Addendum to the Minnesota HIV Strategy: A Comprehensive Plan to End HIV/AIDS *END HIV MN*

September 2022

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

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Acronyms

Please refer to Appendix B: 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

Rationale

This is an Addendum to END HIV MN, the comprehensive long-term plan to end new HIV infections and improve health outcomes for people living with HIV in Minnesota. Minnesota HIV Strategy: A Comprehensive Plan to End HIV/AIDS (END HIV MN or the strategy) was launched in January 2019.

Administrative Responsibility 5 of END HIV MN requires the state to develop and implement a process for ongoing review and reprioritization of tactics. The responsibility details that it should be an "ongoing two-year process" that includes returning to the regions and communities that helped prioritize the original tactics to gather input on what's worked, what hasn't, and what's missing.

Overall, reprioritizing the tactics on a regular basis ensures that the state's efforts to end HIV are:

- guided by the lived experiences of people living with HIV and the expertise of frontline providers;
- responsive to changes over time, such as the COVID-19 pandemic or recent HIV outbreaks; and
- focusing resources on areas where the state can have the greatest impact.

Engaging community members and people affected by END HIV MN is also an opportunity for them to:

- see the state taking accountability and being transparent;
- feel ownership and a sense of partnership with the state; and
- have a positive experience partnering with the state wherein they feel heard.

Update on progress of the initial priority tactics

The initial focus of END HIV MN was on the following ten priority tactics:

- **PROVIDER EDUCATION and TRAINING:** Implement provider education and training. The training should benefit all types of providers (e.g., primary care, specialists, nurses, interpreters). The training should focus on evidence-based, behavioral, and biomedical interventions for HIV prevention and care, as well as cultural competence.
- **AWARENESS CAMPAIGNS:** 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.
- **COMMUNITY OUTREACH:** Increase education and outreach to culturally specific communities.
- **PREVENTION EDUCATION:** Implement comprehensive HIV prevention and sex education in and beyond public schools.
- **CAPACITY BUILDING:** 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.

- **INCLUSION:** Increase meaningful inclusion of voices of disproportionally affected populations in decision-making about HIV programs and funding.
- **WRAPAROUND SUPPORTS:** Enhance wraparound supports for people at risk of dropping out of care.
- **HOUSING SUPPORT:** Support implementation of Minnesota HIV Housing Coalition's HIV Housing Plan.
- **INVENTORY EFFORTS:** 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.
- **TELEMEDICINE:** Develop a regional telemedicine model to ensure the adequate provision of care and prevention services.

Impacts of COVID-19 pandemic

Many staff from the Minnesota Department of Human Services (DHS) and Minnesota Department of Health (MDH) whose work was integral to implementing the initial activities of END HIV MN were reassigned to coronavirus response efforts in 2020 and 2021.

The pandemic response shifted the work for state staff who work on HIV prevention and care. This required MDH and DHS to make changes to business as usual, including:

- Making critical changes to the Program HH/AIDS Drug Assistance Program to ensure that eligible clients continued to receive HIV medications.
- Providing funding so that clients could receive additional food vouchers and personal protective equipment for themselves and their family members.
- Providing guidance and flexibility to partner organizations who had to adapt their service delivery models.
- Working with the AIDSLine to maintain an HIV/AIDS Community Services Directory throughout the pandemic, so that people had a centralized place to find up-to-date information.

Completed priority tactics

Between 2019 and 2021, the activities of END HIV MN under the following two priority tactics were completed.

Housing support

DHS provided requested funding and other support for implementation of the Minnesota HIV Housing Coalitions HIV Housing Plan 2017. The state's ongoing commitment to the HIV Housing Plan continues.

Inventory efforts

DHS and MDH worked with Management Analysis and Development (MAD), a consulting firm housed in Minnesota Management and Budget (MMB), to develop an internal, electronic database of providers, programs, and organizations across Minnesota whose work is directly or indirectly aligned to the goals of END HIV MN.

Priority tactics that are now core work

The work of the following initial priority tactics will continue moving forward as part of MDH and DHS's existing portfolio of HIV care and prevention work. Below are some brief highlights of what has been accomplished so far in these areas.

Provider education and training

In 2021, the state hosted two virtual town hall events on the HIV outbreaks in Minnesota and two virtual provider professional development days targeting HIV care and prevention providers. In 2022, virtual provider learning series on the HIV outbreaks in Minnesota (formerly called virtual town hall events) have continued, and further provider education efforts are being planned now that the MDH HIV Nurse Specialist is back from full-time COVID-19 reassignment.

Awareness campaigns and community outreach

DHS and MDH sponsored the development of an HIV awareness toolkit, featuring people in Minnesota who are living with HIV or who are on PrEP. MDH and DHS also partnered on using some of the initial images and messaging in advertisements about U=U and PreP. In 2022, the HIV Prevention, Care, and Anti-Stigma Social Media Toolkit was released. Dependent on resource availability, DHS will be funding grants for culturally and community-specific organizations to use the Toolkit or to develop their own messaging campaigns. DHS is also exploring options to support an Ambassador Program to train, support, and provide the technology that individual advocates need to fight stigma and share information about HIV care and prevention.

Capacity building

A series of key informant interviews were done with previous, existing, and potential HIV care and/or prevention grantees. The findings from these interviews resulted in changes to the RFP process for the most recent DHS Ryan White grant opportunity, to make the process more equitable. MDH will be incorporating the feedback and making changes to their future RFPs, as well.

DHS and MDH are exploring the feasibility to offer non-competitive HIV grants to tribal nations, as participants in the interviews said that competitive RFPs do not honor the sovereign-to-sovereign relationship with tribal nations.

Grant funding will be available in the future from MDH for small or yet-to-be-formalized community-based organizations to develop capacity to take on more HIV grant funding in the future. This new grant opportunity is in response to input from smaller, culturally specific organizations for whom the traditional RFP process has not been equitable in the past, often because they may lack the infrastructure to apply for and manage grants.

Inclusion

DHS, MDH, and Hennepin County conducted a Partner Engagement Survey, which gathered input from staff at community-based organizations on how the agencies could more effectively engage partners. The survey also asked for input on how the agencies can better engage people with lived experience.

When new federal funding became available in response to the pandemic, DHS worked with partner organizations to survey people living with HIV and used that input to directly inform funding decisions.

MDH and DHS have processes and policies in place to support their commitment to paying people with lived experience for sharing their time and expertise.

In 2022, MDH and DHS will work with the current END HIV MN Advisory Board on plans to add more people with lived experience to the advisory group.

Wraparound supports

DHS has been piloting outreach case management, which helps people overcome eligibility barriers for HIV case management. The agency plans to expand outreach case management in the future. Additional funding is also being used for emergency financial assistance, food vouchers, housing support, and case management.

Priority tactics that could not be completed

There were two initial tactics of END HIV MN where the planned activities were not able to be completed.

Prevention education

As written, the activities of this tactic required a partnership with the Minnesota Department of Education (MDE). MDH and DHS were unable to partner with MDE, both because of capacity issues on MDE's end, especially once the pandemic had such a substantial impact on public education. This work was also not possible because generating support and funding from the legislature was not feasible. While the need for comprehensive sex education in public schools persists, this effort is likely to require advocacy at the state legislature, first.

Telemedicine

Once health care began shifting rapidly in response to the pandemic, it became clear that the activities, as written, in END HIV MN to develop a regional telemedicine model needed to be paused.

Reprioritization process and engagement input

Overview of the engagement process

From August to October 2021, MDH and DHS reviewed input the agencies received in the time since END HIV MN was adopted in early 2019. They also reviewed the progress that had been made on the initial priority tactics (Appendix A).

Based on this work, MDH and DHS identified the following as potential new priority tactics:

- Innovative service delivery
- Harm reduction
- PrEP access and retention
- Capacity development in areas with urgent unmet needs
- Staff reflective of the community
- Community-driven messaging
- Authentic engagement
- Culturally humble and trauma-informed providers
- Greater Minnesota
- Youth and older adults
- Ryan White services
- Mental and chemical health
- Basic needs
- Incentives for care
- Housing for all
- Communication and data sharing

MDH and DHS staff got feedback on this list from the Government HIV Administration Team, the DHS–HIV Supports Section, Executive Directors of the Minnesota HIV/AIDS Service Organization, the END HIV MN Advisory Board, the Minnesota Council for HIV/AIDS Care and Prevention Disparities Elimination Committee, and culturally specific organizations before moving forward with the next phase.

In November and December 2021, with support from Management Analysis and Development (MAD), MDH and DHS hosted a series of online engagement sessions to get broader input and prioritize the potential tactics.

At these meetings, participants heard about the progress of END HIV MN so far and provided feedback on the list of potential tactics identified in Phase 1, identifying what they thought should be the highest priorities for the next two years (2022–2024).

There were eight different sessions offered, organized around the type of participants:

1. Health care
2. Prevention and education

3. Harm reduction
4. Government partners
5. Ryan White providers
6. Consumers and people with lived experience
7. Other health and social service professionals
8. General session (open to all)

During the same period, MAD administered an online survey to gather similar input and feedback from interested participants who were not able to attend one of the online meetings. The survey was promoted during World AIDS Day activities in December.

In total, 67 people attended at least one of the engagement sessions in November or December. Eleven people participated in the online survey.

Table 1. Demographics of participants in the reprioritization process

Self-identified as a/an…	Percent of participants
PLWH, person taking PrEP, advocate, or ally	26%
HIV educator, PrEP navigator, or similar	38%
Doctor, nurse, PA, NP, pharmacist, or similar	10%
Syringe service provider, substance treatment provider, peer support specialist, or similar	26%
Ryan White provider	26%
Government partner (fed, state, local)	29%
Other health or social service provider	9%

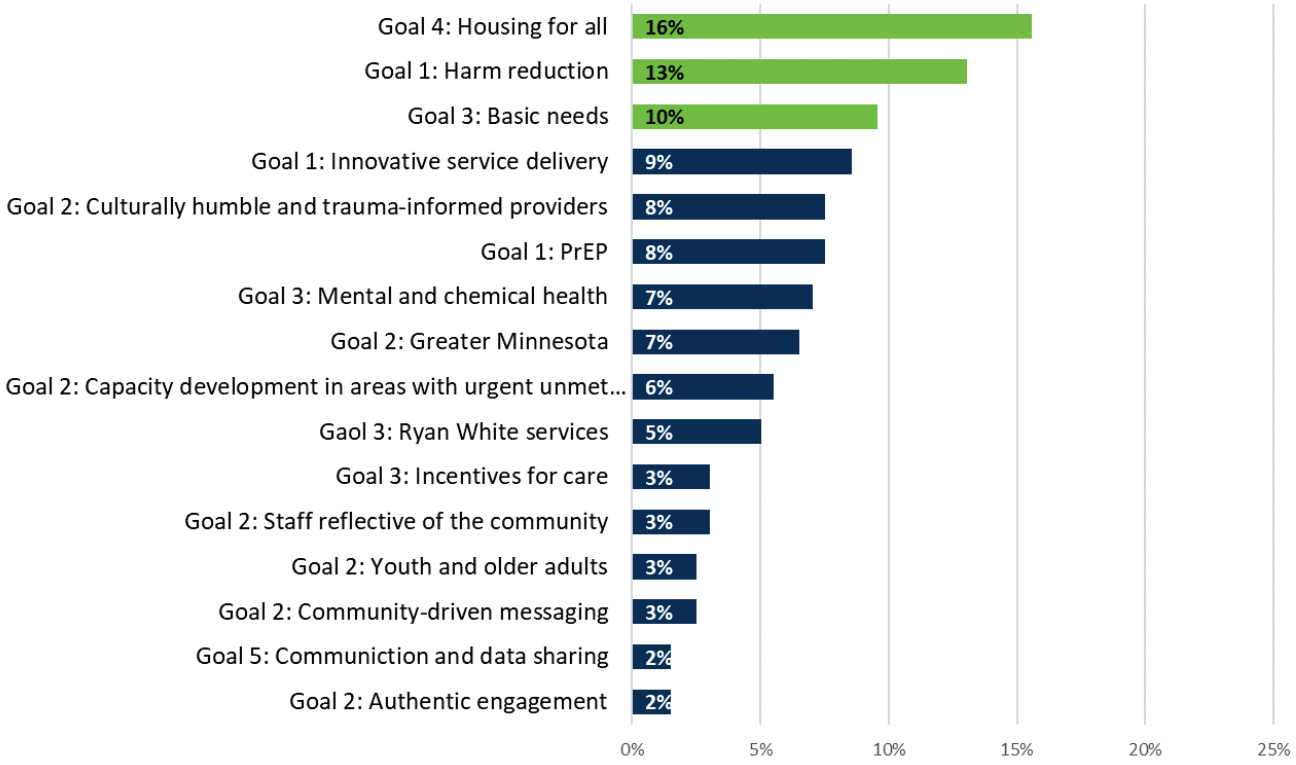
Engagement input

Voting on potential priority tactics

When asked which potential priority tactics were the most important for the state to focus on for the next two years, engagement participants voted most often for:

1. Housing for all
2. Harm reduction
3. Basic needs

Figure 1. Voting results from Phase 2 engagement



Other input received during discussions with participants

Below is a summary of what came up most often in discussions with participants at the engagement sessions.

Focus on people who are unhoused and people who use drugs

- The current outbreaks show where the most work needs to be done, both for prevention and increasing retention in care.
- People cannot focus on their health when they are struggling to meet their basic needs for shelter, food, and safety. That must be addressed first.
- Housing is a key lever for change, but the current system is burdensome, with high barriers.

Harm reduction is more than Syringe Service Programs (SSPs)

This potential tactic was drafted as: "Increase resources and support for existing syringe service programs (SSPs) and support development of new SSPs," but participants said:

- If there is a tactic focused on harm reduction, it needs to encompass more than just SSPs.
    - Harm reduction should be used as an overall approach or philosophy.
    - Harm reduction needs to include safe smoking supplies.
- Not being able to use funding to purchase syringes is a big barrier.

Tactics overlap and are related

While some of the tactics weren't always selected as participants' top three most important, many are related and need to work hand in hand.

- Training for providers on trauma-informed care needs to address harm reduction.
- Access to mental and chemical health services is essential to meet people's basic needs and help folks who access housing to remain housed.

Analysis and decision-making

The above input was presented to the END HIV MN Advisory Board in January 2022.

With additional feedback from the Advisory Board, MDH and DHS staff developed a list of recommended new priority tactics, as well as three new recommended operating principles for the strategy. Input was also gathered from the Minnesota HIV Housing Coalition's HIV Housing Plan Work Group, specifically on the Housing tactic. Based on this feedback, additional revisions were made to the wording and intention of some of the new priority tactics.

The Advisory Board approved the new operating principles and priority tactics in February. DHS and MDH staff are currently working to complete an implementation plan for the new priority tactics, which will be presented to the Advisory Board in August 2022.

Updated operating principles

END HIV MN was built on three operating principles first developed by the Advisory Board in 2017. Operating principles are the lens through which MDH and DHS approach implementation of the tactics and activities of the Strategy. The END HIV MN Advisory Board approved adding three additional operating principles starting in 2022.

- **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.
- **(NEW) A strategy that meaningfully includes people most impacted in decision-making.** People living with HIV and people most at risk for infection are the experts on their own experiences and what is

necessary to end the HIV epidemic. Decisions made as part of implementing the Strategy must start by centering the voices of people who will be impacted by that decision.

- **(NEW) A strategy that centers the foundational principles of harm reduction.** The Strategy recognizes that harm reduction is an effective public health model for reducing the spread of infectious diseases, including HIV. The Strategy will not achieve its vision without meeting people where they're at and without applying harm reduction principles when implementing the activities of the Strategy.
- **(NEW) A strategy that acknowledges solutions must be tailored to meet the needs of different geographic areas.** People living with HIV and who are at risk of infection who live in rural areas of Minnesota have different needs and face different challenges than people living in large, metropolitan areas of the state. The solutions to end the HIV epidemic in Minnesota cannot be one-size-fits-all, but instead must be tailored to the specific needs of each geographic community.

Reprioritized tactics

Based on input received regarding current areas of need and the greatest barriers to ending the HIV epidemic in Minnesota, the END HIV MN Advisory Board approved focusing on the following eight priority tactics for new or enhanced efforts in 2022–2024.

Each of them aligns with a specific goal and strategy within END HIV MN. Some of them also overlap across goals and strategies. This alignment to goals and strategies, in addition to current activities, is included in Appendix A: Updated Goals, Strategies, and Tactics.

- **BASIC NEEDS:** Address people's basic needs for food, shelter, and safety to support prevention and adherence, linkage to care, and retention.
- **CAPACITY DEVELOPMENT IN AREAS WITH URGENT UNMET NEEDS:** Increase capacity within the service system to address the needs of people who are unhoused and/or who use drugs.
- **CULTURALLY HUMBLE AND TRAUMA-RESPONSIVE PROVIDERS:** Update, revise, or develop provider education and training to include a consistent focus in all training on cultural humility and trauma-responsive practices, including using harm reduction principles and practices, and serving people who use drugs. Training should be differentiated for providers who serve clients in Greater Minnesota.
- **HARM REDUCTION:** Increase availability, access, and use of harm reduction practices that prevent HIV infections, including and beyond syringe services programs. Target areas in Greater Minnesota and tailor implementation to meet the needs of providers serving people in rural areas and on tribal lands.
- **HOUSING FOR ALL:** Increase access to housing and support retention in stable housing for PLWH and those at risk of infection. Acknowledge that burdens differ for people depending on where in Minnesota they live.
- **INNOVATIVE SERVICE DELIVERY:** Support the development and expansion of telemedicine and other innovative service delivery models to ensure PLWH and people at risk of infection can access the care and services they need, when they need it, wherever they are (e.g., RAPID ART, service integration, mobile medicine).
- **MENTAL AND CHEMICAL HEALTH:** Address barriers that prevent PLWH and people at risk for infection from accessing mental and chemical health services.

- **STAFF REFLECTIVE OF THE COMMUNITY:** Increase hiring and retention of staff at state agencies, providers, and community-based organizations (CBOs) with lived experience and who reflect the communities being served.

2022–2024 Priority Tactic Action Plan

Below are the specific actions that DHS and MDH will take separately and in conjunction to achieve the goals of END HIV MN through the newly reprioritized priority tactics.

1.1.1: Culturally humble and trauma-responsive providers

Update, revise, or develop provider education and training to include a consistent focus in all training on cultural humility and trauma-responsive practices, including using harm reduction principles and practices, and serving people who use drugs. Training should be differentiated for providers who serve clients in Greater Minnesota.

Action	Responsible agency
Include completion of training and demonstration of cultural humility and respect for others as part of internal state agency staff annual reviews; work to expand this requirement to subrecipients.	**DHS + MDH**
Assess internal state agency policies and systems and make revisions to ensure the system is LGBTQ+ friendly (e.g., expanded gender categories in information systems).	**DHS + MDH**
Develop a model for cultural humility and trauma-responsiveness training for DHS and MDH staff who work on HIV prevention and care; explore expanding such a model to train providers/grantees.	**DHS (lead) + MDH**
Host conversations and trainings where community members are the experts in the room (e.g., HIV Tester Training) that are regionally specific, with folks from that community.	**DHS + MDH**
When updating HIV Minimum Standards in 2022, work to include requirements for staff training on cultural humility and trauma-responsiveness.	**DHS**
Update existing or planned provider and community trainings to include focus on cultural humility and trauma-responsiveness (e.g., Provider Professional Development, MATEC trainings/Town Halls).	**DHS**
Explore using HIV and Substance Use training as a model to expand to other sectors (e.g., mental health professionals).	**DHS**
Explore how to advocate for updated gender categories in EvaluationWeb.	**MDH**
Add training or education for staff on harm reduction to MDH grantee requirements.	**MDH**

1.4.1: Harm reduction

Increase availability, access, and use of harm reduction practices that prevent HIV infections, including and beyond syringe services programs. Target areas in Greater Minnesota and tailor implementation to meet the needs of providers serving people in rural areas and on tribal lands.

Action	Responsible agency
Continue building relationships with tribal nations to expand partnerships that support increased Ryan White and Prevention programing focused on harm reduction and HIV care and supportive services.	**DHS + MDH**
Assess awareness, knowledge, and comfort discussing harm reduction and making referrals among infectious disease medical care providers, housing and shelter providers, and culturally specific organizations.	**DHS + MDH**
Explore ways to expand state support for harm reduction beyond SSPs (e.g., safer smoking supplies, medication treatment).	**DHS + MDH**
Expand Outreach elements of Case Management to reduce access barriers, meet people where they are at, and better support folks who are actively using drugs and alcohol.	**DHS**
Continue working with tribal nations on Joint Powers Agreements related to infectious diseases.	**MDH**
Engage with SSPs and other providers to assess current demand and providers' ability to meet that demand.	**MDH**
Implement a DIS role that specializes in working with people who use drugs.	**MDH**
Explore funding opportunities for SSPs and other harm reduction efforts/programs.	**MDH**
Consider and support new possibilities of SSPs and other harm reduction activities, especially in Greater Minnesota (e.g., mail-based distribution, harm reduction vending machines, mobile services, overdose prevention sites, tele-harm reduction).	**MDH**
Coordinate with tribal nations to complete an inventory of SSPs and other harm reduction efforts/programs and locations; understand rules and regulations as they relate to harm reduction (e.g., fentanyl test strips) and interest in providing new or additional harm reduction efforts/programs.	**MDH**
Raise awareness around harm reduction services in shelters/transitional housing spaces, unhoused spaces, and within organizations that specialize in working with unhoused communities (e.g., folks staying in encampment settings).	**MDH**
Stay informed of shelter and transitional housing spaces in Minnesota and around the country that are designed and managed with a harm reduction lens (e.g., Avivo tiny village, CHUM in Duluth); use finding to educate other providers.	**MDH**

2.4.1: Staff reflective of the community

Increase hiring and retention of staff at state agencies, providers, and CBOs with lived experience and who reflect the communities being served.

Action	Responsible agency
Continue work to ensure state agency job postings for roles working on HIV prevention or care do not require unnecessary degrees or types of education.	**DHS + MDH**

Action	Responsible agency
Continue work to make lived experience a minimum or preferred qualification for relevant roles, including for higher levels of state agencies.	**DHS + MDH**
Intentionally recruit state job applicants from the communities being served.	**DHS + MDH**
Require respondents to RFPs to answer questions about the reflection of the intended client base among staff, leadership, and boards.	**DHS + MDH**
Share best practices at grantee and provider meetings from grantees and sub-recipients who are excelling at recruiting and retaining staff who reflect the communities served.	**DHS + MDH**
Research and get input directly from existing staff on how to retain staff.	**DHS + MDH**
Explore retention strategies with MDH Center for Health Equity and develop a statement with the Center on valuing people with lived experience.	**DHS + MDH**
Practice Inclusive Leadership; check in on a regular basis with staff about needs.	**DHS + MDH**
Support emerging leaders in DHS and MDH with their professional development, including through access to NASTAD's Minority Leadership Program.	**DHS + MDH**
Increase awareness among both state and subrecipient human resources staff of the importance of targeted recruitment, continuing to advocate for seeing lived experience and identity(ies) as relevant in hiring decisions to improve screening of applicants.	**DHS + MDH**
Work with state and subrecipient human resources to use culturally relevant recruiting methods through work with Center for Health Equity.	**DHS + MDH**
As Ryan White Service Standards are reviewed, look closely at requirements for staff qualifications, get community feedback, and reduce requirements for unnecessary degrees or types of education where appropriate.	**DHS**
Explore increased partnerships with MATEC to increase reflectiveness of the clinical workforce, with focus on providers of color, in the Duluth area, and throughout Greater Minnesota.	**DHS**
Expand contract requirements regarding organizational diversity, equity, and inclusion efforts and implement reporting/oversight mechanisms.	**DHS**
Continue working with human resources to ensure employment opportunities are posted/advertised in communities reflective of the communities the positions will serve.	**MDH**

3.4.1: Mental and chemical health

Address barriers that prevent PLWH and people at risk for infection from accessing mental and chemical health services.

Action	Responsible agency
Connect with the new Opioids, Substance Use, and Addiction Subcabinet (on which Commissioners of MDH and DHS serve), new Governor's Addiction and Recovery Director, and Governor's Council on Opioids, Substance Use, and Addiction.	**DHS + MDH**
Identify and connect with other State Advisory Councils that are working to address chemical health issues (e.g., Alcohol and Other Drug Abuse Advisory Council; American Indian Advisory Council on Chemical Dependency).	**DHS + MDH**
Organize and offer a follow-up Triple Threat training for state staff, providers, clinicians, and other stakeholders.	**DHS + MDH**

Action	Responsible agency
Continue training providers and stakeholders on the intersection of HIV and Substance Use Disorder; continue to update to curriculum to offer the most current information.	**DHS**
Identify and connect with State Advisory Councils that are working to address mental health issues (e.g., American Indian Mental Health Advisory Council; State Advisory Council on Mental Health; Governor's Task Force and Mental Health).	**DHS**
Complete an analysis of the Program HH Mental Health Benefit to identify options to improve billing and claims processes, understand which providers are currently billing for these services and identify opportunities to increase awareness and utilization of benefit. Explore barriers to accessing chemical health services for Ryan White eligible people and identify options to address barriers.	**DHS**
Explore ways to increase the number of mental health providers who support clients in active use.	**DHS**
Improve or offer an alternative to the provider portal to make it easier (less challenging to navigate) for people to find providers.	**DHS**

3.5.1: Basic needs

Address people's basic needs for food, shelter, and safety to support prevention and adherence, linkage to care, and retention.

Action	Responsible agency
Strengthen relationships within and between state agencies and organizations helping people access services to meet their basic needs.	**DHS + MDH**
Maintain, expand, and share the inventory of efforts to address HIV as a resource for DIS and other state staff, as well as provider staff, to know where services are available and who to refer clients to.	**DHS + MDH**
Train and provide resources to providers and organizations on service referrals.	**DHS + MDH**
Expand linkage and re-engagement services, including additional cultural and language-specific services for linkage, re-engagement, and retention follow-up.	**DHS + MDH**
Review Needs Assessment 2020 data and other survey data to understand unmet basic needs for PLWH.	**DHS**
Develop and refine tools to model impact of expanding basic needs services for PLWH.	**DHS**
Explore ways to increase access to essential services for categorically ineligible PLWH.	**DHS**
Continue strengthening relationships between DISs and providers that are seeing clients during the outbreak and continue close DIS work with agencies serving people who are living in encampments (i.e., Healthcare for the Homeless).	**MDH**

4.1.1: Housing for all

Increase access to housing and support retention in stable housing for PLWH and those at risk of infection. Acknowledge that burdens differ for people depending on where in Minnesota they live.

Action	Responsible agency
Increase coordination between MDH, DHS, and Minnesota Housing (including, but not limited to HOPWA).	**DHS + MDH**
Bring additional awareness to, and better coordinate with, the state Interagency Council on Homelessness and the Minnesota Heading Home Alliance to ensure statewide plans to end homeless explicitly include and address the needs of PLWH and people at risk of infection.	**DHS + MDH**
Provide information to consumers so that they can act as their own self-advocates and navigate the system without needing case management or similar support.	**DHS + MDH**
Increase awareness among PLWH of where and how to access services to obtain or retain housing without needing to disclose their status, especially in Greater Minnesota.	**DHS + MDH**
Support development of a new Minnesota HIV Housing Coalition strategic plan through a consultant position in the RHM contract.	**DHS**
Coordinate with funders as part of the HIV Housing Plan.	**DHS**
Map the housing service system and ensure providers, case managers, clinicians, and others who have contact with PLWH and people at risk of infection know how and where to refer people to region-specific resources.	**DHS**

5.3.1: Capacity development in areas with urgent unmet needs

Increase capacity within the service system to address the needs of people who are unhoused and/or who use drugs.

Action	Responsible agency
Engage with people and communities impacted by the HIV outbreaks, and with providers working with the populations of focus, to prioritize regions and/or services and understand what support/technical assistance is most needed.	**DHS + MDH**
Audit current systems, policies, and practices to identify ways DHS and MDH can reduce barriers to access and retention in care for people who are unhoused and/or use drugs (e.g., Program HH exploring Foundational Service practices; can we stop requiring addresses?; can we provide phones?).	**DHS + MDH**
Make the END HIV MN website a more robust portal with information for the public and providers about the HIV system of prevention and care, including referrals to services, including an online resource for service providers, agencies, and clients to find related services.	**DHS + MDH**
Break down silos and more intentionally engage with other state agency sections/divisions to collaborate and provide trainings (e.g., OD prevention section at MDH, Opioid Response section at DHS; Behavioral Health/SUD section at DHS).	**DHS + MDH**

Action	Responsible agency
Create a Community of Practice for HIV outbreak response that meets and shares resources and best practices to improve service delivery. Include Ryan White providers to ensure there is a "warm handoff" once people are diagnosed (including ADAP and other RWP services).	**DHS + MDH**
Identify existing or potential funding that could be used to support work in this area (e.g., shelter funding; OERAC funding; upcoming RFPs from federal agencies).	**DHS + MDH**
Explore increasing state staff capacity dedicated to working directly or indirectly to support the populations of focus.	**DHS + MDH**
Implement Eligibility Navigators/Specialists (Centralized Eligibility program) in the field to meet clients where they are.	**DHS**
Review Needs Assessment 2020 data and other survey data to understand regional service needs for people who are unhoused and/or who use drugs.	**DHS**
Conduct and/or share research on the health impacts of continual displacement of people staying in encampments and provide a brief or recommendations based on the findings.	**MDH**
Continue documenting and evaluating the current HIV outbreak response to identify learnings and improve.	**MDH**
Continue coordination of active HIV outbreaks responses, such as the Metro and Duluth area, by MDH Incident Command System (ICS) and HIV Outbreak Partner Engagement (HOPE) Group(s).	**MDH**
Develop capacity-building grants to address the needs of smaller organizations with little to no experience with state RFP process.	**MDH**
Include an HIV testing track for people experiencing homelessness in the next RFP.	**MDH**

5.4.1: Innovative service delivery

Support the development and expansion of telemedicine and other innovative service delivery models to ensure PLWH and people at risk of infection can access the care and services they need, when they need it, wherever they are (e.g., RAPID ART, service integration, mobile medicine).

Action	Responsible agency
Document policies and procedures that have supported telemedicine/telehealth and increased access during the pandemic, refine, and formalize.	**DHS + MDH**
Explore ways to develop or support mobile service delivery (e.g., food truck-style services), including pairing mobile services with existing public resources people use (e.g., libraries).	**DHS + MDH**
Use existing data to identify gaps in types or quality of existing services.	**DHS + MDH**
Work with providers to understand which services can/should use telehealth; what barriers providers are experiencing around building or implementing telehealth; which providers are interested and have capacity to implement telehealth services; best practices from agencies working with populations who face barriers to accessing telehealth services (e.g., Native American Community Clinic).	**DHS + MDH**
Create a Community of Practice and provide technical assistance around RAPID ART.	**DHS + MDH**
Create a Community of Practice and provide technical assistance around service integration.	**DHS + MDH**

Action	Responsible agency
Support providers with obtaining technology and/or hardware needed for telehealth.	**DHS + MDH**
Build online formats for submitting program applications.	**DHS**
Review Needs Assessment 2020 results for services that had reported access issues.	**DHS**
Gather additional feedback from consumers on what kinds of innovative services they would like to see in areas with access issues.	**DHS**
Identify options to provide funding or equipment essential for PLWH to access telehealth services.	**DHS**

Appendix A: Updated Goals, Strategies and Tactics

The goals and strategies, which were developed by the END HIV MN Advisory Board in 2017, are remaining the same as those described in the original strategy plan. Below are how the newly reprioritized tactics align with each goal and strategy, including the other current activities that support all of the goals and strategies.

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.

Priority Tactics and Current Activities	Tactic/Activity
NEW Priority Tactic 1.1.1 ***Culturally humble and trauma-responsive providers*** *(Revised PT 1.1.1)*	Update, revise, or develop provider education and training to include a consistent focus in all training on cultural humility and trauma-responsive practices, including using harm reduction principles and practices, and serving people who use drugs. Training should be differentiated for providers who serve clients in Greater Minnesota.
Current Activity 1.1.2 *(formerly PT 1.1.2 & 1.1.3)*	As part of the implementation of the initial END HIV MN priority tactics, DHS funded the creation of an HIV awareness toolkit that features Minnesotans who are living with HIV or taking PrEP. Dependent on resource availability, DHS is in the process of funding organizations that can utilize the toolkit, adapt it, or create their own messaging campaign to education and raise awareness in culturally specific ways across communities in Minnesota.
Current Activity 1.1.3 *(formerly PT 1.1.2 & 1.1.3)*	DHS is exploring the creation of an Ambassador Program that will train and support individual advocates to be ambassadors and increase awareness within their own communities.
Current Activity 1.1.4 *(formerly CA 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. Provider learning series events on the HIV outbreaks in Minnesota will continue in collaboration with MDH, DHS, Hennepin County Local Public Health (LPH), and St. Louis County LPH.
Current Activity 1.1.5 *(formerly CA 1.1.6)*	DHS funds a vendor to provide training to licensed alcohol and drug counselors and related providers regarding the intersection of HIV and substance use.
Current Activity 1.1.6 *(formerly CA 1.1.7)*	MDH funds agencies to provide HIV prevention education as part of comprehensive HIV testing and syringe services programs. MDH is in the process of updating its routine RFP process to address input provided by current and potential grantees that will make the grant making process more equitable.

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

Priority Tactics and Current Activities	Tactic/Activity
Current Activity 1.2.1	MDH is working to de-duplicate testing programs to ensure that grantees have enough capacity to meet the needs of priority populations and culturally specific communities.
Current Activity 1.2.2 *(formerly FT 1.2.2)*	MDH has hired a nurse to provide HIV education to clinical providers. Part of this training focuses on routine opt-out HIV testing.
Current Activity 1.2.3 *(formerly CA 1.2.1)*	Early intervention services (EIS) under 2022 HIV Prevention Projects Grants will reach the following priority populations: BIPOC MSM (11 county metro), Black Women (11 county metro), Transgender People (11 county metro), People Experiencing Homelessness and/or Housing Instability (11 county metro), and People at Greatest Risk (Greater Minnesota).
Current Activity 1.2.4 *(formerly CA 1.2.2)*	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 and can provide confirmatory results within 15 to 20 minutes.

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

Priority Tactics and Current Activities	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; these sites are also identifying clinical referral options to support rapid initiation of HIV treatment—within 7 days of diagnosis. 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. MDH received a five-year grant through federal COVID-19 relief funding to expand the DIS workforce and is partnering with clinics and tribal nations to hire, train, and increase the capacity of DIS staff.
Current Activity 1.3.3	All newly diagnosed HIV-positive pregnant people 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 people and their exposed infants, as well as consultation and support for their health care providers related to preventing parent-to-child HIV transmission. Hennepin Healthcare provides similar services for HIV-positive pregnant people 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 Tactics and Current Activities	Tactic/Activity
NEW Priority Tactic 1.4.1 ***Harm Reduction***	Increase availability, access, and use of harm reduction practices that prevent HIV infections, including and beyond syringe services programs. Target areas in Greater Minnesota and tailor implementation to meet the needs of providers serving people in rural areas and on tribal lands.
Current Activity 1.4.2 *(formerly CA 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

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

Priority Tactics and Current Activities	Tactic/Activity
Current Activity 2.1.1	DHS is working toward solutions to remove prescription drug co-payments at point-of-sale for PLWH who meet Ryan White eligibility requirements and use Medical Assistance or MinnesotaCare. Currently, rebates are available to cover co-pays, but require the person to have the resources to pay the co-pay initially.

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 Tactics and Current Activities	Tactic/Activity
Current Activity 2.1.1	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 most impacted by HIV to eliminate health inequities.

Priority Tactics and Current Activities	Tactic/Activity
Current Activity 2.3.1 *(**formerly PT** 2.3.1)*	MDH and DHS conducted key informant interviews and focus groups with past, current, and potential grantees to improve the grant making process for small, new, or yet-to-be-formalized culturally specific community-based organizations (CBOs). Based on this input, DHS revised its most recent RFP process for Ryan White grant funding to make it easier for grantees. MDH is currently reviewing its own RFP processes for areas that can be changed to align with the input received. DHS and MDH are exploring options to better partner with and support tribal nations through mechanisms such as non-competitive HIV grants, which would eliminate the need for tribal nations to submit competitive proposals.
Current Activity 2.3.2 *(**formerly PT** 2.3.1)*	MDH will be offering an RFP starting in 2022 to specifically support capacity building of small, new, or yet-to-be-formalized culturally specific CBOs.
Current Activity 2.3.3 *(**formerly PT** 2.3.2)*	MDH and DHS, in partnership with Hennepin County, conducted a survey of partner organizations, which gathered input on how to improve the inclusion of voices most impacted by HIV. Based on that feedback, MDH and DHS made changes to ensure that people with lived experience are compensated for their time and expertise, whenever they are asked to provide input or feedback on decision-making about HIV programs and funding. A survey was conducted in 2021 among PLWH to decide how to allocate supplemental COVID-19 relief funding, and MDH and DHS will continue to engage in similar input gathering activities in the future. Finally, MDH and DHS will be refreshing the END HIV MN Advisory Board starting in 2022 to add additional Board members with lived experience.
Current Activity 2.3.4 *(formerly CA 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. Recent HIV outbreaks have helped inform the areas of greatest need for immediate action and resources.

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 Tactics and Current Activities	Tactic/Activity
NEW Priority Tactic 2.4.1 ***Staff reflective of the community***	Increase hiring and retention of staff at state agencies, providers, and CBOs with lived experience and who reflect the communities being served.
Current Activity 2.4.2 *(formerly CA 2.4.1)*	MDH and DHS continue to work to include more community members and care providers from communities most impacted by HIV in the grant review process, which directly impacts funding decisions.
Current Activity 1.1.2	Current Activity 1.1.2, under Goal 1, also supports reducing HIV-related stigma.

Goal 3: Increase retention in care for people living with HIV

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

Priority Tactics and Current Activities	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; however, this information is not always accessible to the organizations or providers who may be best equipped to re-engage PLWH. DHS and MDH will continue efforts to improve the quality and completeness of this data and train relevant providers on how to access the data to support retention efforts.

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

Priority Tactics and Current Activities	Tactic/Activity
Current Activity 3.2.1 *(formerly CA 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. DHS piloted, and plans to expand, Outreach Case Management, which addresses eligibility barriers to accessing Ryan White services.
Current Activity 3.2.2 *(formerly CA 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

Priority Tactics and Current Activities	Tactic/Activity
Current Activity 3.2.3 *(formerly CA 3.2.4)*	DHS provides funding to implement health education and psychosocial support services, typically through support groups, for individuals living with HIV. A key 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 Tactics and Current Activities	Tactic/Activity
NEW Priority Tactics 1.1.1 and 2.4.1	New Priority Tactics 1.1.1 and 2.4.1 are intended to ensure that clinical and community support settings offer culturally appropriate and affirming services.
Current Activity 3.1.1	Ryan White, state, and rebate funds are used to fund culturally, linguistically, gender, and sexual orientation appropriate services at CBOs and clinics.
Current Activity 3.1.2	All previously diagnosed HIV-positive people 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 people and their exposed infants, as well as consultation and support for their health care providers related to preventing parent-to-child HIV transmission. Hennepin Healthcare provides similar services for HIV-positive pregnant people referred within the Hennepin Healthcare system.

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

Priority Tactics and Current Activities	Tactic/Activity
NEW Priority Tactic 3.4.1 ***Mental and chemical health***	Address barriers that prevent PLWH and people at risk for infection from accessing mental and chemical health services.

Priority Tactics and Current Activities	Tactic/Activity
Currently Activity 3.4.2 *(formerly CA 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 Tactics and Current Activities	Tactic/Activity
NEW Priority Tactic 3.5.1 ***Basic Needs***	Address people's basic needs for food, shelter, and safety to support prevention and adherence, linkage to care, and retention.
Current Activity 3.5.2 *(formerly CA 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 funded through Ryan White or Housing Opportunities for Persons With AIDS (HOPWA) include supportive housing; emergency assistance for mortgage, rent, deposits and housing applications; and transitional housing and permanent subsidies through HIV housing certificates and apartments specifically for PLWH.
Current Activity 3.5.3	MDH Disease Intervention Specialists (DISs) provide active referrals for support services to meet clients' basic needs.

Goal 4: Ensure stable housing for people living with HIV and those at high risk for infection

Strategy 4.1: Identify gaps in affordable housing statewide.

Priority Tactics and Current Activities	Tactic/Activity
NEW Priority Tactic 4.1.1 ***Housing for all***	Increase access to housing and support retention in stable housing for PLWH and those at risk of infection. Acknowledge that burdens differ for people depending on where in Minnesota they live.

Priority Tactics and Current Activities	Tactic/Activity
Current Activity 4.1.2 *(**formerly PT** 4.1)*	MDH and DHS continue to support implementation of the Minnesota HIV Housing Coalition's HIV Housing Plan.
Future Activity 4.1.3	Commission a Statewide HIV & Housing Report through partnership with Housing Opportunities for Persons with AIDS (HOPWA) and the Minnesota HIV Housing Coalition. Utilize the findings of the report to act on more targeted tactics to increase access to housing for all.

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

Priority Tactics and Current Activities	Tactic/Activity
Current Activity 4.2.1	In addition to supporting implementation of the HIV Housing Plan, DHS and MDH continue to develop and maintain their partnerships with HOPWA and the Minnesota HIV Housing Coalition, as well as provide funding to organizations that support PLWH and people at risk of infection with accessing housing.

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

Priority Tactics and Current Activities	Tactic/Activity
NEW Priority Tactics 3.4.1 and 3.5.1	New Priority tactics 3.4.1 and 3.5.1 will, based on research, provide necessary supports to help PLWH and those at high risk of infection access and maintain housing.
Current Activity 4.1.3 *(**formerly PT** 4.1)*	MDH and DHS continue to support implementation of the Minnesota HIV Housing Coalition's HIV Housing Plan.

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

Priority Tactics and Current Activities	Tactic/Activity
Current Activity 4.4.1 *(**formerly PT** 4.1)*	MDH and DHS continue to support implementation of the Minnesota HIV Housing Coalition's HIV Housing Plan.

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.

Priority Tactics and Current Activities	Tactic/Activity
Current Activity 5.1.1 *(**formerly FA** 5.1.1)*	The END HIV MN Advisory Board advises MDH and DHS on priority tactics, gathering community input, and evaluation of the Strategy's implementation. DHS has taken steps to establish the advisory council in statute but has not been successful to this point. MDH and DHS will be refreshing the END HIV MN Advisory Board starting in 2022 to add additional Board members with lived experience.

Strategy 5.2: Integrate HIV prevention, care, and treatment throughout all sectors of government, health care systems, and social services.

Priority Tactics and Current Activities	Tactic/Activity
Current Activity 5.2.1 *(**formerly CA** 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 Tactics and Current Activities	Tactic/Activity
NEW Priority Tactic 5.3.1 ***Capacity development in areas with urgent unmet needs***	Increase capacity within the service system to address the needs of people who are unhoused and/or who use drugs.
NEW Priority Tactic 1.4.1	In order to increase the availability, access, and use of harm reduction practices through New Priority Tactic 1.4.1 to prevent HIV infections, including and beyond syringe services programs, MDH and DHS will need to rely on research the demonstrates the effectiveness and benefits (including economic benefits) of harm reduction.

Strategy 5.4: Establish policies that encourage an innovative culture and delivery of comprehensive statewide services.

Priority Tactics and Current Activities	Tactic/Activity
NEW Priority Tactic 5.4.1 ***Innovative service delivery***	Support the development and expansion of telemedicine and other innovative service delivery models to ensure PLWH and people at risk of infection can access the care and services they need, when they need it, wherever they are (e.g., RAPID ART, service integration, mobile medicine).
Current Activity 5.4.2 *(formerly CA 5.4.1)*	Minnesota was the third state to endorse the U=U campaign. DHS and MDH continue ongoing efforts to educate and raise awareness among providers, PLWH, and people who are at risk of HIV infection on U=U.
Current Activity 5.4.3	In response to the COVID-19 pandemic, MDH and DHS adapted policies that allowed for continuity in care and services for PLWH despite their inability to receive in-person care from medical professionals. MDH and DHS are committed to maintaining these innovations and adaptations into the future and explore further ways to increase access and reduce barriers.

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

Priority Tactics and Current Activities	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.

Appendix B: 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/mm3 (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.

Cultural humility, as defined by the National Institutes of Health (NIH), is "a lifelong process of self-reflection and self-critique whereby the individual not only learns about another's culture, but one starts with an examination of her/his own beliefs and cultural identities."

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. 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 Tlymphocyte 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.

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, multiracial) 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.

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 (SSPs) 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.

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.

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

Trauma-informed care, as defined by the Administration for Children and Families, is a framework of thinking and interventions that are directed by a thorough understanding of the profound effects trauma has on people, recognizing people's interdependent need for safety, connections, and ways to manage their emotions and impulses.

Trauma responsive care, as defined by the Administration for Children and Families, builds on trauma-informed care/systems and focuses on being responsive to the individual as a whole, knowing that trauma is only part of who they are. Becoming trauma-responsive includes looking at an entire organization's programming, environment, language, and values and involving all staff in better serving clients.

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. 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.

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.