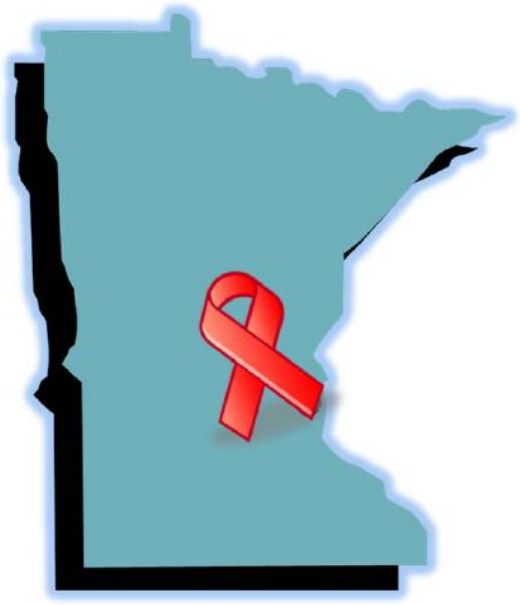
Minnesota Jurisdictional HIV Prevention Plan



Minnesota Department of Health

Community Cooperative Council on HIV/AIDS Prevention

September 7, 2015

Minnesota Jurisdictional HIV Prevention Plan

INTRODUCTION

Status of HIV Prevention in Minnesota

Much has changed since the first case of AIDS was reported in Minnesota in 1982. HIV went from an unknown condition to an epidemic infecting approximately 400 individuals in Minnesota by the early 1990's. Initially, HIV was as almost universally fatal infection and with the advent of effective HIV medications, has become medically manageable. Progress also has been made in preventing HIV infection, with notable successes in preventing mother-to-child transmission and transmission among injecting drug users.

In spite of these efforts, approximately 300 new cases of HIV have been reported in Minnesota for each of the last 12 years. Moreover, the disease has expanded its reach to new populations. Although HIV has been and remains a high concern among men who have sex with men, the percentage of new HIV/AIDS cases among females has increased since the early 1990s (from 11 percent of cases in 1990 to 24 percent in 2014). In addition, communities of color have continued to experience higher rates of infection and disease than others (e.g., the HIV/AIDS diagnosis rate among African Americans was more than 10 times greater than the rate among whites in 2014, whereas African-born persons have a rate of diagnosis more than 20 times higher than whites).

HIV is still a substantial and persistent public health issue in Minnesota. As of the end of 2014, 7,988 persons in the state were known to be living with HIV. Treatment advances may have rendered HIV a manageable condition, but the fact that a growing number of people are HIV-positive means that we need stronger, more targeted prevention efforts as well as services to support infected individuals. New approaches to HIV prevention, including a new emphasis on HIV treatment as a prevention strategy, hold promise. The challenge is implementing HIV prevention activities and maintaining an HIV prevention infrastructure in a fiscally challenged and rapidly changing environment.

MN is a low incidence state

In its fight to reduce the rate of HIV/AIDS infections in the state, Minnesota has developed a strong HIV prevention and care infrastructure – both a well-established HIV care system and a coordinated system of community based nonprofits – all working on HIV/AIDS prevention and care strategies. While Minnesota is considered a low incidence state in comparison to larger population states such as California and Florida, the challenges in preventing new infections are similar. And, with federal HIV funding reductions, Minnesota could easily become a medium incidence state.

Historically, the annual number of new AIDS cases in Minnesota increased steadily from the beginning of the epidemic to the early 1990s, reaching a peak of 361 cases in 1992. Beginning in 1996, both the number of newly diagnosed AIDS cases and the number of deaths among AIDS cases declined sharply, primarily due to the success of new antiretroviral therapies including

protease inhibitors with 160 AIDS cases diagnosed in 2014. The number of HIV (non-AIDS) diagnoses has remained fairly constant over the past decade from 2005 through 2014, at approximately 250 cases per year.

Since the beginning of the epidemic, males have accounted for a majority of new HIV infections diagnosed per year. However, the number and the proportion of cases among females have increased over time. In 2013, 76 percent of new infections occurred among males and 24 percent among females.

Key elements of the environment impacting HIV in Minnesota include:

- **Unaware of Status**: According to CDC national estimates 18-20% of HIV positive people are unaware of their status. Finding and getting these people into care is of the utmost importance in curbing the spread of the virus to others. Some individuals are accessing health care services, but testing and diagnosis opportunities are being missed.
- **Ensuring people are in care:** An estimated 28 percent of Minnesotans living with HIV are not in care. Since HIV medications typically improve the individual's health and reduce their risk of transmitting HIV to others, it is critical that all (uninsured and underinsured as well) have access to HIV therapies and medications.
- **Limited HIV prevention funding:** Federal resources for HIV prevention are being reduced which will impact the amount of funds available to support HIV prevention programs. This means that the existing funds must be allocated wisely based on demonstrated health impact of a service. The lifetime cost of treating HIV is estimated to be $360, 000 per person. Keeping the HIV incidence low (or reducing it even further) will be a key strategy in containing health care costs.
  While the Treatment As Prevention (TAP) strategy will no doubt be effective in the long term, the reduction of funding for Health Education/Risk Reduction programming, intended to keep HIV negative people negative, coupled with the lack of comprehensive sexual health education in schools may end up reducing and/or cancelling out the gains brought about by TAP.
- **Diminished awareness and public concern:** Because HIV is now a manageable infection and is becoming a chronic health issue rather than a public health emergency, media and public attention has dropped. This translates to an increased level of complacency and reduced level of caution and prevention strategies practiced by key populations.
- **Stigma:** The stigma associated with HIV remains extremely high and fear of discrimination causes individuals to avoid learning their HIV status, disclosing their status, or accessing medical care. This is especially a factor in the African American, Latino/a, African-born, Asian/Pacific Islander American and Native American communities, as well as senior citizens and people who inject drugs. HIV/AIDS is often a taboo subject for discussion and education limiting the effectiveness of prevention strategies. Stigma continues to be a factor in the communities of Gay, Bi and other men who have sex with men as well as the transgender community who also face a significant lack of access to health care.
- **Lack of comprehensive sex education:** Sex education, particularly with youth and young adults, is recognized as effective in reducing incidence but political and ideological barriers

block more education. This prevents too many of Minnesota's youth from receiving accurate, realistic, inclusive and comprehensive sex education.

School-Based Evidence-Based sexual health education is delivered to some young people through Health Class, but not enough. The state of Minnesota does not delineate Health Education standards which impedes the time and content expectations for proper delivery of sexuality education. E.g., abstinence is required content but proper condom use is not. Because of a lack of comprehensive sexuality education (inclusive of all gender identities, sexual orientations and relationships, illicit drug use as well as injection drug use) in all Minnesota schools, staff in MDH-funded prevention projects must often start from "square one" with the clients they serve.

HIV infection is preventable. Implementing effective prevention and care strategies is critical to keeping Minnesota a low incidence state. If HIV incidence is not reduced in Minnesota, the numbers of people living with HIV and the cost of their care will continue to grow. Better results are needed from existing resources, and promoting new investments from all levels of government, as well as the businesses and nonprofit sector resources to achieve Minnesota's goals.

(1) DESCRIPTION OF EXISTING RESOURCES AND HOW THEY ARE BEING USED IN THE JURISDICTION

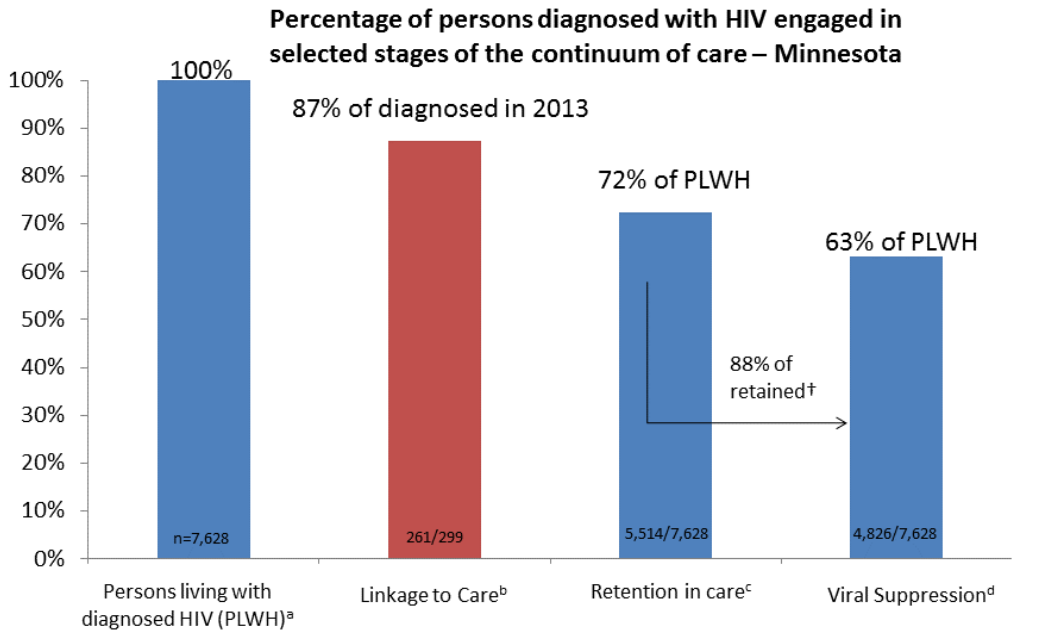
In addition to the prevention and public information services provided directly by the Minnesota Department of Health (MDH), Federal and state dollars are used to support community based HIV prevention programs. These programs target populations at risk, as defined by Minnesota's HIV prevention planning group and are funded through a competitive grant program. Funding allocations are made based on Minnesota's HIV epidemiology in an effort to prevent as many new HIV infections as possible. In 2013, 30 HIV prevention projects were funded at 20 agencies.

- **Treatment Cascade:**

As part of the National HIV/AIDS Strategy for the United States, the Minnesota Department of Health (MDH) has calculated an HIV treatment cascade using HIV surveillance data. These calculations help us better understand the HIV epidemic and the disparities that exist in the delivery of care among HIV positive people in Minnesota.

Overall, in Minnesota there are 7,628 people over the age of 13 who were diagnosed with HIV through 2013 and were living in Minnesota at the end of 2014. Of the 7,628 people living with HIV at the end of 2014, 5,514 (72%) had at least one CD4 or viral load test performed in 2014 (retention in care). Additionally, of the 7,628 people living with HIV/AIDS, 4,826 (63%) had a viral load test of ≤200 copies/mL at their most recent test in 2014 (viral suppression). In 2013, there were 299 persons over the age of 13 who were diagnosed in Minnesota. Of these 299, 261 (87%) had a CD4 or viral load test performed within 90 days of their initial diagnosis (linkage to care).

This cascade has been published on MDH's website and will be updated on an annual basis.
http://www.health.state.mn.us/divs/idepc/diseases/hiv/hivtreatmentcascade.html



[a]Defined as persons diagnosed with HIV infection (regardless of stage at diagnosis) through year-end 2013, who were alive at year-end 2014.
[b]Calculated as the percentage of persons linked to care within 90 days after initial HIV diagnosis during 2013. Linkage to care is based on the number of persons diagnosed during 2013 and is therefore shown in a different color than the other bars with a different denominator
[c]Calculated as the percentage of persons who had ≥1 CD4 or viral load test results during 2014 among those diagnosed with HIV through year-end 2013 and alive at year end 2014.
[d]Calculated as the percentage of persons who had suppressed viral load (≤200 copies/mL) at most recent test during 2014, among those diagnosed with HIV through year-end 2013 and alive at year end 2014.
†Calculated as number of persons who had suppressed VL (≤200 copies/mL) at most recent test during 2014, among those who were retained in care during 2014.

Prevention activities that contributed to reducing HIV infections include:

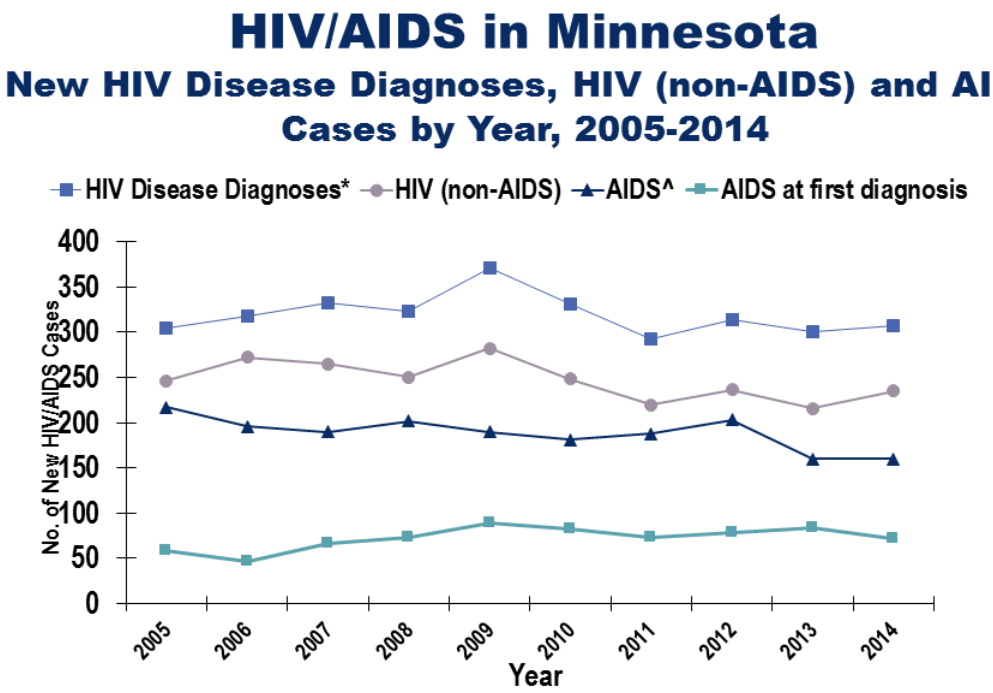
- **HIV testing:** HIV testing has enabled individuals with HIV to become aware of their health status and have the opportunity to get connected with HIV care.
- **Effective screening of the blood supply:** People contracted HIV through blood transfusions early in the history of the disease, but effective blood screening procedures have been effective in eliminating this threat.
- **Screening and treating expectant mothers during pregnancy:** The rate of transmission from mother to child declined from 18 percent 1982 – 1999 to 1.1 percent in 2012 – 2013, with one HIV positive birth to HIV positive mothers in 2014.
- **Minimizing infections from injection drug use:** In 1990, injection drug users comprised 14 percent of new HIV cases in Minnesota compared to 2 percent in 2014. Treatment programs, as well as needle exchange, the Pharmacy Syringe Access Initiative, outreach/harm reduction education and safe sex education have dramatically cut the number of new HIV infections among people who inject drugs by 80 percent since 1990.
- **Advances in HIV therapies:** HIV medications can extend the length and quality of life for infected individuals, and lower the amount of the virus circulating in a person's body, thereby reducing their risk of transmitting HIV to others.
- **School-based Gay/Straight Alliances:** The CDC has identified school-based bullying and harassment as a risk factor for YMSM and GLBT students to engage in HIV and STI sexual risk behavior. LGBTQ 9th and 11th grade students in Minnesota are evidenced to be at

disproportionate risk of bullying and harassment according to the 2013 Minnesota Student Survey data collected at the high school level in grades 9 and 11. School-based bullying and harassment of GLBTQ is correlated to "Out of School Suspension", "In School Suspension" and "Cutting or Skipping Class". Gay Straight Alliances (GSA) are an evidence-based strategy for GLBT youth's school connectedness. The CDC has included the establishment of GSA's as one strategy for HIV risk reduction. Minnesota Department of Education is currently receiving funds from CDC DASH to increase the establishment of GSA's and other inclusive student lead clubs in Minnesota public schools as an HIV prevention strategy. According to CDC DASH School Health Profiles, 26% of Minnesota public schools have established a GSA or similar GLBT inclusive student lead club.

- The importance of sustained support of school-based GSAs and similar groups, including the adults who advise and advocate for the members of these groups, must be acknowledged. Often, students and adults associated with GSAs and similar groups must invest significant amounts of time, energy and emotional effort in getting started and then defending their continued existence with limited ability to focus on issues as a consequence. The fallacious accusations that these school-based groups exist to teach and encourage same-sex sexual experimentation and activity intimidate many GSAs to shy away from discussing important sexual health issues. Tending to this need for broader and longer lived support will allow for more than just establishment of such groups, but also for effective long-lasting cultural and behavioral changes in school communities and beyond.

The stable and ongoing number of new infections does contribute to the larger pool of people capable of transmitting HIV to others (Figure 2). Prevention of mother-to-child HIV transmission and decreases in HIV transmission among intravenous drug users highlight successful HIV prevention efforts.

Figure 1, Minnesota HIV and AIDS Trends

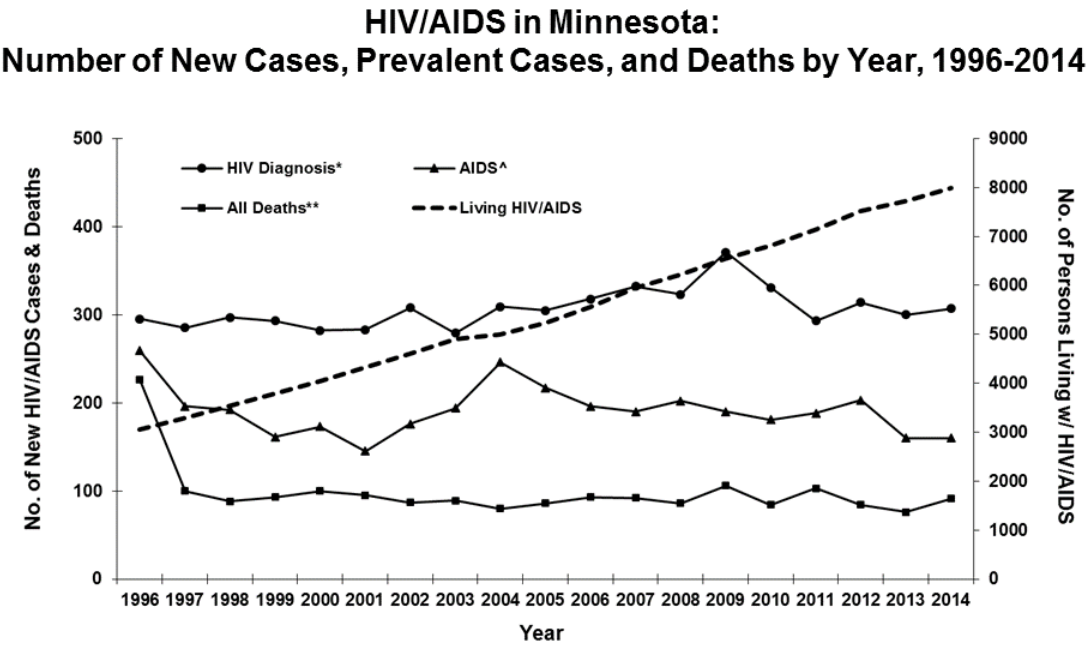


*Includes all new cases of HIV infection (both HIV (non-AIDS) and AIDS at first diagnosis) diagnosed within a given calendar year.

^Includes all new cases of AIDS diagnosed within a given calendar year, including AIDS at first diagnosis. This includes refugees in the HIV+ Resettlement Program, as well as, other refugee/immigrants diagnosed with AIDS subsequent to their arrival in the United States.

HIV/AIDS in Minnesota: Annual Review

Figure 2, Minnesota Trends for People Living with HIV/AIDS and HIV/AIDS Deaths



* InclHIV diagnosis (both HIV (non-AIDS) and AIDS at first diagnosis) diagnosed within a given calendar udes all new cases of year

** Deaths among HIV cases, regardless of cause

^ Includes all new cases of AIDS diagnosed within a given calendar year, including AIDS at first diagnosis. This includes refugees in the HIV+ Resettlement Program, as well as other refugee/immigrants diagnosed with AIDS subsequent to their arrival in the United States

To see the full HIV Surveillance Report click on this link:
http://www.health.state.mn.us/divs/idepc/diseases/hiv/hivstatistics.html

Resources

HIV funding is divided into two categories: care and prevention. The federal Ryan White Care Act provides medical care and support services for those who lack financial resources for their care. In Minnesota, Ryan White funds go to the Minnesota Department of Human Services and Hennepin County. The Centers for Disease Control (CDC) provides funding to MDH for HIV prevention. A wide range of additional governmental and non-governmental partners provide other HIV prevention and care services as well. A description of a sample of the agencies and groups responsible for carrying out HIV prevention and care activities is given below.

To see a full list of providers/resources as of 2014, click on these links:

Minnesota Department of Health STD, HIV & TB Section provides HIV/AIDS prevention funding to community based organizations, clinics and government organizations through a competitive process. For current Grantees:
http://www.health.state.mn.us/divs/idepc/diseases/hiv/hivgrantees.html

Minnesota Department of Health Office of Minority and Multicultural Health supports HIV prevention activities through its Eliminating Health Disparities Initiative (EHDI). This program provides funds to close the gap in the health status of African Americans/Africans, American Indians, Asian Americans, and Hispanics/Latinos in Minnesota compared with Whites. Recent EHDI grants were awarded to organizations implementing Priority Health Areas (PHA) integrated with social determinants of health. Current Grantees:
http://www.health.state.mn.us/ommh/grants/ehdi/ehdigrantees/index.cfm?d=HIV

Ryan White Program – Part A is administered through the Hennepin County Public Health Department which offers grants to both community based organizations and government organization providing services for people living with HIV/AIDS in the 11 metro Minnesota Counties. For more information click here:
http://www.hennepin.us/business/work-with-henn-co/ryan-white-hiv-services

Ryan White Program- Part B is administered through the Minnesota Department of Human Services and provides HIV care services to persons living outside of the 11 county metro area. The AIDS Drug Assistance Program is also administered through the Ryan White Part B program. For more information click here: http://mn.gov/dhs/people-we-serve/adults/health-care/hiv-aids/

Ryan White Program - HIV Services Planning Council, managed through the Hennepin County Public Health has the primary responsibility of establishing priorities for the allocation of Ryan White CARE Act funds in Minnesota. Most of the Council activities can be found at:
http://www.mnhivplanningcouncil.org/

Red Door Services is part of Hennepin County Public Health Clinic, the largest HIV/STD testing site in Minnesota that offers testing, treatment, and health education around HIV/STDs and Ryan White HIV medical care for the uninsured. For specific services offered click here:
http://www.reddoorclinic.org/ .

Besides testing the clinic offers a sexual health and care access program for newly diagnosed HIV+ persons and those at high risk for HIV: http://www.capsprogram.org/ and a sexual health program for gay and bisexual men (http://www.himprogram.org/ .
Red Door Services offers access to PrEP & PEP with a program that focuses on MSM (funded by MDH.) http://www.himprogram.org/PrEP.html .

The Positive Care Center at Hennepin County Medical Center offers access to PrEP and PEP with a program focusing on high risk heterosexuals, including sex workers and clients with mental health issues. (Funded by MDH.)
http://www.hcmc.org/cs/groups/public/documents/webcontent/hcmc_p_058756.pdf

Children's Hospital and Clinics of Minnesota in St. Paul offers access to PrEP and PEP through services for pregnant HIV+ women and training and education on perinatal HIV treatment and prevention programming. (Funded by MDH.) For more information, click here:
http://www.health.state.mn.us/divs/idepc/diseases/hiv/hivperinatal.html

NorthPoint Health & Wellness Center is federally qualified health center that provides multi-specialty medical, dental and mental health services in North Minneapolis. For services provided click here:
http://www.northpointhealth.org/

Health Care for the Homeless is a Hennepin County program that provides a variety of health and wellness services to homeless individuals. For homeless resources click here:
http://www.hennepin.us/residents/health-medical/clinics-services

Minnesota AIDS Project AIDSLine, offers a comprehensive list of HIV/AIDS programs and services available in Minnesota. For the up-to-date online resources list click here:
http://www.mnaidsproject.org/resource-guide/index.php

HIV/STI Prevention programming is offered to schools through the Minnesota Department of Education. The program is intended to reduce sexual risk behaviors and other related health problems among the youth. More information can be obtained at:
http://education.state.mn.us/MDE/StuSuc/Nutr/HIVSTIPrev/index.html

Mental Health and Chemical Health Services for Adults are provided through Hennepin County the largest county and other Minnesota counties as well. For services at Hennepin county:
http://www.hennepin.us/residents/health-medical/adult-mental-health-services

Clinic 555, a program of the Saint Paul - Ramsey County Public Health Department, is one of Minnesota's major STD and HIV clinics. The clinic provides confidential screening, diagnosis, and of sexually transmitted diseases (STD) including HIV testing and counseling. For services offered:
http://www.co.ramsey.mn.us/ph/hs/std_testing_and_treatment.htm

Minnesota Housing is the State's administrator for the Housing Opportunities for persons With AIDS (HOPWA) Formula Funds, offering grants to provide housing assistance and support services to people outside of the 13 county Twin Cities metro area. Minneapolis is the HOPWA

grantee for the 11 county Eligible Metropolitan Statistical Area (EMSA). Uses of HOPWA funds include: rental assistance, short-term rent, utility payments etc. For additional HOPWA resources click here:
http://www.mnhousing.gov/idc/groups/public/documents/document/mhfa_003757.pdf
or http://www.mnhousing.gov

(2) NEEDS ASSESSMENT

The demand for HIV prevention services is increasing, given the consistent increases in the number of people living with HIV. As the pool of infected persons grows by approximately 300 people per year, the need for HIV prevention programs is also increasing. This is compounded by increasing public complacency as HIV is seen as a diminishing health issue. Complacency among people at risk of HIV may also be creating challenges to effectively delivering HIV prevention messages. In addition, HIV has now become entrenched and endemic in specific populations, highlighting the need for culturally appropriate strategies and activities.

Advances in medication and medical treatment mean that HIV infections can be effectively treated, especially when identified early. People living with HIV are able to have relatively long, healthy lives. This change in the trajectory of the disease in conjunction with evidence that HIV treatment is an effective prevention tool has shifted the focus of prevention efforts to the population of people who have tested positive and are living with the disease. This suggests that care and prevention services will be increasingly coordinated and integrated into the broader health care system. HIV testing and access to highly effective antiretroviral therapy upon diagnosis are integral parts of standard medical care. Linking this medical care with a combination of approaches and prevention strategies, including counseling, testing, and referral; partner services; evidence-based mental health and substance use treatment; and tracking and care for other sexually transmitted diseases will provide Minnesota with the most effective way to prevent the spread of the disease.

In addition to the HIV Planning Group (HPG) and Minnesota's epidemiological data, input and feedback regarding needs and gaps to be addressed are contributed by:

- Barriers to Early HIV Testing for African-born Immigrants and Latinos in Minnesota. Key informant interviews with providers around barriers to HIV testing in African and Latino communities.
- Assessing for the Future: HIV Health Care and Community Needs among Latino, Gay, Bisexual and Transgender Individuals in the Twin Cities Area. Authored by the Latino Commission on AIDS. July 2014
- The Path to Care Study: Making and Sustaining the Connection to HIV Care. Bob Tracy, 2009. Prepared for the Minnesota HIV Services Planning Council.
- HIV/AIDS Prevention Assessment among Gay, Bisexual and other Men Who Have Sex with Men. John Snow, Inc. 2010. Prepared for MDH.
- HIV/AIDS Community Discussion. 2009. Held for the White House Office of National AIDS Policy for development of the National AIDS Strategy.

- Out for Equity Survey Results. 2010. Conducted by Out For Equity. Survey of the sexual health education needed and experienced by Gay, Lesbian, Bisexual and Transgender youth in the Twin Cities reached through Gay/Straight Alliance groups (GSAs) in public schools.
- Adapting Minnesota's HIV Prevention Community Planning Model to Incorporate Protective Factors. 2010. Michael G. Lee, University of Minnesota, School of Social Work. (Former HPG member) Purpose: To formulate a social work-based modification to Minnesota's model of planning and prioritizing HIV prevention activities.
- All Provider Meeting. 2010–2014 ongoing. Annual network and training meeting with staff from both HIV prevention and HIV care and services agencies.
- Early Identification of Individuals with HIV/AIDS (EIIHA) Workgroup. 2011-2012. Broad spectrum of stakeholders to develop recommendations regarding strategies to identify and encourage individuals living with HIV but unaware to test and engage in prevention and/or treatment. Advisory committee ongoing.
- Minnesota's Department of Human Services, through the HIV Planning Council, administers an ongoing assessment of HIV care and treatment needs as well as services to aid in the development of a Statewide Coordinated Statement of Need and Comprehensive Plan.

(3) GAPS TO BE ADDRESSED AND RATIONALE FOR SELECTION

Populations at greatest risk

By focusing efforts in communities where HIV is concentrated, Minnesota can have the biggest impact in improving overall public health and lowering collective risk of acquiring HIV. This includes communities of color, gay and bisexual men and other MSM of all races and ethnicities, young gay and bisexual men, transgender people, sex workers, injection drug users, and those communities where stigma is a major barrier.

At their February 2012 meeting, CCCHAP identified the following target populations as the focus for prevention and care strategies (not prioritized):

- MSM (Men having sex with men)
- YMSM (Young men having sex with men)
- Injection drug users
- Young, high risk heterosexuals
- African American high risk heterosexuals
- African born high risk heterosexuals
- The Latino/a high risk heterosexuals
- Native American high risk heterosexuals
- API high risk heterosexuals
- People living in Greater MN (all genders, races, sexual orientations, risk categories)

MSM/IDU is no longer considered a separate target population. Due to reductions in federal HIV Prevention funding levels, CCCHAP made the decision to eliminate the separate category of MSM/IDU. Funded agencies focusing on injection drug users are required to demonstrate

cultural competence regarding MSM and staff must be skilled at discussing transmission risks and prevention strategies for oral, anal and vaginal sex.

To adjust to reductions in federal funding we are re-examining our process for determining allocations for our next HIV prevention RFP in 2016.

While the overall rates of new HIV/AIDS infections in Minnesota have been relatively stable, there have been consistent increases in the numbers of new cases in particular populations, including:

- **MSM (Men having sex with men)**: Roughly 75 percent of new HIV/AIDS cases in Minnesota are among men, the majority of whom are gay, bisexual and other men who have sex with men. Preventive measures are perceived as less important as HIV is seen as a chronic, manageable infection. It remains to be seen what effect the increasing awareness and availability of PrEP has on these numbers.
- **YMSM (Young men having sex with men)**: MSM is the predominant mode of HIV exposure among adolescent and young adult males (ages 13 to 24) accounting for an estimated 93 percent of new HIV infections diagnosed between 2012 and 2014. Since 2001, the number of cases among young males has increased by over 170 percent.

Funding and prevention work targeting Transgender and Genderqueer people remains challenging. Minnesota will continue to support and encourage inclusive and culturally competent HIV testing, outreach and prevention projects. Many of our HIV testing projects reach and test Transgender and Genderqueer clients.

Racial and ethnic minorities experience higher rates of HIV compared to the white population. These groups are disproportionately represented in the HIV epidemic and tend to have poorer health outcomes than Whites due to systemic health disparities. The most recent data illustrate that men and women of color continue to be disproportionately affected by HIV/AIDS. Additionally, the combinations of cultural and community norms often lead to stigmatization of people with the disease.

- **Men of Color** Men of color make up approximately 17 percent of the state's male population and 44 percent of the infections diagnosed among men in 2014. In contrast, white, non-Hispanics make up approximately 83 percent of the male population in Minnesota and 52 percent of the new HIV infections diagnosed among Minnesota men in 2014.
- **Women of Color** Similarly for females, women of color make up approximately 13 percent of Minnesota's female population and 79 percent of the new infections among women. In contrast, white, non-Hispanics make up approximately 83 percent of the state's female population and 19 percent of new infections among Minnesota women in 2014.
- **African American community**: Among young men age 13-24, African American males account for 29 percent and among young women, African Americans made up 13 percent of new infections in 2014.

- **African-born community:** African-born immigrants have the highest HIV rates of any Minnesota community at more than 20 times higher than the rate among whites in 2014. A number of unique challenges are present when providing HIV prevention and care services to African-born individuals including language barriers, cultural issues and intense stigma.
- **Latino/a communities**: Increases in Minnesota's annual number of HIV infections diagnosed among Minnesota's Latino community have been recorded since the late 1990s. In Minnesota in 2014, 34 Hispanic persons.
- **Native American community**: Native Americans have consistently experienced higher rates of HIV than whites. In Minnesota in 2014, 5 Native Americans were newly diagnosed, representing a rate among that population nearly three times higher than whites.
- **Asian Pacific Islander community**: Asian/Pacific Islanders experienced slightly higher rates of HIV than whites. In Minnesota in 2014, 10 Asian or Pacific Islander persons were newly diagnosed.
- **People who inject drugs**: The elimination of federal funding for needle exchange programs put injection drug users at greater risk. There were 5 IDU and 11 MSM/IDU diagnosed in Minnesota in 2014.
- **People living in Greater MN**: Although these communities have fewer HIV/AIDS services and related public health education, they have experienced a decrease of 16 percent in the number of new HIV diagnoses compared to 2013. (Note: Greater Minnesota includes all of the other at-risk target populations, especially MSM, HRH, IDU and homeless youth and people living with HIV who happen to live outside the Twin Cities Metro Area.

Some significant issues to consider include:

- **Women, particularly women of color**: These women face numerous issues including understanding the disease and ways to prevent it, stigma based on community norms, testing options and where to get tested, as well as perinatal transmission issues. Heterosexual contact accounted for an estimated 94 percent of new HIV infections among adolescent and young adult females from 2012 to 2014.
- **Youth**: Each new generation needs to be informed about the disease, how it is transmitted and risk prevention strategies. For many youth today, the disease is perceived as no longer a threat or easily managed with medication, so HIV prevention does not seem as urgent to them. The lack of accurate, inclusive, comprehensive sex education and the use of abstinence only until marriage curricula have left teenagers, especially GLBT youth, woefully uninformed.
- **Late testers**: Persons who receive an AIDS diagnosis concurrently or within one year after receiving their initial HIV diagnosis are considered late testers since they are likely to have had an HIV infection for five to ten years before being tested. These individuals either do not know about testing, have never had the opportunity to be tested, or have avoided testing because they are afraid to find out the results. Additionally, since they

have been unaware of their status they will often have done little concerning prevention.

- **People who are 45 or older living with HIV**: Fifty-eight percent (58 percent) of all people living with HIV are in this age group. In 2014, 43 percent of people diagnosed at 45 years and older were late testers compared to 7 percent of people diagnosed between the ages 13-24.

(4) PREVENTION ACTIVITIES AND STRATEGIES TO BE IMPLEMENTED

The Vision for Minnesota HIV/AIDS

Minnesota will become a place where new HIV infections are rare and when they do occur, every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity or socio-economic circumstance, will have unfettered access to high quality, life-extending care, free from stigma and discrimination.

As we move to achieve Minnesota's vision, HIV/AIDS in Minnesota will be characterized by the following:

- **HIV/AIDS disease is being eradicated:** Health care and prevention services are coordinated and the national approach of treatment as prevention, targeting prevention with persons living with HIV will be increasingly implemented in Minnesota. Prevention services, HIV testing and access to highly effective antiretroviral therapy upon diagnosis are integral parts of the standard medical care each provider offers as HIV care becomes more coordinated and integrated into the broader health care system.

- **People living with HIV/AIDS are well served by the health care system:** Primary health care is a major component of a service system where providers ensure that each patient, no matter what their health concerns are, receives high quality medical services that address their individual health needs**.** HIV services are well integrated into the traditional health care system.

- **People living with HIV/AIDS have financial coverage for their health care**: The healthcare finance system and Ryan White programs work to ensure that people living with HIV/AIDS have access to HIV care and cost is not a barrier to receiving quality care.

- **Stigma and isolation associated with HIV/AIDS are significantly reduced**: Patients feel less stigmatized and isolated because HIV is treated as a chronic disease by primary health care providers. Much work is done to reduce stigma, including same-sex sexual orientation stigma and stigma associated with being transgender.

- **Communities disproportionately affected are experiencing reduced HIV/AIDS infections:** Funding for targeted services is focused on populations who are indicated by public health data to warrant that focus to reduce public health risks. These targeted resources and services overcome the barriers to testing, treatment, and access to care.

- **Medical care providers are educated about HIV/AIDS:** Education of all medical care providers is key to the continued support and implementation of HIV prevention and care programs along with the successful integration of HIV services into the broader health care system. More medical providers need to be informed about PrEP as most health insurance plans will cover it. At this time medical students do not receive sufficient education and training on discussing sexual health issues with patients or working with LGBT patients. This would be an important and powerful improvement in the reduction of HIV and other STDs.

- **The general public are educated about HIV/AIDS:**
  Schools must offer genuinely comprehensive sexual health education. The media needs to be convinced to cover stories about HIV, STDs and hepatitis more than once a year when the previous year's epidemiology numbers come out. Options for adults of all ages to receive comprehensive sexual health education should be made available in all communities on a regular and ongoing basis.

- **Health care services and related resources are well coordinated.** Government agencies, health care providers, and community-based organizations work in close partnership. CBOs have changed their business models significantly and/or have formal relationships with health care providers and a client-centered network of collaborative partners who provide comprehensive prevention services and services for people living with HIV.

Guiding Principles

The following overarching principles drive the decision making process for allocating prevention resources:

- Implementing evidence-based approaches with the potential to have the greatest impact on Minnesota's HIV epidemic.
- Increasing knowledge, capacity and access to PrEP among providers and target populations.
- Making efficient use of existing resources to ensure that we maximize the limited resources available.
- Coordinating approaches across prevention and care. The HIV Prevention Planning Group (CCCHAP) and the HIV Planning Council are currently meeting to plan out the upcoming merger of these two groups.
- Prioritizing cost effective prevention services.
- Focusing resources in communities with the greatest burden of disease.
- Addressing culturally unique needs of target populations with appropriate services.
- Influencing the advance of health equity in Minnesota.
- Monitoring and proactively addressing emerging trends and issues.

Community Engagement and Planning Process

As part of an overall, ongoing community engagement and planning process, the Community Cooperative Council on HIV/AIDS Prevention (CCCHAP) group is Minnesota's HIV prevention planning group that advises the Minnesota Department of Health on its work related to HIV prevention. Membership on the CCCHAP is selected by and composed of community members who represent the cultural and geographic diversity of the HIV epidemic in Minnesota. The HIV Prevention Planning Group (CCCHAP) and the Ryan White HIV Services Planning Council membership have approved integrating their planning groups. MDH and the Part A and Part B Grantees are currently meeting to facilitate the integration with a target date of January 1, 2016 to have the joint prevention and care planning group seated and operating.

Input and ideas for HIV Prevention Planning are solicited and welcomed from a broad range of Minnesotans including: individuals, people living with HIV/AIDS, community groups, community-based groups and organizations that focus on HIV/AIDS, groups and organizations that do not focus on HIV/AIDS but wish to address it in their work, educators, legislators as well as local, state and federal governmental agencies.

The development process includes input gathered through community discussions, focus groups, key informant meetings and through online access.

Minnesota's Priority HIV Prevention Goals

- Reduce new HIV infections
- Increase access to care and improving health outcomes for people living with HIV
- Reduce HIV-related health disparities
- Achieve a coordinated Minnesota response to the HIV epidemic in Minnesota

Strategies and Activities to achieve Minnesota's HIV Prevention Goals

The Minnesota Department of Health is currently funding the following agencies to perform HIV Prevention activities focusing on the various target populations identified by the HIV Prevention Planning Group:

Track 1: HIV Testing and Testing Outreach

Agency	Testing & Outreach	Outreach Only (Connection to Testing)	Target Population
African Health Action	X		HRH - African
Broadway Family Clinic	X		HRH - African-American
Crown Medical	X		HRH - African
Face to Face	X		Young HRH- All Races
High School for Recording Arts		X	Young MSM- African-American
Indigenous Peoples Task Force	X		Native American HRH
Lutheran Social Services - Duluth	X		Greater MN (Homeless Youth)
Minnesota AIDS Project	X		Adult MSM- All Races
Minnesota AIDS Project	X		Young MSM- All Races
Neighborhood House	X		Latino HRH
Neighborhood House	X		Asian/Pacific Islander HRH
Open Cities	X		HRH - African-American
Pillsbury House		X	Adult MSM- African-American
Rural AIDS Action Network	X		Greater MN (MSM, HRH, PWP, IDU)
Red Door Services	X		Adult MSM- All Races
Red Door Services	X		Young MSM – All Races
SAYFSM	X		HRH - African
Westside	X		Adult MSM- Latino
YouthLink		X	Young HRH- All Races

Track 2: Comprehensive Prevention With Positives

Projects include HIV positive people and their sexual and/or needle-sharing partners. Three projects include PrEP for partners.

- Children's Hospital - Perinatal Program
- Hennepin County Community Health Dept.- HIV Intervention Models (HIM) Program
- Minnesota AIDS Project – Positive Link Program
- Minnesota Medical Research Foundation- Positive Care Center at Hennepin County Medical Center
- Rural AIDS Action Network
- University of Minnesota – Youth and AIDS Project

Track 3: Syringe Services

- Minnesota AIDS Project (IDU & MSM/IDU)
- Rural AIDS Action Network (IDU)
- Sacred Spirits (Native American IDU)

Track 4: New Media Prevention for Youth at Risk for HIV

New media – Projects using social media, internet and mobile technology to reach high-risk heterosexual and GLBTQ youth and connect them with local and online sexual health resources.

- Face to Face
- Neighborhood House

- **Strategy: HIV Testing and Testing Outreach**
  Activities
  - **HIV Testing In a Clinic Setting:** Patient risk assessment or sexual health history; meaning of results and need for further diagnostic testing; HIV CTR Link to Care; further screening (STD/Hepatitis), vaccination, and treatment needs; Data Collection; Standards of Practice.

  - **HIV Testing In a community setting:** Client-Centered HIV Prevention Counseling; client risk assessment; meaning of results and need for further diagnostic testing; HIV CTR Link to Care; Referral; Data Collection; Standards of Practice.

  - **HIV/STD/Hepatitis Prevention Outreach:** Recruit highest risk candidates for testing: connect testing candidates with testing site; track testing referrals and results to track positivity rate; Referral; Condom Distribution; data collection.

- **Strategy: Comprehensive Prevention With Positives**
  Activities
  - Locating, Engaging and Recruiting seropositive individuals within the target/client population at risk as well as their sexual and/or needle sharing partners; Connect them with appropriate care, treatment, and prevention services; Test partners or connect partners with testing; Provide Risk-reduction Activities (ILI, GLI, IRRC, PCM); condom distribution; data collection.

- Three MDH funded projects have added Pre-Exposure Prophylaxis (PrEP) for persons whose partners are HIV positive to existing HIV prevention efforts. Staff determines PrEP eligibility, provide risk reduction education, monitor and support medication adherence as part of the broader responsibilities in coordinating the PrEP intervention.
  The target populations for these projects are:
  - Gay, bi and other MSM (all races, ages 18 and over) with an emphasis on HIV positive MSM and their HIV negative sexual partners also known as magnetic (sero-discordant) partners. For PrEP coordination, a special emphasis is on those MSM at significant, ongoing risk for acquiring HIV.
  - High-Risk Heterosexuals partners of positives, and/or high-risk individuals. Staff works with these patients in regards to harm reduction plans, prevention coaching (IRRC), and medication adherence.
  - HIV-negative or unaware pregnant partners of HIV-infected men at-risk of aquiring HIV infection, pregnant women and HIV-positive women/men planning pregnancy.

- **Strategy: Condom Distribution**
  Activities
  - MDH administers a condom distribution program that makes free condoms available to MDH HIV prevention grantees, local public health departments, HIV testing sites and clinics providing STD and HIV care.
  - MDH requires HIV prevention grantees to include condom distribution to persons at high risk of acquiring HIV within their budgets and work plans.

- **Strategy: Policy Initiatives**
  Activities
  - MDH STD, HIV & TB Section staff participate in MDH's Infectious Disease Epidemiology, Prevention and Control (IDEPC) Division's bi-weekly legislative meetings during the state legislative session. The meetings are used to identify policy initiatives in which the Division should be involved and to provide updates on legislative activities. As part of these efforts, staff are involved in writing position statements and policy briefs.
  - MDH STD, HIV & TB Section staff participate in the Minnesota AIDS Project Public Policy Committee. The Public Policy Committee serves as a mechanism for MAP to gather input on the policy agenda they actively pursue at the Minnesota Legislature and provides MDH with a voice on policy issues. On an annual basis, we will ask the committee for their input regarding policy initiatives that MDH should be involved with in the upcoming year and provide an update on activities from the current year.
  - MDH serves as a resource for the HPG, organizations and individuals involved in legislative and policy making activities on local, state, and national levels.
  - On an ongoing basis, MDH solicits and accepts input from the HPG, organizations and individuals regarding policy initiatives that MDH should be involved with in the upcoming year and provide an update on activities from the current year.

- **Strategy: PrEP**
  Activities
    - Upon receiving funding from the Minnesota Department of Human Services, MDH plans to increase and expand access to Pre-Exposure Prophylaxis through grant funded programming as well as increased medical provider and public awareness. MDH hopes to have a PrEP Coordinator in place by January of 2016.

- **Strategy: Syringe Services**
  Activities
    - Needle Exchange and Disposal; HIV/HCV prevention and harm reduction; HCV testing services; Overdose Prevention; Advocacy for MN Syringe Access Law.

- **Strategy: Access high risk persons by working with the sexual and/or needle sharing partners of people who are living with HIV**
  Activities
    - Support testing of the sexual and/or needle sharing partners of people living with HIV/AIDS
    - Encourage persons using the needle exchange programs at MAP and Minnesota Transgender Coalition in the Twin Cities, the Rural AIDS Action Network in Duluth and Sacred Spirits on the White Earth Indian Reservation to bring their partners to use the program.
    - Encourage other publicly funded agencies providing HIV prevention, testing, treatment and care services and chemical dependency/substance abuse program to link IDU persons to the needle exchange programs.
    - Encourage and promote pharmacies participating in the Minnesota Syringe Access Initiative.

- **Strategy: Reduce stigma and increase accessibility of culturally and linguistically appropriate services to communities of color that are highly impacted by HIV**
  Activities
    - Reach undocumented individuals and people of color by increasing outreach and access to testing sites
    - Access formal and informal leaders to request/recommend testing to break down stigma
    - Target community education on the disease, importance of testing, and stigma by working with culturally competent community-based organizations
    - Specific communities have input on crafting messages, evaluation/assessment and how activities are implemented.
    - Funding availability and allocation affects the effectiveness of stigma reduction activities.

- **Strategy: Enhance and increase use of technology**
  Activities
    - Fund programs that will use social media applications and new media for promotion and cross promotion of local and online information resources,

testing resources and opportunities, sexual health-related events, syringe services, sexual violence, dating violence, and other issues that affect the sexual health and wellbeing of youth (all races, genders & sexual orientations) at high risk for HIV, STDs, hepatitis and/or unintended pregnancy; Address access to condoms and/or condom distribution; Stay current on new media and technologies that become popular with the target population.
    - Use social media applications through internet and mobile technology to promote information resources, testing resources, events, and prevention services.
    - Encourage use of new media and modern communication technologies by any and all funded programs, disseminate information and connect target populations to care and services, and Partner Services.
    - CDC contracted CBA providers have been providing capacity building technical assistance and trainings on social media and mobile technology in 2015.

- **Strategy: Increase accurate, age appropriate, and realistic sex education**
  Activities
    - Support policy changes to the current sex-education curriculum in school districts to the extent possible as permitted by the state (Minnesota still does not have a statute that provides statewide standards for comprehensive sexuality education).
    - "Healthier, Happier, Safer: Adolescent Health & Academic Equity" Initiative is a CDC funded (CDC HIV School Based Prevention Federal Grant) spanning 2013-2018. Minnesota is one of only four grants across the nation. The grant is administered by MDE in collaboration with MDH. The initiative works deeply with 10 MN school districts in improving the following three arenas: Safe and Supportive Environment (creating school environments that are welcoming and nurturing to all students, staff and administrators), Exemplary Sexual Health Education (ESHE), and Sexual Health Services (connecting youth to adolescent friendly clinics).

- **Strategy: Increase the number and diversity of stakeholders involved in HIV Prevention**
  Activities
    - Provide information and HIV/AIDS service system training to clinics and doctors to increase understanding, coordination and access
    - Expand testing opportunities to non-traditional testing sites including Community Corrections programs, CD and STI clinics, and community clinics
    - Streamline the system focusing on referrals and communication among clinics/doctors/CD treatment and case managers

- **Strategy: Heighten awareness of HIV/AIDS throughout the state**
  Activities
    - Increase HIV/AIDS awareness by distributing HIV/STD/hepatitis educational materials through bimonthly e-mails to all providers in our listserv.

- Promote HIV/AIDS awareness through news releases sent to local radio and cable television stations (e. g., KMOJ, Somalia, Ethiopian, etc.), and newspapers (e.g., Insight, Mshale, Mestawet etc.), particularly those that target Africans and African Americans who are disproportionately impacted by HIV/AIDS in Minnesota.
- MDH and MDH-funded prevention grantees participate in some of the biggest community social events (e.g., Cinco de Mayo, Rondo Days, Juneteenth, Pride festival, etc.) by distributing HIV/AIDS/STDs/Hepatitis educational materials, condoms, and answering some basic HIV 101 questions.

(5) SCALABILITY

To make a substantial difference in reducing the number of new infections at the state level, priorities for resource allocation are to be placed on interventions that are practical to implement on a large scale, at reasonable cost. More time- and resource-intensive interventions, such as one-on-one or group counseling, will be reserved for people at the very highest risk of transmitting or becoming infected with HIV.

(6) RESPONSIBLE AGENCY/GROUP TO CARRY OUT THE ACTIVITY

For the list of agencies responsible for carrying out activities, please see Section 4, page 15.

(7) RELEVANT TIMELINES

- Evaluation of MDH funded HIV prevention programming through monthly and semi-annual reporting and annual site visits.
- CCCHAP semi-annually addresses Prevention Planning
- Annual All Provider Meeting (Bringing prevention and services together)
- Next HIV Prevention Request For Proposals – 2016
- MDH PrEP Coordinator to oversee PrEP grants and awareness campaigns.

APPENDIX E: Membership and Stakeholder Profile

This profile is to be completed annually by the HPG co-chairs (or appropriate designees). It is designed to assist CDC and health departments in assessing the implementation of HIV planning and will serve also as a useful tool for HPGs in improving prevention planning processes at the local level.

Membership Profile

Name of the HPG/Jurisdiction: Community Cooperative Council on HIV/AIDS Prevention / Minnesota

Type of HPG: **X** Statewide ❒ Directly funded city/local jurisdiction

Structure: **X** HPG only ❒ HPG & Ryan White planning group
❒ HPG & other planning bodies (please describe)
_____

Total # of Voting Members: 19
Total # of Stakeholders that Are Non-voting Members: 0

Epidemic in the Jurisdiction

Please provide a brief description of your jurisdiction's epidemic:
As of December 2014, 7,988 Minnesotans were living with HIV.
48% of people living with HIV/AIDS in Minnesota are people of color.
76% of people living with HIV/AIDS are male.
58% of people living with HIV/AIDS are 45 or older.
86% of new infections occurred in the seven county metro area but over 95% of Minnesota counties have one or more persons living with HIV/AIDS.
62% of new cases among males are men who have sex with men.
5% of new cases among males are men who have sex with men and inject drugs.
1% of new cases among males are people who inject drugs.
In Minnesota, the number of African-born people living with HIV is at a rate almost 16 times higher than whites.
73% of new cases among women were attributed to heterosexual contact.
19% of new cases were among people ages 13-24, an estimated 65% of those were young MSM or MSM/IDU.

Agency Member Description

Please provide a list of all agencies that participate as members of the HPG:

RESOURCE Mental & Chemical Health
Minnesota Transgender Health Coalition

Minnesota Dept. of Health
Minnesota Dept. of Human Services
University of Minnesota - Broadway Family Medicine
Minneapolis Urban League – African Wellness Program
Big Brothers and Big Sisters of the Greater Twin Cities
Minnesota Dept. of Education
Rural AIDS Action Network
National Black Alcoholism and Addiction Council
Minnesota AIDS Project
Face to Face
Indigenous Peoples Task Force
University of Minnesota – Youth & AIDS Project

Agency Non-voting Member Description
Please provide a list of all agencies that participated in the engagement process that are not voting members of the HPG: HPG Meetings and proceedings are open to the public but at this time there are no regular attendees representing other key stakeholders.

Are the community and key stakeholders in alignment with the highest burden of disease areas in the jurisdiction? Yes.

Please describe: Recruitment for membership that accurately and appropriately reflects the communities and areas with the highest burden of disease is an ongoing process. As some members' terms end and others' begin, the precise percentage of representation may vary. This form represents a current snapshot of HPG membership as of August, 2014.

Key Stakeholders – Voting Members

Key Stakeholders	**Social Services**	**PLWHA**	**Behavioral or Social Scientist**	**Epidemiologist**
Total # 19	**5**	**4**		
	Substance Abuse	**Health Dept. (HIV, STD, TB, & Hepatitis)**	**Intervention Specialist**	**Local Education Agencies/ Academic Institutions**
	2	**2**	**6**	**1**
HIV Clinical Care Provider	**Faith Community**	**Business/ Labor**	**Community Health Care Centers**	
			2	
Mental Health	**Homeless Services**	**Corrections**	**HOPWA**	

1	**4**			

*In comments section below, please provide a list of any other key stakeholders that are represented. For example: specific community representative, non-profit agency, injection drug user, health department HIV/AIDS, health department STD, pharmacist, HIV case manager, and research center.

Comments: There are currently 18 Voting members in Minnesota's HPG. Some members represent multiple communities, areas and fields and are counted for each one in the table above. In addition, one member identified as working with Native American Women, another as working with HIV Positive youth.

Geographic Distribution of HPG Members

Urban	Metropolitan	Rural	Total # of HPG members
8	**6**	**5**	**19**

* The HD and HPG will have to decide on which definition they will use to describe their areas listed above; the geographic distribution of members should reflect the jurisdiction's epidemic.

Comments:

HIV Risk by Category of HPG Members

MSM	MSM/IDU	IDU/Needle Sharing	Heterosexual	Non-specific or Unknown	Total # of HPG Members
6			**8**	**5**	**19**

Comments:

HPG Membership Category by Race and Ethnicity

American Indian or Alaska Native	Asian	Black or African American	Native Hawaiian/Other Pacific Islander	White	More than one Race	Unknown	Total # of HPG Members
1	**1**	**1**		**15**	**1**		**19**

Comments:
Recruitment for membership that accurately and appropriately reflects the communities and areas with the highest burden of disease is an ongoing process. As some members' terms end and others' begin, the precise percentage of representation may vary.

HPG Membership Ethnicity

Hispanic or Latino	Not Hispanic or Latino	Unknown	Total # of HPG Members
	15	4	19

Comments:

Age of HPG Members

<13	14-19	20-29	30-39	40-49	50-59	60+	Total # of HPG Members
0	0	4	4	6	4	1	19

Comments:

Gender of HPG Members

Male	Female	Transgender FTM	Transgender MTF	Unknown	Total # of HPG Members
7	11			1	19

Comments:

Note: This form should be used to assess representation of community members, HIV service providers, and key stakeholders involved in the HIV prevention planning process to ensure appropriate participation; membership is also expected to reflect local epidemiology and needs of the jurisdiction.