow. The Volunteer Outreach Team Meetings are creating a base of volunteers knowledgeable of risk reduction and STD basics and have the skills to communicate that knowledge in a variety of settings."

d. How the health department has worked with grantees to stress the importance of fidelity to the core elements of the program model.

The Minnesota AIDS Project is working with the evaluation consultant on a process evaluation project related to the replication of the Mpowerment model. The evaluation plan for this project was finalized in late 2004 and to date, ten instruments have been developed with staff input. One of the goals of this evaluation project is analysis of the fidelity of replication.

The current grantees that are funded through the end of June 2006 were selected through a competitive RFP process conducted in 2002. In that RFP process, applicants were not required to propose the implementation of DEBI interventions or interventions from the Compendium. They were asked to consider a variety of interventions, including those from the Compendium (the DEBI Project did not exist at that time). If they chose to propose an intervention that was not included in the Compendium or identified by the CCCHAP, they were asked to provide supporting evidence of effectiveness for their proposed intervention.

4. Describe the specific HERR issues you plan to address in 2006, the actions you plan to take to address these issues, the outcomes you expect to achieve, and how you will determine whether outcomes are met.

Request for Proposals

Current HERR and prevention with positives contracts will end June 30, 2006, with new contracts beginning July 1, 2006. The MDH will conduct a timely competitive RFP process that incorporates the priority target populations and co-factors/co-factor groupings identified by the CCCHAP, as described in the Community Planning portion of this document. The MDH will release an RFP in October 2005 describing the prioritized target populations eligible for funding, core HIV risk factors, and the priority co-factors and co-factor groupings. The co-factors/co-factor groupings will be included as identified by the CCCHAP with one exception. The MDH decided not to include tuberculosis (TB), which was identified in one of the co-factor groupings for African HRH, in the RFP. This decision was made by the MDH because TB does not impact the risk of HIV infection for an HIV negative person or the risk of HIV transmission for an HIV positive person; the relationship between HIV and TB is that an HIV positive person who has latent TB has a much greater likelihood of the TB becoming active.

Organizations interested in providing prevention services will be asked to respond to the following types of questions:

- Describe their agency's structure and capacity.
- Describe the population(s) they propose to reach.
- Describe how they propose to address core HIV risk factors.
- Describe the type of intervention(s) they propose to implement.
- Describe how they will integrate counseling, testing and referral (CTR) services into the intervention(s) they propose to implement, if interested in providing CTR.
- Describe how they will address one to three of the priority co-factors and/or co-factor groupings through the delivery of the intervention(s).
- Present justification for the effectiveness of the proposed intervention(s) in preventing new infections and the appropriateness for the target population.

As described above, organizations will be asked to describe how they will address at least one and not more than three co-factors or co-factor groupings. Organizations proposing to address a

grouping of co-factors will be required to address all of the co-factors included in the grouping. Proposals will not be evaluated based on the number of co-factors/co-factor grouping(s) to be addressed; rather, they will be evaluated based on how well the proposed intervention(s) will address the co-factor(s)/co-factor grouping(s) and the feasibility of their proposed program(s).

A summary of Diffusing Effective Behavioral Interventions (DEBI) interventions, interventions from the Compendium, and descriptions of other interventions with proven effectiveness will be included as an attachment to the RFP. In addition, after the RFP is released, the MDH will provide an overview training of the various DEBI interventions. Organizations will also have the option of proposing innovative interventions with accompanying justification supporting their effectiveness with the target population(s) and co-factor(s) or co-factor grouping(s).

A proposal review committee made up of community members and MDH staff will be convened to review and score proposals according to criteria developed by the MDH. The criteria will be related to agency capacity, ability to provide the proposed interventions, and feasibility of proposed interventions to address the selected co-factor(s)/co-factor grouping(s). Review committee members will first individually review and score proposals, and make initial recommendations as to whether each proposal should be funded or not. The proposal review committee will then convene in smaller groups to discuss the proposals and arrive at funding recommendations.

Once the proposal review process is completed, an internal review committee of MDH staff will be convened. The purpose of this committee is to ensure that the funding principles are applied so that a comprehensive set of prevention services will be implemented within each of the target populations, to the extent possible based on available resources and proposed activities; that programs are not duplicating efforts funded through other resources; that interventions are cost-effective for the target populations; that there is some geographic distribution of programming; and that prior performance of previously funded grantees is taken into consideration. The internal MDH committee will make final funding recommendations, which will be forwarded to the Commissioner of Health for her review and approval.

Programs selected through this RFP process will be funded for the time period of July 1, 2006 through December 31, 2008.

The MDH developed five principles to be used in making funding decisions. In order to most efficiently prevent new HIV cases, funding will be prioritized to target populations with the highest CCCHAP prioritization scores.

1) In order to most efficiently prevent new HIV cases, funding will be prioritized to target populations with the highest CCCHAP prioritization scores.
2) In order to most effectively prevent new HIV cases, funding will be prioritized to adequately fund a comprehensive spectrum of programs in target populations with the highest CCCHAP prioritization scores rather than funding singular and isolated efforts in all prioritized populations (i.e., focused funding rather than broad funding).
3) In order to reduce duplication and address as many needs as possible, the MDH will assess how its funding fits into broader state and federal funding for HIV prevention in Minnesota.
4) Cost-effectiveness will be considered when identifying eligible interventions and selecting successful proposals.
5) Funding decisions will be as transparent and quantitative as possible.

As a result of applying funding principle #1, the following target populations will not be included for in the upcoming RFP: HIV Positive Youth, HIV Positive Greater Minnesotans, Asian/Pacific Islander HRH, and White HRH. In addition, as a result of applying funding principle #3, Native American HRH will not be included in the RFP. This is because two agencies are receiving significant multi-year federal grants targeting Native Americans that total approximately $450,000, which is close to the amount of funding allocated to the entire HRH category. The five funding principles will continue to be applied throughout the RFP process.

A funding formula was developed by the MDH to determine the proportion of funding to be allocated to each target population. Funding proportions are based on the average of new HIV cases for 2002 – 2004 and living HIV/AIDS cases for 2004 within each target population. Target populations within the HIV Positive Persons category are the only exception to the formula. The allocation for this category of populations was established through discussion with the CCCHAP and is based on the current amount of funding allocated to prevention with positives programs. Funding amounts for the target populations within the HIV Positive Persons category will be determined through the outcomes of the RFP process. Community based grants awarded through the RFP process will be funded through a combination of state and federal dollars. Estimated annual allocations by eligible target populations are as follows:

TARGET POPULATION	ESTIMATED ALLOCATION	PERCENTAGE OF FUNDING	% CHANGE FROM 2005
HIV Positive Persons	**$152,000**	**8%**	**10%**
No separate allocations for HIV+ target populations	-	-	-
Men Who Have Sex with Men	**$993,000**	**52%**	**10%**
MSM of All Races	$673,000	35%	49%
MSM of Color	$260,000	14%	-9%
Young MSM	$60,000	3%	-64%
High Risk Heterosexuals	**$523,000**	**28%**	**14%**
African HRH	$274,000	14%	104%
African American HRH	$122,000	6%	35%
Latino/a HRH	$35,000	2%	N/A
Young HRH	$92,000	5%	-61%
Injecting Drug Users	**$232,000**	**12%**	**2%**
MSM/IDU	$90,000	5%	N/A
MSM of All Races and All Genders	$142,000	7%	-38%
TOTAL Allocations	**$1,900,000**	**100%**	**10%**

N/A = Programs not funded within this target population in previous funding cycle.

The MDH has two desired outcomes in relation to the RFP process: 1) the RFP is completed in a timely manner; and 2) the resulting programs reflect the priorities identified by the CCCHAP. The MDH will know that the outcomes have been achieved if the RFP process meets timeline requirements and administrative processes are completed in time for new programs to start July 1, 2006, and if programs target priority high risk populations with interventions designed to address core HIV risk factors and priority co-factors/co-factor groupings identified by the CCCHAP.

Grantee Staff Turnover

An ongoing issue faced by grantees is staff turnover. The MDH will provide technical assistance to grantees regarding recruitment, retention and incentive building for staff with the desired outcome of maintaining greater stability in staffing. This outcome will be measured by grantee staff remaining in their positions for longer periods of time and grantees maintaining greater consistency in intervention delivery.

Data Collection Tools

Grant managers have identified a need for improved data collection tools. Based on planning that has occurred in 2005, the evaluation consultant will provide technical assistance to grantees identified through the RFP process to assist them in developing data collection tools that will include standard variables across grantees. The exact tools may vary by agency, based on the target population(s) and co-factor(s) they are addressing and the interventions they are implementing.

Prevention with Infected Persons

1. **Describe specific activities undertaken to collaborate with health care providers and primary care clinics on the integration of HIV prevention into care and treatment services for persons living with HIV between January 1 and June 30, 2005. Describe the outcomes of those activities.**

   The MDH provides funding to three agencies to provide HIV prevention education targeting HIV infected persons. One of these agencies, Abbot Northwestern Hospital Clinic 42, provides health care services to HIV infected clients, as well as providing group level and individual level HIV prevention interventions. During the first half of 2005, Clinic 42 has experienced low attendance at the group level interventions. The grantee has begun working on identifying strategies and incentives to improve attendance, and will assess the feasibility of continuing to provide GLI. The grantee was successful in reaching HIV positive male and female clients of the clinic with individual level interventions (ILI). Beyond the interventions funded at Clinic 42, the MDH did not take any specific actions to integrate HIV prevention into care and treatment services for HIV positive persons.

   The three grantees funded to implement prevention with positives programs were supplied with the recently released *Best Practices in Prevention Services for Persons Living with HIV* from CDC.

2. **Describe actions you plan to take to strengthen prevention with persons living with HIV in 2006, the outcomes you expect to achieve, and how you will determine whether the outcomes were met.**

   The MDH is planning to host one or two meetings for funded prevention with positives programs to have them showcase their interventions and strategies. In addition, they will have an opportunity to share both the challenges and successes they have encountered in implementing prevention with positives interventions. One objective of the meeting is to begin a support and collaboration network of these staff that could result in identifying and implementing effective strategies to recruit HIV positive persons to participate in intervention programs.

   MDH staff will also work with the CARE Act Title I grantee to develop an assessment of the jointly funded prevention and care outreach and testing pilot project. The purpose of this project is to identify an efficient and effective method for: 1) providing outreach prevention education in locations where high risk and HIV positive persons are likely to be; 2) providing HIV counseling and testing in those locations; 3) identifying new positives and finding positives who know their status but are not in care; and 4) providing individual care coordination to assist newly diagnosed persons and persons who know their status but are not in care in accessing medical care and support services. The expected outcomes of this project are: 1) high risk and HIV positive individuals will receive HIV prevention education; 2) individuals who may not normally know about and/or choose to test for HIV will receive an HIV test; and 3) newly diagnosed persons and persons who know they are positive but are not in care will be linked to medical care and support services.

Counseling, Testing and Referral Services

1. **Summarize the major actions taken and the outcomes of those actions between January 1 and June 30, 2005 to work with hospitals, health maintenance organizations, and other medical providers to provide routine HIV screening in high prevalence medical settings.**

   Minnesota has four clinical sites that are MDH-supported HIV counseling, testing and referral (CTR) sites: the Red Door Clinic, Room 111, United Family Practice (UFP)-North Memorial Hospital, and WestSide Community Health Services. All four clinical sites provide routine HIV screening in high prevalence medical settings.

   The Red Door Clinic and Room 111 are public health STD clinics. STD clinics have traditionally provided HIV tests to people who believe that they may have been exposed to an STD, including HIV. Both the Red Door Clinic and Room 111 target populations at increased risk, including the uninsured, men who have sex with men, communities of persons of color, intravenous drug users, sex workers, and youth.

   UFP-North Memorial conducts routine testing to target populations at increased risk through its outreach-based testing program. UFP-North Memorial is based out of Minneapolis' near north side; a largely low income, African American neighborhood that has continually had the highest Minnesota STD rates per zip code. The UFP-North Memorial outreach program targets venues such as chemical dependency treatment centers, gay bars, and support groups for individuals trying to exit prostitution for testing.

   The WestSide Community Health Clinic serves a largely Hispanic/Latino community. By offering services in a culturally appropriate, bilingual setting, WestSide is able to target Hispanic/Latino persons who may not seek services elsewhere.

   In addition to the four clinical sites, the MDH and the Ryan White Title I grantee jointly fund a community based organization (CBO), the African American AIDS Task Force, to provide HIV testing within the context of their outreach activities conducted at the Hennepin County Medical Center.

2. **If CTR services were offered in correctional facilities between January 1 and June 30, 2005, describe the types of correctional facilities and the types of testing that occurred.**

   CTR services took place in several correctional facilities in the Minneapolis-St. Paul metropolitan area; resulting in HIV testing being provided to incarcerated youth, men, and women, as well as to offenders living in a non-traditional facility in preparation for re-entry into society.

   Serum draws were completed at several facilities within the Ramsey County Corrections system, including the Juvenile Detention Center, Totem Town (juvenile male facility), the Men's Workhouse, the Volunteers of American Women's Workhouse, and the Adult Detention Center. Staff from Room 111 conducted all Ramsey County facility-based HIV testing.

   OraSure OMT specimens were completed at the Hennepin County Correctional Facility (in the men's workhouse unit) by staff from Access Works, a non-profit CBO. Rapid testing was completed at Re-entry House, a halfway house for offenders exiting corrections in St. Paul, by staff from UFP-North Memorial outreach program.

In addition to these MDH-supported CTR sites, the MDH Disease Intervention Specialists of the Partner Services Unit have traditionally offered the OraSure OMT HIV test to incarcerated patients of the state correctional system who are followed as a result of being named as a needle sharing or sex partner of a known HIV infected individual. The OraSure OMT HIV test is offered when the patient does not want to be tested through the correctional facilities' health services department.

3. **How many CBOs funded by the health department under PA 04012 performed rapid testing between January and June 2005?**

   Minnesota is beginning to have rapid testing more available for those patients and clients seeking the technology. The CDC previously piloted the use of rapid tests in a study involving the UFP-North Memorial outreach program and the Red Door Clinic. UFP-North Memorial has completed their pilot and the CDC no longer supplies that site with test kits; however, the CDC continues to supply rapid test kits to the Red Door Clinic, although in much smaller amounts. During the first half of 2005, the MDH CTR Program worked with the Substance Abuse Mental Health Services Administration (SAMHSA) to obtain free rapid test kits. This arrangement has allowed rapid test kits to continue to be available to UFP-North Memorial and the Red Door Clinic, as well as supplying additional kits to the Indigenous People's Task Force, a CDC directly-funded rapid test site and MDH-supported test site. These were the only three CBOs to which the MDH provided rapid tests kits during the first half of 2005.

   United Migrant Opportunity Services (UMOS), Inc. is the fourth rapid testing site in Minnesota. UMOS, like the Indigenous People's Task Force, is a CDC directly-funded rapid testing site. UMOS has partnered with the MDH CTR Program to provide OraSure testing technology for their clients. This enables UMOS to provide a confirmatory test to clients who have barriers to accessing such care; such barriers include being an uninsured or undocumented individual, being a non-English speaking individual, or living in a rural area with out access to a clinic or medical provider.

4. **Describe the venues in which rapid testing occurred during the first half of 2005.**

   The venues in which rapid testing took place all served the common goal of targeting CTR services in Minnesota to populations with an increased risk of HIV infection. Rapid testing occurred in the largest public health STD clinic in the metropolitan region (Red Door Clinic), on tribal reservations (Indigenous People's Task Force), with Hispanics/Latinos in migrant and farm labor camps (UMOS), at a GBLT youth drop-in center (UFP-North Memorial), at a clinic in a high STD prevalence neighborhood (UFP-North Memorial), at a correctional half-way house (UFP-North Memorial); and at several chemical dependency treatment centers, gay bars, and homeless drop-in centers (UFP-North Memorial).

5. **What was the state's seropositivity rate for tests performed by conventional testing methods between January and June 2005?**

   The jurisdiction's seropositivity rate for tests performed by conventional testing methods was 2.3 percent during the first half of 2005.

6. **What was the state's positivity rate for rapid tests performed between January and June 2005?**

   The jurisdiction's seropositivity rate for rapid tests was 1 percent between January 1 and June 30, 2005.

7. **How many health department full time equivalents (FTEs) are currently devoted to HIV counseling and testing?**

   There is one FTE devoted to coordinating the MDH CTR Program.

8. **What specific CTR issues do you plan to address in 2006? Describe the actions you plan to take to address these issues, the outcomes you expect to achieve, and how you will determine whether outcomes are met.**

   The CTR Program will strive to fill existing gaps in service to the populations that carry the burden of HIV in Minnesota, as well as strive to make sure those most at risk for HIV infection are not only getting tested but are receiving their test results. Through an RFP process, the CTR Program will seek providers that serve high risk populations to conduct MDH supported testing programs in the next grant cycle. The RFP process will be implemented in two steps. CBOs interested in providing CTR services to the eligible priority target populations identified by the CCCHAP will be asked in the HERR RFP to describe how they will integrate CTR into the prevention intervention(s) they are proposing. These programs will be funded July 1, 2006 through December 31, 2008. Currently funded clinic-based CTR sites will continue their programs through December 2006. A separate RFP will be conducted in late 2006 for clinic-based sites interested in providing CTR. The clinic-based sites selected through this process will be funded January 1, 2007 through December 31, 2009.

   In order to address gaps in testing targeted to African and Latino populations, clinic-based sites will be sought through an informal solicitation to provide testing for these populations during 2006. The purpose of doing this is to increase access to testing for these populations, as well as to build capacity in these sites for participation in the clinic-based RFP.

   Outcomes of the CTR Program will be determined by the CTR performance indicators: one, the percent of newly identified, confirmed HIV positive test results among all tests reported by CTR sites; two, the percent of newly identified, confirmed HIV positive test results returned to clients; and three, the percent of facilities reporting a prevalence of HIV positive tests equal to or greater than the jurisdiction's target set in indicator one.

   In 2006, the CTR Coordinator will also develop a document outlining criteria for the use of serum, OraSure and rapid testing technology. This document will be used in assessing which testing technology(ies) could most effectively be used by the organizations responding to the RFPs. The MDH will assess the use of rapid testing by CBOs in 2006, recognizing that it is not the most appropriate technology for all organizations.

9. **Briefly explain any state regulatory or statutory policies that pose barriers to the implementation of rapid testing in medical and non-medical settings.**

   At this time, there are no state regulatory or statutory policies that pose barriers to the implementation of rapid testing in Minnesota's medical and non-medical settings.

Partner Counseling and Referral Services

1. Explain how the health department, health department grantees, and STD clinics and programs worked together to implement Partner Counseling and Referral Services (PCRS) between January 1 and June 30, 2005.

During the reporting period, there was no collaboration with health department grantees to implement PCRS. Collaboration with STD clinics was a continuation of the longstanding practices of MDH PCRS staff: a) actively locating and offering PCRS to persons diagnosed with HIV infection at the state's two dedicated STD clinics (the Red Door Clinic in Minneapolis and the Room 111 Clinic in St. Paul); b) referring those partners who declined a PCRS staff offer of an OraSure test in the field to one of these clinics; and c) referring persons who are newly diagnosed with HIV infection, and who have no immediate access to medical care, to the Ryan White Title I Early Intervention Programs in these STD clinics.

Collaboration with the MDH STD Prevention Program has been institutionalized since 1989 through the joining of PCRS and STD partner services programs in one organizational entity within the STD and HIV Section. PCRS and STD partner services collaboration is most prominent in early syphilis case management. Since 2002, early syphilis has increased substantially and has occurred primarily in men who have sex with men, many of whom were diagnosed as having HIV infection at least one year prior to acquiring syphilis. When early syphilis/HIV co-infected individuals are interviewed, partners who are notified of their exposure to syphilis are also notified of their exposure to HIV and referred for medical evaluation, including HIV testing.

2a. Describe the health department's process for documenting PCRS activities.

Partner elicitation is recorded on the HIV infected client Interview Record (CDC 73.54) and on a local form entitled, "HIV Interview Case Notes," that is made part of the client's PCRS record. Partner notification, counseling, and referrals are recorded on the partner Field Record (CDC 73.2936S) and on the client Interview Record (CDC 73.54). Data pertaining to these activities, except referrals, are entered into the STD*MIS data management system.

2b. How many health department FTEs are currently devoted to HIV PCRS?

Five full time equivalent Disease Intervention Specialists (DIS) are devoted to HIV PCRS.

3. What specific PCRS issues do you plan to address in 2006? Describe the actions you plan to take to address these issues, the outcomes you expect to achieve, and how you will determine whether outcomes are met.

HIV infected African refugees and immigrants and their partners do not consistently receive PCRS. In 2004, 59 African-born persons were diagnosed with HIV infection in Minnesota and reported to the MDH, accounting for 19 percent of new HIV infections. In addition, approximately 50 African refugees known to have HIV infection resettled in Minnesota. Cultural barriers such as paternalism, profound secrecy about HIV risk behaviors, and profound HIV stigma interfere with thorough PCRS. In addition, HIV infected refugees who resettle in Minnesota, primarily in the Minneapolis-St. Paul metropolitan area, are not offered HIV prevention counseling and PCRS. The following table describes specific actions that will be taken to address this issue, the expected outcomes, and outcomes measurements.

ACTIONS	EXPECTED OUTCOMES	OUTCOME MEASUREMENT
Assign one male and one female DIS to provide PCRS to African-born HIV infected clients and their partners.	PCRS provider-client/partner gender congruence will increase PCRS acceptance, partner elicitation, partner notification, and partner referral and testing.	- The proportion of HIV-infected African-born clients who accept PCRS will increase. - The partner index will increase. - The proportion of partners tested will increase.
Arrange African cultural sensitivity and competence training and development for two DIS.	DIS cultural sensitivity and competence will increase PCRS acceptance, partner elicitation, partner notification, and partner referral and testing.	- The proportion of HIV infected African-born clients who accept PCRS will increase. - The partner index will increase. - The proportion of partners tested will increase.
Create and carry out plan with the three voluntary agencies that arrange resettlement for most African refugees to have DIS provide HIV prevention counseling and PCRS contemporaneous to HIV infected refugee resettlement.	HIV infected refugees will receive disease prevention counseling and PCRS.	- The proportion of HIV-infected refugees who receive disease prevention counseling and PCRS will increase.

There is currently no systematic method to document care and services needs of PCRS Program clients, effectively make referrals, and document referral completion. DIS currently identify care and services needs of HIV infected clients and their partners and make referrals to resources. However, the MDH PCRS Program currently has no system to document care and services needs of its clients, effectively make referrals, and document referral completion. The following table describes specific actions that will be taken to address this issue, the expected outcomes, and outcomes measurements.

ACTIONS	EXPECTED OUTCOMES	OUTCOME MEASUREMENT
Arrange for or create and conduct a training session for DIS about how to assess client care and service needs and to effectively refer them to other providers.	DIS will acquire skills to assess client care and service needs and to effectively refer them to other providers.	- Pre-and post-training evaluation.
Implement procedures and monitor practices to confirm and document referral completion.	Baseline data to determine effectiveness of DIS PCRS referral activity.	- Report about referral completion.
Alter PCRS data collection tools and management system to document client care and services needs, referrals made (if any), and referral completion.	Baseline data to document client care and services needs, referrals made (if any), and referral completion.	- Report about client care and services needs, referrals made (if any), and referral completion.

Public Information Programs

1. **Summarize major actions taken to plan, implement and monitor public information programs and the outcomes of those actions to plan during the first half of 2005.**

   The MDH utilized mass media channels as a supplemental strategy to help increase awareness about HIV prevention and promote existing resources to priority audiences identified in the *Minnesota Comprehensive HIV Prevention Plan 2003 - 2005*. Due to budget limitations, the MDH relied primarily on obtaining message placements as a public service. Indoor/outdoor, print, broadcast, electronic and web media channels were used whenever the opportunities presented themselves. The only exception in 2005 to the public service campaigns was the paid syphilis campaign that was held in conjunction with Minnesota's GLBT Pride Month to reach men who have sex with men.

   To increase awareness, most of the public service campaigns were organized around specific state and national health observances. Observances that took place in the first 6 months of 2005 were National Black HIV/AIDS Awareness Day (February), National STD Awareness Month (April), National Hepatitis Month (May), GLBT Pride Month (June), and National HIV Testing Day (June).

   In addition, there were two specialized campaigns that were completed during the first half of 2005 to release the year-end HIV/AIDS surveillance data and the STD surveillance data. These campaigns are designed to provide an overview of the HIV/STD epidemics in Minnesota and to highlight those communities experiencing the highest rates of infection.

   Whenever possible, existing community planning groups and coalitions were used to help develop and distribute campaign messages and materials to audiences disproportionately affected by HIV as identified in the statewide plan. Existing campaign materials were also pursued and adapted from other national organizations, agencies, companies, and coalitions as a cost-saving strategy.

   Technical assistance was offered to MDH funded HIV testing sites, community based prevention agencies, and city/county public health departments so they could implement their own HIV related campaigns or join the state and national health observances.

   The table on the following page summarizes the public information activities and outcomes that have already taken place in 2005.

Public Information Campaigns 2005

CAMPAIGN DESCRIPTION	MEDIA REACH	OUTCOMES
National Black HIV/AIDS Awareness Day (NBHAAD): ▪ February ▪ Minneapolis-St. Paul ▪ African American men and women	- 406 media received news release - 197,477 print media readers - 135 online views of news release - 3,500 electronic readers	- The MAP AIDSLine received 105 calls from African American and African-born residents - 289 hits on NBHAAD web pages on MDH web site
Release of Year-end HIV/AIDS Surveillance Data for MN: ▪ April ▪ Statewide ▪ African refugees and MSM	- 667,477 readers (4 newspapers) - 55,500 readers (2 GLBT papers) - 15,625 readers (6 newsletters) - 3,897 views of web pages - 350,000 listeners (2 radio stations) - 406 media received news release - 366 electronic mail to providers - 474 online views of news release (April)	- The MAP AIDSLine received 1,022 calls during the campaign - 3,471 HIV bar coasters ordered and distributed - 3,897 hits on HIV/AIDS surveillance web pages on MDH web site
National STD Awareness Month and Release of Year-end STD Surveillance Data for MN: ▪ April – May ▪ Statewide ▪ Young African Americans, MSM, MSM of Color, HIV+ and health care providers	- 642,477 readers (6 newspapers) - 300,000 listeners (1 radio station) - 16,400 readers (9 newsletters) - 30,000 readers (GLBT newspaper) - 246 campaign kits distributed - 366 electronic mail to providers - 246 direct mail to providers - 406 media received news release - 490 online views of news release (May)	- 14,579 views of STD web pages - 24,296 STD bar coasters ordered and distributed - 825 calls received by the STD hotline during the campaign; including 206 callers requesting STD testing information
National Hepatitis Month: ▪ May ▪ Statewide ▪ General public, young adults, MSM, IDUs	- 225 received campaign kits - 406 media received Governor's proclamation	- 3,471 hepatitis bar coasters ordered and distributed - 2,053 visits to hepatitis web pages on MDH web site
National HIV Testing Day: ▪ June ▪ Statewide ▪ General public, Greater MN	- 225 direct mail to providers - 700 readers (2 newsletters)	- 5 HIV testing opportunities set up in Greater MN to reach Latinos - 8 HIV testing opportunities set up at GLBT bars
GLBT Twin Cities Pride: Syphilis Campaign (paid campaign) ▪ June ▪ Minneapolis ▪ MSM, HIV+	- 3,591,000 views (bus stop panels) - 300,000 listeners (1 radio station) - 600,000 impressions/month for chat room banner ads - 40,000 visits/month for banner ad on GLBT magazine's web site - 60,000 views (restroom ads) - 451,500 readers (3 newspapers) - 126,000 readers (4 GLBT sources) - 10,700 readers (3 newsletters) - 265 direct mail to providers - 273 electronic mail to providers - 627 views of news release	- 1,648 views/downloads of syphilis web pages - 129 hits to animated syphilis web page from chat room banner ads - 3,471 syphilis bar coasters ordered and distributed - 67 calls received by STD hotline about syphilis

2. **What public information programs are planned for 2006? Describe the expected outcomes and how you will determine whether the outcomes have been achieved.**

The MDH will utilize mass media channels as a supplemental strategy to help increase awareness about HIV prevention and promote existing resources to priority audiences identified in the new *Minnesota Comprehensive HIV Prevention Plan 2006 - 2008*. As in 2005, the MDH will rely on obtaining message placements as a public service due to budget limitations. Indoor/outdoor, print, broadcast, electronic and web media channels will be used whenever the opportunities present themselves.

Public service campaigns will again be organized around specific state and national health observances: National Black HIV/AIDS Awareness Day (February); National STD Awareness Month (April); National Hepatitis Month (May); Minnesota GLBT Pride Month (June); National Latino AIDS Awareness Day (October); and World AIDS Day (December).

Whenever possible, existing community planning groups and coalitions will be used to help develop and distribute campaign messages and materials to audiences disproportionately affected by HIV as identified in the statewide plan. Existing campaign materials will also be pursued and adapted from other national organizations, agencies, companies, and coalitions as a cost-saving strategy. All campaign materials will be routed to the AIDS Materials Review Panel, MDH Communications and Commissioner's Offices, and the Governor's Communications staff prior to their use.

In addition to the public service campaigns, there will be specialized campaigns to address new information or disproportionate disease occurrences or outbreaks within specific communities. Examples of these campaigns may include: year-end release of HIV/STD surveillance data; health alerts for MSM about syphilis, lymphoma granuloma and antibiotic-resistant gonorrhea; and HIV prevention funding announcements and awards. In addition, there will be promotions of specific staff, programs, grantees or activities of the STD and HIV Section, MDH, as these situations present themselves within either the public service or specialized campaigns.

Two campaign plans and their corresponding ads/materials will be field tested in 2006 for potential expansion in 2007 (if funding becomes available). One campaign plan and ad design will be tested to determine if an increase in condom use among gay/bisexual men, adolescents and young adults can be feasible on a limited budget. Another campaign plan and materials will be tested to determine if an increase in the frequency of STD risks assessments, tests and treatments can be achieved among physician/nurse practitioners seeing clients at risk for STDs.

Technical assistance and campaign kits are offered to MDH funded HIV testing sites, community-based prevention agencies and city/county public health departments so they can implement their own campaigns to promote HIV related programs and services in conjunction with the designated state and national observances.

The table on the following pages describes planned public information efforts for 2006 and the expected outcomes. To determine if the outcomes were met for the public service campaigns, data will be gathered from various sources to assess changes during the campaign compared to the non-campaign period. Data will be obtained from the: MDH Web Trend Reports; MAP AIDSLine Semi-annual Report; Minnesota Family Planning & STD Hotline Monthly Reports; and World AIDS Day event summaries. To determine if the outcomes were met for the field-tested campaigns, pre and post surveys will be completed before and after the campaign.

Plans for 2006 Public Information Campaigns

CAMPAIGN DESCRIPTION	CAMPAIGN STRATEGIES	EXPECTED OUTCOMES (DURING CAMPAIGN)
National Black HIV/AIDS Awareness Day (February): ▪ African American	- Press kit - Print media - Posters - MDH & agency web sites	5% increase in calls to the statewide AIDS hotline
Release of Year-end HIV/AIDS Surveillance Data for MN (April): ▪ African American ▪ African-born ▪ MSM ▪ MSM of Color ▪ HIV+	- Press kit - Print media - Radio - MDH web site - E-mail address books	5% increase in calls to the statewide AIDS hotline
National STD Month And Release of Year-end STD Surveillance Data for MN (April – May): ▪ Young African Americans ▪ HIV+ ▪ MSM ▪ MSM of Color ▪ Health Care Providers	- Press kit - Print media - Radio ads - MDH & agency web sites - Internet-based magazines - Phone directories - E-mail address books	5% increase in calls to the statewide STD hotline 5% increase in the downloads of STD fact sheets on MDH web site
National Hepatitis Month (May): ▪ General Public ▪ Young Adults ▪ MSM ▪ Injecting Drug Users	- Press kit - Print media - Posters - Outreach	20% increase in the number of hits to the MDH hepatitis web pages
GLBT Twin Cities Pride (June): ▪ MSM ▪ MSM of Color	- Press kit - Print media - Indoor/outdoor media - Chat room banner ads - Outreach - MDH & agency web sites	5% increase in calls to the statewide hotlines 20% increase in hits to the MDH syphilis web pages
National Latino AIDS Awareness Day (October): ▪ Latino Men and Women	- Press release/proclamation - Print media - Radio - Community events - Internet magazines/bulletins - MDH & agency web sites - E-mail address books	20% increase in downloads of the Spanish HIV fact sheet on the MDH web site

CAMPAIGN DESCRIPTION	CAMPAIGN STRATEGIES	EXPECTED OUTCOMES (DURING CAMPAIGN)
World AIDS Day (November – December): ▪ Health Care Providers ▪ Officials ▪ African-born	- Press release/proclamation - Print media - Radio - Cable TV - Community events - Internet magazines/bulletins - MDH & agency web sites - E-mail address books	200 to attend World AIDS Day events
Social marketing plan to increase condom use (January – December): ▪ Gay/Bisexual men ▪ Adolescents ▪ Young adults	- Locate and acquire existing campaign messages, ads and materials - Campaign materials reviewed by advisory and/or focus groups - Identify audiences for campaign field testing purposes - Distribute and evaluate campaign plan and materials among field testing groups	Determine political feasibility for campaign and ads/messages Determine acceptance of campaign ads/messages among intended audiences Determine if a 10% - 20% increase in condom use can be achieved during field test
Physician and nurse practitioner education campaign plan (January – December): ▪ Physicians and nurses that assess risks and treat STDs among adolescents and young adults	- Locate and acquire existing risk assessment/sexual history instruments - Risk assessment/sexual history instruments reviewed by medical advisory group(s) - Identify practitioners for campaign field testing purposes - Distribute and evaluate campaign plan and materials among field testing groups	Determine acceptance of campaign ads/messages among intended practitioners Determine if a 10% - 20% increase in risk assessment/sexual history usage can be achieved during field test

Perinatal Transmission Prevention

1. **Summarize the major actions taken and the outcomes of those actions during the first half of 2005 to (a) work with health care providers to promote routine, universal HIV screening of all pregnant patients and (b) to work with organizations involved in prenatal and postnatal care for HIV infected women to ensure that appropriate HIV prevention counseling, testing, and therapies are provided to reduce the risk of transmission.**

   Minnesota experiences a very low rate of perinatal transmission of HIV. Between 2000 and 2004, the overall rate of transmission among all HIV positive pregnant women who gave birth was 2 percent, and only 3 cases of perinatal HIV have been reported to the MDH during that time period. The MDH continues to monitor rates of perinatal transmission but did not undertake any specific efforts with health care providers to promote universal HIV screening of pregnant women.

2. **Summarize the testing laws and regulations in Minnesota that pertain to HIV testing of pregnant women.**

   There are no laws governing the HIV testing of pregnant women in Minnesota. Most clinics follow the opt-out model, which means that physicians are required to review with the patient all tests that are a part of routine prenatal care and the patient has the right to decline any of them, including an HIV test. HIV testing is recommended as a routine part of prenatal care for pregnant women.

3. **What issues in perinatal transmission prevention do you plan to address in 2006? Describe the actions you plan to take to address these issues, the outcomes you expect to achieve, and how you will determine whether outcomes are met.**

   As described in Question 1, due to the very low rate of transmission among all HIV positive women in Minnesota, there will be no specific efforts in 2006 to promote HIV testing of pregnant women unless an increase in transmission is noted in 2005.

   The Ryan White Title IV grant funds a perinatal HIV nurse coordinator. This position is responsible for creating and distributing user-friendly tools that explain the recommendations for care of HIV-infected pregnant women, and offer support and education to OB/GYN providers. The nurse coordinator also provides education and support directly to HIV positive pregnant women, or works closely with their case manager. The nurse coordinator is developing a system to help ensure that HIV positive women receive care during and after their pregnancy and their children receive ongoing HIV-related care after birth. Because of the low rates of perinatal transmission, and because of these efforts being undertaken through the Title IV grant, MDH does not plan to engage in additional efforts to promote prenatal and postnatal care of HIV positive women.

Capacity Building Activities

1. **Summarize the actions taken during January through June 2005 to (a) assess capacity building assistance needs of health department grantees and (b) provide capacity building activities for grantees. Describe the outcomes of those actions.**

   Work began in 2004 and continued during the first half of 2005 to develop a plan for capacity building activities. Due to the amount of already existing assessments, it was deemed unnecessary and burdensome to perform additional capacity building needs assessments. In 2004, the MDH hired a student worker to review 14 assessments of capacity and needs that were conducted by the MDH and/or their partners in the past three to five years. Capacity building-related needs and recommendations identified in these assessments were organized into three categories: systems, interventions, and organizations. The development of a capacity building plan based on the review of existing assessments began in 2004 and was completed in the first quarter of 2005. The capacity building plan includes goals and objectives in these primary areas: internal health department capacity, development and delivery of prevention interventions, development and delivery of prevention interventions in health care settings, organizational capacity, participation in planning, and the integration of HIV, STD and hepatitis prevention interventions. Unfortunately, no further work was completed in implementing the plan as the key staff person responsible for disseminating the plan resigned at the beginning of April and the position has not yet been filled.

   An additional assessment activity that occurred in the first half of 2005 was an assessment of grantees' capacity to collect data and the tools they currently use. The MDH intends to use the results in providing technical assistance on developing data collection tools, as well as identifying the needed monetary resources.

   The MDH, in coordination with partner agencies, continually seeks to identify and address capacity building needs of staff and community organizations in relation to organizational infrastructure; and the design, implementation and evaluation of prevention programs. Priority is given to organizations that are currently serving the highest risk populations. Capacity building is primarily provided through contract management, training for providers, and technical assistance related to program planning and evaluation.

   During the first half of 2005, MDH contract managers provided technical assistance during site visits, real time feedback during direct intervention observation, and written feedback in response to narrative progress reports.

   Capacity building was also provided through training sessions for HERR grantees, HIV testing grantees, community health service agencies, community clinics and CARE Act-funded service providers. These trainings were designed to strengthen the capacity of these agencies to design, implement, and sustain effective HIV prevention interventions. These sessions included an overview of available CBA services provided by the National Black Alcoholism & Addictions Council, Inc; an update on 2004 STDs surveillance data with emphasis on syphilis, an update on 2004 HIV/AIDS surveillance data; and trainings on hepatitis and risk reduction techniques, conducting effective outreach, the fundamentals of HIV risk reduction counseling, and strategies for addressing methamphetamine use in the MSM community. Grantees also received a training that included materials and strategies for addressing the issue of methamphetamine use in the

MSM community. In addition, grantees were invited to attend trainings on grant writing, program evaluation and building board capacity that were offered by the OMMH.

The MDH contracted with the St. Paul Chapter of the American Red Cross to develop a culturally and linguistically appropriate curriculum designed to train African community members to deliver basic HIV prevention messages to their communities. The curriculum has been developed with the input of community members and the initial training is scheduled for August 2005.

The MDH currently maintains a contract with a technical assistance provider (Peggy Darrett-Brewer) to design and deliver a project training and technical assistance curriculum for African American agencies funded by the MDH to implement peer outreach, networking, and education activities. Ms. Darrett-Brewer also assisted in providing a capacity building workshop for agencies targeting African communities in April 2005 that included the following topics: grant agreements, work plans and legal obligations, basic fiscal requirements, HERR prevention intervention definitions, evaluation basics, data collection and reporting, adapting prevention models for African communities; and the value of collaboration.

In addition, two MDH staff attended an overview session of available DEBI interventions, as well as the session on adapting and tailoring DEBI interventions offered by the Denver PTC.

2. **Describe the health department's capacity building assistance efforts for CBOs that provide CTR and PCRS during January through June 2005 and the outcomes of those efforts.**

The CTR Coordinator offers three CTR-related trainings on a quarterly basis. Two sessions of each training were provided between January and June 2005, with 33 individuals from 14 agencies participating. These trainings are open to grantees and non-grantees, although employees of agencies supported by MDH to provide OraSure testing are required to complete these three trainings prior to conducting OraSure testing. The first training is on the fundamentals of effective HIV risk reduction counseling. The second training, Issues of Positive Clients, focuses on giving test results to people who test positive and providing effective linkages to follow-up care. The third training is a hands-on session where grantees learn to give the OraSure HIV antibody test and complete the accompanying lab slip required for specimen delivery to the MDH public health lab. The training also covers the proper completion and submission of the HIV Testing System (HTS) data collection form. All trainings provided during the first half of 2005 were very interactive and fostered a group dynamic of sharing and networking.

All PCRS services are delivered by DIS employed by the MDH, so no PCRS-related capacity building activities were offered to CBOs.

3. **Describe capacity building activities planned for 2006 and how outcomes of these activities will be assessed.**

Health Education and Risk Reduction

In 2006, the MDH plans to implement capacity building activities for HERR and prevention with positives grantees related to strengthening organizational accounting capacity, intervention planning, feedback/ formative evaluation regarding intervention delivery, grantee self-monitoring, data collection, and program evaluation.

Financial and Accounting
Initially during the upcoming RFP process, applicants will complete a financial system and accounting capability questionnaire that will provide upfront information about some of the organizational capacity building needs of potential grantees. The health department will use this information to prepare for the level of capacity building assistance that is needed and can be provided for with limited resources.

Intervention Expansion and Planning
The MDH will offer a training session on the DEBI interventions for agencies interested in responding to the RFP and provide a required training on the development of intervention work plans for funded grantees. The MDH will monitor the outcomes of this capacity building assistance by: a) recording attendance at training sessions in grantee files; b) reviewing intervention work plans to identify the inclusion of the training content; and, c) conducting site visits of intervention delivery to monitor activities related to this content.

Intervention Delivery Feedback
The MDH will continue to monitor all stages of grantees' HIV prevention education programming, including intervention planning, implementation and evaluation. During program planning each intervention work plan will be submitted to the health department for review and approval prior to implementation. MDH contract managers will conduct regular on-site program intervention observations to provide real time technical assistance. This technical assistance, akin to formative evaluation, will give grantees an opportunity early in intervention delivery to adjust programming as needed.

Grantee Self Monitoring
The MDH is considering the feasibility of instituting internal program monitoring measures for grantees to identify the degree to which each intervention is implemented according to the intervention work plan. One activity being considered is the direct observation of intervention implementation by program supervisors, who would be responsible for completing an evaluation tool currently used by MDH grant managers during observation of intervention delivery. Grant managers would review and discuss the completed evaluation forms during site visits. Another activity being considered is required regular meetings between program staff and program supervisors to ensure greater levels of internal communication and feedback regarding intervention delivery. Based on the outcomes of these activities and in consultation with the MDH grant managers, modifications in implementation plans and strategies can be made in a timely manner and as needed to achieve the intended intervention outcomes.

Data Collection
Grantees will improve their data collection process with the goal of collection during or immediately after the delivery of interventions. As a result, accurate data can be attained and used to measure the degree of program success, and facilitate formative evaluation. The MDH will provide technical assistance to grantees in the development of data collection tools so that standard variables are being collected across grantees, although the individual data collection tools may vary.

Program Evaluation
Grantees that have attained satisfactory process evaluation will be encouraged to begin planning and implementing outcome monitoring evaluation of their interventions. The MDH will provide technical assistance and training to these grantees. The increased number of outcome monitoring

projects will provide information to grantees regarding the success of their programs and any need to adjust intervention work plans.

Counseling, Testing and Referral

The three required CTR-related trainings described in response to Question 2 will continue to be delivered in 2006. There will be additional continuing education opportunities including community forums, speakers, and updates on CTR guidelines and surveillance programs. Further capacity building needs of CTR providers will be assessed after the new CTR grant contracts are awarded in 2006. If CBOs and/or clinics with no previous experience in rapid test technology are selected through the RFP processes to provide rapid testing, training will be provided to them prior to implementing rapid testing.

The MDH expects that all MDH supported CTR sites will have staff trained in HIV risk reduction counseling and the giving of test results, as well as in the delivery of OraSure tests for those sites implementing OraSure. A log is kept of providers that have taken the CTR trainings provided by MDH. The CTR Program will continue to review participant evaluations of the trainings to assess whether the trainings are meeting their needs. In addition, the CTR Program will continue to analyze epidemiological data and listen to community input to determine if gaps in services have or have not been addressed. The HIV Testing System data will reveal the percent of newly identified, confirmed HIV positive test results among all tests reported by HIV CTR sites; the percent of newly identified, confirmed HIV positive test results returned to clients; and the percent of facilities reporting a prevalence of HIV positive tests equal to or greater than the jurisdiction's target set in indicator one.

Quality Assurance

1. **Describe the extent to which quality assurance plans for each of the following HIV prevention programs/intervention types were implemented by the health department and its grantees between January and June 2005.**

Counseling, Testing and Referral

Several measures have been taken to address the need for more consistency across CTR sites in assuring that controls for quality in services are maintained. All CTR sites were required to have written protocols related to the delivery of CTR services as well as the storage and delivery of lab specimens. The CTR Coordinator conducted site visits throughout the grant cycle, met with program staff; reviewed protocols, risk assessment tools, materials and methods of documentation; and assessed the need for providing on-site technical assistance. A quality assurance form had previously been created to help document these activities and was implemented during this time period.

CTR sites submitted monitoring data to the MDH in two ways. Sites were required to submit quarterly reports to the CTR Coordinator that quantitatively and qualitatively described the CTR services that were provided during the time period. Monitoring data was also submitted through the HIV Test Site (HTS) form. Scanned into the MDH HTS surveillance system, this information was submitted quarterly to the CDC. The HTS form will be replaced by the PEMS form toward the end of calendar year 2005. Information technology staff have worked closely with the CTR Program, assuring the integrity of the surveillance data.

Partner Counseling and Referral Services

No quality assurance plans were implemented between January 1 and June 30, 2005.

Health Education and Risk Reduction, Including Individual Level Interventions (ILI), Group Level Interventions (GLI), Prevention Case Management (PCM) and Prevention with Positives

Intervention Work Plans

Each year, grantees are required to complete intervention work plans for each of their planned interventions that describes the following intervention characteristics: a) staffing needs; b) scientific support for the intervention; c) justification for using the intervention with the target population; d) expected outcomes; e) process objectives; f) strategies to reach individuals from the target population; g) location/setting where the intervention will take place; h) schedule of activities; i) amount of time spent with individuals; j) educational content/messages that will be provided; k) content of materials that will be distributed; l) types and methods of referrals; and m) data collection methods.

In 2005 grantees successfully developed intervention work plans for each planned intervention. MDH grant managers reviewed and assessed these plans, and provided feedback to each grantee. Grantees were required to redevelop any plan component that had missing or erroneous information. In addition, intervention site visits were implemented to assess congruence between intervention work plans and intervention delivery. Grantees were provided summaries of the site visits. MDH required grantees to provide an explanation and plan to address components of the intervention that were found to be inconsistent with their intervention work plan.

HIV Prevention Intervention Comparison Guide
In 2004, the MDH contract managers developed the HIV Prevention Intervention Comparison Guide, which summarizes each type of intervention (Outreach, ILI, GLI, PCM, HC/PI) according to CDC intervention descriptions, and describes the required core elements and the secondary elements of each intervention. Contract managers use this document to train new employees on the various types of interventions and to describe what is expected for the specific intervention(s) that they will be implementing. They also refer to this document as a quality assurance tool during site visits by comparing what is being implemented by the agency to what is described in the guide.

Reporting
Program monitoring and narrative reports are submitted twice each year that describe progress made in achieving objectives in the intervention work plans and the demographics of persons reached with the interventions.

Observation of Intervention Delivery
Site visits are conducted with each grantee to observe the degree to which interventions are delivered in accordance with intervention work plans.

2. Describe the health department's efforts between January and June 2005 to implement a process to ensure that HERR activities are appropriate, understandable and acceptable for the specific populations served. Describe the outcomes of these efforts.

During the first half of 2005, MDH grant managers engaged in a number of activities to ensure that HERR activities were appropriate, understandable and acceptable for the target populations. Grant managers assisted in training new staff at grantee programs to ensure they understand the importance of targeting those at most risk with interventions and activities that are appropriate, acceptable and culturally/linguistically effective. This was most needed and addressed with the Hispanic/Latino, the African-born, and MSM populations. As a result, the programs targeting these individuals successfully met their goals and received positive client feedback regarding the delivery of interventions.

Grant managers provided constructive feedback on the intervention work plans and semi-annual narrative reports that described who was reached, and where and how they were reached. Grant managers also assessed through direct observation at site visits if this goal was being adequately accomplished. Through the review of submitted materials (including curricula), grant managers assessed whether interventions, activities and educational materials were appropriate, understandable, and acceptable for the specific populations served. The AMRP continued to review and recommend changes to ensure that materials used by HERR grantees were appropriate, understandable, and acceptable for the specific populations served.

In addition, MDH employs a diverse group of staff that provides contract management. This diversity enhances processes and communications in regard to language, sexual orientation and culture. As a result, many grantees receive appropriate and culturally specific technical assistance.

3. **What quality assurance issues do you plan to address in 2006? Describe the specific actions you will take, the expected outcomes of those actions, and how you will determine whether outcomes are met.**

Counseling, Testing and Referral

The CTR Program will continue the measures taken in calendar year 2005 to address the need for more consistency across CTR sites in regard to assuring controls for quality in services. The CTR Coordinator will develop a written document outlining basic CTR guidelines or recommendations to be available for both MDH-supported and non-MDH supported HIV testing providers. These guidelines will include basic HIV testing protocols for both field staff and managers. It is hoped that this upcoming document will serve to provide guidance for providers as they design their HIV testing programs, and provide a level of consistency as different sites develop their agency protocols regarding delivery of services to clients.

The MDH expects that consistency in quality control across sites will be revealed through site visits and technical assistance provided to CTR sites by the CTR Coordinator. There is an evaluation plan in draft form to help monitor outcomes in this area. The CTR Program also expects to have the PEMS data system implemented beginning January 2006. This outcome will, in part, be controlled by the timeline as set by the CDC. The MDH has ordered and received the appropriate software, and two of our programming staff have received CDC training on the software.

Partner Counseling and Referral Services

As noted previously, there is currently no systematic method to document care and services needs of PCRS program clients, effectively make referrals, and document referral completion. DIS currently identify care and services needs of HIV-infected clients and their partners and make referrals to resources. However, the PCRS Program currently has no system to document care and services needs of PCRS Program clients, effectively make referrals, and document referral completion. The following table describes specific actions that will be taken to address this issue, the expected outcomes, and outcomes measurements.

ACTIONS	EXPECTED OUTCOMES	OUTCOME MEASUREMENT
Arrange for or create and conduct a training session for DIS about how to assess client care and service needs and to effectively refer them to other providers.	DIS will acquire skills to assess client care and service needs and to effectively refer them to other providers.	- Pre-and post-training evaluation.
Implement procedures and monitor practices to confirm and document referral completion.	Baseline data to determine effectiveness of DIS PCRS referral activity.	- Report about referral completion.
Alter PCRS data collection tools and management system to document client care and services needs, referrals made (if any), and referral completion.	Baseline data to document client care and services needs, referrals made (if any), and referral completion.	- Report about client care and services needs, referrals made (if any), and referral completion.

Health Education and Risk Reduction

The quality assurance issues that will be addressed in 2006 include uniform data collection, intervention work plan development, and training on DEBI projects. Grant managers and the evaluation consultant will plan training and individual technical assistance on the development of improved data collection tools. As result, data will be collected more consistently. In addition, program monitoring through analysis and feedback on program monitoring reports will be subsequently facilitated.

Grantees will receive assistance in understanding and developing their intervention work plans. As a result, intervention delivery will occur in a deliberate and thoughtful manner and will reflect desired program outcomes. The various program monitoring activities described earlier will determine if these outcomes are achieved.

Grantees identified through the RFP process who plan to implement DEBI interventions will be connected to the appropriate trainings if they are interested in adapting these interventions. The trainings will assist grantees in planning and developing programs that are effective for their target populations while maintaining the core elements of the interventions. Fidelity to core elements of the interventions will be assessed through sites visits and review of narrative reports.

STD Prevention Activities

1. **Describe specific ways in which prevention activities were coordinated between STD screening and treatment and HIV counseling and testing between January and June 2005 and the outcomes of the coordination.**

   The Red Door Clinic implemented syphilis and rapid HIV testing at the two-day GLBT Pride Festival in June 2005. The Red Door Clinic consulted with the MDH Syphilis Elimination Coordinator regarding the plan for this event and the processing of serum samples. The plan allowed for anonymous HIV testing and confidential syphilis tests. The Syphilis Elimination Coordinator worked with the MDH Public Health Lab to ensure the availability of test results within three days.

   Twenty-seven (27) Red Door Clinic staff and volunteers staffed a booth at the Pride Festival, with two MDH staff also assisting. The set-up and staffing levels allowed for five HIV tests and one syphilis test to be conducted at the same time, with staff also present to encourage testing, answer questions, provide resources and check clients in. The event was highly successful. During the two days of the festival, over 3,600 individuals received information and had questions answered. A total of 172 HIV tests and 79 syphilis screenings were conducted. Three persons tested positive for syphilis and one tested positive for HIV.

   Of all people tested for syphilis, two-thirds called in for the results of their test. None of the people who tested positive for syphilis called to receive their results. With the assistance of Red Door Clinic staff, MDH DIS were able to contact all three individuals and ensure that they received treatment.

2. **Describe how the health department and its grantees incorporate STD education and prevention messages into HERR and prevention with positives programs.**

   All grantees are contractually required to address STDs, and hepatitis A, B and C in their programming. In the intervention work plans and curricula, grantees describe the STD educational messages that will be provided during the intervention. Some examples of incorporating STDs include specific group educational sessions on STD and hepatitis, youth tours of STD clinics, inclusion of STDs in volunteer training curricula, risk assessments for HIV and STDs, and implementation of community forums focused on syphilis, and on methamphetamines and HIV/STD risk.

   Annual update trainings are held for grantees to share new and up-to-date information. The last update training was held in February 2005 and included presentations by MDH staff on STDs (with an emphasis on syphilis) and hepatitis and safer sex guidelines. At these trainings, grantees are reminded to include STDs in their risk assessments and in their HIV prevention discussions and presentations.

   The MDH also created a syphilis health alert that was made available to all HERR programs. This alert informed programs about the recent syphilis outbreak and provided guidance related to informing clients about syphilis. In addition, the Syphilis Elimination Coordinator was invited by a few HERR Programs to provide syphilis educational presentations to their clients. These presentations included information on syphilis symptoms, transmission, prevention, treatment, and risks of co-infection with HIV.

The Community Syphilis Advisory Team, which meets monthly, is comprised mainly of individuals from agencies funded by the MDH to do outreach targeting MSM. The advisory group has worked hard to ensure that they incorporate information about syphilis into their outreach and HIV testing efforts. Members of the team include syphilis handouts in their safer sex kits and place syphilis posters and postcards in their offices, as well as at several community venues.

3. **Describe plans to enhance the coordination of STD and HIV prevention in 2006. Describe specific actions you will take, the outcomes you expect to achieve, and how you will determine whether outcomes are met.**

Health Education and Risk Reduction

Applicants to the upcoming HERR RFP will be required to describe how the proposed program will integrate health education and risk reduction regarding STDs and hepatitis A, B, and C into the delivery of the interventions that will be funded from July 2006 through December 2008. In addition, the intervention work plans for 2006 will include a specific STD and hepatitis section. Grantees will be required to report how STDs were integrated during the implementation of their interventions.

All grantees will plan and integrate STD and hepatitis prevention education, risk assessment and referral as appropriate to the target population being served. Some grantees will use STD education as a strategy to provide HIV education with specific populations. Grantees will be encouraged to include STD and hepatitis knowledge in position descriptions and job postings, and to assess this knowledge during job interviews. The MDH will provide training on STDs and how to educate target populations regarding STDs. Evidence of STD integration will be identified during site visits and in narrative progress reports.

Syphilis Elimination

In 2005, the MDH received funding from the CDC for a syphilis elimination grant. A portion of this grant is allocated to fund a CBO to address syphilis elimination in 2006. The agency that receives this funding will determine precisely how they will coordinate STD and HIV prevention activities. The RFP process is currently underway and the selected agency will be identified by September 1, 2005.

The Syphilis Elimination Coordinator, along with the Community Syphilis Advisory Team, is in the beginning stages of planning a community syphilis testing event for 2006. While the focus of this event will be increasing community members' knowledge about syphilis and promoting syphilis testing, community agencies will also have HIV prevention information available, as well as services such as rapid HIV testing. The expected outcomes are to have at least 50 members of the affected population attend the event, increase their awareness regarding syphilis, and have at least half of them be tested for syphilis. Outcomes will be measured through counting the number of participants and the number who are tested. It is assumed that everyone's awareness of syphilis will increase by virtue of their attendance at the event.

STD and HIV Trainings in Greater Minnesota

The STD Screening Specialist, HIV Prevention Training Coordinator, CTR Coordinator, Hepatitis Training Coordinator, and the Media and Information Specialist (training team) will be meeting during the last half of 2005 to design a curriculum for a one-day training on STDs and a one-day training on HIV. These trainings, to be held back-to-back, will be offered at three

locations in Greater Minnesota during the first half of 2006. The prospective plan is to continue these trainings throughout 2006.

Feedback from participants in a series of trainings done in Greater Minnesota during 2004 and 2005 in collaboration with the Minnesota Department of Human Services revealed a need for more in-depth training on STDs and HIV. They requested both basic information and an update on latest developments. There was a clear need expressed for information in a technical format that can address the needs of health care practitioners and a more general format for non-medical service providers. The training committee will attempt to utilize the same community venues, contact agencies and mailing lists used in the previous training series in order to reach the same audience. By doing this, we expect to provide information to at least 45 medical practitioners and 45 non-medical service providers in three locations in Greater Minnesota by June 30, 2006.

The training team will request evaluations from participants attending the trainings. The training team, in conjunction with the STD and HIV Section's Evaluation Coordinator, will then evaluate the responses and determine if these trainings have been effective as structured or if changes need to be made. The training team will also assess how many participants reported they received the information they needed. This evaluation process will continue when additional trainings are conducted.

Collaboration and Coordination

1. Describe major actions taken to collaborate with the following entities and the outcomes of those actions between January and June 2005.

CDC Directly Funded CBOs

MDH grant managers have each been assigned as a liaison to one of the three CDC directly funded programs in Minnesota. As liaisons, grant managers are responsible for responding to local technical assistance needs of the directly funded programs and maintaining current knowledge regarding the programs plan.

HIV/AIDS Care Programs

The CTR Program is collaborating with the Ryan White Title I grantee to fund a two-year combined prevention and care outreach and testing pilot project, which began in March 2005. The funded agencies are expected to provide outreach activities that include the distribution of prevention literature, safer sex kits, and bleach kits; the provision of field based testing; and referral to prevention services. Persons who test positive, or people who already know they are positive but are not in care, will be assisted in accessing care and support services. The four CBOs that were awarded funds were the African American AIDS Task Force, targeting testing at the Hennepin County Medical Center; Access Works, targeting testing at the Hennepin County Correctional Facility men's workhouse; Minnesota AIDS Project, targeting testing in the IDU community; and the Red Door Clinic, targeting testing in substance abuse treatment centers.

When CARE Act Title II funds first came to Minnesota, the MDH served as the grantee; however, in 2001, administration of the Title II grant moved to the Minnesota Department of Human Services (DHS). The DHS contracts with the MDH to maintain continued participation in planning for care services for people living with HIV. This has been a priority for the MDH in order to maintain the public health perspective in care planning and to ensure that linkages between prevention and care are in place. Thus, the MDH maintains a seat on the Minnesota HIV Services Planning Council (Planning Council) and participates as a member of the Governmental HIV Administrative Team (GHAT). The GHAT is made up of representatives from the MDH; the DHS; and the Hennepin County Human Services and Public Health Department (HSPHD), the CARE Act Title I grantee. During the first half of 2005, the GHAT continued to meet on a bi-monthly basis for the purpose of discussing issues related to grant administration, data collection, contracting, and community planning.

The DHS, in collaboration with the HSPHD, the MDH and several CBOs, delivered trainings in rotating regions of Greater Minnesota. The trainings were targeted at providers in Greater Minnesota and the purpose was to provide information about available care and support services and to provide an opportunity for networking. In addition, the STD Screening Specialist from DHS provided an STD update as part of these trainings. During the first half of 2005, 51 providers attended the training session.

The MDH Hepatitis Coordinator is supporting the DHS HIV and Hepatitis programs in their efforts to enhance the AIDS Drug Assistance Program (ADAP) by providing medications for HIV/Hepatitis C co-infected patients. The Hepatitis Coordinator is assisting in the identification of physicians to promote this program.

Hepatitis Prevention Programs

Access Works, an HERR grantee, facilitates a Hepatitis Clinic once a month. The Hepatitis Clinic is a collaborative effort with the Community University Health Care Clinic (CUHCC) and Clinic 42, another HERR grantee. The clinic offers Hepatitis education, individual risk assessments, screening for Hepatitis A, B, and C, vaccinations for Hepatitis A and B, individual counseling, and HIV testing. Numbers are not yet available for the entire first half of 2005. However, during January through March 2005, the Hepatitis Clinic was held three times with a total of 28 participants attending. Eleven persons were screened for hepatitis, four people were tested for HIV, and 19 began their hepatitis A and/or B vaccination series.

The Hepatitis Coordinator was involved in number of collaborative activities during the first half of 2005. The Hepatitis Coordinator delivered presentations on the basics of hepatitis during two HERR grantee trainings, resulting in increased awareness and increased hepatitis screening of clients. The Hepatitis Coordinator also provided technical assistance to the Recovery Resource Center, MAP and Access Works in developing a collaborative grant application for funds from SAMHSA to support HIV and hepatitis C prevention with communities of color, IDUs and persons returning to the community after incarceration. The MDH supplied a letter of support for the grant application. The notice of awards for this grant has not yet been released. Finally, the Hepatitis Coordinator and the CTR Coordinator began meeting to identify testing sites to target with hepatitis training. The goal is to ensure that CTR providers consistently integrate messages of hepatitis awareness and prevention into the testing counseling session.

MDH collaborated with the Minnesota Environmental Protection Assistance (EPA) agency, the Minnesota Chapter of the American Diabetes Association and CBOs targeting injecting drug users in reconstructing Minnesota's disposal brochure, "Safe Disposal Options for Needles and Syringes," the core product of a statewide disposal plan. This brochure is based on the EPA's latest "Community Options for Safe Needle Disposal" brochure. This brochure promotes using new syringes and will be published on multiple web sites, and will also be distributed at retail pharmacies selling new syringes, during outreach to injecting drug users, and to clients of organizations working with diabetics. The brochure also includes telephone numbers of agencies serving these populations. As part of Minnesota's statewide syringe and needle disposal plan, this information will be widely distributed.

Criminal Justice Programs

The Minnesota Department of Corrections (DOC) and county correctional facilities throughout Minnesota have been more than welcoming of CTR services being offered within correctional facilities by MDH-funded CTR grantees and PCRS staff. The CTR Coordinator has also begun to collaborate with the DOC Infection Control Nurse to provide ongoing informational exchanges and educational trainings for DOC nursing staff by MDH staff.

Substance Abuse and Mental Health Treatment Programs

During the first half of 2005, the CTR Program began a collaboration with SAMHSA to enable Minnesota to take part in SAMHSA's Rapid HIV Testing Initiative (RHTI). At this point, the MDH has received an initial provision of rapid test kits that have gone to the three existing MDH-supported rapid test sites, two of which conduct rapid testing in substance abuse treatment centers. Methods of data exchange are being coordinated.

2. **Describe areas in which you will focus efforts to strengthen collaboration and coordination in 2006.**

The HERR Unit and the CTR Coordinator will focus efforts on strengthening the outreach and testing project that is being jointly funded with the CARE Act Title I grantee, as well as to identify any other opportunities for collaboration. Joint grant manager meetings are scheduled for 2006 to discuss and address program planning, implementation and monitoring challenges of the joint outreach programs and other agencies funded by both entities. A joint provider training will also be held in 2006 for all organizations receiving prevention and/or CARE Act Title I and II funds. These joint trainings are generally offered once a year, and provide the opportunity for grantees to learn about each other's programs and strengthen their effectiveness in providing referrals. MDH staff will continue to participate in GHAT. The CTR Coordinator will continue collaborative efforts with the Hepatitis Coordinator and will strive to continue participation in the SAMHSA RHTI.

3. **Describe the specific actions you plan to take to strengthen collaboration and coordination, the expected outcomes of those actions, and how you will determine whether outcomes have been achieved.**

HIV/AIDS Care Programs

The GHAT will review two collaboration and coordination plans developed in the past several years and determine which, if any, collaborative activities are feasible and appropriate to implement in 2006 and over the next several years. GHAT members share a commitment to expanding joint efforts in appropriate areas that can simultaneously respond to both prevention and care goals and objectives. If collaborative activities are identified, an implementation plan will be developed that identifies responsible parties and a timeline. Progress will be assessed at the bi-monthly meetings.

The HERR Unit and CTR Coordinator will continue to attend the quarterly meetings with grant managers from the CARE Act Title I and II grantees. A major focus of these meetings will be to share project data on the joint outreach and testing pilot project, as well as information about other organizations that receive both care and prevention funding. The CTR Coordinator will accompany the Title I grant manager on site visits to the joint outreach programs, and provide assistance to the grant manager in assessing performance in relation to the prevention outreach and testing components of the programs.

The anticipated outcomes of the joint outreach and testing project are: 1) high risk and HIV positive individuals will receive HIV prevention education; 2) individuals who may not normally know about and/or choose to test for HIV will receive an HIV test; and 3) newly diagnosed persons and persons who know they are positive but are not in care will be linked to medical care and support services. Outcomes will be assessed by reviewing the number of people contacted through outreach, the number of people tested, the positivity rate, and the number of HIV positive persons who begin receiving HIV services.

Hepatitis Prevention

The Hepatitis Coordinator will continue to work with the CTR Program to incorporate hepatitis counseling into existing HIV counseling and testing training, as well as continue to incorporate this information into trainings for HERR grantees. The Hepatitis Coordinator will also provide presentations to MDH staff and CCCHAP members in order to increase knowledge and awareness of viral hepatitis, and the impact and risks of hepatitis for HIV positive persons and

those at risk of HIV infection. Finally, the Hepatitis Coordinator will seek out collaborative grant opportunities to increase the availability of hepatitis screening and vaccination in Minnesota.

Two desired outcomes of these activities are an increased awareness about hepatitis on the part of MDH staff, grantees and CCCHAP members, and an increase in requests for education, materials and technical assistance. Another is an increase in the amount of hepatitis counseling, screening and vaccination provided by HERR grantees or other providers. The outcomes will be measured by tracking the number of people who receive training on viral hepatitis and the number of requests for education and technical assistance. The number of people receiving hepatitis screening and vaccination through MDH-funded organizations will be monitored to determine whether there has been an increase.

Substance Abuse and Mental Health Programs

The CTR Coordinator will continue to be the lead person to coordinate efforts of MDH, SAMHSA, MayaTech (OraQuick supplier), and Westat (data collection) for the RHTI. Through the collaboration with SAMHSA, it is hoped that more providers will be trained on how to conduct rapid testing and rapid test kits will become available to those sites. How long the SAMHSA RHTI will be available to Minnesota is unknown at this time.

Major Issues During the Reporting Period

1. **Describe any funding and staffing issues that impacted work between January and June 2005.**

   During the fall of 2004, the MDH Office of Workforce Diversity conducted an assessment of the STD and HIV Section workplace environment. As a result of the assessment findings, all section staff participated in at least one committee that met weekly for the first three months of 2005. There were six committees: 1) Workplace Climate, 2) Communications, 3) Issue Resolution, 4) Technical Work Team, 5) Policies and Procedures, and 6) Management Infrastructure. Each group developed a set of recommendations that were then reviewed by the management team of the section. During the second half of 2005 two ongoing committees, Policies and Procedures and Workplace Climate, will begin implementing recommendations. The time commitment required by this process, particularly for the management team, resulted in some delays in implementing 2005 objectives.

   There were several staff position vacancies in the STD and HIV Section that impacted work during the reporting period. The STD and HIV Section Planner position has been vacant since the beginning of April, which has impacted implementation of the capacity building plan. Between January 1 and June 30, 2005, available staff to provide PCRS in the Minneapolis-St. Paul metropolitan area was reduced by 50 percent due to the reassignment of one DIS in March and the leave of absence of another DIS during February, March, and April. The HERR Unit was missing one staff person who was out on a twelve-month leave. During this time, an additional eighteen agencies were funded to provide health communication/public information interventions targeting African individuals, requiring a shifting in grant management responsibilities.

   In addition, six of twenty grantees had staff turnovers or significant personnel changes that required frequent meetings between grant managers and grantee staff to develop recruitment plans, provide orientation of new staff and develop a timeline for completing any needed HIV prevention training of new staff.

Capacity Building Assistance Needs

1. What are your capacity building needs for 2006?

The Early Diagnosis and Intervention Unit would benefit from a PCRS train-the-trainer course. This would allow the DIS to then train CTR program personnel at MDH-supported sites to effectively counsel patients who test positive on the importance of partner notification; to provide coaching on how to notify partners and refer them to testing; and for clients who test confidentially, to effectively explain the benefits of the PCRS services that will be offered to them when they are contacted by a DIS. The Early Diagnosis and Intervention Unit also needs a training course for PCRS staff and CTR providers on effectively making and tracking referrals.

The HERR Unit would benefit from assistance in planning and delivering DEBI training to grantee staff. The HERR Unit would also benefit from assistance in providing organizational and programmatic capacity building assistance to grantees, particularly to agencies serving African populations.

Performance Indicators

Overall HIV Performance Indicators						
Indicator A.1: The number of newly diagnosed HIV infections						
2003 (Baseline)		**2005** (Target)		**2006** (Target)	**2008** (5-Year Goal)	
Original	**Revised**	**Original**	**Revised**	**New**	**Original**	**Revised**
291		**300**		**293**	**276**	

1. How did you develop your new 2006 target measure for this performance indicator? List data sources (e.g., surveillance data, sample surveys, other resources/documents) and describe analytic methods used to develop this measure (e.g., trend analysis, peer consultation).

MDH reviews surveillance data to develop targets for this indicator. Based on the number of cases reported to date, MDH expects to meet the 2005 target of 300 new HIV infections this year. A target of 293 new HIV infections in Minnesota in 2006 keeps MDH on track to reach its overall 2008 target of a 5% decrease in HIV infections from baseline.

2. Please provide justification for any baseline, target, and/or performance goal measures that **are not** provided in this 2005 Interim Progress Report.

Not applicable.

Answer questions 3-5 below if you revised your 2003 baseline, 2005 target, and/or 2008 5-year performance goal measures for this performance indicator. Indicate "Not applicable" (NA) as needed.

3. For each measure listed below, explain your reason(s) for revising the original measure. Describe any challenges you experienced in developing the original measure.

Not applicable.

4. How did you address the challenges described above in order to revise your 2003, 2005, and/or 2008 measures?

Not applicable.

5. Explain how you developed each revised measure. List data sources (e.g., surveillance data, sample surveys, other resources/documents) and describe analytic methods used to develop the revised measure (e.g., trend analysis, peer consultation).

Not applicable.

Overall HIV Performance Indicators						
Indicator A.2: Number of newly diagnosed HIV Infections, 13-24 years of age						
2003 (Baseline)		**2005** (Target)		**2006** (Target)	**2008** (5-Year Goal)	
Original	Revised	Original	Revised	New	Original	Revised
38		**45**		**41**	**34**	

1. How did you develop your new 2006 target measure for this performance indicator? List data sources (e.g., surveillance data, sample surveys, other resources/documents) and describe analytic methods used to develop this measure (e.g., trend analysis, peer consultation).

MDH reviews surveillance data to develop targets for this indicator. Based on the number of cases reported to date, MDH expects to meet the 2005 target of 45 new HIV infections this year. A target of 41 new HIV infections in Minnesota in 2006 keeps MDH on track to reach its overall 2008 target of a 10% decrease in HIV infections from baseline.

2. Please provide justification for any baseline, target, and/or performance goal measures that **are not** provided in this 2005 Interim Progress Report.

Not applicable.

Answer questions 3-5 below if you revised your 2003 baseline, 2005 target, and/or 2008 5-year performance goal measures for this performance indicator. Indicate "Not applicable" (NA) as needed.

3. For each measure listed below, explain your reason(s) for revising the original measure. Describe any challenges you experienced in developing the original measure.

Not applicable.

4. How did you address the challenges described above in order to revise your 2003, 2005, and/or 2008 measures?

Not applicable.

5. Explain how you developed each revised measure. List data sources (e.g., surveillance data, sample surveys, other resources/documents) and describe analytic methods used to develop the revised measure (e.g., trend analysis, peer consultation).

Not applicable.

Counseling, Testing and Referral Services Performance Indicators							
Indicator B.1: Percent of newly identified, confirmed HIV-positive test results among all tests reported by HIV counseling, testing, and referral sites							
	2003 (Baseline)		**2005** (Target)		**2006** (Target)	**2008** (5-Year Goal)	
	Original	Revised	Original	Revised	NEW	Original	Revised
Numerator: The number of newly identified, confirmed HIV positive test results	**73**		**73**		**77**	**86**	
Denominator: The total number of tests for clients with a previous negative or unknown HIV status reported by HIV counseling, testing and referral sites	**9569**		**9569**		**9569**	**9569**	
Percent = (numerator / denominator) x 100	**0.8%**		**0.8%**		**0.8%**	**0.9%**	

1. How did you develop your new 2006 target measure for this performance indicator? List data sources (e.g., surveillance data, sample surveys, other resources/documents) and describe analytic methods used to develop this measure (e.g., trend analysis, peer consultation).

MDH reviews data from our HIV Testing System to develop targets for this indicator. Based on data received to date, MDH expects to meet the 2005 target of 0.8% new HIV infections reported among all tests reported by CTR sites this year. A target of identifying 77 new and confirmed HIV positive test results out of 9569 total tests in 2006 keeps MDH on track to reach its overall 2008 target of 86/9569 (0.9%).

2. Please provide justification for any baseline, target, and/or performance goal measures that **are not** provided in this 2005 Interim Progress Report.

Not applicable.

Answer questions 3-5 below if you revised your 2003 baseline, 2005 target, and/or 2008 5-year performance goal measures for this performance indicator. Indicate "Not applicable" (NA) as needed.

3. For each measure listed below, explain your reason(s) for revising the original measure. Describe any challenges you experienced in developing the original measure.

Not applicable.

4. How did you address the challenges described above in order to revise your 2003, 2005, and/or 2008 measures?

Not applicable.

5. Explain how you developed each revised measure. List data sources (e.g., surveillance data, sample surveys, other resources/documents) and describe analytic methods used to develop the revised measure (e.g., trend analysis, peer consultation).

Not applicable.

Counseling, Testing and Referral Services Performance Indicators							
Indicator B.2: Percent of newly identified, confirmed HIV-positive test results returned to clients.							
	2003 (Baseline)		**2005** (Target)		**2006** (Target)	**2008** (5-Year Goal)	
	Original	Revised	Original	Revised	NEW	Original	Revised
Numerator: The number of clients informed of a newly identified, confirmed HIV positive test result among clients visiting HIV counseling, testing, and referral sites.	**60**		**64**		**70**	**82**	
Denominator: The number of clients with a newly identified, confirmed HIV positive test result among clients visiting HIV counseling, testing, and referral sites.	**73**		**73**		**77**	**86**	
Percent = (numerator / denominator) x 100	**82%**		**88%**		**91%**	**95%**	

1. How did you develop your new 2006 target measure for this performance indicator? List data sources (e.g., surveillance data, sample surveys, other resources/documents) and describe analytic methods used to develop this measure (e.g., trend analysis, peer consultation).

MDH reviews data from our HIV Testing System to develop targets for this indicator. Also, the denominator for this indicator is linked to indicator B.1 (targets for the numerator of B.1 and denominator for B.2 are the same). Based on data received to date, MDH expects to meet the 2005 target of 88% of all positive HIV test results returned to clients this year. A target of 70 out of 77 (91%) positive test results returned to clients in 2006 keeps MDH on track to reach its overall 2008 target of 82/86 (95%) returned positive results.

2. Please provide justification for any baseline, target, and/or performance goal measures that **are not** provided in this 2005 Interim Progress Report.

Not applicable.

Answer questions 3-5 below if you revised your 2003 baseline, 2005 target, and/or 2008 5-year performance goal measures for this performance indicator. Indicate "Not applicable" (NA) as needed.

3. For each measure listed below, explain your reason(s) for revising the original measure. Describe any challenges you experienced in developing the original measure.

Not applicable.

4. How did you address the challenges described above in order to revise your 2003, 2005, and/or 2008 measures?

Not applicable.

5. Explain how you developed each revised measure. List data sources (e.g., surveillance data, sample surveys, other resources/documents) and describe analytic methods used to develop the revised measure (e.g., trend analysis, peer consultation).

Not applicable.

Counseling, Testing and Referral Services Performance Indicators							
Indicator B.3: Percent of facilities reporting a prevalence of HIV positive tests equal to or greater than the jurisdiction's target set in B.1.							
	2003 (Baseline)		**2005** (Target)		**2006** (Target)	**2008** (5-Year Goal)	
	Original	Revised	Original	Revised	NEW	Original	Revised
Numerator: The number of HIV counseling, testing, and referral sites reporting at or above the jurisdiction's target percent of newly identified, confirmed HIV positive test results among all HIV tests.	**1**		**1**		**1**	**3**	
Denominator: The number of HIV counseling, testing, and referral sites.	**20**		**20**		**20**	**20**	
Percent = (numerator / denominator) x 100	**5%**		**5%**		**5%**	**15%**	

1. How did you develop your new 2006 target measure for this performance indicator? List data sources (e.g., surveillance data, sample surveys, other resources/documents) and describe analytic methods used to develop this measure (e.g., trend analysis, peer consultation).

MDH reviews data from our HIV Testing System to develop targets for this indicator, and calculates confidence intervals to identify sites for the numerator with positivity rates above the rate for all sites within the 95% confidence range. In addition, MDH takes into account the sites funded and the timing within the funding cycle when assigning targets for this indicator. Based on performance on this measure in previous years and given that some new sites will be funded to conduct these services in 2006, the MDH targets that 1 site will have a positivity rate significantly above the overall rate out of 20 total sites funded (10%) in 2006, with a 1 site/year increase in the numerator in subsequent years.

2. Please provide justification for any baseline, target, and/or performance goal measures that **are not** provided in this 2005 Interim Progress Report.

Not applicable.

Answer questions 3-5 below if you revised your 2003 baseline, 2005 target, and/or 2008 5-year performance goal measures for this performance indicator. Indicate "Not applicable" (NA) as needed.

3. For each measure listed below, explain your reason(s) for revising the original measure. Describe any challenges you experienced in developing the original measure.

Not applicable.

4. How did you address the challenges described above in order to revise your 2003, 2005, and/or 2008 measures?

Not applicable.

5. Explain how you developed each revised measure. List data sources (e.g., surveillance data, sample surveys, other resources/documents) and describe analytic methods used to develop the revised measure (e.g., trend analysis, peer consultation).

Not applicable.

Partner Counseling and Referral Services Performance Indicators							
Indicator C.1: Percent of contacts with unknown or negative serostatus receiving an HIV test after PCRS notification.							
	2003 (Baseline)		**2005** (Target)		**2006** (Target)	**2008** (5-Year Goal)	
	Original	Revised	Original	Revised	NEW	Original	Revised
Numerator: The number of contacts receiving an HIV test within 3 months of being contacted by an HIV partner counseling and referral service provider.	**104**						
Denominator: The number of contacts who have unknown or negative serostatus provided by an index case.	**130**						
Percent = (numerator / denominator) x 100	**80%**		**83%**		**83%**	**85%**	

1. How did you develop your new 2006 target measure for this performance indicator? List data sources (e.g., surveillance data, sample surveys, other resources/documents) and describe analytic methods used to develop this measure (e.g., trend analysis, peer consultation).

MDH reviews case management reports from STD*MIS to set targets for this indicator. As we described in our 2004 APR, MDH has set target percentages for this indicator, but would like technical assistance from CDC to help develop targets for the numerators and denominators. The target measures set by MDH for this measure are fairly conservative due to the fact that levels are already quite high.

2. Please provide justification for any baseline, target, and/or performance goal measures that **are not** provided in this 2005 Interim Progress Report.

As was stated in the 2004 APR, MDH seeks technical assistance in setting target goals for numerators and denominators for this indicator. MDH has provided target percentages for this measure, but without feedback from CDC, has not yet provided corresponding numerator and denominator targets.

Answer questions 3-5 below if you revised your 2003 baseline, 2005 target, and/or 2008 5-year performance goal measures for this performance indicator. Indicate "Not applicable" (NA) as needed.

3. For each measure listed below, explain your reason(s) for revising the original measure. Describe any challenges you experienced in developing the original measure.

Not applicable.

4. How did you address the challenges described above in order to revise your 2003, 2005, and/or 2008 measures?

Not applicable.

5. Explain how you developed each revised measure. List data sources (e.g., surveillance data, sample surveys, other resources/documents) and describe analytic methods used to develop the revised measure (e.g., trend analysis, peer consultation).

Not applicable.

Partner Counseling and Referral Services Performance Indicators							
Indicator C.2: Percent of contacts with a newly identified, confirmed HIV positive test among contacts who are tested.							
	2003 (Baseline)		**2005** (Target)		**2006** (Target)	**2008** (5-Year Goal)	
	Original	Revised	Original	Revised	NEW	Original	Revised
Numerator: The number of contacts accepting HIV partner counseling and referral services (PCRS) who receive notification of a newly identified, confirmed HIV positive test result within 3 months of being contacted by an HIV PCRS provider.	**12**						
Denominator: All contacts receiving a test within 3 months of being contacted by an HIV PCRS providers	**104**						
Percent = (numerator / denominator) x 100	**12%**		**12%**		**13%**	**14%**	

1. How did you develop your new 2006 target measure for this performance indicator? List data sources (e.g., surveillance data, sample surveys, other resources/documents) and describe analytic methods used to develop this measure (e.g., trend analysis, peer consultation).

MDH reviews case management reports from STD*MIS to set targets for this indicator. Based on data received to date as well as program performance last year, MDH expects to meet the 2005 target of 12% of all partners contacted receiving a new HIV positive test this year. In 2006, MDH expects that the PCRS program will increase this percentage to 13%. As we described in the MDH 2004 APR submitted to CDC in May 2005, MDH has set target percentages for this indicator, but would like technical assistance from CDC to help develop targets for the numerators and denominators.

2. Please provide justification for any baseline, target, and/or performance goal measures that **are not** provided in this 2005 Interim Progress Report.

As was stated in the 2004 APR, MDH seeks technical assistance in setting target goals for numerators and denominators for this indicator. MDH has provided target percentages for this measure, but without feedback from CDC, has not yet provided corresponding numerator and denominator targets.

Answer questions 3-5 below if you revised your 2003 baseline, 2005 target, and/or 2008 5-year performance goal measures for this performance indicator. Indicate "Not applicable" (NA) as needed.

3. For each measure listed below, explain your reason(s) for revising the original measure. Describe any challenges you experienced in developing the original measure.

Not applicable.

4. How did you address the challenges described above in order to revise your 2003, 2005, and/or 2008 measures?

Not applicable.

5. Explain how you developed each revised measure. List data sources (e.g., surveillance data, sample surveys, other resources/documents) and describe analytic methods used to develop the revised measure (e.g., trend analysis, peer consultation).

Not applicable.

Partner Counseling and Referral Services Performance Indicators							
Indicator C.3: Percent of contacts with a known, confirmed HIV positive test among all contacts							
	2003 (Baseline)		**2005** (Target)		**2006** (Target)	**2008** (5-Year Goal)	
	Original	Revised	Original	Revised	NEW	Original	Revised
Numerator: The number of contacts who are HIV positive either by self-report or medical record confirmed HIV positive status.	**65**						
Denominator: All sex and needle sharing contacts of an HIV infected person	**268**						
Percent = (numerator / denominator) x 100	**24%**		**24%**		**25%**	**27%**	

1. How did you develop your new 2006 target measure for this performance indicator? List data sources (e.g., surveillance data, sample surveys, other resources/documents) and describe analytic methods used to develop this measure (e.g., trend analysis, peer consultation).

MDH reviews case management reports from STD*MIS to set targets for this indicator. Based on data received to date as well as program performance last year, MDH expects to meet the 2005 target of 24% this year. In 2006, MDH expects that the PCRS program will increase this percentage to 25%. As we described in our 2004 APR, MDH has set target percentages for this indicator, but would like technical assistance from CDC to help develop targets for the numerators and denominators.

2. Please provide justification for any baseline, target, and/or performance goal measures that **are not** provided in this 2005 Interim Progress Report.

As was stated in the MDH 2004 APR submitted to CDC in May 2005, MDH seeks technical assistance in setting target goals for numerators and denominators for this indicator. MDH has provided target percentages for this measure, but without feedback from CDC, has not yet provided corresponding numerator and denominator targets.

Answer questions 3-5 below if you revised your 2003 baseline, 2005 target, and/or 2008 5-year performance goal measures for this performance indicator. Indicate "Not applicable" (NA) as needed.

3. For each measure listed below, explain your reason(s) for revising the original measure. Describe any challenges you experienced in developing the original measure.

Not applicable.

4. How did you address the challenges described above in order to revise your 2003, 2005, and/or 2008 measures?

Not applicable.

5. Explain how you developed each revised measure. List data sources (e.g., surveillance data, sample surveys, other resources/documents) and describe analytic methods used to develop the revised measure (e.g., trend analysis, peer consultation).

Not applicable.

Perinatal Transmission Prevention							
Indicator D.1 and D.4: Proportion of women who receive an HIV test during pregnancy.							
	2003 (Baseline)		**2005** (Target)		**2006** (Target)	**2008** (5-Year Goal)	
	Original	Revised	Original	Revised	NEW	Original	Revised
Numerator: All pregnant women who deliver and have an HIV test during pregnancy.							
Denominator: All pregnant women who deliver.							
Proportion = (numerator / denominator) x 100	**62%**		**70%**		**70%**	**85%**	

1. How did you develop your new 2006 target measure for this performance indicator? List data sources (e.g., surveillance data, sample surveys, other resources/documents) and describe analytic methods used to develop this measure (e.g., trend analysis, peer consultation).

The MDH will measure this indicator using data from the Pregnancy Risk Assessment Monitoring System (PRAMS). MDH submits this data to CDC for processing and there is a considerable lag between the time data is collected and when analyzed data is available. The most current available PRAMS data is from 2002. Data from 2003 will be available this summer, and 2004 data will likely be available next summer. Also, 2004 is the first year in which the question "At any time during your most recent pregnancy or delivery, did you have a test for HIV (the virus that causes AIDS)?" Baseline data came from a different data source and indicated that 62% of pregnant women in Minnesota received an HIV test while pregnant. Until more data is available, MDH will keep annual targets, including that for 2006, at the 2004 and 2005 level of 70%.

2. Please provide justification for any baseline, target, and/or performance goal measures that **are not** provided in this 2005 Interim Progress Report.

The MDH baseline data came from a review of 605 charts conducted in 1998 and 1999. The numerator and denominator used to develop the baseline will be very different from the sample drawn for the PRAMS data we will use to measure this indicator in the future, so the baseline numbers for the numerator and denominator do not help when developing target numerators and denominators. In addition, PRAMS data to measure this indicator was not available prior to 2004, so the MDH does not have historical trend data to review to help set target numerators and denominators for this measure. Therefore, the MDH has only provided a target for the proportion for this indicator.

Answer questions 3-5 below if you revised your 2003 baseline, 2005 target, and/or 2008 5-year performance goal measures for this performance indicator. Indicate "Not applicable" (NA) as needed.

3. For each measure listed below, explain your reason(s) for revising the original measure. Describe any challenges you experienced in developing the original measure.

Not applicable.

4. How did you address the challenges described above in order to revise your 2003, 2005, and/or 2008 measures?

Not applicable.

5. Explain how you developed each revised measure. List data sources (e.g., surveillance data, sample surveys, other resources/documents) and describe analytic methods used to develop the revised measure (e.g., trend analysis, peer consultation).

Not applicable.

Community Planning Performance Indicators							
Indicator E.1: Proportion of populations most at risk (up to 10), as documented in the epidemiologic profile and/or the priority populations in the Comprehensive Plan, that have at least one CPG member that reflects the perspective of each population.							
	2003 (Baseline)		**2005** (Target)		**2006** (Target)	**2008** (5-Year Goal)	
	Original	Revised	Original	Revised	NEW	Original	Revised
Numerator: The number of populations most at risk (up to 10), as documented in the epidemiologic profile and/or the priority populations in the Comprehensive Plan, that have at least one CPG member that reflects the perspective of each population.	**6**		**6**		**6**	**8**	
Denominator: The number of populations most at risk (up to 10), as documented in the epidemiologic profile and/or the priority populations in the Comprehensive Plan.	**10**		**10**		**10**	**10**	
Proportion = (numerator / denominator) x 100	**60%**		**60%**		**60%**	**80%**	

1. How did you develop your new 2006 target measure for this performance indicator? List data sources (e.g., surveillance data, sample surveys, other resources/documents) and describe analytic methods used to develop this measure (e.g., trend analysis, peer consultation).

In 2005, the Minnesota CPG prioritized new priority populations for 2006. To set this target, we reviewed current membership and compared it to the new priority populations and developed a 2006 target for this indicator of 6/10 or 60% of priority populations represented by at least one CCCHAP member.

2. Please provide justification for any baseline, target, and/or performance goal measures that **are not** provided in this 2005 Interim Progress Report.

Not applicable.

Answer questions 3-5 below if you revised your 2003 baseline, 2005 target, and/or 2008 5-year performance goal measures for this performance indicator. Indicate "Not applicable" (NA) as needed.

3. For each measure listed below, explain your reason(s) for revising the original measure. Describe any challenges you experienced in developing the original measure.

Not applicable.

4. How did you address the challenges described above in order to revise your 2003, 2005, and/or 2008 measures?

Not applicable.

5. Explain how you developed each revised measure. List data sources (e.g., surveillance data, sample surveys, other resources/documents) and describe analytic methods used to develop the revised measure (e.g., trend analysis, peer consultation).

Not applicable.

Community Planning Performance Indicators

Indicator E.2: Proportion of key attributes of an HIV prevention planning process that CPG membership agreed have occurred.

	2003 (Baseline)		2005 (Target)		2006 (Target)	2008 (5-Year Goal)	
	Original	Revised	Original	Revised	NEW	Original	Revised
Numerator: The number of key attributes of which CPG members agreed occurred.	**596**						
Denominator: The total number of valid responses ("agree" and "disagree").	**685**						
Proportion = (numerator / denominator) x 100	**87%**		**87%**		**88%**	**90%**	

1. How did you develop your new 2006 target measure for this performance indicator? List data sources (e.g., surveillance data, sample surveys, other resources/documents) and describe analytic methods used to develop this measure (e.g., trend analysis, peer consultation).

Each September, the Minnesota CPG completes the CPG membership survey. MDH uses results from this survey to measure and set targets for this indicator. The CPG has completed this survey twice, in 2003 and 2004. Based on 2003 and 2004 data, MDH proposes to increase the performance on this measure to 88% in 2006. Note: It is difficult to set targets for this measure because of the effect that changes in the CPG membership each year have on the overall level of understanding of the community planning process (i.e. new members may have more "don't know" answers that are not included in the indicator calculation).

2. Please provide justification for any baseline, target, and/or performance goal measures that **are not** provided in this 2005 Interim Progress Report.

The numerator and denominator for this measure are dependent on the number of members participating when the CPG membership survey is completed each September, as well as the make-up of the group (the number of new versus seasoned members). For the two years that this survey has been conducted, the numerator and denominator have been very different. Therefore, we have provided target proportions for this measure, but as we stated in our 2004 APR, we request technical assistance from CDC to set targets for the numerator and denominator for this indicator.

Answer questions 3-5 below if you revised your 2003 baseline, 2005 target, and/or 2008 5-year performance goal measures for this performance indicator. Indicate "Not applicable" (NA) as needed.

3. For each measure listed below, explain your reason(s) for revising the original measure. Describe any challenges you experienced in developing the original measure.

Not applicable.

4. How did you address the challenges described above in order to revise your 2003, 2005, and/or 2008 measures?

Not applicable.

5. Explain how you developed each revised measure. List data sources (e.g., surveillance data, sample surveys, other resources/documents) and describe analytic methods used to develop the revised measure (e.g., trend analysis, peer consultation).

Not applicable.

Community Planning Performance Indicators							
Indicator E.3: Percent of prevention interventions/other supporting activities in the health department's CDC funding application specified as a priority in the comprehensive HIV prevention plan.							
	2003 (Baseline)		**2005** (Target)		**2006** (Target)	**2008** (5-Year Goal)	
	Original	Revised	Original	Revised	NEW	Original	Revised
Numerator: The number of prevention interventions/other supporting activities in the health department's CDC funding application specified as a priority in the comprehensive HIV prevention plan.	**91**		**75**		**90**	**90**	
Denominator: The number of all prevention interventions/ other supporting activities identified in the health department's CDC funding application.	**99**		**108**		**100**	**100**	
Percent = (numerator / denominator) x 100	**92%**		**69%**		**90%**	**90%**	

1. How did you develop your new 2006 target measure for this performance indicator? List data sources (e.g., surveillance data, sample surveys, other resources/documents) and describe analytic methods used to develop this measure (e.g., trend analysis, peer consultation).

MDH compares information submitted in the CDC funding application each fall to the Minnesota Comprehensive HIV Prevention Plan to measure and set targets for this indicator. Changes to funded interventions in 2003 and 2004 resulted in a decrease in this measure from baseline in both 2004 and 2005. Because of this, MDH revised the 2005 target to 69% for this indicator (see MDH 2004 APR). In 2006, MDH will be operating under a different comprehensive plan that resulted from a new community planning process, which should lead to improved performance on this measure. With these changes, MDH expects to reach the target of 90% for this measure next year.

2. Please provide justification for any baseline, target, and/or performance goal measures that **are not** provided in this 2005 Interim Progress Report.

Not applicable.

Answer questions 3-5 below if you revised your 2003 baseline, 2005 target, and/or 2008 5-year performance goal measures for this performance indicator. Indicate "Not applicable" (NA) as needed.

3. For each measure listed below, explain your reason(s) for revising the original measure. Describe any challenges you experienced in developing the original measure.

Not applicable.

4. How did you address the challenges described above in order to revise your 2003, 2005, and/or 2008 measures?

Not applicable.

5. Explain how you developed each revised measure. List data sources (e.g., surveillance data, sample surveys, other resources/documents) and describe analytic methods used to develop the revised measure (e.g., trend analysis, peer consultation).

Not applicable.

Community Planning Performance Indicators

Indicator E.4: Percent of health department-funded prevention interventions/other supporting activities that correspond to priorities specified in the comprehensive HIV prevention plan.

	2003 (Baseline)		2005 (Target)		2006 (Target)	2008 (5-Year Goal)	
	Original	Revised	Original	Revised	NEW	Original	Revised
Numerator: The number of funded prevention interventions/ other supporting activities that correspond to priorities specified in the most current comprehensive HIV prevention plan.	**75**		**75**		**90**	**90**	
Denominator: The number of all health department-funded prevention interventions/ other supporting activities.	**92**		**108**		**100**	**100**	
Percent = (numerator / denominator) x 100	**82%**		**69%**		**90%**	**90%**	

1. How did you develop your new 2006 target measure for this performance indicator? List data sources (e.g., surveillance data, sample surveys, other resources/documents) and describe analytic methods used to develop this measure (e.g., trend analysis, peer consultation).

MDH compares interventions funded each year to the Minnesota Comprehensive HIV Prevention Plan to measure and set targets for this indicator. Changes to funded interventions in 2004 resulted in a decrease in this measure from baseline in 2004. Because of this, MDH revised the 2005 target to 69% for this indicator (see MDH 2004 APR). In 2006, MDH will be operating under a different comprehensive plan that resulted from a new community planning process that should lead to improved performance on this measure. With these changes, MDH expects to reach the target of 90% for this measure next year.

2. Please provide justification for any baseline, target, and/or performance goal measures that **are not** provided in this 2005 Interim Progress Report.

Not applicable.

Answer questions 3-5 below if you revised your 2003 baseline, 2005 target, and/or 2008 5-year performance goal measures for this performance indicator. Indicate "Not applicable" (NA) as needed.

3. For each measure listed below, explain your reason(s) for revising the original measure. Describe any challenges you experienced in developing the original measure.

Not applicable.

4. How did you address the challenges described above in order to revise your 2003, 2005, and/or 2008 measures?

Not applicable.

5. Explain how you developed each revised measure. List data sources (e.g., surveillance data, sample surveys, other resources/documents) and describe analytic methods used to develop the revised measure (e.g., trend analysis, peer consultation).

Not applicable.

Evaluation Performance Indicator							
Indicator F.1: Proportion of providers reporting representative process monitoring data to the health department in compliance with CDC's Program Announcement							
	2003 (Baseline)		**2005** (Target)		**2006** (Target)	**2008** (5-Year Goal)	
	Original	Revised	Original	Revised	NEW	Original	Revised
Numerator: The number of providers reporting representative process monitoring data to the health department in compliance with CDC's Program Announcement.	**6**		**10**		**10**	**10**	
Denominator: Total number of health department funded providers that are implementing HIV prevention interventions.	**19**		**20**		**20**	**20**	
Proportion = (numerator / denominator) x 100	**32%**		**50%**		**50%**	**50%**	

1. How did you develop your new 2006 target measure for this performance indicator? List data sources (e.g., surveillance data, sample surveys, other resources/documents) and describe analytic methods used to develop this measure (e.g., trend analysis, peer consultation).

MDH reviews process-monitoring data submitted by HIV HERR grantee agencies to measure and set targets for this indicator. As described in the MDH 2004 APR submitted to CDC in May 2005, there have been a number of changes over the past several years to the MDH data collection and reporting requirements for grantees conducting HERR programs. These changes have made it difficult to report on a number of indicators, including this one. For this indicator, we have kept targets at 50% through 2008 due to the lack of consistent data from recent years on which to base the measure, and the uncertain nature of when new data collection efforts will be in place (PEMS) and what effect this will have on this indicator.

2. Please provide justification for any baseline, target, and/or performance goal measures that **are not** provided in this 2005 Interim Progress Report.

Not applicable.

Answer questions 3-5 below if you revised your 2003 baseline, 2005 target, and/or 2008 5-year performance goal measures for this performance indicator. Indicate "Not applicable" (NA) as needed.

3. For each measure listed below, explain your reason(s) for revising the original measure. Describe any challenges you experienced in developing the original measure.

Not applicable.

4. How did you address the challenges described above in order to revise your 2003, 2005, and/or 2008 measures?

Not applicable.

5. Explain how you developed each revised measure. List data sources (e.g., surveillance data, sample surveys, other resources/documents) and describe analytic methods used to develop the revised measure (e.g., trend analysis, peer consultation).

Not applicable.

Capacity Building Performance Indicator							
Indicator G.1: Proportion of providers who have received at least one health department-supported capacity building assistance, specifically in the form of trainings/workshops in the design, implementation, and evaluation of science-based HIV prevention interventions.							
	2003 (Baseline)		**2005** (Target)		**2006** (Target)	**2008** (5-Year Goal)	
	Original	Revised	Original	Revised	NEW	Original	Revised
Numerator: The number of providers/agencies that received at least one health department-supported capacity building assistance, specifically in the form of trainings/ workshops in the design, implementation, and evaluation of science-based HIV prevention interventions.	**22**		**22**		**22**	**22**	
Denominator: The total number of health department-funded providers/agencies that are implementing HIV prevention interventions.	**22**		**22**		**22**	**22**	
Proportion = (numerator / denominator) x 100	**100%**		**100%**		**100%**	**100%**	

1. How did you develop your new 2006 target measure for this performance indicator? List data sources (e.g., surveillance data, sample surveys, other resources/documents) and describe analytic methods used to develop this measure (e.g., trend analysis, peer consultation).

MDH requires that agencies funded to provide HIV prevention services attend training to improve the design, implementation, and evaluation of programs. This measure decreased below what was expected in 2004 and 2005 due to the funding of fifteen agencies to implement short-term health communication/public information activities in African communities. MDH required these agencies to attend a culturally appropriate AIDS 101 curriculum for Africans; however, this training was not of the type specified in this indicator. With the funding of new agencies to conduct HIV prevention interventions in 2006 that will all have the same training requirements, we expect this indicator to reach original targets set (100%) through 2008.

2. Please provide justification for any baseline, target, and/or performance goal measures that **are not** provided in this 2005 Interim Progress Report. **Not applicable.**

Answer questions 3-5 below if you revised your 2003 baseline, 2005 target, and/or 2008 5-year performance goal measures for this performance indicator. Indicate "Not applicable" (NA) as needed.

3. For each measure listed below, explain your reason(s) for revising the original measure. Describe any challenges you experienced in developing the original measure. **Not applicable.**

4. How did you address the challenges described above in order to revise your 2003, 2005, and/or 2008 measures? **Not applicable.**

5. Explain how you developed each revised measure. List data sources (e.g., surveillance data, sample surveys, other resources/documents) and describe analytic methods used to develop the revised measure (e.g., trend analysis, peer consultation). **Not applicable.**

Health Education/Risk Reduction Performance Indicators							
Indicator H.1: Proportion of persons that completed the intended number of sessions for each of the following interventions: individual level interventions (ILI), group level interventions (GLI), and prevention case management (PCM).							
	2003 (Baseline)		**2005** (Target)		**2006** (Target)	**2008** (5-Year Goal)	
	Original	Revised	Original	Revised	New	Original	Revised
Individual Level Interventions (ILI):							
Numerator: Number of persons who completed the intended number of sessions for ILI.							
Denominator: The number of persons who were enrolled in ILI							
Proportion = (numerator / denominator) x 100							
Group Level Interventions (GLI):							
Numerator: Number of persons who completed the intended number of sessions for GLI							
Denominator: The number of persons who were enrolled in GLI							
Proportion = (numerator / denominator) x 100							
Prevention Case Management (PCM):							
Numerator: Number of persons who completed the intended number of sessions for PCM							
Denominator: The number of persons who were enrolled in PCM							
Proportion = (numerator / denominator) x 100							

1. How did you develop your new 2006 target measure for this performance indicator? List data sources (e.g., surveillance data, sample surveys, other resources/documents) and describe analytic methods used to develop this measure (e.g., trend analysis, peer consultation).

See response to number 2 on next page.

Health Education/Risk Reduction Performance Indicators
2. Please provide justification for any baseline, target, and/or performance goal measures that **are not** provided in this 2005 Interim Progress Report. Note: MDH also included the following justification in the 2004 APR submitted to CDC in May 2005. **In 2003, the MDH introduced a new client level data collection system for grantees funded to conduct HIV HERR programs. Shortly after implementing this system, MDH learned about PEMS and the new data variables requirements from CDC. Because of problems with our new system, and knowing that substantial changes were coming from CDC, the data system that we began in 2003 was discontinued in June of 2004 due to lack of available resources to update the system. Beginning in July of 2004, data collection requirements returned to an aggregate data collection system that includes information needed to calculate this indicator. However, because of confusion surrounding the changes in the data collection requirements, data reported to MDH was incomplete for 2004. After reviewing the data available to us in 2003 and 2004, we have decided that our measures will be more accurate if we use 2005 data as a baseline, and continue to measure our progress in subsequent years after grantees are familiar with new data collection requirements.**
Answer questions 3-5 below if you revised your 2003 baseline, 2005 target, and/or 2008 5-year performance goal measures for this performance indicator. Indicate "Not applicable" (NA) as needed.
3. For each measure listed below, explain your reason(s) for revising the original measure. Describe any challenges you experienced in developing the original measure. **Not applicable.**
4. How did you address the challenges described above in order to revise your 2003, 2005, and/or 2008 measures? **Not applicable.**
5. Explain how you developed each revised measure. List data sources (e.g., surveillance data, sample surveys, other resources/documents) and describe analytic methods used to develop the revised measure (e.g., trend analysis, peer consultation). **Not applicable.**

Health Education/Risk Reduction Performance Indicators							
Program Performance Indicator H.2: Proportion of the intended number of the target populations to be reached with any of the following specific interventions: ILI, GLI, or PCM, who were actually reached.							
	2003 (Baseline)		**2005** (Target)		**2006** (Target)	**2008** (5-Year Goal)	
	Original	Revised	Original	Revised	New	Original	Revised
Numerator: Sum of the number of the target populations reached through any of the following specific interventions: ILI, GLI, or PCM.							
Denominator: Sum of the number of target populations that were intended to be reached through the following interventions: ILI, GLI, or PCM.							
Proportion = (numerator / denominator) x 100							

** Use this table to determine the numerator and denominator.*

Numerator/Denominator	**ILI**	**GLI**	**PCM**	**Total**
Population 1:				
Population 2:				
Population 3:				
Population 4:				
Population 5:				
Population 6:				
Population 7:				
Population 8:				
Population 9:				
Population 10:				
Total				$^{N}/_{D}$ =

Health Education/Risk Reduction Performance Indicators
1. How did you develop your new 2006 target measure for this performance indicator? List data sources (e.g., surveillance data, sample surveys, other resources/documents) and describe analytic methods used to develop this measure (e.g., trend analysis, peer consultation). **See response to number 2 below.**
2. Please provide justification for any baseline, target, and/or performance goal measures that **are not** provided in this 2005 Interim Progress Report. Note: MDH also included the following justification in the 2004 APR submitted to CDC in May 2005. **In 2003, the MDH introduced a new client level data collection system for grantees funded to conduct HIV HERR programs. Shortly after implementing this system, MDH learned about PEMS and the new data variables requirements from CDC. Because of problems with the new system, and knowing that substantial changes were coming from CDC, the data system that MDH began in 2003 was discontinued in June of 2004 due to lack of available resources to update the system. Beginning in July of 2004, data collection requirements returned to an aggregate data collection system that includes information needed to calculate this indicator. However, because of confusion surrounding the changes in the data collection requirements, data reported to MDH was incomplete for 2004. After reviewing the data available to us in 2003 and 2004, MDH has decided that the measures will be more accurate if we use 2005 data as a baseline, and continue to measure our progress in subsequent years after grantees are familiar with new data collection requirements.**
Answer questions 3-5 below if you revised your 2003 baseline, 2005 target, and/or 2008 5-year performance goal measures for this performance indicator. Indicate "Not applicable" (NA) as needed.
3. For each measure listed below, explain your reason(s) for revising the original measure. Describe any challenges you experienced in developing the original measure. **Not applicable.**
4. How did you address the challenges described above in order to revise your 2003, 2005, and/or 2008 measures? **Not applicable.**
5. Explain how you developed each revised measure. List data sources (e.g., surveillance data, sample surveys, other resources/documents) and describe analytic methods used to develop the revised measure (e.g., trend analysis, peer consultation). **Not applicable.**

Health Education/Risk Reduction Performance Indicators							
Program Performance Indicator H.3: The mean number of outreach contacts required to get one person to access any of the following services: Counseling & Testing, Sexually Transmitted Disease Screening & Testing, ILI, GLI or PCM.							
	2003 (Baseline)		**2005** (Target)		**2006** (Target)	**2008** (5-Year Goal)	
	Original	Revised	Original	Revised	New	Original	Revised
Numerator: The number of outreach contacts who were referred to any of the following services: CT, STD screening and testing, ILI, GLI or PCM							
Denominator: Number of individuals who accessed any of the following services: CT, STD screening and testing, ILI, GLI or PCM							
Mean = (numerator / denominator)							

1. How did you develop your new 2006 target measure for this performance indicator? List data sources (e.g., surveillance data, sample surveys, other resources/documents) and describe analytic methods used to develop this measure (e.g., trend analysis, peer consultation).

See response to number 2 below.

2. Please provide justification for any baseline, target, and/or performance goal measures that **are not** provided in this 2005 Interim Progress Report.

Note: MDH also included the following justification in the 2004 APR submitted to CDC in May 2005.

In 2003, the MDH introduced a new client level data collection system for grantees funded to conduct HIV HERR programs. Shortly after implementing this system, MDH learned about PEMS and the new data variables requirements from CDC. Because of problems with the new system, and knowing that substantial changes were coming from CDC, the data system that MDH began in 2003 was discontinued in June of 2004 due to lack of available resources to update the system. Beginning in July of 2004, data collection requirements returned to an aggregate data collection system that includes information needed to calculate this indicator. However, because of confusion surrounding the changes in the data collection requirements, data reported to MDH was incomplete for 2004. Because of issues associated with the changes to the data collection system over the past two years, MDH will use 2005 data as a baseline, and continue to measure our progress in subsequent years after grantees are familiar with new data collection requirements.

Also, using current data collection systems, MDH will be able to report baseline and target measures for this indicator for the number of outreach contacts referred to CTR and the number of individuals who accessed CTR based on an outreach referral. MDH does not have mechanisms to measure the number of individuals who accessed STD screening and testing or ILI, GLI and PCM services based on an outreach referral.

Health Education/Risk Reduction Performance Indicators
Answer questions 3-5 below if you revised your 2003 baseline, 2005 target, and/or 2008 5-year performance goal measures for this performance indicator. Indicate "Not applicable" (NA) as needed.
3. For each measure listed below, explain your reason(s) for revising the original measure. Describe any challenges you experienced in developing the original measure. **Not applicable.**
4. How did you address the challenges described above in order to revise your 2003, 2005, and/or 2008 measures? **Not applicable.**
5. Explain how you developed each revised measure. List data sources (e.g., surveillance data, sample surveys, other resources/documents) and describe analytic methods used to develop the revised measure (e.g., trend analysis, peer consultation). **Not applicable.**

Prevention with Infected Persons Performance Indicators							
Program Performance Indicator I.1: Proportion of HIV infected persons that complete the intended number of sessions for prevention case management (PCM)							
	2003 (Baseline)		**2005** (Target)		**2006** (Target)	**2008** (5-Year Goal)	
	Original	Revised	Original	Revised	New	Original	Revised
***Numerator**: The number of HIV infected persons that completed the intended number of sessions for PCM.*							
***Denominator**: The number of HIV infected persons enrolled in PCM.*							
***Proportion** = (numerator / denominator) x 100*	***69%***		**69%**		**69%**	**80%**	

1. How did you develop your new 2006 target measure for this performance indicator? List data sources (e.g., surveillance data, sample surveys, other resources/documents) and describe analytic methods used to develop this measure (e.g., trend analysis, peer consultation).

MDH reviews process-monitoring data submitted by grantee agencies conducting PCM with HIV+ individuals to measure and set targets for this indicator. Currently, there are a limited number of HIV+ clients who receive PCM services from MDH HIV prevention program grantees. Until more data is available, we will keep the target for this measure at the baseline level of 69%.

2. Please provide justification for any baseline, target, and/or performance goal measures that **are not** provided in this 2005 Interim Progress Report.

Note: MDH also included the following justification in the 2004 APR submitted to CDC in May 2005.

Numerators and denominators are not provided for the baseline measure because the baseline was arrived at by asking agencies conducting PCM to estimate a percentage of their clients reached who completed the planned number of sessions. MDH did not provide numerators or denominators for the target goals because historical data to help develop these targets is not available. MDH has provided a target proportion for the one and five year goals. It would be helpful to have more information in the technical assistance guidelines regarding setting targets for all of the indicators, especially where targets for numerators and denominators are to be provided.

Answer questions 3-5 below if you revised your 2003 baseline, 2005 target, and/or 2008 5-year performance goal measures for this performance indicator. Indicate "Not applicable" (NA) as needed.

3. For each measure listed below, explain your reason(s) for revising the original measure. Describe any challenges you experienced in developing the original measure.

Not applicable.

4. How did you address the challenges described above in order to revise your 2003, 2005, and/or 2008 measures?

Not applicable.

5. Explain how you developed each revised measure. List data sources (e.g., surveillance data, sample surveys, other resources/documents) and describe analytic methods used to develop the revised measure (e.g., trend analysis, peer consultation).

Not applicable.

Prevention with Infected Persons Performance Indicators							
Program Performance Indicator I.2: Percent of HIV infected persons who, after a specified period of participation in prevention case management, report a reduction in sexual or drug using risk behaviors or maintain protective behaviors with seronegative partners or with partners of unknown status.							
	2003 (Baseline)		**2005** (Target)		**2006** (Target)	**2008** (5-Year Goal)	
	Original	Revised	Original	Revised	New	Original	Revised
Numerator: The number of HIV infected persons in PCM reporting a reduction in sexual or drug using risk behaviors or maintain protective behaviors with seronegative partners or with partners of unknown status.							
Denominator: The number of HIV infected persons enrolled in PCM.							
Proportion = (numerator / denominator) x 100							

1. How did you develop your new 2006 target measure for this performance indicator? List data sources (e.g., surveillance data, sample surveys, other resources/documents) and describe analytic methods used to develop this measure (e.g., trend analysis, peer consultation).

See response to number 2 below.

2. Please provide justification for any baseline, target, and/or performance goal measures that **are not** provided in this 2005 Interim Progress Report.

Currently, one agency is funded by the MDH to provide PCM for persons living with HIV/AIDS. In 2003, this agency provided PCM services to three HIV+ persons, two of whom were found to have reduced their risk behaviors after receiving PCM services. In 2004, this same agency provided PCM services to two HIV+ individuals, and reported a reduction in HIV risk behavior for both of those clients. Despite these observed changes, as we reported in our last interim progress report, MDH does not feel it has adequate information with which to develop a baseline measure or target goals for this indicator due to the low numbers of clients reached.

Answer questions 3-5 below if you revised your 2003 baseline, 2005 target, and/or 2008 5-year performance goal measures for this performance indicator. Indicate "Not applicable" (NA) as needed.

3. For each measure listed below, explain your reason(s) for revising the original measure. Describe any challenges you experienced in developing the original measure.

Not applicable.

4. How did you address the challenges described above in order to revise your 2003, 2005, and/or 2008 measures?

Not applicable.

5. Explain how you developed each revised measure. List data sources (e.g., surveillance data, sample surveys, other resources/documents) and describe analytic methods used to develop the revised measure (e.g., trend analysis, peer consultation).

Not applicable.

Other Required Information

A. Assurance of Compliance

The Assurance of Compliance is included as Attachment B.

B. Grants Management Checklist

The Grants Management Checklist is included as Attachment C.

C. Letter of Concurrence

The letter of concurrence from the CCCHAP is included as Attachment D.

D. Comprehensive HIV Prevention Plan

The *Minnesota Comprehensive HIV Prevention Plan 2006 – 2008* is included as Attachment E (not included).

Attachment A

Budgets for Modified HERR Programs

(not included)

Attachment B

Assurance of Compliance

ASSURANCE OF COMPLIANCE
with the

"REQUIREMENTS FOR CONTENTS OF AIDS-RELATED WRITTEN MATERIALS, PICTORIALS, AUDIOVISUALS, QUESTIONNAIRES, SURVEY INSTRUMENTS, AND EDUCATIONAL SESSIONS IN CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC) ASSISTANCE PROGRAMS"

By signing and submitting this form, we agree to comply with the specifications set forth in the "Requirements for Contents of AIDS-Related Written Materials, Pictorials, Audiovisuals, Questionnaires, Survey Instruments, and Educational Sessions in Centers for Disease Control and Prevention (CDC) Assistance Programs," as revised June 15, 1992, 57 Federal Register 26742.

We agree that all written materials, audiovisual materials, pictorials, questionnaires, survey instruments, proposed group educational sessions, educational curricula and like materials will be submitted to a Program Review Panel. The Panel shall be composed of no less than five (5) persons representing a reasonable cross-section of the general population; but which is not drawn predominantly from the intended audience. (See additional requirements in attached contents guidelines, especially paragraph 2.c. (1)(b), regarding composition of Panel.)

We agree that all written materials, audiovisual materials, pictorials, questionnaires, survey instruments, proposed group educational sessions, educational curricula and like materials will be submitted to a Program Review Panel. The Panel shall be composed of no less than five (5) persons representing a reasonable cross-section of the general population; but which is not drawn predominantly from the intended audience. (See additional requirements in attached contents guidelines, especially paragraph 2.c. (1)(b), regarding composition of Panel.)

The Program Review Panel, guided by the CDC Basic Principles (set forth in 57 Federal Register 26742), will review and approve all applicable materials prior to their distribution and use in any activities funded in any part with CDC assistance funds.

Following are the names, occupations, and organizational affiliations of the proposed panel members: (If panel has more members than can be shown here, please indicate additional members on the reverse side.)

NAME	OCCUPATION	AFFILIATION
Howard Ellis	Health Educator/Outreach Worker	Turning Point
Luz Sánchez	Latino Program Manager	HealthEast Care System – St. Joseph's Hospital
Alice Lynch	Executive Director	Black, Indian, Hispanic and Asian Women in Action
Amy Weiss	Director of Communications	Minnesota AIDS Project
Aaron Keith Stewart	DEBI Adaptation Specialist	Program in Human Sexuality
Roy Nelson	Health Educator	Minnesota Department of Health
Rob Yaeger	Program Specialist	Minnesota Department of Health *(panel chair)*
Charlie Tamble	Community Health Specialist	Hennepin County *(consultant to review panel)*
Dori Makundi	African Services Initiative Coordinator	Minnesota AIDS Project

Minnesota Department of Health **Applicant/Grantee Name**	U62/CCU523491 **Grant Number (If Known)**
K Beardsley **Signature: Project Director**	Mark Benzoit **Signature: Authorized Business Official**
Date: September 7, 2005	**Date: September 7, 2005**

CDC 0.113 (Revised 3/93)

Statement of Compliance with Content of HIV/AIDS-Related Written Materials, Pictorials, Audiovisuals, Questioners, Survey Instruments, and Education Sessions

NO NEW HIV/AIDS RELATED MATERIALS FORM

Agency Name:	Minnesota Department of Health
Date:	September 7, 2005
Program Announcement:	04012
Award Number:	U62/CCU523491

To comply with the requirements described in the Review of Contents of *HIV/AIDS-Related Written Materials, Pictorials, Audiovisuals, Questioners, Survey Instruments, and Education Sessions*, published in the Federal Register on June 15, 1992, I certify that from the period of January 1, 2005 through August 31, 2005 that all of the materials we are using have been approved by our content review panel. We also certify that we have previously sent documentation of approval or disapproval to CDC for all the materials we are currently using.

Sincerely,

Signature:	K Beardsley
Name:	Kip Beardsley
Title:	Manager, STD and HIV Section

Statement of Compliance with Content of HIV/AIDS-Related Written Materials, Pictorials, Audiovisuals, Questioners, Survey Instruments, and Education Sessions

MATERIALS SUBMITTED WAITING FOR RESPONSE FORM

Agency Name:	Minnesota Department of Health
Date:	September 7, 2005
Program Announcement:	04012
Award Number:	U62/CCU523491

To comply with the requirements described in the Review of Contents of *HIV/AIDS-Related Written Materials, Pictorials, Audiovisuals, Questioners, Survey Instruments, and Education Sessions*, published in the Federal Register on June 15, 1992, I certify that there are no submitted materials pending review from the period January 1, 2005 through August 31, 2005.

Sincerely,

Signature:	K Beardsley
Name:	Kip Beardsley
Title:	Manager, STD and HIV Section

Statement of Compliance with Content of HIV/AIDS-Related Written Materials, Pictorials, Audiovisuals, Questioners, Survey Instruments, and Education Sessions

SUBMITTED MATERIALS FORM

Agency Name:	Minnesota Department of Health
Date:	September 7, 2005
Program Announcement:	04012
Award Number:	U62/CCU523491-01

To comply with the requirements described in the Review of Contents of *HIV/AIDS-Related Written Materials, Pictorials, Audiovisuals, Questioners, Survey Instruments, and Education Sessions*, published in the Federal Register on June 15, 1992, I certify that the following list of materials were submitted and reviewed by our Content Review Panel.

Name of Material	Date of Approval	Date of Disapproval
"9 Sexually Responsible Behaviors" brochure	1/24/05	
"African Proverb Posters" (six varieties)	1/24/05	
"African Talking Posters" (five varieties)	1/24/05	
"AIDS Information Duluth – Street Smart Program" brochure	1/24/05	
"AIDS Information Duluth" brochure	1/24/05	
"Developmental Stages of Bisexual Men in Straight Relationships" article	1/24/05	
"FAQs Safer Sex" brochure	1/24/05	
"FAQs STD" brochure	1/24/05	
"Grrls on Grrls and HIV" brochure	1/24/05	
"H.I.M. Program Between Men Discussion Group" pre/post test evaluation	1/24/05	
"HIV – Understanding Your Risk" brochure	1/24/05	
"How to Say No to Unwanted Sexual Attention" brochure	1/24/05	
"MAP AIDSLine Brief" newsletters: winter '05	1/24/05	
"MAP Gay/Bi Health Life Skills Group: Series 1" curriculum	1/24/05	
"MAP Gay/Bi Health Outreach Team Meetings Jan-June 2005" curriculum	1/24/05	
"Pillsbury House – Health Education Program" insert for safer sex packets	1/24/05	

Name of Material	Date of Approval	Date of Disapproval
"Sex, Communication and Respect" brochure	1/24/05	
"STD Test – Get Yours" brochure	1/24/05	
"Street Smart Enrollment Form" form	1/24/05	
"Street Smart Focus Group Interview Evaluation" evaluation	1/24/05	
"Street Smart Focus Group Interview" planning sheet	1/24/05	
"Street Smart Participant Intake Form" form	1/24/05	
"Street Smart Survey" survey	1/24/05	
"Teaching Your Teen About Sexual Responsibility" brochure	1/24/05	
"Mbiu – Issue #2" newsletter	2/14/05	
"A Guide to HIV Drug Resistance" booklet	3/21/05	
"Abscess 411" brochure	3/21/05	
"Bear, Butch, Femme or Fag?" Café Chat curriculum	3/21/05	
"Big Gay Movie Night 2005 Movie Selections" listing	3/21/05	
"Could You Have Hepatitis C?" brochure	3/21/05	
"Hepatitis B: Your Child at Risk" brochure	3/21/05	
"Hepatitis C…Isn't that the one I have been vaccinated for?" post card	3/21/05	
"Hepatitis: What You Should Know" fact sheet		3/21/05
"HIV Disclosure Issues" curriculum	3/21/05	
"HIV Quick Quiz" quiz	3/21/05	
"How to Prevent Hepatitis B" brochure	3/21/05	
"Pow-Wow Leadership Training" Module	3/21/05	
"Safer Sexuality: Erotic Choices III" DVD	3/21/05	
"Sex & the Internet" curriculum & media	3/21/05	
"STD Fact Sheets"	3/21/05	
"Straight Folks Together" flyer & curriculum	3/21/05	
"What Older Adults Need to Know About HIV and Other STDs" brochure	3/21/05	
"A Call to Men of Color / HIV and Men" brochure	5/16/05	
"African HIV/AIDS Educational Brochure" brochure	5/16/05	
"Aliveness Project Newsletter" article (May '05 edition)	5/16/05	
"Beyond Vanilla" DVD	5/16/05	

Name of Material	Date of Approval	Date of Disapproval
"Crystal Meth Pride 2004" poster	5/16/05	
"Huge Sale! Buy Crystal, Get HIV Free!" poster	5/16/05	
"Keep Free from HIV: For Men" brochure	5/16/05	
"La Planifcacion Familiar?" book (half of book)	5/16/05	
"MAP AIDSLine Brief" newsletters: Pride / June edition	5/16/05	
"Meth = Death" card	5/16/05	
"Positive Power Retreat and Core Group Curriculum" curriculum	5/16/05	
"Protect Yourself from HIV: For Women" brochure	5/16/05	
"Safe Disposal Options For Home – Generated Needles and Sharps" brochure	5/16/05	
Crystal Cards: "My rule was to always use condoms…"; "I hooked up with these bruthas at a sex party…"; "We had a few cocktails…"; "I wanted to forget about being HIV positive…"; "I hooked up with these guys at the bathhouse…"; "I did some crystal so I could party all night…"; "I never wanted to give him HIV…"; "I did a bump of crystal on Friday night…"; "I was looking to hook up online and PNP…"; "I never wanted to give anyone HIV…"; "I used to always play safe…"; "Cada fin de semana nos íbamos de fiesta…"	5/16/05	
Crystal Mess posters: "Horny and impotent, what an attractive combination."; "Your career took up too much time anyways."	5/16/05	
Life or Meth posters: "Would you ingest drain cleaner & antifreeze?"; "Tina destroys the life & soul of the party."; "Turn your back on Meth…not on life."; "You can break free…from Tina's grip."; "Just one night with Crystal Meth…can undo years of safe sex."	5/16/05	
Project Neon Meth posters: "If you want to know about shooting crystal, ask someone who knows…"; "I just told my best friend I shoot crystal…"; "My best friend just told me he shoots crystal…"; "Live thru crystal"	5/16/05	
"Mbiu" newsletter	6/25/05	
"For Comfort and Safety, Use Insulin Needles Only Once" instructional card	7/18/05	
"We're Here for You" outreach card	7/18/05	
"La Planificación Familiar?" book (second half of book)	7/18/05	
"MAP AIDSLine Brief" newsletters: July/August '05	7/18/05	
"MAP Gay/Bi Health Outreach Team Meetings Curricula, July – December 2005" curriculum	7/18/05	

Name of Material	Date of Approval	Date of Disapproval
"Safe Sex Counts…And So Do You!" / "El Sexo Seguro Cuenta…y también cuentas tú!" outreach card	7/18/05	
"HIV Prevention and the Whole Person" article by Bill Burleson	7/18/05	
"Knowing is Beautiful" set of 9 ads	7/18/05	
"The KNOW is spreading" set of 5 ads	7/18/05	

Sincerely,

Signature:	K Beardsley
Name:	Kip Beardsley, MPH
Title:	Section Manager & State AIDS Director STD and HIV Section

CERTIFICATION OF COMPLIANCE

Requirement: Content of AIDS-Related Written Materials, Pictorials, Audiovisuals, Questionnaires, Survey Instruments and Educational Sessions – **Recipient Web Site Notices**

Grant/Cooperative Agreement Number: U62/CCU52349

Grantee Name: Minnesota Department of Health

☑ I certify that this organization has complied with the terms and conditions of the above referenced requirement.

☐ I certify that the requirement for a web notice is not applicable to this organization. If the requirement is not applicable, please state why:

Please list below the primary web address(es) (URLs) impacted by this requirement:

http://www.health.state.mn.us/divs/idepc/diseases/hiv/index.html

Signature of Authorized Certifying Official:	**Title:**
K Beardsley	Manager, STD and HIV Section
Applicant Organization:	**Date Submitted:**
Minnesota Department of Health	September 7, 2005

Attachment C

Grants Management Checklist

GRANTS MANAGEMENT CHECKLIST

Business Official **to be notified if an award is to be made.**	**Program Director/Project Director/Principal Investigator** **designated to direct the proposed project or program.**
NAME: Mark Bergquist	NAME: Kip Beardsley
TITLE: Federal Grants Administrator	TITLE: Section Manager/State AIDS Director
ORGANIZATION NAME: Minnesota Department of Health	ORGANIZATION NAME: Minnesota Department of Health
ADDRESS: (Include 5+zip code) 85 East 7th Place, PO Box 64882 St. Paul, MN 55164-0882	ADDRESS: (Include 5+zip code) 717 Delaware Street SE, PO Box 9441 Minneapolis, MN 55440-9441
E-MAIL ADDRESS: mark.bergquist@health.state.mn.us	E-MAIL ADDRESS: kip.beardsley@health.state.mn.us
TELEPHONE NUMBER: 651-215-6050	TELEPHONE NUMBER: 612-676-4038
FAX NUMBER: 651-296-5276	FAX NUMBER: 612-676-5739

Attachment D

Letter of Concurrence

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, maintaining and improving the health of all Minnesotans

September 20, 2005

Centers for Disease Control and Prevention
Acquisition and Assistance Branch A
Procurement and Grants Office
Attn: Merlin Williams, Grants Management Specialist
PA 04012 for Year 3
2920 Brandywine Road, Room 3000, Mailstop E-15
Atlanta, Georgia 30341

Re: HIV Prevention Cooperative Agreement No. **U62/CCU523491-03**

Dear Ms. Williams:

We are pleased to submit for your consideration the interim progress report/continuing application from the Minnesota Department of Health (MDH) for the continuation of Minnesota's HIV prevention funding under program announcement 04012. The total amount requested for the maintenance of our planning efforts and prevention programs is $3,269,160.

The Community Cooperative Council on HIV/AIDS Prevention (CCCHAP) confirmed by consensus on September 9, 2005 its concurrence with the application. The CCCHAP has reviewed the proposed activities and budget for 2006 and finds them to be responsive to the priorities identified by the CCCHAP and described in the *Minnesota Comprehensive HIV Prevention Plan 2006 – 2008*.

We feel that the process used to review the prevention plan and application provided the opportunity for CCCHAP members to provide input and guidance for the documents. Each community planning group member received two chapters of the draft version of the new *Minnesota Comprehensive HIV Prevention Plan 2006 – 2008* two weeks prior to the August meeting. The chapters were assigned so that at least five CCCHAP members were responsible for reviewing each chapter. The entire draft plan was also available to members who wished to review more than the two chapters they were assigned. Feedback and suggested changes and additions were solicited from members at the August meeting, and those that could not attend were invited to submit comments by phone or e-mail.

CCCHAP members subsequently received a copy of the draft interim progress report/application two weeks prior to the September meeting. At the same time, they received a copy of the entire comprehensive prevention plan, which had been revised based on the feedback provided by the CCCHAP. On the first day of the September meeting, the CCCHAP provided feedback on the interim progress report/application. Several changes to the application were made based on CCCHAP feedback, and the revisions were presented to the CCCHAP on the second day of the meeting.

The CCCHAP then engaged in small group and large group discussion related to concurrence. The concurrence discussion focused on comparing the priorities established by the CCCHAP in 2005 as described in the prevention plan to the description in the application of the Request for Proposals (RFP) process that will be implemented by the MDH in October 2005, with funding to start on July 1, 2006. The co-chairs then called for consensus on concurrence from the full membership.

We believe that the RFP process described in this application responds to the priorities established through the community planning process and that the programs selected through the RFP process will contribute to limiting HIV infection and associated morbidity and mortality in Minnesota.

However, we would like to take this opportunity to voice the following concerns:

- The amount of federal HIV prevention funding available to the state of Minnesota is inadequate. Although the HIV prevention needs of HIV positive and high-risk populations have become more diverse and complex over time, the amount of federal funding has not increased. Instead, Minnesota has experienced a decrease in federal funding during the past few years and no increase in state HIV prevention funds. In 2006, the amount of federal and state funding will not be sufficient to implement comprehensive HIV prevention programs in all of the priority target populations identified by the CCCHAP; in fact, some of the priority populations will receive no funding at all. Following are specific examples of the impact of inadequate funding:
  - The amount of funding is insufficient to address disparities that impact HIV infection and transmission within communities of color and sexual minority populations.
  - The amount of funding does not allow the MDH to adequately implement counseling, testing and referral (CTR) services and efforts to normalize HIV testing within some populations that experience the greatest HIV-related stigma.
  - There is not enough funding to support culturally and linguistically appropriate education and informational materials in Asian/Pacific Islander communities that experience language barriers to mainstream HIV prevention education efforts.

- The current political climate places constraints on implementing interventions that have been scientifically proven to be effective with high-risk populations. This political climate particularly impacts effective HIV prevention efforts targeting youth and men who have sex with men.

- The MDH did not develop and share its plan to allocate funds to each target population until after the CCCHAP had completed its prioritization process (in the past, the MDH has only allocated funds to the major populations categories [e.g. HIV+, MSM, HRH, IDU] and funding to each of the target populations was determined through the RFP process). The allocations formula based on incidence and prevalence does not provide sufficient funding to youth populations. Youth tend to get tested for HIV at a later age and so are not adequately represented in incidence and prevalence data.

Please contact Kip Beardsley, Manager of the STD and HIV Section, at 612-676-4038 if you have any questions, or would like more information on any aspect of this interim progress report/continuing application. Thank you for your consideration.

Sincerely,

Geraldine Anderson

Minister Geraldine Anderson, Community Co-chair
Community Cooperative Council on HIV/AIDS Prevention

Rosemary Thomas

Rosemary Thomas, Community Co-chair
Community Cooperative Council on HIV/AIDS Prevention

K Beardsley

Kip Beardsley, MDH Co-chair
Community Cooperative Council on HIV/AIDS Prevention

Attachment E

Minnesota Comprehensive HIV Prevention Plan

(not included)

Correction to MDH HIV Prevention Funding Application, pages ~~32–34~~ 27-29

B. Modifications to Health Education and Risk Reduction Grantees

This table summarizes the information requested for HERR grantees that had modifications to their contracts. From July 2004 through June 2005, fifteen agencies were funded through a competitive RFP process to implement health communication/public information activities targeting African communities. An additional three agencies were added for the time period of January 2005 through June 2005. These contracts were implemented in response to steadily increasing rates of new HIV infections among African-born individuals reported to the MDH in recent years. Health communication/ public information was chosen as the intervention based on needs assessment activities conducted in 2003 that indicated a need for greater community awareness of HIV in order to combat the very high levels of stigma and denial that exist in African communities, as well as to increase individual knowledge regarding HIV and risk reduction strategies.

A subset of these agencies was identified for continued funding from July 2005 through June 2006. The eleven agencies were selected based on the following criteria: programs target African communities with the highest incidence and prevalence (Ethiopian/Oromo, Kenyan, Cameroonian, Liberian, and Somali); programs satisfactorily met the requirements of the original grant agreement; and programs met the objectives of the original grant agreement. Grant managers' observations during site visits were also taken into consideration.

The funded agencies are required to submit narrative reports on their progress twice a year, and the contract manager conducts site visits with each agency to identify successes, challenges, and technical assistance needs.

All of the agencies are funded through state dollars. The itemized budgets and budget narratives are provided for all agencies in Attachment A (not included).

Agency and Period of Performance	Target Population	Interventions and # of Clients (6 month target)	Evidence Basis
African Assistance Program, Inc (AAP) 7710 Brooklyn Boulevard, Suite # 206 Brooklyn Park, MN 55428 July 1, 2005 – June 30, 2006	Liberian	*Health Communication/Public Info* – HIV/AIDS public service announcements (PSAs) on Cable TV most watched by the Liberian community (2,500 viewers) – HIV/AIDS educational TV programs targeting three Liberian tribes (2,500 viewers) – Collaborate with Project Lifeline to conduct HIV/AIDS presentations at Liberian places of worship, awareness training to Liberian clergy; host HIV/STD prevention and awareness events, reach youth through music and poetry	Needs assessment data

AGENCY AND PERIOD OF PERFORMANCE	TARGET POPULATION	INTERVENTIONS AND # OF CLIENTS (6 MONTH TARGET)	EVIDENCE BASIS
Kids Home International (KHI) 2700 Stevens Ave South Minneapolis, MN 55408 July 1, 2005 – June 30, 2006	Kenyan	*Health Communication/Public Info* – HC/PI presentation targeting youth (10 youth) – In collaboration with places of worship, conduct HC/PI presentations during services (203 people) – Conduct HC/PI presentations to different Kenyan cultural groups (190 people)	Needs assessment data
Mestawet Ethiopian Newspaper 1821 University Avenue West, Suite #318 Saint Paul, MN 55104 July 1, 2005 – June 30, 2006	Ethiopian	*Health Communication/Public Info* – HC/PI presentations at two Ethiopian places of worship (200 participants) – Newspaper HIV/AIDS fact sheets (7,500) – In collaboration with Abissinia Ethiopian TV and Ethiopian radio, regularly interview leaders on HIV/AIDS related topics. Also run HIV/AIDS PSAs on radio/TV (5,000 Ethiopian listeners/viewers)	Needs assessment data
Minnesota African Women's Association (MAWA) 1201 37th Avenue North Minneapolis, MN 55412 July 1, 2005 – June 30, 2006	Liberian	*Health Communication/Public Info* – HC/PI presentations to Liberian women in small groups at locations they congregate (100 participants) – Provide basic HIV education on African Cable TV targeting the Liberian community as a whole	Needs assessment data
Nyagetinge Umoja 2316 Fernside Lane Mound, MN 55364 July 1, 2005 – June 30, 2006	Kenyan	*Outreach* – HIV prevention education activities at social events, birthday parties, pre-wedding parties (225 people) *Health Communication/Public Info* – HC/PI presentations at places of worship and at Kenyan community forum (100 people) – Reach youth through music and poetry performed by peers (50 youth)	Needs assessment data
Oromo Community of Minnesota, Inc (OCM) 1505 South 5th Street Minneapolis, MN 55454 July 1, 2005 – June 30, 2006	Oromo	*Health Communication/Public Info* – Two HC/PI presentation targeting youth (28 youth) – Two HC/PI presentation targeting an existing Oromo women group that meets monthly (28 women) – Two HC/PI presentation targeting elders (25 elders) – Two HC/PI presentations at community events (300 people) – HIV/AIDS prevention education on Oromo TV and radio (3,500 listeners/viewers)	Needs assessment data

AGENCY AND PERIOD OF PERFORMANCE	TARGET POPULATION	INTERVENTIONS AND # OF CLIENTS (6 MONTH TARGET)	EVIDENCE BASIS
Project Valentine (PV) 2135 44th Avenue North Minneapolis, MN 55364 July 1, 2005 – June 30, 2006	Cameroonian	*Health Communication/Public Info* – Present HIV/AIDS education to large group in the form of drama, poetry and music (200 people)	Needs assessment data
Somali Community Resettlement Services, Inc (SCRS) 1903 S. Broadway Rochester MN 55904 July 1, 2005 – June 30, 2006	Somali	*Health Communication/Public Info* – HIV/AIDS PSAs on local Somali TV (7,500 viewers) – HC/PI for Somali youth group, women's group, and Somali community as a whole (103 people) – Conduct interviews on local Somali TV on HIV/AIDS epidemic among Africans (7,500 viewers)	Needs assessment data
Somali Health Project (SHP) 416 E Hennepin Avenue, Suite #109 Minneapolis, MN 55414 July 1, 2005 – June 30, 2006	Somali	*Health Communication/Public Info* – HC/PI presentations at Somali community gatherings, community center, Somali places of worship, etc. (240 people)	Needs assessment data
Sub-Saharan African Youth and Family Services in Minnesota (SAYFSM) 1885 University Ave West Saint Paul, MN 55104 July 1, 2005 – June 30, 2006	Oromo and Ethiopian	*Health Communication/Public Info* – HC/PI presentations in community and/or places of worship (150 participants) – Collaborative broadcasts (Oromo and Amharic radio and cable TV) to present and educate in the area of HIV/AIDS (5,500 listeners/viewers) – Collaborate with Wee Care Family Services Inc. to provide HIV/AIDS HC/PI presentations specific to youth, women, and men separately (60 participants)	Needs assessment data
Zyombi Project (ZP) 1351 23rd Street Minneapolis, MN 55404 July 1, 2005 – June 30, 2006	Cameroonian	*Health Communication/Public Info* – HC/PI presentations to community leaders (20 community leaders) – HC/PI presentations at traditional Cameroonian festivities, birthdays, weddings, etc. (100 people) – HC/PI presentations to three Cameroonian cultural groups (60 people)	Needs assessment data