Chris Steller

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Sent: Monday, February 4, 2019 9:36 PM
To: Chris Steller
Subject: FW: MDH Report - HIV Strategy Update
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Sent: Thursday, January 3, 2019 2:23 PM
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Subject: MDH Report - HIV Strategy Update

Good afternoon,

I'm pleased to share with you the attached report on the Minnesota HIV Strategy. The strategy provides a roadmap for coordinating efforts and resources to address HIV, with the ultimate goal of eliminating HIV/AIDS in Minnesota. This strategy is in partnership with DHS and is the result of extensive stakeholder engagement and input throughout 2017 and 2018. Please let me know if you have any questions or if you would like to discuss this information further.

Thanks,

Melissa Finnegan
Director of Legislative Relations | Executive Office

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Minnesota HIV Strategy: A Comprehensive Plan to End HIV/AIDS

Report to Minnesota Legislature
01/03/2019

Minnesota HIV Strategy: A Comprehensive Plan to End HIV/AIDS

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As requested by Minnesota Statute 3.197: This report cost approximately $240,047 to prepare, including staff time, printing and mailing expenses.

Table of Contents

Acronyms

Please refer to Appendix A: Glossary for definitions of terms used in this report.

AIDS: Acquired Immunodeficiency Syndrome

ART: Antiretroviral therapy

CDC: Centers for Disease Control and Prevention

CBO: Community-based Organization

DHS: Minnesota Department of Human Services

HIV: Human Immunodeficiency Virus

IDU: Injection Drug Users

MDE: Minnesota Department of Education

MDH: Minnesota Department of Health

MSM: Male-to-Male Sexual Contact

MSM/IDU: Men Who Have Male-to-Male Sex and Inject Drugs

NHAS: National HIV/AIDS Strategy

PEP: Post-exposure Prophylaxis

PrEP: Pre-exposure Prophylaxis

PLWH: People Living With HIV

PWID: People Who Inject Drugs

STD: Sexually Transmitted Disease

U=U: Undetectable = Untransmittable

UNAIDS: Joint United Nations Programme on HIV/AIDS

Acknowledgements

Thank you to everyone who contributed to the successful development of the Minnesota HIV Strategy. In particular, thank you to Wilder Research for facilitating meetings of the Minnesota HIV Strategy Advisory Board, for facilitating workshops throughout Minnesota to gather input on how to implement the goals of the Minnesota HIV Strategy, and for developing the evaluation plan and assisting with the development of the implementation plan. Thank you to members of the Minnesota HIV Strategy Advisory Board who prioritized tactics to be implemented in 2019 and provided valuable input on this update to the Minnesota HIV Strategy.

Additional thanks go to the former Minnesota HIV Strategy Coordinator, the former Minnesota HIV Strategy Student Worker, and Minnesota Department of Health (MDH) and Minnesota Department of Human Services (DHS) staff who planned meetings and workshops, identified a broad range of stakeholders, and assisted with implementing the workshops. DHS has been a vital partner to MDH in the planning and development of the Minnesota HIV Strategy.

And most of all, thank you to the many people living with HIV; people at risk; providers; members of the faith community; and staff from state, local, and tribal government agencies who took the time to share their experiences and expertise.

Executive Summary

Human immunodeficiency virus (HIV) continues to be a significant health issue in Minnesota despite innovations in HIV treatment, prevention, and policy. Since 1982, there have been 11,598 cases of HIV/AIDS reported to the Minnesota Department of Health (MDH). For the past decade, the number of new HIV diagnoses in Minnesota has remained relatively steady at approximately 300 cases per year. At the end of 2017, a total of 8,789 people were believed to be living with HIV/AIDS infection in Minnesota.

For the first time, the knowledge and tools exist to effectively end the HIV epidemic. Treating HIV prevents new infections from occurring and is known as "treatment as prevention." One highly effective HIV prevention strategy is antiretroviral therapy (ART), which decreases the amount of virus in the bodies of people living with HIV (PLWH) to undetectable levels, allowing them to live long, healthy lives. Another highly effective HIV prevention strategy is pre-exposure prophylaxis (PrEP), a daily pill taken by people who do not have HIV in order to prevent infection. If an HIV negative person is exposed to HIV, they can take post-exposure prophylaxis (PEP) to reduce their risk of infection.

HIV Health Inequities and Disparities

Even though there are advances in prevention and care, Minnesota is facing growing health inequities and HIV health disparities in many communities across the state. The data clearly show that the HIV epidemic disproportionately affects historically marginalized populations. The populations in Minnesota hardest hit by HIV are:

- Gay, bisexual and other men who have sex with men (gay and bisexual men[a])
- People who inject drugs (PWID), including gay and bisexual men who inject drugs
- Populations of color and American Indians
- Transgender people

Now is the time for Minnesota to have a statewide strategy to address inequities and close the HIV disparity gap. A focus on addressing these health inequities is in line with Minnesota's efforts to advance health equity.[1]

Goals of the Minnesota HIV Strategy

The Minnesota HIV Strategy (the Strategy) provides a roadmap for coordinating efforts and resources to address HIV with the ultimate goal of eliminating HIV/AIDS in the state. The Strategy is the state's blueprint to end the HIV epidemic by leveraging new knowledge and tools; reducing the number of newly diagnosed individuals; ensuring that individuals living with HIV have access to quality, life-

[a] Includes men who have sex with men and do not self-identify as gay or bisexual.

extending care regardless of race, gender, sexual orientation, or socioeconomic circumstances; and ensuring the coordination of a statewide response to reach the goal of eliminating HIV in Minnesota. While the Strategy was written by MDH and the Minnesota Department of Human Services (DHS), it is not meant to be supported solely by these two state agencies. The success of the Strategy depends on the involvement and cooperation of a wide range of key stakeholders within and outside of state government.

The vision of the Strategy is that by 2025, Minnesota will be a state where new HIV diagnoses are rare and all people living with HIV and those at high risk of HIV infection will have access to high quality health care and resources they need to live long healthy lives, free from stigma and discrimination.

To achieve health equity and to end the epidemic, the Strategy has five goals:

1. Prevent new HIV infections
2. Reduce HIV-related health disparities and promote health equity
3. Increase retention in care for PLWH
4. Ensure stable housing for PLWH and those at high risk for HIV infection
5. Achieve a more coordinated statewide response to HIV

DHS and MDH will use four quantifiable outcomes and eight indicators to measure Minnesota's progress towards reaching these goals and realizing the Strategy's vision.

Stakeholder Involvement and Strategy Implementation

In order for the Strategy to be meaningful and successful, MDH and DHS felt it was critical to gather the input of a broad range of stakeholders. In 2017, input was gathered through a series of focus groups and key informant interviews conducted throughout the state. Participants identified important areas of need, as well as recommendations to address those needs. In 2018, Wilder Research conducted 15 regional and community facilitated workshops around the state. Wilder Research also conducted a web-based survey for stakeholders who were not able to attend a workshop. Participants prioritized strategies of the Minnesota HIV Strategy that were most important for their region or community and developed tactics for implementing them.

Members of the Minnesota HIV Strategy Advisory Board played a significant role in both years. In 2017, they focused on developing the goals, strategies and indicators. In 2018, they selected 10 priority tactics after reviewing recommended tactics generated through the workshops. They also provided input on how to implement the priority tactics and how to evaluate progress being made toward achieving the outcomes and indicators of the Strategy.

DHS and MDH then developed action steps for implementing the 10 priority tactics, as well as action steps for administrative responsibilities. The plan primarily covers the 2019 calendar year, with some action steps that extend into 2020. Much of the early work focuses on building additional infrastructure and capacity within and outside of state government. The plan is intended to be a starting place for implementation of the Strategy and will be revised and extended, as needed, once processes are underway or as additional information becomes available.

Introduction

The Minnesota HIV Strategy (the Strategy) is a legislatively mandated plan, signed into law by Governor Mark Dayton on May 20, 2017. Minnesota Session Laws 2017, Chapter 75, section 1 (Appendix B) requires the Commissioner of Health, in coordination with the Commissioner of Human Services and in consultation with community stakeholders, to develop a strategic statewide comprehensive plan to end HIV/AIDS in Minnesota. The Minnesota HIV Strategy Advisory Board (Advisory Board) was convened to provide advice, information, and recommendations regarding development of the Strategy (see Appendix D for roles and responsibilities).

The 2017 legislation coincided with work on a statewide HIV strategy already started by the Minnesota Department of Health (MDH) and the Minnesota Department of Human Services (DHS) in August 2016 in response to stakeholder input gathered in 2015 related to the administration of Minnesota's HIV care and prevention programs. The legislation reinforced the work that MDH and DHS had initiated.

Why Is the Strategy Important Now?

Advancements

Numerous advancements have been made that give Minnesota the ability to end the HIV epidemic. Treating HIV prevents new infections from occurring (treatment as prevention). Adhering to the medications used to treat HIV, known as antiretroviral therapy (ART), decreases the amount of HIV in the bodies of people living with HIV (PLWH) to "undetectable levels," allowing them to live long, healthy lives. Key studies[2,3] have shown that once PLWH have undetectable amounts of virus in their body (undetectable levels), they cannot sexually transmit HIV to their partners. This concept is known as Undetectable = Untransmittable (U=U).

HIV medication can also be taken by HIV negative people (people who do not have HIV) to reduce their risk of becoming infected with HIV. Pre-exposure prophylaxis (PrEP) is a daily pill taken by people who do not have HIV. The Centers for Disease Control and Prevention (CDC) recommends PrEP for people who are at high risk for HIV infection through sex without a condom or by sharing injection drug equipment. When taken as prescribed, PrEP can greatly reduce the risk of HIV infection.

Post-exposure prophylaxis (PEP) is when an HIV negative person takes ART after being potentially exposed to HIV to prevent becoming infected. PEP is meant to be used in emergency situations and must be started within 72 hours of a possible exposure to HIV during sex, sharing injection drug equipment, sexual assault, or through work.

Concerns

In spite of these advancements, Minnesota is experiencing increasing health inequities and HIV-related health disparities. Data reported to MDH clearly shows that the HIV epidemic

disproportionately affects historically marginalized communities. The populations in Minnesota hardest hit by HIV are:

- Gay, bisexual and other men who have sex with men (gay and bisexual men[b])
- People who inject drugs (PWID), including gay and bisexual men who inject drugs
- Populations of color and American Indians
- Transgender people

These populations experience stigma, discrimination, and poorer HIV health outcomes, as well as other health disparities and health inequities. These populations are not mutually exclusive. For example, a person could be American Indian and gay or bisexual, or a person could inject drugs and be African-American and transgender.

There is a difference between the populations hardest hit by HIV and the risk behaviors that can lead to transmitting HIV (mode of transmission). In this report, terms describing mode of transmission are used in the sections with data about HIV in Minnesota. "MSM" is used to refer to male-to-male sexual contact and "IDU" refers to injection drug use. "MSM/IDU" refers to having risk behaviors of both male-to-male sex and injection drug use.

The number of people uninsured in Minnesota decreased between 2011 and 2015 because of the Affordable Care Act (ACA). However, in recent years that has changed. The overall percentage of uninsured Minnesotans increased from 4.3 percent in 2015 to 6.3 percent in 2017, leaving approximately 349,000 Minnesotans without insurance coverage. This was one of the largest one-time increases that Minnesota has experienced in its uninsurance rate. The increase was due to a decrease in private group and individual health insurance coverage.[4] The following populations had experienced disparities in the past and continued to have the highest uninsurance rates in 2017: young adults ages 18 – 34 (10.9 percent); people with incomes below 200 percent of the federal poverty guidelines (11.3 percent); people with a high school education or less (11.9 percent); and people of color and American Indians (13.9 percent).[5]

Another concern is that the growing opioid epidemic could result in an HIV outbreak among people who inject drugs in Minnesota. The state is experiencing an alarming increase in opioid use, and opioid-involved deaths increased 18 percent from 2015 to 2016.[6] From 2013 to 2017, Minnesota saw an almost two-fold increase in new HIV infections among PWID. The risk of becoming infected with HIV is very high if an HIV negative person uses injection drug equipment that someone with HIV has used.[7]

[b] Includes men who have sex with men and do not self-identify as gay or bisexual.

What Is the Strategy?

The Strategy provides a roadmap for coordinating efforts and resources to address HIV with the ultimate goal of eliminating HIV/AIDS in the state. The Strategy will leverage new knowledge and tools; reduce the number of newly diagnosed individuals; ensure that individuals living with HIV have access to quality, life-extending care regardless of race, gender, sexual orientation, or socioeconomic circumstances; and ensure the coordination of a statewide response to reach the goal of eliminating HIV in Minnesota. While the Strategy was written by MDH and DHS, it is not meant to be supported solely by these two state agencies. The success of the Strategy depends on the involvement and cooperation of a wide range of key stakeholders within and outside of state government.

Stakeholder Involvement

In order for the Strategy to be meaningful and successful, MDH and DHS felt it was critical to gather the input of a broad range of stakeholders. In 2017, the former strategy coordinator and a student worker gathered input through a series of 36 focus groups and 15 key informant interviews conducted throughout the state. Focus group and key informant interview participants identified important areas of need, as well as recommendations for how to address those needs. Participants in the focus groups were mainly PLWH (44 percent) or community members from populations disproportionately impacted by HIV (26 percent). The remainder were clinical and non-clinical providers, as well as local and state government staff.[8]

In 2018, DHS contracted with Wilder Research to facilitate 15 regional and community workshops around the state and conduct a web-based survey for stakeholders who were not able to attend one of the workshops. The workshops included a facilitated process that helped participants prioritize strategies in the Minnesota HIV Strategy that were most important for their region or community and develop tactics for implementing them. The greatest percentage of workshop participants were HIV service providers (32 percent); advocates for, or members of, high-risk populations (26 percent); and city or county public health or human services professionals (23 percent). According to an anonymous and voluntary questionnaire distributed at the end of each workshop, nine percent of participants identified as HIV positive.[9] While there was a concerted effort to invite PLWH and high-risk individuals to participate in the 2017 focus groups and key informant interviews, there was a greater focus on inviting providers to participate in the facilitated workshops. Based on the purpose of the workshops, the recruitment effort was focused on individuals who could bring service delivery expertise and/or systems expertise, both within and outside of the traditional HIV services system.

Advisory Board members played a significant role in both years. In 2017, they focused on developing the goals, strategies and indicators. In 2018, they selected 10 priority tactics after reviewing recommended tactics generated through the facilitated workshops. They also provided input on how to implement the priority tactics and how to evaluate progress being made toward achieving the outcomes and indicators of the Strategy.

Information That Informed Development of the Strategy

In addition to stakeholder input, MDH gathered information from the following:

- The National HIV/AIDS Strategy: Update for 2020[10] and the 90-90-90 Initiative[11]
- The Minnesota and Minneapolis-St. Paul Transitional Grant Area Integrated HIV Prevention and Care Plan 2017 - 2021 (Integrated HIV Prevention and Care Plan)[12]
- Positively Hennepin[13]
- Strategies from other states and local jurisdictions
- On-site technical assistance provided by the New York City Department of Health and Mental Hygiene

Relationship to Other Minnesota HIV Plans

The Minnesota HIV Strategy is by design more comprehensive than either Positively Hennepin or the Integrated HIV Prevention and Care Plan.

Positively Hennepin is Hennepin County's strategy to achieve no new HIV infections in Hennepin County by 2027 and was developed in 2015. The Minnesota Council on HIV/AIDS Care and Prevention developed the Integrated HIV Prevention and Care Plan in 2015. While it considers HIV-related needs in the whole state, it is focused on what can be achieved using federal Ryan White HIV/AIDS Program funds, rebate dollars generated through the 340B Drug Discount Program, federal HIV prevention funds, state HIV case management and medication funds, and state HIV prevention funds.

In 2019, a comparison will be done between the Strategy and the Integrated HIV Prevention and Care Plan to identify similarities and differences. Where there is alignment between the two plans, the Strategy will be used to ensure that efforts are not duplicated. In addition, because the Strategy has a broader scope, it will address gaps where the Integrated Plan does not address a need identified in the Strategy or a need addressed by the Integrated Plan is not fully met.

Implementation of the Minnesota HIV Strategy

The Strategy is a multi-faceted approach to HIV prevention and care that will enhance the state's ability to reduce new HIV diagnoses; ensure that PLWH have access to quality, life-extending care and treatment regardless of geography, race, gender, sexual orientation, or socioeconomic circumstances; reduce HIV-related health disparities; increase health equity for communities and target populations most affected by HIV/AIDS in Minnesota; and ensure the coordination of a statewide response to reach the ultimate goal of eliminating HIV in Minnesota.

DHS and MDH have developed a plan for implementing the 10 priority tactics selected by the Advisory Board. The plan primarily covers the 2019 calendar year, although there are some action steps that extend into 2020. The implementation plan also includes action steps for administrative responsibilities. Much of the early work focuses on building additional infrastructure and capacity among a broad range of providers who work with PLWH and high-risk individuals, as well as at the

state government level. Building infrastructure and capacity includes ensuring appropriate levels of staffing, increasing knowledge and skills, translating knowledge into practice, developing and implementing relevant policies and procedures, as well as maintaining or expanding programs according to need.

The plan is intended to be a starting place for implementation of the Strategy and will be revised and extended, as needed, once processes are underway or as additional information becomes available.

Over time the Strategy will:

- Pursue a treatment as prevention approach that includes:
  - Routine and targeted HIV testing
  - Early linkage to HIV care and treatment
  - Retention in care, including re-engagement of people who have fallen out of care
  - Provision of PrEP, a daily pill that is given to individuals at risk of acquiring HIV to keep them HIV negative
- Provide a comprehensive approach based on regional and community HIV-related needs to:
  - Eliminate the inequities and burden of the epidemic in the most marginalized and underserved communities
  - Reduce stigma and create opportunities for community healing
  - Meet basic needs and provide person-centered care
- Provide recommendations for the allocation of research and programmatic funds to ensure there are sufficient resources and assistance for those living with HIV, particularly in communities experiencing HIV disparities.

The HIV Care Continuum

The HIV care continuum—sometimes referred to as the HIV treatment cascade—is a nationally recognized methodology that outlines the sequential steps or stages of HIV medical care for PLWH from initial diagnosis to achieving the goal of viral load suppression (a very low or undetectable level of HIV in the body). The HIV care continuum will be an important tool in measuring the successes of the Strategy.

Recent scientific advances have shown that ART, the medications used to treat HIV, can prevent the destruction of the immune system caused by HIV infection, including AIDS.[14] The ultimate goal of HIV treatment is to achieve viral suppression, meaning the amount of HIV in the body is very low or undetectable, because it leads to improved health for PLWH and substantially lowers the risk of HIV transmission. Ensuring that PLWH are aware of their status and are subsequently rapidly linked to care, begin ART, stay in care, and achieve viral suppression are critical steps towards reducing new infections in Minnesota and in the United States.

The HIV care continuum is represented as a unidirectional framework, but in reality PLWH experience the care continuum in a less linear fashion as they may exit the continuum for a period of time and regress to an earlier stage. It is important to recognize that PLWH may not be in a position to reach viral suppression because of factors that limit treatment access (e.g., inadequate access to care, poverty, racism, denial, stigma, discrimination, and criminalization). Others may choose not to be treated.

Since 2013, the care continuum has been developed on an annual basis to help Minnesotans better understand the state's HIV epidemic and the disparities that exist in delivery of care among PLWH.[c]

Stages of the HIV Care Continuum

The HIV care continuum consists of the following stages, with the ultimate goal of viral suppression:

- **HIV Diagnosis:** The HIV care continuum begins with a diagnosis of HIV infection. The only way to know for sure that a person is infected with HIV is to be tested. Individuals need to be aware of their infection before they will seek HIV care and treatment.
- **Linkage to Care:** Being linked to competent HIV medical care within 30 days of diagnosis and starting ART early significantly lowers the possibility of developing AIDS and other illnesses and reduces the risk of transmitting HIV to others.
- **Retention in Care:** HIV has no cure so treatment is a lifelong process that requires a person to receive ongoing medical care. Because of the benefits of ART, it is critical that persons with HIV

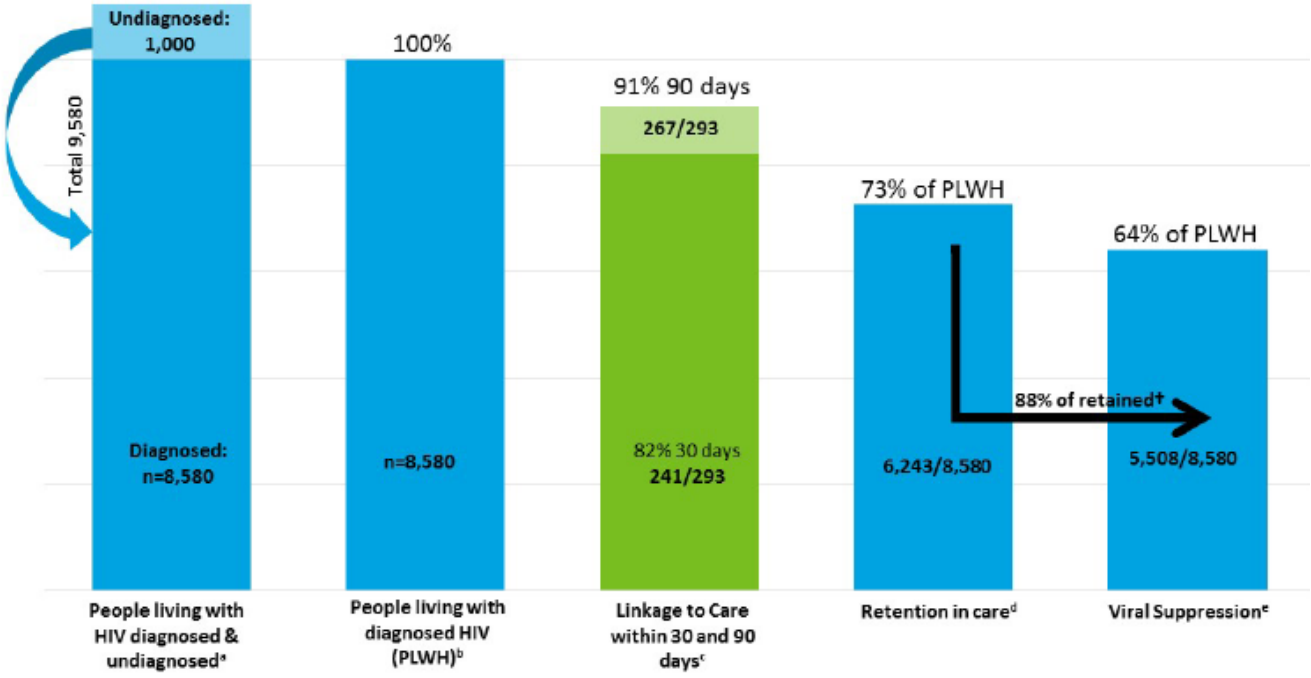
[c] Unless otherwise noted, all data presented in this section are from the Minnesota HIV/AIDS Surveillance System.

infection stay in care over time. For PLWH, retention in medical care is an important precursor to becoming virally suppressed.

- **Viral Suppression:** Having very low or undetectable levels of HIV in the blood helps PLWH stay healthy and live longer, and eliminates the risk of transmitting HIV to sex partners. Viral suppression does not mean a person is cured; HIV still remains in the body, just at a undetectable level. If ART is discontinued, the person's viral load will likely return to a detectable level.

Minnesota's 2017 HIV Care Continuum

Figure 1: Percentages of People with HIV[d] in Stages of the Care Continuum, Minnesota, 2017



The bars of the HIV care continuum in Figure 1 are defined as follows:

- **Persons living with HIV diagnosed and undiagnosed:** The number of people living with HIV includes an estimate of the number of people living in Minnesota with undiagnosed HIV infection as well as the number of people who were diagnosed with HIV infection.

  According to the 2017 care continuum, an estimated 9,580 people ages 13 and older are living with HIV (diagnosed and undiagnosed) in Minnesota. Of these, 8,580 (90 percent) are diagnosed with HIV. The remaining 1,000 (10 percent) are estimated to be undiagnosed/unaware of their HIV status. This means that approximately one in ten people living with HIV in Minnesota are

[d] The HIV care continuum does not include persons with HIV who are less than 13 years of age.

unaware of their infection, and therefore not accessing the care and treatment they need to stay healthy and reduce the likelihood of transmitting HIV to others.

- **Persons living with diagnosed HIV (PLWH):** The number of people who were diagnosed with HIV infection (regardless of stage of disease at infection) in Minnesota by the end of 2016 and were still alive at the end of 2017. There were 8,580 people who met these criteria.
- **Linkage to care:** This bar is shown with a different denominator because it only includes people who were newly diagnosed with HIV during 2016 and who visited a health care provider within 30 days or 90 days after initial diagnosis.

  Of the 293 people diagnosed with HIV in 2016, 82 percent (241) were linked to care within 30 days and 91 percent (267) were linked within 90 days of their initial diagnosis.
- **Retained in Care:** The number of people who were diagnosed with HIV by the end of 2016, were alive at the end of 2017, and had received HIV medical care. HIV medical care is defined as having results from one or more viral load or CD4 tests during 2017.

  Among the 8,580 people living with HIV in Minnesota at the end of 2017, 73 percent (6,243) were retained in care.
- **Virally Suppressed:** The number of people who were diagnosed by the end of 2016, were alive at the end of 2017, and whose last viral load test during 2017 was suppressed (at a very low level) of less than or equal to 200 copies/mL.

  Of the 8,580 people living with HIV in Minnesota at the end of 2017, 64 percent (5,508) were virally suppressed at their last lab test in 2017. In other words, only six out of 10 PLWH in Minnesota had the virus under control.

  Of the 6,243 PLWH who were retained in care during 2017, 88 percent (5,508) were virally suppressed.

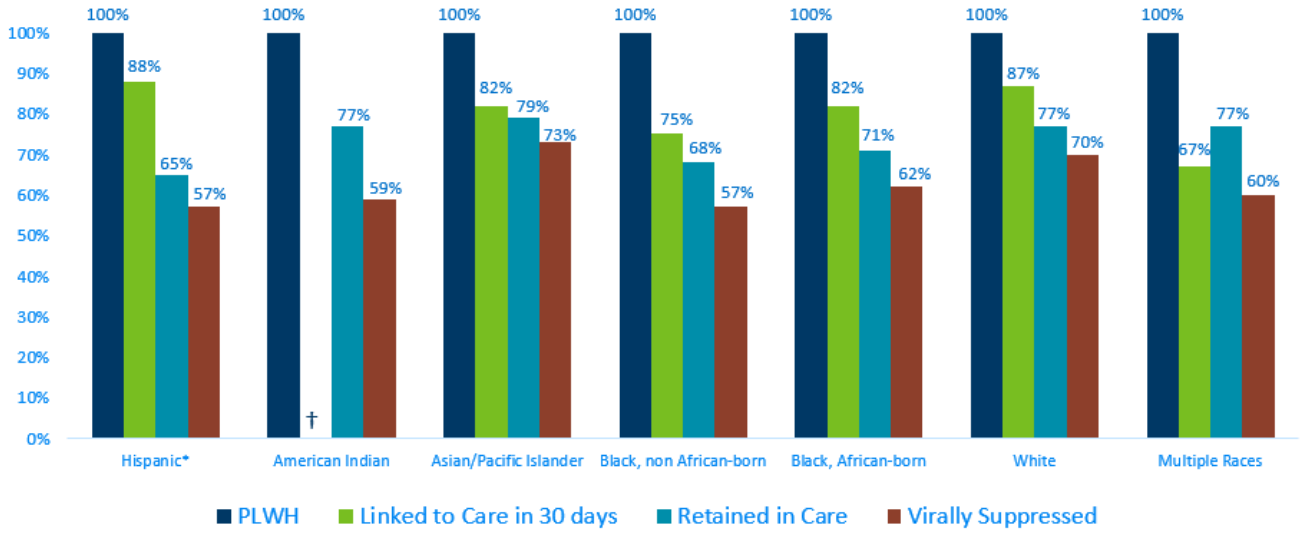
The HIV care continuum clearly indicates areas where increased attention is needed to ensure that all individuals living with HIV in Minnesota are aware of their infection and able to realize the full benefits of available care and treatment. The estimated number of people with undiagnosed HIV infection (1,000) underscores the importance of continued and intensified efforts to reach more people with testing. In addition, it is important to make sure that PLWH receive prompt care and treatment and, even more importantly, stay in ongoing care so they can live longer, healthier lives and prevent the spread of HIV to others.

The care continuum also demonstrates that efforts need to continue to focus on communities with the highest rates of new HIV diagnoses and highest percentages of out of care individuals in order to decrease and ultimately eliminate new HIV diagnoses in Minnesota.

Disparities in Outcomes Along the Care Continuum

By closely examining the proportion of people living with HIV in each stage of the HIV care continuum, policy makers and service providers can pinpoint where gaps exist. Knowing where the drop-offs are most pronounced and for which populations is vital to identifying how, where, and when to intervene to improve health outcomes for PLWH and break the cycle of HIV transmission in Minnesota.

Figure 2: Percentage of People Diagnosed with HIV (n=8580) in Stages of the Care Continuum, By Race/Ethnicity in Minnesota, 2017



†Not reportable, <5 in population

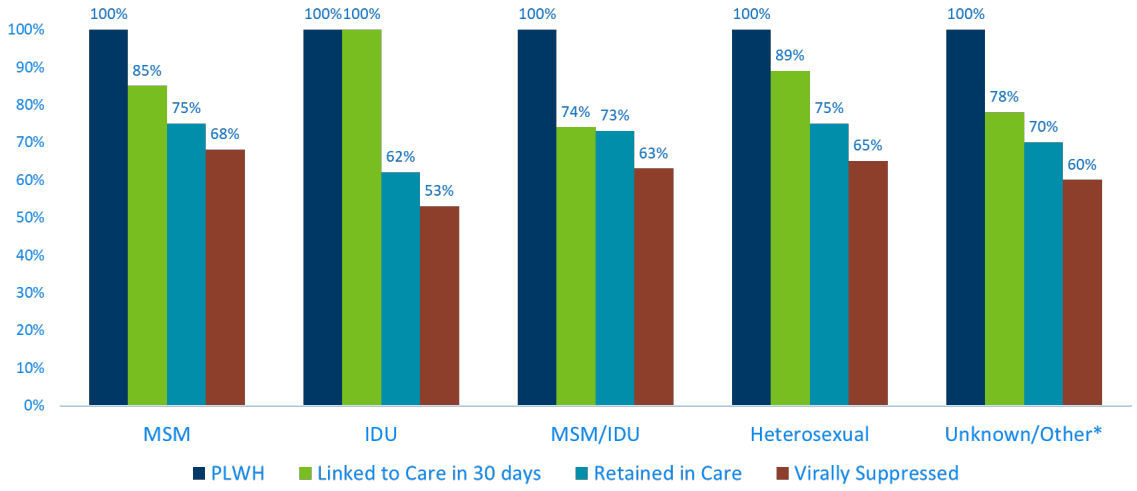
**Hispanic includes all races, all other races are non-Hispanic*

Figure 2 shows the HIV care continuum by race and Hispanic ethnicity. The percentage of newly diagnosed Black, African-Americans (75 percent) and Black, African-born (82 percent) linked to HIV medical care within 30 days of their HIV diagnosis is lower than whites (87 percent) and below the national goal of 85 percent. In addition, Black, African-Americans; Hispanics; Black, African born; and American Indians have lower rates of viral suppression at 57, 57, and 59 percent respectively, whereas whites are at 70 percent.

The out of care population are PLWH who were not retained in care, which is defined as not having a CD4 or viral load test conducted during the calendar year. Black, African-born; Black, African-American; and Hispanics of any race have the highest percentages of being out of care at 29, 32, and 35 percent respectively compared to whites (23 percent).

Figure 3 shows differences in the care continuum based on mode of transmission. People whose mode of transmission was injection drug use (IDU) alone experience much lower percentages of retention in care (62 percent) and viral suppression (53 percent) compared to other modes of transmission.

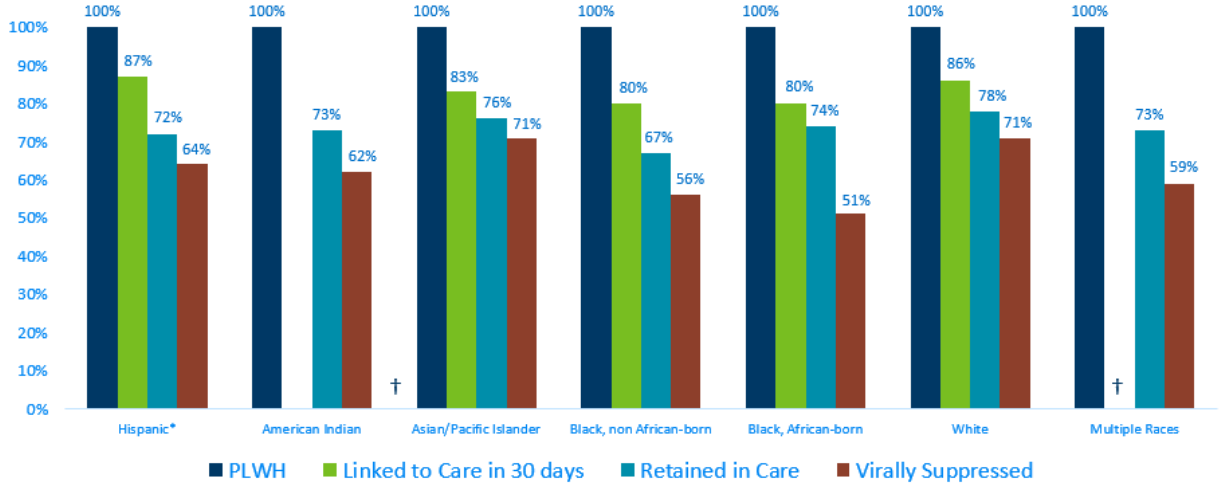
Figure 3: Percentage of People Diagnosed with HIV (n=8580) in Stages of the Care Continuum, by Mode of Transmission† in Minnesota, 2017



†Mode of transmission is collected at time of HIV diagnosis and may not be representative of current transmission risk
**Unknown includes no mode of transmission identified. Other includes those with unspecified risk, hemophilia, transplant recipients, transfusion recipients, or a mother with HIV or HIV risk.*

In general, men of color whose mode of transmission was male-to-male sex (MSM) have lower viral suppression than white gay and bisexual men. Black, African-American and Black, African-born gay and bisexual men have the lowest percentages of viral suppression at 56 percent and 51 percent respectively (Figure 4). Hispanics of any race; American Indian; and Black, African-American gay and bisexual men have the highest percentages of being out of care at 28, 27, and 33 percent respectively.

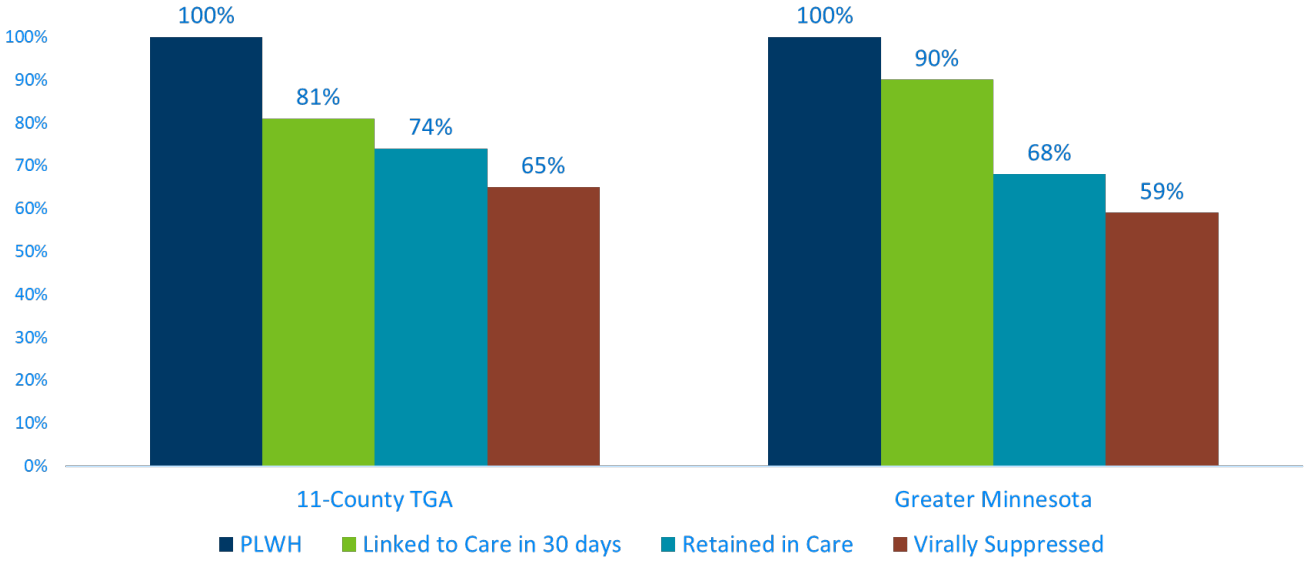
Figure 4: Percentage of MSM^ (n=4694) Diagnosed with HIV in Stages of the Care Continuum, by Race/Ethnicity in Minnesota, 2017



†Not reportable, <5 in population
**Hispanic includes all races, all other races are non-Hispanic*
^"MSM" refers to MSM and MSM/IDU modes of transmission

Care continuum data also highlight unequal engagement in HIV care based on geography. PLWH residing in Greater Minnesota have lower percentages of retention in care and viral suppression compared to PLWH living in the 11-county transitional grant area (TGA) (Figure 5).

Figure 5: Percentage of People Diagnosed with HIV (n=8580) in Stages of the Care Continuum, by Geography in Minnesota, 2017



** TGA includes Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington, and Wright counties*

Factors Impacting Access and Adherence to Care

Social Determinants of Health

Effective systems to treat HIV must take into account the social determinants of health. Social determinants of health are the conditions in the environment in which people are born, grow, live, work, and age[15] that directly or indirectly affect their access to care and their ability to benefit from HIV treatment. They include factors like socioeconomic status, education, physical environment, employment, social support networks, and access to health care. Social determinants of health play a critical role in HIV infection and the ability of PLWH to seek treatment, care, and support.

The Advisory Board identified the following factors that can negatively impact a person's self-esteem and can reduce their ability to protect themselves from HIV: stigma and discrimination, homelessness, racism, homophobia, physical and sexual abuse, addiction, lack of education, poverty/limited income, powerlessness, untreated mental health problems, lack of health insurance, language barriers, lack of transportation, economic disparities, lack of choice, lack of legal resident status, and lack of social support.

Stigma and Discrimination

PLWH may experience structural stigma due to societal attitudes, practices, policies, and services that marginalize them because of their HIV infection. HIV-related stigma refers to the "negative beliefs, feelings and attitudes towards PLWH, groups associated with PLWH (e.g., the families of people living with HIV) and other key populations at higher risk of HIV infection, such as people who inject drugs, sex workers, men who have sex with men, and transgender people."[16]

HIV-related discrimination refers to the "unfair and unjust treatment (act or omission) of an individual based on his or her real or perceived HIV status. HIV-related discrimination is usually based on stigmatizing attitudes and beliefs about populations, behaviors, practices, sex, illness, and death. Discrimination can be institutionalized through existing laws, policies and practices that negatively focus on people living with HIV and marginalized groups, including criminalized populations."[17] HIV-related stigma and discrimination add to the barriers and disparities experienced by PLWH when they try to access appropriate housing and care and maintain adherence to HIV treatment.

PLWH and people at high risk of acquiring HIV often experience overlapping types of stigma. These may be related to gender identity, race or ethnicity, sexual orientation, poverty, homelessness, drug use, and/or mental health conditions.

PLWH anticipate stigma and discrimination because they are aware of the negative social perceptions towards HIV. As a result, they may internalize their experiences related to their HIV status by accepting stigmatizing attitudes. PLWH who have other marginalized intersecting identities (e.g., race, gender, sexual orientation, and economic status) are even more likely to experience stigma.[18]

Vision of the Minnesota HIV Strategy

By 2025, Minnesota will be a state where new HIV diagnoses are rare and all people living with HIV and those at high risk of HIV infection will have access to high quality health care and resources they need to live long healthy lives, free from stigma and discrimination.

Operating Principles

The Strategy is built on the following three operating principles developed by the Advisory Board in 2017:

- **A strategy that requires all hands on deck.** Creating and implementing the Strategy will require broad support, coordination, and collaboration among state, local and tribal government agencies; community-based organizations (CBOs); health care providers; faith communities; community members; academic institutions; correctional and drug treatment facilities; and other key stakeholders. All Minnesotans, working in partnership, have a part to play in helping to achieve the Strategy's vision.
- **A strategy that calls for dynamic action.** Ending the HIV epidemic will require policy changes to further the implementation of the Strategy's goals.
- **A strategy that focuses on equity and social justice.** The HIV epidemic does not affect Minnesotans equally. It disproportionately affects historically marginalized communities that continue to face discrimination. The epidemic will end when these communities are equal and active partners in the Strategy's implementation. These partnerships will create new solutions and ensure that all Minnesotans benefit from efforts to end the epidemic.

Outcomes

Successful implementation of the Strategy will require achievement of the four measurable outcomes mandated in the legislation. The Advisory Board identified the year by which each outcome will be achieved.

1. Increase the percentage of individuals living with HIV who know their HIV status to at least 90 percent by 2025;
2. Increase the percentage of individuals diagnosed with HIV[e] who are retained in care[f] to at least 90 percent by 2025;
3. Of individuals retained in care, increase the percentage of individuals who are virally suppressed to at least 90 percent[g] by 2025; and
4. Reduce the annual number of new HIV diagnoses by at least 75 percent by 2035, with an interim outcome of reducing the annual number of new HIV diagnoses by at least 25 percent by 2025.[h]

The outcomes are ambitious but attainable. Implementing routine opt-out HIV testing according to CDC guidelines; increasing HIV testing within key communities hardest hit by HIV; increasing access and adherence to PrEP; enhancing programs that link newly diagnosed individuals to care; ensuring that HIV positive individuals begin and stay on ART; and re-engaging those who have fallen out of care will aid in achieving these legislatively mandated outcomes.

Increasing the percentage of people who are aware of their status (Outcome 1) and reducing the number of new HIV diagnoses (Outcome 4) appear to contradict each other. Increasing the percent of people who know their status means that more people will test HIV positive, which is at odds with decreasing the number of new diagnoses. However, once 90 percent or more of PLWH are aware of their status, engaged in ongoing HIV medical care, and have achieved viral suppression, Minnesota will be in an optimal situation to achieve Outcome 4. In other words, a 75 percent reduction in annual diagnoses is a long-term goal that depends on first achieving Outcomes 1 through 3.

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[e] The phrases “Individuals diagnosed with HIV” or “living with diagnosed HIV” or “diagnosed PLWH” refer to people who have been diagnosed with HIV at some point in their life and their diagnosis has been reported to MDH’s HIV surveillance program. “New diagnoses” or “newly diagnosed” refer to people who received an HIV diagnosis for the first time during a given year and were reported to MDH’s HIV surveillance program.

[f] The corresponding outcome in the legislation refers to “individuals living with HIV who are receiving treatment.” However, receiving treatment is not something that can be measured on a statewide level through the Minnesota HIV/AIDS surveillance system. Retained in care is measured using CD4 and/or viral load lab results that are reported to MDH and is a proxy measure for receiving treatment.

[g] The original corresponding outcome in the legislation is “Increase the percentage of individuals diagnosed with HIV who are virally suppressed to at least 90 percent.” The Advisory Board modified the outcome in 2018 to be more in line with the 90-90-90 Initiative.

[h] The Advisory Board added an interim outcome of reducing the number of new HIV diagnoses by at least 25 percent by 2025.

Comparison of the Minnesota HIV Strategy, National HIV/AIDS Strategy, and 90-90-90 Initiative

The Strategy aligns with the National HIV/AIDS Strategy (NHAS): Update for 2020, as well as the 90-90-90 Initiative. The NHAS was first released by the White House in 2010 and was updated in 2015 with indicators to be achieved by 2020. The 90-90-90 Initiative was released in 2014 by the Joint United Nations Programme on HIV/AIDS (UNAIDS) and includes three treatment targets to also be achieved by 2020. The first three outcomes of the Strategy are to be achieved by 2025 and the fourth one is to be achieved by 2035.

Table 1: Comparison of Similar Minnesota HIV Strategy Outcomes, National HIV/AIDS Strategy Indicators and 90-90-90 Initiative Targets

Minnesota HIV Strategy	National HIV/AIDS Strategy	90-90-90 Initiative
• Increase the percentage of individuals living with HIV who know their HIV status to at least 90 percent	• Increase the percentage of people living with HIV who know their serostatus to at least 90 percent	• 90 percent of all people living with HIV will know their HIV status
• Increase the percentage of individuals diagnosed with HIV who are retained in care to at least 90 percent	• Increase the percentage of persons diagnosed with HIV infection who are retained in HIV medical care to at least 90 percent	• 90 percent of all people diagnosed with HIV infection will receive sustained antiretroviral therapy
• Increase the percentage of individuals diagnosed with HIV who are virally suppressed to at least 90 percent	• Increase the percentage of people with diagnosed HIV infection who are virally suppressed to at least 80 percent	• 90 percent of all people receiving antiretroviral therapy will have viral suppression
• Reduce the annual number of new HIV diagnoses by at least 75 percent	• Reduce the number of new diagnoses by at least 25 percent	N/A

Indicators

In addition to the legislatively mandated outcomes, the Advisory Board identified eight indicators to monitor progress towards achieving the goals and outcomes. Data from 2017 will be used as the baseline for measuring most of the indicators.

Indicator 1: By 2025, increase the percentage of newly diagnosed individuals who are linked to HIV care within 30 days of diagnosis to 90 percent.

Indicator 2: By 2025, increase the percentage of persons prescribed PrEP at MDH-funded programs by 500 percent**.**

Indicator 3: By 2025, decrease the number of new HIV diagnoses among American Indians and people of color hardest hit by HIV[i] by 25 percent.

Indicator 4: By 2025, increase the percentage of American Indians and people of color hardest hit by HIV who are retained in care to 90 percent.

Indicator 5: By 2025, increase the percentage of American Indians and people of color hardest hit by HIV who have achieved viral suppression to 90 percent.

Indicator 6: By 2025, decrease the percentage of American Indians and people of color hardest hit by HIV who are diagnosed with AIDS at or within one year of initial HIV diagnosis by 15 percent**.**

Indicator 7: By 2025, increase the percentage of PLWH re-engaged in care[j] through the Care Link Services and Data2Care programs by 5 percent each year.

Indicator 8: By 2025, at least 95 percent of people living with HIV who have been served through the Ryan White HIV/AIDS Programs are stably housed.

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[i] People of color hardest hit by HIV are individuals who belong to the following populations: Black (African-American and African-born) gay and bisexual men, Hispanic gay and bisexual men, African-American women, African-born women (in particular from Somalia, Liberia, Ethiopia, Kenya, and Cameroon), Hispanic women, and transgender women of color. When measuring indicators 3 through 6, results will be reported in aggregate and by specific population.

[j] The denominator for Indicator 7 will be the total number of cases assigned to the Care Link Services and Data2Care programs *minus* cases determined to already be in care and cases that are unable to be located, are confirmed to have moved out of Minnesota, or are confirmed as deceased. A case is assigned to one of these programs by the MDH HIV Surveillance Team if the person has not had a viral load or CD4 lab reported to MDH within the past 15 months.

Goals, Strategies and Tactics

The goals, strategies and initial tactics that will move Minnesota towards achieving the four legislatively mandated outcomes are presented on the following pages, along with a partial list of activities that are already happening and planned future activities. The development of a more complete inventory of ongoing efforts is one of the priority tactics that will be implemented in 2019.

The goals and strategies were developed by the Advisory Board in 2017. The 10 tactics listed below were prioritized by the Advisory Board in 2018 to be implemented in 2019. The tactics were developed and prioritized after reviewing recommendations made by participants of 15 regional and community workshops conducted around the state by Wilder Research in 2018. Nine of the workshops were conducted with participants who reflected communities highly impacted by HIV and the remaining six workshops were conducted in different regions across the state. The workshops included a facilitated process that helped participants prioritize the strategies that were most important for their region or community and develop tactics for implementing them. Wilder Research also conducted a web-based survey to collect input from stakeholders who were unable to participate in the workshops.

In order to identify the 10 priority tactics, the Advisory Board focused on tactics that would have the largest impact on the goals and could be implemented statewide, keeping in mind that implementation of the tactics would be tailored for individual communities and regions. They were asked to identify at least one priority tactic per goal. The Advisory Board reviewed a summary of the results of the workshops and the survey,[19] as well as the 83 specific tactics recommended by workshop participants. Through a voting process, the Advisory Board selected the priority tactics listed below:

- Implement provider education and training. The training should benefit all types of providers (e.g., primary care, specialists, nurses, interpreters, etc.). The training should focus on evidence-based, behavioral and biomedical interventions for HIV prevention and care, as well as cultural competence.
- Implement messaging campaigns, advertising, and public service announcements (PSAs) to increase awareness of HIV and increase knowledge about evidence-based, behavioral and biomedical interventions for HIV prevention and care. Tailor content and delivery of messaging to meet the needs of specific communities and regions.
- Increase education and outreach to culturally-specific communities.
- Implement comprehensive HIV prevention and sex education in and beyond public schools.
- Increase the organizational capacity of small, new or yet-to-be-formalized culturally specific, community-based organizations necessary to successfully apply for, secure, and implement state and federal HIV funding.
- Increase meaningful inclusion of voices of disproportionally affected populations in decision making about HIV programs and funding.
- Enhance targeted wraparound supports for people at high risk of dropping out of care.

- Support the implementation of the Minnesota HIV Housing Coalition's *HIV Housing Plan 2017* (HIV Housing Plan).[20]
- Develop a comprehensive inventory of all ongoing efforts being made to address HIV across Minnesota in order to: a) identify opportunities to collaborate and leverage services; and b) identify gaps in services.
- Develop a regional telemedicine model to ensure the adequate provision of care and prevention services.

Following the prioritization process, DHS and MDH developed action steps for implementing the 10 priority tactics, as well as action steps for administrative responsibilities. The implementation plan primarily covers the 2019 calendar year, although some items extend into 2020. Much of the early work focuses on building additional infrastructure and capacity among a broad range of providers who work with PLWH and high-risk individuals, as well as at the state government level. Building capacity and infrastructure includes ensuring appropriate levels of staffing, increasing knowledge and skills, translating knowledge into practice, developing and implementing relevant policies and procedures, as well as maintaining or expanding programs according to need. The implementation plan begins on page 43.

A full list of tactics identified by workshop participants, survey participants, and participants of focus groups conducted across Minnesota in 2017 is included as Appendix E. The Advisory Board will review this list as additional tactics are prioritized in future years.

Some of the 10 priority tactics are related to more than one goal or strategy. If a priority tactic is listed in more than one place, it is listed with the number (e.g., Priority Tactic 1.1.1.) that corresponds to the goal and strategy under which it was originally prioritized. The tactics/activities are categorized as a priority tactic (i.e., one of the 10 prioritized tactics), a current activity, or a future activity.

The information provided about current activities indicates that the work is in progress or, in some cases, is expanding. This does not mean that work related to that particular strategy is complete or that the need has been fully met.

Goal 1: Prevent New HIV Infections

Over the past decade, approximately 300 cases of new HIV infection have been reported every year despite innovations in HIV treatment, prevention, and policy. These improvements include health care reform, treatment as prevention, PrEP, PEP, syringe services programs, and harm reduction. Now is the time to take full advantage of these improvements in order to end Minnesota's HIV epidemic. However, many of the benefits of these innovations cannot be realized unless Minnesotans know their HIV status, which underscores the importance of HIV testing.

Strategy 1.1: Increase HIV education and awareness for all Minnesotans, especially health professionals, students, and high-risk populations.

Priority Tactic, Current Activity or Future Activity	Tactic/Activity
Priority Tactic 1.1.1.	Implement provider education and training. The training should benefit all types of providers (e.g., primary care, specialists, nurses, interpreters, etc.). The training should focus on evidence-based, behavioral and biomedical interventions for HIV prevention and care, as well as cultural competence.
Priority Tactic 1.1.2.	Implement messaging campaigns, advertising, and public service announcements (PSAs) to increase awareness of HIV and increase knowledge about evidence-based, behavioral and biomedical interventions for HIV prevention and care. Tailor content and delivery of messaging to meet the needs of specific communities and regions.
Priority Tactic 1.1.3.	Increase education and outreach to culturally-specific communities.
Priority Tactic 1.1.4.	Implement comprehensive HIV prevention and sex education in and beyond public schools.
Current Activity 1.1.5.	The Minnesota Midwest AIDS Training and Education Center (MATEC) provides training and education programs to health care professionals in the field of HIV clinical care and management. Minnesota MATEC programs include didactic and skills-building opportunities, individualized clinical consultation by expert HIV clinicians to other health care professionals, individually tailored mentorship programs for clinicians practicing in under-served communities, technical assistance to medical organizations expanding or enhancing their HIV services, and information dissemination.
Current Activity 1.1.6.	JustUs Health provides training to licensed alcohol and drug counselors regarding the intersection of HIV and substance use. These free two-day trainings are held at locations throughout the state. The program has also developed a series of webinars designed to reach those who cannot attend a specific training and as a refresher for those who have previously attended a training.

Priority Tactic, Current Activity or Future Activity	Tactic/Activity
Current Activity 1.1.7	MDH funds agencies to provide HIV prevention education as part of comprehensive HIV testing and syringe services programs targeting high-risk populations. Education includes prevention and risk reduction, HIV and hepatitis C testing resources, STD education, overdose prevention and other high impact prevention messages.

Strategy 1.2: Increase routine opt-out HIV testing and early intervention services.

Priority Tactic, Current Activity or Future Activity	Tactic/Activity
Current Activity 1.2.1.	DHS-funded early intervention services (EIS) were expanded in 2018 to reach Black and Latino gay/bisexual men and gay/bisexual men who inject drugs in the metropolitan zip codes that account for nearly 30 percent of the HIV disease burden (these zip codes vary slightly from year to year). In addition, outreach and EIS services were expanded in Greater Minnesota to reach foreign-born populations and people who inject drugs (PWID). These expanded EIS programs will continue in 2019, and additional sites will be funded to reach American Indian communities in Greater Minnesota that have experienced large increases in primary and secondary syphilis over the past few years.
Current Activity 1.2.2.	After a pilot project with four HIV testing sites in 2017, all DHS- and MDH-funded EIS and HIV testing programs are now implementing rapid-rapid testing, which involves using two rapid HIV tests of different brands. If a person's first rapid test is positive, they can be immediately tested with a second rapid HIV test and receive the confirmatory results within 15 to 20 minutes. Confirmatory tests were previously done through a blood draw and the person had to wait weeks to get the results back from the lab.
Future Activity 1.2.2	MDH will hire a nurse in 2019 to provide HIV education to clinical providers. Part of this training will focus on routine opt-out HIV testing. MDH will also develop a recommendation in support of CDC's recommendations regarding routine opt-out HIV testing.

Strategy 1.3: Immediately link newly diagnosed individuals to person-centered HIV care and treatments.

Priority Tactic, Current Activity or Future Activity	Tactic/Activity
Current Activity 1.3.1.	Individuals who test positive through MDH- or DHS-sponsored HIV testing and/or EIS programs are immediately linked to confirmatory testing and HIV medical care. All funded non-clinical testing sites partner with an HIV specialty clinic to ensure confirmatory testing and linkage to care is completed. Individuals who test positive are also referred to Ryan White services.
Current Activity 1.3.2.	Partners of newly diagnosed individuals who receive partner services and test positive for HIV are referred by Disease Intervention Specialists (DIS) to HIV care and treatment.
Current Activity 1.3.3.	All newly diagnosed HIV positive pregnant women are assigned to MDH's Care Link Services Program by the HIV Surveillance Team. The Care Link Services Program works to ensure that those who are not in medical care are immediately linked. The Minnesota Perinatal and Pediatric HIV Program at Children's Hospital and Clinics provides time-sensitive interventions to HIV positive pregnant women and their exposed infants, as well as consultation and support for their health care providers related to preventing mother-to-child HIV transmission. Hennepin Healthcare provides similar services for HIV positive pregnant women referred within the Hennepin Healthcare system.

Strategy 1.4: Increase availability, access and use of evidence-based interventions that prevent HIV infections, such as PrEP, PEP, syringe services programs, and partner services.

Priority Tactic, Current Activity or Future Activity	Tactic/Activity
Priority Tactic 1.1.1.	This priority tactic of educating providers listed under Strategy 1.1 will include general education and protocols for implementing PrEP and PEP programs with the objective of increasing the number of providers who offer PrEP and PEP throughout the state.
Current Activity 1.4.1.	High-risk individuals who test negative through HIV testing and EIS programs are referred to PrEP services and syringe services programs as appropriate.

Goal 2: Reduce HIV-related Health Disparities and Promote Health Equity

In Minnesota, the HIV epidemic continues to disproportionally impact people of color and American Indians. To end the epidemic, health equity must be achieved among American Indians and populations of color that are hardest hit by HIV. Currently, these populations are Black (African-American and African-born) MSM, Hispanic MSM, African-American women, African-born women (in particular from Cameroon, Ethiopia, Kenya, Liberia and Somalia), Hispanic women, and transgender women of color. The populations of color hardest hit by HIV may change over time as the epidemic evolves.

American Indians and these populations of color experience greater HIV incidence (number of newly diagnosed cases) and prevalence (number of living HIV/AIDS cases), in addition to disparities in HIV-related outcomes, such as reduced access to HIV care, higher out of care rates, lower viral suppression rates, and higher HIV-related health complications and mortality. The disparities are in part due to the lack of culturally and linguistically appropriate services and the geographic distribution of appropriate HIV care and treatment services. These barriers make it difficult for PLWH to access appropriate HIV care and treatment in certain regions of the state.

Strategy 2.1: Protect and enhance advancements in health care policies, including Minnesota Health Care Programs expansion, coverage for people with pre-existing conditions, and access to preventive treatments without cost sharing.

Priority Tactic, Current Activity or Future Activity	Tactic/Activity
Current Activity 2.1.1.	DHS is working towards solutions to remove prescription drug co-payments for PLWH who meet Ryan White eligibility requirements and use Medical Assistance or MinnesotaCare.

Strategy 2.2: Engage community leaders, non-profit agencies, PLWH, and other community members to identify and address barriers that prevent testing and person-centered care.

Priority Tactic, Current Activity or Future Activity	Tactic/Activity
Current Activity 2.2.1.	MDH-funded HIV testing and syringe services programs integrate ongoing input from high-risk populations to continually improve programming efforts. This includes addressing barriers to testing, linking to HIV medical care, retention in HIV medical care and viral suppression. MDH also works with the Minnesota Council for HIV/AIDS Care and Prevention's Disparities Elimination Committee to gather information about barriers and how to address them.

Strategy 2.3: Dedicate adequate resources to American Indians and populations of color hardest hit by HIV to eliminate health inequities.

Priority Tactic, Current Activity or Future Activity	Tactic/Activity
Priority Tactic 2.3.1.	Increase the organizational capacity of small, new, or yet-to-be-formalized culturally specific CBOs necessary to successfully apply for, secure, and implement state and federal HIV funding.
Priority Tactic 2.3.2.	Increase meaningful inclusion of voices of disproportionately affected populations in decision making about HIV programs and funding.
Current Activity 2.3.3.	The Minnesota Council for HIV/AIDS Care and Prevention considers current surveillance and other relevant data when prioritizing populations for prevention services and when prioritizing care and service funding.

Strategy 2.4: Reduce HIV-related stigma, systemic racism, and other forms of structural discrimination that prevent people from accessing HIV care and prevention services.

Priority Tactic, Current Activity or Future Activity	Tactic/Activity
Priority Tactics 1.1.2. and 1.1.3.	An objective of these two tactics listed under Strategy 1.1 is that they will contribute to reducing HIV-related stigma and discrimination.
Current Activity 2.4.1.	MDH and DHS are exploring ways to restructure the Request for Proposal (RFP) process to be more inclusive for those agencies reaching individuals at greatest risk of HIV infection. This will include having community members and care providers from these populations participating in the review process which leads to funding decisions. MDH and DHS are committed to continuing to explore additional opportunities to incorporate community voices in planning and evaluation efforts.

Goal 3: Increase Retention in Care for People Living with HIV

Positive health outcomes for PLWH in Minnesota greatly depend on two factors—rapid linkage to care and retention in care. A culturally competent and skilled workforce is an essential component of addressing these two factors. Models of care that treat the whole person (i.e., person-centered care) are equally vital to ensure that Minnesota residents living with HIV have healthy and vibrant lives. Additionally, robust polices that support a person's basic needs are critical for the timely linkage to and retention in HIV care.

Strategy 3.1: Employ high-impact public health approaches to identify and re-engage individuals who are out of HIV care and treatment.

Priority Tactic, Current Activity or Future Activity	Tactic/Activity
Current Activity 3.1.1.	The Care Link Services Program at MDH and Data2Care Program at Hennepin County Red Door Services use HIV surveillance data to identify people who are believed to be out of care because they have not had a CD4 or viral load result reported to MDH within the past 15 months. The Data2Care Program focuses on people living in Hennepin County and the Care Link Services Program focuses on people living in all other counties, as well as all HIV positive pregnant women regardless of county of residence. The two programs follow up with the last known provider to find out if the people are truly out of care. If they are out of care, the programs reach out to the individuals and assist those who are willing with becoming re-engaged in care.
Current Activity 3.1.2	HIV surveillance data about CD4 and viral load tests are imported on a monthly basis into the data system used to collect demographic, service utilization, and limited clinical information for HIV positive clients served through Ryan White, state and rebate funding. The HIV surveillance data can assist medical case managers and other providers in the coordination and provision of care.

Strategy 3.2: Ensure person-centered strategies that support long-term retention in care.

Priority Tactic, Current Activity or Future Activity	Tactic/Activity
Priority Tactic 3.2.1.	Enhance targeted wraparound supports for people at high risk of dropping out of care.

Priority Tactic, Current Activity or Future Activity	Tactic/Activity
Current Activity 3.2.2.	Ryan White Parts A and B fund wraparound services such as medical transportation, medical case management, non-medical case management, psychosocial support groups, emergency financial assistance, food support, housing, and others. Programs funded through Ryan White must demonstrate that program activities support people to stay in care.
Current Activity 3.2.3.	The Care Link Services and Data2Care programs routinely assess patients' barriers to retention in care. Care Link Services and Data2Care staff provide active referrals to needed supportive services, including case management, as an effort to remove those barriers.
Current Activity 3.2.4.	MDH funds CBOs to implement peer support groups for individuals living with HIV. The primary purpose of these support groups is to provide peer support and peer identified strategies to keep group members engaged in HIV medical care and reach viral suppression.

Strategy 3.3: Provide culturally and linguistically appropriate services, as well as gender and sexual orientation appropriate services in clinical and/or community support settings.

Priority Tactic, Current Activity or Future Activity	Tactic/Activity
Current Activity 3.3.1.	Ryan White, state and rebate funds are used to fund culturally, linguistically, gender and sexual orientation appropriate services at CBOs and clinics.
Current Activity 3.3.2.	All previously diagnosed HIV positive women who become pregnant are assigned to the Care Link Services Program by the HIV Surveillance Team if the pregnancy is reported to MDH as required. The Care Link Services Program works to ensure that those who are not in medical care are connected immediately. The Minnesota Perinatal and Pediatric HIV Program at Children's Hospital and Clinics provides time-sensitive interventions to HIV positive pregnant women and their exposed infants, as well as consultation and support for their health care providers related to preventing mother-to-child HIV transmission. Hennepin Healthcare provides similar services for HIV positive pregnant women referred within the Hennepin Healthcare system.

Strategy 3.4: Identify and reduce barriers to mental health and substance use services and care.

Priority Tactic, Current Activity or Future Activity	Tactic/Activity
Current Activity 3.4.1.	Ryan White Part B provides access to mental health therapists statewide through the Minnesota Medicaid Information System (MMIS) for individuals who have no other means to pay for the service (i.e., no insurance or public program). Ryan White Part A funds several agencies to provide mental health services. Ryan White Parts A and B fund substance abuse assessment and support care coordination for those individuals seeking this service, harm reduction services through funded programs, and training to chemical health providers to help increase skill around working with PLWH and individuals at risk.

Strategy 3.5: Ensure access to services that meet the basic needs of PLWH.

Priority Tactic, Current Activity or Future Activity	Tactic/Activity
Current Activity 3.5.1.	Ryan White Parts A and B support several types of services that meet basic needs of PLWH. Food assistance is provided through on-site meals, home delivered meals, food shelf and food certificates. Transportation is provided for medical appointments. Housing activities include supportive housing; emergency assistance for mortgage, rent, deposits and housing applications; transitional housing and permanent subsidies through HIV housing certificates and apartments specifically for PLWH.

Goal 4: Ensure Stable Housing for People Living with HIV and Those at High Risk for HIV Infection

Safe, secure, and affordable housing is a basic human need. It is essential to eliminate circumstances in which PLWH have to make desperate choices about which necessities to prioritize. Housing stability is the base that makes good health a possibility for PLWH and those at high risk for HIV infection. Housing status is a stronger predictor of HIV health outcomes than individual characteristics such as gender, race, age, drug and alcohol use, mental health issues, and receipt of social services. Stable housing improves the health of PLWH. Housing also plays a significant role in HIV prevention. In fact, the condition of homelessness is independently associated with increased rates of behaviors that can transmit HIV.[21]

HIV-related staff at DHS and MDH do not have the expertise to address stable housing for PLWH and those at high risk for HIV infection, making it essential for DHS and MDH to partner with experts in the housing field to achieve Goal 4. As a result, there is only one priority tactic that applies to all of the strategies under this goal: **Priority Tactic 4.1. Support implementation of the HIV Housing Plan**.

Strategies from the HIV Housing Plan are listed below their corresponding strategy from the Minnesota HIV Strategy.

Strategy 4.1: Identify gaps in affordable housing statewide.

HIV Housing Plan Strategies

- 4.1.1. Develop common metrics with HIV housing providers and traditionally underserved communities that can be readily compiled and shared (both housing and health outcomes).
- 4.1.2. Develop systems which can share data, including having reliable common sources for housing needs.
- 4.1.3. Work with leaders of traditionally underserved communities to collect data that will identify unmet HIV housing needs and gaps.

Strategy 4.2: Build partnerships that increase the supply of safe, affordable housing units for PLWH and those at high risk of HIV infection.

HIV Housing Plan Strategies

- 4.2.1. Increase partnerships with housing providers across the state to set aside affordable, quality units for PLWH.
- 4.2.2. Partner with policy makers to increase units for PLWH and people most at risk of HIV that allow for flexibility and ready access.
- 4.2.3. Pilot and test new innovative housing models for PLWH.

Strategy 4.3: Ensure that PLWH and those at high risk of HIV infection have access to necessary supports that maintain their housing stability.

HIV Housing Plan Strategies

- 4.3.1. Create an HIV Housing Continuum so PLWH can access a range of support services to stay in their desired housing and maintain their health in both metro and rural areas
- 4.3.2. Ensure a range of support services including mental health and substance abuse services are available so PLWH can remain in their housing.
- 4.3.3. Partner with community providers who offer a range of services that provide access to resources and information/education that address barriers to maintaining preferred housing for PLWH

Strategy 4.4: Secure long-term, sustainable resources to meet the growing need for affordable housing and supportive services.

HIV Housing Plan Strategies

- 4.4.1. Work in partnership with elected and appointed public officials, government staff, and advocacy organizations to identify and increase funding for the development of housing specifically for PLWH, rental assistance, and support services

Goal 5: Achieve a More Coordinated Statewide Response to HIV

A coordinated statewide approach is needed to reduce the number of new HIV infections in Minnesota. This will require an all-hands-on-deck approach to take advantage of new knowledge and tools to treat and to prevent HIV. Enhanced collaboration and coordination of services among and within government agencies, tribal nations, not-for-profit CBOs, faith organizations, harm reduction services, universities, health care clinics, mental health services, correctional services, and others are needed in order to expand the scope of partners in the journey to end the HIV epidemic.

Strategy 5.1: Create a leadership structure that is held accountable for implementing and updating this Strategy. This leadership structure will include key stakeholders that this Strategy affects, such as government leadership, CBOs, PLWH, and Minnesota residents hardest hit by the HIV epidemic.

Priority Tactic, Current Activity or Future Activity	Tactic/Activity
Future Activity 5.1.1.	DHS will establish an advisory council in statute with membership and chair to be appointed by the commissioner of human services. Membership requirements are still to be defined but at a minimum will include a representative with public health research and evaluation expertise; one HIV physician and one primary care physician; representatives from mental health, substance use, housing, and non-clinical HIV services; representatives from Greater Minnesota, and representatives who are reflective of the HIV epidemic in Minnesota. At least 40 percent of the membership will include individuals representing high-risk communities and PLWH. Duties of the advisory council will include advising on priority tactics, advising on processes to gather additional community input, providing feedback on implementation and evaluation progress, and other duties as authorized by the commissioner.

Strategy 5.2: Integrate HIV prevention, care, and treatment throughout all sectors of government (e.g., health, human services, education), health care systems, and social services.

Priority Tactic, Current Activity or Future Activity	Tactic/Activity
Priority Tactic 5.2.1.	Develop a comprehensive inventory of all ongoing efforts being made to address HIV across Minnesota in order to: a) identify opportunities to collaborate and leverage services; and b) identify gaps in services.
Current Activity 5.2.2.	The current development and upcoming implementation of the Minnesota HIV Strategy is integral to achieving Strategy 5.2.

Priority Tactic, Current Activity or Future Activity	Tactic/Activity
Current Activity 5.2.3.	DHS, MDH and Hennepin County Public Health meet regularly as the Governmental HIV Administration Team (GHAT) to share information among the agencies, coordinate planning for clients' continuum of prevention and care, develop consistent messages for communication, provide peer support, and consider Minnesota Council on HIV/AIDS Care and Prevention decisions in administrative planning.

Strategy 5.3: Identify, research, and replicate new, effective interventions through partnerships between local public health and state governments, tribal nations, HIV providers, community-based and religious organizations, the University of Minnesota and other academic institutions, research partners, and others.

Priority Tactic, Current Activity or Future Activity	Tactic/Activity
Current Activity 5.3.1.	MDH-funded syringe services programs provide some education about the benefits of needle exchange programs to their local law enforcement agencies.
Future Activity 5.3.2.	A temporary position at MDH will educate law enforcement about the benefits of needle exchange programs.
Future Activity 5.3.3.	Consider experiential evidence regarding the effectiveness of interventions in addition to research evidence when making funding decisions in future request for proposal (RFP) processes.

Strategy 5.4: Establish policies that encourage an innovative culture and delivery of comprehensive statewide services. An innovative culture includes recognizing that prevention and treatment options evolve and leadership must be willing to respond to new technologies to reduce HIV burden.

Priority Tactic, Current Activity or Future Activity	Tactic/Activity
Priority Tactic 5.4.1.	Develop a regional telemedicine model to ensure the adequate provision of care and prevention services.
Current Activity 5.4.1	Minnesota was the third state to endorse the U=U campaign. An MDH communications specialist has provided numerous U=U-related trainings across the state and has promoted it at several national conferences.
Current Activity 5.4.2	DHS and MDH are developing a communications plan for stakeholders outlining the key components of the Strategy and encouraging them to participate in activities that will allow them to continue to give input into the Strategy.

Priority Tactic, Current Activity or Future Activity	Tactic/Activity
Future Activity 5.4.3	DHS and MDH will identify ways that technology can be used more effectively to gather input from stakeholders around the state.

Strategy 5.5: Create effective information sharing partnerships and systems that produce reliable data and that inform decision-making, strategy development, and program accountability.

Priority Tactic, Current Activity or Future Activity	Tactic/Activity
Current Activity 5.5.1	DHS, MDH and Hennepin County Public Health have current data sharing agreements and are also engaged in a process to identify additional data needs and potential data sources to enhance planning and implementation of HIV prevention and care services, and to evaluate effectiveness of efforts.
Current Activity 5.5.2	The Minnesota HIV Housing Coalition is working in coordination with other entities to develop and implement a centralized HIV housing waiting list system.

Facilitated Workshops with African-born and American Indian Communities

As cited in Wilder Research's *Ending HIV/AIDS in Minnesota: Final Report on Identifying Tactics for the Minnesota HIV Strategy*,[22] two of the facilitated workshops conducted in 2018 were unique in their process and content. During the workshop focusing on the African-born community, participants called for a different process to share their feedback. Several participants did not feel that their communities were represented in the Strategy and were therefore uncomfortable using it as the starting place for the facilitated conversations. Instead, participants held a set of small group conversations focused on their key concerns. A follow-up meeting was held to review and confirm what they shared.

Another workshop consisted of talking circles focused on ending HIV in American Indian communities. This workshop took a different form in order to recognize and respect the sovereignty of tribal nations and because the state recognized a need to learn more about the needs and concerns regarding HIV in these communities before work could begin to develop tactics that will meet their needs. Input captured during these two workshops was summarized separately from the other regional and community workshops.

High-level Summary of African-born Participant Input

- Authentic engagement with African communities is essential. This includes acknowledging that different communities have different needs and allowing for multi-directional communication and partnership-building, face-to-face interactions, and ongoing mutual accountability.
- Processes need to be community-driven, community-led, and culturally responsive, which includes engaging community leaders (including faith leaders), existing networks, and community organizations to work toward ending HIV.
- Funding in the African-born community needs to be consistent and ongoing, with an emphasis on making funding and capacity building support accessible to organizations who are already doing this work.
- Stigma is a large barrier in this community, and there is a need for community-driven education and awareness around this issue.

High-level Summary of American Indian Participant Input

- Stigma surrounding HIV is a major problem in American Indian communities, which prevents people from getting tested or seeking services.
- There is a shortage of HIV services and resources in American Indian communities, and providers who do serve these communities may lack knowledge about HIV prevention and treatment.
- To make progress on ending HIV in American Indian communities, several things are needed, including: education, adequate health care services, competent providers, support for basic

needs such as housing and transportation, and outreach to increase HIV awareness and promote service utilization.

- To support efforts to end HIV in American Indian communities, participants recommended that state agencies should offer more dedication and commitment to this topic in their communities. They also recommended changing and maximizing available funding and resources, collaborating with other state agencies and with smaller organizations, and improving sex education.

Next Steps

One area of focus for DHS and MDH will be to continue engaging with African-born and American Indian communities. The implementation plan includes information about how this will be done in 2019.

More detailed information about the processes conducted with these communities and the input received can be found in the following reports prepared by Wilder Research: *Ending HIV/AIDS in African-Born Communities in Minnesota: Summary of Community Stakeholder Input*[23] and *Talking Circles Regarding HIV/AIDS in Native American Communities: A Summary of Key Themes*.[24]

Relationship Between Priority Tactics and Outcomes

Many of the 10 priority tactics are related to building infrastructure and capacity. At first glance they may not appear to have an impact on achieving the four legislatively mandated outcomes. However, the tables below describe short-term and intermediate outcomes that will be achieved through implementing the priority tactics and identify which of the legislatively mandated outcomes each tactic will influence in the longer term.

Although the implementation plan focuses on 2019 and into 2020, it is anticipated that efforts related to many of the priority tactics will continue over time. The implementation plan is focused on getting the tactics up and running. Evaluation data will be used in part to determine whether tactics need to be modified or discontinued.

Goal 1: Prevent New HIV Infections

Priority Tactic	Short-term Outcomes	Intermediate Outcomes	Outcome 1: Increase % of individuals living with HIV who know their HIV status	Outcome 2: Increase % of individuals diagnosed with HIV who are retained in care	Outcome 3: Increase % of individuals retained in care who are virally suppressed	Outcome 4: Decrease annual number of new HIV diagnoses
1.1.1. Implement provider education and training. The training should benefit all types of providers (e.g., primary care, specialists, nurses, interpreters, etc.). The training should focus on evidence-based, behavioral and biomedical interventions for HIV prevention and care, as well as cultural competence.	• Providers have increased knowledge of HIV preventive measures (e.g. testing, PrEP, U=U) • Providers have increased cultural competence • Providers have increased knowledge of HIV care	• More providers prescribe PrEP • Providers increase routine HIV testing • Providers reduce HIV-related stigma in medical care • Patients feel more comfortable with providers • Patients receive appropriate treatment for HIV	✓	✓	✓	✓

Priority Tactic	Short-term Outcomes	Intermediate Outcomes	Outcome 1: Increase % of individuals living with HIV who know their HIV status	Outcome 2: Increase % of individuals diagnosed with HIV who are retained in care	Outcome 3: Increase % of individuals retained in care who are virally suppressed	Outcome 4: Decrease annual number of new HIV diagnoses
1.1.2. Implement messaging campaigns, advertising, and PSAs to increase awareness of HIV and increase knowledge. Tailor messaging to meet the needs of specific communities and regions.	• People are aware that HIV is still an issue • People know how to get tested for HIV • People know preventive measures exist • People know about U=U • PLWH are aware of treatment options	• Stigma decrease as more people become knowledgeable about HIV • More people are tested • More PLWH are connected to care	✓	✓		✓
1.1.3. Increase education and outreach to culturally-specific communities.	• Community members given messages that are culturally appropriate and increase awareness of HIV • Community leaders decide what works best in their community and have agency and resources to implement education as appropriate • Community awareness of HIV prevention and care increases	• Stigma decrease as community awareness increases • Communities employ prevention and care strategies that work for them • Community members seek testing • PLWH seek ongoing care	✓	✓	✓	✓
1.1.4. Implement comprehensive HIV prevention and sex education in and beyond public schools.	• Students are aware of safe sex practices • Students are aware of HIV prevention and treatment	• Students who engage in sex use safer sex practices				✓

Goal 2: Reduce HIV-related Health Disparities and Promote Health Equity

Priority Tactic	Short-term Outcomes	Intermediate Outcomes	Outcome 1: Increase % of individuals living with HIV who know their HIV status	Outcome 2: Increase % of individuals diagnosed with HIV who are retained in care	Outcome 3: Increase % of individuals retained in care who are virally suppressed	Outcome 4: Decrease annual number of new HIV diagnoses
2.3.1. Increase the capacity of small, new or yet-to-be-formalized culturally specific, community-based organizations necessary to successfully apply for, secure and implement state and federal HIV funding.	• Organizations have increased capacity to apply for and secure grant funding • Organizations have increased capacity to implement funded activities	• Organizations receive grant funds • More linguistically and culturally specific care and prevention services are available	✓	✓	✓	✓
2.3.2. Increase the meaningful inclusion of voices of disproportionately affected populations in decision making about HIV programs and funding.	• People from hardest hit populations are effectively engaged in decision-making (qualitative measure)	• Funding and programmatic decisions are better aligned with the needs and preferences of targeted and disproportionately affected populations • More linguistically and culturally specific care and prevention services are available	✓	✓	✓	✓

Goal 3: Increase Retention in Care for People Living with HIV

Priority Tactic	Short-term Outcomes	Intermediate Outcomes	Outcome 1: Increase % of individuals living with HIV who know their HIV status	Outcome 2: Increase % of individuals diagnosed with HIV who are retained in care	Outcome 3: Increase % of individuals retained in care who are virally suppressed	Outcome 4: Decrease annual number of new HIV diagnoses
3.2.1. Enhance targeted wraparound supports for people at high risk of dropping out of care.	• Data analysis identifies factors correlated with high risk of dropping out of care • People who are at high risk of dropping out of care receive effective wraparound supports (qualitative measure)	• Programs are designed or modified to address factors correlated with high risk of dropping out of care • People who are at high risk of dropping out of care and receive wraparound supports are retained in care		✓	✓	✓

Goal 4: Ensure Stable Housing for PLWH and Those at High Risk for HIV Infection

Priority Tactic	Short-term Outcomes	Intermediate Outcomes	Outcome 1: Increase % of individuals living with HIV who know their HIV status	Outcome 2: Increase % of individuals diagnosed with HIV who are retained in care	Outcome 3: Increase % of individuals retained in care who are virally suppressed	Outcome 4: Decrease annual number of new HIV diagnoses
4.1. Support implementation of the HIV Housing Plan.	• There is an overall better understanding of housing needs for PLWH	• The number of PLWH who are stably housed increases		✓	✓	✓

Goal 5: Achieve a More Coordinated Statewide Response to HIV

Priority Tactic	Short-term Outcomes	Intermediate Outcomes	Outcome 1: Increase % of individuals living with HIV who know their HIV status	Outcome 2: Increase % of individuals diagnosed with HIV who are retained in care	Outcome 3: Increase % of individuals retained in care who are virally suppressed	Outcome 4: Decrease annual number of new HIV diagnoses
5.2.1. Develop a comprehensive inventory of all ongoing efforts being made to address HIV across Minnesota in order to: 1) identify opportunities to collaborate and leverage services; and 2) identify gaps in services.	• Increased awareness of efforts happening across state agencies, tribes, public health agencies, and other partners (qualitative measure)	• Improved coordination of efforts for maximum efficiency and impact (qualitative measure)	✓	✓	✓	✓
5.4.1. Develop a regional telemedicine model to ensure the adequate provision of care and prevention services.	• Increased use of telemedicine for prevention and care	• Increased access to prevention and care for individuals at risk of or living with HIV	✓	✓	✓	✓

Implementation Plan

DHS and MDH developed a plan to implement the 10 priority tactics. The plan primarily covers the 2019 calendar year, although there are some action steps that extend into 2020. The plan includes specific action steps as well as timelines and agency(ies) or staff position(s) responsible for the steps. One of the priority tactics has two approaches; each approach has its own set of action steps. The implementation plan also includes action steps for administrative responsibilities.

Much of the early work focuses on building additional infrastructure and capacity within and outside of state government. This includes ensuring appropriate levels of staffing, increasing knowledge and skills, translating knowledge into practice, developing and implementing relevant policies and procedures, as well as maintaining or expanding programs over time according to need.

The plan is intended to be a starting place for implementation of the Strategy and will be revised and extended, as needed, once processes are underway or as additional information becomes available. Findings from the *Literature Review for the Minnesota HIV Strategy: Key Takeaways Related to the Prioritized Tactics for 2019*[25] will be used to further inform implementation of the tactics.

Priority Tactic 1.1.1.

Implement provider education and training. The training should benefit all types of providers (e.g., primary care, specialists, nurses, interpreters, etc.). The training should focus on evidence-based, behavioral and biomedical interventions for HIV prevention and care, as well as cultural competence.

Summary of objective/approach for this priority tactic

Provide education and training for primary care providers:

- Expand access to PrEP and HIV testing in Greater Minnesota with culturally responsive delivery
- Raise awareness of and compliance with CDC recommendations around opt-out HIV testing
- Provide information about regional resources for infectious disease care
- Increase capacity to conduct risk assessment/sexual history with different populations

Action Step	Who is Responsible	Target Completion Date	Notes or Comments
1. Hold preliminary conversations to determine what Minnesota MATEC is interested in and capable of doing in relation to this work.	MDH Capacity Building Coordinator	Q1 2019	
2. Work with Minnesota MATEC and MDH STD Nurse Specialist to obtain list of primary care providers.	MDH Capacity Building Coordinator	Q1 2019	
3. Research what is required for MDH to provide Continuing Medical Education (CME) credits for health care professionals who participate in trainings. Develop and implement an MDH process to provide CME credits based on results of the research.	MDH Capacity Building Coordinator	Q3 2019	
4. Identify appropriate trainings and trainers to provide comprehensive HIV education, PrEP and cultural competency. Prioritize trainings that include CMEs.	MDH HIV Nurse Specialist, MDH Capacity Building Coordinator, DHS Training Coordinator	Q1 2019 and ongoing	Training content could include basic HIV training for primary care providers; PrEP; talking with patients about sex, risk behaviors, HIV test results; competency working with the populations served by primary care providers.
5. Develop HIV training plan that includes a combination of DHS and MDH developing and delivering training and using other existing local and national training resources.	MDH HIV Nurse Specialist, MDH Capacity Building Coordinator, DHS Training Coordinator	Q2 2019	Tailor an existing STD-related assessment to include information about what DHS/MDH can offer and ask providers to identify what they need. Develop talking points about available trainings that DHS and MDH staff can use when doing presentations.
6. Based on needs identified in training plan, request trainings through CDC's Capacity Building Assistance Request Information System (CRIS).	MDH Capacity Building Coordinator	Starting in Q2 2019 and ongoing	As a recipient of CDC HIV prevention funding, MDH is able to request training through the CRIS system.
7. Implement HIV training plan.	MDH HIV Nurse Specialist, DHS Training Coordinator	Starting in Q2 2019 and ongoing	

Other important thoughts and considerations about these action steps:

- The "etc." in the description of the tactic includes mental health and chemical health providers.
- The first year (2019) focuses on primary care providers. In 2020, expand to other providers including local public health nurses, physician assistants, and nurse practitioners.

Priority Tactic 1.1.2.

Implement messaging campaigns, advertising, and PSAs to increase awareness of HIV and increase knowledge about evidence-based, behavioral and biomedical interventions for HIV prevention and care. Tailor content and delivery of messaging to meet the needs of specific communities and regions.

Summary of objective/approach for this priority tactic

Increase awareness of HIV testing, prevention and care using the methods identified as most effective by members of the communities/regions being targeted.

Action Step	Who is Responsible	Target Completion Date	Notes or Comments
1. Identify audiences and key community members.	Strategy Coordinator, MDH and DHS staff, Advisory Board members	Q1 2019	
2. Identify and hire a consultant to work with key leaders in obtaining information about delivering HIV education/messaging in the most culturally and linguistically appropriate ways to reach target audiences.	Strategy Coordinator, MDH and DHS staff	Q2 2019	Consultant must have experience working with communities to develop appropriate and meaningful messaging. The same consultant will be used for tactic 1.1.3.
3. Develop messages using a community based participatory approach.	Consultant	Q3 2019	
4. Get feedback from community members on messages and revise as needed.	Consultant	Q4 2019	Include community members and providers. Include facilitated workshop participants who said they were interested in working on this tactic. Possible methods for input are focus groups and DHS Virtual Insight Panel.
5. Implement/kick off campaign.	TBD	Q1 2020 and ongoing, as possible	Also use messages during community events (Cinco de Mayo, Pride, Rondo Days, etc.) as appropriate.

Other important thoughts and considerations about these action steps:

- The campaigns/ads/PSAs need to include a call to action.

Priority Tactic 1.1.3.

Increase education and outreach to culturally-specific communities.

Summary of objective/approach for this priority tactic

Incorporate HIV education into existing health efforts by working with community leaders. The objective is to raise awareness about HIV and reduce stigma.

- Join existing health fairs and provide financial support for other educational opportunities in communities that have a need
- Build relationships with faith-based communities
- Use community health workers and tribal health workers to deliver education since they already have a relationship with the communities they serve

Action Step	Who is Responsible	Target Completion Date	Notes or Comments
1. Incorporate the task of assuring HIV testing programs are culturally and linguistically appropriate for target populations into the new Greater Minnesota HIV Testing Coordinator's position.	MDH Prevention Unit Supervisor	Q1 2019	
2. Work with key community leaders to identify the best way to educate their community.	Consultant, MDH Capacity Building Coordinator, Strategy Coordinator	Q2 2019	This work will be done by the same consultant hired for tactic 1.1.2.
3. Learn what community and tribal health workers do and what is currently included in certification training.	HIV Testing Coordinator	Q1 2019	Reach out to existing organizations that provide community and tribal health worker certification. MDH has information on its website about community health workers.
4. Work with organizations that certify community and tribal health workers to include HIV training in certification training.	MDH Capacity Building Coordinator/DHS Training Coordinator	Q2 2019	Offer MDH quarterly HIV testing training/certification to community and tribal health workers.
5. Work with faith-based organizations to provide education to their faith-based communities in a culturally appropriate way.	MDH Capacity Building Coordinator/DHS Training Coordinator	Q3 2019	

Action Step	Who is Responsible	Target Completion Date	Notes or Comments
6. Identify and prioritize currently existing health fairs.	MDH Communications Specialist	Q1 2019	
7. Work with community leaders to develop models to incorporate into health fairs or other educational opportunities that community leaders identify as being effective.	DHS Training Coordinator/MDH Capacity Building Coordinator	Q4 2019	Develop a few options of educational materials/outreach kits with community leaders that could be used or modified by communities. Combine these efforts with tactic 1.1.2.

Other important thoughts and considerations about these action steps:

- Need to also consider education around re-engagement in care.

Priority Tactic 1.1.4.

Implement comprehensive HIV prevention and sex education in and beyond public schools.

Summary of objective/approach for this priority tactic

Educate superintendents and/or other key personnel about the importance of comprehensive sex education in order to gain their buy-in and change curriculum used on a district-by-district basis.

Action Step	Who is Responsible	Target Completion Date	Notes or Comments
1. Identify what has been done in the past (e.g., Commissioner of Health's letter of support, previous legislative efforts) and any next steps that were previously identified.	Minnesota Department of Education (MDE), MDH STD Nurse Specialist, MDH Syringe Services Program (SSP) Coordinator, MDH Assistant Section Manager, MDH Legislative Liaison	Q1 2019	The MDH STD Nurse Specialist and MDH SSP Coordinator have been very engaged in previous work in this area.
2. Discuss the approach of educating superintendents and/or other key personnel with MDE and explore the feasibility of partnering with them.	Strategy Coordinator, MDH Capacity Building Coordinator, DHS Training Coordinator	Q1 2019	MDE was doing this work with five school districts and providing technical assistance (TA) to other school districts as needed. However, the funding was discontinued and staff laid off.
3. Review current definition of comprehensive sexual education definition and determine if revisions are needed.	MDE and MDH, other stakeholders	Q2 2019	Review letter of support signed by Commissioner of Health in 2017 and determine if the definition used is still appropriate.
4. Identify existing evidence-based curricula and important components of those curricula.	MDE, MDH STD Nurse Specialist, MDH SSP Coordinator	Q2 2019	

Action Step	Who is Responsible	Target Completion Date	Notes or Comments
5. Develop a plan for engaging with superintendents and/or other key personnel that identifies what MDE/MDH would like to learn from them, what MDE/MDH are asking them to do, and what we can provide in terms of resources.	MDE. MDH, other stakeholders	Q3 2019	Things to learn from school districts could include what is currently being taught, level of interest/support for implementing comprehensive sex education, road blocks they have encountered. Ask MDE what information already exists.
6. Identify superintendents and/or other key personnel that should be the points of contact.	MDE	Q3 2019	
7. Implement engagement plan.	MDH, MDE, other stakeholders	Q4 2019 and ongoing	

Other important thoughts and considerations about these action steps:

- The details of this plan will need to be developed with MDE.
- Comprehensive sexual education is a huge issue that cannot be accomplished in one year. This action plan is intentional about only working with superintendents of K-12 public school districts. Additional actions will need to be taken in future years.

Priority Tactic 2.3.1.

Increase the organizational capacity of small, new or yet-to-be-formalized culturally specific, community-based organizations necessary to successfully apply for, secure, and implement state and federal HIV funding.

Summary of objective/approach #1 for this priority tactic

Revise the current RFP processes used by DHS and MDH so that smaller and more diverse organizations are able to effectively participate in obtaining grants to perform HIV-related services.

Action Step	Who is Responsible	Target Completion Date	Notes or Comments
1. Talk with people at DHS who implemented innovations grants and a parallel RFP process for different communities to see how they did it, what worked well and what didn't, and what kind of justification they used to get the processes approved.	DHS Grant Managers	Q1 2019	
2. Follow up with DHS and MDH grant management divisions about how they are going to build more equity into the contract template.	DHS Grant Managers and MDH Grant Management Workgroup	Q1 2019	
3. Talk with grant managers and financial management about what would be possible (this should include what policies and procedures are required vs. which are not).	MDH Financial Grant Manager	Q1 2019	Potential processes and procedures that will be investigated: RFPs for agencies never previously funded, parallel RFP processes for different communities, verbal components to proposal process such as being able to talk with agencies with questions about proposals.
4. Determine next steps based on learnings from steps 1 through 3.	DHS and MDH Grant Managers	Q2 2019	

Other important thoughts and considerations about these action steps:

- Include cost for fiscal agents in contracts so that organizations can stay in compliance.

Summary of objective/approach #2 for this priority tactic

Assist with building the capacity of smaller agencies so they understand:

- Process and rules for writing a proposal
- Expectations of funded agencies related to implementing all aspects of a contract
- How to access resources to apply for and secure state and federal grants

Action Step	Who is Responsible	Target Completion Date	Notes or Comments
1. Identify and hire a consultant to develop a workshop series to build capacity related to grant writing and implementing funded activities.	DHS	Q3 2019	Has to be provided outside of a specific RFP process.
2. Get input from communities about best ways to deliver the workshops.	Consultant	Q3 2019	Get input from community leaders who work at culturally-specific agencies, hold community luncheons. Ask about best times, locations, and methods for delivering workshops.
3. Develop and deliver workshop series.	Consultant	Q4 2019 and Q1 2020	
4. Identify ways to distribute information about funding opportunities more broadly.	Consultant/MDH Capacity Building Coordinator	Q4 2019	Gather input through DHS' Virtual Insight Panel and from MDH Eliminating Health Disparities Initiative (EHDI) grant managers.
5. Determine how grant opportunities will be broadly promoted to ensure those that are not currently in the "HIV network" are notified.	DHS Training Coordinator/MDH Capacity Building Coordinator	Q4 2019	This could include advertising opportunities in community-based papers, radio stations, etc.
6. Implement RFP process for capacity building grants for small and/or grassroots organizations.	DHS (work with MDH to develop RFP)	Q1 2020	Timed to occur after workshop series has been offered. This process must include a contract with a technical assistance provider that all funded agencies are required to work with throughout the grant period.

Other important thoughts and considerations about these action steps:

- Convene foundations and other grant-making organizations to communicate the need for resources beyond federal and state funding to support HIV care and prevention services and ask them to contribute to these capacity building activities.

Priority Tactic 2.3.2

Increase meaningful inclusion of voices of disproportionately affected populations in decision making about HIV programs and funding.

Summary of objective/approach for this priority tactic

Implement best practice policies to integrate community voices throughout all steps of the grant process, including funding decisions, for HIV-related grants intended for disproportionately affected populations.

Action Step	Who is Responsible	Target Completion Date	Notes or Comments
1. Contact DHS Office of Equity, Performance and Development; MDH Center for Health Equity; and the State of Minnesota's Office of Grants Management to seek their expertise about their approach, policies and best practices to hear the voices of impacted communities and how to involve impacted communities in decision-making around funding and programming.	DHS Grant Managers, MDH Grant Managers	Q2 2019	MDH has almost completed an RFP template that includes language outlining equity priorities, equity-related questions to ask applicants, and equity-related scoring criteria.
2. Contact external partners (e.g., tribal governments, nonprofits that work with HIV, other jurisdictions) to seek their expertise about their approach, policies and best practices to hear the voices of impacted communities and how to involve impacted communities in decision-making around funding and programming.	MDH Prevention Unit Supervisor, DHS Ryan White Part B Director	Q3 2019	
3. Analyze info from steps 1-2, compare with DHS' and MDH's current practices and policies, and make recommendations to hear the voices of impacted communities and how to involve impacted communities in decision-making around funding and programming.	MDH Prevention Unit Supervisor, DHS Ryan White Part B Director	Q4 2019	
4. Revise DHS' and MDH's current practices and policies as appropriate based on analysis on step 3.	MDH Prevention Unit Supervisor, DHS Ryan White Part B Director	Q1 2020	

Action Step	Who is Responsible	Target Completion Date	Notes or Comments
5. Determine and implement best practices for intentionally sharing all steps of the funding and programmatic decision-making processes with impacted communities.	MDH Prevention Unit Supervisor, DHS Ryan White Part B Director	Q1 2020	
6. Develop a plan for communicating what comes out of steps 4 and 5, highlighting what is new and different.	MDH Prevention Unit Supervisor, DHS Ryan White Part B Director, MDH and DHS Communications	Q1 2020	

Other important thoughts and considerations about these action steps:

- This plan should be a priority for 2019. This will have a huge impact on the relationships that DHS and MDH have with communities.
- Communities may not be able to make final funding decisions.
- DHS and MDH should go to communities before writing the RFP.
- DHS and MDH can ask people to participate in RFP review committees.

Priority Tactic 3.2.1.

Enhance targeted wraparound supports for people at high risk of dropping out of care.

Summary of objective/approach for this priority tactic

Develop a plan to provide wraparound services to support PLWH to remain in care and prevent PLWH from falling out of care.

Action Step	Who is Responsible	Target Completion Date	Notes or Comments
1. Analyze data about people who are in and out of care to understand factors that contribute to staying in care.	MDH HIV Prevention and Care Epidemiologist	Q2 2019	Obtain data from multiple sources including national studies, Minnesota CAREWare, HIV/AIDS surveillance system, etc.
2. Conduct additional analyses to learn about the underlying root causes for each factor.	MDH HIV Prevention and Care Epidemiologist/ Strategy Coordinator	Q2 2019	
3. Based on findings from steps 1-2, develop recommendations/plan for providing targeted wraparound services	Strategy Coordinator	Q3 2019	Recommendations may include what DHS and MDH should do differently in addition to best practices for external partners.
4. Based on recommendations/plan developed in step 3, adopt strategies that support retention in care for clients, especially those who are identified as being high risk for dropping out.	Strategy Coordinator/ DHS and MDH Management (funding decisions)	Starting Q4 2019 and ongoing	

Other important thoughts and considerations about these action steps:

- Need to define “wraparound services.”
- Identify barriers to not being in care (client-focused).
- Do people have access to all the needed services throughout the state?
- Analysis of characteristics of people who are not in care (are not currently in care or never were in care).
- Research successful models for targeted wraparound services.
- Create strong arguments that support the benefits of wraparound services (better viral suppression, saving money, etc.).
- Explore options for funded providers to work together to meet the needs of clients.
- Review HIV Care Continuum to identify people who are not in care, etc.
- Training for social workers, etc. about how to navigate through all the services available for clients.
- There will need to be a training component for providers (broad definition).

Priority Tactic 4.1.

Support implementation of the HIV Housing Plan.

Summary of objective/approach for this priority tactic

Provide policy support and financial resources to support implementation of the HIV Housing Plan.

Action Step	Who is Responsible	Target Completion Date	Notes or Comments
1. Receive recommendations from housing experts, including the Minnesota HIV Housing Coalition, Minnesota Housing Finance Agency (MHFA), nonprofit organizations, and the DHS housing group for specific ways that DHS can provide policy support and financial resources to support implementation of the HIV Housing Plan.	Strategy Coordinator	Q2 2019	Recommendations may include incentives and education for landlords.
2. Determine how DHS can support the Minnesota HIV Housing Coalition in the development of a centralized HIV housing waiting list.	Strategy Coordinator, DHS Management	Q3 2019	

Other important thoughts and considerations about these action steps:

- Refer to the HIV Housing Plan.
- Provide statewide funding and technical assistance to organizations that currently provide scattered site housing in order to enable them to use a number of different models to support housing for PLWH.

Priority Tactic 5.2.1.

Develop a comprehensive inventory of all ongoing efforts being made to address HIV across Minnesota in order to: a) identify opportunities to collaborate and leverage services; and b) identify gaps in services.

Summary of objective/approach for this priority tactic

Adapt current resource lists to create a comprehensive list of all ongoing efforts being undertaken by MDH, DHS, partner organizations, local public health agencies in highly affected communities, and tribal health.

Action Step	Who is Responsible	Target Completion Date	Notes or Comments
1. Identify and hire a consultant to do this work.	Strategy Coordinator	Q2 2019	
2. Identify current lists of resources.	Consultant	Q3 2019	
3. Engage service providers.	Consultant	Q3 2019	The purpose of this step is to ensure that organizations that provide services are included on the resource list.
4. Integrate newly-identified resources into the resource list.	Consultant	Q4 2019	
5. Identify gaps in the resource list, services that may be duplicative, and recommendations for how to better coordinate existing services.	Consultant	Q1 2020	
6. Create a plan to address the findings in step 5.	Consultant, Strategy Coordinator	Q2 2020	

Other important thoughts and considerations about these action steps:

- Consultant will have to engage MDH and DHS in the implementation of these action steps.

Priority Tactic 5.4.1.

Develop a regional telemedicine model to ensure the adequate provision of care and prevention services.

Summary of objective/approach for this priority tactic

Explore the initiation of telemedicine/telehealth for HIV care and prevention statewide.

Action Step	Who is Responsible	Target Completion Date	Notes or Comments
1. Identify and hire a consultant to research telemedicine/telehealth and provide recommendations to DHS and MDH about next steps.	Strategy Coordinator	Q2 2019	Request that consultant contact TeleECHO, Iowa's TelePrEP, and other organizations that use telemedicine/telehealth to provide HIV care and prevention in Minnesota and throughout the U.S.
2. Receive recommendations from the consultant.	Strategy Coordinator	Q4 2019	
3. Determine how to implement and fund the applicable recommendations from the consultant.	Strategy Coordinator, DHS and MDH management	Q1 2020	

Other important thoughts and considerations about these action steps:

- Reimbursement issues will need to be carefully considered and addressed.
- TelePrEP is a recommendation that came up several times in the facilitated workshops. If feasible, DHS and MDH may want to develop a plan specifically for TelePrEP.
- DHS and MDH are not planning on hosting the telemedicine/telehealth platforms. They are looking to fund organizations to start and maintain these services and champion adequate reimbursement for these services.

Administrative Responsibility 1

Conduct fiscal analysis and determine appropriateness of resource allocation modeling for Minnesota.

Action Step	Who is Responsible	Target Completion Date	Notes or Comments
1. Identify experts who can help DHS and MDH determine what can and should be included in a fiscal analysis.	DHS, MDH	Q1 2019	
2. Gather information and recommendations from experts about needed content of a fiscal analysis.	DHS, MDH	Q2 2019	
3. Discuss fiscal analysis with the Advisory Board and make decision about what it will entail.	DHS, MDH	Q2 2019	
4. Implement fiscal analysis.	TBD	Begin work in Q3 2019	It is unknown at this time how long it will take to complete.
5. Learn more about the benefits and limitations of resource allocation modeling.	DHS, MDH	Q3 2018	Held initial technical assistance calls in August and September 2018.
6. Talk with additional jurisdictions about resource allocation modeling they have done, including lessons learned.	DHS, MDH	Q1 2019	
7. Discuss resource allocation modeling with the Advisory Board and decide whether to do some type of modeling for Minnesota.	DHS, MDH	Q2 2019	

Administrative Responsibility 2

Document evidence basis for Minnesota HIV Strategy tactics.

Action Step	Who is Responsible	Target Completion Date	Notes or Comments
1. Conduct literature review on the current 10 prioritized tactics to inform how to successfully implement them.	Wilder Research	Q4 2018	Completed mid-October 2018.
2. Conduct a literature review on all remaining identified tactics in preparation for next prioritization process.	TBD	Q2 2019	

Administrative Responsibility 3

Monitor the implementation and evaluation plans.

Action Step	Who is Responsible	Target Completion Date	Notes or Comments
1. Determine what "monitoring" means.	DHS, MDH	Q1 2019	After Strategy Coordinator is hired so they are part of the conversation.
2. Determine frequency of monitoring.	DHS, MDH	Q1 2019	After Strategy Coordinator is hired so they are part of the conversation.
3. Monitor implementation and evaluation plans.	Strategy Coordinator	Q2 2019 and ongoing	

Administrative Responsibility 4

Develop and maintain an online Minnesota HIV Strategy dashboard where, at a minimum, progress towards meeting the outcomes and indicators will be reported.

Action Step	Who is Responsible	Target Completion Date	Notes or Comments
1. Clarify role delineation between content expert and technical expert.	Strategy Coordinator and Minnesota Information Technology (MNIT) staff	Q2 2019	
2. Determine what elements to include in dashboard.	DHS, MDH, Advisory Board	Q2 2019	
3. Determine reporting schedule (frequency and time of year).	DHS, MDH	Q2 2019	Suggestion is to report annually for outcomes and indicators.
4. Determine design of dashboard.	DHS, MDH	Q2 2019	
5. Determine where the dashboard will be posted.	DHS, MDH	Q4 2019	
6. Create the dashboard.	TBD	Q4 2019	
7. Post baseline (2017) and 2018 results to dashboard.	TBD	Q4 2019	
8. Post results to dashboard according to determined schedule.	TBD	TBD	

Administrative Responsibility 5

Develop and implement a process for ongoing review and prioritization of tactics.

Action Step	Who is Responsible	Target Completion Date	Notes or Comments
1. Develop (and maintain) a list of all tactics and their status (in process, not considered yet, moved under/combined with another tactic, describe why taken off the list if something is taken off).	Strategy Coordinator	Q2 2019 and ongoing	Include tactics identified through workshops, web-based survey, and focus groups.

Action Step	Who is Responsible	Target Completion Date	Notes or Comments
2. Design an ongoing two-year process. Year one will focus on reviewing tactics, evaluation data and progress on outcomes and indicators, and prioritizing what will be done the next two years. Year two will focus on returning to regions/communities and getting input on what's missing, what hasn't worked (can it be modified or should it end?), what has worked.	Strategy Coordinator, DHS, MDH, Advisory Board	Q2 2019	Prioritization in May or June of even (non-budget) years so DHS/MDH have time to prepare budget proposal for odd (budget) years. Statewide Coordinated Statement of Need (SCSN) and needs assessments can also help inform gaps.
3. Implement process.	Strategy Coordinator, DHS, MDH, Advisory Board	Q3 2019 and ongoing	

Administrative Responsibility 6

Work with tribal nations and American Indians living in the metro area.

Action Step	Who is Responsible	Target Completion Date	Notes or Comments
1. Determine the information that needs to be gathered to inform how to most effectively work with tribal nations and American Indians living in the metro area.	DHS, MDH, MDH American Indian Health Director, DHS Tribal Liaison, Tribal Health Directors	Q2 2019	
2. Hire a consultant to develop and implement a process for gathering input from tribal nations and American Indians living in the metro area.	Strategy Coordinator	Q3 2019	
3. Develop and implement process for gathering input.	Consultant	Q1 2020	
4. Develop a process for working with tribal nations and urban American Indians on HIV prevention, testing, and care based on input gathered.	Tribal Health Directors, Metropolitan Urban Indian Directors, DHS, MDH	Q3 2020	

Administrative Responsibility 7

Work with African-born communities.

Action Step	Who is Responsible	Target Completion Date	Notes or Comments
1. Identify opportunities for authentic engagement with African communities, recognizing that engagement will differ with different communities.	DHS, MDH, African community and religious leaders	Q2 2019	
2. Build relationships and partnerships with African communities based on guidance received in step 1.	DHS, MDH	Q3 2019 and ongoing	
3. Develop tactics for addressing HIV in African communities to incorporate into the Strategy.	African community leaders and members in coordination with Strategy Coordinator	Q4 2019	
4. Work with African communities to build an understanding of what success in HIV work looks like within their communities and establish what mutual accountability means.	DHS, MDH, African community and religious leaders	Q1 2020	

Administrative Responsibility 8

Develop and implement communications plan related to the Minnesota HIV Strategy.

Action Step	Who is Responsible	Target Completion Date	Notes or Comments
1. Identify and hire consultant to develop and implement a communications plan.	DHS, MDH	Q4 2018	Completed
2. Develop and implement a communications plan related to a Strategy release event to be held in late spring 2019.	Consultant, DHS, MDH	Q2 2019	Develop name and tagline, color palette, and insignia for the Strategy. Also develop materials to hand out and post online.
3. Develop and implement longer term communications plan related to the Strategy.	Consultant, DHS, MDH	Q4 2019	

Administrative Responsibility 9

Conduct a comparative analysis between the Strategy and the Integrated HIV Prevention and Care Plan.

Action Step	Who is Responsible	Target Completion Date	Notes or Comments
1. Finalize the comparative analysis of the Strategy of the Integrated HIV Prevention and Care Plan.	MDH Assistant Section Manager	Q1 2019	Analysis was begun in 2018 by the former Strategy Coordinator but other MDH staff did not have time to complete it after the position was vacated.
2. Identify gaps and integrate that information into ongoing two-year planning cycle.	DHS, MDH, Strategy Coordinator	Q2 2019	
3. Identify and address duplication of effort.	DHS, MDH, Hennepin County Public Health	Q3 2019	

Evaluation Plan

As the implementation plan is rolled out, it will be important to monitor and evaluate those efforts to determine the effectiveness of the tactics. It is also critical to know how all of the tactics are working together, combined with additional work happening in Minnesota around HIV, to achieve the five goals and four legislatively mandated outcomes in the Strategy. This evaluation plan includes proposed data points, targets, data sources, and the parties responsible for analyzing and reporting the data for each of the five goals. It also includes suggestions for moving forward with creating subsequent evaluation plans for the priority tactics.

DHS is creating a new position to coordinate and report on the progress of the implementation and evaluation plans, as well as progress in reaching the outcomes and indicators included in the Strategy. As tactics are successfully implemented in coming years, additional tactics will be prioritized and added to the implementation and evaluation plans. If a tactic is found not to be effective, it will be modified or discontinued.

Evaluation Metrics

The highest level of this evaluation plan includes the approach to measure progress toward the four legislatively mandated outcomes identified in the Minnesota HIV Strategy:

1. Increase the percentage of individuals living with HIV who know their HIV status to at least 90 percent by 2025.
2. Increase the percentage of individuals with HIV who are retained in care to at least 90 percent by 2025.
3. Of individuals retained in care, increase the percentage who are virally suppressed to at least 90 percent by 2025.
4. Reduce the annual number of new HIV diagnoses by at least 75 percent by 2035, with an interim outcome of reducing the annual number of new HIV diagnoses by at least 25 percent by 2025.

Data for each of these four outcomes are updated annually by MDH. The baseline year of measurement for most indicators is 2017. MDH will continue to update the Minnesota HIV Care Continuum data and graphic presented on page 11 of this report on an annual basis. Visualizing these data over time will serve as the highest level “dashboard indicator” for this evaluation.

The next level of the evaluation plan is to evaluate progress on each goal. The tables on the following pages show suggested data points, targets identified in the Strategy, potential data sources, and responsible party for analyzing and reporting data around each goal. These tables were developed by Wilder Research in conjunction with MDH, DHS and a subcommittee of the Advisory Board.

Using these tables, MDH and DHS will be developing an online dashboard to share progress on the outcomes and indicators listed below so that information will be available to legislators, Advisory Board members, DHS, MDH, and all interested stakeholders. These bigger picture items will help monitor movement on these indicators over time.

Goal 1: Prevent New HIV Infections

Data Points	Targets Identified in the Minnesota HIV Strategy	Data Source	Responsible Party
# of new cases (incidence)	Outcome 4: Reduce the annual number of new HIV diagnoses by at least 75 percent by 2035, with an interim outcome of reducing the annual number of new HIV diagnoses by at least 25 percent by 2025.	Annual HIV care continuum	MDH
# of PLWH aware of status	Outcome 1: Increase the percentage of individuals living with HIV who know their HIV status to at least 90 percent by 2025.	Annual HIV care continuum	MDH
# prescribed PrEP	Indicator 2: By 2025, increase the number of persons prescribed PrEP at MDH-funded programs by 500 percent.	Quarterly reports from funded programs	MDH
# of people retained in care who are virally suppressed	Outcome 3: By 2025, of those retained in care, increase the percentage of those who are virally suppressed to 90 percent.	Annual HIV care continuum	MDH

Goal 2: Reduce HIV-related Health Disparities and Promote Health Equity

Data Points	Targets Identified in the Minnesota HIV Strategy	Data Source	Responsible Party
# of new cases by race	Indicator 3: By 2025, decrease the number of new HIV diagnoses among American Indians and people of color hardest hit by HIV by 25 percent.	HIV surveillance data	MDH
# retained in care by race	Indicator 4: By 2025, increase the percentage of American Indians and people of color hardest hit by HIV who are retained in care to 90 percent.	Annual HIV care continuum	MDH
# virally suppressed by race	Indicator 5: By 2025, increase the percentage of American Indians and people of color hardest hit by HIV who have achieved viral suppression to 90 percent.	Annual HIV care continuum	MDH

Data Points	Targets Identified in the Minnesota HIV Strategy	Data Source	Responsible Party
# of people diagnosed with AIDS at or within one year of initial HIV diagnosis by race	Indicator 6: By 2025, decrease the percentage of American Indians and people of color hardest hit by HIV who are diagnosed with AIDS at or within one year of initial HIV diagnosis by 15 percent.	HIV surveillance data (using a rolling 10-year average as the baseline)	MDH
Community members report reduced stigma	DHS and MDH will continue to work with the Advisory Board in 2019 to determine how reduced stigma can be measured.	Interviews or focus groups with community leaders and/or members	To be determined

Goal 3: Increase Retention in Care for People Living with HIV

Data Points	Targets Identified in the Minnesota HIV Strategy	Data Source	Responsible Party
# of people linked to care within 30 days of diagnosis	Indicator 1: By 2025, increase the percentage of newly diagnosed individuals who are linked to HIV care within 30 days of diagnosis to 90 percent.	Annual HIV care continuum	MDH
# of people retained in care	Outcome 2: Increase the percentage of individuals with HIV who are retained in care to at least 90 percent by 2025.	Annual HIV care continuum	MDH
# of people re-engaged in care	Indicator 7: By 2025, increase the percentage of PLWH re-engaged in care thorough the Care Link Services and Data2Care programs by 5 percent each year.	Quarterly reports from Care Link Services and Data2Care programs (baseline will be 2019)	MDH
# of people retained in care who are virally suppressed	Outcome 3: By 2025, of those retained in care, increase the percentage of those who are virally suppressed to 90 percent.	Annual HIV care continuum	MDH

Goal 4: Ensure Stable Housing for People Living with HIV and Those at High Risk for HIV Infection

Data Points	Targets Identified in the Minnesota HIV Strategy	Data Source	Responsible Party
# of people served by Ryan White HIV/AIDS programs are stably housed	Indicator 8: By 2025, at least 95 percent of people living with HIV who have been served through the Ryan White HIV/AIDS Programs are stably housed (using the HRSA definition).	Minnesota CAREWare	MDH

Goal 5: Achieve a More Coordinated Statewide Response to HIV

Data Points	Targets Identified in the Minnesota HIV Strategy	Data Source	Responsible Party
State agency staff, service providers, and people living with HIV/AIDS experience a more effective system that is better able to meet the needs of PLWH	• A centralized eligibility system (Minnesota RWISE) for Ryan White services will be up and running by mid-2019. Future evaluation efforts will focus on whether the centralized eligibility system has achieved its desired purpose. • A comprehensive resource inventory will be developed by the end of 2019. Future evaluation efforts will focus on whether the resource inventory has achieved its desired purpose.	Minnesota RWISE Resource inventory	DHS DHS

Next Steps Related to the Evaluation Plan

It is important to evaluate the priority tactics to determine which activities are most effective but it is not feasible, practical, or the best use of resources to rigorously evaluate every tactic regardless of the stage or extent of implementation. Process evaluation measures will be useful in understanding to what extent the activities under each tactic were implemented. DHS and MDH will complete selected outcome evaluations to measure progress on the short-term and intermediate outcomes (see the Relationship Between Priority Tactics and Outcomes section on page 38) once a tactic is being implemented and/or significant resources are directed toward a tactic. Evaluation data will be used by DHS, MDH, and the Advisory Board to make decisions about which tactics to continue, modify, or end.

Evaluation of Ryan White Part B Administration

Why?

The development of this Strategy was recommended during discussions with the community in 2015 about the possibility of moving administration of the Ryan White Part B (Part B) grant from DHS to MDH. The question of moving Part B administration was put on hold following those discussions. During the first phase of Strategy development, DHS and MDH committed to conducting an assessment in 2018 to re-examine the question.

What?

In Minnesota, DHS is the designated state entity that manages the Part B grant funds. Within Part B, DHS currently administers support services as well as the AIDS Drug Assistance Program (ADAP) and other health insurance-related services, while MDH administers statewide HIV/AIDS prevention services.

Who?

DHS and MDH contracted with Management Analysis and Development (MAD), an independent consulting group within Minnesota state government, to research and provide recommendations regarding administrative improvements for Part B, including whether its program components are best located at DHS or MDH.[k]

How?

MAD conducted interviews with DHS and MDH staff, as well as other subject matter experts and stakeholders on the effective administration of Part B programs. MAD also conducted state comparison research to investigate how other states manage their Part B programs and what Minnesota might learn from those states. MAD will use the research findings to develop recommendation for DHS and MDH.

When?

MAD is conducting research between July and December 2018. MAD will present a final report to DHS and MDH by the end of January 2019. The final report will be a publicly available document.

[k] The AIDS Drug Assistance Program (ADAP) will remain with DHS regardless of recommendations on other program components of Part B.

Next Steps

More details about next steps are included in the implementation plan but some of the priority next steps for DHS and MDH are:

- Hire the Strategy Coordinator position at DHS.
- Implement the priority tactics and administrative responsibilities outlined in the implementation plan.
- Fully define the ongoing two-year planning process that will be used to select new priority tactics and gather input on implementation of the Strategy, as well as input on needs and gaps.
- Continue engaging with American Indian and African-born communities.
- Develop and submit statutory language for new advisory council for the Strategy.

Appendices

Appendix A: Glossary

AIDS is Acquired Immunodeficiency Syndrome, the most advanced stage of HIV infection. HIV destroys the CD4 T lymphocytes (CD4 cells) of the immune system, leaving the body vulnerable to life-threatening infections and cancers. To be diagnosed with AIDS, a person with HIV must have an AIDS-defining condition or have a CD4 count less than 200 cells/mm^3 (regardless of whether the person has an AIDS-defining condition).

Care Link Services and Data2Care programs: The Care Link Services Program at MDH and Data2Care Program at Hennepin County Red Door Services use HIV surveillance data to identify people who are believed to be out of care because they have not had a CD4 or viral load result reported to MDH within the past 15 months. The Data2Care Program focuses on people living in Hennepin County and the Care Link Services Program focuses on people living in all other counties, as well as all HIV positive pregnant women regardless of county of residence. The two programs (which both fall under the category of data to care programs) follow up with the last known provider to find out if the people are truly out of care. If they are, the programs reach out to the individuals and assist those who are willing with becoming re-engaged in care.

CD4 count is a test that measures the amount of CD4 cells in the blood. CD4 cells, or T-cells, are a type of white blood cell that play a role in the immune system response. Usually the CD4 count increases as the HIV virus is controlled with effective HIV treatment.

Culturally and linguistically appropriate services (CLAS) consist of 14 standards organized by the themes of culturally competent care, language access services, and organizational supports for cultural competence. The standards are primarily directed at health care organizations but individual providers are also encouraged to use the standards to make their practices more culturally and linguistically accessible. Some of the standards are requirements for all recipients of federal funds. CLAS is a way to improve the quality of services provided to all individuals, which helps reduce health disparities and achieve health equity. CLAS is about respecting the whole individual and responding to the individual's health needs and preferences.

Early intervention services (EIS) include the following components (although the specific components vary slightly based on the category of Ryan White HIV/AIDS Program funding): counseling individuals with respect to HIV, targeted HIV testing, referral and linkage to HIV care and treatment services, outreach and health education/risk reduction services related to HIV diagnosis, and other clinical and diagnostic services related to HIV diagnosis.

Goal is simply what you would like to accomplish.

Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm reduction refers to policies, programs and practices that aim primarily to reduce the adverse health, social and economic consequences of the use of legal and

illegal psychoactive drugs without necessarily reducing drug consumption.[26] Syringe services programs fall within the realm of harm reduction.

Health equity is the attainment of the highest level of health for all people. Health Equity means efforts to ensure that all people have full and equal access to opportunities that enable them to lead healthy lives.

Health inequities are differences in health that are avoidable, unfair, and unjust. These are avoidable inequalities in health between groups of people within countries and between countries.

Health disparities are preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations

High impact public health approach is an approach to medicine that is concerned with the health of the community as a whole. Public health is the science of protecting the safety and improving the health of communities through education, policy making and research for disease and injury prevention.

HIV (human immunodeficiency virus) is the virus that can cause AIDS (acquired immune deficiency syndrome). HIV is most commonly transmitted during anal and vaginal sex, while sharing syringes or equipment to inject drugs or other substances, and less commonly, during pregnancy, childbirth or breastfeeding.

Housing Opportunities for Persons With AIDS (HOPWA) program is the only federal program dedicated to the housing needs of people living with HIV (PLWH).

Incidence in epidemiology is a measure of the probability of occurrence of a given medical condition in a population within a specified period of time. Although sometimes expressed simply as the number of new cases during a specific time period, it can also be expressed as a proportion or a rate with a denominator. Incidence conveys information about the risk of contracting the disease.

Incidence rate is the number of new cases per 100,000 population in a given time period.

Incidence of diagnosed HIV/AIDS cases is the number of new HIV/AIDS cases diagnosed in a given time period.

Indicator is a specific, observable, and measurable characteristic or change that represents achievement of a goal.

Late tester is a person living with HIV who is diagnosed with AIDS within a year of their HIV diagnosis or who is first diagnosed at the AIDS stage. The immunity of a late tester is already severely impaired by the time the disease has been first diagnosed. This designation includes those who have a CD4 T-lymphocyte count of less than or equal to 200 copies/mL at the time of diagnosis and those who are first recognized as having HIV/AIDS because they have an AIDS-defining illness even though they did not seek medical care earlier.

New HIV diagnoses refers to individuals who were diagnosed in a particular calendar year and reported to the health department. This includes persons whose first diagnosis of HIV infection is AIDS (AIDS at first diagnosis).

Outcome is the final result of a process or activity.

Opt-out testing means a health care provider tells the patient an HIV test will be part of their routine bloodwork unless the patient specifically declines the HIV test.

Partner services include a variety of related services that are offered to persons with HIV or other sexually transmitted diseases (STDs) and their sexual or needle-sharing partners. By identifying infected persons, confidentially notifying their partners of their possible exposure, and providing infected persons and their partners a range of medical, prevention, and psychosocial services, partner services can improve the health not only of individuals, but of communities as well.

Person-centered HIV care involves keeping the person at the center of their HIV care, using individualized interventions and honoring the person's preferences.

Pre-exposure prophylaxis (PrEP) involves taking HIV medicines daily to lower a person's risk of getting infected. PrEP can stop HIV from taking hold and spreading throughout the body. It is highly effective if used as prescribed. Daily PrEP reduces the risk of getting HIV from sex by more than 90 percent. Among people who inject drugs or other substances, it reduces the risk by more than 70 percent. A person's risk of getting HIV from sex can be even lower if PrEP is combined with condoms and other prevention methods.[27]

Prevalence is the number or proportion of cases in the population at a given time rather than rate of occurrence of new cases. Prevalence is the proportion of the total number of cases to the total population and is a measure of the burden of the disease on society.

Populations most affected by the HIV epidemic in Minnesota:

- Gay, bisexual, and other men who have sex with men
- People who inject drugs (PWID), including gay and bisexual men who inject drugs
- Populations of color (African-Americans, African-born, Hispanic, Asian/Pacific Islanders, multi-racial) and American Indians
- Transgender people

Post-exposure prophylaxis (PEP) means taking antiretroviral medicines (ART) after a potential HIV exposure to prevent becoming infected. PEP must be started within 72 hours after a potential exposure to HIV. If a person thinks they have been recently exposed to HIV during sex or through sharing syringes or other injection-related equipment, they should talk with a health care provider or an emergency room doctor about PEP right away.[28]

Resource allocation modeling is a methodology for determining how resources should be allocated to most effectively reach the desired outcome(s).

Ryan White HIV/AIDS Program is a federally funded comprehensive system of care that includes primary medical care and essential support services for people living with HIV who are uninsured or underinsured. The program distributes funds to cities, counties, states, and local community-based organizations and clinics to provide HIV care and treatment services to more than half a million

people in the United States each year. The Ryan White HIV/AIDS Programs consists of different parts (i.e., Parts A, B, C, D, and F) that each have specific areas of focus.

Serostatus is the state of either having or not having detectable antibodies against a specific antigen, as measured by a blood test (serologic test). For example, *HIV seropositive* means that a person has detectable HIV antibodies; *HIV seronegative* means that a person does not have detectable HIV antibodies.

Strategy is the approach you take to achieve your goal. Strategies are broadly-stated activities required to achieve the goals.

Structural discrimination (also known as structural inequality or systemic discrimination) is an unintentional form of discrimination resulting from policies that were enacted with the intent to be neutral with regard to characteristics such as race and gender. Structural discrimination occurs when these policies, despite apparently being neutral, have disproportionately negative effects on certain groups. Some structural discrimination is a result of past policies that continue to impact present-day inequality, while other policies still exist today and with disproportionately negative effects on minority groups.

Structural racism is the normalization of an array of dynamics—historical, cultural, institutional and interpersonal—that routinely advantage white people while producing cumulative and chronic adverse outcomes for populations of color and American Indians. Structural racism is deeply embedded in American society and is a potent factor leading to inequities in all major indicators of success and wellness.

Supportive housing is affordable housing with on-site services that help formerly homeless, disabled tenants live in the community.

Surveillance is the ongoing, systematic collection, analysis, and interpretation of health data essential to the planning, implementation, and evaluation of public health practice, closely integrated with the timely dissemination to those who need to know. HIV surveillance data describe who is infected (age, gender, race, ethnicity), geographical location of cases, when cases were diagnosed, and dates and results of subsequent CD4 and viral load tests.

Syringe services programs is an umbrella term for services to clients who use injection drugs, including hormones. Most syringe services programs offer other prevention materials (e.g., alcohol swabs, vials of sterile water, condoms) and services, such as education, on safer injection practices and wound care; overdose prevention; referral to substance use disorder treatment programs including medication-assisted treatment; and counseling and testing for HIV and hepatitis C.[29]

Systemic racism is about the way racism is built right into every level of our society. It is a popular way of explaining, within the social sciences and humanities, the significance of race and racism both historically and in today's world.

Systemic means that the core racist realities are manifested in each major part of U.S. society—the economy, politics, education, religion, the family—reflects the fundamental reality of systemic racism.[30]

Tactics are the activities you do to accomplish a goal and implement a strategy.

Temporary or short-term housing means that the housing situation is intended to be very short-term or temporary (30, 60, or 90 days or less). It includes the following:

- Transitional housing for homeless people
- Temporary arrangement to stay or live with family or friends
- Other temporary arrangement such as a Ryan White HIV/AIDS Program housing subsidy
- Temporary placement in an institution (e.g., hospital, psychiatric hospital or other psychiatric facility, substance abuse treatment facility, or detoxification center)
- Hotel or motel paid for without emergency shelter voucher

Treatment as prevention refers to the use of antiretroviral medication to prevent HIV transmission. Treatment as prevention involves prescribing antiretroviral medication to PLWH in order to reduce the amount of virus in their blood to undetectable levels so there is effectively no risk of HIV transmission.

Underserved populations are specific groups of people who face economic, geographic, cultural, linguistic and/or other barriers to accessing health care and other supportive services.

Unstable housing includes the following:

- Emergency shelter, a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings, including a vehicle, an abandoned building, a bus/train/subway station/airport, or anywhere outside.
- Jail, prison, or a juvenile detention facility.
- Hotel or motel paid for with emergency shelter voucher.

Undetectable = Untransmittable (U=U) As of October 23, 2017, Minnesota became the third state to endorse the U=U consensus statement and sign on as a community partner. With this endorsement, Minnesota joined more than 400 organizations from 60 countries to endorse the U=U Campaign, which describes the scientific consensus that people living with HIV who take antiretroviral therapy daily and achieve and maintain an undetectable viral load have effectively no risk of transmitting HIV to their sex partners.[31] The U=U campaign destigmatizes HIV because it removes fear of PLWH as "risky" and "infectious" to their sexual partners thus dismantling HIV stigma at the community, clinical, and personal level further improving the lives of people living with HIV.[32, 33]

Viral load refers to the number of copies of HIV per mL of blood. In other words, it's the amount of virus in the blood.

Viral suppression is when the level of circulating virus in the blood is reduced to a very low level of less than or equal to 200 copies/mL.

Appendix B: Legislation Mandating the Minnesota HIV Strategy

CHAPTER 75--H.F.No. 2047

An act relating to health; requiring the commissioner of health to develop a comprehensive strategic plan to end HIV/AIDS.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. **COMPREHENSIVE PLAN TO END HIV/AIDS.**

(a) The commissioner of health, in coordination with the commissioner of human services, and in consultation with community stakeholders, shall develop a strategic statewide comprehensive plan that establishes a set of priorities and actions to address the state's HIV epidemic by reducing the number of newly infected individuals; ensuring that individuals living with HIV have access to quality, life-extending care regardless of race, gender, sexual orientation, or socioeconomic circumstances; and ensuring the coordination of a statewide response to reach the ultimate goal of the elimination of HIV in Minnesota. The commissioner, after consulting with stakeholders, may implement this section utilizing existing efforts. The commissioner must develop the plan using existing resources available for this purpose.

(b) The plan must identify strategies that are consistent with the National HIV/AIDS Strategy plan, that reflect the scientific developments in HIV medical care and prevention that have occurred, and that work toward the elimination of HIV. The plan must:

(1) determine the appropriate level of testing, care, and services necessary to achieve the goal of the elimination of HIV, beginning with meeting the following outcomes:

(i) reduce the number of new diagnoses by at least 75 percent;

(ii) increase the percentage of individuals living with HIV who know their serostatus to at least 90 percent;

(iii) increase the percentage of individuals living with HIV who are receiving HIV treatment to at least 90 percent; and

(iv) increase the percentage of individuals living with HIV who are virally suppressed to at least 90 percent;

(2) provide recommendations for the optimal allocation and alignment of existing state and federal funding in order to achieve the greatest impact and ensure a coordinated statewide effort; and

(3) provide recommendations for evaluating new and enhanced interventions and an estimate of additional resources needed to provide these interventions.

(c) The commissioner shall submit the comprehensive plan and recommendations to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by February 1, 2018.

Presented to the governor May 17, 2017
Signed by the governor May 20, 2017, 3:43 p.m.

Appendix C: Overview of HIV/AIDS in Minnesota

Human immunodeficiency virus (HIV) is the virus that can lead to acquired immune deficiency syndrome (AIDS). HIV is most commonly transmitted through anal and vaginal sex and sharing injection drug equipment, and less commonly through pregnancy, childbirth, or breastfeeding.

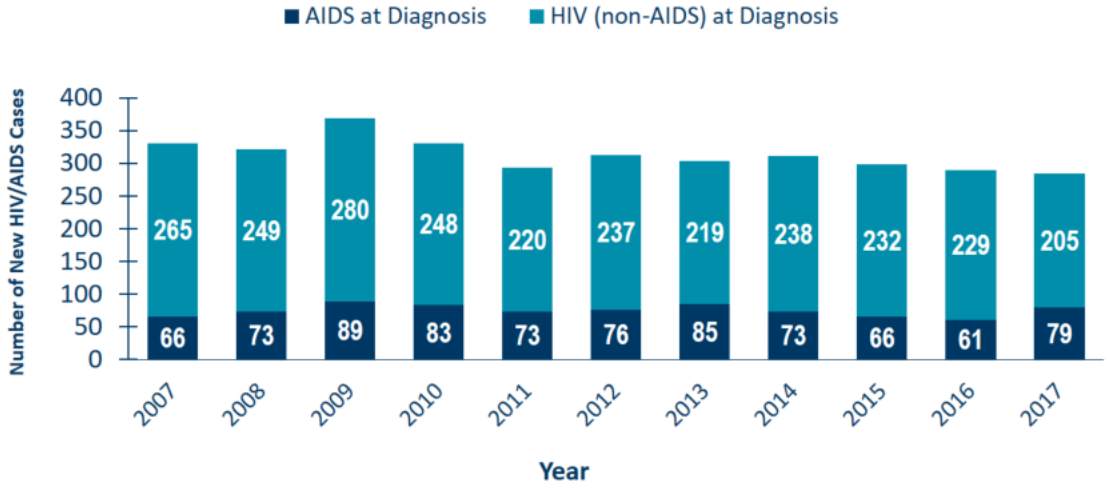
Despite innovations in HIV treatment, prevention, and policy, the HIV epidemic remains a significant health issue for Minnesota. It is important to understand the epidemic in order to identify effective strategies to end the HIV epidemic in Minnesota.[l]

There is a difference between people or populations and the risk behaviors that can lead to transmitting HIV (mode of transmission). In this report, gay, bisexual men, and other men who have sex with men are referred to as "gay and bisexual men." This term includes men who have sex with men but don't self-identify as gay or bisexual. The term "people who inject drugs (PWID)" is a more self-explanatory description of the population it refers to.

Terms describing mode of transmission are used in this appendix and in the HIV Care Continuum section. "MSM" refers to male-to-male sexual contact and "IDU" refers to injection drug use. "MSM/IDU" refers to having risk behaviors of both male-to-male sex and injection drug use.

Since 1982, there have been 11,598 cases of HIV/AIDS reported to MDH. Over the past decade, the annual incidence of diagnosed HIV/AIDS cases has ranged from 284 to 369 cases a year, with a relatively stable average of 300 cases diagnosed per year during 2013 – 2017 (Figure 7).

Figure 7: New HIV Diagnoses[m] by Year, 2007-2017



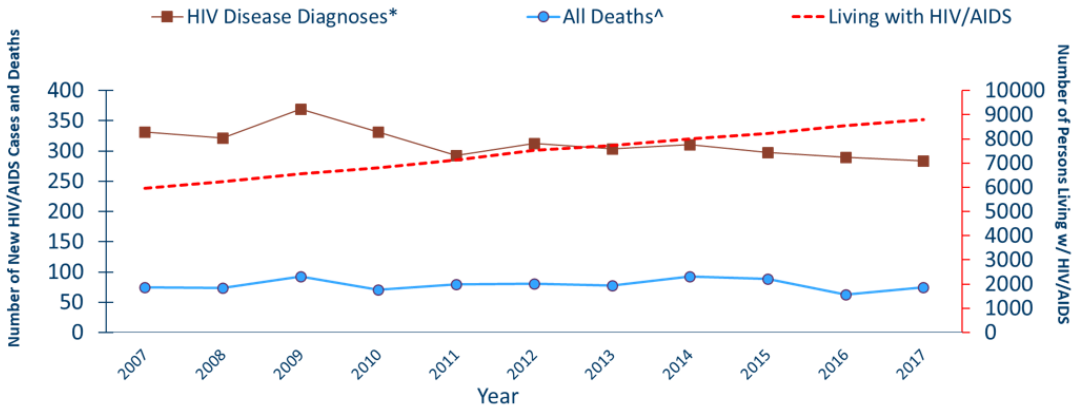
Includes all new cases of HIV infection, both HIV and AIDS at first diagnosis, diagnosed within a given calendar year

[l] Unless otherwise noted, all data presented in this section are from the Minnesota HIV/AIDS Surveillance System.

[m] At the time a person is first diagnosed, they are diagnosed with HIV, or with AIDS if the disease is more advanced and meets certain criteria. Both types of diagnoses are counted as new HIV diagnoses for the year in which the diagnoses occurred.

The number of people living with HIV (PLWH) in Minnesota continues to grow as people are living longer and healthier lives due to advances in treatment. Over the past decade the number of PLWH increased 32 percent from 5,950 cases in 2007 to 8,789 as of December 2017. During the same period, deaths among PLWH in Minnesota have ranged between 63 to 93 deaths per year (Figure 8).

Figure 8: New HIV Disease Diagnoses, Deaths, and Cases Living with HIV/AIDS by Year, 2007-2017



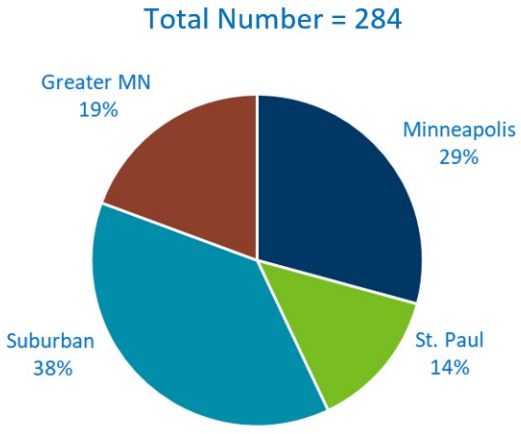
**Includes all new cases of HIV infection (both HIV (non-AIDS) and AIDS at first diagnosis) who were diagnosed within a given calendar year*

^Deaths in Minnesota among people with HIV/AIDS, regardless of location of diagnosis and cause of death

New Diagnoses by Residence at Time of Diagnosis

The majority of new HIV cases live in the seven-county metro area; with almost four of 10 new cases (38 percent) residing in the suburban seven-county metro area, about three of 10 (29 percent) residing in Minneapolis, and one in 10 (10 percent) residing in St. Paul. In Greater Minnesota, almost two of every 10 (19 percent) new HIV cases resided outside the seven-county region (Figure 9).

Figure 9: HIV Diagnoses* in Minnesota by Residence at Diagnosis, 2017



**HIV or AIDS at first diagnosis*

Suburban = Seven-county metro area including Anoka, Carver, Dakota, Hennepin (except Minneapolis), Ramsey (except St. Paul), Scott, and Washington counties

Greater MN = All other Minnesota counties outside of the seven-county metro area

New Diagnoses by Mode of Transmission

Male-to-male sexual contact has been the most commonly reported mode of transmission since the beginning of the epidemic. In 2017, MSM accounted for 48 percent (136/284 cases) of new HIV diagnoses. Twenty-five percent (72/284 cases) of newly diagnosed HIV cases in 2017 reported heterosexual contact as their primary mode of exposure; 86 percent of these (62/72 cases) occurred in females. The risk factors of injection drug use (IDU) and MSM/IDU accounted for nine percent (26/284 cases) of new diagnoses compared to 14 new diagnoses in 2013, an almost two-fold increase.

Perinatal HIV Transmission

The ability to stop the transmission of HIV from mother to child with antiretroviral therapy (ART) and appropriate prenatal care is an important accomplishment in the history of the HIV/AIDS epidemic. Rates of new HIV diagnoses among newborns range from 25-30 percent without ART, but decrease to less than one percent with appropriate medical intervention.[34]

Over the past two decades, the rate of mother-to-child HIV transmission in Minnesota decreased from 15 percent between 1994 and 1996 to 1.8 percent between 2015 and 2017. Over the past decade, the number of births to HIV-infected women has ranged between 50-71 births (2007-2017). During that time, there have been eight cases of perinatal transmission reported, with three of the cases reported during the past three years.

Late HIV Diagnoses

Despite the availability of effective antiretroviral therapy, many cases of HIV infection continue to be diagnosed at advanced stages. In Minnesota, the proportion of late testers (i.e., patients who receive an AIDS diagnosis at or within 12 months of their HIV diagnosis) has remained relatively stable over the past 10 years and was 24 percent in 2016 (most recent year available). Approximately 85 percent of late testers are diagnosed with AIDS at the time of their initial HIV diagnosis.

Disparities in New HIV Diagnoses

Disparities by Race/Ethnicity

Each year MDH calculates the rate of new HIV diagnoses by race and ethnicity to assess the burden of HIV within each community. The rate takes into account the population size of each racial/ethnic group in Minnesota. Table 2 shows people of color experienced the greatest health disparities compared to whites. Four of every six (65 percent) of the 290 HIV cases reported in 2017 were among people of color.

Table 2: Number of Cases and Rates (per 100,000 persons) of HIV Diagnoses* by Race/Ethnicity[ŧ] and Rates Compared to White, non-Hispanics, Minnesota 2017

Race/Ethnicity	Cases	%	Rate	Rates Compared to White, non-Hispanics
White, non-Hispanic	98	35%	2.2	—
Black, African-American	76	27%	46.6	21 times higher
Black, African-born	60	21%	55.6~	25 times higher
Hispanic	33	12%	13.2	6 times higher
American Indian	2	1%	#	#
Asian/Pacific Islander	8	3%	3.7	1.7 times higher
Other^	4	1%	X	X
Total	284	100%	5.4	—

** HIV or AIDS at first diagnosis; 2010 U.S. Census Data used for rate calculations*
ŧ "African-born" refers to Blacks who reported an African country of birth; "African-American" refers to all other Blacks
~Estimate of 107,880 Source: 2014-2016 American Community Survey. Additional calculations by the State Demographic Center
^ Other = Multi-racial persons or persons with unknown or missing race
 # Number of cases too small to calculate reliable rate
X Other population estimate is not available so a rate cannot be calculated

It is important to note that, as sovereign nations, Minnesota tribal communities are not held to the State of Minnesota Communicable Disease Reporting Rule, Chapter 4605 (https://www.revisor.mn.gov/rules/4605/) although many choose to report. As a result, the number of actual HIV cases among Americans may be underreported. Sovereignty does not extend to urban clinics, such as the Native American Community Clinic and the Indian Health Board, or other clinics throughout the state where American Indians may be tested or treated for HIV.

Disparities by Country of Birth

Of new HIV diagnoses in Minnesota during 2017, 31 percent were among foreign-born people, the majority of whom were from Africa, followed by Latin America and the Caribbean. Based on 2010-2012 American Community Survey data, foreign-born people make up only seven percent of the total Minnesota population and are, therefore, disproportionately affected by HIV. The number of new HIV infections diagnosed among foreign-born people has steadily increased from 20 cases in 1990 to 89 cases in 2017. The largest number of cases occur among African-born people, increasing from eight cases in 1990 to 60 cases in 2017.

Disparities by Gender and Race

There are differences in the racial/ethnic distribution by gender. Among males, Black, African-American and Black, African-born men made up 40 percent of cases and Hispanic males of any race accounted for 14 percent of cases.

Among women, the disparities are even more apparent with women of color representing 80 percent of all the newly diagnosed females in 2017. Specifically, Black, African-born women account for

almost half (47 percent) of the cases and Black, African-American women accounted for about another quarter (24 percent) of cases.

Mode of Transmission and Gender Identity Disparities

Male-to-male sexual contact results in the highest rate of HIV diagnoses compared to any other sub-category of transmission. According to CDC, if current national diagnoses rates continue, one in two African-American and one in four Hispanic gay and bisexual men are at risk of being diagnosed with HIV in their lifetime.[35]

In 2017, the estimated rate of HIV diagnosis among men who reported male-to-male sex in Minnesota was 150.0 per 100,000 population (Table 3). This is 56 times higher than the rate among men who reported heterosexual contact.

Table 3: Number of Cases of Adult and Adolescent HIV Diagnoses* by Gender Identity and Risk[t], Minnesota 2017

Gender/Risk	Cases	%	Rate
Men (Total)	(204)	72%	7.8
MSM[t]	136	(67%)	150.0
Heterosexual Contact	68	(33%)	2.7
Women	70	25%	2.6
Transgender (Total)	9	3%	X
Male to Female	6	(67%)	X
Female to Male	3	(33%)	X
Total	283	100%	5.3

** HIV or AIDS at first diagnosis over the age of 13*
[t] "MSM" refers to both MSM and MSM/IDU risk. Male gay/bisexual population estimated at 92,788 in Minnesota
X No current transgender population estimate available so a rate cannot be calculated

Late Tester Disparities

During the past decade, foreign-born cases have had a higher rate of late testers compared to U.S.-born cases. In 2016 (most recent year available), 35 percent of foreign-born cases were late testers compared to 18 percent of U.S.-born cases.

Disparities among People Living with HIV

Disparities by Race/Ethnicity

As with new diagnoses, when looking at rates of living HIV/AIDS cases in Minnesota, people of color experience the greatest health disparities (Table 4).

Table 4: Number of Cases and Rates (per 100,000 persons) of Persons Living with HIV/AIDS by Race/Ethnicity[ł] and Rates Compared to White, non-Hispanics, Minnesota 2017

Race/Ethnicity	Cases	%	Rate	Rates Compared to White, non-Hispanics
White, non-Hispanic	4,119	47%	93.4	—
Black, African-American	1,885	21%	1,155.5	12 times higher
Black, African-born	1,368	16%	1,268.1~	14 times higher
Hispanic	852	10%	340.4	4 times higher
American Indian	113	1%	203.2	2 times higher
Asian/Pacific Islander	191	2%	88.0	< 1 time lower
Other^	249	3%	X	X
Total	8,777	100%		—

ł "African-born" refers to Blacks who reported an African country of birth. "African American" refers to all other Blacks

~ Estimate of 107,880 Source: 2014-2016 American Community Survey. Additional calculations by the State Demographic Center

^Other = Multi-racial persons or persons with unknown race

X Other population estimate is not available so a rate cannot be calculated

Census data used for rate calculations

Disparities by Country of Birth

Between 1990 and 2017, the number of foreign-born people living with HIV/AIDS in Minnesota increased substantially, especially among the African-born population. In 1990, 50 foreign-born people were reported to be living with HIV/AIDS and by 2017, this number had increased to 2,101.

Table 5: Countries of Birth Among Foreign-born People[ł] Living with HIV/AIDS, Minnesota 2017

Country of Birth	Cases
Ethiopia/Oromia	315
Mexico	273
Liberia	235
Kenya	173
Somalia	143
Cameroon	113
Sudan	70
Other^	779
Total	2101

[ł] Includes persons arriving to Minnesota through the HIV Positive Refugee Resettlement Program, as well as other refugees and immigrants arriving to Minnesota with an HIV diagnosis prior to arrival in Minnesota

^Includes 100 additional countries

Mode of Transmission and Gender Identity Disparities

MSM accounts for the highest rate of transmission among persons living with HIV/AIDS. In 2017, the estimated prevalence of HIV among men who reported male-to-male sex was 5192.8 per 100,000 population. This is more than 74 times higher than the rate among men who reported heterosexual contact (Table 6). It is important to note that MSM transmission includes cases from all racial/ethnic categories and therefore cannot be directly compared to the prevalence in various race/ethnicity subpopulations.

Table 6: Number of Cases and Rates (per 100,000 persons) of Adults and Adolescents* Living with HIV/AIDS by Gender Identity and Risk[ŧ], Minnesota 2016

Gender/Risk	Cases	%	Rate
Men (Total)	(6,486)	75%	245.6
MSM[ŧ]	4,708	(73%)	5,192.8
Heterosexual Contact	1,778	(27%)	70.0
Women	2,064	24%	77.3
Transgender^ (Total)	80	1%	X
Male to Female	62	(78%)	X
Female to Male	18	(22%)	X
Total	8,630	100%	162.7

** HIV or AIDS at first diagnosis over the age of 13*

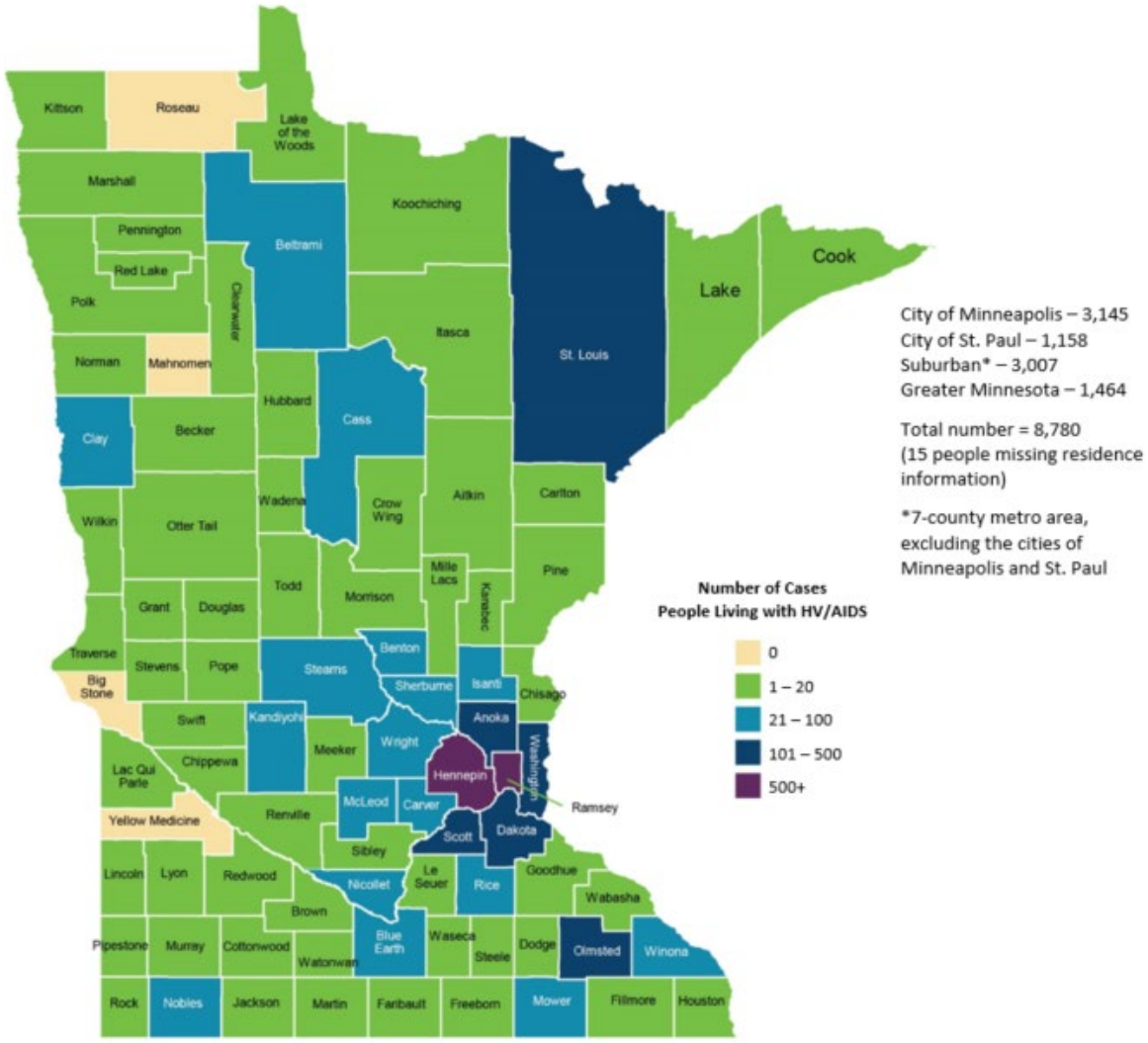
[ŧ] "MSM" refers to both MSM and MSM/IDU risk. Male gay/sexual population estimated at 92,788 in Minnesota

^ No current transgender population estimate available

People Living with HIV/AIDS by County of Residence

There are people living with HIV or AIDS in 95 percent (83 out of 87) of counties in Minnesota (Figure 10). Of the 8,789 PLWH who were reported to the Minnesota Department of Health (MDH), the majority (83 percent) reside in the seven-county metropolitan area surrounding Minneapolis and St. Paul (Hennepin, Ramsey, Anoka, Carver, Dakota, Scott and Washington counties). However, there is a considerable and increasing share of morbidity spread across the state.

Figure 10: Living HIV/AIDS Cases by County of Residence, 2017



HIV and Co-infections

HIV and syphilis have a long history of co-infection. One-third of all new cases of syphilis diagnosed in 2017 had previously been diagnosed with HIV. Among MSM diagnosed with syphilis in 2017, almost half (46 percent) had previously been diagnosed with HIV. Of PLWH in Minnesota, 10 percent are co-infected with either hepatitis B, C, or both. Among PLWH that are co-infected with HIV and hepatitis (n=890), 46 percent are diagnosed with hepatitis B and HIV, 48 percent are diagnosed with hepatitis C and HIV, and five percent are diagnosed with both hepatitis B, C and HIV.

Appendix D: Minnesota HIV Strategy Advisory Board Roles and Responsibilities

Members of the 2018 Advisory Board: Colleen Bjerke, Osahon Kings Enodunmwenben, Eva Enns, Roger Ernst, Abiel Gebrehiwot, Mary Johnson, Chryssie Jones, Daniel Jude, Keith Horvath, Jake Maxon, Amy Moser, Ephraim Olani, Asneth Omare, Richard Oni, Chuck Peterson, Meghan Rothenberger, Antony Stately, Mary St. Marie, Matt Toburen, and Gwen Velez.

Minnesota HIV Strategy Coordinator (through June 2018): Dr. Alvine Laure Ekame
Minnesota HIV Strategy Student Worker (through April 2018): Esther Mwangi

Purpose and Scope

Minnesota HIV Strategy Advisory Board (Advisory Board) members will:

- Prompt innovation
- Provide expertise
- Provide support

Prompt Innovation

May Meeting (3 hours)

- Present results from qualitative data analysis (2017 focus groups and key informant interviews).
- Present 2017 HIV and hepatitis C/HIV co-infection data and 2016 STD/HIV co-infection data.
- Work in small groups to develop recommendations to implement the following:
  - Assist collaborative conversations and efforts with ASOs to increase efficiency in HIV prevention and care services and outcomes that should be expected.
  - Encourage new partnerships between organizations providing HIV services and small organizations that are culturally specific.
  - Innovative ways to increase partnerships, collaboration and communication among community members and leaders in the eight regions of Minnesota (Northwest, Northeast, West Central, Central, Southwest, South Central, Southeast, Metro).

Provide Expertise

August Meeting (full-day retreat)

- Present results from regional, metro and tribal facilitated workshops.
- Work in small groups to review prioritized tactics and local action plans developed through the facilitated workshops and make recommendations.
- Present highlights of recommendations to the large group.

September Meeting (3 hours)

- Review and refine tactics prioritized at August meeting.

October Meeting (3 hours)

- Review updated Minnesota HIV Strategy (Strategy) based on results of work completed in 2018.
- Work in small groups to provide feedback on the draft updated Strategy.
- Present highlights from small group discussion of their recommendations to the large group.

Provide Support

- Advocate for the Strategy and increase its visibility locally and regionally.

Structure of the Board

- Meetings will be co-facilitated by the Strategy Coordinator and Wilder Research.
- Small groups will meet during meetings to work on specific portions of the Strategy. Each small group will include advisory board members and others who are present at the meeting.
- Ad hoc groups will be formed and meet as needed.

Responsibilities of Guests at Advisory Board Meetings

Advisory Board meetings are open to the public.

- Non-members are encouraged to contact the meeting facilitators in advance in order to allow for proper meeting set-up.
- Non-members can provide input during the meetings according to direction provided by the facilitators.
- Non-members do not participate in voting.

Membership

We are committed to:

- Advisory Board membership that reflects the HIV epidemic in Minnesota, particularly populations that are disproportionately impacted.
- Members from HIV-specific and non-HIV-specific clinical and non-clinical providers who serve people living with and at high risk for HIV in Minnesota.

Government Leadership Structure

- Leadership representatives from the Minnesota Departments of Health and Human Services (MDH and DHS) HIV programs will assure accountability and collaboration among partners responsible the Strategy.
- DHS and MDH will work between meetings on a variety of tasks including member recruitment, logistics for the facilitated workshops, comparing the Strategy with the Integrated Prevention and Care Plan, and conducting a fiscal analysis.

Appendix E: Tactics Identified Through Workshops, Survey, and Focus Groups

The tables in this appendix provide a list of the tactics that were recommended by participants of facilitated workshops and a web-based survey conducted in 2018, as well as by participants in a series of focus groups conducted in 2017. The process used for each was somewhat different.

Facilitated Workshops

Wilder Research conducted 15 facilitated workshops around the state with a total of 224 participants. Each workshop focused on a specific region of the state or a high-risk community. The first step in each facilitated workshop was for participants to identify strategies from the Minnesota HIV Strategy (Strategy) that they thought were most important for ending HIV in their region or community. They were not given a definition of "important" but were offered some examples of what it could mean (e.g., it would impact a large number of people, would impact a very high-need group of people, it addresses a very critical point of the care continuum, etc.) and instructed to define it as they saw fit. Small groups first identified their top four strategies, which they shared with the large group. Each participant was given four votes to distribute across any of the strategies that had been identified by the small groups. The strategies with the largest number of votes, or prioritized strategies, advanced to the next stage. Participants then broke into small groups again, with each group focused on a specific prioritized strategy. Each group brainstormed tactics for achieving their prioritized strategy without concern for feasibility or cost.

The next step was for workshop participants to participate in a grid ranking activity where they ranked their small group's four most preferred tactics in terms of feasibility of implementation and level of impact. Each participant within a small group was given one sticker per tactic and was instructed to place their sticker into the appropriate place on the grid based on whether they thought it would be highly or less feasible to implement and if it would have a high or low level of impact. After conducting the grid ranking exercise, participants discussed the trends in their responses and each small group selected their two top recommended tactics for implementation. Regional and community workshop participants recommended 83 tactics for implementation; all are included in the tables of this appendix. These tactics do not include input from the west central region as the workshop was canceled due to low participation.[36]

Two of the workshops were unique in their process and content. During the workshop focusing on the African-born community, participants called for a different process to share their feedback. Several participants did not feel their communities were represented in the Strategy and were therefore uncomfortable using it as the starting place for the facilitated conversations. Instead, a set of small group conversations focused on the key concerns of participants and a follow-up meeting was held to review and confirm what was shared. The workshop focused on American Indian communities was intentionally planned and conducted differently in order to recognize and respect the sovereignty of tribal nations and because the state recognized a need to learn more about the needs and concerns of these communities

before working to prioritize strategies and develop tactics that could meet their needs. Input captured during these two workshops is summarized separately from the other regional and community workshops.[37, 38]

Web-based Survey

Invitees who were not able to attend a workshop were invited to provide input through a web-based survey. A total of 124 people completed the survey. Respondents were asked to choose the three strategies they felt were most important for ending HIV in the community or regions for which they were completing the survey. Survey participants were also given some examples of what "important" might mean and asked to define it as they saw fit. Survey respondents were then also asked to recommend one tactic for each of their prioritized strategies.

In order to determine which tactics would be included in these tables, Wilder Research considered the total number of survey participants from each community and region. Approximately 30 percent of participants from a region or community had to identify a strategy as priority in order for tactics recommended under that strategy to be included.

The survey had participants who responded on behalf of the African-born community and west central region. The survey data do not include responses on behalf of American Indian communities. The survey questions weren't similar enough to the questions used in the talking circles so invitees who were not able to participate in the talking circle were not invited to participate in the survey.[39]

Focus Groups

In 2017, a series of 36 focus groups and 15 key informant interviews were conducted across the state with a total of 252 individuals by the former strategy coordinator and student worker. Participants provided information in two ways—individual written responses at the beginning and group discussion of questions presented during the focus group. Participants were given general information about the Strategy but were not asked to prioritize strategies or identify tactics that fit under a specific strategy. People living with HIV (PLWH) and community members from high-risk populations were asked about their experiences with different types of services and providers, about needs and ideas for addressing them, and suggestions for addressing HIV-related stigma and discrimination. The focus groups did not include a process for coming to agreement about or prioritizing needs or the suggestions for how to address them.[40]

The tactics included in these tables are recommendations for addressing identified needs that were suggested by more than one focus group. They were placed under the respective strategies as part of the qualitative data analysis process. Because the recommendations are not attributed to a specific focus group, the location and community columns of the tables are not filled in for tactics that were identified through focus groups.

Recommended Tactics for Goal 1: Prevent New HIV Infections

Strategy 1.1: Increase HIV education and awareness for all Minnesotans, especially health professionals, students and high-risk populations.

Tactic	Location	Community	Source
[Create] visibility - more advertisements, more billboards, advertisements on buses. There are so many advertisements about everything else, why not more about HIV (e.g., from MDH for testing)?	St. Cloud	Central	Workshop
Advocate for changes in state education policies around sex education. Incentivize comprehensive sex education instead of abstinence-only.	St. Cloud	Central	Workshop
[Develop] language and education targeted to meet people's needs regardless of age or culture over the lifespan.	Metro	Hispanic	Workshop
[Engage in] open discussions and education with community-based organizations/grantees by the Minnesota Department of Human Services (DHS), Hennepin County, and the Minnesota Department of Health (MDH). Allow for flexibility with funding and room to collaborate to create best practices as a collective group to really meet the needs of Latino; men who have sex with men (MSM); injection drug users (IDU); and lesbian, gay, bisexual transgender and queer (LGBTQ) people affected by HIV/AIDS. New partnerships and equitable disbursement of funding. Innovative partnerships to create a new approach to serving the needs [of the community]. Educate grant makers and grant seekers with the shared vision of creating adequate/equitable/innovative sexual health partnerships and programming.	Metro	Hispanic	Workshop
Develop a succinct messaging campaign (including ideas on ongoing danger, hope, and treatment) that is in all sorts of materials (social media, print, messages, etc.). Go beyond HIV, include all sexually transmitted diseases (STDs).	Duluth	Northeast	Workshop
Develop statewide school standards for sex education and put into mandate through Minnesota Board of Education. Health people develop and education people implement. Require at all levels and have specific guidelines for levels.	Duluth	Northeast	Workshop
Develop public service announcements (PSAs): provide information, reduce stigma, inform people rates are going down, tell people they can reduce their viral loads, share where to be tested in the region, get celebrities involved, and have MDH take the lead on development of messaging. Present information on TVs in social service waiting rooms. Use social media strategies to reach youth.	Bemidji	Northwest	Workshop
Identify information and referral numbers for people to contact at the regional level.	Bemidji	Northwest	Workshop
Provide an HIV-specific education session or outreach to local schools serving students age 13 and older through local public health. This could be paired with existing presentations that focus broadly on sexual health.	Mankato	South Central	Workshop
[Host a] regional conference with breakout sessions for differing levels of knowledge. [Invite a] comprehensive group – school staff, police officers, etc. This could be a webinar.	Mankato	South Central	Workshop
Develop social media messaging. [Use] technology, apps, Facebook, and Instagram.	Rochester	Southeast	Workshop

Tactic	Location	Community	Source
Increase community education. Start with community education then progress to comprehensive sex education.	Rochester	Southeast	Workshop
[Teach] sexual health in settings including at schools. Education in schools [varies].	Worthington	Southwest	Workshop
[Provide] more education to culturally specific communities. Think about cultural needs and consult the community or a community leader when developing educational activities.	Worthington	Southwest	Workshop
Educate students and high-risk populations about transmission and the importance of being tested and treated if engaged in risky behaviors.		Northeast	Survey
[Provide] strategies for making wise choices like abstinence or one partner. [Do so in] health classes, gym classes, biology classes, homeless shelters, gyms, YMCAs, bars, community events.		Northeast	Survey
Have a messaging campaign that is consistent and applicable across the population.		Northeast	Survey
[Host] one-day seminars with continuing education credits.		Northwest	Survey
Hold groups and informational meetings in all communities. Provide county human services, public health, mental health, housing authorities, and church communities or others that will listen with information to give to their clients.		Northwest	Survey
Work with professionals to bring the issue forward.		Northwest	Survey
[Offer] e-learning for all health professionals, including mental health professionals. Highlight easy to understand statistics and education on locations to obtain help.		Northwest	Survey
[Run] ads on local TV regarding HIV.		Northwest	Survey
Make up-to-date education available on YouTube that local public health agencies could use for educating staff and the public as needed.		Northwest	Survey
Offer more conferences and webinars to professionals. [Use] more PSAs to reach high-risk populations.		People who inject drugs (PWID)	Survey
Develop online education programs and webinars.		South Central	Survey
Provide communication content and tools to local public health and community partners to deliver in their settings and in any outreach work they do.		South Central	Survey
[Conduct] outreach activities within schools, community events, and clinics to ensure all are aware of prevention and appropriate testing.		South Central	Survey
[Provide] education to help ensure HIV risk awareness for all, but targeted to those most at risk.		Southeast	Survey

Tactic	Location	Community	Source
Identify and provide educational tools and training for those who provide services to youth and high-risk individuals such as schools, mental health services, sexual health services, STD clinics, jails, clinics and hospitals, and health and human services agencies.		Southeast	Survey
[Implement] media campaigns, continuing education for professionals, education by community leaders and trusted messengers so they can get the message out.		Southwest	Survey
Provide regional updates and training to health professionals.		Southwest	Survey
Offer HIV education in public and private schools. Also provide education in community organizations such as the YMCA.		Southwest	Survey
[Confirm that physicians] in Greater Minnesota are up to date as far as current HIV care (medications and follow up). [This may] perhaps make doctors think about HIV. [Greater Minnesota HIV] rates are often a lot lower than metro [rates], [it is] hard to sustain programs in these areas.		Southwest	Survey
[Implement] testing for new immigrants coming from other countries [to understand] how many are coming here with the disease.		Southwest	Survey
Use social media to get an updated message out.		Southwest	Survey
Implement local classes or programs that are part of an already existing system or require health professionals and students to attend classes.		Southwest	Survey
Start with giving better information to school-aged children. Not just how to wear a condom, but more [information on] what HIV is, how it is transmitted, prevention, [and] not to be afraid of normal contact.		West Central	Survey
[Have] public forums, focus groups, [and] events.		West Central	Survey
[Make] information available like brochures [that can be accessed] on a smart phone [because] the younger generation is very tech savvy.		West Central	Survey
Include information at all educational levels from elementary to the college. Have professionals or educators in the field trained to relay the information, and possibly certify people to be the educators or professionals.		West Central	Survey
Perhaps more billboard signs, signs in public transportation and on bus stop seats. Or television. Ads in weekly local news magazines. Online advertising.		White Gay/ Bisexual Men[n]	Survey

[n] The term “gay/bisexual men” includes men who have sex with men but don’t self-identify as gay or bisexual.

Tactic	Location	Community	Source
Increase funding and technical assistance for implementing evidence-based or evidence-informed programs that include HIV education as part of a more comprehensive program, such as FLASH or Positive Prevention Plus. Support Minnesota-developed programs and the development/evaluation of them.		Youth	Survey
Provide support, including funding, for youth leadership and peer education groups to focus on addressing HIV.		Youth	Survey
Offer funding for organizations to pilot, evaluate, and adapt interventions with community and youth input.		Youth	Survey
[Ensure] comprehensive sex education for all students in Minnesota. [Provide] HIV education for adults and senior citizens throughout the state. Teach people how to have the conversation about protection with their partner.		Youth	Survey
Increase the public's awareness of HIV.			Focus groups
Increase the public's awareness of pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP).			Focus groups
Provide more HIV education and training for providers (primary care providers, mental health providers, substance abuse counselors, nurses, social workers, local public health, and others that work with high risk populations or PLWH).			Focus groups
Provide more PrEP/PEP education and training for providers.			Focus groups
Provide more training in HIV diagnosis and patient encounters for primary care providers.			Focus groups

Strategy 1.2: Increase opt-out HIV testing and early intervention services.

Tactic	Location	Community	Source
Research potential barriers such as HIPAA impact and cost.	Metro	White Gay/ Bisexual Men	Workshop
Look at where health policy for each clinic or health system is regarding HIV opt-out testing. Minnesota Statewide Quality Reporting and Measurement System (SQRMS) ratings.	Metro	White Gay/ Bisexual Men	Workshop
Provide more HIV testing and counseling services in Greater Minnesota.			Focus groups

Strategy 1.3: Immediately link newly diagnosed individuals to person-centered HIV care and treatments.

Tactic	Location	Community	Source
[Implement] geographically specific, community responsive, long-term, flexible case management.	Metro	Youth	Workshop

Tactic	Location	Community	Source
Coordinate between agencies/clinics conducting tests and person-centered care agencies.		African-American	Survey
Engage providers serving this community. Recruit more providers within the community to serve this community. Build on existing relationships with community groups.		African-American	Survey
[Locate] services at clinics and doctors' offices to immediately start working with people who are diagnosed.		African-American	Survey
Use trusted community persons to help connect individuals to care and treatment. Make sure cost concerns are addressed.		African-American	Survey
Let clinics know where to refer patients by providing regularly updated information. There are online resources, but at the clinic level, we need easy and immediate access for patients and staff.		Central	Survey
Have a task force that has resources available in one spot so any health professional can click on a link, get answers, send referrals, etc.		Central	Survey
Connect people living with HIV to a provider that has experience in treating HIV and connect them to Rural AIDS Action Network for additional support.		Central	Survey
[Implement] same-day initiation of antiretroviral therapy (ART) upon diagnosis. This may require adding access to ART in testing locations so people do not fall between the cracks when referred elsewhere.		PWID	Survey
Develop an easy to use referral system to link individuals to a provider who specializes in HIV treatment.		PWID	Survey
Provide early connection to mental health services at initial HIV diagnosis.			Focus groups
Provide early connection to case managers at initial HIV diagnosis.			Focus groups
Provide peer educators to assist newly diagnosed PLWH in navigating health care and social services systems.			Focus groups

Strategy 1.4: Increase availability, access and use of evidence-based interventions that prevent HIV infections, such as PrEP, PEP, syringe services programs, and partner services.

Tactic	Location	Community	Source
[Implement] large scale advertising. [Hold] events for normalizing prevention.	Metro	African-American	Workshop
Increase [the number of] providers who offer PrEP/PEP.	Metro	African-American	Workshop

Tactic	Location	Community	Source
[Provide] mobile units for syringe exchange, PrEP, testing, and beyond.	Duluth	Northeast	Workshop
Educate healthcare professionals about PrEP.	Bemidji	Northwest	Workshop
Normalize point of care HIV testing.	Bemidji	Northwest	Workshop
Integrate syringe services programs (SSP) into other services (e.g., primary care, treatment agencies, and emergency rooms). Embed this in places like Positive Care Center. This will improve retention in care and this would also help [address] transgender needs. [Increase number of] safe disposal sites; [implement] syringe take back at pharmacies, community incinerator, and community visible disposable sites (like in Denver). Need more licensed alcohol and drug counselors and Rule 25 assessors integrated at syringe services programs (SSPs).	Metro	PWID	Workshop
[Implement] peer delivery of syringes. More money is needed for supplies. [Implement] secondary exchangers (replicate Washington Heights model) and drug user organizing. Engage drug consumers in design and delivery.	Metro	PWID	Workshop
Identify where people of color (POC) congregate (e.g., social establishments, pride events).		African-American	Survey
[Improve] access to and availability of syringe services.		African-American	Survey
Have more people that look like and represent the people we are trying to reach out in the communities on a constant basis, not just when there is a need for data. Build relationships that people can trust. Offer incentives, transportation, non-labeled safe places for people to go and be tested or ask questions, etc. Have phone line information available for each targeted population.		African-American	Survey
Have these services available in prisons, high schools, junior highs, workhouses, job corps, etc. to educate and give services to especially young men and women of color.		African-American	Survey
Talk to people more in schools to educate and teach them how to take care of themselves better. Have more trained case managers and outreach workers who meet with people one on one.		African-American	Survey
Engage CentraCare in assisting with this work. Educate providers in evidence-based interventions and prevention strategies. Assist public health agencies in accessing funding for evidence-based programs such as syringe services. Help reduce the stigma in central Minnesota. None of this will happen until people can talk about HIV.		Central	Survey
[Provide] low- to no-cost transportation to the client and easy availability.		Central	Survey
Get Medicaid and other health plans to reimburse for the medications involved without barriers or challenges. Currently, it is very difficult to get health plans to cover PrEP without prior authorization and excessive advocacy.		Gay/Bisexual Men of Color	Survey
[Provide] syringe service options. [Add] more community options for testing and treatment [and] more community providers.		Hispanic	Survey

Tactic	Location	Community	Source
[Have] community HIV testing [provided] by Latin health advocates.		Hispanic	Survey
Educate about options in at-risk populations. Often persons who may have risks for certain diseases don't understand options in prevention of that disease.		PWID	Survey
Offer more education to providers regarding PrEP and PEP. Expand syringe services programs to rural areas.		PWID	Survey
Work with pharmacies to reduce the stigma around purchasing syringes. At most pharmacies it's up to the pharmacist if they want to sell them or not.		PWID	Survey
Encourage and give incentives to clinics to provide services.		Northwest	Survey
[Offer] needle exchange programs and [provide] rural HIV treatment access with insurance coverage.		Northwest	Survey
[Implement an] ad campaign or news reports. [Offer] local education updates related to HIV with no charge to attend.		Northwest	Survey
Educate primary care providers on PrEP—most don't know about it or use it.		Northwest	Survey
Utilize northwest local public health departments who offer HIV testing to begin offering PrEP.		Northwest	Survey
Offer opportunities for syringes to be turned in (i.e., drop off locations). Needle exchange is not universally supported by policy makers in the northwest region, currently, and this is a beginning tactic they may be amenable to.		Northwest	Survey
[Increase] education. [Ensure] private access.		South Central	Survey
[Implement] programs for those that are under-insured or that have no insurance so [that] those individuals can be [informed] of available resources and because the medication is so expensive. Indian Health Services is not able to provide needle-exchange services; [they] often have to refer to tribal health [centers], which are only open limited times during the week. This is great for those that live on the reservation, but many of the patients live outside of the reservation.		West Central	Survey
Do more education in Greater Minnesota around the advantages of PrEP, PEP, and syringe exchange programs to increase buy-in. Communities in this area are extremely resistant to "harm reductionist" strategies due to their perceived "counter-intuitive nature." If there is buy-in for programs such as these, then funds and resources can and will follow. There are energized people in the community and local organizations to implement this work, but they cannot do it without proper supports.		West Central	Survey
All payers should pay 100% of treatment costs for both patient and partner.		West Central	Survey
Utilize mobile or home-based efforts to better reach rural areas.		West Central	Survey
Meet people where they are with real-time services and support. Don't wait for them to come to [a] facility. Provide a holistic approach to assess all health risks and provide hands-on case management.		West Central	Survey

Tactic	Location	Community	Source
Break down the stigma of obtaining these services. This is a rural, conservative area and the most significant barrier to people obtaining any of these services is cultural. Enlisting churches to help would be a major breakthrough.		West Central	Survey

Recommended Tactics for Goal 2: Reduce HIV-related Health Disparities and Promote Health Equity

Strategy 2.1: Protect and enhance advancements in health care policies, including Minnesota Health Care Programs expansion, coverage for people with pre-existing conditions, and access to preventive treatments without cost sharing

Tactic	Location	Community	Source
Do not gut the Affordable Care Act (ACA) - address this with lawmakers.		Central	Survey
Do not make this just HIV specific. This should be general public policy to maximize health equity.		Northeast	Survey
Make sure our legislators are aware of health care barriers.		Northwest	Survey
[Use] inclusive language with minimal "red tape" for all sexual health services.		Northwest	Survey
Lobby for legislative action and [provide] education for elected officials.		South Central	Survey
[Implement] legislation to secure that pre-existing conditions are always covered.		South Central	Survey

Strategy 2.2: Engage community leaders, non-profit agencies, PLWH, and other community members to identify and to address barriers that prevent testing and person-centered care.

Tactic	Location	Community	Source
Conduct focus groups or public forums. Identify trusted leaders in the community, churches, and tribes to take the lead. Identify local care providers willing to participate.	Worthington	Southwest	Workshop
Identify trusted leaders as champions for integrated care that minimizes stereotyping. Include youth as leaders.	Worthington	Southwest	Workshop
[Hold] community conversations like you did for continued or ongoing conversation.		African-American	Survey
[Engage community-based individuals.] I will be repetitive. Just as one person cannot run another person's home effectively, so outside-of-the-community experts cannot address local community and individual needs effectively.		African-American	Survey

Tactic	Location	Community	Source
Engage African-American leaders to target test their own community. Educate them about how to teach about HIV and then let them educate other folks of color.		African-American	Survey
[Use] social media for the biggest impact. Those communities that are at higher risk could and would be introduced to information on HIV in their local community. Since it is social media it would be able to be utilized without "outing" someone in public.		African-American	Survey
[Engage] community health workers (CHW) and Minnesota Local Public Health Association (MLPHA) [in] conversations with leaders.		African-born	Survey
[Provide] training on basic HIV/AIDS issues and stigma to community leaders, religious leaders, and other leaders. They should know how to respond to an HIV/AIDS problem when it arises in their community and be able to counsel, refer, and connect [community members] with service providing organizations.		African-born	Survey
Give them the skills to advocate and ask for [what they] want [and] need; listen.		African-born	Survey
[Engage community-based individuals.] Just as one person cannot run another person's home effectively, so outside-of-the-community experts cannot address local community and individual needs effectively.		African-born	Survey
[Host a] one-day seminar with continuing education credits for attending.		Northwest	Survey
[Hold] targeted community conversations that include contacts not immediately identified as partners (i.e., outside of other local planning) or [have] strategic involvement with regular local community health needs assessments. [Engage] with public health and local hospitals to identify HIV/AIDS strategies that connect with other general priorities set by the community.		Southeast	Survey
Build a community of practice [which is a] frequently meeting group of stakeholders to learn from each other and engage in strategic problem solving.		Youth	Survey

Strategy 2.3: Dedicate adequate resources to populations of color hardest hit by HIV to eliminate health inequities.

Tactic	Location	Community	Source
Conduct community engagement with populations hardest hit by HIV to learn what they wish the tactic would be to remedy their situation.		African-American	Survey
Provide face-to-face interactions and phone line assistance. Allocate more funds to areas where the targeted populations live. [Have] full-time outreach efforts within the community with people who look like them.		African-American	Survey
[Increase] funding. [Use] Medical Assistance billable services.		African-American	Survey

Tactic	Location	Community	Source
Have HIV positive individuals speak at various agencies serving people of color. Give free education, condoms, and syringes.		African-American	Survey
Have a cocktail hour with free drinks to entice people to the location where a presentation can occur.		African-American	Survey
Talk to people who are receiving public benefits. Education is key.		African-American	Survey
Include those that are hardest hit in advisory group capacities.		Central	Survey
[Conduct] outreach [with] culturally specific staff [who are] embedded in the communities that are not receiving the same services or lack the education to know about the services.		Gay/Bisexual Men of Color	Survey
Connect with organizations that are representative of and responsive to populations of color.		Northeast	Survey

Strategy 2.4: Reduce HIV-related stigma, systemic racism, and other forms of structural discrimination that prevent people from accessing HIV

Tactic	Location	Community	Source
Hold leaders accountable. Call out leaders and vote them out if they are not following through with promises. Use your vote! Show up to meetings and workshops.	Metro	African-American	Workshop
Add HIV to general conversations. Talk openly about it without shame, like talking to people about other health concerns like blood pressure.	Metro	African-American	Workshop
[Form a] Community Advisory Committee.	Metro	Gay/Bisexual Men of Color	Workshop
[Provide] diverse representation for [grant application] reviewers.	Metro	Gay/Bisexual Men of Color	Workshop
Include people in service delivery. “Nothing about us without us.”	Metro	Hispanic	Workshop
Take down systems, shift cultural norms, address white folks--white people need to hold others accountable. “Dear White People.”	Metro	Hispanic	Workshop
[Address] systemic racism. Go where people are to exchange needles—do not just do the service at white agencies or by white people. Go to agencies of color [to implement] needle exchange. Bring people to the table to make better decisions.	Metro	PWID	Workshop
[Decrease] structural discrimination. Decriminalize possession of syringes and narcotics through legislation.	Metro	PWID	Workshop

Tactic	Location	Community	Source
Hire from the transgender community.	Metro	Transgender	Workshop
Develop medical strategies that are conducive to the patient's life and needs as a transgendered individual.	Metro	Transgender	Workshop
[Ensure that] all AIDS Service Organizations (ASOs) acknowledge that different communities have different perspectives. There need to be more culturally responsive services.	Metro	White Gay/ Bisexual Men	Workshop
Modify legislation around HIV criminalization laws to reflect modern science. [Legislation] currently requires disclosure of status or condom use. It should include pre-exposure prophylaxis (PrEP), Undetectable= Untransmittable (U=U), etc. Syringe access should be mandated.	Metro	White Gay/ Bisexual Men	Workshop
[Engage] individuals who know the African-born cultures.		African-born	Survey
[Produce] more media about the changes in HIV. People are still stuck in the 1980s about transmission. [There are] patients [who] refuse to set up local primary care because they believe they will experience discrimination. [Provide] education on professional confidential laws. Educate the population about the importance of primary care.		African-born	Survey
Education.		African-born	Survey
[Increase] education/engagement/awareness!		Gay/Bisexual Men of Color	Survey
Require racial equity training for large organizations doing this work.		Gay/Bisexual Men of Color	Survey
Offer community education and [create] media campaigns that address HIV stigma.		Hispanic	Survey
[Have] HIV information including medication, appointments, and insurance information available in Spanish.		Hispanic	Survey
Attempt to normalize the conversations.		South Central	Survey
Bring a variety of people to the table and educate them - this is the most important piece in addressing issues about HIV stigma, racism and structural discrimination on a systems level. People do not want to discuss the role racism, stigma, and other discrimination/oppression plays in not only "othering" certain communities, but also perpetuating these public health crises. This is mostly because the general community, of both professionals and the public, do not believe that these issues exist in their community unless they are directly impacted by it. This is very dangerous.		West Central	Survey
Provide information to broader audiences to encourage diversity.		West Central	Survey
Have pastors and local politicians openly use the term "HIV" to break down the stigma.		West Central	Survey
Education.		White Gay/ Bisexual Men	Survey

Recommended Tactics for Goal 3: Increase Retention in Care for People Living with HIV

Strategy 3.1: Employ high-impact public health approaches to identify and to re-engage individuals who are out of HIV care and treatment.

Tactic	Location	Community	Source
Develop a referral process to local public health by MDH.	Mankato	South Central	Workshop
[Provide] holistic nurse case management with medication administration, education, referral to services, and care coordination.	Mankato	South Central	Workshop
Have a case worker contact people directly.		White Gay/ Bisexual Men	Survey

Strategy 3.2: Ensure person-centered strategies that support long-term retention in care.

Tactic	Location	Community	Source
Provide resources and support around individually personalized strategies to providers and their support staff that accept the care of HIV positive clients.		South Central	Survey
Provide connection to case managers throughout HIV care and treatment.			Focus groups
Provide support groups for PLWH.			Focus groups
Provide patient education about medications.			Focus groups

Strategy 3.3: Provide culturally and linguistically appropriate services, as well as gender and sexual orientation appropriate services in clinical and/or community support settings.

Tactic	Location	Community	Source
Hire more staff who reflect the community they serve.	Metro	African-American	Workshop
[Create] culture-specific agencies, organizations, referral services.	Metro	African-American	Workshop
[Provide] funding that focuses broadly on men--we can get rid of a lot of the labels and this will help us reach a broader community.	Metro	Gay/Bisexual Men of Color	Workshop
[Work with] church outreach programs. Men of color talking about sex with men with church leaders and community representation.	Metro	Gay/Bisexual Men of Color	Workshop

Tactic	Location	Community	Source
Provide more formalized training for interpreters on HIV, and more training on HIV across the board. In conjunction with training on HIV, have education for the community and the providers on respecting transgender and LGBTQ community (lots of stigma in the Hispanic community - the biggest issue is with elders and newcomers to the country).	Metro	Hispanic	Workshop
Build a network to share information - a holistic approach across organizations to provide information on resources like housing, mental health, chemical dependency, eating habits, etc. Share learning across cultural communities.	Metro	Hispanic	Workshop
Make it a requirement for providers/practitioners to go through an immersive, intensive cultural competence training where that individual is then the minority.	Metro	Youth	Workshop
Create requirements, where possible, for providers/practitioners to be from that community.	Metro	Youth	Workshop
[Provide] more community resources for those with Anuak language for meeting basic needs such as county services. Anuak interpreters are difficult to find, and language is very important for medical care.		African-born	Survey
[Make] health navigators available to newly diagnosed patients.		African-born	Survey
Speak to functional African-born HIV/AIDS related agencies in Minnesota.		African-born	Survey
Provide cultural sensitivity training to staff (including front desk folks, janitorial staff, and even executive directors).		African-born	Survey
[Identify] a community outreach worker who is trained and can bring the message to their own community and be the liaison with the medical community.		Southwest	Survey
[Improve] education, translation, and patient advocacy. [Implement] audio/visual services since many patients cannot read or write in their own language.		Southwest	Survey
[Hire] well-trained staff able to offer empathy and support in a caring non-judgmental way.		Southwest	Survey

Strategy 3.4: Identify and reduce barriers to accessing mental health and substance use services and care.

Tactic	Location	Community	Source
[Have] navigators (health, basic needs, etc.) for PLWH while using a person-centered approach. This person can address individual needs and connect them to appropriate services.	St. Cloud	Central	Workshop
Set minimum benefits for mental health and substance abuse. [Ensure they are] provided, seamless, and uniform.	St. Cloud	Central	Workshop
Offer ongoing mental health/substance use care and supports to PLWH regardless of exposure category. Provide comprehensive assessment and immediate referrals for integrated care.	Metro	PWID	Workshop

Tactic	Location	Community	Source
Increase peer supports and case management for PLWH with mental health and substance use issues.	Metro	PWID	Workshop
Reduce stigma through a provider outreach initiative. Link providers to groups who are not accessing care.	Mankato	South Central	Workshop
Increase awareness among providers. Educate [to improve] provider competency. [Teach providers to use a] standardized screening process [for mental health and substance abuse issues].	Mankato	South Central	Workshop
Integrate on-demand treatment into HIV care.		PWID	Survey
MDH and insurance carriers need to provide coverage for [mental health and substance abuse] services. Offer incentives to caregivers if they provide services.		South Central	Survey
Recruit additional mental health providers for rural Minnesota even if through tele-medicine.		South Central	Survey
[Implement] legislation and [provide] funding to support this important area.		South Central	Survey
Identify where patients can find free or low-cost (and ideally Spanish speaking) mental health and substance use services and care.		Southeast	Survey
Work through legislation to enact bills to ensure access.		Southeast	Survey
[Address the] long wait to be seen by a therapist and lack of affordable mental health services.		Southwest	Survey
[Implement] more incentives for mental health providers and substance abuse help. There is often a lack of resources in greater Minnesota--namely the number of providers able to help due to burnout and low numbers of this profession graduating with degrees in this field.		Southwest	Survey
Provide statewide percentage reimbursement of student loans for those who are trained as counselors and will serve within this capacity for a set amount of time.		Southwest	Survey
Develop mental health and substance abuse programs and facilities for southwest Minnesota.		Southwest	Survey
Provide connection to mental health services throughout HIV care and treatment.			Focus groups

Recommended Tactics for Goal 4: Ensure Stable Housing for PLWH and Those at High Risk for HIV Infection

Strategy 4.1: Identify gaps in affordable housing statewide.

No tactics were recommended for Strategy 4.1.

Strategy 4.2: Build partnerships that increase the supply of safe, affordable housing units for PLWH and those at high risk of HIV infection.

Tactic	Location	Community	Source
Build relationships with/educate landlords and property managers around low-income housing to create flexibility for tenants (e.g., lower requirements for credit if people can show they are working on it).	Bemidji	Northwest	Workshop
Build/renovate/utilize tax credit housing to increase housing supply through Minnesota Urban and Rural Homesteading Program (MURL) type programs, Habitat or other rehab/building programs. Allow tax credit housing projects in greater Minnesota.	Bemidji	Northwest	Workshop

Strategy 4.3: Ensure that PLWH and those at high risk of HIV infection have access to necessary supports that maintain their housing stability.

Tactic	Location	Community	Source
Co-locate services (e.g., Project for Pride in Living or Rise within Aliveness, JustUs Health, etc.) to be people-centered.	Metro	White Gay/ Bisexual Men	Workshop
Help people navigate employment and staying employed; this increases self-worth and income (and allows someone to pay rent), helps with access to insurance and care. People are afraid to work and lose benefits. Ryan White funds can't go to employment services, and this creates a gap.	Metro	White Gay/ Bisexual Men	Workshop

Strategy 4.4: Secure long-term, sustainable resources to meet the growing need for affordable housing and supportive services.

Tactic	Location	Community	Source
[Provide] flexible funding for rent (e.g., [a] pool of funds).	Metro	African-American	Workshop
[Offer] scattered-site housing, chosen by people living with HIV/AIDS.	Metro	African-American	Workshop
Advocate for changes in policy.	Duluth	Northeast	Workshop

Tactic	Location	Community	Source
Obtain long-term funding for established programs and services.	Duluth	Northeast	Workshop
[Provide] support services attached to housing support to increase retention. [Start] "de-siloing services" and making them more accessible.	Metro	PWID	Workshop
[Implement] looser eligibility requirements (Housing first, harm reduction housing). Increase flexibility in funding. Have tighter network of housing resources and increase [their] congruence.	Metro	PWID	Workshop
Allow for financing at a legislative level to provide housing/resources for long-term homelessness. [Use] Minnesota Housing Tax Credit financing. Expand the target population for supportive housing from just high priority homeless population to a broader array.	Metro	Transgender	Workshop
Continue to build and keep money going into the right areas/organizations/agencies that are already supplying supportive housing so that they can expand housing opportunities. Have resources for housing (transportation, food, supplies, etc.).	Metro	Transgender	Workshop
Put public monies into affordable housing and relationship education.		Northeast	Survey
Educate everyone, but particularly policy makers, about the real scope of the challenge. For example, there are 665 households on waiting lists for affordable housing in Duluth, but due to lack of resources, we build about 12 units a year. Enlist the private builders who know about cost control in the construction phase. Use cost control mechanisms in the private market and in the subsidized market (use modularized/panelized systems; build with metal frame instead of wood, etc.). Plan for scale - figure out how to build 10, 50-unit buildings over 5 years and fund that rather than a building every other year.		Northeast	Survey

Recommended Tactics for Goal 5: Achieve a More Coordinated Statewide Response to HIV

Strategy 5.1: Create a leadership structure that is held accountable for implementing and updating this strategy. This leadership structure will include key stakeholders that this strategy affects, such as government leadership, CBOs, PLWH, and Minnesota residents that the HIV epidemic hits hardest.

No tactics were recommended for Strategy 5.1.

Strategy 5.2: Integrate HIV prevention, care and treatment throughout all sectors of government (e.g., health, human services, education), health care systems, and social services.

Tactic	Location	Community	Source
[Offer] routine testing for new immigrants/students/visa holders in Minnesota.	St. Cloud	Central	Workshop
Create a regional HIV coordinator [position] and have state link reported cases to regional HIV coordinator. This would be a resource for patients and providers—one HIV contact number for each region.	St. Cloud	Central	Workshop
[Provide] ongoing professional education through webinars and conferences.	Mankato	South Central	Workshop
Build on existing coalitions and networks.	Mankato	South Central	Workshop
Conduct a gaps analysis for what exists for curriculum and resources so that we can identify all organizations working on HIV. Build a list of organizations and an updated resource guide.	Rochester	Southeast	Workshop
Build partnerships across sectors (local health, colleges, mobile testing, housing providers, corrections, treatment, medical providers)—efforts are being duplicated. Get people at the same table via convening, conference, and/or co-location.	Rochester	Southeast	Workshop
[Provide] state support to try to get schools talking about HIV and standardized sex education.	Worthington	Southwest	Workshop
Develop relationships across sectors and have conversations. Frame it in a way so that it matters to others like JBS.	Worthington	Southwest	Workshop
Integrate HIV related services (syringe exchange, testing, condoms, sex education) into all health care facilities. Everyone deserves access to condoms, testing, and clean syringes at the very least.		Gay/Bisexual Men of Color	Survey
Have advocates and agencies serving PLWH participate in the Continuum of Care to ensure that the homeless response system is integrating the prevention, care, and treatment that it can/should.		Southeast	Survey
Start from the top down.		Southeast	Survey

Strategy 5.3: Identify, research, and replicate new, effective interventions through partnerships between local public health and state governments, tribal nations, HIV providers, community-based and religious organizations, the University of Minnesota and other academic institutions, research partners, and others.

Tactic	Location	Community	Source
Provide resources for organizations to work together to plan social events and educate (not just for World AIDS Day).	Metro	African-American	Workshop
Talk with community, church, and political leaders to educate them and learn what is working or is not working.	Metro	African-American	Workshop
[Provide] capacity funds for public [messaging] of prevention, care, and treatment services. [Conduct] outreach to other service providers.	Mankato	South Central	Workshop
Develop an inventory of best practices in other states. MDH/DHS take the lead to collect and or compile these resources/best practices.	Mankato	South Central	Workshop

Strategy 5.4: Establish policies that encourage an innovative culture and delivery of comprehensive statewide services. An innovative culture includes recognizing that prevention and treatment options evolve and leadership must be willing to respond to new technologies to reduce HIV burden.

Tactic	Location	Community	Source
[Develop] targeted web-based outreach to Latino MSM with incentives for testing.	Metro	Hispanic	Workshop
[Provide] telemedicine for HIV care and PrEP (can be bilingual).	Metro	Hispanic	Workshop
Increase Community Health Worker (CHW) and Public Health Nurse (PHN) staffing for outreach, education, testing opportunities.		Hispanic	Survey
[Communicate about innovation.] There may be innovation but unless there is a comprehensive communication to others, it is not known.		Youth	Survey
Explore the possibilities of telemedicine/telehealth in treating HIV patients.			Focus groups

Strategy 5.5: Create effective information sharing partnerships and systems that produce reliable data and that inform decision-making, strategy development, and program accountability.

Tactic	Location	Community	Source
Provide capacity-building, operating funds for small grassroots community-connected organizations to better compete for grants.	Metro	Transgender	Workshop
Provide funding that is "open-source" (organizations define own goals, restrictions not imposed by grants). DHS, MDH, CDC pool funding and streamline process for grantees. Unify grant application process [to have] "coordinated entry" for grants.	Metro	Transgender	Workshop
Provide capacity building, operating funds for small grassroots community-connected organizations to better compete for grants.	Metro	Transgender	Workshop

Appendix F: References

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