HIV/AIDS Unmet Need and Rebate Fund Use Report

MN DHS DSD HIV/AIDS Unit
Dec. 14, 2014

For more information contact:

Minnesota Department of Human Services
HIV/AIDS Unit
P.O. Box 64972
St. Paul, MN 55164-0972
651-431-2414

Minnesota Department of **Human Services**

Legislative Report

This information is available in accessible formats to individuals with disabilities by calling 800-627-3761

Or by using your preferred relay service.

For other information on disability rights and protections, contact the agency's ADA coordinator.

Minnesota Statutes, Chapter 3.197, requires the disclosure of the cost to prepare this report. The estimated cost of preparing this report is $105,669.

Printed with a minimum of 10 percent post-consumer material. Please recycle.

I. Table of Contents

I. Executive summary

This report was created as a response to the Legislative mandate directing the DHS HIV/AIDS Unit to work with stakeholders to identify unmet needs for persons living with HIV/AIDS in Minnesota and the appropriate use of AIDS Drug Assistance Program (ADAP) pharmaceutical rebate revenue to meet the identified needs. As directed by the mandate, the planning process involved community stakeholders including the Minnesota Ryan White HIV Services Planning Council. The information contained in the report outlines the process and conclusions reached by the DHS HIV/AIDS Unit in conjunction with our community partners for the appropriate use ADAP rebate revenue. DHS is not requesting any legislative action.

II. Legislation

Laws of Minnesota 2014, Chapter 312, Article 30, Section 2:

Services for individuals living with HIV/AIDS.

The commissioner shall work with community stakeholders, including the HIV Planning Council, to identify gaps in services for individuals living with HIV/AIDS and, within allowable state and federal law and guidelines, develop and implement a plan to use funds in the ADAP drug rebates special revenue account to enhance existing service levels and establish an amount to retain in the account to ensure long-term stability of services. The commissioner shall report the results of this work with stakeholders and the progress on implementing the plan to the chairs and ranking minority members of the senate health and human services finance division and the house of representatives health and human services finance committee by December 15, 2014. DHS was given legislative authority to implement this system and DHS is not requesting any legislative action.

III. Implementation and Spending Priorities

The DHS HIV/AIDS Unit contracted with consulting firm Advanced Strategies Inc. to assist in engaging community Stakeholders in a planning process to identify gaps in services for persons living with HIV/AIDS in Minnesota. The use of an outside consulting firm was intended to help DHS remain as transparent as possible in the process. Participants at the meetings were encouraged to submit all ideas for where they felt need existed and not just limit their ideas to previous types of services that have been provided through Ryan White funding.

The planning process involved a series of three meetings. The first meeting was designed to define what services a successful HIV Care Continuum would contain and initial brainstorming of what the unmet needs are. The second meeting identified criteria for ranking unmet need and identifying and describing what those needs were. The third meeting applied the criteria to the unmet need and developed a ranked list of those needs. The complete planning process is outlined and detailed in the Advanced Strategies Report, which is attached at the end of this report.

Based on fiscal forecasting, DHS HIV/AIDS Unit staff submitted to the stakeholders a fiscal estimate of $4,750,000 to be held in reserve to ensure the ongoing operation of program services. That estimate includes $1,500,000, which would allow for 90 days of grant contract operation. Grant contract operations include HIV medical case management and other supportive services. $3,250,000 would be held for the ongoing operation of the ADAP program. The ADAP Program funds are used to purchase HIV anti-retroviral medications and the payment of insurance premiums.

Some of the rationale for arriving at this fiscal forecast included:

Revenues

- There is a trend of decreasing revenues from FY 13-15.
    - DHS received a **double state appropriation** in FY 13 to repay a payment shift from previous fiscal years. **(Roughly $2.2 million).** In FY 14, the State received the standard state appropriation amount for insurance- about **($1.1 million).** In FY 15, the State appropriation was **eliminated** on a one-time basis.
    - The rebate collections are down for FY 15. In FY 13 and FY 14, we received about $**9.3-$9.7 million in rebate revenues.** However, we are not receiving as much in supplemental rebate funds. We are showing reduced rebate revenue in FY 15 of about **$4.5 million and then $6 million ongoing.**

Expenditures:

- The trend until FY 15 has been steady: Since 2011, we spent about **$10 million** and in FY 14, we spent about **$10.7 million**. This includes spending for insurance, medications and other program costs and administrative costs. Drug costs have been very steady with some variations in insurance costs (which dropped in FY 14) and increases in other program costs.
    - In FY 15, we are projecting higher program costs for rebate (**about $8 million**) That figure also includes making up for the eliminated appropriation for case management about **$1.1** million.

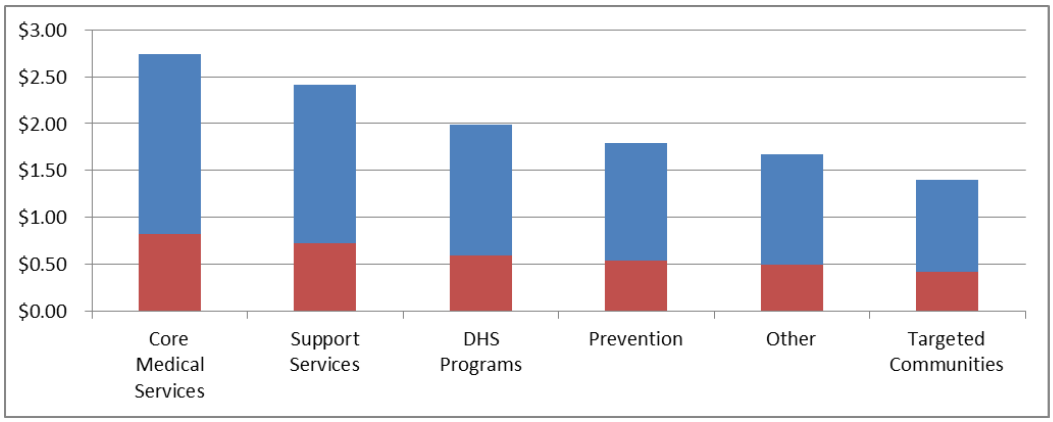
- In FY 15, we are also assuming that insurance costs will return to normal spending amounts. We will be reviewing these trends as well for the updated forecast.
- In FY 16-17, we did not project as much spending in other rebate costs. We included only the projections that we had in the previous forecast.

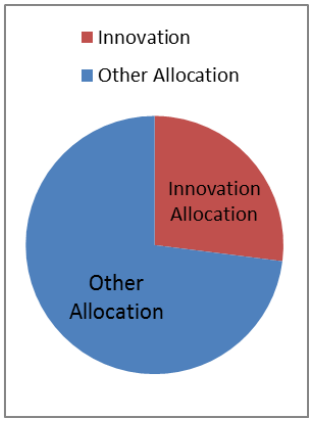
The group was presented with a figure of $12 million, which could be used for meeting the unmet needs identified through the planning process. As a result, the group reached this consensus for how these additional funds should be distributed.

Category	Dollars Allocated (in millions)	Percent of Total
Core Medical Services*	$2.72	23%
Support Services*	$2.41	20%
DHS Programs	$1.99	17%
Prevention	$1.79	15%
Other	$1.67	14%
Targeted Communities**	$1.40	12%

*Highest Priority for Fund Allocation

** Some participants felt that the needs of targeted communities would be addressed by activities in the other categories.





Based on the distribution plan agreed on by the group, DHS is recommending a $12 million disbursement to be implemented in three phases beginning 02/01/2015. By phasing implementation, those recommendations that can be implemented quickly will be acted upon first, while others that require more time to appropriately recruit interest, select vendors and develop contracts will follow. The first phase would be implemented by 06/30/2015 and would include funding to expand ADAP services by raising the eligibility criteria for services and expanding the scope of services provided. This includes raising the income eligibility standard for the Ryan White program from 300% to 400% of the Federal Poverty Guideline (FPG), and paying for the Medical Assistance for Employed Persons with Disabilities (MA-EPD) and Minnesota Care (MNCare) premiums for people who are in Program HH. The first phase would also allow for existing contract expansion, new grant RFPs and Centralized intake planning, which is a project that would create one centralized point for determining eligibility for Ryan White programs. This centralized intake process will include Program HH and all other support services provided through Ryan White funding. Centralized intake would allow a potential client to

apply to one entity and have eligibility determined for all services provided through the Ryan White HIV Care Continuum.

The second phase of funding would be committed by 10/31/2015 and the third phase would be committed by 01/15/2016. The second and third phases would build on items rolled out in phase one and allow for further expansion of services through RFP's. A phased spending plan will also allow us to monitor the continued implementation of the Affordable Care Act and any impact that may have on the Program fiscal forecast.

HIV/AIDS Unmet Needs Prioritization Facilitators' Report

December 15, 2014

Provided for:
Dave Rompa
MN DHS-HIV/AIDS Unit
dave.rompa@state.mn.us

Prepared by:
Kathleen Burek, Richard Branton and Kahil Branton
Advanced Strategies, Inc.
kburek@advstr.com
rbranton@advstr.com
kbranton@advstr.com

I. Executive Summary

As part of meeting its legislative mandate to develop and implement a plan to use funds in the ADAP drug rebates special revenue account to enhance existing service levels, the Minnesota Department of Human Services contracted with Advanced Strategies, Inc. to facilitate three community meetings between July and November 2014.

The meetings, which were open to any interested person, concerned about unmet needs of persons living with HIV/AIDs. Over 90 people attended at least one meeting. Participants consisted of people with a wide range of perspectives, including consumers with HIV/AIDS, community advocates (including the MN AIDS Project), providers of services, public and private agencies and members of advisory groups such as the HIV Planning Council. The facilitators also provided a website with meeting summaries, handouts, surveys, and an email address. The website permitted people who were not able to attend meetings to follow the process, and to communicate their thoughts with the facilitators.

DHS ultimately determined that $12 million could be made available from the drug rebate fund for additional services for persons living with HIV/AIDS. As a cumulative result of these meetings, participants in the November 20 session recommended that the funds be distributed as follows, with 20%-30% allocated to innovative programs:

Category	Total Dollars Allocated (millions)	Innovation Dollars (millions)	Highest Priority Subcategories
Core Medical Services	$2.74	$0.55--$0.82	Mental health services
Support Services	$2.41	$0.48--$0.72	Housing: short-term assistance Case management-nonmedical (tied with) Emergency financial assistance
DHS Administered Programs	$1.99	$0.40--$0.60	Financial assistance for deductibles, copayments and premiums Expand eligibility for Ryan White to 400%
Prevention	$1.79	$0.40--$0.54	Prevention education
Other	$1.67	$0.33--$0.50	Housing: long-term assistance
Targeted Communities	$1.40	$0.28--$0.42	Not ranked

Following receipt of this report, DHS will review the conclusions and make its recommendations and plan to the Minnesota Legislature.

II. MN DHS HIV/AIDS Unmet Needs Prioritization Project

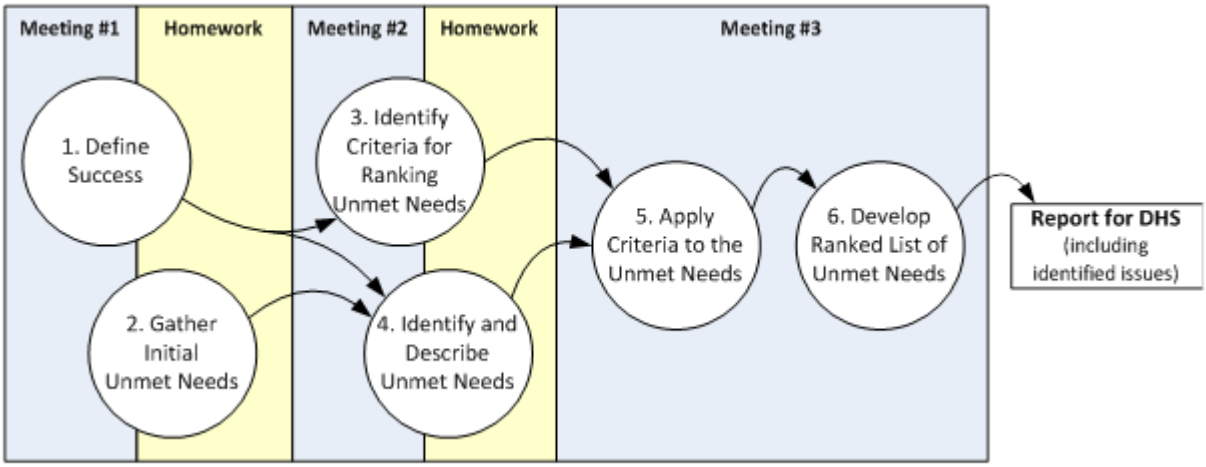
1. Introduction

In the spring of 2014, the Minnesota Legislature passed legislation requiring the Minnesota Department of Human Services to,

> "…work with community stakeholders, including the HIV Planning Council, to identify gaps in services for individuals living with HIV/AIDS and, within allowable state and federal law and guidelines, develop and implement a plan to use funds in the ADAP drug rebates special revenue account to enhance existing service levels and establish an amount to retain in the account to ensure long-term stability of services. The commissioner shall report the results of this work with stakeholders and the progress on implementing the plan to the chairs and ranking minority members of the senate health and human services finance division and the house of representatives health and human services finance committee by December 15, 2014".

To meet this requirement, the Minnesota Department of Human Services contracted with Advanced Strategies, Inc., to facilitate a series of community meetings. The purpose of the engagement was to gather input from stakeholders and develop consensus around priorities for the use of the ADAP drug rebate funds. Initially, the Department sought recommendations from this process by early fall. However, to accommodate community schedules and need for more time to communicate with their constituencies, the deadline for the Advanced Strategies report was extended into early December.

The initial process proposed by Advanced Strategies is summarized in the following diagram.



Advanced Strategies' approach was designed to develop consensus about unmet needs priorities. The consensus-building process works by first obtaining consensus on desired end results, and then on criteria for evaluating areas of need. If a group can agree on what is to be achieved, and which evaluation criteria are more important than others, then the priorities among the categories of unmet need could be set on agree-upon principles.

The most important driver for the project was obtaining the opinions of community participants about unmet needs. Hearing from consumers, advocates and service providers directly was a critical first step. Collection of "hard" data might be a subsequent step, but the priorities of stakeholders should be a crucial factor in driving the data collection priorities.

In an effort to ensure the broadest possible participation in the effort, Advanced Strategies developed a website specifically for the project, www.mnunmetneeds.com. The facilitators had hoped that asking for consumer input via this website would allow people who were unable to attend the

meetings to provide their input. (So that the community can continue to access project documents during the implementation phase, the website will be available until July 2015). Advanced Strategies understands that many in the HIV/AIDS community do not have internet access, so we also asked participants to work with their constituencies to gather their input.

2. Summaries of Community Meetings

Agendas and meeting notes from each of the Community Meetings are found in Appendix A. DHS staff sent meeting invitations to everyone on their mailing list. Meeting flyers were widely distributed. One objective was to broaden the participation beyond formal advisory committees and advocacy groups to persons living with HIV/AIDS.

Community Meeting #1—July 24, 2014

Advanced Strategies provided an overview of the project approach summarized above. Assistant Commissioner Loren Colman then addressed the group, and asked that participants include any unmet needs, not only those that might be funded via Ryan White drug rebate dollars. Mr. Colman explained that the Department wished to know what the unmet needs were, so that if necessary, new programs could be developed and new funding sought to meet the needs of the HIV/AIDS community.

To generate an initial list of unmet needs, participants were asked to respond to the following questions:

- What are the major challenges faced by:
  - People with HIV/AIDS?
  - Providers?
  - Family and Support Systems?
- What is working well for:
  - People with HIV/AIDS?
  - Those who provide services to people with HIV/AIDS?
  - Family and Caregivers/Support Systems?
- What are your major fears/concerns/worries going forward about services and programs provided to people with HIV/AIDS?
- What are your major hopes going forward about services and programs provided to people with HIV/AIDS?
- What are your initial thoughts on unmet needs of people living with HIV/AIDS?

Key themes emerging from the hundreds of comments received include (not in rank order):

- There are many different races, cultures, genders, sexual orientations, ages and life situations of persons living with HIV/AIDS. “One size” of programming does not fit all
- Chemical dependency and substance abuse treatment is a critical need in helping people keep jobs, insurance, maintain their drug regimens and also prevents the spread of the disease
- Basic survival needs such as housing and food are important needs., There is a desire for more housing that can help support persons living with HIV/AIDS to maintain their treatment, and to help care for people with HIV/AIDS who become ill
- More providers-of all kinds-are needed who are knowledgeable about the disease, and its impacts
- Drugs which reduce viral loads, and help prevent the spread of the disease, are an important need
- Prevention education is needed so people can avoid contracting the disease, and avoid spreading it

- The needs of an aging population of persons living with HIV/AIDS will impact existing facilities serving seniors
- The 300% of the Federal Poverty Guideline for eligibility for Minnesota's Ryan White program was felt to be too low. Concerns were also expressed about the "cliff effect" of cutoffs as opposed to sliding scales. A person whose income varies above and below the limit over time can cycle on and off programs, disrupting care.

The concerns noted above is not an exhaustive list, but sufficient to illustrate concerns of the HIV/AIDS community.

After the meeting, Advanced Strategies compiled all of the comments and generated a list of unmet needs categories, and developed a statement of desired end results and program characteristics. (See Appendix B). Advanced Strategies also developed a set of possible ranking criteria to use in prioritizing unmet needs. Participants were asked via the website to give us feedback on the documents posted there. Approximately 30 people responded. Results of the feedback survey were shared with the group on September 11.

Community Meeting #2—September 11, 2014

The objectives for the second meeting were:

- Identify and prioritize ranking criteria
- Share results from survey (as of 9/10/14)
- Identify categories of needs
- Assess categories of needs

The plan for achieving those objectives was to have the group discuss and re-work the ranking criteria, then to rank the criteria themselves.

The ranking criteria consisted of three categories:

- Unmet needs categories
- Candidate (possible) solutions
- Allocating funds

The group was then to examine the categories of unmet needs, and suggest any adjustments to the list. The group would then assess the unmet needs categories against the criteria. For example, if the group had felt that reducing disparities among communities (e.g., African Americans or rural Minnesotans) was more important than addressing total numbers of persons with the need, they might rank the categories of needs differently than if the importance of the criteria was revered. The revised Ranking Criteria are found in Appendix B.

After reviewing the ranking criteria and the survey feedback, some participants expressed frustration with the focus on process. They expressed their view that the primary objective of the project was to allocate the drug rebate dollars, and wanted to move more quickly to that objective. Assistant Commissioner Colman asked Advanced Strategies to revise the approach to meet the participants' requests for quicker action. It was agreed that via the website, consumers and providers would be asked to identify unmet needs and possible solutions. Providers would also be asked to provide an overview of their current programs, so that consumers would have a better idea of what services are available. The Department was asked to provide cost information about possible solutions for meeting unmet needs.

Several providers and consumers responded by submitting "mini-proposals". (See Appendix C).

The Department provided an assessment of unmet needs and costs of various possible solutions. (See Appendix D).

Community Meeting #3—November 20, 2014

The objectives for this meeting were to hear from DHS about how much drug rebate money would be available for distribution and to answer questions about the cost estimates. Then, participants would be able to allocate available drug rebate dollars across 6 high-level categories. Finally, the group would set priorities among the sub-categories of unmet needs. Proposals submitted by providers were included as examples, but not specifically allocated funds, or ranked.

Alex Bartolic, Director of the Disabilities Services Division, presented a draft forecast of the drug rebate fund. She indicated that up to $12 million of the drug rebate fund would be made available for new services to consumers.

Each participant was provided a table, which clustered unmet need categories into higher-level categories (see Appendix A, pp 25-26). Participants were given dots representing $500,000 and asked to allocate these across the top-level categories listed below. In each column, subcategories were listed (see pages 8-9 and 25-26). Some participants felt the proposals or items within the categories overlapped, making it difficult to allocate funds across the top-level categories. The Department will need to make the necessary adjustments during the implementation process.

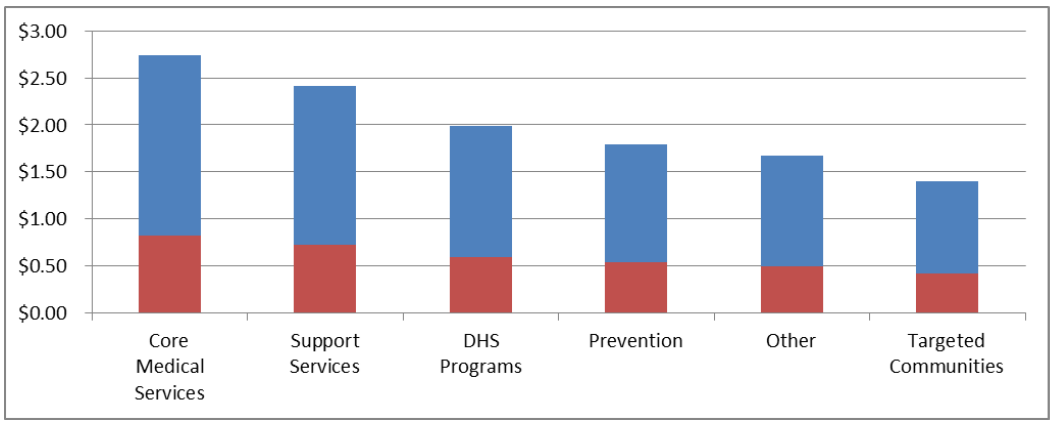
- DHS-administered programs
- Core Medical
- Support Services
- Targeted Communities
- Prevention
- Other

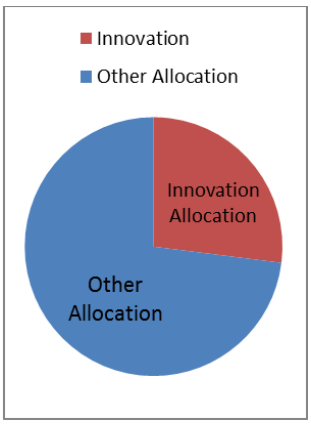
Recommended Allocation of Funds

Category	Dollars Allocated (in millions)	Percent of Total
Core Medical Services*	$2.72	23%
Support Services*	$2.41	20%
DHS Programs	$1.99	17%
Prevention	$1.79	15%
Other	$1.67	14%
Targeted Communities**	$1.40	12%

*Highest Priority for Fund Allocation

** Some participants felt that the needs of targeted communities would be addressed by activities in the other categories.





Discussion of Prioritization Results

As the group discussed the resulting rankings, several participants expressed an interest in setting aside some funds for "Innovative" programs and/or providers. A show of hands suggested that reserving 20-30% of the funds in each category was the most frequently preferred range.

Subcategory Rankings

After the prioritization ranking above, each individual chose their top third among the options listed in each category, with these results. Consistent with the direction to include all unmet needs, not all subcategories may be eligible for drug rebate funding.

* *In tables indicates below categories and subcategories with clearly higher rankings*

DHS Administered Programs

DHS-Administered Programs Subcategory	Votes
Financial assistance for deductibles, copayments, premiums*	32
Expand eligibility for Ryan White to 400% FPG*	30
Prescription drugs	8
Health insurance	7
Dental care	7

Core Medical Services Priorities

Core Medical Services Subcategory	Votes
Mental health services*	33
Case management-medical	20
Medical treatment (outpatient ambulatory medical Care)	19
Chemical dependency (substance abuse)-outpatient	17
Oral health/Dental	16
Home and community based services, not including long-term care	10
Home health care	9
Medical Nutrition	3
Hospice	0
Local AIDS Pharmaceutical Assistance Program	0

Support Services Priorities

Support Services Subcategory	Votes
Housing-short term assistance*	36
Case management-nonmedical*	29
Emergency financial assistance*	29
Support groups	16

Support Services Subcategory	Votes
Food bank/Delivered meals	14
Psychosocial support for PLWHA	14
Health Education/Risk Reduction	13
Chemical dependency (substance abuse) -residential	11
Transportation for medical appointments	11
Legal	9
Outreach services	8
Linguistic	5
Medication Adherence	5
Referrals to resources	3
Respite/Caregiver Support	2
Child Care while receiving RW services	1
Rehabilitation Services	1

Prevention

Prevention Subcategory	Votes
Prevention education*	25
Preventive services (e.g., condoms)	12
Expand HIV/AIDS testing (generally)	6

Other

Other Subcategory	Votes
Housing-long-term financial assistance*	33
Provider training/capacity building	19
Employment/jobs training	16
Housing-construction	9
Training for providers	8

Targeted Communities

Rather than ask participants to rank one community's needs higher than another's, participants discussed other considerations (see Meeting #3 notes, Appendix A). Added to the existing list of targeted communities were:

- People recently released from incarceration
- Young Africans and African Americans who are gay or bi but do not identify as gay or bi
- People who are "out of care"
- Older persons, since the disease accelerates the aging process

- People who don't know their status

Some participants expressed the need for "hard" data, and suggested the HIV Treatment Cascade. This framework for collecting and analyzing data is found at http://www.aids.gov/federal-resources/policies/care-continuum/. These data show how many persons living with HIV/AIDS are diagnosed, linked to care, retained in care, prescribed anti-retroviral drugs and have reduced viral loads. This website also provides national data showing demographic differences among age groups and racial groups. Presenting Minnesota-specific information prior to engaging in priority setting would be useful in future priority-setting efforts.

The facilitators reviewed this site, and concluded that the framework would be useful for collecting data about needs, by ethnic/racial, geographic and other relevant factors. This framework would certainly assist HIV/AIDS planners in identifying relative gaps in the continuum. However, the community meetings were primarily intended to hear directly from consumers and others in the community about their ideas regarding unmet consumer needs and priorities. The categories used in the ranking exercises were, therefore, specific to needs experienced by consumers.

III. Conclusions

The comments received by participants in the first community meeting, taken together, paint a picture of the varying needs of persons living with HIV/AIDS. Participants in this process emphasized the difficulties faced by many (but not all) persons living with HIV/AIDS. These include poverty, homelessness, mental health and substance abuse problems. Persons living with HIV/AIDS are frequently unable to work, and may lack health insurance or the financial means to pay for medical care, including prescription drugs needed to manage the disease. When HIV+ persons are unable to obtain, or maintain, their drug therapies, their viral load increases and the community is at greater risk for spread of the HI virus.

Participants also pointed out that different communities face different issues accessing programs designed to assist persons living with HIV/AIDS. Participants feel there is a scarcity of providers qualified to deal with HIV/AIDS. Persons from immigrant communities noted language barriers, and lack of knowledge about the disease in their communities. Women, bisexual and transgender persons feel that programs designed for gay men do not often meet their needs. The stigma associated with HIV/AIDS, and its association with homosexuality and drug use, can deter persons from seeking care.

Some cautions must be made in interpreting the funding allocations and priorities. The meetings were held in the Twin Cities, during business hours. Persons from Greater Minnesota and those who have day jobs without have paid time off are likely under-represented. People without internet access would have been unable to participate via the web. It is also likely that people who are not fluent in English would have difficulties with the process and the material. Notwithstanding the limitations of the process, the group had a fairly high degree of cohesion (although some participants disagreed with the outcomes). It may be that persons from under-represented groups might share the same sense of the highest priorities.

Putting the fund allocation together with the subcategory rankings yields the following:

Category	Total Dollars Allocated (millions)	Innovation Dollars (millions)*	Highest Priority Subcategories
Core Medical Services	$2.74	$0.55--$0.82	Mental health services
Support Services	$2.41	$0.48--$0.72	Housing: short-term assistance Case management-nonmedical (tied with) Emergency financial assistance
DHS Administered Programs	$1.99	$0.40--$0.60	Financial assistance for deductibles, copayments and premiums Expand eligibility for Ryan White to 400%
Prevention	$1.79	$0.40--$0.54	Prevention education
Other	$1.67	$0.33--$0.50	Housing: long-term assistance
Targeted Communities	$1.40	$0.28--$0.42	Not ranked

*Range=20-30%; rounded

Programs and services for persons living with HIV/AIDS are highly interrelated. Expanding the eligibility for Ryan White, for example, may result in more people being enrolled in insurance programs, which provide coverage for mental health services. HIV/AIDS service providers who tie eligibility for their services to Ryan White eligibility may face an increased case load that they are not currently staffed to handle. Expanding eligibility for services does not address the lack

of supply of qualified providers in certain parts of Minnesota, or who can effectively deal with some of the targeted communities. DHS, its partner organizations and members of the HIV/AIDS community will need to collaborate to effectively resolve these complexities.

Further examination of the categories and proposals might reveal that some of the unmet needs cannot be addressed with Ryan White funds. A future meeting of DHS, its partner organizations and members of the HIV/AIDS could address how else those needs might be addressed. The group could also conduct another round of fund allocation and prioritization of subcategories to redistribute funds that could not be used as the group intended.

Appendices
Appendix A Community Meeting Agendas & Notes

Community Meeting #1

Thursday, July 24, 2014 1pm – 4pm

"We all do better when we all do better"
Paul Wellstone

Agenda
~1:00pm
1) Opening Comments
2) Legislative Background
3) Overview of Today's Session
4) Project Approach
5) SCSN Overview
~2:10pm
6) Breakout Activity
~3:50pm
7) Next Steps
8) Adjourn
~4:00pm

Project Objectives
- Help fulfill intent of legislation by:
    - Gathering community input on unmet needs
    - Developing consensus-based ranking criteria
    - Applying consensus criteria to unmet needs
    - Presenting community recommendations to DHS, including areas where consensus cannot be reached

Meeting Objectives
- Gather feedback from the community on the project approach towards identifying and ranking unmet needs
- Gather input to help define success for the effort
- Gather initial input on unmet needs

Session Notes
Opening Comments
Loren Colman – Assistant Commissioner Continuing Care Administration
- Thank you for taking time out of your schedules to work with us today
- Try to relax
    - This is a good opportunity
    - This is something we have not had in front of us before
    - Collectively we can make this a positive initiative

- As a result of the last session of legislature – we were tasked to work with community to identify unmet needs (gaps) and work towards solving some of those
    - Through collecting rebates and other initiatives, we have some funds available that the legislature wants us to use to purposefully improve services
    - No decisions have been made
    - There is no secret plan
    - This is the beginning of conversation
    - We want you to identify gaps and unmet needs
    - Don't use acronyms and self-limit ourselves
    - For now this is about people
    - For now, don't worry about what bucket money comes from
- There are other planning processes
    - This is unique
    - Came up at end of legislature session
    - Made commitment to work with community to come up with plan
    - Not reflection on other processes currently in place
    - Not trying to critique what has been done before
- Not focusing on the money, but what we know about services not available or that we need to expand
    - Develop list of services
    - Look for data to compute what it would take to solve some of these challenges
    - Will talk about money (e.g. fund balances) at a later meeting
    - Want a clean discussion about needs
    - Want to get all elements out on the table
- Not a reflection of past or existing programs
    - We've done a good job in MN identifying and forwarding to meet people's needs
    - Don't think something has been done wrong
- This is about the people we are all trying to find better ways to serve
    - Not about HERSA, DHS, the organizations, …
        - We will worry about these later
- I was directly involved in the discussion with the senators and initiatives to craft this plan
- I want these series of meetings to be productive and help us capture the opportunities before us
- This is unique and doesn't happen in many states

Dave Rompa – HIV/AIDS Unit Supervisor

- We really want to get your information and ideas and have the focus on your participation during this and subsequent meetings
- We brought in independent facilitators as part of this process
- We are following a plan to ensure big and small agencies and consumers had an opportunity to be engaged in the process

Richard Branton – Principal of Advanced Strategies, Inc.

- We are very pleased to be part of this effort
- We have no preconceived notions of the solution
    - We want consensus among you given the diverse sets of needs and perspectives
    - Want to provide a process to give everyone a chance to be heard and considered

  - Ultimately want you to speak as one community
- We care. We want the greatest possible outcomes for the individuals and communities being served
- The robust treatment and prevention of HIV/AIDS serves the interest of all the people of MN
  - Regardless of demographics, location, risk factors
  - This is an important thing to do and a human thing to do
  - State of MN has a reputation for caring
- **"We all do better when we all do better"** (Paul Wellstone)
  - We're meeting at the Wellstone Center, and this quote struck me as I entered
  - This sentiment should be a theme of what we are doing in this process
  - (*This theme was subsequently included on meeting documents*)
- Look forward to providing an open, fair, transparent process and a forum for all ideas to be heard and considered
  - We feel privileged to be a part of this
  - Kathy – is the lead consultant focused on leading community planning
  - Kahil – is here capturing a record of the event; not a transcription
- We have substantial experience in the state of MN in a number of arenas.

Kathy – Lead Consultant, Advanced Strategies, Inc.

- As a citizen of MN, I have an interest in making sure the citizens are served well and we are making effective use of resources
- We are smarter together than as individuals
  - You can all bring your different perspectives to bare

Background on Legislation

Laws of Minnesota 2014, Chapter 312, Article 30, Section 2, lines 538.11-538.30 provides the legislative authority for this effort.

> **Services for individuals living with HIV/AIDS.** The commissioner shall work with community stakeholders, including the HIV Planning Council, to identify gaps in services for individuals living with HIV/AIDS and, within allowable state and federal law and guidelines, develop and implement a plan to use funds in the ADAP drug rebates special revenue account to enhance existing service levels and establish an amount to retain in the account to ensure long-term stability of services. The commissioner shall report the results of this work with stakeholders and the progress on implementing the plan to the chairs and ranking minority members of the senate health and human services finance division and the house of representatives health and human services finance committee by December 15, 2014.

Laura Sayles – DHS Legislative Assistant

- "Work with community stakeholders"
  - is language that directs us to work with all of you
- "Report the results … by December 15, 2014"
  - Supposed to report on results of work and progress to date
    - The work does not have to be done at that point
    - The process doesn't end as far as implementing by December 15
  - We have started no RFPs as result of the work that might come out of these meetings

        - There are some RFPs coming out that were related to previously planned initiatives
    - Please contact me if you have questions around what is planned

Participant Discussion

Participant Question: Is December 15 the date that $10-15 million must go out to the community?

- Our understanding is that Dec 15 is just to report on the progress to date, not that money has been released by Dec 15, 2014.
    - In fact, there may be some legislative changes required which would go beyond this date.
    - This is partially why we want to start with what the needs are distinct of the money.
    - It would be difficult to get the dollars out within this timeframe and be confident that we are addressing the needs as best as possible.
    - Want to move as rapidly as possible, but we want it to be orderly and make sense
- At future meetings we will talk about the money
    - At times in the past, we had to do cost sharing and limiting due to concerns regarding running out of money
        - We do not want to go back to that.
        - We don't want to cause collateral harm because we did not take the appropriate time to scope and plan effectively
        - My hope is we would make substantial progress towards getting money out

Participant Question: Is this merely for services or legislative improvements that could benefit the lesbian, gay and transgendered community?

- We are hoping we don't limit it to things that are already being done, but think outside of the box and see what may be accomplished with this money
    - There may be ideas that emerge that we do not have money for
    - It is still valuable to document those needs and talk about other strategies to solve those gaps
    - Don't limit thinking to what have we done in the past, or what do we think is eligible for funding
    - Would rather have broader conversation and then have conversation about all funding methods available and how to best use these funds
    - This is why we want to park the funding discussion

Participant Question: Is this just for things currently not eligible to other people?

- Don't want to say we only have limited funds so let's not propose ideas yet
    - May be current services that need to be expanded
    - This may be very relevant – maybe needs outweigh capacity available and needs to be expanded
    - May be that new needs arise
    - Expect it to be both

Participant Question: How far ahead are we looking? Some could be only one time. Or do you project this rebate money will be coming for the next 5 years?

- We want both of those things.
    - We want to know about immediate, one time, short term and longer term needs.

Participant Question: Is there a current allocation to help with health plan deductibles? Is there one for health insurance premiums?

- This is a question for the HIV/AIDS staff, but this is a good example of the types of things that would be provided as part of the breakout activity

Statewide Coordinated Statement of Need (SCSN) Overview

Andy Ansell – Program HH Policy

- A document we have to prepare as part of the documents we have to author to stay in compliance with some of our grants
    - The lifespan is usually 3 years
        - The current was written in 2012
        - The previous one was authored in 2008
        - Before the action at the legislature, we were beginning an internal review of the SCSN
    - It talks about the needs of people living with HIV, what are the gaps, and how can we work with all of the resources available and our partners to close some of the gaps
    - The document is available via our website
        - The shortened version has the 5 priority areas, each containing desired outcomes
    - This can be input into the conversation
- In subsequent meetings we will also talk about what we feel as DHS to accomplish the priorities that are laid out in this document

Project Objectives & Approach

Kathy Burek – Lead Consultant

- We want honest disagreements
    - Do not want to gloss over places where the group is not able to come to consensus agreement
- We will have homework for you to provide feedback throughout the entire process

Participant Question: In reviewing the docs, not sure if thinking about people living with HIV or people at risk of HIV. Is prevention on the table?

- Dave R. – Don't want to limit the discussion.
    - E.g. in Washington state they are using care dollars to do prep prevention
    - Our rebate dollars are governed by HERSA standards, but we do know there are creative things being done because prevention equals care
    - Will have fruitful discussion
    - As a community you will discuss how to prioritize those prevention ideas against care and see how we will go about making these things happen
- Loren – we want to hear about those.
    - It would be a missed opportunity if we don't hear about prevention, even if we are not able to do something immediately
    - We will strategize about how to go about solving the challenges afterwards

Participant Question: Should we align our discussion with the priorities for 2012?

- Loren – priorities identified in 2012 are a good guide, but would not limit thinking.
    - But, most likely ideas will fit into the priorities.
    - But, if have an idea that not sure will fit then provide it anyway
- Dave – purpose of midterm review is to upgrade these priorities.
    - So, it is very appropriate to talk about this

Participant Comment: Typically housing is not a considered thing, but would like this to be kept in mind.

- Loren – again, housing is a necessary component in our life.
    - Again, let's emerge with a list of needs and gaps.
        - Then we can put the puzzle together.
        - If it is not available in an existing allowance of funding it allows us to try different strategies, e.g. legislative initiative or repurposing of funds.
    - Don't run to what we know of eligibility in the past.
        - Focus on needs and gaps. Certainly housing has been an active topic the last few years

- We are not committing to have funding to solve this for this particular project, but useful to document.

Participant Question: Helpful to see this project approach. It would have been helpful to see this earlier. Has there been community input into this process? Is it welcome?

- Certainly we would welcome community input.
  - Please make sure you forward any thoughts on to us
- Loren – if there is an additional step we need, then we want to hear about this.
  - If there is a different way, we are open to that.
  - We want this to work.
  - If there is something that has been missed by these expert planners, we should hear about that
- Dave – if you do leave early, please sign your name and email if you intend to come to future meetings.
- Richard B. – Success is having the maximum impact
  - To achieve success we want to start as open as possible
  - Richard told a story about a child being taught how to cook a roast by their parent
    - Let's not be constrained by the past
      - Certainly we have to comply with the regulations in place
    - The thing Loren is asking for is to determine what the ultimate impact is.
      - We will define success in a more formal way.
      - Then we can say, if someone comes up with a need how do we assess that need to see if we can impact
      - If we agree on criteria then we can assess all needs no matter where they come from
      - Will lead to a community consensus of what the appropriate approach is to meet the success as defined

Participant Question: Are you looking in the process to leverage other entities? State of MN has a GR8 program that could be utilized (e.g. only need a small amount to initiate program) – so are you looking to collaborate with other sources of funding?

- Loren – I don't know what the RFPs will look like because we haven't made any decisions yet
  - We are all connected to other parts of the department. This is why a comprehensive set of needs is essential.
    - E.g. if we hear of needs that we are not responsible for, we can link to other departments or forward to other departments who are responsible.
      - We can develop a playbook to follow up with our partners
    - E.g. many of you will most likely interact with legislators in the upcoming session. For us to be able to collectively identify these needs and agree what the list is and what we have strategies and funding for, but we still have unmet needs.
      - Talking off of the same list is valuable. It does not guarantee anything, but allows us to talk with a similar voice.
      - Let's focus on the people for this part of the process

Participant Question: Are there plans in the work to open places in St. Paul area for HIV advocates to be a part of this?

- Dave – these are great ideas, but we want to generate these in the breakout session

Participant Question: From a planning council standpoint, the timeline feels too aggressive to get feedback from our consumers state wide. Can we adjust these dates?

- Dave – these are suggested dates, but have not booked anything. We want to have that discussion.
  - This is a discussion that needs to occur amongst the planning council

Introduce Breakout Activity
Kathy Burek – Lead Consultant
Participant Question: Are we responding to other people's ideas?
- Okay to ask question, provide context, but not challenge.

Participant Question: can people share conflict of interests?
- Disclose affiliations you might have to provide context for your breakout group members.

Participant Comments:
"We belong to a community that has needs."
"As a community member, the same thing that affects people with HIV affects everyone."

Closing Comments
- *The grouped discussed extending the timeline*
- *The group held a moment of silence for the victims of the airplane crash over Ukraine*

- Thanks for your time and effort
  - A lot of work was done
  - Anxious to see what ends up on the website
  - Good luck with your homework
  - Safe travels

Community Meeting #2
Thursday, September 11, 2014 9am – 4pm

"We all do better when we all do better"
Paul Wellstone

Project Objectives
- Help fulfill intent of legislation by:
  - Gathering community input on unmet needs
  - Developing consensus-based ranking criteria
  - Applying consensus criteria to unmet needs
  - Presenting community recommendations to DHS, including areas where consensus cannot be reached

Meeting Objectives
- Identify and prioritize ranking criteria
- Share results from survey (as of 9/10/14)
- Identify categories of needs
- Assess categories of needs

Session Notes

Opening Comments

Loren Colman – Assistant Commissioner Continuing Care Administration

- Thank you for taking time out of your schedules to work with us today

Dave Rompa – HIV/AIDS Unit Supervisor

- *Dave thanked the participants for their time*

Laura Sayles – DHS Legislative Assistant

- *Laura emphasized the importance of the communities input and thanked them for their time*
- We would like your forthright feedback
    - Welcome your feedback
    - Not constrained by whether or not we can spend the money, have we done it before, etc.
    - Want to identify needs prior to determining how to pay for it
    -

Richard Branton – Principal of Advanced Strategies, Inc.

- *Richard introduced Advanced Strategies, Inc., emphasized the need for all to work together, and handed off to the facilitator, Kahil Branton*

Ranking Criteria

In breakout groups, the participants refined the draft criteria for ranking unmet needs, potential solutions to those needs, and funding criteria.

After the initial portion of this exercise was undertaken there was significant discussion around the approach for the Community Meetings and an expressed desire to emphasize the Ryan White related funding and prioritization of unmet needs instead of an expanded focus on all needs and without regard to funding mechanisms. After the discussion, the groups shared their feedback on the ranking criteria and the session was adjusted to gather feedback on unmet needs and potential programs/services.

Participant Comment: Request that time during this session be spent prioritizing programs, initiatives and funding to make the best use of our time as experts.

Participant Question: Will we get to review the document distributed on December 5?

- It is important that consumers review this prior to submission to legislation
    - The document will be available on website for you to see what was said or concluded from these 3 meetings
    - Report going to legislature is different. Given layers which must be traversed within DHS and tight timeframe for turn-around, will likely not be able to get this out for review prior to submittal to the legislature
- Will there be a formal public comment period?
    - May or may not have impact on legislative report because of time
    - Legislative report is primarily to report on the steps we have taken up to that point, not to convey final decisions. It is a report on progress, not decisions.
    - Getting feedback from the community will continue long beyond 15th of December
        - Because need to decide what recommendations we will do based on feedback
    - Report on 15th is just what steps have we been taking, such as this process, not what we have concluded

Participant Comment: Request that time during next session be devoted to discussing the reserve in the account.

- Will talk about this during the third meeting, but not sure if will be concluded by Dec 15th.
- We have looked at several states and formulas.
    - Very different from state to state.
    - Putting formulas forth and doing calculations to see impact based on our numbers.
    - Still working on calculation

Participant Question: When we are looking at formularies, MN is an ACA state, and are we bringing the variable into the conversation. How does expanded Medicaid in our state reflect in the ADAP formulary and what is needed in the account?

- When looking at first wave after going to 75% it was a wash, but we are looking to see if next phase has impact.

Participant Comment/Question: A number people are on Ryan White planning council – we just finished a plan process for priority of needs for next year. Why can't we use the results of that information as part of the process?

- Planning Council will forward the results of their prioritization process to the facilitation team
- We have been instructed by HRSA that planning process needs to remain with the state, but to solicit as much as possible from all the planning bodies. Legislature thought to implement planning council. Think very appropriate to include them in the process.
- A large percent has been consistent with planning council.
    - Some feel it is not representative enough of the entire community. Whether you are agreeing with planning council or not.
- Please submit to us. We want as broad of an input as we can get from anywhere.
- Want access to best thoughts of entire community as best as we can get it.

Participant Question: How much money are we working with and how long to spend?

- Not a deadline because account rolls over
- Amount is based on how much should remain in reserve
- Balance today is ~$21 million – total amount
    - Seeing a significant reduction in collection of rebates as change in 340B rules and working hard to not double bill for claims across any agencies – about a 40% reduction in last two quarters
- Laura – try not to think too much about specific money – may be things that legislature could take on itself or community, …

Participant Comment: We would like to leverage knowledge of DHS staff

- Made a change this session to include their work
- Together they can leverage their knowledge
- We can dominate sometimes – a power role that could influence the discussion
- Don't want their role to carry too much weight in the community discussion

Participant Comment: We would not be here if not some confusion at legislative level of why so much rebate $ in the account. There needs to be a conversation around how DHS makes sure the legislatures overseeing the budget know what these dollars are for and do not put general revenue funds at risk.

Group Question/Comment: Parts of the group expressed frustration with the process. Why focusing on all needs? We should emphasize unmet needs which can be met by Ryan White funding first and then circle back to other needs and other sources of funding later.

- **Loren Colman – Assistant Commissioner Continuing Care Administration**
  - We should not limit ourselves with our current budget
  - Let's get a comprehensive of needs on a computer and then less talk about what it takes to meet those needs
  - There will be some limit, but we should not fit the needs into a financial box and limit our thinking about what we can do.
- **Question:** Why aren't we focusing the needs to program changes?
  - We are trying to identify the needs regardless of funding sources
  - If we focus on the funding source, we will limit
  - If we can get a comprehensive needs, we could then identify existing funding sources
    - Then identify the funding gaps,
    - Then we can look at legislation, etc. and other source
- **Comment**: The discussion should not be about what is fair, but what is equitable across the entire demographic
- **Comment:** This does not feel like the best use of our time and our ability
  - There are a variety of opinions about what needs to be done
  - What we are trying to do is give everyone an opportunity to provide their feedback
  - Loren – the message is clear, "Pick up the pace and get this part done, you want to get to the meat of the matter"
- **Question:** Why did this go to the legislative auditor first?
  - The department doesn't decide; the legislature decides
- **Comment:** I wanted to ask everybody be patient; it is great that DHS is involving us in this.
- **Comment:** I think this group wants to hurry up and get our hands dirty
- **Comment:** Don't forget the common folk, because some of us don't have the understanding the rest of the group does

Community Meeting #3
Thursday, November 20, 2014 9am – 4pm

"We all do better when we all do better"
Paul Wellstone

Session Notes

1. Welcome and introductions
Dave Rompa – HIV/AIDS Unit Supervisor
--3rd in series to try to address unmet needs and allot funding.
--Bob H. passed away. Will truly be missed. Made huge contribution, will miss him.
--Hope spirit of Bob's work carries through to our work today.

2. Review objectives and agenda
Kathy Burek – Advanced Strategies

1. Welcome & Introductions
2. Review Meeting Objectives & Agenda
3. Recap Project to Date
4. Briefing: Background Information from DHS
5. Allocate Dollars Across High-Level Unmet Needs Categories
6. Announce Results/Discussion
7. Prioritize Subcategories
8. Announce Results/Discussion
9. Review Next Steps
10. Debrief
11. Adjourn

3. Reconnect
Kathy Burek – Advanced Strategies

--Legislation passed last session, set priorities of unmet needs
--Started process in July
--Have had website with summaries of community meetings, places to get feedback, ask questions
--Last time, developed principles

4. Briefings: DHS
Alex Bartolic – Dept. of Human Services
--It's an honor to be involved in this project and with your community
--Want to understand the needs because we know it is diverse
--We know this process hard and some people may be frustrated
--In this meeting, we can't get right down to actual allocation because of RFP constraints
--Some things we can accomplish with this process, but others will take longer
--We don't intend to sit on the money – will work as fast as we can to get money/services out to people
--Dollars need to be about services
--But there are limits with what we can do with this money
--We are trying to be as transparent as we can

--We're happy to share and discuss all of this in the future
--Need to realize that things might change, may need to reevaluate
--Thank you for dealing with the process
--We have about $12M
--Budgeting is complex and uncertain, lots of moving parts, includes ACA
--There is an existing budgeting process
--Have carry over from previous year plus incoming revenue
--Need reserve of about $4.7M in reserve to cover existing obligations

Participant Comments

#	Comment
1.	Some persons were critical of process in the last meeting, but thank you for getting to the numbers in this meeting so quickly. (Applause)
2.	What is the time span for spending of funds? A: If in existing contacts, can be faster. If in new RFP, will be Jan-Feb of 2015.
3.	I'm worried about capacity in community. Over what time span can money be spent? A: Depends on your priorities. Can be extended. Doesn't have to be all at once.
4.	I'm worried about sustainability. A: Could revisit criteria at some point.
5.	Some persons were critical of process in the last meeting, but thank you for getting to the numbers in this meeting so quickly. (Applause)
6.	What is the time span for spending of funds? A: If in existing contacts, can be faster. If in new RFP, will be Jan-Feb of 2015.
7.	I'm worried about capacity in community. Over what time span can money be spent? A: Depends on your priorities. Can be extended. Doesn't have to be all at once.
8.	I'm worried about sustainability. A: Could revisit criteria at some point.

Nick Metcalf –Department of Human Services
Nick Metcalf presented an overview of the Department's estimates of unmet needs proposals. This document is posted at
http://nebula.wsimg.com/ddd6d46d0dd6d30302117ef877aaed2d?AccessKeyId=04FCC61BBCB7320FF810&disposition=0&alloworigin=1
--Unmet needs assessment
--Took needs categories submitted online and put them into groups
--Compared to HRSA (Health Resources and Services Administration, part of US Department of and Human Services) categories
--Looked at what we currently fund, whether we could expand, whether is core medical, etc.
--Some didn't fit in categories
--Analyzed whether eligible to use for rebate money
--Caveat: Ryan White is payer of last resort
--Update: Caregiver support/respite is a fundable source

Participant Comments

#	Comment
1.	Q: In #9, can't give money to just advocacy?
	A: No. HRSA won't allow. Can't advocate for HIV in general, but can tweak and define more narrowly so e.g. advocacy for dental care, etc. might be acceptable.
2.	Q: Just Part B? A: Yes.
3.	Q: Are numbers on side rankings? A: No.
4.	Q: Is money is bound by HRSA rules? How flexible is it? A: Yes, but can negotiate a bit with HRSA.
5.	Q: Is the money only for people living with AIDS? A: No. Also persons with HIV.
6.	Q: Is it possible to expand eligibility for programs? A: Yes.

5. Allocation of Funds Across Unmet Needs Categories

Kathy Burek, Advanced Strategies
HIV/AIDS staff and I met to review the specific categories of proposals, and clustered them into 6 higher level categories. Some suggestions are clearly not eligible for Ryan White funding. Some might be, depending on how they are structure. In some cases, more research needs to be done to determine eligibility. (See page 5 for table).

--Note: the Aliveness Project sent a proposal via the website that we didn't receive. We apologize for the technology failure. Here are their proposals; higher level category is in parentheses).

- Case management (listed under core medical for medical case management, or
- Benefits counselor (support service)
- Nutrition Counseling for Greater Minnesota (support)
- Food program (support)
- Integrative therapy program (not eligible)
- Funding to help cover capital needs (not eligible)

--Shortly, will ask you to assign dots to the top-level categories; each dot will be worth $500,000
--You have $12,000,000 to spend
--There is collaboration across state agencies, so even if a category is not eligible for Ryan White funding it could be funded by another state agency
--This is a budget session coming up
--You can always talk to your legislators about your ideas in this coming session
--State agencies, however, can't support proposals not in Governor's budget; county staff may also be constrained to support their county's overall budget priorities

NOTE: There is a formatting problem which is causing the table to break in the wrong place. The text begins on page 5. The table requires 8 ½ x 14 paper for printing.

Categories of Unmet Needs and Potential Activities/Program Areas/Proposals

DHS Programs	Core Medical Services	Support Services	Targeted Communities	Prevention	Other

• Expand Eligibility for MN Ryan White to 400%
• Financial assistance for copayments, deductibles, premiums
  • Private insurance
  • Pay MN Care Premiums
  • Pay MA-EPD Premiums
• Dental Care (core medical service)
• Health insurance (core medical service)
• Prescription Drugs
 	
Sample Community Proposals:
❖ **Fund Planning Council**
	• Case management-Medical
	• Chemical dependency (substance abuse)-outpatient
	• Home and community based services, not including long-term care
	• Home health care
	• Medical Nutrition
	• Medical treatment (outpatient ambulatory medical Care)
	• Mental health services
	• Oral health/Dental
	
	Funding-Eligible Categories That Did Not Come Up Previously:
	o Hospice
	o Local AIDS Pharmaceutical Assistance Program
		• Chemical dependency (substance abuse) - residential
		• Case management-Nonmedical
		• Emergency financial assistance
		• Food bank/Delivered meals
		• Health Education/Risk Reduction
		• Housing-short term assistance
		• Legal
		• Linguistic, including
		  • Translation services
		  • ASL
		  • Braille
		• Medication Adherence
		• Psychosocial support for PLWHA
		• Outreach services
		• Referrals to resources
		• Respite/Caregiver Support
		• Support groups
		• Transportation for medical appointments
		
		Funding-Eligible Categories That Did Not Come Up Previously:
			• African Americans
			• African American women
			• African Born
			• Asian Born
			• Asian Americans
			• Latino/Latina
			• Native Americans
			• Undocumented persons
			• Bisexual Persons
			• Gay men
			• Transgender persons White men
			• Women
			• Greater MN/Rural
			• St. Paul Residents
			• Older Persons
			• Young Adults
			• Youth/Teens
			• Persons with disabilities
			  • Visual, hearing, mobility, developmental
			• IV Drug users
			• Sex workers
			
			Sample Community Proposals:
			❖ **Persons with HEP-C (evaluation & treatment)**
				• Expand HIV/AIDS testing (generally)
				• Prevention education
				• Preventive services (e.g., condoms)
				
				Sample Community Proposals:
				❖ **Enhanced partner testing services**
				❖ **nPEP**
				❖ **PrEP**
					• Employment/jobs training
					• Provider training/capacity building
					• Housing-construction
					• Housing-long-term financial assistance
					• Training for providers
					
					Sample Community Proposals:
					❖ **Education for faith-based organizations and communities of color**
					❖ **Involvement of African American churches in HIV/AIDS education, etc.**
					❖ **Stigma**
					❖ **Support for US Conference on AIDS attendance**
					❖ **Uncompensated care for PLWHA**
					❖ **Expanded Paramedic pilot program**
					❖ **PharmD smoking cessation**
					❖ **Capital needs**

HIV/AIDS Unmet Need and Rebate Fund Use Report

DHS Programs	Core Medical Services	Support Services	Targeted Communities	Prevention	Other
		o Child Care while receiving RW services o Rehabilitation Services **Sample Community Proposals:** • **Care coordination** • **Linkage to care**			

Bold = Proposal submitted by the community as "Consumer" or "Provider" proposals

DHS Programs	Core Medical Services	Support Services	Targeted Communities	Prevention	Other
Ineligible Use of Drug Rebate Money					
		•		• Comprehensive sex education • Needle exchanges	• Advocacy • Long-term care/Assisted living • Psychosocial support for caregivers • Transportation to jobs, groceries • Vision care

Participant Comments on Unmet Needs Categories

#	Comment
1.	Q: Many community proposals from HCMC. No designation whether eligible for funding (6-8). If wanted to support HepC, for example. A: We can't have you putting dots on proposals because of conflict of interest. Expansion of HepC is under Targeted Communities. No policy across all DHS on HepC; we could broaden this.
2.	Q: What is baseline spending for different categories? A: (DHS) Don't know off top of head, but we report this information and it is available publically and report to council and HRSA. We can make this available on our program website.
3.	Q: What are the current percentages? A: 75/25 split not as important because of drugs.
4.	Q: Can you clarify on how funding could be allocated through existing contracts? A: (DHS) This depends on what law will allow. Will need to work with DHS lawyers. Some could be allocated quickly without issuing an RFP, under existing contracts.
5.	Q: Many of these services already exist. So we may want to expand? A: (DHS) Yes. In some cases, we're already spending money on services and may want to increase. In other cases, it will be completely new spending.
6.	Q: How many new people do you expect to cover if expand eligibility to 400%? What do we tell consumer? A: (DHS) The number may be low. We are estimating right now and will do a more in-depth estimate later. It's complicated because DHS generates more rebate money when more people are eligible.
7.	Q: If expand eligibility to 400%, how will it affect the rest of the services? Will more money need to be put into them? A: (DHS) Maybe. Will need to look at the whole system.
8.	It will be easier for consumer if everything is at 400.
9.	Could we cover copays for non-HIV meds like antidepressants? A: (DHS) We already do. We have formulary committee that reviews requests for new drugs regularly.

MORNING BREAK

6. Reporting of votes

Kathy Burek, Advanced Strategies

--Clarification: The process doesn't automatically allocate money to things. DHS still may have to go through RFI/RFP process for some new projects.

Participant Comments

#	Comment
1.	Q: What if think some categories are "Core medical"? Disagree with how this is put in category. A: DHS –OK if group wants to move them and DHS will reconsider at time of implementation.
2.	C: Can get glasses and smoking cessation materials, are other ways.
3.	Q: Not clear what all categories mean. A: DHS staff here to help. We know it can be confusing.
4.	Q: 5 of 6 categories about services, 1 (communities) is not. Can we do two-part voting? A: No, don't want to pit groups against each other. A: DHS Are based on general comments.
5.	Q: Can't we do as-is and deal with subcategories and deal with the targeted communities. A: Yes, we need to stay with the process.
6.	Q: Can we move into other categories: Uncompensated care, etc. moved to Core Medical? A: DHS—OK to move. May still need to check with HRSA.

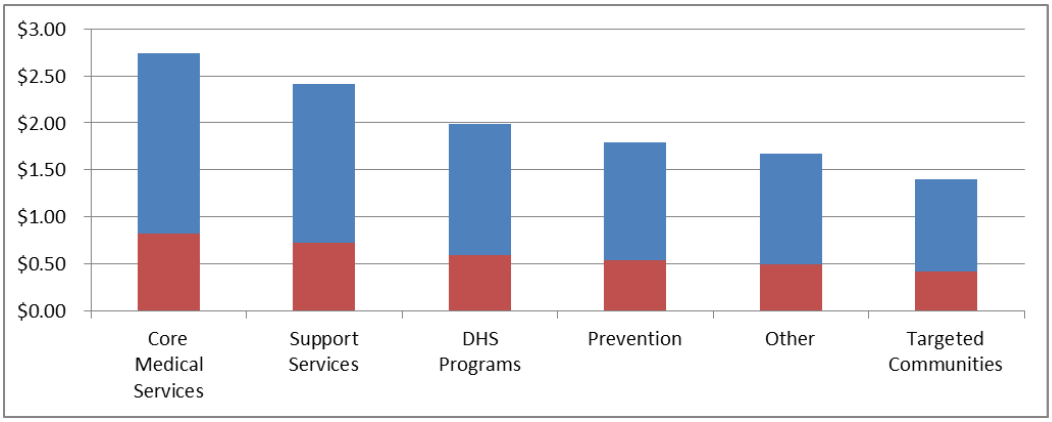
VOTING

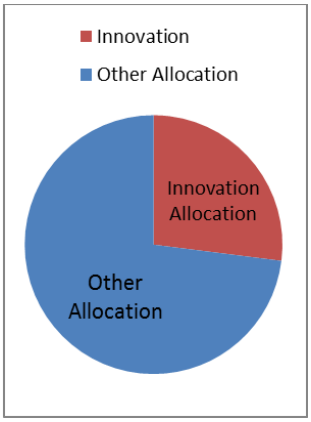
--Votes tallied and announced

Category	Dollars Allocated (in millions)	Percent of Total
Core Medical	$2.72	23%
Support Services	$2.41	20%
DHS Programs	$1.99	17%
Prevention	$1.79	15%
Other	$1.67	14%
Targeted Communities	$1.40	12%

Bar chart reflecting allocations:

HIV/AIDS Unmet Need and Rebate Fund Use Report





Participant Comments

#	Comment
1.	Did this voting under protest. Did "0" under targeted communities because included in all the other categories because thought it would filter down in later process.
2.	Thought support services would be higher because ACA would increase, didn't think core services would be as high.
3.	People don't know how much is in each category right now.
4.	Some of the core medical is not related direct medical care.
5.	Objections: Putting money under targeted muddies waters. Skewed things. Also don't know the gaps, so hard to know if this makes sense.
6.	Should move targeted services into other groups. These groups already served under current structure.
7.	Worried about disparities continuing, basically putting money in the same places.
8.	Devil is in the details. Ex: if move to 400%, could be spent well or in a disappointing way.
9.	Expanding existing services is OK, but would be disappointed if expanded with existing providers because might not serving different people.
10.	Better to put targeted communities under "other"?
11.	Need to know how effective a program is.
12.	As provider, hope grantee will do RFP for programs that are new and innovative. Don't want to drop into existing projects. A chance to do something new, not just more of what we already think works. This group is somewhat limited in representation.
13.	Somewhat happy, but hope not doing core medical from the past.
14.	Could there be a set aside for greater Minnesota? Would like to allocate a portion of this money to innovative programs.
15.	Q: How closely will adhere to this allocation? A: (DHS) We will use this as a guide, but will need to do further analysis to determine needs
16.	Important for consumer's voice to be head. Don't just put out RFPs.
17.	Q: There are only 45 people here. What is the process for getting others' opinions? A: Yes, we will discuss this. Will see about using website. We understand this is a limited group.
18.	HIV-positive population is growing older and requiring different services. This works needs to reflect that.

Richard Branton, Advanced Strategies
--Through a show of fingers on hands, what percentage of the new money should be spent on innovative projects?
--Looks like you're averaging about 20-30%.

8. Prioritize Subcategories
Kathy explained the next exercise: Each person should now place a check mark on their top priorities within each of the high-level categories. Check marks are limited to one-third of the options under each category. We will not rank "Targeted Communities", so we do not pit one community against the other. We will discuss these separately.

9. Announce and discuss prioritization results
Kathy Burek, Advanced Strategies
--Where the breakpoints are, there the greatest unmet needs are.
--We'll see where things land and then we'll make adjustments if need be.
--Clarification: Non-medical case management includes benefits counseling.
--Clarification: Some changes in eligibility
--Clarification: Part B may not be used for construction/capital

Highest Priority Subcategories indicated by *

Subcategory	Votes
Financial assistance for deductibles, copayments, premiums*	32
Expand eligibility for Ryan White to 400% FPG*	30
Prescription drugs	8
Health insurance	7
Dental care	7

Core Medical Services Priorities

Subcategory	Votes
Mental health services*	33
Case management-Medical	20
Medical treatment (outpatient ambulatory medical Care)	19
Chemical dependency (substance abuse)-outpatient	17
Oral health/Dental	16
Home and community based services, not including long-term care	10
Home health care	9
Medical Nutrition	3
Hospice	0

Subcategory	Votes
Local AIDS Pharmaceutical Assistance Program	0

Support Services Priorities

Subcategory	Votes
Housing-short term assistance*	36
Case management-Nonmedical*	29
Emergency financial assistance*	29
Support groups	16
Food bank/Delivered meals	14
Psychosocial support for PLWHA	14
Health Education/Risk Reduction	13
Chemical dependency (substance abuse) - residential	11
Transportation for medical appointments	11
Legal	9
Outreach services	8
Linguistic	5
Medication Adherence	5
Referrals to resources	3
Respite/Caregiver Support	2
Child Care while receiving RW services	1
Rehabilitation Services	1

Prevention

Category	Votes
Prevention education*	25
Preventive services (e.g., condoms)	12
Expand HIV/AIDS testing (generally)	6

Other

Subcategory	Votes
Housing-long-term financial assistance*	33
Provider training/capacity building	19
Employment/jobs training	16
Housing-construction	9
Training for providers	8

Participant Comments on Subcategory Prioritization

#	Comment
1.	Q: Can we change the numbers for each? A: No, not possible with this size group. The rankings give DHS a sense of relative importance, as guidance for what they look at first.
2.	Table 3 – on DHS Programs -- 4 votes is just ADAP at 100%
3.	Table 3 – In Prevention include nPEP, PrEP and engagement through intervention services
4.	Table 6 – Include special assistance for MEPD payments (in DHS programs?)
5.	If go to 400% (of Federal Poverty Guidelines), will we have enough capability in system to handle?
6.	Response: Think ADAP would cover the insurance premiums, that's why
7.	No FPL limit, can determine on state by state. Doesn't necessarily mean all services need to be at 400%.
8.	Agree that not all services need to be at 400% --
9.	Many people need case management who aren't eligible.
10.	Increasing will help persons with families. Not all will need all services.
11.	Might not need all of the services.
12.	Many just need access to medications. Shouldn't discourage work.
13.	Many people run out of care, resulting in viral load going up.
14.	As discussed in first session, looks like it reflects our priorities: medical, case management, housing, dental, vision are top.
15.	Surprised that outreached is low
16.	Surprised less interest in childcare (But no confusion about this.)
17.	Surprised about prevention – bias for Prep/nPEP program.
18.	Is this about new housing construction? DHS: No.
19.	Sounds good, but don't know how RFPs will come out. But decision left to pros. Can we look at other options instead of just vouchers and a quick fix?
20.	We need to go out to our communities and get ideas about what innovation is.
21.	Had to choose from bullet points. A: Faith-based org welcome to submit, but had to be careful because of RFP process.
22.	Note: Table 4 had call-in voter.

AFTERNOON BREAK

Kathy Burek, Advanced Strategies
--Regarding the targeted communities, are some communities more underserved than others? What considerations are there in considering the needs of targeted communities? Any additions?

#	Comment
1.	Persons who have been recently released from prison.
2.	Young African American who are gay or bi but don't identify as such.
3.	African-born, gay or bi and don't identify as gay or bi

#	Comment
4.	Women in general.
5.	Older men who have HIV because it ages you faster.
6.	Persons "out of care".
7.	Persons who don't know their status.
8.	Need to get past the stigma, should be more of a national health concern.
9.	Need to get past HIV/Aids stigma for providers.
10.	Need to address disparities, looking at continuum, need to use this state-level data to target.
11.	Need to respect each other's culture, help each other.

9. Next Steps

Kathy Burek – Advanced Strategies

--Comments by EOD Tuesday
--Draft will be posted on website by on Wed (*Note: this will not be possible, due to the death of Kahlil's son. The draft report will instead be emailed to the participant list.)*
--Will submit to DHS by 12/5
--May be follow up meetings, as Alex Bartolic indicated

Dave Rompa – HIV/AIDS Unit Supervisor

--DHS will review AS report and write additional material
--Submit to Legislature by 12/15
--At same time, will start looking at first phase to get first $4M based on priorities set today

Participant Comments on Next Steps

#	Comment
1.	Q: Where does it go in legislature? A: Chairs of HHS Policy and Finance committee.
2.	W: Will get posted somewhere? A: On MNUnmetNeeds.com and DHS websites.
3.	Q: First $4M out by January or Feb of 2015? A: In three $4M phases in order to be manageable for staff. Need contracting and quality checks, etc. for this.
4.	Q: Will there be ongoing information going out on this? A: Need to see as it unfolds. Many of these projects will require community involvement as well.

10. Participant Debrief

Participant Comments

#	Comment
1.	Overall: Is a learning process
2.	Overall: Much better meeting than the first two because it was concrete. More focused.
3.	Overall: We need to have the results from this so we can approach our legislators.

HIV/AIDS Unmet Need and Rebate Fund Use Report

#	Comment
4.	Overall: Most effective and productive of all three meetings.
5.	Overall: Much better than earlier meetings. Less turf issues.
6.	Overall: Having exercises is good.
7.	Overall: Can take it "on the chin" because this.
8.	Do better: Hard to not be presented with more data to make these decisions.
9.	Do better: A lot of money, so must manage perceptions/expectations.
10.	Do better: Need to help people understand how consensus is reached.
11.	Do better: Planning council does this regularly but with much more data to make decisions. Felt like we were reinventing the wheel used at the Planning Council.
12.	Do better: Website not that helpful. Sporadic updates. Not sure what was new.
13.	Do better: Make sure people can download documents.

11. Closing

Kathy Burek, Advanced Strategies

--It's been an honor and a pleasure
--Thank you all for your hard work
--Happy Thanksgiving!

Richard Branton, Advanced Strategies

--We all do better when we all do better, like Wellstone quote.
--Working together as important as just allocating money.
--Thank you for all DHS staff work.

Appendix B Revised Success Elements

An earlier version of the Definition of Success was posted on www.unmetneed.com, and participants had the opportunity to assess the elements and provide comments via a survey. The Definition was then adjusted based on participant feedback. Numbers in parentheses reflect average rank on a scale of 1=Strongly Disagree to 5=Strongly Agree). Only items ranked an average of 3.5 or greater were included in the revised version. The revised version, below, was again posted on the website. The comments of one participant follow the revised definition.

Desired End Results

- All people living with HIV/AIDs will have access to appropriate care, including
  - Comprehensive medical care (for HIV/AIDS and other conditions experienced by the HIV+ person, such as diabetes) (4.26)
  - Prescription drugs (4.23)
  - Case management (4.13)
  - Mental health and chemical dependency treatment (4.06)
  - Services for other diseases such as Hepatitis-C that disproportionately impact the people living with HIV (4.06)
  - Nutrition (4.03)
  - Other support services needed for persons living with HIV/AIDS to have a high quality of life (3.81)
- Reduction in the number of people living with HIV/AIDS who are
  - Uninsured (4.06)
  - Without access to services (4.06)
  - Homeless or living in unsafe, substandard housing (4.03)
- The general public will be educated about HIV/AIDS
  - To reduce exposure (3.97)
  - To reduce stigma (3.93)
  - To reduce fear (3.93)
- Reduction in the number of HIV+ people who are unaware of their status (3.90)
- Minnesotans living with HIV/AIDs, regardless of sexual orientation, age, culture/ethnicity, family status, gender, language, legal status, religion, place of residence, disability will be provided with resources for a high quality of life (3.90)
- Minnesotans living with HIV/AIDs, regardless of sexual orientation, age, culture/ethnicity, family status, gender, language, legal status, religion, place of residence, disability will be provided with resources for a high quality of life (3.90)
- Basic needs of low-income people living with HIV/AIDS will be met, including housing, transportation, job training and placement (3.90)
  - Reduce the number of people living with HIV/AIDS who are unemployed or underemployed (3.52)
- Reduction in the number of new HIV cases (3.81)
- Persons living with HIV/AIDs and their families and friends will have access to education and support services (3.58)

Desired Characteristics of Programs

- Partnerships among organizations providing services should be encouraged and supported (4.45)
- Personnel serving people with HIV/AIDS will be appropriately trained (4.38)
- Learning from the success of others is important (4.38)
- The system of applying for services will be easy for applicants and their families to understand and navigate (4.38)
- Services will be accessible in a timely manner (4.34)
- Persons receiving services will have a voice in determining how their needs will be served (4.30)
- Services and programs for people with HIV/AIDS will meet quality standards (4.24)
- Obstacles to receiving services will be minimized (4.24)
- Services and programs will be administered efficiently and effectively (4.21)
- Groups and individuals involved in care of persons with HIV/AIDS and in developing policy will communicate effectively with one another (4.21)
- Persons receiving services will be empowered to advocate for their needs (4.20)
- Minnesotans with HIV/AIDS, and their families and friends, will be treated with dignity and respect (4.18)
- Services and programs will address the many needs (medical and other) of people living with HIV/AIDS (4.17)
- Service providers will collaborate with one another to serve the client's interests (4.10)
- Services, programs, and outreach will be culturally relevant to racial/ethnic/linguistic groups of persons living with HIV/AIDS and to the broader communities impacted by HIV/AIDS (4.00)
- Programs and services will be targeted at specific groups or geographic areas of greatest need, i.e., the degree of impact of HIV/AIDs on a specific group when compared to currently available programs and services (4.00)
- Service providers will be fairly reimbursed (4.00)
- Funding will support innovation (3.93)
- Funding should be flexible (3.90)
- Funding for services and programs will be equitable across subpopulations (3.75)
- Family and friends of people with HIV/AIDS are an important constituency, and also need access to services (3.72)
- Programs should be sustainable (inadvertently omitted from survey; no ranking)
- Funding should be stable (inadvertently omitted from survey; no ranking)

Feedback on Revised Success Elements

Below are comments on the revised Success Elements, received electronically, as of December 3, 2014.

On the Revised End Results: 3 agree with minor reservations; 1 disagree with major reservations

- Some areas seem a bit broad and need some discussion. I also feel that we need to move quickly before the next legislative session begins.
- I would include legal services in basic needs and/or resources for a high quality of life
- Needs to include: Increase in the proportion of PLWH who are retained in care Increase in the proportion of PLWH who have suppressed virus Community organizing to

mobilize disproportionately impacted communities (gay/bi/msm, African American gay/bi/msm, African American women, African-born, etc.) to end the epidemic Universal implementation of routine HIV testing according to CDC guidelines in primary care settings statewide Unfettered access to PreP and nPEP for high risk individuals

- My major reservations are that there are programs that are close to shutting down or reducing services due to inadequate funding and/or sharp insurmountable deficits. To fund what I perceive to be "extras" when there are basic needs that are not being met is very challenging to me and the patients and providers I work with.

On the Revised Program Characteristics: 3 agree with minor reservations; 1 disagree with major reservations

- Some areas seem a bit broad and need some discussion. I also feel that we need to move quickly before the next legislative session begins.
- Revisions: Services, programs and outreach will be culturally relevant to racial/ethnic/linguistic/sexual minority/transgender/low income/age groups of persons living with HIV/AIDS and to the broader communities impacted by HIV/AIDS (4.00) All programs will work towards linking PLWH to care and facilitating retention in care.
- Once again, there are many "extras" in these revised program characteristics. Additionally, there should not be a need to fund a large number of these characteristics since it should be happening already as part of service delivery.

Appendix C Ranking Criteria

Background: Conflicts often occur because people are using different criteria for setting priorities. Mistrust occurs when decisions are made and the affected community doesn't understand, or agree with, the rationale for those decisions. There are three areas where decisions about priorities need to be made.

- Unmet Needs: People living with HIV/AIDS have many needs. We would like to hear from people living with HIV/AIDS, their family and friends, providers of services to persons living with HIV/AIDS, and HIV/ADIS advocates about which of these unmet needs should be given highest priority.
- Possible Solutions: There is any number of programs, interventions or strategies we might try to address unmet needs. In order to decide which of these to try first, we need explicit criteria.
- Allocation of Funds: Once we know which unmet needs have the highest priority, and which possible solutions we would like to try, we need to decide how to allocate funds among them. Allocating money also requires explicit decision criteria.

Data may not be available to apply each of the criteria to every unmet need. However, one can still rank the criteria in order of their importance, so that when data is available, the unmet needs can be ranked. If data is not available, that points to another unmet need.

Ranking Criteria for Unmet Needs/Ranking Scale

- Total Numbers: Meet the needs that impact the most people living with HIV/AIDS, regardless of any other considerations. (E.g., if more people are without dental care than without drugs, drugs would be more important).
- Disparities: Meet the needs of subpopulations that are underserved before giving additional services to subpopulations better served. (E.g., if more African immigrants are without medical treatment for HIV/AIDS, their needs should be met before adding services to subpopulations that are already receiving services).
- Unserved/Underserved Individual: Meet the needs of individuals who are unserved or underserved before giving additional services to individuals who already are receiving services. (E.g., if JJ and MS are two white, gay, Twin Cities men. JJ is on the Ryan White program; MS is not. Get MS on the Ryan White program before providing JJ with additional drugs, or additional services, like dental or vision care).
- Necessary for Life/Health: Meet needs in categories that are considered by persons living with HIV/AIDS to be most critical or essential to their existence.

Ranking Criteria for Possible Solutions (programs, interventions, strategies, etc.)/Ranking Scale

- **Alignment with Success Elements (Desired End Results/Program Characteristics):** Success elements would be based on the first homework exercise, as revised based on feedback, and confirmed in the final session.
- **Ease of Implementation**: Possible solutions that can be implemented quickly, within existing funding and legislative authority.
- **Quality of Life**: Possible solutions likely to have the greatest impact on the quality of life of persons living with HIV/AIDS.
- **Pilot Projects/Experiments**: Possible solutions that can provide information about what works and what doesn't.

- **Data-gathering and Analysis**: Possible solutions to gather data on what unmet needs are, how extensive, which communities are most impacted, etc., so that future decisions are informed by better information.
- **Community Investment/Capacity-building**: Possible solutions that develop the infrastructure needed to serve the community, or builds the capacity of the community to provide services.
- **Systems Improvements**: Possible solutions that streamline administrative processes and make it easier for the consumer to access services.
- **Track Record**: Possible solutions that have been tried elsewhere, and have demonstrated good results.

Fund Allocation Criteria: Once we know which needs are the highest priorities, and which candidate solutions have the highest priority, we need to decide how to allocate funds among them.

- **Cost**: Priority should be given to candidate solutions with low start-up and ongoing costs
- **Cost-Effectiveness**: Priority should be given to candidate solutions likely to have the greatest benefit for the money spent
- **Leveraging**: Priority should be given to candidate solutions that can generate matching dollars (e.g., from federal government, state programs, foundations, etc.), or that are eligible for in-kind contributions
- **Sustainability**: Priority should be given to funding strategies that are likely to be sustainable over the long term (e.g., 5 or more years).
- **Start-ups**: Priority should be given to funding new programs, to help them get started.
- **Hold-Harmless**: Funding for current, successful programs should not be cut in order to fund new activities.
- **Innovation**: 20-30% of funds should be allocated to innovative programs (added as a result of discussion on Nov. 20, 2014)

Appendix D Mini-Proposals from Community

The following proposals were submitted by consumers and providers. At the request of one provider, identifiers were removed.

Proposal #1: Program Ideas

Unmet Need	Proposal for Meeting Unmet Need
1. Women	Support Groups & Programming Education, Safer Sex
2. Seniors	More housing
3. Housing	Option for mental health
4. Support Groups	Services, programming & Support Groups
5. St. Paul Area	FBO (Faith Based Organization), Communities of Color
6. Education	Huge disparity for both women, men MSM, education: Faith Based
7. African American Community	Organization, stigma
8. Transgender	Basic –Services: housing, programming
9. HIV advocates	People that communicate with Elected Officials & Community/Public Speakers

Proposal #2: Program Ideas

Unmet Need (Service and/or Client Types)	Program Idea	Roughly Estimated Cost	Estimated Implementation Time Needed
Uncompensated primary and HIV medical care for PLWH/A	Funding would be used to cover otherwise uncompensated medical cost incurred by PLWH/A on the HCMC campus. In 2013, HCMC provided approximately $3.4 million dollars in uncompensated medical care to this population.	$500,000	Could be implemented immediately
Community Paramedic Program	Program would extend existing HCMC Community Paramedic Program to serve PLWH/A. Program would allow adherence support, medication support, brief medical assessments and interventions to reach vulnerable patients in the community where they reside even if marginally housed. Program would improve linkage to care and medical outcomes for the most vulnerable of the Positive Care Center patients.	$200,000/yr Proposed 5 year pilot	6 months
Care Coordination	Program would fund additional services of existing nurse run Care Coordination Program for specific high-risk patients identified by the PCC. The current program	$150,000 / year ongoing	3 months

Unmet Need (Service and/or Client Types)	Program Idea	Roughly Estimated Cost	Estimated Implementation Time Needed
	has already significantly improved the quality of life and decreased the medical cost of care for certain PCC patients.		
Linkage to care (inpatient to outpatient)	The transition from the inpatient setting to the outpatient clinic is a vulnerable point in attempt to link patients to HIV care. For new patients and those previously lost to care, this transition is particularly important. This program would create a structured patient navigation program to improve linkage to care at this transition. The navigation services would likely incorporate PCC social work and retention staff to build upon their current roles.	$65,000/year (ongoing)	6 months
Enhanced partner testing services	Currently PCC operates partner testing service that has been successful in identifying new HIV+ patients. This program would extend testing services through peer distributed home- based tests with a coordinated effort for linkage to care of those who test positive. The program would allow testing services to reach new populations that may rarely, if ever, test for HIV and provide them a rapid access to HIV clinical services.	$45,000/year (ongoing)	6 months
PharmD smoking cessation program	Recent medical research has demonstrated that smoking related illnesses now kill more HIV+ individuals in the United States that HIV itself. This program would fund a PharmD- based smoking cessation program in the PCC. Previous efforts at smoking cessation have had poor uptake and retention. Embedding these services in the primary HIV clinic with a 'familiar face' PharmD will possibly improve uptake, retention, clinical outcomes and ultimately reduce smoking related morbidity.	$90,000/year (ongoing)	3 months
Non-occupational HIV post-exposure prophylaxis (nPEP)	Financial and insurance constraints routinely limit the rapid access of medications for those presenting for nPEP services. This program would fund 'starter pack' supplies for qualified nPEP patients. The 'starter packs' would allow for medication coverage for the first few critical days of nPEP therapy while additional financial and insurance hurdles are overcome. By filling this gap, the program would support a critical	$22,500/year (ongoing)	Immediately

Unmet Need (Service and/or Client Types)	Program Idea	Roughly Estimated Cost	Estimated Implementation Time Needed
	intervention in HIV prevention services.		
Hepatitis C (HCV) infected persons – improve and increase access to evaluation and treatment in high- prevalent rural and urban underserved populations by replicating the Project ECHO model in Minnesota. Since 15-30% of HIV-infected persons are co-infected with HCV, this program will significantly impact the health and well-being of HIV-infected individuals.	This initiative, which will replicate the internationally successful Project ECHO model, will establish a PROJECT ECHO Hepatitis C Center in Minnesota. The goal is to expand the capacity of HCV knowledgeable providers to provide best practice care for HCV-infected persons in rural and underserved urban areas and monitor program related outcomes. In order to implement this program and pursue more permanent funding, we request startup funding support. Proprietary Project ECHO technology (multipoint videoconferencing and Internet) combined with case-based teaching and mentoring by specialists allows local providers to develop HCV expertise. By developing this expertise, local providers can manage HCV-infected patients at their primary care clinic site rather than referring these patients to specialty clinics. This approach has been demonstrated to increase the number of persons receiving care while achieving comparable outcomes. This project will offer new services to current and new client groups. Multiple steps, along with funding, are needed to start a Project ECHO Center. We have already started key steps as summarized below: 1. We have identified HCV specialists in Minnesota who will participate and mentor local clinic providers and their staff to develop HCV expertise. 2. One of these HCV specialists (Kay Schwebke, M.D.) recently attended a full day Project Echo orientation session in Albuquerque, New Mexico and has specifically discussed replication interests and efforts in Minnesota with Project ECHO staff. 3. We have discussed this initiative with University of Minnesota Provost Karen Hanson. Our proposal is coordination of this project through the University of Minnesota, with discussions ongoing.	$300,000 startup funding is requested for the first year. We will pursue ongoing funding through the Minnesota legislature, the Indian Health Service and other sources.	Estimated implementation time is 6 months, once funding is secured.

Unmet Need (Service and/or Client Types)	Program Idea	Roughly Estimated Cost	Estimated Implementation Time Needed
	We have started to identify rural and urban high need and underserved communities with a high prevalence of HCV infection. Although no specific clinics have been identified, we believe several primary care clinics in Minnesota would benefit from this program, such as Indian Health Service clinics, methadone clinics and West Side Community Health Services.		

Proposal #3: Program Ideas

Unmet Need (Service and/or Client Types)	Program Idea
Access to PrEP	We are in critical need of additional funding for our PrEP program. Currently we are underfunded in this intervention. Our program was originally designed to serve 60 clients in a 12 month period and we currently receive no reimbursement for clinicians and lab tests serving patients without medical insurance. We have enrolled 140 new patients in 2014 and would like to expand staffing of this program to 2 full time Community Health Specialists and also receive funding to support Nurse Practitioner time to serve individuals without health insurance. Any funding would be beneficial and the program could be expanded based on any increment of funding. PrEP benefits people living with HIV because it curbs new HIV infections for partners of known HIV positive people and reduces new infections for others at high risk. PrEP is a tool that can enhance intimate relationships and addresses stigma in two ways. PrEP reduces the anxiety level of individuals concerned about transmitting HIV to their sexual partners dependent on their viral load or consistency of condom use. PrEP also allays fear of people becoming infected and can serve as a bridge for sero-discordant couples to be sexually fulfilled without the worry of transmission.

Proposal #4: Program ideas

Unmet Need	Proposal for Meeting Unmet Need
Involvement of the African American Church in HIV/AIDS education, testing, awareness and support groups.	The Foundation was formed in 1992 to build community through the African American Church. The African American Church continues to be the most important and influential organization in the African American Community. Proposer is committed to strengthening the capacities of African American churches to solve problems in its community by building relationships and connections from which it is possible to address health problems. To demonstrate the efficacy of the church network and to launch efforts to cl[illegible] the health disparities that plague African-Americans proposer imp[illegible]nted There Is A Balm. TIAB is a health-focused effort begun i[illegible]2 in response to an Eliminating Health Disparities RFP from the M[illegible]sot[illegible]partment of Health. The proposer's response in[illegible]lved utilizing [illegible] church network by imbedding health site coordinat[illegible]n collaborating c[illegible]rches. Currently we have over 35 individua[illegible]m churches of all den[illegible]inations serving as Church Health Coordinato[illegible]nd Navigators, providing [illegible]lthy living programs, MnSure enrollment, c[illegible]mmunity o[illegible]reach service[illegible]d educational services through our Be[illegible] Bo[illegible] To me[illegible]et needs of pe[illegible]living with HIV/AIDS we propose the followin[illegible]Th[illegible]gh the Founda[illegible]n network of churches, host educationa[illegible]works[illegible]s for the co[illegible]egation, stress the importance that everyone ge[illegible]ested a[illegible]ow their [illegible]us by providing HIV screenings at [illegible]e church in p[illegible]rtnershi[illegible](for exam[illegible]e) Open Cities who we already ha[illegible]a relationsh[illegible]w[illegible]throug[illegible]Free Flu Shot Clinics. Get the chur[illegible]more invo[illegible]by recognizing National Black HIV Awareness Day at th[illegible]church and [illegible]sting events that highlight the disproportionate im[illegible]is having o[illegible]he community at 3-6 centrally located churches, [illegible]each in [illegible]ul, So[illegible]Minneapolis and North Minneapolis. As well as [illegible]n site coord[illegible]rs to facilitate support groups at each of these centr[illegible]located churches for people infected and affected by HIV/AIDS. Participa[illegible]churches would receive a stipend for hosting HIV Screenings [illegible]their chu[illegible]and receive a monthly stipend for facilitating support g[illegible]ps. Involved churches would join the Black Church and HIV: The So[illegible]l Justice Imperative initiative.

HIV/AIDS Unmet Need and Rebate Fund Use Report

Proposal #5:

Unmet Need	Proposal for Meeting Unmet Need
1. A 2012 study by PFUND: Twin Cities LGBT Aging Needs Assessment found that LGBTQ people are nearly twice as likely to be caregivers, and provide non-kin caregiving for friends, coworkers and chosen family. Many persons with HIV/AIDS are part of the cohorts of both caregivers and care receivers. 2. Among the Priorities List Home & Community-Based Health Services (HCBS) were ranked at the bottom (9 of 10). HIV exploded 25-30 yrs ago. It is possible that a significant number of those persons are now or soon to be among the boomer population and HCBS services will be crucial. 3. The provider profile appears to be a self-assessment of services the Provider expects to provide. How can the survey help providers consider the quality of their services for the aging population and, particularly the LGBTQ population? How will Provider needs for additional education and training related to this aging population be determined? 4. Unfortunately, "Family and friends of people with HIV/AIDS who are an important constituency and also need services" received one of the lowest rankings (5th of 73 items) resulting in no mention on the Priorities List. 5. The Summary of Feedback on Elements of Success (as of 9/10/14) Question 36 is a strong	Since research also reveals that older LGBTQ persons are more likely to be single and living alone offer resources and support to these non-kin caregivers. Supporting HCBS orgs is critical for any older adults including those with HIV/AIDS. They need these services to have continued good health while living with the chronic disease and this would be especially true for LGBTQ persons who don't have strong family ties or are living alone. Reframe survey with additional questions to draw out the needs of the aging population, as well as aging LGBTQ persons. Along with the direct support to the person living with a chronic condition, particularly as they age, support for family and friends (the caregivers) must be considered. As already acknowledge, for older LGBT persons, especially those who live alone, these caregivers are the backbone of their survival. Assess services for the older adult cultural framework. Assess services for the lesbian, gay and bisexual cultural framework.

Unmet Need	Proposal for Meeting Unmet Need
indicator that focusing on the "older" aspect of adults living with HIV/AIDS is part of a culturally sensitive service. 6. Conversely, the Summary of Feedback on Elements of Success (as of 9/10/14) Question 36 does not reflect upon the need for culturally sensitive service for the lesbian, gay or bisexual person living with HIV/AIDS.	

Proposal #6: Program Ideas

Unmet Need (Service and/or Client Types)	Program Idea	Roughly Estimated Cost	Estimated Implementation Time Needed
Case Management	Add on new case manager	$60,0[illegible] / year	[illegible] months
Benefits Counselor	Provide benefits counseling and advocacy to clients	$[illegible]00 / year	2 [illegible]nths
Nutritional Counseling for Greater MN	Additional funding to current grant	$5,000 /year	immed[illegible]ly
On site Meal Program	Additional funding for hot meals for [illegible] clients	$20,0[illegible]ar	immediately
On-site Meal Program	New salad bar	$10,000 (on[illegible]	1 month
Food Shelf Program	Additional funding for F[illegible]lf to add 2 more days of servi[illegible]er we[illegible]	$75[illegible]ear	[illegible]onths
Integrative Therapy Program	Funding for acupunc[illegible]e, massage[illegible]d other body therapies	[illegible]5,000 / year	immediately
Funding to help cover capital needs	New pa[illegible]itional t[illegible] room[illegible]rk on com[illegible]ity roo[illegible]	$1[illegible]000 (one [illegible]ime)	6 months

Proposal #7: Additional Support for Minnesota Department of Health

The following are unofficial suggestions, received after the report deadline.

- Enhance MDH capacity for analyzing and sharing surveillance data
- Enhance MDH capacity for moving newly diagnosed people into care and people out of care back into care
- Enhance MDH capacity for working with underserved communities
- Enhance ability of hospitals, clinics and labs to report HIV data
- Scale up HIV testing for at-risk populations
- Develop an application to provide MSM with information about HIV testing, safe sex, linking with care
- Build capacity with other health care workers
- Report on Minnesota's ability to meet national HIV/AIDS goals

Appendix E DHS Cost Data

The following data was provided by the Department of Human Services, HIV/AIDS Unit.

Unmet Needs Assessment of Funding

- Program Exists Now = Yes/No
- Eligibility for Funding via Ryan White Drug Rebate money
  - Now = Need category can be funded using Ryan White drug rebate money within current laws and policies
  - Feasible = Need category could be funded with Ryan White drug rebate money with statutory or policy changes that are easily Implemented
  - Challenging = Not likely that Ryan White drug rebate money could be used for this needs category
- Ryan White is always the payer of last resort. Many of these service areas can have other funding sources, but the Ryan White Grantees must ensure that Ryan White funds are used as the payer of last resort.
- Rebate funds can only be used to fund services for persons living with HIV.
- There is a rebate report for reference on past rebate spending. **Attachment A**
- There is Program HH enrollment by County information. **Attachment**

				Comments
1.	Advocacy	No	No	Client advocacy services are fundable through Ryan White; however, legislative advocacy is not a fundable service. It is unclear what is meant by advocacy. Stigma is a concern that frequently arises. Possible option: Stigma campaign ($150,000-one time)
2.	Adherence Support-Medications	Yes	Yes	Funded through Planning Council and MTM Services
3.	Caregiver Support (e.g. respite care)	Yes	Yes	
4.	Case Management-Medical	Yes	Yes	319 clients served through 39,960 units of service.
5.	Case Management-Non-Medical	Yes	Yes	436 clients served through 1,367 units of service. Possible Option: Continue the two ACA Benefit Counselors ($140,000 yearly)
6.	Chemical Dependency Treatment Services	Yes	HRSA does not approve use for treatment	This is a broad area. It requires more clarification. Ryan White funds are currently used for rural 25 assessments and Chemical Dependency training. Possible Option: Continue funding the HIV

#	Needs Category	Program Exists Now?	Eligible Use of Drug Rebate Money?	Comments
			but can be used for assessment	Chemical Dependency Counselor Training ($75,000 yearly)
7.	Comprehensive Sex Education	No	No	
8.	Dental Care	Yes	Yes	108 clients were served through 259 units of service
9.	Employment/Jobs	No	Possible	Most recently Education For Life (EFL) was funded through rebate and supported by HRSA. So they are open to pilot/demonstration projects.
10.	Financial Assistance for Meeting Copays, Deductibles, & Premiums	Yes	Yes	This service is currently available. HIP served 36 clients through 114 units of service. Could be expanded to cover the following: MA-EPD Premiums $75,000 (est)(yearly) MNCare Premiums $75,000 (est) (yearly) FPG (Poverty Level-Program Eligibility Level) Increase $ 300,000 (est) (yearly)
11.	Financial Assistance-Emergency	Yes	Yes	993 clients served through 1,582 units of service
12.	Food	Yes	Yes	757 clients were served through 3,016 units of service. Currently it appears that Greater MN Food is under-funded
13.	Health Insurance	Yes	Yes	Currently sustaining the need; reliant on rebate funds
14.	HIV/AIDS Testing	Yes	Yes, for Early Intervention Services (EIS) only	DHS currently funds this service through MAI funds and rebate at two agencies.
15.	Home & Community Based Services	Yes	Yes	Provided by Part A
16.	Housing	Yes	Yes. HRSA guidance is still being interpreted	The Planning Council is finalizing their recent allocation to Housing. Part B will be contributing a portion of the $100,000 allocation.
17.	Legal Services	Yes	Yes	27 clients served through 64 units of service

#	Needs Category	Program Exists Now?	Eligible Use of Drug Rebate Money?	Comments
18.	Lack of Knowledge about Resources Available and How to Access Them	Yes	Yes	This area is being addressed through MCM, Outreach, EIS, DHS Customer Care, MN AIDSLine
19.	Long-term Care/Assisted Living	No	No	
20.	Medical Nutrition	Yes	Yes	Currently being used within Part A & B budgeted amounts. Possible Option: Assess the prior authorization, dietician funding and nutrition product distribution through a needs assessment to improve services ($75,000 – one time)
21.	Medical Treatment	Yes	Yes	This requires more detail before a response can be provided. Ryan White funds are used for outpatient ambulatory medical care and clients can use insurance to cover medical expenses. Additional funds could be made available to cover client out-of-pocket medical expenses.
22.	Mental Health Services	Yes	Yes	50 clients were served through 176 units of service. This area has been impacted by recent HRSA guidance and we have seen a reduction in utilization. This may be an area to consider possible pilot/demonstration projects.
23.	Prescription Drugs	Yes	Yes	Currently meeting consumer needs and is heavily reliant on rebate funds for 6 months out of every AIDS Drug Assistance Program (ADAP) fiscal year.
24.	Prevention Education for At-Risk Persons	Yes	Yes (Outreach & EIS)	HRSA has guidance around the balance of prevention with the "care" outreach and early intervention services to care. Now that prevention=care this may be an area for pilot/demonstration projects.
25.	Preventive Services for At-Risk Persons (e.g., condoms, needle exchanges)	Yes	Yes (condoms only for EIS only)	Currently Available through 2 EIS-funded agencies only. 9 clients served through 9 units of service. (report from 1 agency)
26.	Providers	Yes	Yes	Program HH has worked with the Planning
	Knowledgeable/Sensitive to HIV/AIDS and GLBT clients			Council and MATEC to create brochures for service providers regarding HIV/AIDS.
27.	Psychosocial Support-Persons living with HIV/AIDS	Yes	Yes	Funded through Planning Council

#	Needs Category	Program Exists Now?	Eligible Use of Drug Rebate Money?	Comments
28.	Psychosocial Support-Caregivers, family, friends of PLWHA	No	No	
29.	Reduce/Remove Communications Barriers-Non-English speakers/readers	Yes	Yes	Linguistic services are currently covered by Parts A & B
30.	Reduce/Remove Communications Barriers-Persons with hearing impairments/deaf	Yes	Yes	Resources already exist with current resources
31.	Reduce/Remove Communications Barriers-Persons with visual impairments/blind	Yes	Yes	
32.	Referrals to Services	Yes	Yes	143 clients served through 239 units of service.
33.	Training for Providers (about HIV/AIDS, sensitivity, etc.)	Yes	Yes	This is a broad category. Ryan White funded case managers receive training and are offered on-going opportunities to expand knowledge. MATEC works to provide training to medical providers around HIV/AIDS
34.	Targeted Services –African Americans	Yes	Yes	One agency is receiving money to provide Case Management Services for African American. MAI funding is also targeting Early Intervention and Outreach Services.
35.	Targeted Services –African Immigrants	No	Yes	While there are not programs specifically targeted at African-born persons, all Program HH funded services are available to any eligible client.
36.	Targeted Services-Asian immigrants	No	Yes	While there are not programs specifically targeted at Asian immigrants, all Program HH funded services are available to any eligible client.
37.	Targeted Serviced-Asian	No	Yes	While there are not programs specifically
	Americans			targeted at Asian Americans persons, all Program HH funded services are available to any eligible client.
38.	Targeted Services-Bisexual persons	No	Yes	While there are not programs specifically targeted at bisexual persons, all Program HH funded services are available to any eligible client.
39.	*Targeted Services-Gay men*	*No*	*Yes*	*While there are not programs specifically*

#	Needs Category	Program Exists Now?	Eligible Use of Drug Rebate Money?	Comments
				targeted at Gay men, all Program HH funded services are available to any eligible client.
40.	Targeted Services— Intravenous drug users	No	Yes	While there are not programs specifically targeted at Intravenous drug users, all Program HH funded services are available to any eligible client.
41.	Targeted Services-Latino/Latina	No	Yes	While there are not programs specifically targeted at Latino persons, all Program HH funded services are available to any eligible client. Possible Option: Fund an annual Latino Health Summit ($25,000 annually)
42.	Targeted Services-Native Americans	No	Yes	While there are not programs specifically targeted at Native Americans, all Program HH funded services are available to any eligible client. Currently support HIV/Hepatitis Conference at White Earth Reservation. Possible Option: Continue this support beyond 2015. $50,000 annually.
43.	Targeted Services-Greater MN	Yes	Yes	HRSA Site Visit had concerns regarding Greater MN services being under-funded
44.	Targeted Services-Older Persons	No	Yes	While there are not programs specifically targeted at older persons, all Program HH funded services are available to any eligible client.
45.	Targeted Services-Transgender persons	No	Yes	While there are not programs specifically targeted at Transgender persons, all Program HH funded services are available to any eligible client.
46.	Targeted Services-Sex workers	No	Yes	While there are not programs specifically targeted at Sexworkers, all Program HH funded services are available to any eligible client.
47.	Targeted Services-Undocumented persons	No	Yes	While there are not programs specifically targeted at undocumented persons, all Program HH funded services are available to undocumented persons.
48.	Targeted Services-White men	No	Yes	While there are not programs specifically targeted at white men, all Program HH funded services are available to any eligible client.

#	Needs Category	Program Exists Now?	Eligible Use of Drug Rebate Money?	Comments
49.	Targeted Services-Young adults	Yes	Yes	MCM Covered for one agency serving youth.
50.	Targeted Services-Youth/Teens	Yes	Yes	MCM Covered for one agency serving youth.
51.	Targeted Services-Women	No	Yes	While there are not programs specifically targeted at women, all Program HH funded services are available to any eligible client. Projected Options: Support Group (1 Annually $20,000) Annual Women's Conference ($100,00)
52.	Targeted Services-Persons with Disabilities • Visual • Hearing • Mobility • Developmental • Other	Yes	Yes	Through a variety of resources, there are services available to assist serving these consumers.
53.	Transportation to Medical Services	Yes	Yes	1,567 clients were served through 16,181 units of service.
54.	Transportation for groceries, jobs	No	No	
55.	Vision Care	No	No	
56.	Support Groups Option for mental health	Yes	Yes	The Planning Council funds some psycho- social support with support group components.
57.	Seniors	No	Yes	Education, Safer Sex
58.	St. Paul Area Services, programming & Support Groups	Yes	Yes	Some Ryan White services are available in St Paul. There are always opportunities to expand the types of services being offered in any geographic region of the State.
59.	Education- FBO (Faith Based Organization), Communities of Color	No	Possible	Needs more clarification
60.	African American	No	Possible	Needs more clarification
	Community- Huge disparity for both women, men MSM, education: Faith Based Organization, stigma			
61.	Funding the Planning Council	Yes	Yes	Possible Option: Increase funding from $200,00 annually to $500,00 annually
62.	Support for USCA attendance	Yes	Yes	Provided 3 staff and 3 consumer slots at USCA this year. Continue this support. Possible Option: Continue this funding

#	Needs Category	Program Exists Now?	Eligible Use of Drug Rebate Money?	Comments
				$15,000 annually)

Proposals from community

#	Needs Category	Program Exists Now?	Eligible Use of Drug Rebate Money?	Comments
63.	Uncompensated primary and HIV medical care for PLWH/A	No	Yes	Community Recommendation: Funding would be used to cover otherwise uncompensated medical cost incurred by PLWH/A on the HCMC campus. In 2013, HCMC provided approximately $3.4 million dollars in uncompensated medical care to this population. $500,000 Could be implemented immediately
64.	Community Paramedic Program	No		Community Recommendation: Program would extend existing HCMC Community Paramedic Program to serve PLWH/A. Program would allow adherence support, medication support, brief medical assessments and interventions to reach vulnerable patients in the community where they reside even if marginally housed. Program would improve linkage to care and medical outcomes for the most vulnerable of the Positive Care Center patients.
65.	Care Coordination	Yes		Community Recommendation: Program would fund additional services of existing nurse run Care Coordination Program for specific high-risk patients identified by the PCC. The current program has already significantly improved the quality of life and decreased the medical cost of care for certain PCC patients. $150,000/year (ongoing) 3 months
66.	Linkage to care (inpatient to outpatient)	Yes		Community Recommendation: The transition from the inpatient setting to the outpatient clinic is a vulnerable point in attempt to link patients to HIV care. For new patients and those previously lost to

#	Needs Category	Program Exists Now?	Eligible Use of Drug Rebate Money?	Comments
				care, this transition is particularly important. This program would create a structured patient navigation program to improve linkage to care at this transition. The navigation services would likely incorporate PCC social work and retention staff to build upon their current roles. $65,000/year (ongoing) 6 months
67.	Enhanced partner testing services			Community Recommendation: Currently PCC operates partner testing service that has been successful in identifying new HIV+ patients. This program would extend testing services through peer distributed home- based tests with a coordinated effort for linkage to care of those who test positive. The program would allow testing services to reach new populations that may rarely, if ever, test for HIV and provide them a rapid access to HIV clinical services.
68.	PharmD smoking cessation program			Community Recommendation: Recent medical research has demonstrated that smoking related illnesses now kill more HIV+ individuals in the United States that HIV itself. This program would fund a PharmD- based smoking cessation program in the PCC. Previous efforts at smoking cessation have had poor uptake and retention. Embedding these services in the primary HIV clinic with a 'familiar face' PharmD will possibly improve uptake, retention, clinical outcomes and ultimately reduce smoking related morbidity.
69.	Non-occupational HIV post-exposure prophylaxis (nPEP)	No		Community Recommendation: Financial and insurance constraints routinely limit the rapid access of medications for those presenting for nPEP services. This program would fund 'starter pack' supplies for qualified nPEP patients. The 'starter packs' would allow for medication coverage for the first few critical days of nPEP therapy while additional financial and insurance hurdles are overcome. By filling this gap, the program would support a critical

#	Needs Category	Program Exists Now?	Eligible Use of Drug Rebate Money?	Comments
				intervention in HIV prevention services. $22,500/year (ongoing) Immediately
70.	Hepatitis C (HCV) infected persons – improve and increase access to evaluation and treatment in high-prevalent rural and urban underserved populations by replicating the Project ECHO model in Minnesota. Since 15-30% of HIV-infected persons are co-infected with HCV, this program will significantly impact the health and well-being of HIV-infected individuals in	Yes, Hep C Medication	Yes, for HIV dually diagnosed	Community Recommendation: This initiative, which will replicate the internationally successful Project ECHO model, will establish a PROJECT ECHO Hepatitis C Center in Minnesota. The goal is to expand the capacity of HCV knowledgeable providers to provide best practice care for HCV-infected persons in rural and underserved urban areas and monitor program related outcomes. In order to implement this program and pursue more permanent funding, we request startup funding support. Proprietary Project ECHO technology (multipoint videoconferencing and Internet) combined with case-based teaching and mentoring by specialists allows local providers to develop HCV expertise. By developing this expertise, local providers can manage HCV-infected patients at their primary care clinic site rather than referring these patients to specialty clinics. This approach has been demonstrated to increase the number of persons receiving care while achieving comparable outcomes. This project will offer new services to current and new client groups. Multiple steps, along with funding, are needed to start a Project ECHO Center. We have already started key steps as summarized below: . 1. We have identified HCV specialists in Minnesota who will participate and mentor local clinic providers and their staff to develop HCV expertise. 2. One of these HCV specialists (Kay Schwebke, M.D.) recently attended a full day Project Echo orientation session in Albuquerque, New Mexico and has specifically discussed replication interests

#	Needs Category	Program Exists Now?	Eligible Use of Drug Rebate Money?	Comments
				and efforts in Minnesota with Project ECHO staff. $300,000 startup funding is requested for the 1st year. We will pursue ongoing funding through the Minnesota legislature, the Indian Health Service and other sources. 3. We have discussed this initiative with University of Minnesota Provost Karen Hanson. Our proposal is coordination of this project through the University of Minnesota, with discussions ongoing. . 4. We have started to identify rural and urban high need and underserved communities with a high prevalence of HCV infection. Although no specific clinics have been identified, we believe several primary care clinics in Minnesota would benefit from this program, such as Indian Health Service clinics, methadone clinics and West Side Community Health Services. Estimated implementation time is 6 months, once funding is secured.
71.	Access to PrEP	No	Yes, with very specific HRSA guidance	Community Recommendation: We are in critical need of additional funding for our PrEP program. Currently we are underfunded in this intervention. Our program was originally designed to serve 60 clients in a 12 month period and we currently receive no reimbursement for clinicians and lab tests serving patients without medical insurance. We have enrolled 140 new patients in 2014 and would like to expand staffing of this program to 2 full time Community Health Specialists and also receive funding to support Nurse Practitioner time to serve individuals without health insurance. Any funding would be beneficial and the program could be expanded based on any increment of funding. PrEP benefits people living with HIV because it curbs new HIV infections for partners of known HIV positive people and

#	Needs Category	Program Exists Now?	Eligible Use of Drug Rebate Money?	Comments
				reduces new infections for others at high risk. PrEP is a tool that can enhance intimate relationships and addresses stigma in two ways. PrEP reduces the anxiety level of individuals concerned about transmitting HIV to their sexual partners dependent on their viral load or consistency of condom use. PrEP also allays fear of people becoming infected and can serve as a bridge for sero-discordant couples to be sexually fulfilled without the worry of transmission. DHS is unable to project a cost at this point. DHS is working with Red Door Clinic to project this cost.
72.	Involvement of the African American Church in HIV/AIDS education, testing, awareness and support groups.	No	Yes to some	Disparities RFP from the Minnesota Department of Health. The proposer's response involved utilizing the church network by imbedding health site coordinators in collaborating churches. Currently we have over 35 individuals from churches of all denominations serving as Church Health Coordinators and Navigators, providing healthy living programs, MnSure enrollment, Community outreach services and educational services through our Belief Bowl. To meet unmet needs of people living with HIV/AIDS we propose the following: Through the Foundation network of churches, host educational workshops for the congregation, stress the importance that everyone get tested and know their status by providing HIV screenings at the church in partnership with (for example) Open Cities who we already have a relationship with through our Free Flu Shot Clinics. Get the church more involved by recognizing National Black HIV Awareness Day at their church and hosting events that highlight the disproportionate impact HIV is having on the community at 3-6 centrally located churches, 1-2 each in St. Paul, South Minneapolis and North Minneapolis.

#	Needs Category	Program Exists Now?	Eligible Use of Drug Rebate Money?	Comments
				As well as train site coordinators to facilitate support groups at each of these centrally located churches for people infected and affected by HIV/AIDS. Participating churches would receive a stipend for hosting HIV Screenings at their church and receive a monthly stipend for facilitating support groups. Involved churches would join the Black Church and HIV: The Social Justice Imperative initiative.

ATTACHMENT A

Minnesota Department of **Human Services**

Minnesota Department of Human Services HIV/AIDS Rebate Program Report for State Fiscal Years 2010-2014

(07/01/09-06/30/14)

August 2014

Minnesota Department of Human Services HIV/AIDS Division

ADAP Rebate Program Report July 1, 2009-June 30, 2014

General ADAP Rebate Information (340B)

Since the creation of ADAPs, States have worked hard to maximize resources in order to provide medications to as many low-income and inadequately insured individuals living with HIV/AIDS as possible. In recent years, however, States have faced enormous challenges because of rapid growth in ADAP enrollment, the number of prescriptions per enrollee and the cost of treatments. Much of this growth has been due to the introduction of new antiretroviral medications.

On June 29, 1998, the Health Resources and Services Administration published a final Federal Register notice that allows State ADAPs to use rebates to access the drug pricing program authorized by Section 340B of the Public Health Service Act which was effective July 29, 1998. The rebate option allows ADAPs currently using a reimbursement model to achieve cost savings that are closer to the savings received by ADAPs purchasing drugs at the 340B discount. All ADAPs are eligible to participate in the 340B program by virtue of receiving financial assistance under Title XXVI. All manufacturers that have current 340B agreements with the Secretary of Health and Human Services (HHS) and sell covered outpatient drugs to ADAPs must provide 340B rebates to participating ADAPs. Failure to do so will jeopardize their agreement with the Secretary and their participation in Medicaid.

HRSA sent a letter to ADAPs on January 9, 2007 stating that funds generated by rebates must be considered program income. The Ryan White HIV/AIDS Treatment Modernization Act (Public Law 109-415*)* requires rebate funds be put back in Part B (with preference, but not a requirement, that they be placed in ADAP).

Rebate income has increased steadily through the years, along with utilization and ADAP expenditures. Rebate income has grown from $20,106 in SFY 2000 to a combined total federal and non-federal rebate income of $7,939,536 in SFY 2013. An additional $1,812.055 was

received in supplemental rebates which are additional non-federal rebates negotiated by NASTAD on behalf of the Ryan White ADAPs.

Because of the additional program income received from the rebate program, MN has not had to limit services, reduce the formulary, re-implement cost share or establish a wait list as other states have had to the past few years. Rebate funds enable our program to provide more services to a greater number of people and cover the gaps in funding for the MN ADAP program.

2010 Rebate spending - 7/1/09-6/30/10

Activity	Amount	Percent
ADAP	$1,434,653.02	44.98%
MCM	$647,612.53	20.30%
Hennepin County	$234,783.26	7.36%
Back to Work/EFL	$200,089.24	6.27%
Adherence	$120,497.25	3.78%
Nutrition	$117,996.16	3.70%
Chemical Health	$85,890.00	2.69%
Outreach	$72,791.51	2.28%
MDH CareLink	$65,338.89	2.05%
Indirect (Overhead expenses)	$119,769.50	3.75%
MDH CareWare	$50,306.85	1.58%
Administration**	$39,898.51	1.25%
Totals	**$3,189,626.72**	**100%**

2011 Rebate spending - 7/1/10-6/30/11

Activity	Amount	Percent
ADAP	$ 3,470,201.56	77.98%
Back to Work EFL	$265,646.57	5.97%
AIDSLINE	$75,974.17	1.71%
Adherence	$63,356.19	1.42%
Chemical Health	$62,597.18	1.41%
MDH CareLink	$55,738.37	1.25%
Nutrition	$44,342.47	1.00%
Outreach	$39,560.22	0.89%
MCM	$25,331.62	0.57%
Greater MN Meals	$517.44	0.01%
MDH CareWare	$173,522.61	3.90%
Indirect (Overhead expenses)	$138,510.10	3.11%
Administration	$34,612.26	0.78%
Totals	**$4,449,910.76**	**100%**

2012 Rebate spending - 7/1/11- 6/30/12

Activity	Amount	Percent
ADAP	$3,591,764.07	65.04%
Medical Case Management	$1,131,573.00	20.49%
Outreach	$136,938.31	2.48%
AIDSLINE	$78,407.00	1.42%
Chemical Health	$70,008.47	1.27%
Back to Work EFL	$59,315.58	1.07%
MDH CareLink	$57,471.36	1.04%
Nutrition	$27,996.32	0.51%
Adherence	$12,602.61	0.23%
DB101	$10,000.00	0.18%
MDH CareWare	$150,017.84	2.72%
Indirect (Overhead expenses)	$148,428.00	2.69%
Administration	$36,702.30	0.66%
Facilitators-SCSN & RFP	$11,365.00	0.21%
Totals	**$5,522,589.86**	**100%**

2013 Rebate Spending - 7/1/12 - 6/30/13

Activity	Amount	Percent
ADAP	$ 1,985,513.21	72.8%9
AIDSLINE	$77,275.40	2.84%
Nutrition	$24,878.07	0.91%
Chemical Health	$71,957.63	2.64%
Adherence	$12,315.24	0.45%
Back to Work EFL	$175,383.38	6.44%
Greater MN meals	$4,036.55	0.15%
CareWare	$155,484.09	5.71%
Indirect (Overhead expenses)	$143,254.30	5.26%
Administration	$73,937.38	2.71%
Totals	**$ 2,724,035.25**	**100%**

HIV/AIDS Unmet Need and Rebate Fund Use Report

2014 Rebate Spending - 7/1/13 - 6/30/14

Activity	**Amount**	**Percent**
ADAP	$2,704,975.64	63.21%
Medical Case Management	$517,042.33	12.08%
Benefits Counseling	$236,475.10	5.53%
MDH Contract-CareWare & data	$201,078.67	4.70%
Back to Work EFL	$149,669.66	3.50%
AIDS Line	$78,682.39	1.84%
Chemical Health Training	$76,193.00	1.78%
Outreach	$47,747.28	1.11%
Nutrition	$31,155.32	0.73%
Greater MN Meals	$15,114.88	0.35%
Administration (CAC, space, travel)	$86,066.78	2.01%
Hennepin County Redirects	$7,929.33	0.19%
Indirect (Overhead expenses)	$127,671.00	2.98%
Totals	**$4,279,528.71**	**100%**

Appendix F Advanced Strategies Personnel

Richard Branton—Executive Sponsor/Facilitator/Coach
Kathleen Burek—Project/Engagement Manager/Facilitator
Kahil Branton—Facilitator/Technical Support/Recording Analyst/Coach
Paul Strebe—Recording Analyst