Annual HIV/STD 2022 Data Release Webinar Q&A

In this document, the Minnesota Department of Health (MDH) STD/HIV/TB Section provides responses to questions submitted during the 2022 data release that could not be answered during the time provided. Questions that originally asked about both HIV and STDs have been separated because the responses are different due to the greater (but still insufficient) amount of funding available to address HIV.

General

Any data separating African American from African Born populations?

- The 'country of birth' variable is not completed with enough frequency on chlamydia or gonorrhea case reports to allow data to be presented in this way. For early syphilis and HIV diagnoses, providers can assist with the completeness of this variable, or this information may be collected during the interview with partner services.

Do we have data about folks who identify as nonbinary or gender nonconforming?

- We do collect gender at time of report on each of our disease case report forms. Nonbinary or transgender individuals represent a very small number of cases that get reported to MDH. Therefore, some analyses require us to suppress our data as to not identify individuals per MDH and CDC policies, but we'll continue to look for ways to improve our ability to present this data publicly. If you have specific questions, please submit a data request via STD/HIV/TB Data and Presentation Request (vovici.com) and we can follow up with you.
- New HIV case report forms being released later this spring will expand data collection in the areas of sexual orientation and gender identity, allowing MDH to better represent populations in our analyses moving forward. We are working to ensure that providers know how to accurately report this data.

Does MDH have plans to address the racial disparities?

- MDH is developing syphilis awareness media campaigns targeting some of the communities that are disproportionately impacted.
  - One campaign will integrate syphilis, HIV and mpox prevention. The overall target population is MSM in the metropolitan area and Duluth. A focus population in the metropolitan area will be African American men who have sex with men (MSM).
  - Two other syphilis specific campaigns will target African American women in the metro area and American Indian women in Northwest Minnesota.
  - The awareness campaigns are projected to be implemented early 2024.
- As noted in more detail later in this document, HIV prevention funding has specifically been allocated to reach Black and Brown communities. During the 2022 Request for

Proposal (RFP) process, applicants were awarded additional points for proposing to reach the following subpopulations: Black MSM, Latino MSM, American Indian MSM, American Indian people who inject drugs (PWID)/people who use drugs (PWUD), and/or Black PWID/PWUD.

If in a future year, you learn specific exposure for someone who was originally diagnosed as unknown exposure, do you revise the previous data?

- Yes, every year we run our annual data but that also includes the data from previous years. If we learn we have an updated exposure then that information is updated.

When do you consider an outbreak over?

- There are different standards for evaluating when to close an outbreak. We look to understand whether transmission has been successfully interrupted or whether more work is needed, assess the impact of the investigation and interventions, and identify lessons learned for future outbreak response activities. The key factor will be whether transmission in the outbreak has been successfully interrupted.
- The key strategy to understanding if transmission has been successfully interrupted is monitoring transmission over time to identify new cases added to the outbreak. When new cases are identified, further investigation is needed to better understand the factors that facilitated transmission or establish information that provides a better understanding of opportunities for intervention. Continued monitoring over time can reveal unexpected new diagnoses after outbreak activities have ceased, which could suggest that transmission has not been interrupted.
- Another consideration is the potential for future growth. Are HIV-infected persons in the outbreak remaining virally suppressed or have previously suppressed persons no longer virally suppressed? Are there factors that raise concern for ongoing growth, such as ongoing risk factors? Have there been increases in hepatitis C infections or changes in drug-use patterns? If any of the above are seen, then consider the ongoing intervention activities need to continue.

Can we get the names and spellings of the presenters?

- Christine Jones, STD/HIV/TB Section manager (opening remarks)
- Khalid Bo-Subait (overview of STDs)
- Nathan Blumenfeld (HIV/AIDS)

Can you talk about culture appropriate education?

- MDH recognizes that diverse communities have different cultural values, and we encourage communities experiencing disparities to apply for funding. MDH ensures that services, education, and literature that we provide directly and those provided by our funded grantees are culturally appropriate. MDH endeavors to hire staff from the impacted communities. We require staff to expand their cultural competencies through training and education. We prioritize partnerships with key stakeholders and people with lived experience that are most disproportionately impacted by STDs and HIV.

- END HIV MN (https://www.health.state.mn.us/diseases/hiv/partners/strategy/index.html), which is a plan to end new HIV infections and improve health outcomes for people living with HIV in Minnesota, was developed and driven through community feedback. The most recent addendum to END HIV MN includes tactics related to ensuring culturally humble and trauma-responsive providers/grantees and staff reflective of the community at both the government and provider/grantee levels. MDH works with its human resources department to recruit a diverse and inclusive staff.

Do you have mpox data to share? Given the large volume of press and vaccination efforts over the past year, especially targeting the MSM community, are positive cases still prevalent?

- For more information on mpox, visit Mpox (https://www.health.state.Minnesota.us/diseases/monkeypox). Our section does not house mpox disease response. However, we know that many of the same communities are impacted by HIV, mpox, and other STDs. We are working on some data analysis collaboration.

STDs

The data presented shows that 29% of the total number of primary and secondary syphilis cases are within the African American community. 42% of early syphilis infections account for Black and Latine communities. Can we anticipate a collective and significant public health response (or declared emergency) from MDH to address the high STI rates among Black and Brown communities?

- STD surveillance data is monitored and discussed with MDH and local public health leadership on a regular basis. Strategies are developed to address increases based on available resources. Outbreaks are declared when data meets an established outbreak case definition as supported by CDC guidance. Response efforts are guided by available resources.
- Minnesota only receives federal funding to address STDs. The state does not allocate any funding for STD prevention and treatment. The federal funds are used to support disease investigation (partner services), surveillance, training and education, and limited testing and treatment.

Does MSM data include transgender people?

- People who report their current gender as male at time of report and also report the gender of their sex partners as male are considered MSM. This includes people who identify as male and report the gender of sex partners as male and female.
- We do have some information in the slide decks that tries to break this out a little bit more. As we are able to collect better data on identity going forward, hopefully we'll be able to break that out more thoroughly.

Has syphilis ever been a standard test for prenatal care?

- Pregnant people across Minnesota are at risk of getting syphilis before or during pregnancy. MDH updated the provider guidelines and information on our website to recommend that all people who are pregnant get screened at first prenatal care visit early in their third trimester, as well as at time of delivery. That is the standard recommendation for testing people who come into the clinic as pregnant.

Do you have any information on women where congenital syphilis is seen? Is there less prenatal care? Other aspects?

- In 2020, MDH began a congenital syphilis review board where every congenital case that is reported to MDH gets reviewed by the by members of the review board. The goal is to identify missed opportunities and identify potential interventions that could be used to prevent cases moving forward. MDH does not break out congenital syphilis data in our annual data release because we typically have a small number of cases. With small numbers, aggregate information can become identifiable when broken out further and we want to protect the individuals' anonymity as much as possible. One common theme seen by the review board is that many of the cases had limited or no prenatal care visits prior to delivery.

Generally, what factors could lead to a county having high STD rates?

- First, there would need to be an increase in disease burden in a specific county. A key thing to remember is that 150 cases in Hennepin County is going to be a much lower rate because of the large number of people who live in that county when compared to 150 cases in a less populated county of our state. A rate is computed by the incidence of disease over time divided by the number of people who live in that specific county. We would need to see an increase in the number of cases of disease as well as keeping in mind where we're seeing it demographically in our state.

How does Minnesota syphilis compare to New York's population, or Texas?

- To compare rates by jurisdiction, please visit the NCHHSTP AtlasPlus (https://www.cdc.gov/nchhstp/atlas/index.htm) page for data on HIV, hepatitis, STD, TB, and social determinants of health data.

HIV Resource Allocation and Response

Will we see the same level of response and resource allocation for African American and Hispanic communities impacted by HIV like we are currently seeing for persons living in encampments and persons experiencing homelessness and/or injecting drugs?

- The STD/HIV/TB Section uses HIV surveillance and testing data, along with qualitative data and input from community partners, to establish funding priorities for HIV prevention interventions, with a focus on addressing health disparities. The following tables provide the priority populations identified for HIV prevention activities in 2023 and 2024, along with the annual funding amount and percentage of total annual funding awarded through the 2022 RFP process.

Early Intervention Services (EIS) Programs* - $1,175,869 Awarded

Priority Population	Funding Amount	% Total EIS Funding
Black MSM in 11-county metro area	$231,877	20%
Latino MSM in 11-county metro area	116,699	10%
Black women in 11-county metro	$282,629	24%
Transgender individuals in 11-county metro	$190,891	16%
People experiencing homelessness/ unstable housing in 11-county metro	$114,604	10%
People at greatest risk in Greater Minnesota	$239,169	20%

**Also known as HIV testing programs.*

Harm Reduction Programs* - $755,396 Awarded

Priority Population	Funding Amount	% Total Harm Reduction Funding
Native American PWID/PWUD in 11-county metro	$322,970	43%
Black PWID)/PWUD) in 11-county metro	$180,777	24%
Other PWID/PWUD in 11-county metro	$59,580	8%
PWID/PWUD in Greater Minnesota	$192,069	25%

**Also known as Syringe Services Programs (SSPs)*

Pre-Exposure Prophylaxis (PrEP) Programs - $299,735 Awarded

Priority Population	Funding Amount	% Total Harm Reduction Funding
People at greatest risk in 11-county metro area	$299,735	100%
People at greatest risk in Greater Minnesota*	$0	0%

**No qualified proposals received for Greater Minnesota*

- A portion of the funding provided to HIV grantees may be used to also provide syphilis and hepatitis C testing. This is often done by partnering with organizations serving MSM, Black Women, People Experiencing Homelessness, PWID, and outbreak populations in Greater Minnesota.
- MDH is limited to the state and federal funding we receive to address HIV.
  - Governor Walz' budget proposal includes two years of funding to serve communities that are disproportionately impacted by HIV. The Minnesota Legislature is still in the

process of finalizing the Health and Human Services Omnibus bill that contains this proposed funding.

- Minnesota is experiencing HIV outbreaks in people who experience the following risk factors:
  - Use of injection drugs or sharing of needles and works
  - Homelessness or unstable housing
  - Male to male sex
  - Exchanging sex for income and other items they need
- Surveillance data has shown an increase in HIV cases in Hennepin and Ramsey counties and the Duluth area in persons with these risk factors. In response to these outbreaks MDH partners with EIS/HIV testing grantees, local public health agencies, and medical providers to contain the spread of infections and ensure linkage to care and other supportive services.

How will MDH support continuous access to PrEP and efforts to increase uptake of PrEP by Black and Brown communities?

- MDH is committed to continued support for PrEP access, availability, use and increased uptake among priority populations with the highest rates of new HIV diagnoses and low PrEP use. Specifically, grantees are to target their services and prioritize reaching American Indian, Black African-born, Black African American, and Latino/Latine communities.
  - MDH recognizes PrEP as a core component of comprehensive HIV prevention in all publicly funded HIV prevention programs, including PrEP standalone programs.
  - MDH funds HIV prevention programs that integrate PrEP and provide PrEP education, awareness, screen for eligibility, and refer/link eligible persons to PrEP providers statewide.
  - MDH-funded program must frequently monitor and evaluate uptake to ensure populations that need PrEP most are using it. Specifically, grantees must track, collect, document and report aggregate client-level data and establish a baseline to monitor percent of persons prescribed PrEP by race/ethnicity.
  - MDH provides technical assistance to PrEP grantees and other primary care providers interested in and willing to offer PrEP services.
  - MDH has a list of identified PrEP resources on its website that includes a PrEP provider locator.
  - MDH has six goals and objectives about PrEP access and use in the 2022-2026 Integrated HIV Prevention and Care Plan. One goal is specifically about addressing PrEP disparities among priority populations with the highest rates of new HIV diagnoses and low PrEP use (American Indian, Black African-born, Black African American, and Latino/Latine communities).

- MDH will share PrEP grantees performance measure towards achieving their program goals and objectives annually at a Minnesota Council for HIV/AIDS Care and Prevention meeting.

HIV Surveillance Data

Any trend in people living with HIV/AIDS moving in versus out over last 5-10 years?

- Trends are not currently known. That is something that we could look at more closely. People do seem to be moving around a lot, but there hasn't been any clearer trend that we've seen of people coming or leaving.

How many deaths so far?

- In 2022, there were 121 deaths among people living with HIV in Minnesota, regardless of location of diagnosis and cause of death. Of the 121 deaths, 28 deaths were due to an underlying cause of death due to HIV disease (see Prevalence Tables, Table 4 for deaths among persons living with HIV in Minnesota over the past decade).

When will cascade of care data be available?

- We present that data usually late summer, early fall. So that's our hope, to do a similar timeline this year. Our care continuum for 2022 will be released in a few months; we don't have that data today.

Thoughts on what accounts for the large percentage of unknown mode of transmission for HIV amongst adolescent / young females? What accounts for the incredibly high percentage of people assigned female at birth whose mode of HIV transmission is unknown?

- Of the group of females aged 13-24 diagnosed during 2020-2022 with unknown mode of transmission, about half of them had indicated sex with male. In order to receive a status of 'Heterosexual Contact' as mode of transmission, additional risk factor information needs to be documented by the person. If any of the following additional risk factors are indicated, then mode of transmission status is 'Heterosexual Contact':
  - Heterosexual contact with intravenous drug user
  - Heterosexual contact with bisexual male
  - Heterosexual contact with person with hemophilia/coagulation disorder with documented HIV infection
  - Heterosexual contact with transfusion recipient with documented HIV infection
  - Heterosexual contact with transfusion transplant recipient with documented HIV infection
  - Heterosexual contact with person with documented HIV infection, risk not specified
- For the other half of the group with no information, we were not able to get any information from a case report or with an interview. Either the person was unable to be

found for an interview or the person refused to be interviewed by a disease investigator.

- We need adult risk factor information collected and reported on case reports or during disease investigation interviews and unfortunately, we may not know the exposure for some people.

Is there a slide that shows the total number of people living with HIV/AIDS over the past decade in Minnesota? Similar to the slide that showed the total number of people living with HIV/AIDS who were foreign born, but the totals?

- Yes, that slide is in the prevalence slide deck available on the website.

The dip in new HIV cases in 2020 makes sense from a reporting and prevention/testing standpoint. What are your thoughts around the dip in number of pregnant women with HIV in 2020?

- We're not sure [why]. Maybe during the pandemic, pregnancy rates during part of the first two years were up and now they're at a low. With more data and time, we'll be able to see if that trend was true in Minnesota or across the United States. But we conduct a match with cases in our surveillance database to match with birth certificates of pregnant persons that delivered for that year. We did not find any new cases. Over time we'll see if this trend continues or, as you can see in the incident tables (5a), it goes up and down throughout the years. In the past 10 years, it has averaged around 60 cases per year.

For HIV, are there patterns in people who identify with multiple races being more representative of one race? Hispanic? American Indian?

- A review of persons living with HIV that have more than one race identified shows that about half (47%) self-identify as Black/African American and White, another 18% identify as American Indian/Alaska Native and White, and 11% identify as American Indian/Alaska Native and Black/African American.

There is a statistic nationally that 1 in 2 Black non-African born men who have sex with men have HIV. Is there any such statistic specific to Minnesota?

- There is no comparable data available for Minnesota.

Is there any data to reflect if African-born Black individuals diagnosed with HIV have recently moved to Minnesota or have they been living here for a period of time?

- When providers indicate on case reports recent arrival in Minnesota and/or notification from our colleagues in the Refugee and International Health Program, this is taken into consideration when determining the place of residence at diagnosis, but the amount of time someone has been living outside of their birth country is not collected.

How are the stats reported for people living with HIV/AIDS who are incarcerated?

- There are currently known to be 17 people living in state facilities in Minnesota.

- There are currently known to be 10 people living in federal prison facilities in Minnesota. However, it is not always reported to us when people are transferred or released.

Additional Information

For additional information about statewide STD and HIV prevention activities, please contact Chryssie Jones at Christine.Jones@state.Minnesota.us.

Minnesota Department of Health
STD/HIV/TB Section
www.health.state.Minnesota.us/std

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To obtain this information in a different format, call: 651-201-5414.