Annual HIV, STI, and Hepatitis 2023 Data Release Live Webinar Transcript

Introduction

Slide 1

Afternoon, everyone. This is Chrissy Jones. I am the section manager for the STI, HIV, and TB Section at the Minnesota Department of Health. I want to welcome you all and thank you for joining our annual HIV, STI, and hepatitis 2023 data release webinar. We'll go ahead and wait about one more minute for people to join and then we'll get started.

Slide 2

Welcome everybody again this is Chrissy Jones from the Minnesota Department of Health. I am the section manager of the STI, HIV, and TB Section. Thank you all again for joining us for the annual HIV, STI, and hepatitis 2023 data release. I'll quickly go through the agenda. One thing I just want to point out for many of you who have been regular participants in our annual data releases, we're going to be doing it a little bit different this year. We're going to actually be having some of our prevention partners sharing some of the great work that they've been doing but have no fear. While there may be less data presented in these slides, we'll be doing the general data on the slides, on our website is the entire data release that you are used to seeing, so you can get all that information there.

So first we'll be doing just doing the introduction. Again, thank you and welcome you all. Then we'll be going through the 2023 STI data. We'll move on to the HIV data, then the hepatitis data. And then as I said we'll have two of our partner organizations sharing some information: Southside Harm Reduction and Native American Community Clinic. We will wrap up with a partner services update and then we will have time for any questions and answers.

Slide 3

As a reminder, throughout this webinar please submit your questions to the Q&A and we will answer those at the end. That Q& A option is to the left of your settings gear near the top of your screen. Select the more option on your screen to enable subtitles if that is something that would make this more accommodating for you.

Slide 4

The state of Minnesota is home to 11 federally recognized Indian tribes with elected tribal government officials. The State of Minnesota acknowledges and supports the unique status of the Minnesota tribal nations and their absolute right to existence, self-governance, and self-determination. The United States and the State of Minnesota have a unique relationship with federally recognized Indian tribes, formed by the Constitution of the United States, treaties, statutes, case law, and agreements. The State of Minnesota and the Minnesota Tribal governments significantly benefit from working together, learning from one another, and partnering where possible.

This partnership, through a government-to-government relationship, with the eleven tribal nations of Minnesota has the potential to effectively address inequities and build trust that will lead to better outcomes for all of Minnesota.

Slide 5

And before I turn it over to my colleague Khalid for the STI update, I just want to give a reminder that today is Dining Out for Life. So hopefully you get an opportunity to go and frequent one of the restaurants that support all of the amazing and wonderful work that continues in the field of HIV. All right, how about I turn it over to you?

STI Presentation

Slide 5

Good afternoon, everybody. Yep, my name is Khalid Bo-Subait. This will be my 4th or 5th data release. But yeah, we'll jump into it because we're going to go a little bit faster this year so we can cover more broader topics with all the work we do here. So, next slide.

Slide 6

Under Minnesota law, physicians and laboratories are required to report all lab confirmed cases of chlamydia, gonorrhea, syphilis, and chancroid to MDH within one working day. We don't collect data for non-reportable thing: STIs like herpes, HPV, genital warts. This slide deck reports incidence of disease, not people. And this analysis excludes federal and private prisons. Next slide.

Slide 7

Surveillance data is the systemic collection of data from cases for the purpose of monitoring the frequency and distribution of STIs in a given population. STI surveillance data is used to detect problems, prioritize resources, developand target interventions, and evaluate effectiveness of interventions. Next slide.

Slide 8

Factors that impact completeness and accuracy of STI data include levels of STI screening by healthcare providers, individual test seeking behavior, sensitivity of diagnostic tests, compliance with case reporting, completeness of case reporting, timeliness of case reporting. Increases and decreases in STI rates can be due to actual changes in disease occurrences and or changes in one or more of the above factors. COVID-19 lockdowns likely played a role in the number of cases reported or diagnosed during the COVID-19 pandemic year, so keep that in mind when we look at some of the longitudinal time reporting of STIs.

Slide 9

Interpreting STI surveillance data – so it’s important generally in the slide deck to remember that it's all positive lab results. We need a positive lab result. Cases after 2012 started including only lab reports and no longer case report forms. So this increased the number of unknowns. One of the benefits of COVID-19 was that we started getting more electronic lab reporting

which helps cases be reported like an accurate number of cases, but it does introduce some variability with variables being more unknown. So we do see some unknowns when it comes to things like race, gender, sex of partner - stuff like that. Rates are computed using census data. Census data uses weighted estimates to calculate census estimates. Surveillance data represents cases of infections, not individual, and a person can have multiple infections in a given year, and those infections are counted for each infection, not just the person. Caution is warranted when interpreting changes in STI numbers that can seem disproportionately large when a number of cases is small. Next slide.

Slide 10

I wanted to highlight some of the updates we did this for this analysis for using census estimates, so we started using three-year estimates. So, when we're looking at our longitudinal slides in this presentation and then also moving forward in the future, this is some of the explanation of what census estimates we used. So, for 2014 through 2016, we used 2014 census estimates. 2017 to 2019, we used the 2017 census estimates. 2020 to 2022, we utilized the 2020 census estimates. And for 2023 data, we've utilized 2022 estimates that were published in June of 2023. Next slide.

Slide 11

And then next slide.

Slide 12

So, in the year 2023, we 31,232 STIs cases reported to MDH in 2023. 21,767 cases of chlamydia, 7,717 cases of gonorrhea and 1,748 syphilis cases and no chancroid cases. Next slide.

Slide 13

The rates of chlamydia in Minnesota decreased 1.6% in 2023 compared to 2022. Gonorrhea decreased 5% from 2022 to 2023, and the rates of primary and secondary syphilis decreased by 25% from 11.8 in 2022 to 8.8 in 2023. Next slide.

Slide 14

Jumping into syphilis. Next slide.

Slide 15

We can see the overall syphilis rate is 30.8 per 100,000, a 4% decrease from 2020 but 180% decrease from a decade ago. Of concern is the primary secondary syphilis which is an 84 increase from a decade ago. Next slide.

Slide 16

Here we can see the City of Minneapolis. The City of Minneapolis reports the highest number or the highest rate of syphilis followed by Saint Paul, then the suburban seven-county metro area in Greater Minnesota. And then and again in total Minnesota, we had 8.8 per 100,000. Next slide.

Slide 17

Taking a look at primary secondary syphilis by resident – we can see the City of Minneapolis again have a larger portion of all primary and secondary cases with 35, followed by the seven-county suburban area with 27, Greater Minnesota at 24, and Saint Paul at 12. Next slide.

Slide 18

Looking at gender and primary secondary syphilis rates, we can see males have the highest rates of primary secondary syphilis at 12.5 per 100,000 and the rate of primary and secondary syphilis in females is 5.1 per 100,000. Next slide.

Slide 19

Now looking at age and gender, we can see that males have higher rates of primary secondary syphilis than females in all age groups, and the rate in males is 2.5 times higher than females. 30- to 39-year-old males had the highest rate overall at 61.4 and 30- to 39-year-old female had the highest rate in the female population at 34.1 per 100,000. Next slide.

Slide 20

Now looking at primary secondary syphilis by race and we can see 38% of all of the primary secondary are found in the white, non-Hispanic population. Black non-Hispanic cases made up 41% and we can see American Indian Alaskan Natives reported 8%, with Hispanic reporting 10% and Asian Pacific Islanders reporting 3%.

Slide 21

Looking at the next slide, we can see just age by primary and secondary syphilis, and we can see that the highest rates were 30- to 39-year-olds with 22.5, a 31% decrease from 2022. 25- to 29-year-olds and 20- to 24-year-olds had the next highest rates at 17.4 and 15.4 per 100,000 respectively. Next slide.

Slide 22

So now looking at topic of interest, which is early syphilis amongst females in congenital in Minnesota. Next slide.

Slide 23

Here we can just see that the overall number of early syphilis cases has increased dramatically over the last 10 years from 13 cases in 2011 to 345 in 2020 and 268 in 2023. This is an increase of 553% over the last 10 years, so pretty remarkable.

Slide 24

This next slide looks at all stages. I just wanted to include this over the last 10 years, which shows a 508% increase of all stages of syphilis amongst females - just to highlight that all any stage of syphilis can produce a congenital syphilis case. So, I just wanted to show all those cases that are possible. Next slide.

Slide 25

This slide shows distribution of residence by diagnosis for early syphilis cases amongst females. So, we can see 31% were in Greater Minnesota, 20% were in the seven-county metro area, 33% were in Minneapolis, and 16% were in Saint Paul. Next slide.

Slide 26

Here we see there's large disparities that continue with women with syphilis. 19% of all early syphilis cases are found in the American Indian Alaskan native population and 29% in the Black African American population. Next slide please.

Slide 27

This is a slide that just shows the overall number of cases of congenital syphilis we've had and the number and the rate that we reported this past year. One thing that I wanted to point out is that we're not unique in Minnesota. What we're seeing in Minnesota is being echoed nationwide. CDC reported that more than 3,700 congenital syphilis cases reported in 2022, reflecting an alarming 937% increase nationwide in the past decade. So, what we're seeing is not unique to just us. Next slide.

Slide 28

Here we can see in Minnesota over the last decade, syphilis has increased 1275% amongst females aged 15 to 44. This slide includes the number of congenital syphilis cases we had in conjunction with the rate of primary and secondary syphilis. Next slide.

Slide 29

This is a breakdown of how the 113 congenital syphilis cases that have been reported in Minnesota over the last 10 years or so have come to fruition. So there were 113 cases that were reported and we've got three categories that mimic what CDC has included in their McDonald MMWR released in December of 2020 we can see 34 out of the 113 cases in Minnesota that were reported had timely meaning patient knew, clinician knew and MDH knew that the patient had a positive test result. So a good chunk of our cases were tested at 30 days prior delivery. 38 cases had late or no testing at all during pregnancy and 41 of our cases had late identification of seroconversion meaning that they had a previous negative but tested positive less than 30 days prior to delivery or at delivery and what this just really highlights is that cases are being caught, but there's more work that could be done when it comes to preventing getting people adequately treated prior to delivery. Next slide.

Slide 30

Looking at the 106 birthing parents that were reported at that time period, we can see that they're are disparities are seen in race and ethnicity of birth parent of an infant with congenital syphilis with 20 and 26% of congenital cases being reported amongst American Indian Alaska native and Black non-Hispanic populations, respectively, accounting for over half of the congenital syphilis cases compared to a combined approximately 9% of the population, so a big disparity when it comes to what we would have expected to see versus what was observed. Next slide, please.

Slide 31

So, what's being done in Minnesota? MDH Partner Services continues to help on all early syphilis cases and all pregnant people. They follow up on all HIV coinfected cases. Physicians are encouraged to continue to screen MSM folks annually and ask about sex partners, and we did update our screening guidelines for pregnant people to be tested now three times, including at delivery. MDH will be looking to update screening recommendations in non-pregnant people in 2024.

Slide 32

From 2014 to 2023, chlamydia rates increased 4.3% over the last 10 years. The rate in gonorrhea has increased 80%, and syphilis has increased 166% in the last 10 years. Adolescent and young adults make up a good chunk of the majority of chlamydia or gonorrhea at 54% of all of our cases. Syphilis has resurged in Minnesota the last decade with MSM and those coinfected with HIV being especially impacted. However, the number of females impacted is near a record high over the last decade as well. People of color and American Indians continue to be disproportionately affected by all STIs in Minnesota. Disparities in the rates of STIs are not explained by differences in sexual behavior, but are due to differences in health insurance coverage, employment status, and access to healthcare with preventative screening and treatment services. Thank you all. I'll pass it over now to our HIV folks.

HIV Presentation

Slide 33

Great, thanks, Khalid. Hello everyone. My name is Hannah Giles. I'm the HIV care and prevention epidemiologist at MDH, one of several epidemiologists and other staff who have been working hard on this data. So, let's jump into HIV. Next slide, please.

Slide 34

After gathering feedback from community, the HIV team has decided to break out the MSM transmission category which you will notice in the slides. We now break out transgender women who have sex with men. You will see this at the bottom of this slide, abbreviated TWSM from the MSM category as well as trans women that have sex with men and IDU. TWSM includes individuals assigned male at birth that identify as female who have had sexual contact with males. More details are on our website. Next slide, please.

Slide 35

We'll start by looking at incident data – new diagnoses in Minnesota in 2023. Next slide, please.

Slide 36

In this report, the term new HIV diagnoses refers to Minnesota residents living with HIV who are diagnosed in a particular calendar year and reported to MDH. This includes people whose first diagnosis of HIV infection is AIDS. Prior to 2020, new diagnoses per year were trending down on average 5.5 diagnosis per year. 2020 saw a 16% decrease in HIV diagnosis from 2019, and a rebound effect was seen in 2020. Then another rebound in 2023 from 2022 where new

HIV cases increased by 24%. It may take more time and data analysis to accurately assess COVID-19's impact on HIV over the last three years. Next slide, please.

Slide 37

A majority of cases diagnosed in 2023 reside in the suburban area at 35%. 31% of new diagnoses live in the city of Minneapolis and 21% reside in Greater Minnesota, which is all counties in Minnesota surrounding the seven-county metro. Next slide, please.

Slide 38

Comparing the racial and ethnic distribution of new HIV diagnoses to the general population of Minnesota, it is apparent that disparities continue to exist. Non-Hispanic African American and Black African-born Minnesotans jointly make up about 8% of the population in Minnesota yet accounted for 31% of the newly diagnosed cases of HIV in 2023. Similarly, Hispanics of any race account for approximately 6% of the population, but account for 22% of the newly diagnosed cases. This is an increase from 14% in 2022. Next slide, please.

Slide 39

There are differences in the racial and ethnic distribution by sex assigned at birth. Left to right are data for people assigned male and female at birth. Non-Hispanic Black, non African born and Black, African born males made up 28% of cases and Hispanic males of any race accounted for 25% of cases. This is an increase from 17% in 2022. Among the 57 people assigned the sex of female at birth, the disparities of new HIV diagnoses are even more apparent among people of color. They represent 72% of new HIV cases assigned female at birth, versus 65% of new HIV cases assigned male at birth. Nearly half of female infections, or 46% combined, are Black African born and non-African born. Next slide, please.

Slide 40

Here we look at cases and rates of the 324 new HIV infections by gender identity. Cisgender men represent 79% of all new HIV diagnosis. Cisgender women are 17%, and transgender people made up 3% of all new diagnosis in 2023. Next slide, please.

Slide 41

MSM and unspecified mode of exposures continues to make up the largest groups of transmission every year. Unspecified risk is due to challenges collecting these data, especially when discussing sensitive information. Transgender women who have sex with men, or TWSM, IDU, MSM and IDU, and heterosexual contact continue to be the largest transmission categories. Next slide, please.

Slide 42

The ability to interrupt the transmission of HIV from mother to child via antiretroviral therapy and appropriate perinatal care is an important accomplishment in the history of the HIV/AIDS epidemic. Without antiretroviral therapy, newborn HIV infection rates range from 25 to 30%, but decrease to 1 to 2% with appropriate medical intervention. The rate of transmission has decreased from 15% between 1994 and 1996 to 0% in the past several years. The last HIV

perinatal transmission was in 2017. For the past decade, the number of births to pregnant parents living with HIV has ranged between 37 to 66 births. Next slide, please.

Slide 43

Now just spend a few moments on a new trend we saw in 2023. Next slide, please.

Slide 44

In 2023, there were 86 cases of newly reported HIV among foreign born people. This is one fourth of all new cases. There was a shift in data in 2023 of new diagnosis by country of birth. Up until 2022, the majority of foreign-born cases were from Africa. In 2023, the majority of foreign-born cases were from Latin America and the Caribbean, making up 47% of all foreign-born cases. Next slide, please.

Slide 45

In 2023, the number of Hispanic males nearly doubled from 2022. The number of Hispanic people, both males and females, increased by 90% from 2022 to 2023. Next slide, please.

Slide 46

Latin America, which includes Mexico, the Caribbean, Central America, and South America, continue to make up the largest region of birth among Hispanic people diagnosed with HIV. From 2022 to 2023, there was an increase in Hispanic people from the United States, Latin America, and other regions. Next slide, please.

Slide 47

Now to spend a few moments on another group where we have been seeing an increase in cases: adolescents and young adults, which is people aged 13 to 24. Next slide please.

Slide 48

The number of new HIV diagnosis among people assigned male sex at birth age 13 to 24 has ranged from 32 to 60 cases over the past decade. Since the low in 2018, we've seen an increase of new diagnosis among males in this age group, where there were 59 cases reported in 2023. In 2023, the total number of cases among adolescents and young adults was a slight decrease from 2022, but still higher than any other year in the last 10 years. Next slide, please.

Slide 49

To look at this group in more detail by race and ethnicity, we combine three years of data, 2021 to 2023. Between the years 2021 and 2023, we had 171 cases assigned male sex at birth reported among adolescents and young adults. For people assigned male sex at birth, non-Hispanic African American accounted for 40% of the cases. Non-Hispanic white and Hispanic of any race young adults accounted for about one in four cases each in the 13 to 24 age group. Among people with female sex assigned at birth, non-Hispanic white accounted for about one third and black African born and African American jointly accounted for 36% of the cases in this age group. Next slide, please.

Slide 50

Let's spend a minute talking about prevalence of HIV in Minnesota looking at people living with HIV in our state. Next slide, please.

Slide 51

As of Dec. 31, 2023, there were 9,996 persons alive and living with HIV in Minnesota. This number included 58% living with HIV that had not progressed to an AIDS diagnosis and 42% living with AIDS. Next slide please.

Slide 52

98% of prevalent cases are cisgender. 57% of cisgender Minnesotans living with HIV are among people of color, whereas only 17% of the general population are people of color. Among transgender Minnesotans living with HIV, the distribution is even more skewed toward people of color. 38% are black, non-African born. 22% are Hispanic, and 2% are African born. 73% of prevalent transgender HIV cases are among people of color. Next slide please.

Slide 53

Before we end HIV, we'll take a look at our two HIV outbreaks in Minnesota. Next slide please.

Slide 54

Please find outbreak resources, outbreak response work, and regularly updated case counts by county on our website, as well as much more annual data that we just published. You can subscribe to our list serve to receive HIV and STI prevention updates to your e-mail.

There are two outbreaks in Minnesota, one in Hennepin Ramsey counties and then one in the Duluth region. The most recent case count for the Hennepin Ramsey outbreaks is 250 and 39 in the Duluth region. People at risk for the Hennepin Ramsey outbreak include people who use injection drugs or share needles, people experiencing homelessness or unstable housing, and people who exchange sex for income or other items they need. People at risk for the Duluth region outbreak are people who use injection drugs or share needles, people experiencing homelessness or unstable housing, people exchange sex for income or other items, and men who have sex with men. Next slide please.

Slide 55

And thank you for your time. I will pass it on to our hepatitis team.

Hepatitis Presentation

Slide 56

Thank you so much. Good afternoon. My name is Genny Grilli and I am the supervisor of the hepatitis unit at MDH. I'll be giving some updates on viral hepatitis within the state. Next slide, please.

Slide 57

So, I always got to start with some data limitations. My colleagues mentioned quite a few already but I wanted to add on just a few for hepatitis. So, these data are current through Dec.

31, 2023. There are some inherent limitations to surveillance data. We only know about individuals who have been tested for hepatitis and reported to MDH and we assume people are alive and living within the state unless we have knowledge of their death or relocation. Next slide.

Slide 58

So, we'll actually dive in by looking at the acute case data within the US. These data represent cases that are believed to be new, recently acquired infections. In the US, the rate of hepatitis A, which is the dark blue line, decreased 88% between 2019 and 2022. The US was experiencing a nationwide hepatitis A outbreak and has since returned to more normal disease activity levels. Over the last year, rates of acute hepatitis B, which is the lime green line, remains stable and rates of acute hepatitis C, which is our last line light blue, were relatively stable with just a moderate decrease of 6.3% nationwide. Next slide.

Slide 59

Moving to the Minnesota data next, our rate of hepatitis A (again the dark blue line) has stabilized following the outbreak that began in 2019. Our acute hepatitis B cases, which is the lime green line, we're on the very low end of average and our acute hepatitis C cases (again, the light blue line) continued the downward trend from last year. So if you see from the scale on the side, this really is just a small burden of viral hepatitis within the state. Between these three diseases there were 75 acute infections identified, however the vast majority of our hepatitis disease burden is in individuals who are living with chronic disease. We'll focus on chronic hepatitis C for the remaining slides. Next slide.

Slide 60

One more.

Slide 61

So as of Dec. 31, 2023, there were just under 32,000 people living with hepatitis C in Minnesota. Next slide.

Slide 62

In this slide, we can see the breakdown of current residents for these individuals with 44% residing in Greater Minnesota. This is particularly notable as access to treatment may be more limited in these areas of the state. Next slide.

Slide 63

This slide shows the age distribution of hepatitis C cases with a median age of 62 years old. The highest burden continues to be in our baby boomer population which is not surprising, well described – you know this information. However, we are still seeing many infections in our younger populations as well, which is particularly concerning because those are believed to be much more recent infections. Next slide.

Slide 64.

This slide shows the significant racial disparities that exist within hepatitis C, with American Indian Alaskan Native populations hugely disproportionately impacted. Rates of disease are more than eight times higher in this population compared with the white population and our Black African American populations have disease rates that are more than three times higher than are white population. Next slide.

Slide 65

Hepatitis C is a chronic disease that can be easily cured. Treatment is either generally 8 weeks or 12 weeks and has minimal side effects. These medications are taken orally and actually cure disease in more than 95% of patients. Despite the existence of these groundbreaking medications, the treatment rates in Minnesota have actually leveled off over the last four years. Elimination of hepatitis C is an achievable goal and a notable public health priority, but we need easier access to medications and more primary care providers prepared to take on treatment of their patients. Next slide.

Slide 66

There are resources available for healthcare providers and other partners who are interested in learning more about hepatitis C treatment and care. Project ECHO is an online learning community designed to expand access to care for vulnerable populations around a wide variety of disease topics. We are fortunate enough to have a Minnesota Project ECHO centered around viral hepatitis that began last year. The Minnesota Community Collaboration on Viral Hepatitis (ECHO) facilitates collaboration between clinicians, community partners, addiction treatment centers, harm reduction partners, and agencies serving people experiencing homelessness. Project ECHO is held the first and third Tuesday of each month over the lunch hour and is funded by MDH and led by Hennepin Healthcare. For those interested in learning more, their website is included on this slide. Next slide.

Slide 67

Lastly, there have been many updates to testing and vaccine recommendations around hepatitis over the last few years. It is now recommended that nearly all adults be tested for hepatitis B and hepatitis C at least once in their lifetime. This is an addition to the long-standing recommendations for screening persons who are at high risk of disease. There are also new recommendations to test for hepatitis C during each pregnancy. Vaccination for hepatitis B is now routinely recommended for adults under 60 years of age who are not already vaccinated in childhood. Some of these recommendations were made in the midst of the COVID pandemic. and they really might not be on the radar of healthcare providers or the general public. It's vital that we do all that we can to prevent, identify, and treat viral hepatitis within Minnesota. Next slide.

Slide 68

Thank you so much for your time.

Prevention Presentation

Slide 69

Good afternoon, everybody. This is Peggy Darrett-Brewer, I'm the STI, HIV, TB prevention unit manager. I'm gonna talk a little bit about our grantees. Next slide.

Slide 70

Our HIV programs and the planning and delivery of the programs and services are based on priority populations identified through the prevention planning process. In 2022, MDH released their most recent HIV RFP. The grant cycle is started in 2023 and will end in 2025. In order to identify prioritize populations, the Minnesota Department of Health analyzed HIV surveillance data from 2016 to 2020 for both incidence, which are new cases, and prevalence, which are already existing cases, and HIV testing data from our funded testing sites through our evaluation web database. The prioritized populations were based on those analyses and the approval came from the Minnesota Council of HIV/AIDS.

So, I am going to talk about our prioritized populations in HIV testing. The BIPOC MSM community living in the 11-county metropolitan area, and they are Black MSM, Latino MSM, American Indian MSM, other BIPOC MSM, black women living in the 11-county metropolitan area, transgender people living in the 11-county metropolitan area, people experiencing homelessness or housing instability living in the 11-county metropolitan area and people at greatest risk living in Greater Minnesota. Next slide, please.

Slide 71

Now I'm going to talk about our programs and the priority populations that they serve. So, our HIV prevention, for those who don't know the acronym, harm reduction services (our SSPs) are people who inject drugs and people who use drugs living in Greater Minnesota. We provide services to American Indian, Black, and other PWID/PWUD. In the 11-county metropolitan area, we provide services to American Indian, Black and other. We also provide services to people experiencing homelessness and unstable housing. Onto our prevention programs for people who are negative at greatest risk (PrEP). We serve people living at greatest risk in Greater Minnesota and people at greatest risk living in the 11-metropolitan area. Next slide please.

Slide 72

So who are EIS programs for people with greatest risk? We provide HIV testing. 51% of the people tested in these programs must be from the priority population. This gives our grantees capacity to respond in the event of outbreaks to be able to test friends, family members, and partners.

- So for the BIPOC MSM in the metro (Black MSM), we have Clinic 555, African American AIDS Task Force, Red Door Clinic, and Annex Teen Clinic.
- For BIPOC MSM in the metro area serving Latino MSM, we have Minnesota Community Care.
- For black women in the metro, we have Sub Saharan Youth and Family Services, Annex Teen Clinic, Youth and AIDS Project, and Clinic 555
- For transgender people living in the metro, we have Aliveness, Minnesota Community Care, and the Youth and AIDS Project.

- For unstably housed people in the metro, we have Native American Community Clinic, Face to Face.
- In Greater Minnesota, we have Lutheran Social Services and Planned Parenthood.

Slide 73

For our HIV prevention programs and harm reduction services (or SSPs):

- In the black community, we have Clinic 555, Northpoint, Red Door Clinic, and Neighborhood HealthSource.
- In the metro in the American Indian community, we have Southside Harm Reduction Services, Native American Community Clinic, Clinic 555, and Red Door.
- In the metro other, there is Clinic 555, Aliveness Project, and Avivo.
- And then we have in greater Minnesota: Harm Reduction Sisters, Rural AIDS Action Network in Duluth and in Saint Cloud. And we also have Fond du Lac. Next slide please.

Slide 74

Prevention programs for HIV negative people at greatest risk through our PrEP programs. In the metro we have Red Door Clinic and Clinic 555, and in Greater Minnesota we are happy to say that we've expanded to provide three additional clinics: Planned Parenthood, Lake Superior Community Health Center, Rural AIDS Action Network in partnership with the Aliveness which is great. And then I put the PrEP locator link on here for agencies that we don't fund or you can look for clinics or hospitals that provide PrEP in areas that we don't have funded programs. Next slide please.

Slide 75

We wanted to take time to feature some of our awesome grantees and so we asked Southside Harm Reduction Services to come and Native American Community Clinic, and we are going to hear from Jack Martin and Zach Johnson from Southside Harm Reduction Services and Anna Bosch, who's the harm reduction manager for Native American Community Clinic and we will hear from them respectively. Thanks for your time you guys, have a great day.

Southside Harm Reduction

Hey everyone. My name is Jack Martin. Thank you so much for inviting us. And we are excited to share a little bit about our organization and unfortunately, Zach was not able to make it today. So it's just me. Like I said, my name is Jack Martin. I'm Southside Harm Reduction director and co-founder. We are a harm reduction organization that started in 2017 in response to increase in overdoses among primarily Native American populations in South Minneapolis. At the time, there were very little access to naloxone and harm reduction supplies south of the city and at the time I was working actually at the Native American Community Clinic and we were just seeing folks that just did not have access to the resources that they needed. And so Southside formed from that need and was a volunteer run organization for quite some time. And we have grown now to have staff and have grown a lot right now.

Our goals remain the same. We work to reduce overdose deaths and the transmission of infectious diseases related to drug use, and we now are able – while our heart is in South Minneapolis, we do offer those services across the metro.

We're working from a harm reduction framework where we really try to reduce stigma, uplift the voices of people who use drugs, and build all of our work off of a non-coercive relationship that we build with people that are actively using and at highest risk for overdose.

Some of the services that we offer right now: we have a mobile delivery service where anyone in Minneapolis can text or call one number and then we have both staff and volunteers that can drive directly to wherever people are. We often meet people in parking lots and houses and encampments just wherever people are and we try to offer those services outside of regular business hours. And currently we offer that three times a week. And in the mobile deliveries, people can have access to naloxone, sterile syringes, smoking supplies, safer sex supplies. We provide education linkage to care, and then we layer HIV testing and hepatitis C testing on top of that. In addition to the mobile deliveries, we currently have a mobile outreach team that goes and primarily works in encampments in South Minneapolis and places where that aren't really served by our mobile delivery service and through that we offer a lot of the same services.

We also do something called pop ups where we really try to work on inviting partners and creating a bridge between our services and healthcare, housing, and other things that people might want or are high need. We also provide a regular weekly participant meeting where we invite people who use drugs to this meeting where we talk about harm reduction and we talk about needs. We do provide classes but also it is very much driven by people who use drugs so we also have done like art classes and writing and stuff like that which is really helpful and we really try to blend harm reduction into all of that.

Like I said, we a lot of our work is centered around reducing HIV and hepatitis C, and we have HIV and hepatitis C testing integrated into all of these services, so the way that we think about it is that we have these base level services (harm reduction, syringe service programming) and then we try to integrate as much as we can into that in a non-coercive way in a way that participants want and are supported. And in this work some key factors, in particularly related to infectious or infectious diseases, is partnership, so we rely heavily on partners like the Native American Community Clinic, Healthcare for the Homeless, and our fellow syringe exchange programs to be able to try to meet the needs of people use drugs.

Since starting Southside, we've just constantly been in a place where the needs outweigh what we are able to offer and what a lot of our partners are able to offer as well. And so we keep continue to scale up and try to meet the needs, but it feels like the needs are always larger than what we're able to offer and I think that is often reflected in some of the disease data that we see and I think looking into the future we really see that mobile health care is a central part of addressing some of these issues, working with partnerships through the pop up models and other accessible services. We also really see the need for more drop-in services and really expanding what services are available in a low barrier way that are targeting people who use drugs in Minneapolis and people who engage in sex work and live outside. So I think that's what

we are. I'm not quite sure how much time I have taken up, so I'm going to end it there. But if anyone has any questions, I'll put my e-mail in the chat.

Native American Community Clinic (NACC)

Thanks, Jack. I'll chime in here with just a few minutes. So my name's Anna Bosch, I use she/her pronouns. I'm the harm reduction manager here at Native American Community Clinic. I formerly worked at the Minnesota Department of Health as their harm reduction coordinator. So if you recognize my name, that might be why. I've been at NACC about two months now and thanks for inviting me to share about some of the awesome work that we do. So NACC is a federally qualified Health Center in South Minneapolis that provides a whole plethora of health related services from primary care to medication assisted treatment. We have a lot of social service support providers, a dental clinic, behavioral health programs, intensive outpatient programs, and health promotion and maintenance programs. And then we also have a robust infectious disease and harm reduction team, which is what I'm here to talk about.

So a little bit of background about how we got here: NACC's prevention work in this area started around 2018 when folks working for NACC started offering syringe exchange within the clinic and an outreach to encampments. And it was around this time that NACC started seeing an uptick in new HIV diagnoses among patients at the clinic that would later be associated with the current HIV outbreak that we've been responding to for quite a while now, and NACC found that the traditional infectious disease model of care wasn't meeting the needs of our patient population. And so we started working with MATEC to build up our clinical capacities to offer more prevention and treatment services within our primary clinic. It was called the practice transformation project. So currently at NACC, we do provide prevention services like PrEP and then we also provide HIV care services and in a really flexible way that meets the needs of our participants, many of whom are highly mobile and many of whom are people who use drugs. So we have same day appointments, walk-in visits and then a really great team providing a whole plethora of wrap around support. So I'll tell you a little bit about our team.

We have an embedded disease intervention specialist that we feel like is really important to how our team works, building trust with our patients. It's really awesome that we have this person on site to provide interviewing and direct linkage to care that's culturally specific within NACC and providing more intentional 3D case management for folks with multilayered needs. We also have two Ryan White non-medical case managers that are part of that team as well. We have a harm reduction outreach educator and lead and a tribal outreach and engagement specialist who facilitates the Midwest Tribal ECHO, which is an ECHO that provides capacity building support to folks around the state, but also provides every other week an echo with an expert coming to present and talk about this work. And then we also have an infectious disease nurse that works really closely with our team and I always like to share that that's our infectious disease and harm reduction team but we also at NACC, I think it's a really special place because that care within our team is happening alongside the providers at NACC as well.

So our providers are really well versed in harm reduction and kind of at the forefront of figuring out what types of services related to infectious disease and harm reduction are best suited for the clients that we serve and so we're really happy to see a clinic and have a clinic that has

harm reduction embedded in the heart of all of the services that we provide, not just within our harm reduction team.

A little bit about our programming. Some of the specific things that we provide: we have a large scale Monday event every Monday that we host behind the clinic. We provide HIV and hepatitis C rapid testing in partnership with Southside and safer smoking supply distribution along with a meal and snacks and different hygiene supplies for our unhoused relatives. And I do want to mention that being able to purchase safer smoking supplies for our participants has really greatly impacted our work and I think our hope is that now that folks have more broad access to these supplies, we might see a reduction, hopefully in infectious disease transmission related to injection drug use. We also provide quite a bit of consistent harm reduction outreach to encampment settings and other spaces that are serving people experiencing homelessness like Avivo Villiage. We have an in-clinic syringe services program, I think I mentioned before, a Midwest tribal ECHO, and then we also have a volunteer program where participants come in once a week and volunteer packing kits and things like that for distribution. And we provide support to the monthly pop-ups that Southside organizes. And then I amidst all of our programs, we provide traditional healing services as well to our participants.

And then I think I mentioned a little bit about rapid start ART and PrEP – we do a lot of STI screening and presumptive treatments. We serve as a resource for other SSP's and community that are doing like rapid hep C and HIV testing to do direct linkage to care if they have a reactive test or confirmatory testing into NACC. And we have a direct linkage to care line that those folks are able to connect with. We incentivize most all of our services around this so our volunteers, and getting confirmatory testing, and showing up for care appointments and things like that.

And then one thing that we're really excited, and I know that Jack mentioned this too, is being able to provide more nursing or medical care services in a mobile format, so not telehealth, but care that is actually brought to like a street medicine format. And so we are really excited that we're starting up a mobile nurse program and we are hiring an outreach nurse to work really closely with our harm reduction team, but it's a joint position between NACC and Southside harm reduction services, so we're really excited to get that program up and running.

And I think the last thing I want to share is that NACC was with some other funding was recently able to purchase a van for a harm reduction team. And so hopefully folks will see us out and about and I would be remiss if I didn't share: the van has been named Dan Dan after a participant of our program that our team lost and we wanted to honor and name it Dan Dan The Van.

I think that's all I have I will put my e-mail in the chat - or I don't know if folks can see my chat but anyways folks know where to find me giving find me at NACC and happy to chat more with anybody about the services we provide. Thanks a lot y'all!

Partner and Care Link Services Presentation

Slide 76

Good afternoon. My name is Marcie Babcock and I am the manager of the Partner and Care Link Services unit at MDH. Next slide, please.

Slide 77

My unit is comprised of Partner Services and HIV Care Link services. Partner Services is a program that offers people who are diagnosed with HIV or reportable STIs, such as syphilis, referrals to medical, prevention, and other services and assistance with the notification of their contacts or partners. HIV Care Link services assist persons living with HIV who are not in medical care to access care and other supportive services. Both programs are free, confidential, and offered statewide. Participation in both programs is strictly voluntary.

The programs are implemented by disease intervention specialists there, better known as DIS. We have nine DIS at MDH and through contractual agreements we have DIS embedded at the Red Door Clinic, Clinic 555, and as Anna mentioned, at NACC, Leech Lake Band of Ojibwe Health Division, Bois Forte Band of Chippewa Health Services. Next slide.

Slide 78

If you are not familiar with DIS: DIS are highly trained public health professionals who conduct disease investigations and interviews to prevent and control STI's, including HIV. To give you a flavor for the work that they have done in the last year, DIS in 2020 conducted over 1500 disease investigations, over 800 interviews, and actively participated in the response to the syphilis, HIV, and monkeypox outbreak. Next slide.

Slide 79

And now I will turn it over to Noah Schumacher, one of our MDH DIS, to tell you a bit more about DIS work.

Thanks, Marcie. Good afternoon, everybody. My name is Noah Schumacher and like Marcie said, I'm a disease intervention specialist at the Minnesota Department of Health. As others have touched on, we are seeing some outbreaks of syphilis and HIV in the Twin Cities and in Duluth and this slide shows a short summary of our work. And as you can see, the work of a DIS contains multitudes. There is a lot of overlap between all of these roles. For example, we are always engaging in disease investigation whether we're preparing for an interview, conducting the interview, or analyzing information after an interview, and all these pieces of our work that you see on this slide combine towards our primary goal of disease intervention – or in other words, reducing the spread of communicable diseases and improving sexual health outcomes in our communities. So for the sake of time, I'll tackle one of these points to expand upon, but just know that they're all connected and I might inevitably end up touching on other points too.

Interviewing folks who are newly diagnosed with syphilis or HIV is an important piece to our work. The purpose of an interview is to get more information about the person, the stage of their infection (of it's a syphilis case), to ensure they were adequately treated for their infection, or in the case of an HIV diagnosis, ensuring they are connected to care or already in care. A big piece to an interview is also talking to the individual about their sexual partners and to collaborate with them on notifying those partners so they too can have an opportunity to get tested and get treated. An interview is also conversation with the patient, where the autonomy

and health of the patient is centered. An interview is completely confidential and voluntary. We emphasize this at the beginning and throughout the interview to gain the individual's consent. It's also educational. We gauge their comprehension of their infection. We supplement their knowledge by providing accurate information if it's needed and we answer all of their questions and address any concerns that might come up. Next slide please.

Slide 80

Another big part of our work is locating people who are newly diagnosed with an STI or HIV, or people who are named as a partner during the interview process, and to notify them they were possibly exposed to an STI or HIV. A considerable amount of energy is spent on locating people, and these are a few of the methods that we employ to do that. So you know, obviously we try to call people if there's a phone number and if the patient has access to a phone. We reach out to emergency contacts if needed. You know, we use social media if we can't locate someone through a phone. A lot of the interviews do occur over the phone but again, if we can't locate someone, we'll go to social media and we'll try and reach them there. We send letters. We do field visits. If we can't locate folks through other means, we'll do a field visit, maybe to their house or to their place of work. So and in that case, we might conduct the interview in person. And so we get really creative with how we locate people and a lot of the time we're locating folks to notify them that they were either possibly exposed to an infection or to inform that they tested positive and to help them navigate the healthcare system and get treated. So with that, I think we are right about at time. So thanks for your time today. Thanks for listening.

Questions and Answers

Alright, looks we're at about time, but presenters will hang on for a few minutes to answer the questions submitted. If we don't get to your question, we will be collecting them along with all the responses and uploading it to the website along with a recording of this webinar. So as a reminder, the Q&A button is by the settings and with that I will open it up to the presenters.

Question: Was the decrease in HIV diagnoses in 2020 partially due to less people getting tested due to the pandemic?

Yes, that's what we believe – that because everyone was sheltering in place for most of 2020, that our healthcare system was not functioning at it's highest and many people were not receiving care. And that has led to people being diagnosed in later years, but again more time and analysis is really needed to understand what really the long term impact of COVID was specifically for HIV, but for other diseases as well.

Question: What proportion of PrEP funding goes to metro area providers?

I think my slides were not correct because I do believe we have more PrEP providers in the metro now since our last RFP and then this last set of funding was legislated, had helped equity funds. But we've always had more funding in the metro than Greater Minnesota. What I'll do is I will get back to you on that question because I do think the slides were wrong and we do have more PrEP agencies in the metro.

Question: Has HCV treatment costs become more affordable or is it still extremely expensive?

This is Genny. There was just one question so I can tackle that. There was a lot of publicity around how expensive the medications were and then not really much publicity around when those medications decreased in price. So, there are two authorized generics for two of the medications that are out there. And then there's also a few medications that don't have an authorized generic but also have lowered prices as the market price kind of goes down. So now there are treatment regimens that are as low as $24,000 for a course of treatment. And of course, that would be the full cost. Insurance and patient assistance programs and things like that should be able to bring it to an extremely reasonable point for the vast majority of people. The cost of treatment really should not be a barrier to anyone being able to get treated for hepatitis C.

Alright, thank you. And with that, we will wrap up the Q&A session for the webinar. But again, we will be uploading a document with all of the responses to the questions submitted. A recording will also be uploaded to the website as I mentioned along with the full reports and tables that you can view now. Thank you to all the presenters and thank you for everyone for attending this year's data release. I will now close this session.

Minnesota Department of Health
STI, HIV, and TB Section
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