Ryan White HIV/AIDS Program
Part B Proposal Q & A

Why is this being considered?
In response to requests by community members and legislators and in accordance with the new National HIV/AIDS Strategy, two years ago the commissioners of Department of Human Services (DHS) and the Minnesota Department of Health (MDH) began a discussion on how HIV care and prevention services are organizationally structured and delivered.

In recent years, there has been an emphasis at the federal level on the diminishing distinction between prevention and care. In response to the demonstration of early initiation of antiretroviral treatment as a highly effective prevention intervention (a.k.a. treatment as prevention), the Centers for Disease Control and Prevention (CDC) refocused its funding priorities to increase HIV testing to identify people with undiagnosed HIV infection, ensure early linkage to care, and implement highly effective prevention interventions with people living with HIV.

With the reauthorization of the Ryan White Act in 2009, the HRSA increased its focus on identifying the undiagnosed, linking those infected to early care and supporting lifetime adherence to treatment.

Having Ryan White Part B and prevention funds administered by MDH would provide the ability to avoid duplicating efforts to achieve these overlapping priorities from CDC and HRSA, thus allowing the State to be a better steward of limited HIV resources.

What does this mean to me as a person living with HIV/AIDS?
No disruption or change to services. People will continue to have access to the highest possible customer care.

What does this mean to me as a provider of services to persons living with HIV/AIDS?
We expect that streamlined administration will be more efficient and less of a burden for contracted agencies. MDH and DHS contract managers would utilize and share the best practices for contract management, learning from each other. Administrative coordination with Hennepin County will continue to minimize the number of contracts with individual providers necessary to accomplish HIV care and prevention program goals and objectives.

Existing contracts would run through their expiration date. As already planned, a new Request for Proposal (RFP) process would begin in 2016. The transfer of Part B federal grant responsibilities would coincide with the start of the new Part B fiscal year in April 2016.

What does this mean for the new Minnesota Council for HIV/AIDS Care and Prevention?
Hennepin County, MDH and DHS and members of the Planning Council and CCCHAP agreed in early 2014 to merge the two planning groups into one group that will identify both prevention and care priorities for Minnesota. The current plan for the new Minnesota Council for HIV/AIDS Care and Prevention would continue, and is expected to be in place by January 1, 2016. DHS will continue to be a government partner in HIV prevention and care planning and have a presence on the new Council.
What does this mean for MDH or DHS staff?
Five current DHS staff would likely move to MDH.

What other states have organized themselves in this way and what was the result?
Only Minnesota and Rhode Island continue to separate the delivery of their prevention and care programs in the U.S.

Other states have care and prevention located together. For example, New York State and Washington State have been successful in lowering number of new cases. They have increased the number of individuals in care through high impact public health approaches using integrated surveillance and care services data. “Data to Care” projects such as these are very difficult to employ when disparate data systems exist in different government agencies.

- New York State has achieved a 40 percent reduction in new HIV cases over the last decade, as well as significant decrease in new HIV cases across all categories of race, ethnicity, gender, age and risk.
- Washington State has decreased the number of new HIV cases from 504 in 2008 to 470 in 2013.

How will input from the community be used?
Input from the community will be used to help the commissioners make a final decision regarding the proposal.

In addition, community input will be used to identify what could be done to ensure that the proposed transition of the Ryan White Part B grant to MDH would be handled most successfully. The commissioners want to understand what a smooth and seamless transition would look like from the community’s perspective and to ensure the State isn’t missing anything essential. The commissioners want to learn about how this proposal meets the our goals.

The goals of MDH and DHS are to:
1. Reduce new HIV infections
2. Improve access to care, linkage to care and health outcomes
3. Reduce HIV-related health disparities
4. Achieve a more coordinated response

From an administrative perspective, the goals are to:
- Improve coordination of grant processes for both prevention and care services
- Decrease the administrative burden of providers who are funded to deliver both prevention and care services
- Increase integration of surveillance, HIV testing, prevention, and Ryan White services data in order to more effectively allocate and target resources

When will this happen?
After the results of the listening sessions are evaluated, a final decision will be made. We anticipate that this will be done by the end of October 2015. Once that decision is made, the two departments will need to engage in planning subsequent steps.
Provide cost analysis.
MDH and DHS are both working to understand the cost of moving.

Why isn’t surveillance at the county level and why can’t clients can be connected to care from there?
The CDC requires HIV surveillance be collected by the state.

MDH has a cooperative agreement with the CDC to conduct HIV Surveillance and contribute a National HIV Surveillance System (NHSS). Under Component A of the NHSS: “Case surveillance is to be conducted in all state health departments, six independently funded local health departments (Chicago, Houston, Los Angeles, New York City, the City of Philadelphia and San Francisco), the District of Columbia, the Commonwealth of Puerto Rico, and the U.S Virgin Islands.”

Similarly, SAMHSA has a competitive process to award contracts for Ryan White Services. SAMHSA contracts with Hennepin County to administer Ryan White Part A, the State to offer Ryan White Part B services, and individual agencies for Ryan White Part C.

Does MDH have the capacity to offer services?
The Part B-funded services that would move to MDH are those that are contracted out to agencies and clinics. Staff at the funded agencies and clinics provide the services to clients. DHS staff currently serve in a contract management role in relation to those services and they would continue to serve in that role at MDH. MDH has many years of experience with managing contracts for prevention services. MDH also previously managed contracts for Ryan White Part B services from 1990 – 2001 when MDH was the original Part B grantee. Two of the staff who managed those contracts are still working in the STD/HIV/TB Section.

MDH also offers the Care Link Services Program designed to increase the proportion of people living with HIV in Minnesota who are engaged in HIV care and on successful antiretroviral therapy. The Care Link Counselor uses HIV surveillance data to identify PLWH who appear to be poorly engaged in care and/or not likely to be on antiretroviral therapy and tries to link or re-engage them to sustained HIV medical care. In addition, the Care Link Counselor assesses barriers to medical care and offers transportation services and referrals to other social services such as medical case management and housing. Currently, services are provided to prioritized populations but the services will be expanded in 2016.

Does MDH get state funding?
Yes, MDH receives 1.281 million dollars for HIV prevention that is given out in community grants. The state dollars can’t be used for staffing or any internal MDH activities. All monies must be given to the community.

As the only other state that operated closely to Minnesota, how does Rhode Island handle having prevention and care separate? What trouble have they run into?
Krissie Guerard at MDH is meeting with Rhode Island on September 21 and will update the Q and A as soon as the meeting is complete.

What is the plan for ensuring ongoing input from the community?
MDH and DHS will utilize the MN Council for HIV/AIDS Care and Prevention that will begin in 2016 to ensure ongoing input from the community. Both agencies would also have representation at the DHS Consumer Advisory Committee (CAC) meetings.
Do other states have separate health and human service departments?
It depends on the state. Some states have separate health and human services departments and some have integrated health and human services.

Why transfer large RW grant to a department that manages smaller federal grants?
Although the STD/HIV/TB Section manages a smaller amount of funding, it manages four different federal grants totaling $7.8 million with close to 40 staff within the Section. The IDEPC Division, in which the Section is located, has a great amount of experience with managing larger grants along with a dedicated fiscal team to help in the process. The Section has previously managed Part B funds and has the working knowledge to do so again. The concept of managing community grants is the same regardless of funding.

It’s comforting to call one person at DHS with questions and not be bounced around.
Since Program HH would remain at DHS, consumers would still be able to call the Customer Care Specialist with questions and they would not be transferred from one person to another.

What is HIV Prevention and what does MDH do?
The goal of HIV prevention projects funded through MDH is to prevent as many new infections of HIV. This is achieved through targeted HIV testing to reach populations at highest risk and populations with greatest disparities; comprehensive prevention with positives through prevention counseling with HIV positive individuals, linkage to and re-engagement in care and linkage to treatment adherence services; targeted condom distribution to increase the number of HIV positive and high risk negative persons receiving condoms and information on correct use; PrEP services for high risk individuals and who wish to conceive; and syringe services for individuals who inject drugs.

MDH currently funds 20 organizations that target African, African-born, Hispanic, men who have sex with men, and injecting drug user populations as indicated by surveillance data. In addition to media campaigns, MDH also funds innovative social media projects that have successfully reached individuals that have not been reached in other ways. This has resulted in increased HIV testing and other prevention activities.

MDH also provides partner services and care link services that were previously described. In addition, MDH supports efforts to align structures, policies and regulations in MN to achieve optimal prevention, care and treatment.

Were community members who brought this issue to legislators living with HIV or did they have other interests?
In the past, individuals had conversations with Senators Lourey, Dibble, and Representative Hayden regarding the desirability of MDH managing Ryan White Services Part B. DHS cannot speak to the motives and HIV status of the individuals who met with the legislators.

What is the authority for these two agencies to proceed with the proposed change?
Both agencies believe it is within their purview to organize themselves to achieve maximum effectiveness and efficiency. However, if the proposal moves forward, and if it is later determined that legislative approval is needed, the authority will be sought.

Why leave Program HH at DHS?
Program HH is a health care program, providing insurance service for people who would be uninsured. DHS administers health care programs for the State.
Will the Consumer Advisory Committee continue?
Yes, the CAC will continue.

Contacts

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