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Financial and Human Resources Inventory

Minnesota & Minneapolis - St. Paul Transitional Grant Area Integrated HIV Prevention and Care Plan 2017-2021

REGION	Midwest
PLAN TYPE	Integrated state/city/county prevention and care plan
JURISDICTIONS	State of Minnesota and Hennepin County
HIV PREVALENCE	Medium

The Minnesota financial inventory and workforce development section is clear and precise. The financial inventory section provides a great amount of detail while remaining clear and simple. They provide graphics that help make the information easy to understand, including a chart which breaks down the percentage of total funds available to the program. A strength of the workforce development section is a thoughtful narrative detailing different workforce areas, including care and prevention workforce. In addition, this section provides a robust discussion around gaps, as well as steps being taken to change them.

SELECTION CRITERIA: FINANCIAL AND HUMAN RESOURCES INVENTORY

Exemplary Financial and Human Resources Inventory sections met the following criteria (based on the Integrated HIV Prevention and Care Plan Guidance):

- ☑ Includes amount of financial resources from both private/public funding sources
- ☑ Description of how resources are being used and which components of the HIV prevention program or HIV Care Continuum is/are impacted
- ☑ Description of Workforce capacity including what resources/services are missing/lacking and steps to address

Additional exemplary plan sections are available online:
www.targetHIV.org/exemplary-integrated-plans

Section I: Statewide Coordinated Statement of Need/Needs Assessment

C. Financial and Human Resource Inventory

Financial and Human Resources Inventory (Section I: C. a.)
This section of the Statewide Coordinated Statement of Need (SCSN) Needs Assessment provides an inventory of the financial and service delivery provider resources available in a jurisdiction to meet the HIV prevention, care, and treatment needs of the population as well as resource gaps. The Financial and Human Resource Inventory includes:

- Funding sources for HIV prevention, care, and treatment services in the jurisdiction,
- The dollar amount and the percentage of the total available funds in fiscal year 2016 for each funding source;
- The services delivered; and
- HIV Care Continuum steps impacted.

Minnesota HIV Resource Inventory

Funding Sources	Funding Amount ($)	Funded Service Provider Agencies	Services Delivered	HIV Care Continuum Steps Impacted
Minnesota Department of Human Services (DHS)				
ADAP, supplemental, Federal Rebate,	$5,667,634.00	DHS	ADAP Drug Program	ART, Viral Suppression
ADAP, Fed Rebate, State appropriation	$2,257,460.00	DHS	ADAP Insurance Program	ART, Linkage to Care, Retention in Care, Viral Suppression
Federal Rebate	$75,000.00	Mom's Meals	Food Bank/Home Delivered Meals	Retention in Care
Rebate	$113,300.00	University of Minnesota Youth and AIDS Project (contract pending)	Health Education and Risk Reduction	Linkage to Care, Retention in Care, ART, Viral Suppression
Rebate	$215,000.00	Minnesota AIDS Project, Clare Housing	Housing	Retention in Care, ART, Viral Suppression

Funding Sources	Funding Amount ($)	Funded Service Provider Agencies	Services Delivered	HIV Care Continuum Steps Impacted
Part B, Rebate, State appropriation	$2,035,216.00	Aliveness Project, Indigenous Peoples Task Force, Minnesota AIDS Project, Mayo Clinic, Rural AIDS Action network, Youth and AIDS Project	Medical Case Management	Linkage to Care, Retention in Care, Viral Suppression
Part B	$12,000.00	Mayo Clinic	Medical Transportation	Retention in Care
ADAP, Rebate	$55,347.00	DHS	Medication Therapy Management	ART, Viral Suppression
Part B	$10,296.00	DHS	Mental Health	Linkage to Care, Retention in Care
Part B and Rebate	$417,874.00	Minnesota AIDS Project, Rural AIDS Action Network, Hennepin Health Systems Positive Care Clinic	Non-Medical Case Management (Benefits Counseling)	Linkage to Care, Retention in Care
Rebate	$60,000.00	DHS	Nutritional Supplements	Retention in Care, Viral Suppression
Part B	$155,000.00	DHS	Oral Health	Retention in Care
Rebate	$44,829.00	Mayo Clinic	Outpatient Health Care Services	Case Finding, Linkage to Care, Retention in Care, Viral Suppression
MAI, Rebate	$111,000.00	African American AIDS Task Force	Outreach	Linkage to Care, Retention in Care
Part B, Rebate	$267,989.00	Minnesota AIDS Project	Resource and Referral	Linkage to Care, Retention in Care

Funding Sources	Funding Amount ($)	Funded Service Provider Agencies	Services Delivered	HIV Care Continuum Steps Impacted
Rebate	$100,000.00	Minnesota AIDS Project	Capacity Building Housing Advocacy	Retention in Care
Rebate	$72,610.00	Minnesota AIDS Project	Capacity Building Substance Use	Linkage in Care, Retention in Care, ART, Viral Suppression
Rebate	$50,000.00	Family Partnership	Capacity Building MCM Clinical Supervision	Linkage to Care, Retention in Care, ART, Viral Suppression
Rebate	$75,000.00	White Earth Nation – Summit in May 2016	Capacity Building Substance Use	Diagnosis, Linkage to Care, Retention in Care, ART, Viral Suppression
Rebate	$140,000.00	Midwest AIDS Training and Education Center	Capacity Building Medical	Diagnosis, Linkage to Care, Retention in Care, ART, Suppression
Minnesota Department of Health (MDH)				
MN State HIV Prevention	$946,173	African Health Action Corporation, Hennepin County Public Health Department – Health Interventions for Men (HIM) Program at Red Door, High School for Recording Arts, Indigenous People's Task Force, Face to Face, Lutheran Social Service – Duluth, Minnesota AIDS Project, Neighborhood House, Pillsbury United	HIV Testing and Testing Outreach	Diagnosis and Linkage to Care

Funding Sources	Funding Amount ($)	Funded Service Provider Agencies	Services Delivered	HIV Care Continuum Steps Impacted
		Communities, Rural Action AIDS Network (RAAN), Sub-Saharan Youth and Family Services in Minnesota (SAYFSM), Turning Point, West Side Community Health Services, and YouthLink		
MN State HIV Prevention	$236,822	Children's Hospitals and Clinics of MN – Perinatal Program, Hennepin County Public Health Department – Health Interventions for Men (HIM) Program at Red Door Minneapolis Medical Research Foundation – Positive Care Center at Hennepin Health System, Minnesota AIDS Project, and Youth and AIDS Projects (University of Minnesota)	Prevention with Positives	Linkage to Care, Retention and Viral Suppression
MN State HIV Prevention	$300,282	Minnesota AIDS Project, Rural Action AIDS Network (RAAN), and Sacred Spirits – First Nations Coalition,	Syringe Services	Prevention
MN State HIV Prevention	$50,000	Face to Face and Neighborhood House	Prevention for Youth at High Risk for HIV Infection	Prevention
CDC HIV Prevention	$338,699	MDH Public Health Lab, Hennepin County Public Health Department – Red Door Clinic, St. Paul Ramsey County Public Health – Clinic 555, and Minneapolis Medical Research Foundation – Positive Care Center at Hennepin Health System	HIV Counseling, Testing and Referral	Diagnosis and Linkage to Care

Funding Sources	Funding Amount ($)	Funded Service Provider Agencies	Services Delivered	HIV Care Continuum Steps Impacted
CDC HIV Prevention	$313,567	MDH and Hennepin County Public Health Department – Red Door Clinic	Partner Services	Prevention, Diagnosis and Linkage to Care
CDC HIV Surveillance Programs	$432,692	Minnesota Department of Health, STD/HIV/TB Section	Case Surveillance and eHARS	Linkage to care
DHS Contract Funding with MDH	$1,414,163	Minnesota Department of Health, STD/HIV/TB Section	PrEP, HIV Prevention Epidemiology, CareWare Maintenance	Diagnosis, Linkage to Care, Retention in Care
Hennepin County Public Health Department				
Part A	$41,300	Hennepin County Public Health Clinic	Early Intervention Services	Diagnosis, Linkage to Care
Part A	$98,100	Minnesota AIDS Project	Emergency Financial Assistance	Linkage to Care, Retention in Care, ART
Part A	$538,900	Minnesota AIDS Project, Open Arms of Minnesota, Aliveness Project,	Food Bank-Home Delivered Meals/Food Vouchers	Linkage to Care, Retention in Care, Viral Suppression
Part A	$80,800	Minnesota AIDS Project, Hennepin County Public Health, West Side Community Health Services	Health Education-Risk Reduction	Linkage to Care, Retention in Care, Viral Suppression
Part A	$7,300	Minnesota AIDS Project	Health Insurance Premium Assistance	Linkage to Care, Retention in Care, ART, Viral Suppression
Part A	$137,600	Pinnacle Services	Home and Community-Based Health Services	Retention in Care

Funding Sources	Funding Amount ($)	Funded Service Provider Agencies	Services Delivered	HIV Care Continuum Steps Impacted
Part A	$80,800	Minnesota AIDS Project	Housing-Rental Assistance	Linkage to Care, Retention in Care, Viral Suppression
Part A	$1,900	Various Hennepin County Vendors	Linguistic Services	Diagnosis, Linkage to Care, Retention in Care, ART, Viral Suppression
Part A	$96,800	Minnesota AIDS Project	Legal Services	Linkage to Care, Retention in Care
Part A	$1,607,700	Allina Health System¸ African American AIDS Task Force, Children's Hospitals and Clinics HealthPartners, Hennepin Health System, Saharan Youth and Family Services in Minnesota, West Side Community Services	Medical Case Management	Linkage to Care, Retention in Care, ART, Viral Suppression
Part A	$191,800	African American AIDS Task Force, West Side Community Health Services	MAI - Medical Case Management	Linkage to Care, Retention in Care, ART, Viral Suppression
Part A	$30,200	Allina Health System	MCM - Adult Foster Care	Linkage to Care, Retention in Care, ART, Viral Suppression
Part A	$418,200	Allina Health System, Hennepin Health System	Treatment Adherence/ Medication Adherence	ART, Viral Suppression

Funding Sources	Funding Amount ($)	Funded Service Provider Agencies	Services Delivered	HIV Care Continuum Steps Impacted
Part A	$44,000	Aliveness Project, Hennepin Health System	Medical Nutritional Therapy	Retention in Care, ART, Viral Suppression
Part A	$186,000	Hennepin Health System, SubSaharan Youth and Family Service of Minnesota¸ West Side Community Health Services	Mental Health	Retention in Care, Viral Suppression
Part A	$810,700	Hennepin Health System, HealthPartners, West Side Community Health Services,	Outpatient-Ambulatory Medical Care Primary Care	Linkage to Care, Retention in Care, ART, Viral Suppression
Part A	$158,800	Aliveness Project, Hennepin County Public Health Clinic	Outreach	Linkage to Care, Retention in Care
Part A	$88,400	African American AIDS Task Force, Minnesota AIDS Project, Saharan Youth and Family Services in Minnesota, West Side Community Health Services	Psychosocial Support	Linkage to Care, Retention in Care
Part A	$139,900	Hennepin Health System, Minnesota AIDS Project	Substance Abuse Services/Outpatient	Linkage to Care, Retention in Care, Viral Suppression
Part A	$24,000	SubSaharan Youth and Family Service of Minnesota	Transportation-Medical	Linkage to Care, Retention in Care, ART
Part B	$384,300	Minnesota AIDS Project	Emergency Financial Assistance	Linkage to Care, Retention in Care, ART

Funding Sources	Funding Amount ($)	Funded Service Provider Agencies	Services Delivered	HIV Care Continuum Steps Impacted
Part B	$138,000	Rural AIDS Action Network, Minnesota AIDS Project	Food Bank/Home Delivered Meals	Linkage to Care, Retention in Care, Viral Suppression
Part B	$3,600	Minnesota AIDS Project	Health Insurance Premium & Cost Sharing Assistance	Linkage to Care, Retention in Care, ART, Viral Suppression
Part B	$7,500	Minnesota AIDS Project	Legal Services	Linkage to Care, Retention in Care
Part B	$3,900	Interpretation and Translation	Linguistics Services	Diagnosis, Linkage to Care, Retention in Care, ART, Viral Suppression
Part B	$5,100	Aliveness Project	Medical Nutritional Therapy	Retention in Care, ART, Viral Suppression
Part B	$417,200	African American AIDS Task Force, Allina Health System, Aliveness Project, Health Partners, Hennepin County Public Health, Hennepin Health System, Minnesota AIDS Project, Rural AIDS Action Network	Medical Transportation Services	Linkage to Care, Retention in Care, ART
Part B	$45,000	Aliveness Project	Outreach Services	Linkage to Care, Retention in Care

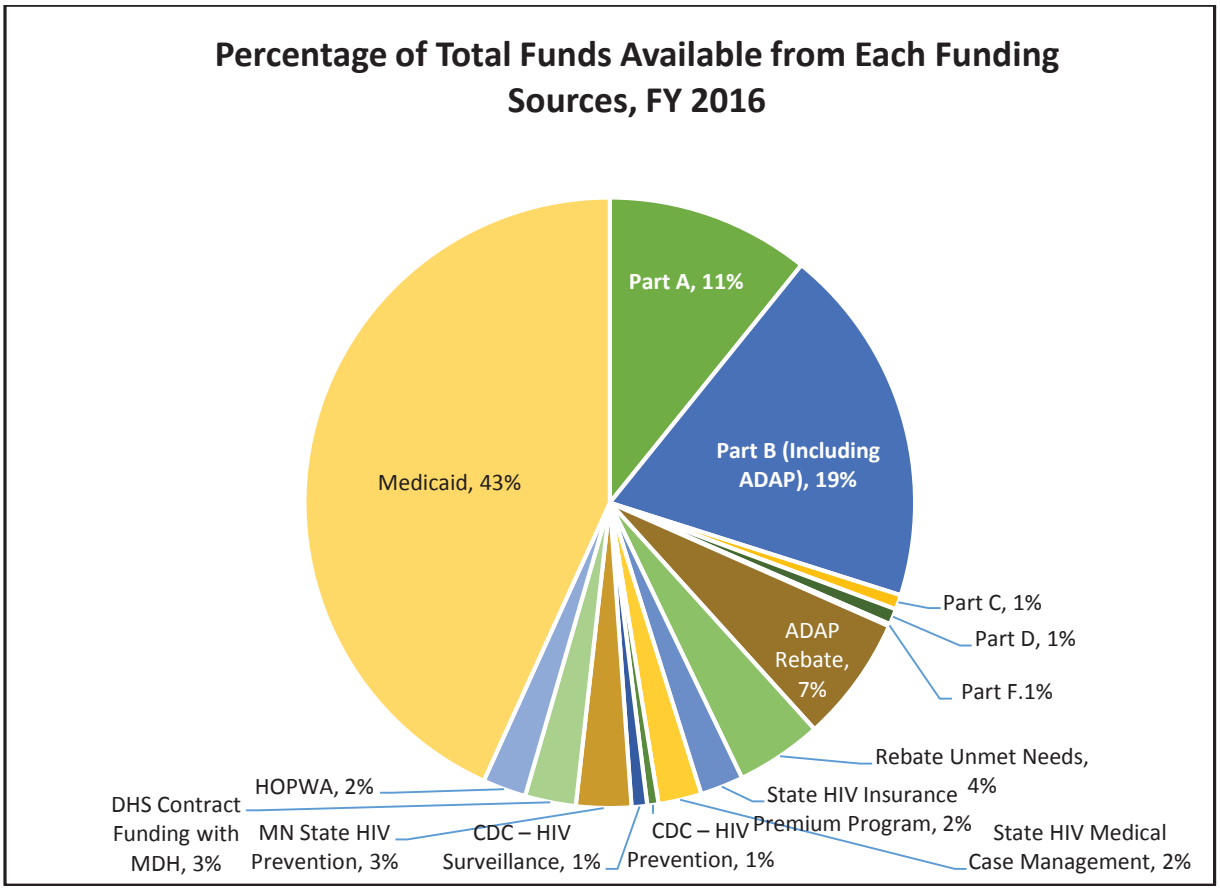
Funding Sources	Funding Amount ($)	Funded Service Provider Agencies	Services Delivered	HIV Care Continuum Steps Impacted
Rebate	$300,200	Aliveness Project, Hennepin County Public Health,	Early Intervention Services - African-born	Diagnosis, Linkage to Care
Rebate	$30,000	Minnesota AIDS Project	Emergency Financial Assistance - All Populations	Linkage to Care, Retention in Care, ART
Rebate	$10,075	Aliveness Project	Food Bank/Home Delivered Meals (GTR MN Food Shelf)- Greater MN	Linkage to Care, Retention in Care, Viral Suppression
Rebate	$96,700	Children's Hospital, Minnesota AIDS Project	Health Education-Risk Reduction – DAC	Linkage to Care, Retention in Care, Viral Suppression
Rebate	$88,350	Minnesota AIDS Project	Housing Services - Statewide	Linkage to Care, Retention in Care
Rebate	$272,000	African American AIDS Task Force, Hennepin Health System	Medical Case Management – DAC	Linkage to Care, Retention in Care, ART, Viral Suppression
Rebate	$34,075	African American AIDS Task Force, Rural AIDS Action Network	Medical Transportation DAC	Linkage to Care, Retention in Care, ART
Rebate	$85,000	Aliveness Project	Non-Medical Case Management – DAC	Linkage to Care, Retention in Care

Funding Sources	Funding Amount ($)	Funded Service Provider Agencies	Services Delivered	HIV Care Continuum Steps Impacted
Rebate	$10,000	Hennepin Health System	Outpatient Ambulatory Care - Statewide	Linkage to Care, Retention in Care
Rebate	$85,000	Hennepin County Public Health	Outreach Services – DAC	Linkage to Care, Retention in Care
Rebate	$30,000	Hennepin County Public Health	Psychosocial Support Services – DAC	Linkage to Care, Retention in Care
Rebate	$70,000	Hennepin Health e System, Minnesota AIDS Project	Substance Abuse Outpatient - Statewide	Linkage to Care, Retention in Care, Viral Suppression
HOPWA	$1,055,090	Metro HRA	Housing – Rental Assistance	Linkage to Care, Retention in Care
HOPWA	$153,742	Minnesota Housing Finance Agency	Housing – Rental and Mortgage Assistance	Linkage to Care, Retention in Care
Medicaid - Federal	$30,063,571	Minnesota Department of Human Services	Outpatient Health Care Services	Diagnosis, Linkage to Care, Retention in Care, ART, Viral Suppression
Minnesota Care – Federal/State	$1,024,419	Minnesota Department of Human Services	Outpatient Health Care Services	Diagnosis, Linkage to Care, Retention in Care, ART, Viral Suppression
Hennepin County	$104,902	Hennepin County Public Health Clinic	Early Intervention Services	Diagnosis, Linkage to Care.

Funding Sources	Funding Amount ($)	Funded Service Provider Agencies	Services Delivered	HIV Care Continuum Steps Impacted
Hennepin County	$166,500	Minnesota AIDS Project	Transitional Housing Services	Linkage to Care, Retention in Care
Hennepin County	$17,234	Hennepin County Public Health Clinic	Outreach Services	Linkage to Care, Retention in Care
City of Minneapolis	$41,200	Department of Health and Family Services	Medical Case Management	Linkage to Care, Retention in Care, ART, Viral Suppression
St. Paul – Ramsey Public Health Department	$121,187	Clinic 555	Early Intervention Services	Diagnosis, Linkage to Care.

Percentage of Total Funds Available from Each Funding Sources (Table), FY 2016

Funding Source	Amount	Percentage of Total Funds
Part A	$5,671,107	11.14%
Part B (Including ADAP)	10,030,522	19.70%
Part C	407,656	0.80%
Part D	437,613	0.86%
Part F	63,185	0.12%
ADAP Rebate	3,503,848	6.88%
Rebate Unmet Needs	2,400,000	4.71%
State HIV Insurance Premium Program	1,063,678	2.09%
State HIV Medical Case Management	1,156,169	2.27%
CDC – HIV Prevention	313,567	0.62%
CDC – HIV Surveillance	432,692	0.85%
MN State HIV Prevention	1,533,277	3.01%
HOPWA	1,208,832	2.37%
Medicaid (Medical Assistance)	22,698,658	44.58%
TOTAL	**$50,920,804**	100.00%



HIV Workforce Capacity (Section I: C. b.)
This section describes the HIV workforce capacity and how it impacts the HIV service delivery system in Minnesota.

Care Workforce
There are 19 organizations including medical clinics and community based non-profit agencies with 111 full-time equivalent (FTE) contracted staff to provide services through either the Part A or Part B recipients. Most of these organizations offer multiple services providing clients a menu of services available at one location. In addition, providers within the HIV-service system have a high level of knowledge of programs and services available at other agencies and there is extensive client referrals among them. In addition, many service activities are available at multiple locations providing not only geographic convenience but also allowing clients to choose their self-determined most suitable provider. This means, for example, that a client may choose to receive medical case management at their HIV medical clinic or, through a community based organization that meets their culturally specific needs.

Minnesota is fortunate to have several excellent HIV care clinics both within the TGA and in Greater Minnesota. These clinics serve a highly diverse population and strive to provide care that serves both the cultural and linguistic needs of all patients. These medical clinics offer a range of medical services with physicians, nurse-practitioners, registered nurses, registered dietitians, licensed social workers, Licensed Alcohol and Drug Counselors (LADC's), Pharm-D's, medical case managers, behavioral health professionals and, paraprofessionals who have long experience

and training in working with HIV-positive clients. Several of these clinics provide services such as HIV testing or PrEP services to partners of patients and other high-risk populations.

Minnesota has a well-developed social safety net both inside and outside the HIV service system. HIV Supportive Services workers include health educators, care linkage specialists, outreach workers, housing specialists, non-medical case managers primarily providing benefits counseling, lawyers, group facilitators, peer navigators, and homemaker service workers. These workers make referrals to and work in coordination with other non-HIV specific providers to meet the needs of their clients which in effect, extends the HIV workforce.

While 86% of known HIV-positive Minnesotans live in the TGA, the remaining 14% are scattered broadly across a large and mostly rural geographic area. In order to provide access to experienced medical and social service providers in rural areas with low prevalence rates, Part B provides training to increase capacity in locations throughout the state. This is a work in progress but as an example, Part B provides funding to train LADC's on substance abuse care needs of individuals living with HIV. In the last year, 50 LADC's attended one of seven two-day trainings. Similarly, the Midwest AIDS Training and Education Center is surveying Community Health Centers to learn their readiness and skill in providing primary care to HIV-positive individuals. Once this data has been analyzed, they will begin to offer training to these clinics based on the outcomes from the data. The goal of these capacity building efforts is to increase the ability of non-HIV specific providers to deliver competent, stigma-free care to a population they may encounter only sporadically.

Minnesota has a systemic lack of mental health capacity especially for outpatient psychiatric appointments and inpatient mental health care. This is not an HIV-specific issue and in fact, the Governor has created a special task force to improve access to a range of needed mental health services for all Minnesotans. As a partial remedy, several HIV clinics have developed relationships with mental health clinics to circumvent the lack of capacity for medication checks or other appointments with psychiatrists, but inpatient care remains a difficulty. Individuals receiving medical care from generalized infectious disease clinics do not have access to mental health services within a clinic and may therefore face long wait times. Dental care also lacks capacity, especially for low-income residents living in Greater Minnesota. Many dentists site low reimbursement rates for limiting the number of Medicaid patients they accept and this impacts individuals with HIV ability to obtain oral health care despite having access to insurance or ADAP oral health care assistance.

In general, the HIV workforce is very experienced and clients can generally find the medical and supportive services they need. This is more difficult for clients living in Greater Minnesota however, medical case management services scattered across the state has allowed access to needed services both HIV specific and non-specific. The lack of mental health and dental services is also somewhat amplified in Greater Minnesota but despite targeted HIV resources remains a systems issue for all populations.

Prevention Workforce

Minnesota's HIV prevention workforce included staff at the Minnesota Department of Health, STD, HIV and TB Section (MDH) and staff at 18 agencies funding through the MDH. The MDH utilizes federal and state funding to support approximately 26 FTEs. These positions

include grant management, capacity building and technical assistance, administrative support services, epidemiology and surveillance, partner and care link services, and administrative management. These funds are also used to support approximately 24 FTEs at community and clinical based organizations to provide HIV testing and outreach testing, prevention with positives, syringe services and condom distribution activities. Staff at these organizations include medical case managers, community health workers, outreach specialists, HIV testing coordinators, prevention case managers, nurses and other licensed providers, and many other paraprofessionals with extensive experience in HIV prevention activities.

Interaction of Funding Sources to Ensure Continuity of HIV Prevention, Care and Treatment Services in Minnesota (Section I: C. c.)

Minnesota coordinates different funding sources at both the prevention, care and treatment levels of the continuum.

Prevention Funding Source Coordination

Minnesota is unique in the country in that Ryan White Part B funding and HIV Prevention funding are administered by different state agencies. The MDH serves as the grantee for the State's CDC prevention funding and the Department of Human Services (DHS) serves as the grantee for Minnesota's Ryan White Part B program. Ryan White Part A funding goes directly to Hennepin County. Due to separate federal funding sources and different priorities, there has historically been minimal integration of prevention and care resource administration and planning in Minnesota.

In more recent years, there has been a greater emphasis at the federal level on diminishing the distinction between prevention and care. In 2010, the White House issued the National HIV/AIDS Strategy (NHAS) to guide the nation's effort to end the epidemic. The fourth goal of the NHAS calls for "increased coordination of HIV programs across the federal government and between federal agencies and state, territorial, tribal, and local governments." In response to the NHAS and the demonstration of early initiation of antiretroviral treatment (ART) as a highly effective prevention intervention, the Centers for Disease Control and Prevention (CDC) refocused its funding priorities to scale up HIV testing, The intent is to identify the estimated 18% of people living with HIV who are undiagnosed, ensure early linkage to care, and implement highly effective prevention interventions with people living with HIV.

Reauthorization of the Ryan White Act in 2009 increased the Ryan White Program's focus on identifying the undiagnosed, linking those infected to early care and supporting lifetime adherence to treatment. In 2016, CDC and HRSA jurisdictions are required to submit a joint statewide HIV prevention and care strategy. Given all of these factors, the three government agencies (MDH, DHS and Hennepin County) and members of the former Planning Council and Community Cooperative Council on HIV/AIDS Prevention (CCCHAP) agreed in early 2014 to merge the two planning groups into one planning body. Through an intergovernmental cooperative agreement supported by all three agencies, the Minnesota Council for HIV/AIDS Care and Prevention (MCHACP) was formed and began meeting in February 2016. Hereinafter MCHACP will be referred to as the "Council". The Council's role is to identify both prevention and care priorities for Minnesota.

With full implementation of the Affordable Care Act (ACA) including Minnesota's expansion of Medicaid and a health insurance exchange in 2014, many more Minnesotans living with HIV have access to affordable health care. At-risk insured Minnesotans also have access to free HIV and STD testing through their health care providers. With flat or diminishing HIV public health resources, these circumstances demand much tighter coordination of HIV prevention and care activities to ensure a more cost effective and integrated approach to ending Minnesota's HIV epidemic. DHS, Minnesota's Part B grantee, is using use ADAP rebate revenue for care linkage, increased epidemiological support to employ data-to-care strategies, and is funding the efforts to develop a statewide HIV strategy to end the epidemic.

Service and Treatment Funding Source Coordination

Minnesota coordinates its Part A and B Ryan White planning efforts by utilizing the newly formed Council to carry out its prioritization and allocation responsibilities. For Part A, Council decisions on priorities and allocations are decisive and for Part B Council decisions are considered to be advisory, although historically nearly always followed. This creates an effective system of care and provides a level of funding coordination that maximizes service provision to people living with HIV/AIDS.

In planning the continuum of care and services, prioritizing services, and allocating Ryan White resources, services funded by sources other than Ryan White interact with Ryan White funds in the following ways:

a) Other sources of funding are considered when the Council sets priorities, makes allocations, and reallocates resources to ensure that Ryan White is the payer of last resort and that Ryan White funds are not supplanting other funding sources.

b) Priority setting and resource allocation processes consider Medicaid and other state-funded healthcare programs. The Minnesota Department of Human Services (DHS), the Part B grantee and agency responsible for Medicaid and all other state-funded healthcare programs, is a party to the Intergovernmental Cooperative Agreement. In addition, DHS has a designated seat on the Council, one from the state Medicaid office and one from the Part B grantee office.

c) DHS staff determines eligibility of PLWH who may qualify for state-sponsored insurance and Ryan White funded programs such as ADAP to ensure the Ryan White program is the payer of last resort.

d) The Part A and B grantees and Council receive an annual report from DHS on the number of PLWH disease enrolled in all Minnesota Healthcare Programs (MHCP), including Medicaid. The report also includes spending on HIV outpatient medical care, dental care, mental health and chemical dependency treatment services, and home and community-based support services.

e) Through ADAP and the HIV Insurance Program, Minnesota's Part B grantee provides additional assistance to individuals with incomes up to 400% of the federal poverty level who are enrolled in Medicare Part D. A state appropriation provides support for the HIV Insurance Program. Part B funds provide benefits counseling (non-Medical Case Management) to help consumers identify the most comprehensive private and public healthcare programs to ensure continued access to affordable treatment. This helps those who are Medicare eligible to enroll in

the Part D prescription drug plans and extra-help programs. DHS provides the Council with information on the number of PLWH on Medicare who are also enrolled in ADAP and the HIV Insurance Program.

f) Through ADAP and the HIV Insurance Program, Minnesota's Part B grantee provides assistance to individuals with incomes up to 400% of the federal poverty level who are enrolled in Medicare Part D insurance. A state appropriation provides support for the HIV Insurance Program. Part B funds provide benefits counseling (non-Medical Case Management) to help consumers identify the most comprehensive private and public healthcare programs to ensure continued access to affordable treatment. This helps those who are Medicare eligible to enroll in the Part D prescription drug plans and the Extra-Help program. DHS provides the Council with information on the number of PLWH on Medicare who are also enrolled in ADAP and the HIV Insurance Program.

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

h) The Minnesota Housing Finance Agency (MHFA) and the City of Minneapolis receive Housing Opportunities for Persons with AIDS (HOPWA) formula funding. The Minneapolis program provides rental subsidies and the MHFA program provides both rental and mortgage assistance outside the TGA. A Council member, a Part B representative, and the Council Coordinator participate in the Minnesota HIV Housing Coalition. The co-chair of the Housing Coalition presents on HOPWA funded services at the Council's informational sessions. The TGA's largest AIDS service organization receives local funds for a transitional housing program, is a sub-recipient of state formula HOPWA funds and also has a Part A contract to provide rental assistance. The grantees works closely with this agency to coordinate Part A, Part B, and HOPWA funds.

i) Other social service programs are considered during the planning and priority setting process in ways similar to those described above. The Minnesota DHS HIV/AIDS program is situated in the DHS's Disabilities Services Division. The DHS HIV/AIDS director apprises the Council of other state funded programs for persons with disabilities such as Minnesota's Pathways to Employment‖ program and the state's Medicaid waiver home and community support programs. Administrators of other state and local support programs, such as targeted case management, participate in the Council and its committees, as well as in formulating the SCSN.

j) The Part A grantee office is co-located with Hennepin County's Public Health Clinic, which is the largest local public health agency in Minnesota. The Council allocates resources to services provided by Hennepin County's Public Health Clinic including: early invention, outreach, health Education and risk reduction, medical transportation and mental health services. As a result, Ryan White funding is closely coordinated with the state's largest CDC-funded HIV counseling, testing and referral provider. Hennepin County's Public Health Clinic also receives both CDC and state funding for HIV and syphilis prevention targeting MSM. The Part A grantee

coordinator meets with both Minnesota's STD and AIDS Director from the MDH and the DHS HIV/AIDS Program Administrator monthly to coordinate local and state prevention and care funding and programming.

k) DHS also administers state and federally funded substance use services and provides key information for the Council about how substance use disorder (SUD) treatment services are funded and utilized by PLWH enrolled in Medicaid and other publicly funded healthcare programs. In general, treatment on demand is available for low income people living with HIV disease. Treatment services are paid for through the state's Consolidated Treatment Fund supported through a Substance Abuse and Mental Health Services Administration Block Grant. The Council allocates Part A funding for chemical health assessment, treatment placement, short term counseling and follow up at the TGA's largest HIV specialty clinic and largest AIDS service organization. These programs facilitate access to SUD treatment funded through other public sources and ensure that a continuum of care exists for PLWH who are substance users. In addition to DHS's oversight of SUD services, its staff participates in the planning, priority setting and allocations processes. DHS also provides training for SUD treatment centers on appropriate care and resources for people living with HIV.

l) Part A and B grantee managers work to ensure coordinated administration of Part A, B, and state appropriations for HIV services. Reimbursement methods and standards for service delivery are uniform across providers regardless of which government agency manages contracts. Grantees work to prevent duplication of state and local funding of HIV services.

Services which are not being Provided & Steps Taken to Secure them (Section I: C. d.)
A key goal of the Integrated HIV Prevention and Care Plan, Ryan White Legislation, the National HIV/AIDS Strategy, and Health People 2020 is to reduce or eliminate the gaps in resources and services that prevent people living with HIV disease from entering into or remaining in care. Unmet need estimates produced by the MDH approximates 27% of all people living with HIV disease in the Minneapolis-St. Paul Transitional Grant Area who know their HIV status and are not receiving medical care. In addition, there are an estimated 12% who are HIV positive and are not aware of their status. The identification of resources and services which are not being provided and the steps taken to secure the needed resources and services is separated into three major themes including resources and services for communities of color, Greater Minnesota, and along the HIV Continuum of Care. There are many steps being taken at each stage in the continuum to ensure there are adequate resources to meet the needs of PLWH.

Linkage to Care
An ongoing challenge is to determine what prevents those who are HIV-positive from being engaged in care. Minnesota, along with the rest of the nation, is challenged to cultivate new ways of delivering prevention and education messages particularly targeted at young people at risk, people who have been diagnosed but are not engaged in care, communities of color, and immigrant (non-English speaking) populations.

To address these resource and service gaps the Council has allocated Part A resources for early intervention services (EIS) at Hennepin County's Public Health Clinic (PHC). This clinic is the largest public health clinic in the TGA and diagnoses 25% of Minnesota's annual number of new infections. At the PHC all newly diagnosed PLWH meet with a nurse practitioner at the time of diagnosis and have their blood drawn for CD4 count and viral load tests. In addition, they meet

with an HIV positive navigator who arranges follow up appointments and brokers both internal and external connections with services that support ongoing retention in care. The PHC has a cooperative referral agreement to have a medical appointment scheduled for a newly diagnosed individual within 48 hours at Hennepin County Medical Center's (HCMC) Positive Care Clinic (PCC) - the largest HIV specialty clinic in the TGA. The PCC is a five-minute skyway walk from the PHC and both clinics share a clinical director. The PHC has referral agreements with the other four largest HIV primary care providers in the TGA. The PHC provides confirmatory testing for many of the community-based organizations in the TGA that provide HIV testing which broadens the reach of their EIS program. In addition, the PHC receives funding for medical transportation, health education/risk reduction and psychosocial support services that facilitate linkage to care and ongoing retention.

Part B recently funded a small EIS program through a HIV Clinic in southern Minnesota. It is the only EIS program outside the TGA. Its service area includes two counties with a much higher than average rate for HIV among rural counties. Both counties are home to industries that employ many Latino and African-born workers. While this EIS program is small, it is hoped that it can reach out to these populations which are both high risk and most likely to be late testers and expand it to high risk communities in other geographic locations in Greater Minnesota

MDH currently has a Care Link Services Program which is funded through DHS. The program uses CD4, viral load (VL), and other surveillance data reported to MDH to increase the proportion of PLWH/A begin and remain or re-engage in HIV medical care, thus improving their health outcomes and reducing the risk of transmitting HIV to others while receiving anti-retroviral therapy. The populations of focus, in order of highest priority first, are: 1) HIV-positive pregnant women not in care or whose care status is unknown; 2) newly diagnosed African women; 3) those newly diagnosed at a facility without an affiliated HIV medical provider; 4) those who have not initiated HIV care within 90 days after their first positive HIV test; and, 5) racial and ethnic minority men who have sex with men (MSM) and who have been out of care (OOC) for more than 12 months. This project addresses the focus areas of 1) enhanced linkage to and retention in care for persons with new and prior diagnoses of HIV infection, and 2) programmatic and epidemiologic use of CD4, viral load and other surveillance data to assess and reduce HIV transmission risk. The program will expand its priorities as Hennepin County begins doing all cases in the jurisdictions.

Although Minnesota has current linkage, engagement and reengagement programs it isn't adequate to meet all of the state's needs. According to the last estimate, Minnesota still has 30 percent of individuals living with HIV not in care. Without all PLWH/A in care, the state will not reach the National HIV Strategy's goal for viral suppression. Without having all PLWH/A reaching viral suppression Minnesota will not get to zero new infections.

Retention

Services designed to retain PLWH in care have proven to be effective in achieving viral suppression and ultimately prevention of the spread of HIV. Data from MN CAREWare suggest that PLWH receiving Ryan White services are more likely to be retained in care and have suppressed HIV compared to the total population of PLWH. Medical case management (MCM) is a key medical care access facilitator that significantly impacts movement across the HIV Care Continuum from linkage to suppressed virus through its support of ART adherence and mitigation of economic and psychosocial barriers to care. The Council's largest allocation of Part

A funds for services is to MCM. Part B, state and rebate funds MCM primarily at community based organizations (CBO's) within the TGA and at both CBO's and HIV clinics in Greater Minnesota. In addition, Part A and MAI funds for MCM are allocated to a Federally Qualified Health Center that provides care to a quarter of Minnesota's Latinos living with HIV. Part A funds are also allocated for MCM to the African American AIDS Task Force that reaches African Americans experiencing significant barriers to health care access and retention. Part B MAI funds are used to promote enrollment of African American men into ADAP ensuring they have access to health care plans and/or medications to promote retention.

Supportive services have a major role in retention in care. Supportive services such as housing, transportation, access to food through home delivered meals and food shelves or Emergency Assistance as well as addressing clients' needs for mental health and substance abuse care all are critical in care retention. Funds from Parts A and B and Rebate are used both in the TGA and statewide to support these services. Part B recently funded increased housing services because it has been well documented that stable housing is a key factor in all aspects of the continuum but may have greatest impact in care retention and subsequent viral suppression. These funded services will provide:

- Additional financial support for emergency housing assistance,
- Provide supportive housing, and
- Fund a program to work to increase housing availability and provide education to HIV service providers on how to access subsidized housing for their clients. This is necessary due to a systemic shortage of affordable and subsidized housing statewide.

Beginning in 2016, Hennepin County's PHC receives HIV surveillance data on PLWH living in Hennepin County from the MDH to implement a *Data to Care* project. The majority of the TGA's population of PLWH reside in Hennepin County. The surveillance data will enable PHC disease intervention and service navigation staff to reach out to those who are out of care and help them restart their movement across the HCC by connecting them to services they need to support retention and achieve viral suppression. In addition, Hennepin County (Part A grantee) in collaboration with the MDH and the DHS (Part B grantee) are finishing up a pilot called "eHARS to CAREWare". This pilot project migrates CD4 counts and viral load values from the eHARS into CAREWare so these values are known for Ryan White Program recipients in Minnesota. This will facilitate both Part A and B funded medical case manager monitoring of retention and viral suppression of their clients so they can more effectively target treatment adherence interventions.

Viral Suppression

With full implementation of the ACA only 4% of Minnesotans are now uninsured providing increased access to health care which should raise retention and viral suppression rates among PLWH. This means that direct funding for HIV clinical services has largely been spared from budget cuts. However, disparities in access to economic supports for health care coverage continue to exist among people of color. This is particularly true for those who were born outside of the United States.

To address these resource and service gaps, Part A and MAI funds are allocated to outpatient health care services (OHCS) provided by two of the largest HIV specialty clinics in the TGA and a Federally Qualified Health Center (FQHC). The FQHC reaches PLWH born in Latin American countries who do not qualify for Medicaid or Medicare and are unable to obtain a qualified

health plan with advanced premium tax credits through Minnesota's health insurance exchange because of immigration status. ADAP is used to purchase health care insurance through the exchange market for many of these individuals but for others, OHCS programs fill gaps in medical care especially for those PLWH who are newly diagnosed or re-entering care and uninsured, temporarily lose coverage due to "churning" caused by changes in eligibility for publicly funded programs resulting from fluctuations in income, loss of employer sponsored coverage, and annual changes in qualified health plans available through Minnesota's insurance exchange during open enrollment. The growth in both the epidemic and the number of PLWH utilizing Ryan White funded services in an atmosphere of flat funding presents a challenge to ensuring access to care.