

# OUTPATIENT/AMBULATORY MEDICAL CARE SERVICE AREA REVIEW

## Service Area Definition:

**Outpatient/Ambulatory Medical Care (Health Services)** is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings. Services includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). Funds may be used to pay co-pays, coinsurance costs and/or deductibles for uninsured or underinsured patients.

**Service Activity:** Primary Medical Care and Culturally Appropriate Primary Medical Care  
*[Formerly Medical and Dental Services, Primary Medical Care and Culturally Appropriate Primary Medical Care]*

**HRSA Core Medical Service: A. Outpatient/Ambulatory Medical Care (Health Services)**

## Service Activity Definition:

**Primary Medical Care** - the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies.

**Culturally Appropriate Primary Medical Care** - services that provide and/or increase access to outpatient HIV health care in a culturally appropriate manner.

**2006-08 SERVICE AREA PRIORITY: 1 of 23**

**2004-06 SERVICE AREA PRIORITY: 1 of 15**

2006-7 Allocation	2006-7 Expenditure	Activity	2007-8 Post Award Allocation
\$162,000	\$161,974	Primary Care	\$286,174
\$91,400	\$91,400	Culturally Appropriate Primary Care	\$123,829

In 2006, 418 **people** used primary health care services, according to MDH services utilization data. This is 7.5% of all HIV+ people, and 10.8% of all HIV+ people in services.

*Demographics	Epi #	Epi %	ALL Service Use #	ALL Service Use %	Primary Care Service Use #	Primary Care Service Use %
All	5566	100%	3888	100%	<b>418</b>	<b>100%</b>
Male	4300	77.3%	2838	73.0%	<b>283</b>	<b>67.7%</b>
Female	1266	22.7%	1027	26.4%	<b>129</b>	<b>30.9%</b>
Transgender			23	0.6%	<b>6</b>	<b>1.4%</b>

<b>Race:</b>						
American Indian	97	1.7%	123	3.2%	9	2.2%
Asian/Pacific Islander	83	1.5%	119	3.1%	13	3.1%
Black	1889	33.9%	1241	31.9%	118	28.2%
Caucasian	3035	54.5%	1727	44.4%	83	19.9%
Other	35	0.6%	427	11.0%	100	23.9%
<b>Ethnicity:</b>						
Hispanic/Latino	427	7.7%	251	6.5%	95	22.7%
<b>*Demographics</b>	<b>Epi #</b>	<b>Epi %</b>	<b>ALL Service Use #</b>	<b>ALL Service Use %</b>	<b>Primary Care Service Use #</b>	<b>Primary Care Service Use %</b>
<b>Transmission:</b>						
MSM	2844	51.1%	1493	38.4%	131	31.3%
IDU	394	7.1%	218	5.6%	31	7.4%
MSM/IDU	289	5.2%	117	3.0%	17	4.1%
Heterosexual	662	11.9%	1054	27.1%	165	39.5%
Perinatal	50	0.9%	27	0.7%	0	0%
Blood/hemophilia	45	0.8%	45	1.2%	3	0.7%
Unknown	1282	23.0%	034	24.0%	71	17.0%
<b>Age*:</b>						
<13	27	0.5%	17	0.4%	0	0%
13-19	43	0.8%	27	0.7%	1	0.2%
20-24	169	3.0%	152	3.9%	22	5.3%
25-29	398	7.2%	352	9.1%	62	14.8%
30-34	507	9.1%	395	10.2%	61	14.6%
35-39	846	15.2%	604	15.5%	77	18.4%
40-44	1235	22.2%	834	21.5%	97	23.2%
45-49	1030	18.5%	669	17.2%	51	12.2%
50+	1303	23.4%	838	21.6%	47	11.2%
Unknown	8	0.1%	0	0%	0	0%
<b>Geography:</b>						
Hennepin	3175	57.0%	2273	58.5%	212	50.7%
Ramsey Co.	991	17.8%	692	17.8%	90	21.5%
Other 7 counties	625	11.2%	359	9.2%	57	13.6%
Other 13 counties**	65	1.2%	26	0.7%	2	0.5%
Greater Minnesota	741	13.3%	386	9.9%	6	1.4%
Unknown	34	0.6%	11	0.3%	51	12.2%
<b>Country of Origin:</b>						
United States	2444	43.9%	2064	53.1%	95	22.7%
Other	1005	18.1%	588	15.1%	154	36.8%
Unknown	2117	38.0%	1235	31.8%	169	40.4%

Data from "Persons Living with HIV/AIDS by Exposure Category, etc. Minnesota 2006, by MDH, n.d.

Epi data does not include Wisconsin counties.

9 uninfected clients were served in 2006.

Transgender identity is not collected in surveillance/epi. All transgender people reported through CLRS in 2006 (N=23) were male-to-female.

"Other" race/ethnicity category "Unknown," "Other," "refused", and "More than 1 race"

Hispanic ethnicity is reported separately from race for surveillance/epi and services.

Other 7-county metro includes clients living in Anoka, Carver, Dakota, Scott and Washington counties (7-county metro area excluding Hennepin and Ramsey counties).

Other 13—county metro includes clients living in Chisago, Isanti, Sherburne, and Wright counties in MN and Pierce and St. Croix counties in WI (13 county EMA excluding the 7 county metro area).

Unknown for services geography includes 11 out-of-state clients.

**SERVICE ACTIVITY UTILIZATION HISTORY FOR PRIMARY MEDICAL CARE:**

Year	Primary Medical Care	Total Epidemiology	Percent of Epidemiology	Total in HIV Services	Percent of those in HIV services
<b>2006</b>	<b>418</b>	<b>5,566</b>	<b>7.5%</b>	<b>3888</b>	<b>10.8%</b>
<b>2005</b>	<b>289</b>	<b>5,233</b>	<b>5.5%</b>	<b>3752</b>	<b>7.8%</b>
<b>2004</b>	<b>33</b>	<b>5,002</b>	<b>0.7%</b>	<b>3,838</b>	<b>0.9%</b>

**EVALUATION OF CULTURALLY APPROPRIATE PRIMARY CARE SERVICE ACTIVITY**

There is one outcome for primary care: **Improved Clinical Outcomes**. [This means that CD4 counts increase, while viral loads decrease.] This report, for August 2006, includes clinical information for a cumulative total of 173 unduplicated clients who have been receiving culturally appropriate primary health care.

**DEMOGRAPHICS:**

Of the 173 unduplicated patients for whom we have information:

- 76.9% (133) identified as male, 22.0% (38) identified as female, and 1.2% (2) identified as transgender
- 72.8% (126) patients identify themselves as Latino; 9.2% (16) as Caucasian/White; 7.5% (13) each as African and African American; and 0.6% (1) each American Indian and Asian/Pacific Islander. There was either missing information or the identification of "Unknown/Unreported" for 1.7% (3) patients.

**YEAR WHEN PATIENT BEGAN HIV CARE:**

Of the 173 unduplicated patients receiving culturally appropriate medical care for HIV:

- 26.6% (46) began care between 2004 and 2006;
- 34.7% (60) began care between 2001 and 2003;
- 29.5% (51) began care between 1998 and 2000;
- 4.6% ( 8) began care before 1998;
- Information is missing for 0.5% (1) patient.

**TARGET GROUPS:**

For the 173 unduplicated clients in the current data base:

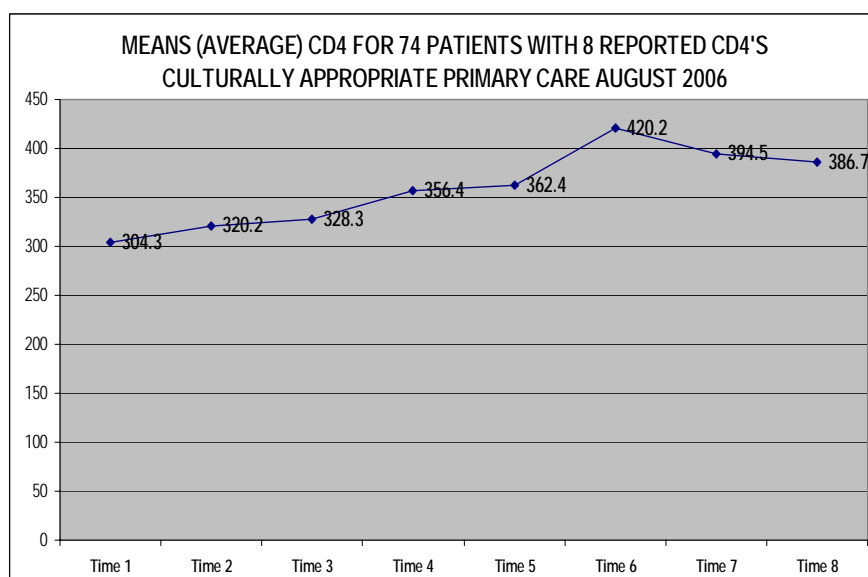
- 24.3% (42) are identified as coping with chemical dependency;
- 9.8% (17) are currently using chemicals/alcohol in a way which affects health care use.
- 6.4% (11) have unstable housing;

**OUTCOME: IMPROVED CLINICAL OUTCOMES**

**CD4 COUNTS**

There are a number of ways in which this report analyzes the reported CD4 counts for patients receiving culturally appropriate primary care. All of them show improvement (increase) over time for the majority of patients. Specifically this report indicates the following:

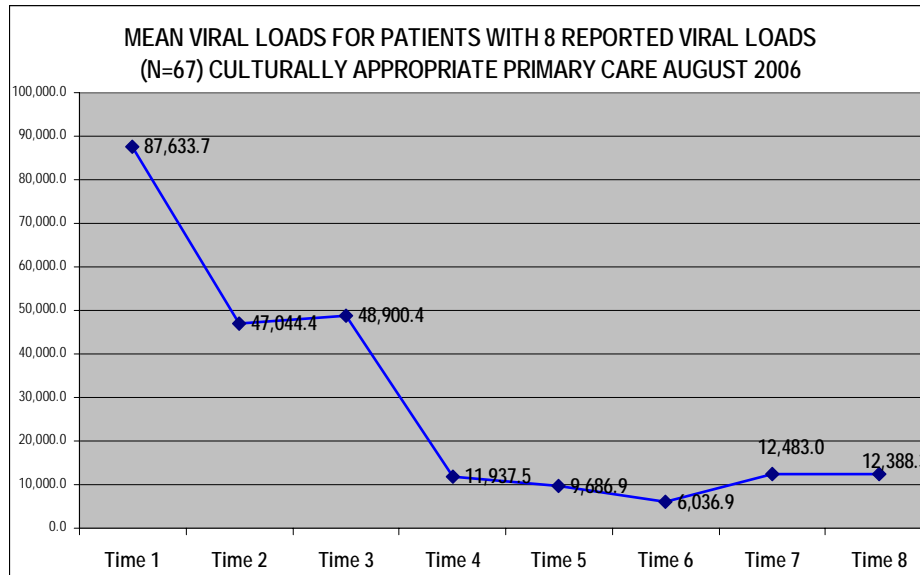
- At the baseline (the first CD4 count when patients began receiving HIV medical care through this program), 32.7% (55) of patients had CD4 counts of 200 or less; 35.7% (60) had counts between 201 and 400; 16.7% (28) had counts between 401 to 600, and 10.1% (17) had CD4 counts over 600. Information was missing for 4.8%.
- Among all patients (varying N), the average CD4 count increased from 312.3 at baseline to 392.3 at Time 8; the median increased from 282.5 at baseline to 346.0 at Time 8.
- Looking at clinical reports over eight time points (using the CD4 counts for only the 74 patients who had eight reported CD4's), **there was a statistically significant improvement in CD4 counts.** (Using a one-way repeated measures ANOVA revealed a significant effect for time, Wilks' Lambda,  $p = .009$ ) For these 74 patients, the average CD4 count increased from 304.3 at Baseline to 386.7 at Time 8.
- We also examined progress for patients who had CD4 counts of 200 or below at baseline (55, or 32.7% of the 173 patients at baseline). At Time 8, among those who began with CD4 counts <200 and had eight reported CD4's, **78.6% had improved their CD4 counts to above 200.**



## VIRAL LOADS

There are a number of ways in which this report analyzes the reported viral loads for patients receiving culturally appropriate primary care. All of them show improvement (decrease) over time for the majority of patients. Specifically this report indicates the following:

- At baseline, 78.0% (135) of the 147 patients had detectable viral loads, while **13.7% (23) had undetectable viral loads.** 18.5% (31) of clients had low viral loads [76 to 5000]; 39.9% (67) had medium [5001 to 50,000] and 22.0% (37) had high viral loads [ $>50,000$ ].
- Among all patients, the *mean* (average) viral load decreased from 72,502.2 at Baseline to 11,064.4 at Time 8. The *median* (midpoint) decreased from 16,880.5 at the Baseline to 75.0 (undetectable) at Time 8.
- Looking at clinical reports over eight time points for 67 patients (who had eight reported viral loads), **there was not a statistically significant improvement in viral load reports.** Among these 67 patients, the average viral load decreased from 178,851.8 at Baseline to 42,711.9 at Time 8. [There was, however, a statistically significant change at Time 7 (Wilks Lambda,  $p = .005$ )]
- We also examined those who had detectable viral loads at the Baseline; **by Time 8, 55.7% of those who had an eighth viral load reported had moved from detectable to undetectable viral load.**



### CHANGE FOR INDIVIDUALS

Examining changes for each individual was done using categories and looking at changes between the Baseline and subsequent points. Change between each time point was statistically significant for both CD4 and viral loads. This comparison revealed that:

- From Baseline to Time 2, (129 patients with CD4 tests), 13% showed improvement; 78% remained the same, and 9% had worse reports of CD4 counts.
- From Baseline to Time 3 (127 patients with viral load tests) 35% improved, 54% remained the same and 11% reported worse viral load reports.
- Comparing Baseline to Time 8, (79 patients) **47% improved their CD4 count; 35% remained the same (by category) and 18% had worse CD4 counts (by category).**
- For viral loads between Baseline and Time 8, (76 patients), **66% had the same VL (by category); while 26% improved and 8% had worse viral load reports.**

### TARGET GROUP DIFFERENCES

Comparison of means for both CD4 and viral load at all time points by target group characteristics found:

- There was a statistically significant difference ( $p=.048$ ) only at Baseline based on housing stability.
- Statistically significant differences based on coping with chemical dependency at Time 2 ( $p=.000$ ), Time 3 ( $p=.022$ ); Time 4 ( $p=.025$ ); Time 5 ( $p=.003$ ); and Time 6 ( $p=.003$ ) but NOT at Time 7 or Time 8.
- There was a statistically significant difference based on actively using chemicals/ alcohol in a way which affects health care only at Time 2 ( $p=.044$ ).

In short, although there are some statistically significant differences at Baseline or early in their health care, over time those differences in clinical indicators do not persist.

# Assessing the Needs of Minnesotans Living With HIV or AIDS: Results of a Community Survey

Positive Outcomes, Inc. and Community Consulting Group, LLC August 2006

The Hennepin County Human Services and Public Health Department funded a voluntary survey of Minnesota HIV-infected residents to assess access to HIV clinical and psychosocial support services, evaluate the impact of recent changes in Minnesota State health insurance programs, measure unmet need, and help to plan the allocation of HIV services funds. Residents of Minnesota counties included in the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act Title I Eligible Metropolitan Area (EMA) were surveyed. These counties include Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington, and Wright Counties. Residents of other Minnesota counties also were surveyed. The survey was designed and conducted by Positive Outcomes, Inc. (POI) and Community Consulting Group (CCG).

A voluntary survey of 379 HIV-infected Minnesota residents was conducted in Spring 2006. The survey administered by HIV program staff assessed respondents' health insurance coverage, use of HIV clinical and support services, and unmet need.

Almost all survey respondents (96%) reported being enrolled in private health insurance, health maintenance organizations (HMOs), or publicly-funded health insurance. National estimates of uninsured HIV-infected individuals are five-times higher than among those surveyed. Almost one-half (46%) of privately insured and HMO beneficiaries reported that their premiums increased in the twelve months before the survey. Copayments and deductibles were reported by 40% of beneficiaries to have increased.

A wide array of Minnesota publicly funded health insurance programs serve as a safety net for the HIV-infected disabled, employed individuals unable to afford health insurance premiums, and unemployed indigent individuals. Almost one-half (47%) of survey respondents were enrolled in the Minnesota Medical Assistance Program (Medicaid). About one-quarter of respondents (23%) were enrolled in the Minnesota Department of Human Services (DHS) HIV/AIDS Insurance Program while 15% were enrolled in the Minnesota AIDS Drug Assistance Program (ADAP), 13% in the General Assistance Medical Care Program, 8% in the Minnesota Supplemental Aid (MSA) Program, 6% in the MinnesotaCare Program, and 6% in the Medical Assistance for Employed Persons with Disabilities (MAEPD) Program. Enrollment in Minnesota publicly funded programs was reported to be relatively stable in the twelve months before the survey.

Medicare enrollment also has contributed to the high rate of health insurance coverage among HIV-infected Minnesotans, with over one-third (35%) of respondents enrolled in Medicare. Among this group, 72% got help from an organization, family member, or other source to enroll in Medicare Part D. Only 7% of Medicare beneficiaries enrolled in Part D reported that they needed help to enroll in Medicare Part D but did not get it.

The array of Minnesota private and public insurers have contributed to the relatively high rate of HIV-infected survey respondents (98%) with a usual source of HIV primary care. Most respondents (92%) had visited a doctor's office, clinic, or emergency room (ER) within the six months before the survey. Only 1% of respondents reported no HIV medical visits in the twelve months before the survey. Only 7% of respondents reported that they needed but did not get specialty medical care in the six months before the survey. Over three-quarters (78%) of respondents were taking HIV medications at the time of the survey. Only 2% of the respondents reported that they stopped taking HIV medications during the six months before the survey.

While respondents were almost universally insured and had high rates of HIV medical care rates, some respondents reported financial trade-offs between paying for health care and essentials of daily living. About one-tenth (13%) of respondents reported that they had to go without health care because the money was needed for food, clothing, housing, etc. Conversely, 18% of respondents reported that they had to go without the money for these essentials of daily living because the money was needed for health care or medication.

The relationship between demographic and geographic characteristics and health insurance coverage, service use, and unmet need was explored. Women respondents were significantly less likely than men to be uninsured and more likely to be enrolled in publicly funded health insurance programs. The rates of having a usual source of HIV primary care, being on HIV medications, and a usual source of dental care were similar for women and men. Women had a higher average number of HIV medical visits than men in the twelve months before the survey. No gender differences were found in the probability of trading off the cost of medical care and medications and the essentials of daily living.

The relationship between race and ethnicity and health insurance coverage, service use, and unmet need were assessed. Whites had a higher rate of private health insurance and HMO enrollment than non-Whites. Conversely, non-Whites had a higher rate of enrollment in Minnesota publicly funded programs. Race and ethnicity was not associated with having a usual source of HIV primary care, currently using HIV medications, stopping HIV medication in the last six months, or financial trade-offs between paying for health care and essentials of daily living. No race or ethnic differences were found in the rates of needing but not getting HIV medical care, specialty medical care, drug or alcohol treatment, or psychiatric, psychological, or mental health counseling. There was no statistically significant race or ethnic difference in the average number of HIV primary care visits in the twelve months before the survey..

Disability rates were statistically significantly different in the HIV exposure groups, ranging from 69% for IDUs and MSM/IDUs to 53% for MSM, and 31% for individuals infected with HIV due to heterosexual contact. Rates of AIDS diagnosis; however, were not associated with HIV exposure group. There was a statistically significant difference in the average number of HIV primary care visits made in the twelve months before the survey. Male MSM IDUs had an average of 4.9 visits compared to 6.3 visits for MSM, 7.9 visits for IDUs, and 8.1 visits for individuals infected with HIV through heterosexual contact.

The survey responses of MSM were studied to determine if there were differences in health insurance coverage, service use, and unmet need among White and non-White MSM. The rate of White MSM enrolled in private insurance or HMOs was significantly higher than the rate of non-White MSM, 31% versus 14%. Non-White MSM were more likely than White MSM to report needing but not getting case management in the six months before the survey, 18% versus 6%. White MSM were statistically significantly more likely than non-White MSM to have a usual source of dental care, 72% versus 54%. The average number of services needed but not received in the six months before the survey was statistically significantly different, with non-White MSM reporting an average of 2.3 needed services and Whites reporting an average of 1.6 services.

No geographic differences between EMA and non-EMA residents were identified in rates of being uninsured or enrollment in private health insurance, HMOs, Medicaid, Medicare, or the Minnesota DHS HIV/AIDS Insurance Program. ADAP enrollment rates did differ; however, with 13% of EMA respondents compared to 25% of non-EMA respondents enrolled in ADAP. There was a statistically significant geographic difference in the rate of current HIV medication use. EMA residents were statistically significantly less likely to report currently using HIV medications than residents of other counties (77% versus 86%). No geographic differences were found in other service utilization or unmet need rates.

## **Do survey respondents have access to HIV clinical services and HIV medications?**

Almost all (98%) respondents have a usual source of HIV primary care. This rate is the same as was reported by the 2004 CLEAR survey. Only one individual reported that the emergency room was their usual source of HIV primary care. Respondents with no usual source of care did not report any factors impairing their access to HIV primary care. Less than 1% of respondents reported no visits to a doctor's office, clinic, or ER for HIV care in the previous twelve months. Respondents with a usual source of care reported having an average of seven visits. Only 7% of respondents had one or two visits, fewer than recommended by Public Health Service guidelines for adolescents and adults. Most (92%) respondents had visited a doctor's office, clinic, or ER for HIV care within the six month before the survey, while 7% had their most recent visit in 2005, and less than 1% had their most recent visit in 2004.

Less than one-tenth (7%) of respondents reported needing HIV medical care in the six months before the survey but not getting it. Among this small group, 32% reported they could not afford HIV medical care,

16% did not know where to find care, 4% could not take the time to get help, 4% could not get an appointment, 12% could not get transportation, 12% reported that there was no one available to help that the respondent liked or trusted, and 8% did not know where to find help from someone who speaks the same language as the respondent. There was no statistically significant difference in barriers to HIV medical care identified in obtaining care between respondents residing in the EMA or outside the EMA.

Respondents were asked about their need for specialty medical care, such as a dermatologist, neurologist, gynecologist, or obstetrician. Specialty medical care was reported to be needed but not received in the six months before the survey by 7% of respondents. Among this group, 54% reported that they could not afford help, 15% did not know where to find help, 8% could not get an appointment, and 8% could not get transportation.

While survey respondents were almost universally insured and had excellent access to HIV primary care, some respondents reported financial trade-offs between paying for health care and essentials of daily living. Slightly greater than one-tenth (13%) of respondents reported that at sometime in the six months before the survey, they had to go without health care because the money was needed for food, clothing, housing, etc. Health care included co-payments, deductibles, cost shares, or medication payments. Conversely, 18% of respondents reported that at some time in the last six months they had to go without the money for food, clothing, housing, etc. because the money was needed for health care. The small number of responses related to foregoing health care or essentials of daily living precluded analysis of associated respondent characteristics.

Over three-quarters (78%) of respondents were taking HIV medications at the time of their interview. Among respondents that did not use HIV medications at the time of the survey:

- . 34% reported that their doctor did not prescribe any HIV medications,
- . 13% did not think that they needed the medication,
- . 9% reported that the medications have side effects,
- . 5% reported that they could not afford the medication,
- . 4% reported that the medication is too complicated, and
- . 3% reported that people told the respondent that the medications were no good.

Only 2% of the respondents reported that they stopped taking HIV medications during the six months before the survey. Respondents not taking HIV medications tended to be younger than their counterparts taking medications (40 versus 43 years of age), HIV-infected for a shorter time (seven versus ten years), disabled, IDUs, and/or uninsured. Small response rates; however, hampered the analysis examining demographic, insurance, or other factors associated not using HIV medications.

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## **2003 CONSUMER RANKING OF SERVICES**

This information is based on interviews with 242 HIV+ Minnesota conducted during 2003 (where applicable comparison is made with the 1999 needs assessment). The people interviewed may or may not have been in services, or at the time using case management services.

After asking each person four questions about each service, we asked each participant to choose the top five (or most important) services, and the bottom five, (or least important) services – as they saw them.

[Imagine that we are looking at a theoretical 1210 votes – @ 242 people x 5 votes. In actuality, there were 1125 votes cast in ranking the five highest services, and 1041 for the ranking of the five lowest services. The service which gets the most votes is ranked highest (for top ranked services) or lowest (for bottom ranked services).] The results are on the following tables.

SERVICES	1999 RANKINGS			2003 RANKINGS		
	Rank (of 24)	# of Top Five Votes	% of Top Five Votes	Rank (of 25)	# of Top Five Votes	% of Top Five Votes**
Emergency Financial Assistance	4	68	6.62%	1	135	12.1%
Case Management	3	84	8.18%	2	127	11.3%
<b>Primary Medical</b>	<b>1</b>	<b>143</b>	<b>13.93%</b>	<b>3</b>	<b>117</b>	<b>10.4%</b>
ADAP	2	100	9.74%	4	95	8.4%
Transportation	8	60	5.84%	5	86	7.6%

Note: In the ranking of the bottom five services – those that would be cut if need be – there was only one vote out of 1041 for Primary Health Care.

## KEY POINTS FOR PRIMARY CARE AND CULTURALLY APPROPRIATE PRIMARY CARE

*[Key points are created for and approved by the Needs Assessment and Evaluation Committee, based on their review of a service area/activity (SAR), which includes utilization data, outcome data, and detailed information from past Needs Assessments.]*

In reviewing this activity, the Needs Assessment and Evaluation Committee notes that the funding and utilization information are based on the Part A & B funding for primary care or culturally appropriate primary care only. This does not reflect all funding, or utilization, of primary care for HIV. There are additional funds covered through health insurance (whether private or public) as well as additional funds which come from other Parts/Titles of Ryan White.

The Committee would also like to emphasize that while there is funding for a culturally specific provider (including Minority AIDS Initiative funding) for primary health care/ambulatory/outpatient medical care, all health care providers see ethnically, culturally, racially, and linguistically diverse patients. There have also been efforts in this TGA [Transitional Grant Area] to provide training and assistance in developing cultural competence among all Ryan White-funded providers.

The Needs Assessment and Evaluation Committee understands the increasing emphasis from HRSA on gathering CD4 and viral load formation from all providers who are funded for primary health care/ambulatory outpatient medical care. At the same time, Committee members want to emphasize that this is not the only way to assess patient outcomes and are concerned about how such data might be used. [Committee members want to stress that such data never be used to assess patient adherence, nor considered for planning or implementing rationing of primary medical care.] If additional data are collected, this should be done in a way which does not impose additional, undue burden, on providers.

### POINTS FROM NEEDS ASSESSMENT & EVALUATION COMMITTEE DISCUSSION:

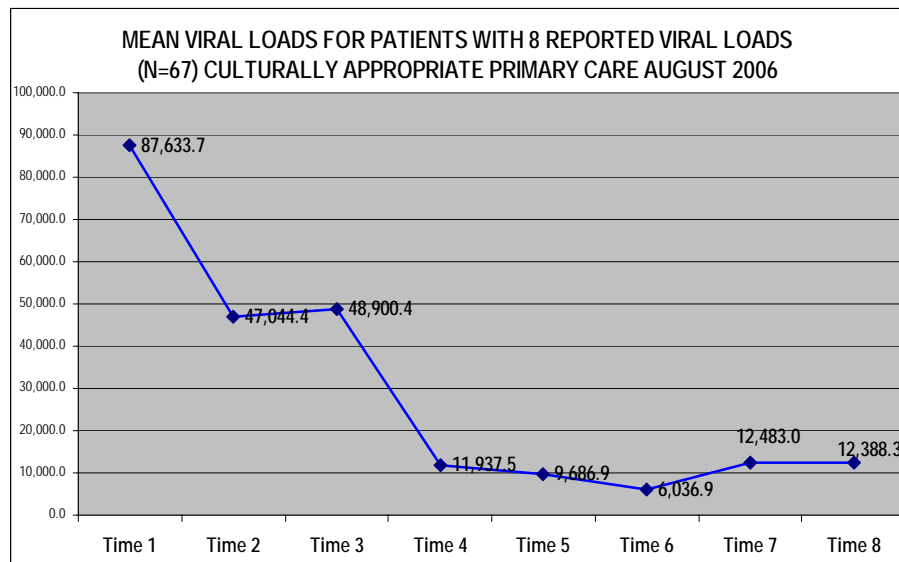
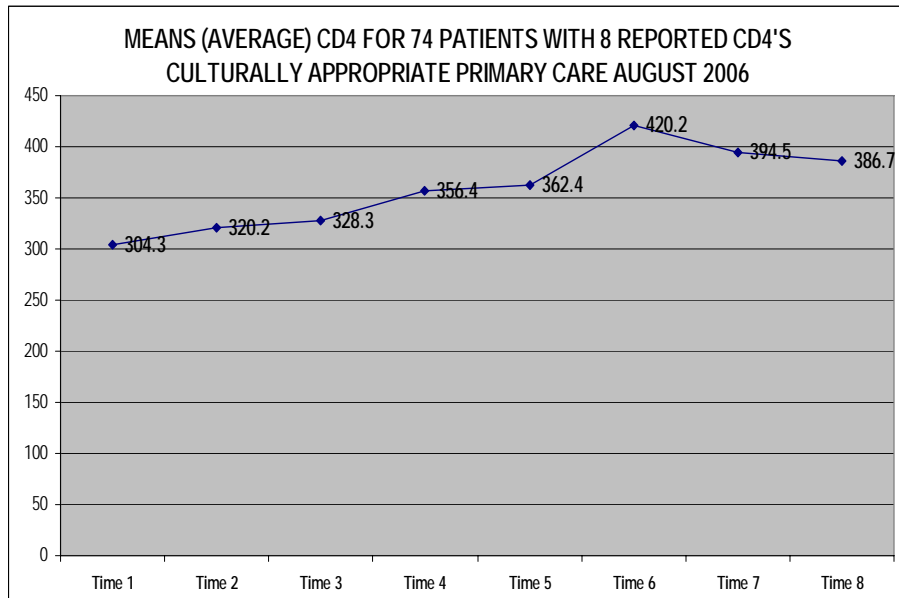
- ◆ The TGA's (Transitional Grant Area) estimate of unmet need for primary health care (defined as people who know their HIV+ status and have not had a (reported or estimated) CD4 or viral load test in the previous 12 months) is currently 26%, and, in the past, has ranged from 35 to 40%. This underscores the importance of providing both core medical and supportive services to help HIV+ Minnesotans get into and maintain primary HIV care.
- ◆ It is important to understand that Ryan White funds, as payer of last resort, supplement gaps in medical costs, even for insured patients. This is important to maintain care for patients, and to assure that the system of care is not threatened or undermined by funding gaps and underpayment.
- ◆ It is also important to understand that the medical care needed becomes increasingly complex as people live longer with this disease.

### COMMENTS ABOUT THE CULTURALLY-SPECIFIC PROGRAM:

- ◆ The currently funded culturally specific program is an important and effective program of primary care for HIV. It serves relatively small numbers of people and, by definition, people who do not have other sources or means to pay for primary care. Note: this program receives MAI (Minority AIDS Initiative) funding.
- ◆ The currently funded program provides culturally appropriate primary care in Spanish, serving primarily, but not exclusively, Latino patients. This is important as the disease prevalence is disparate for Latinos (rate of 30.7 compared to the European American population rate of 3.6, according to MDH 2006 Surveillance Report.). In addition, changes in access to publicly funded health insurance have made it more difficult for some Latinos (and others who are out of status) to have access to other resources for health care. [The NA&E Committee notes

that the rates for African Americans and Africans are also disproportionately high; and the documentation and status challenges are also issues for many Africans.]

- ◆ A previous needs assessment and the ongoing epidemiological updates also find Latinos disproportionately represented in those who are diagnosed with AIDS at the time of initial testing for HIV. Since 2004, the proportion of Latinos who had AIDS at first HIV diagnosis was greater than any other racial or ethnic group. Given these data, it would seem likely that the current demand for culturally appropriate HIV primary health care will continue and probably increase.
- ◆ Outcomes from the current program [*Culturally Appropriate Primary Health Care Outcomes Report, August 2007, CLEAR*] indicate that patients who receive ongoing care have improved clinical outcomes – an increase in CD4 counts and a decrease in viral load. The following graphs illustrate this:



Revised after NA&E Committee discussion, June, July and October 2007.  
Adopted 11/27/2007

## APPENDIX: INFORMATION FROM 2003 NEEDS ASSESSMENT RELEVANT TO PRIMARY MEDICAL CARE

This information is based on interviews with 242 HIV+ Minnesota conducted during 2003 (where applicable comparison is made with the 1999 needs assessment). The people interviewed may or may not have been in services, or at the time using case management services.

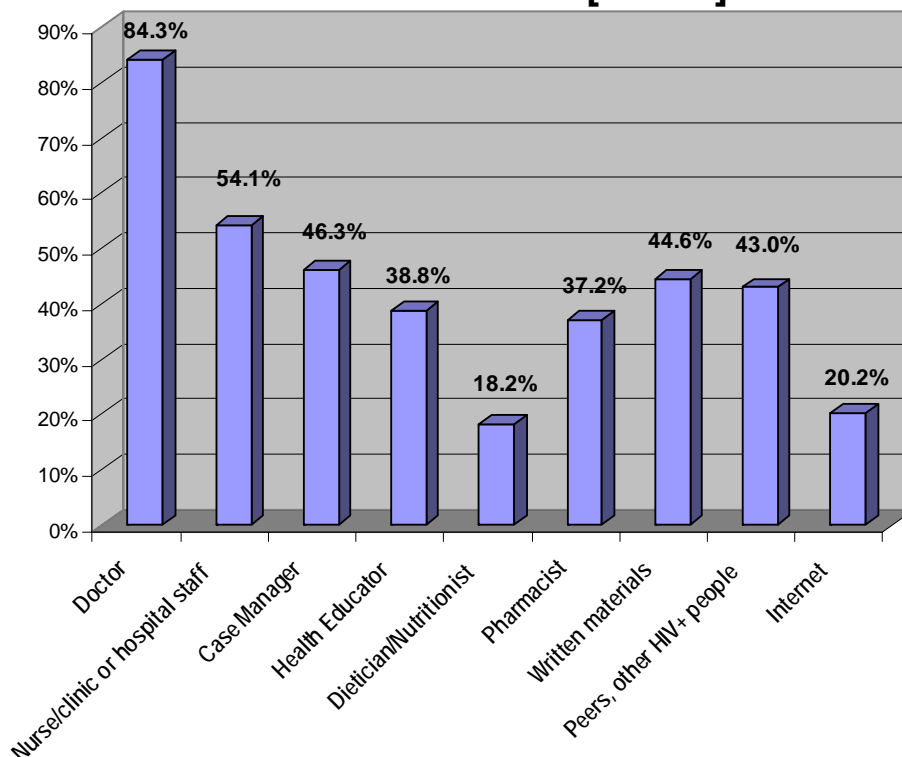
### SOURCES OF INFORMATION ABOUT HIV MEDICAL CARE.

We were interested in knowing what sources of information people found useful for learning about medical care and treatments for HIV/AIDS (as compared to services). We asked, "How useful have the following sources of information been in providing you with clear, useful information about medical care and treatments for HIV/AIDS?"

SOURCE OF INFO	Very Useful		Somewhat Useful		Not Very Useful		Have Not Used		NA /Missing	Mean
	#	%	#	%	#	%	#	%		
<b>2003 DOCTOR</b>	<b>204</b>	<b>84.3%</b>	<b>23</b>	<b>9.5%</b>	<b>6</b>	<b>2.5%</b>	<b>8</b>	<b>3.3%</b>	<b>1</b>	<b>2.85</b>
1999 Doctor	164	74.5%	34	15.5%	3	1.4%	13	5.9%	5	
<b>2003 NURSE/ CLINIC STAFF</b>	<b>131</b>	<b>54.1%</b>	<b>56</b>	<b>23.1%</b>	<b>22</b>	<b>9.1%</b>	<b>17</b>	<b>7.0%</b>	<b>16</b>	<b>2.52</b>
1999 Nurse, etc.	141	64.1%	47	21.4%	11	5.0%	15	6.8%	6	
<b>2003 CASE MANAGER</b>	<b>112</b>	<b>46.3%</b>	<b>51</b>	<b>21.1%</b>	<b>21</b>	<b>8.7%</b>	<b>48</b>	<b>19.8%</b>	<b>10</b>	<b>2.50</b>
1999 Case manager	109	49.5%	61	27.7%	11	5.0%	32	14.5%	7	
<b>2003 HEALTH EDUCATOR</b>	<b>94</b>	<b>38.8%</b>	<b>41</b>	<b>16.9%</b>	<b>15</b>	<b>6.2%</b>	<b>70</b>	<b>28.9%</b>	<b>22</b>	<b>2.53</b>
1999 Health Educator										
<b>2003 DIETICIAN/ NUTRITIONIST</b>	<b>44</b>	<b>18.2%</b>	<b>33</b>	<b>13.6%</b>	<b>10</b>	<b>4.1%</b>	<b>132</b>	<b>54.5%</b>	<b>23</b>	<b>2.39</b>
1999 Dietician/nutritionist	26	11.8%	37	16.8%	11	5.0%	132	60.0%	14	
<b>2003 PHARMACIST</b>	<b>90</b>	<b>37.2%</b>	<b>52</b>	<b>21.5%</b>	<b>9</b>	<b>3.7%</b>	<b>68</b>	<b>28.1%</b>	<b>23</b>	<b>2.54</b>
1999 Pharmacist	57	25.9%	63	28.6%	15	6.8%	73	33.2%	12	
<b>2003 WRITTEN MATERIALS</b>	<b>108</b>	<b>44.6%</b>	<b>55</b>	<b>22.7%</b>	<b>11</b>	<b>4.5%</b>	<b>49</b>	<b>20.2%</b>	<b>19</b>	<b>2.56</b>
1999 Written Materials	92	42.3%	65	29.5%	13	5.9%	38	17.3%	11	
<b>2003 PEERS/HIV+ PEOPLE</b>	<b>104</b>	<b>43.0%</b>	<b>57</b>	<b>23.6%</b>	<b>13</b>	<b>5.4%</b>	<b>54</b>	<b>5.8%</b>	<b>14</b>	<b>2.52</b>
1999 Peers, etc.	90	40.9%	55	25.0%	13	5.9%	53	24.1%	9	
<b>2003 INTERNET</b>	<b>40</b>	<b>20.2%</b>	<b>27</b>	<b>11.2%</b>	<b>15</b>	<b>6.2%</b>	<b>131</b>	<b>54.1%</b>	<b>20</b>	<b>2.37</b>
1999 Internet	36	16.4%	21	9.5%	2	0.9%	155	70.5%	6	
<b>2003 OTHER</b>	<b>34</b>	<b>14.0%</b>	<b>9</b>	<b>3.7%</b>	<b>3</b>	<b>1.2%</b>	<b>120</b>	<b>49.6%</b>	<b>76</b>	<b>2.67</b>

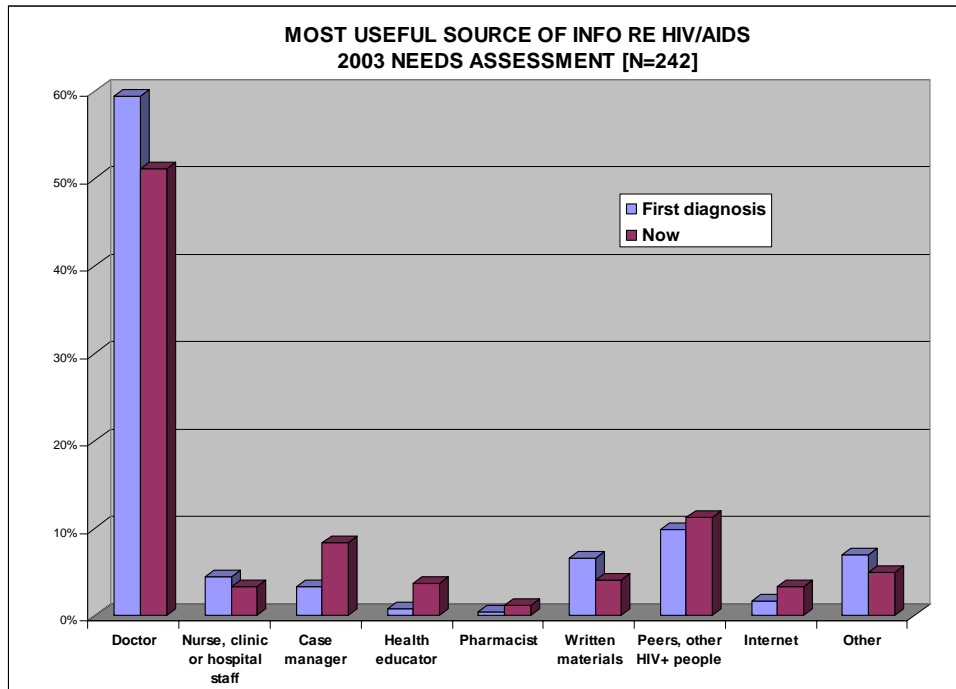
\*The mean/average is based on only those who report using this source.

## VERY USEFUL SOURCES OF INFO RE: HIV/AIDS 2003 NEEDS ASSESSMENT [N=242]



We also asked respondents to indicate which of these sources of information was most useful to them when first diagnosed, and which was most useful now. Responses are indicated on the following table. *Note that doctors stand out as the source rated most useful by the largest number of people at both time points – first diagnosis and “now.”*

MOST USEFUL INFO SOURCE	Most useful at first diagnosis		Most useful now	
	Frequency	Percent	Frequency	Percent
Doctor	144	59.5%	124	51.2%
Nurse, clinic or hospital staff	11	4.5%	8	3.3%
Case manager	8	3.3%	20	8.3%
Health educator	2	0.8%	9	3.7%
Pharmacist	1	0.4%	3	1.2%
Written materials	16	6.6%	10	4.1%
Peers, other HIV+ people	24	9.9%	27	11.2%
Internet	4	1.7%	8	3.3%
Other	17	7.0%	12	5.0%
No info/missing/does not apply	15	6.2%	21	8.7%
<b>Total</b>	<b>222</b>	<b>100%</b>	<b>242</b>	<b>100%</b>



**PHYSICIANS.** We also asked a number of questions about physicians. We asked those surveyed if they have a physician for HIV care, and a series of questions about their relationship with their physician. The results indicate that **92.3% of those interviewed report that they have an HIV doctor.**

Question	1999 Frequency	1999 Percent	2003 Frequency	2003 Percent
Do you have a primary care physician for HIV treatment?	207	92.7%	<b>226</b>	<b>93.4%</b>
Do you feel like your physician is knowledgeable about HIV?	194	88.2%	<b>219</b>	<b>90.5%</b>

**HOW OFTEN DO YOU SEE YOUR DOCTOR?** We also asked survey participants about how often they see their physician. The following chart indicates that a relatively small number (about 3%) of people see their physician frequently, which tends to correlate with poor health. **The majority (84.4%) see their physician on some interval of three months or less. About 9% see their physician less often and 8% did not report seeing a physician on a regular basis.**

HOW OFTEN SEE YOUR HIV DOCTOR	1999 Frequency	1999 Percent	2003 Frequency	2003 Percent
More than once a month	17	7.7%	<b>7</b>	<b>2.9%</b>
Monthly or every six weeks	83	37.7%	<b>65</b>	<b>26.9%</b>
Every three months	82	37.3%	<b>130</b>	<b>53.7%</b>
Every six months	13	5.9%	<b>16</b>	<b>6.6%</b>
Once a year or less	8	3.6%	<b>6</b>	<b>2.5%</b>
Missing/no answer/does not apply	17	7.7%	<b>18</b>	<b>8.4%</b>
Total	220	100%	<b>242</b>	<b>100%</b>

We also asked the date each respondent last saw his or her doctor. About 75% had seen his/her doctor in the previous three months.

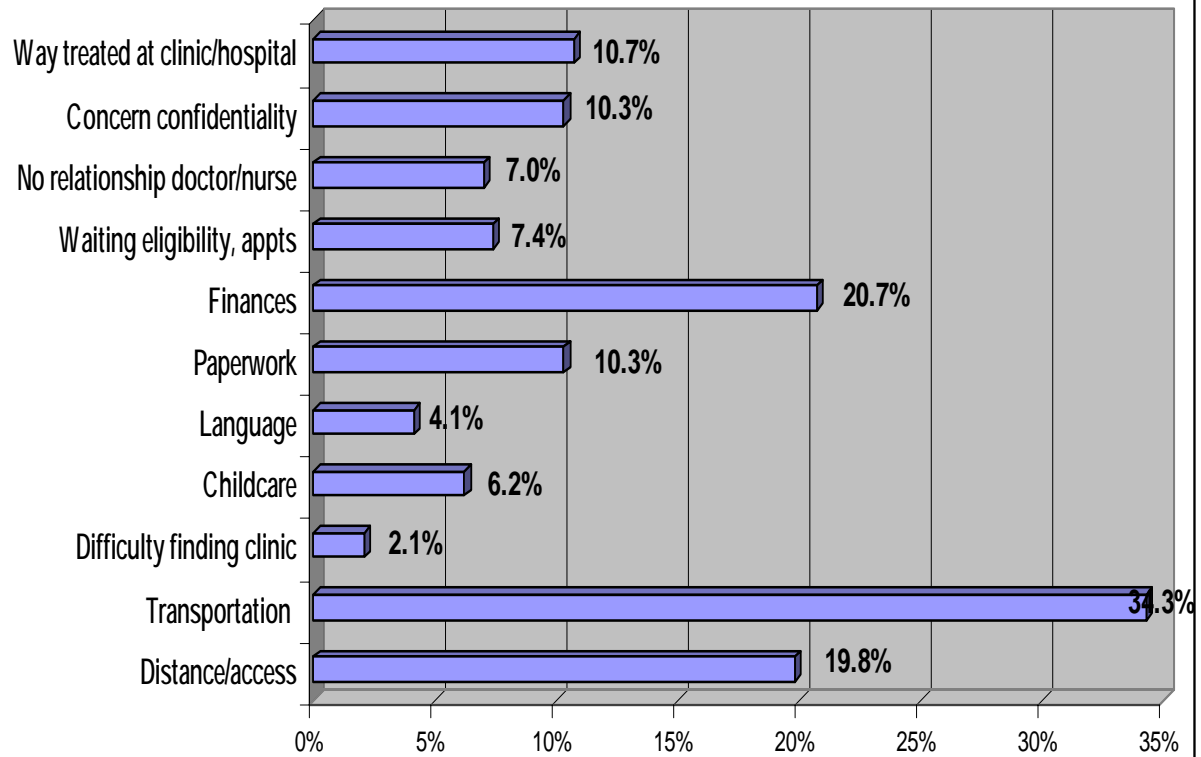
<b>LENGTH OF TIME LAST SAW DOCTOR</b>	<b>2003 Frequency</b>	<b>2003 Percent</b>
In the past month	<b>114</b>	<b>47.1%</b>
More than one month, less than 3 months	<b>72</b>	<b>29.8%</b>
More than 3 months, less than 6 months	<b>29</b>	<b>12.0%</b>
More than 6 months, less than 1 year	<b>8</b>	<b>3.3%</b>
More than one year ago	<b>2</b>	<b>0.8%</b>
More than two years ago	<b>2</b>	<b>0.8%</b>
Does not apply, not in care/no doctor	<b>9</b>	<b>3.7%</b>
Missing/no information	<b>6</b>	<b>2.5%</b>
<b>Total</b>	<b>242</b>	<b>100%</b>

## **BARRIERS AND FACILITATORS TO GETTING AND MAINTAINING MEDICAL CARE.**

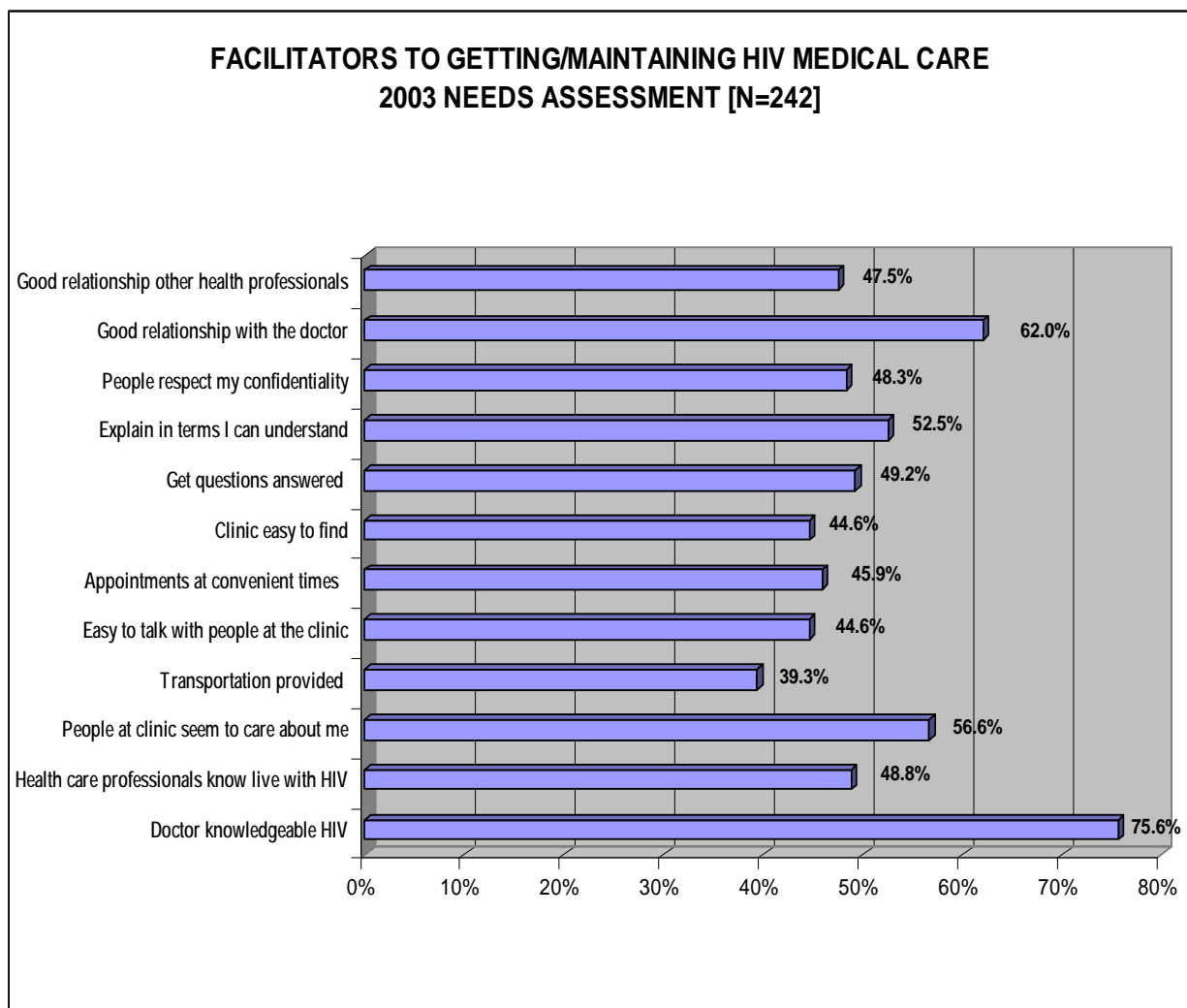
We asked each person interviewed to identify things that are *barriers* to getting and maintaining medical care, as well as things that work as *facilitators* to getting and maintaining medical care for HIV.

<b>HAVE ANY OF THE FOLLOWING BEEN BARRIERS TO GETTING OR MAINTAINING YOUR MEDICAL CARE FOR HIV?</b>	<b>2003 Frequency</b>	<b>2003 Percent</b>
Distance/access	<b>48</b>	<b>19.8%</b>
Transportation to appointments	<b>83</b>	<b>34.3%</b>
Difficulty finding the office or clinic	<b>5</b>	<b>2.1%</b>
Childcare	<b>15</b>	<b>6.2%</b>
Language	<b>10</b>	<b>4.1%</b>
Paperwork	<b>25</b>	<b>10.3%</b>
Finances	<b>50</b>	<b>20.7%</b>
Time waiting for eligibility, appointments	<b>18</b>	<b>7.4%</b>
No relationship with doctor or nurse, "feel like a number"	<b>17</b>	<b>7.0%</b>
Concern about confidentiality	<b>25</b>	<b>10.3%</b>
The way I was treated by people at clinic/hospital	<b>26</b>	<b>10.7%</b>

## BARRIERS TO GETTING/MAINTAINING HIV MEDICAL CARE 2003 NEEDS ASSESSMENT [N=242]



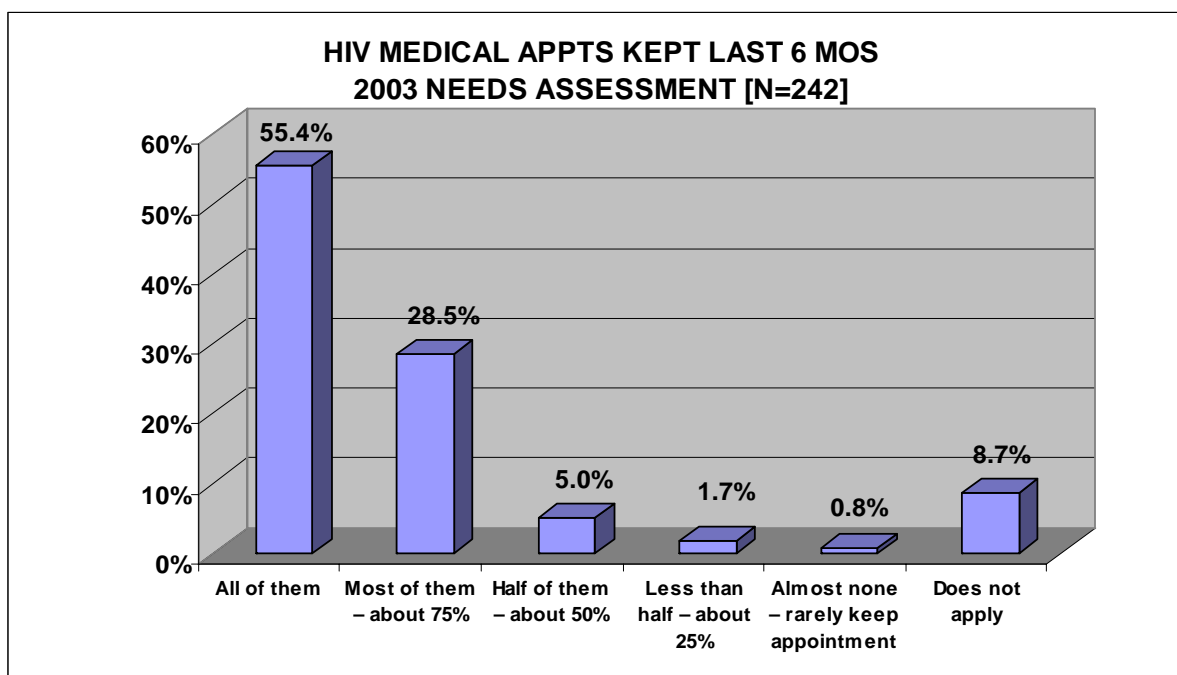
HAVE ANY OF THE FOLLOWING BEEN HELPFUL (FACILITATORS) FOR GETTING OR MAINTAINING YOUR MEDICAL CARE FOR HIV?	2003 Frequency	2003 Percent
Excellent doctor knowledgeable about HIV	183	75.6%
Other health care professionals knowledgeable about how to live with HIV	118	48.8%
People at the clinic seem to care about me	137	56.6%
Transportation is provided to get to medical care	95	39.3%
Easy to talk with people at the clinic	108	44.6%
Offers appointments at times convenient for me	111	45.9%
Clinic is easy to find	108	44.6%
I get my questions answered at the clinic	119	49.2%
People explain things in terms I can understand	127	52.5%
People respect my confidentiality	117	48.3%
Good relationship with the doctor	150	62.0%
Good relationship with nurse or other health professionals	115	47.5%



## MEDICAL ADHERENCE – MAKING AND KEEPING HIV MEDICAL APPOINTMENTS.

We asked about keeping medical appointments in the prior six months. In case management outcomes, case managers reporting on client's keeping medical appointments shows that about 75% of them keep most or all of their appointments. [This figure goes down to 32% for clients who are in unstable housing and currently using chemicals/alcohol in a way that interferes with health care.]

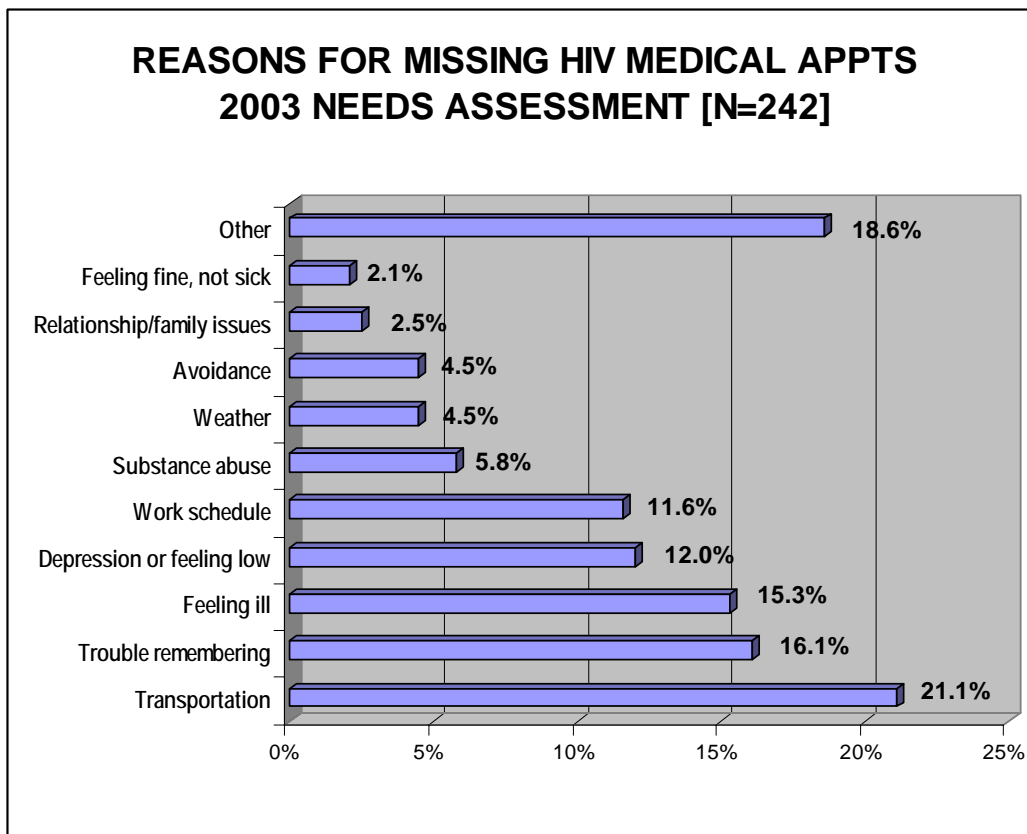
IN THE PAST SIX MONTHS, HOW MANY OF YOUR HIV MEDICAL APPOINTMENTS HAVE YOU KEPT?	2003 Frequency	2003 Percent
All of them	134	55.4%
Most of them – about 75%	69	28.5%
Half of them – about 50%	12	5.0%
Less than half – about 25%	4	1.7%
Almost none – rarely keep appointment	2	0.8%
Missing/no info/does not apply	21	8.7%
Total	242	100%



We also asked what people do when they miss a medical appointment. *The majority – 185 or 76.4 % -- indicated they call to reschedule.* Only 3 people (1.2%) indicated they wait until contacted, and 2 people (0.8%) said they do nothing until they get sick. We also asked people to indicate reasons they miss medical appointments.

<b>REASON FOR MISSING HIV MEDICAL APPOINTMENT*</b>	<b>2003 Frequency</b>	<b>2003 Percent</b>
Transportation	<b>51</b>	<b>21.1%</b>
Trouble remembering	<b>39</b>	<b>16.1%</b>
Feeling ill	<b>37</b>	<b>15.3%</b>
Depression or feeling low	<b>29</b>	<b>12.0%</b>
Work schedule	<b>28</b>	<b>11.6%</b>
Substance abuse	<b>14</b>	<b>5.8%</b>
Weather	<b>11</b>	<b>4.5%</b>
Avoidance	<b>11</b>	<b>4.5%</b>
Relationship or family issues	<b>6</b>	<b>2.5%</b>
Feeling fine, not sick	<b>5</b>	<b>2.1%</b>
Other	<b>45</b>	<b>18.6%</b>

\*People could indicate multiple reasons; there is no cumulative total here. 115 people did indicate "Does Not Apply."



**PHYSICIANS AND MEDICATIONS.** A related series of questions asked about physicians and antiretroviral medications. Results indicate that nearly **78% of those interviewed have had their physician recommend the medications**; **62% were taking these medications** at the time of this survey.

<b>QUESTION: ANSWERING "YES":</b>	<b>1999 Frequency</b>	<b>1999 Percent</b>	<b>2003 Frequency</b>	<b>2003 Percent</b>
Have you talked with your doctor about antiretroviral medications?			<b>215</b>	<b>88.8%</b>
Has your doctor recommended [in 1999 -- the new] anti-retroviral therapies for you?	167	75.9%	<b>188</b>	<b>77.7%</b>
Are you taking HIV antiretroviral medications?	133	60.5%	<b>150</b>	<b>62.0%</b>
Do you think your doctor respects your right to make decisions about taking medications?	151	68.6%	<b>216</b>	<b>89.3%</b>
Are you taking any over the counter medications?	59	26.8%	<b>78</b>	<b>32.2%</b>
Are you taking vitamins, herbs or nutritional supplements?	119	54.1%	<b>163</b>	<b>67.4%</b>

For those who are not currently taking anti-retroviral medications, we asked the reasons why they were not taking them. The following table summarizes those reasons:

<b>REASON NOT CURRENTLY TAKING MEDICATIONS</b>	<b>2003 Frequency</b>	<b>2003 Percent</b>
I don't need them yet.	<b>30</b>	<b>12.4%</b>
I have become resistant to available medications.	<b>1</b>	<b>0.4%</b>
The side effects were too much.	<b>8</b>	<b>3.3%</b>
I am being monitored on a drug holiday.	<b>1</b>	<b>0.4%</b>
I wasn't able to take medications on schedule	<b>3</b>	<b>1.2%</b>
Other	<b>12</b>	<b>5.0%</b>
Missing/no info/does not apply	<b>187</b>	<b>77.3%</b>
Total	<b>242</b>	<b>100%</b>

**SELF REPORTED CD4 AND VIRAL LOAD COUNTS.** We also asked everyone in this survey if they had ever had CD4/T-cell and viral load tests, the dates of their most recent test and the results of their most recent tests. Nearly 94% reported they have had CD4/T-cell counts and 91.1% reported viral load tests.

<b>QUESTION:</b>	<b>1999 Frequency</b>	<b>1999 Percent</b>	<b>2003 Frequency</b>	<b>2003 Percent</b>
Have you ever had a CD4/T cell count?	194	88.2%	<b>227</b>	<b>93.8%</b>
Have you ever had a viral load test?	192	87.3%	<b>223</b>	<b>92.1%</b>

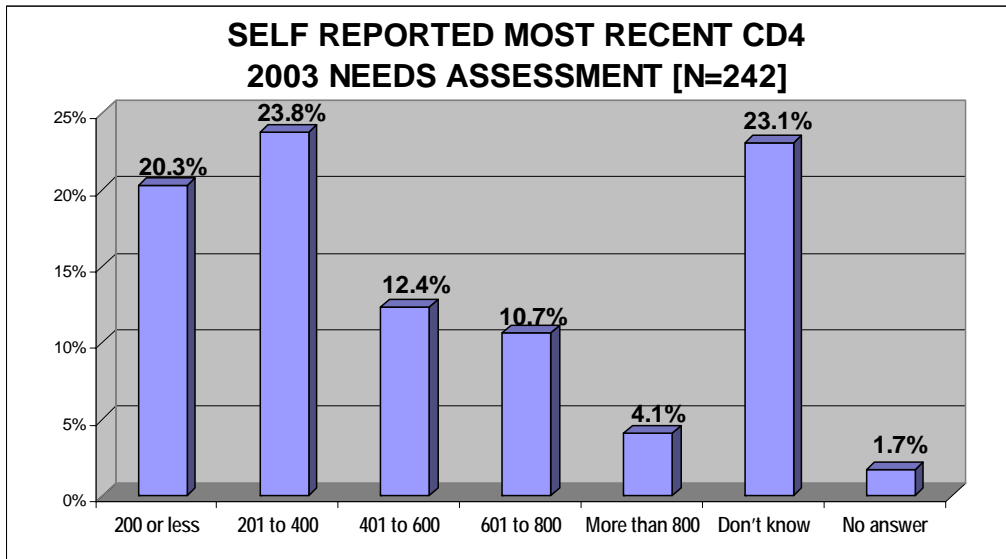
We also asked when their most recent test/s occurred.

<b>MOST RECENT CD4/T-CELL COUNT</b>	<b>1999 Frequency</b>	<b>1999 Percent</b>	<b>2003 Frequency</b>	<b>2003 Percent</b>
Less than 6 months ago	175	79.5%	<b>214</b>	<b>88.4%</b>
More than 6 mos, less than 1 yr	16	7.3%	<b>7</b>	<b>2.9%</b>
More than one year ago	7	3.2%	<b>4</b>	<b>1.7%</b>
Can't remember	5	2.3%	<b>7</b>	<b>2.9%</b>
Never had a CD4 count			<b>4</b>	<b>1.7%</b>
No answer	17	7.7%	<b>6</b>	<b>2.5%</b>
<b>Total</b>	<b>220</b>	<b>100.0%</b>	<b>242</b>	<b>100%</b>

<b>MOST RECENT VIRAL LOAD</b>	<b>1999 Frequency</b>	<b>1999 Percent</b>	<b>2003 Frequency</b>	<b>2003 Percent</b>
Less than 6 months ago	166	75.5%	<b>210</b>	<b>86.8%</b>
More than 6 mos, less than 1 yr	13	5.9%	<b>6</b>	<b>2.5%</b>
More than one year ago	6	2.7%	<b>4</b>	<b>1.7%</b>
Can't remember	4	1.8%	<b>5</b>	<b>2.1%</b>
Never had a viral load			<b>2</b>	<b>0.9%</b>
No answer	31	14.4%	<b>12</b>	<b>5.0%</b>
<b>Total</b>	<b>220</b>	<b>100.0%</b>	<b>242</b>	<b>100%</b>

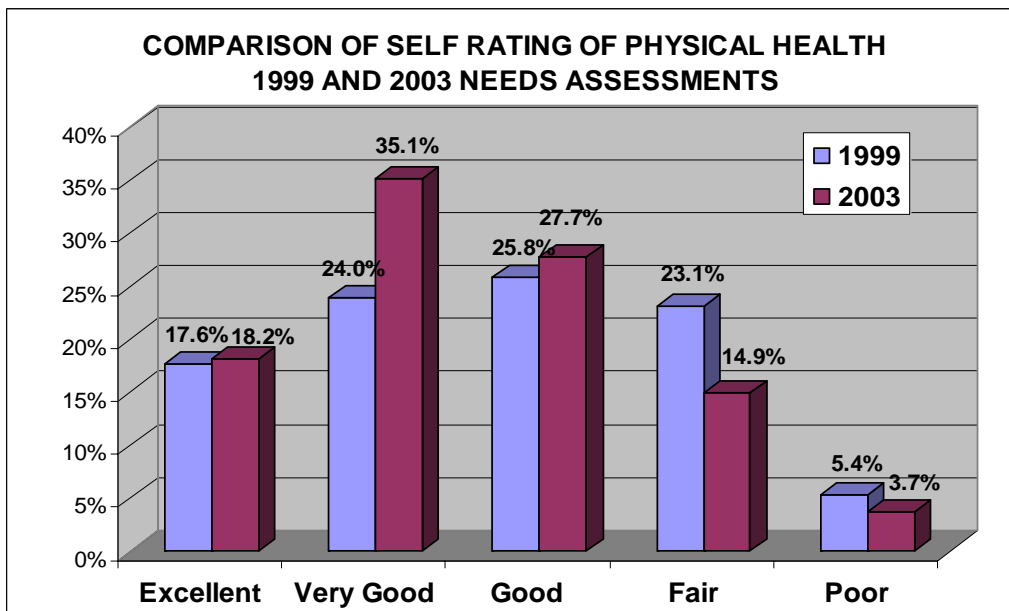
**SELF REPORTED CD4/T CELL COUNT.** Participants also reported their test results. The following summarize these *self reported* results.

<b>Self Reported CD4/T cell count</b>	<b>1999 Frequency</b>	<b>1999 Percent</b>	<b>2003 Frequency</b>	<b>2003 Percent</b>
200 or less	41	18.6%	<b>58</b>	<b>20.3%</b>
201 to 400	57	25.9%	<b>57</b>	<b>23.8%</b>
401 to 600	31	14.1%	<b>30</b>	<b>12.4%</b>
601 to 800	19	8.6%	<b>26</b>	<b>10.7%</b>
More than 800	10	4.5%	<b>10</b>	<b>4.1%</b>
Don't know/Can't remember	38	17.3%	<b>56</b>	<b>23.1%</b>
No answer	24	10.9%	<b>4</b>	<b>1.7%</b>
<b>Total</b>	<b>220</b>	<b>100.0%</b>	<b>222</b>	<b>100%</b>



**SELF RATING OF PHYSICAL HEALTH.** Finally, as a summary or outcome question, we asked a question about how the person interviewed would rate their physical health. The following table and graph show the results of this rating.

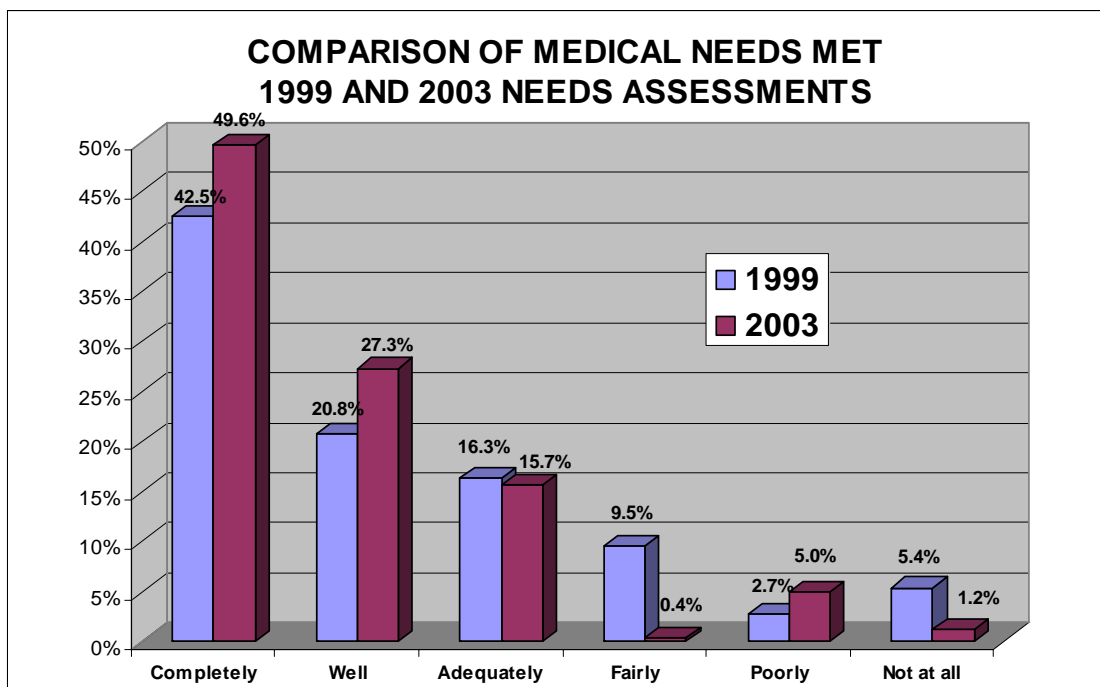
SELF RATING PHYSICAL HEALTH	1999 Frequency	1999 Percent	2003 Frequency	2003 Percent
Excellent	39	17.6%	44	18.2%
Very Good	53	24.0%	85	35.1%
Good	57	25.8%	67	27.7%
Fair	51	23.1%	36	14.9%
Poor	12	5.4%	9	3.7%
Missing or No Answer	8	3.6%	1	0.4%
Total	220	100%	242	100%



## SELF RATING OF HOW WELL MEDICAL NEEDS ARE MET.

We also asked a summary question about how well the person interviewed felt their medical needs were being met. The following table and graph show these ratings.

SELF RATING MEDICAL NEEDS MET	1999 Frequency	1999 Percent	2003 Frequency	2003 Percent
Completely	94	42.5%	120	49.6%
Well	46	20.8%	66	27.3%
Adequately	36	16.3%	38	15.7%
Fairly	21	9.5%	1	0.4%
Poorly	6	2.7%	12	5.0%
Not at all	12	5.4%	3	1.2%
Missing/no info/does not apply	5	2.3%	2	0.8%
Total	220	100%	242	100%



## KNOWLEDGE, USE AND RANKING OF SERVICES

The top five services cited in terms of knowledge are:

- 99.5% Case management
- 91.3% Emergency financial assistance
- 86.4% Food shelf
- 84.3% Transportation
- 81.0% Primary medical care

For services used in the prior year, the top five services cited were:

- 78.9% Emergency Financial Assist.
- 73.6% Case Management
- 68.6% Primary Medical Care

- 59.1% Food Shelf
- 55.4% Info and Referral

Service:	1999 - Know about this service?		1999 - Have used in the past year?		2003 - Know about this service?		2003 - Have used in the past year?	
	#	%	#	%	#	%	#	%
<b>Primary Medical Care</b>	<b>218</b>	<b>99.1%</b>	<b>189</b>	<b>85.91%</b>	<b>196</b>	<b>81.0%</b>	<b>166</b>	<b>68.6%</b>
Pharmacy/ADAP	163	74.1%	149	67.73%	109	45.0%	49	20.2%
Dental Care	138	62.7%	94	42.73%	152	62.8%	92	38.0%

The highest ratings for needs currently being completely, well or adequately met were:

- 80.2% Emergency Financial Assist.
- 76.4% Case Management
- 71.5% On Site Meals
- 69.4% Primary Medical Care
- 67.8% Info and Referral

Service:	1999 – Currently need met		1999 – Currently need NOT met		2003 – Currently need completely/well met		2003 – Currently need met poorly/not at all	
	#	%	#	%	#	%	#	%
<b>Primary Medical Care</b>	<b>195</b>	<b>88.6%</b>	<b>16</b>	<b>7.3%</b>	<b>168</b>	<b>69.4%</b>	<b>5</b>	<b>2.1%</b>
Pharmacy/ADAP	187	85.0%	22	10.0%	93	38.2%	5	2.1%
Dental Care	136	61.4%	70	31.8%	117	48.3%	19	7.8%

SERVICE:	1999 Might need in the future		2003 Might need in the future	
	#	%	#	%
<b>Primary Medical Care</b>	<b>207</b>	<b>94.1%</b>	<b>202</b>	<b>83.5%</b>
Pharmacy/ADAP	201	91.4%	172	72.1%
Dental Care	198	90.0%	181	74.8%
Medication Adherence			166	68.6%
Case management	166	75.5%	216	89.3%

After asking each person four questions about each service, we asked each participant to choose the top five (or most important) services, and the bottom five, (or least important) services – as they saw them.

[Imagine that we are looking at a theoretical 1210 votes – @ 242 people x 5 votes. In actuality, there were 1125 votes cast in ranking the five highest services, and 1041 for the ranking of the five lowest services. The service which gets the most votes is ranked highest (for top ranked services) or lowest (for bottom ranked services).] The results are on the following tables.

SERVICES	1999 RANKINGS			2003 RANKINGS		
	Rank (of 24)	# or Top Five Votes	% of Top Five Votes	Rank (of 25)	# of Top Five Votes	% of Top Five Votes**
Ranking of Top Services [where comparable services]						
Emergency Financial Assistance	4	68	6.62%	1	135	12.1%
Case Management	3	84	8.18%	2	127	11.3%
<b>Primary Medical</b>	<b>1</b>	<b>143</b>	<b>13.93%</b>	<b>3</b>	<b>117</b>	<b>10.4%</b>
ADAP	2	100	9.74%	4	95	8.4%
Transportation	8	60	5.84%	5	86	7.6%

Note: In the ranking of the bottom five services – those that would be cut if need be – there was only one vote out of 1041 for Primary Health Care.

**SERVICE ACTIVITY: CLINICIAN CONSULTATION**

[Formerly Short Term Intervention (STI). Previously a service activity under Medical and Dental Services]

**HRSA Core Medical Service: A. Outpatient/Ambulatory Medical Care (Health Services)**

**Service Activity Definition:**

**Clinician Consultation** - educational consultation provided by expert physicians, pharmacists and dentists supports the primary patient-provider relationship so the provider can manage the clinical situation. To this end the consultant gathers information about the clinical situation from the provider and assesses the learning needs of the provider in this clinical context. Based on the needs assessment, the consultant communicates concepts of HIV management, data from clinical trials, or other information to help the provider make a more informed decision about managing the clinical situation. The goal is to improve patient care in the immediate case and also to empower the clinician to better manage similar cases that he or she encounters in practice.

**2006-08 PRIORITY: 1 out of 23** (Part of Ambulatory/Outpatient Medical Care)

**2004-05 PRIORITY: 1 out of 15** [Part of Medical and Dental Services.]

2006-7 Allocation	2006-7 Expenditure	Activity	2007-8 Post Award Allocation
\$7,000	\$3,406	Clinician Consultation	\$4,000

- This service activity creates, prints and distributes a brochure that publicizes the volunteer network of HIV/AIDS Clinical Support and Consultation Services for Health Care Providers. The network is a resource for Minnesota health care providers caring for persons with HIV disease and managing occupational exposures to blood-borne pathogens. It is also a service to link Minnesota providers to education, training, and clinical consultation resources for the management of HIV disease through local and national experts who volunteer their time.
- In the spring of 2007, MATEC distributed 20,000+ brochures across the state to licensed physicians, nurses, nurse practitioners and pharmacists. The brochure was also shared with trainers from the

Minnesota Department of Health, the Department of Human Services, and several of the consultants who wished to distribute them at trainings.

- The brochure is available online in PDF format at the MATEC website ([www.mnmatec.umn.edu](http://www.mnmatec.umn.edu)) and at the Minnesota Department of Health website.

## KEY POINTS CLINICIAN CONSULTATION

- Although it is not possible to systematically evaluate the program (i.e., it isn't feasible to ask volunteer physicians who receive no funding to serve as volunteer consultants to record and report phone calls and consultation services), the types of calls received suggest there is an ongoing need for this service. Phone calls range from very basic information (needs assessment, testing and treatment) to the most complex issues involved in the treatment of HIV disease.
- Anecdotally, participating physicians who serve as volunteer consultants receive hundreds of calls annually, suggesting that there is a high need for this service. It is not known whether or not the brochure is the reason for any of the individual phone calls.
- In June 2007, MATEC staff attempted to evaluate the usage of the network by contacting the consultants and asking if they were receiving calls that could be attributed to the brochure. One-third of the volunteer consultants responded to the request for information. Of those who responded, two clinicians reported that they had been contacted specifically because of the brochure.

*Discussed by the NA&E Committee 8/24/2007; approved 9/25/2007.*

## SERVICE ACTIVITY: EARLY INTERVENTION SERVICES

[Formerly Short Term Intervention (STI). Previously a service activity under Medical and Dental Services]

### HRSA Core Medical Service: E. Early Intervention Services (EIS)

#### Service Activity Definition:

Early Intervention Services (EIS) includes counseling individuals with respect to HIV/AIDS; testing (including tests to confirm the presence of the disease, tests to diagnose to extent of immune deficiency, tests to provide information on appropriate therapeutic measures); referrals; other clinical and diagnostic services regarding HIV/AIDS; periodic medical evaluations for individuals with HIV/AIDS; and providing therapeutic measures.

**2006-08 PRIORITY: 1 out of 23** (Part of Ambulatory/Outpatient Medical Care)

**2004-05 PRIORITY: 1 out of 15** [Part of Medical and Dental Services.]

2006-7 Allocation	2006-7 Expenditure	Activity	2007-8 Post Award Allocation
\$41,100	\$34,069	Short Term Intervention	\$52,100

In 2006, 41 **people** used short term intervention services, according to MDH services utilization data. This is 0.7% of all HIV+ people, and 1.1% of all HIV+ people in services.

*Demographics	Epi #	Epi %	ALL Service Use #	ALL Service Use %	STI Service Use #	STI Service Use %
Total N	5566	100%	3888	100%	41	100%
<b>Gender:</b>						
Male	4300	77.3%	2838	73.0%	36	87.8%
Female	1266	22.7%	1027	26.4%	5	12.2%
Transgender			23	0.6%	0	0%
<b>Race:</b>						
American Indian	97	1.7%	123	3.2%	2	4.9%
Asian/Pacific Islander	83	1.5%	119	3.1%	1	2.4%
Black	1889	33.9%	1241	31.9%	13	31.7%
Caucasian	3035	54.5%	1727	44.4%	20	48.8%
Other/Unknown	35	0.6%	427	11.0%	1	2.4%
<b>Ethnicity:</b>						
Latino	427	7.7%	251	6.5%	4	9.8%

<b>*Demographics</b>	<b>Epi #</b>	<b>Epi %</b>	<b>ALL Service Use #</b>	<b>ALL Service Use %</b>	<b>STI Service Use #</b>	<b>STI Service Use %</b>
	<b>#</b>	<b>%</b>	<b>#</b>	<b>%</b>	<b>#</b>	<b>%</b>
<b>Transmission:</b>						
MSM	2844	51.1%	1493	38.4%	28	68.3%
IDU	394	7.1%	218	5.6%	1	2.4%
MSM/IDU]	289	5.2%	117	3.0%	1	2.4%
Heterosexual	662	11.9%	1054	27.1%	9	22.0%
Perinatal	50	0.9%	27	0.7%	0	0%
Blood/hemophilia	45	0.8%	45	1.2%	0	0%
Unknown	1282	23.0%	934	24.0%	2	4.9%
<b>Age:</b>						
<13	27	0.5%	17	0.4%	0	0%
13-19	43	0.8%	27	0.7%	1	22.4%
20-24	169	3.0%	152	3.9%	7	17.1%
25-29	398	7.2%	352	9.1%	13	31.7%
30-34	507	9.1%	395	10.2%	3	7.3%
35-39	846	15.2%	604	15.5%	7	17.1%
40-44	1235	22.2%	834	21.5%	6	14.6%
45-49	1030	18.5%	669	17.2%	0	0%
50+	1303	23.4%	838	21.6%	4	9.8%
Unknown	8	0.1%	0	0%	0	0%
<b>Geography:</b>						
Hennepin Co.	3175	57.0%	2273	58.5%	23	56.1%
Ramsey Co.	991	17.8%	692	17.8%	11	26.8%
Other 7 counties	625	11.2%	359	9.2%	5	12.2%
Other 13 counties**	65	1.2%	26	0.7%	0	0%
Greater Minnesota	741	13.3%	386	9.9%	0	0%
Unknown	34	0.6%	11	0.3%	2	4.9%
<b>Country of Origin</b>						
United States	2444	43.9%	2064	53.1%	33	80.5%
Other	1005	18.1%	588	15.1%	7	17.1%
Unknown	2117	38.0%	1235	31.8%	1	2.4%

Data from \*Persons Living with HIV/AIDS by Exposure Category, etc. Minnesota 2006, by MDH, n.d.

Epi data does not include Wisconsin counties.

9 uninfected clients were served in 2006.

Transgender identity is not collected in surveillance/epi. All transgender people reported through CLRS is 2006 (N=23) were male-to-female.

"Other" race/ethnicity category "Unknown," "Other," "refused", and "More than 1 race"

Hispanic ethnicity is reported separately from race for surveillance/epi and services.

Other 7-county metro includes clients living in Anoka, Carver, Dakota, Scott and Washington counties (7-county metro area excluding Hennepin and Ramsey counties).

Other 13—county metro includes clients living in Chisago, Isanti, Sherburne, and Wright counties in MN and Pierce and St. Croix counties in WI (13 county EMA excluding the 7 county metro area).

Unknown for services geography includes 11 out-of-state clients.

## UTILIZATION HISTORY:

This area is listed as "Early Intervention" on the CLRS/bubble sheet.

Year	# using STI	Total Epi	Percent of Epi	Total in RW Services	Percent of those in services
2006	41	5,566	0.7%	3,888	1.1%
2005	37	5,233	0.7%	3,752	1.0%
2004	42	5,002	0.8%	3,838	1.1%
2003	41	4,895	0.8%	3,399	1.2%
2002	43	4,598	0.9%	3,121	1.4%
2001	30	4,331	0.7%	2,801	1.2%
2000					
1999	52	4,031	1.3%	2,758	1.9%

## SHORT TERM INTERVENTION OUTCOMES

The intended outcomes for this program are:

- 1) To increase patient's knowledge about HIV/AIDS; and
- 2) To assure patients get into medical care for HIV.

Short-term intervention providers collect information in an ongoing way. Information has been collected for patients who received short term services at one provider since March, 2001. By February 2007, there is information about 63 patients.

The following information is from the most recent report (February 2007).

According to the completed forms for short-term intervention, this service has been provided to:

**GENDER:** 51 (81%) male; 6 (9.5%) female, 1 (1.6%) transgender; and (5 or 7.9% missing information).

**RACE/ETHNICITY:** 5 (7.9%) American Indian; 1 (1.6%) Asian Pacific Islander; 13 (20.6%) African American; 2 (3.2% African born); 35 (55.6%) Caucasian/White; and 5 (8.2%) Latino. Information is missing for 2 (3.2%).

**SEXUAL ORIENTATION:** 45 (71.4%) Homosexual/gay/lesbian; 10 (15.9%) Heterosexual/straight; 4 (6.3%) Bisexual; 4 (6.4%) missing information)

**CLINICAL STATUS:** 34 (54.0%) of the 63 clients had **CD4 counts below 400.**

When asked about how their **short term intervention appointment** was helpful in increasing their knowledge:

- **88.9%** said it was very helpful in learning about **community resources for HIV+ people.**
- **84.1%** said it was very helpful in learning **where to get medical care for HIV;**
- **84.1%** said it was very helpful in learning about **what a CD-4, Tcell count** means;
- **79.4%** said it was very helpful in learning how **to protect themselves and others'**

- **79.4%** said it was very helpful in learning **what a viral load means**; and
- **76.2%** said it was very helpful in learning about **how to get insurance to cover medical care**;
- **74.6%** said it was very helpful in learning about **how HIV might affect health**;
- **74.6%** said it was very helpful in learning more about **the HIV disease**;
- **73.0%** said it was very helpful in learning about **the difference between HIV and AIDS**.

During the **follow-up contacts**, the following information was obtained:

## **INSURANCE**

- **30 (47.6%)** of people had **current health insurance**; **27 (42.9%)** did not have **current health insurance**.
- Another **18 (28.6%)** people had either **applied for insurance** or were awaiting a coverage date;
- In total, **48 (76.2%)** of the people seen in short term intervention were covered or seeking coverage by **medical insurance**.

## **MEDICAL APPOINTMENTS**

- **46 (73.0%)** of patients indicated they were able to make a doctor's appointment in the prior three months; **11 (27.0%)** did not make a **doctor's appointment**; no information is available for 6 (9.5%).
- **42 (66.7% of all and 91.3%** of those who made appointments) **kept the doctor appointments**.
- However, **4 (6.3% of all and 8.7%** of those who made appointments) **did not keep medical appointments**.
- Of those who **did not make medical appointments in the prior three months** (11 or 17.5% of all patients) the identified reasons were financial or insurance related.
- Of those who had **made an appointment but did not keep it** (8 or 12.7% of all patients), the issues were work schedules and forgetting (1 patient).

## FROM THE 2006 CONSUMER SURVEY by Positive Outcomes and CCG

The Hennepin County Human Services and Public Health Department funded a voluntary survey of Minnesota HIV-infected residents to assess access to HIV clinical and psychosocial support services, evaluate the impact of recent changes in Minnesota State health insurance programs, measure unmet need, and help to plan the allocation of HIV services funds. A voluntary survey of 379 HIV-infected Minnesota residents was conducted in Spring 2006. The survey administered by HIV program staff assessed respondents' health insurance coverage, use of HIV clinical and support services, and unmet need.

There were no specific questions relevant to Short Term Intervention on the 2006 Consumer Survey.

## Consumer Ranking of Services

This information is based on interviews with 242 HIV+ Minnesota conducted during 2003 (where applicable comparison is made with the 1999 needs assessment). The people interviewed may or may not have been in services, or at the time using case management services. After asking each person four questions about each service, we asked each participant to choose the top five (or most important) services, and the bottom five, (or least important) services – as they saw them.

*[Imagine that we are looking at a theoretical 1210 votes – @ 242 people x 5 votes. In actuality, there were 1125 votes cast in ranking the five highest services, and 1041 for the ranking of the five lowest services. The service which gets the most votes is ranked highest (for top ranked services) or lowest (for bottom ranked services).] The results are on the following tables.*

**Short Term Intervention has been part of the Primary Medical Care area and was not broken out as a separate service in either of the assessments.**

## KEY POINTS EARLY INTERVENTION SERVICES [EIS]

- This service provides counseling and support for newly diagnosed HIV+ Minnesotans, to improve their access to HIV medical care. [As always, RWCA funds are for the 'payer of last resort,' so this service provides coverage for newly diagnosed Minnesotans without other health insurance or coverage.] One committee member noted that this program was developed here as a model, seamless program that has been emulated elsewhere. [Dr. Keith Henry, NA&E meeting]
- This program (currently available at two metro locations) serves a relatively small number of those who test positive for HIV in Minnesota each year (41 last year, out of approximately 300 who test positive in Minnesota each year). This has changed over the past decade due to more diverse and decentralized testing strategies that have been available throughout the state.
- In 2006, two programs were contracted to serve 40 clients, and served 41 clients.

### **SAR DATA:**

- The available outcome data (*Short Term Intervention Outcomes Update, 2.07, CLEAR*) suggest that this service has been consistently rated to be very useful (80 to 90% of patients) in providing newly diagnosed individuals with information about HIV and medical care options.
- Of concern are the proportion of patients (54%) who have CD4 counts of 400 or less at initial testing.
- Referral and coordination with insurance assistance is important, as only 43% of those in the outcomes data base had current health insurance at the point of testing.
- The outcomes data suggests that 82% of patients made medical appointments, and 87% kept their initial medical appointments by the time of follow-up, three to six months later. [This is a higher percentage than the typical show rates at some clinics.]

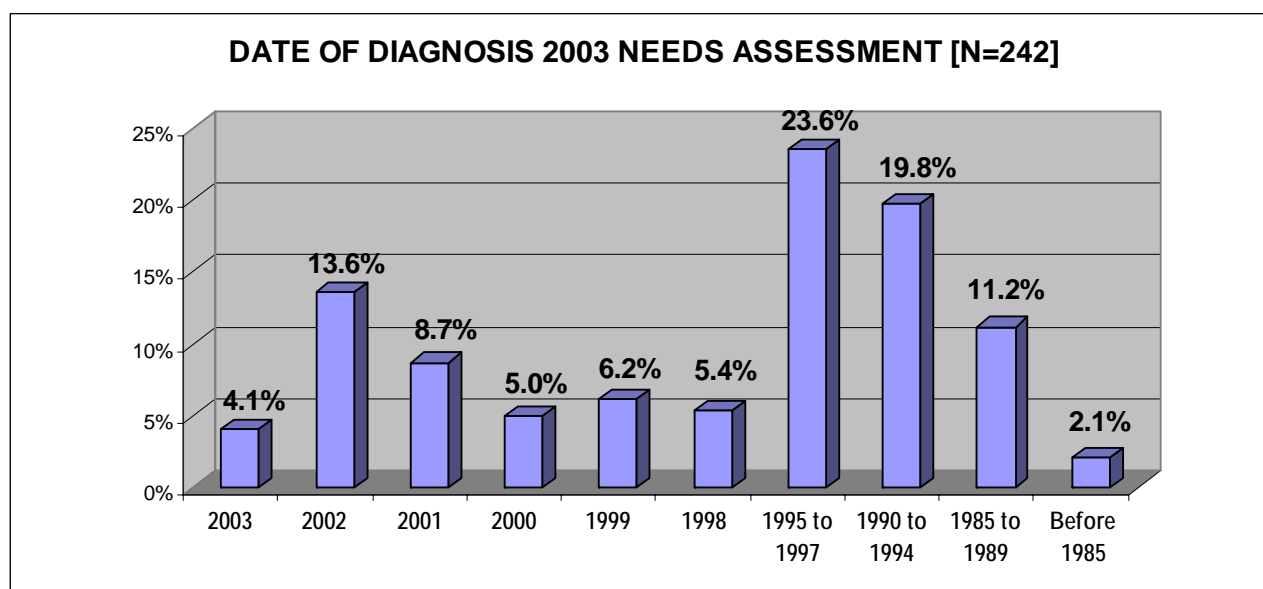
*Discussed by the NA&E Committee July and October/2007; approved 11/27/2007.*

## APPENDIX A: 2003 COMPREHENSIVE NEEDS ASSESSMENT INFORMATION RELEVANT TO SHORT TERM INTERVENTION

This information is based on two needs assessments conducted with people who are HIV+ Minnesota. The first assessment was conducted in 1999 with 220 people; the second in 2003 with 242 people. The people interviewed may or may not have been in services, or at the time using case management services. The following provides information from those assessments relevant to case management.

**YEAR OF DIAGNOSIS.** The next table indicates the year when survey participants first tested positive. Nearly 27% reported they received their first positive test results in the past three years, while 14% received their first positive diagnosis prior to 1990.

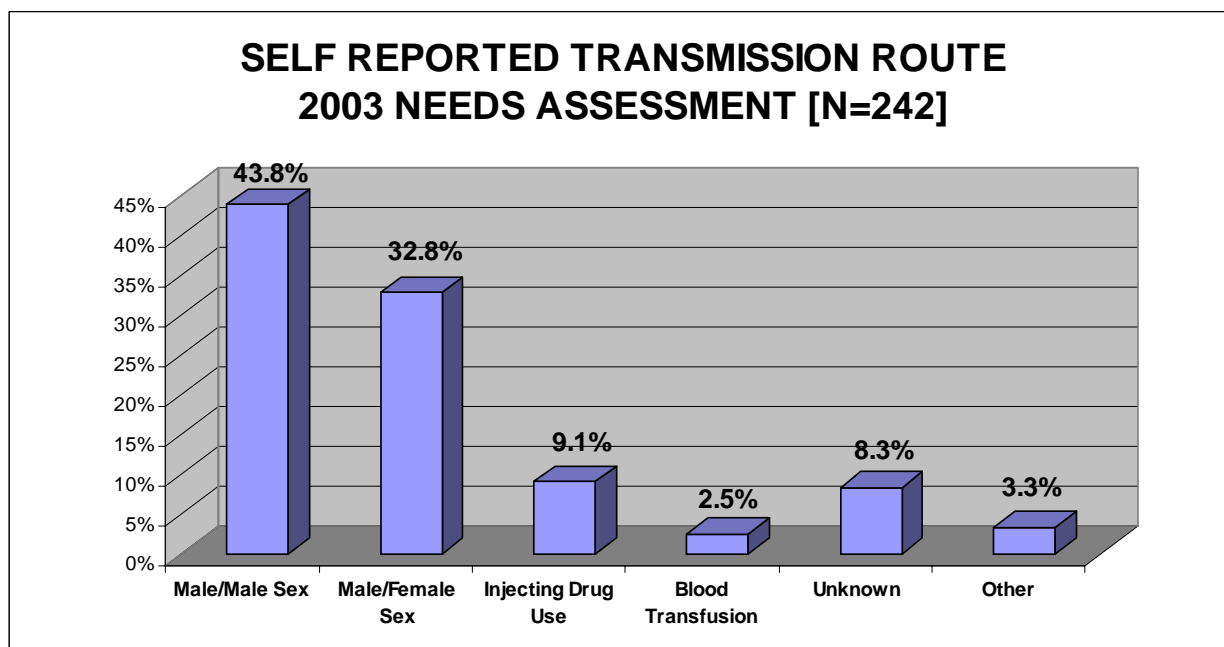
YEAR	1999 Frequency	1999 Percent	2003 Frequency	2003 Percent
2003	--	--	10	4.1%
2002	--	--	33	13.6%
2001	--	--	21	8.7%
2001	--	--	12	5.0%
1999	17	7.8%	15	6.2%
1998	21	9.7%	13	5.4%
1995 to 1997	53	24.4%	57	23.6%
1990 to 1994	69	31.8%	48	19.8%
1985 to 1989	46	21.2%	27	11.2%
Before 1985	11	5.0%	5	2.1%
Missing	4	1.8%	1	0.4%
Total	220	100.0%	242	100%



**TRANSMISSION ROUTE.** Those interviewed were also asked to identify the likely transmission route, by which they became HIV+. Self reported results are summarized on the following table. [Note that this

self report information does not necessarily match how surveillance information is used to determine transmission route.]

ROUTE	1999 Frequency	1999 Percent	2003 Frequency	2003 Percent
Male/Male Sex	91	41.2%	106	43.8%
Male/Female Sex	63	28.5%	79	32.8%
Injecting Drug Use	37	16.7%	22	9.1%
Blood Transfusion	8	3.6%	6	2.5%
Unknown	15	6.8%	20	8.3%
Other	6	2.7%	8	3.3%
Missing/no info	1	0.5%	1	0.4%
Total	220	100%	242	100%



**FACTORS PLAYING A ROLE IN BECOMING HIV+.** Participants in these interviews were asked two questions about factors that may have played a role in becoming HIV+ -- sexual abuse and substance use (drugs or alcohol). The results are summarized on the following tables.

QUESTION	THOSE ANSWERING "YES"	1999 Frequency	1999 Percent	2003 Frequency	2003 Percent
Do you believe that sexual abuse played a role in your becoming HIV+?		44	20.0%	40	16.5%
Do you believe that substance (drugs or alcohol) use (abuse) played a role in your becoming HIV+?		131	59.5%	138	57.0%

**GEOGRAPHIC LOCALE OF TESTING.** We asked people what state they were living in when they first tested positive.

<b>STATE TESTED POSITIVE:</b>	<b>1999 Frequency</b>	<b>1999 Percent</b>	<b>2003 Frequency</b>	<b>2003 Percent</b>
Minnesota	148	67.3%	162	66.9%
Other Midwest (IL, IN, WI, N./S.Dak's)	23	10.4%	26	10.7%
Other US states/territories	46	20.9%	51	21.1%
Non US	3	1.3%	3	1.2%
Total	220	100.0%	242	100

**MAIN REASON FOR TESTING.** People interviewed for this needs assessment were also asked about the main reason they tested for HIV, and the kind of facility or location at which they tested when were first given positive test results. The following tables summarize the results.

<b>MAIN REASON FOR TESTING</b>	<b>1999 Frequency</b>	<b>1999 Percent</b>	<b>2003 Frequency</b>	<b>2003 Percent</b>
Illness	54	24.5%	72	29.8%
Member of risk group	55	25.0%	39	16.1%
Amnesty program, immigration	--	--	3	1.2%
Surgery	11	5.0%	2	0.8%
Insurance exam	1	0.5%	1	0.4%
Sex partner was sick	37	16.8%	35	14.5%
Blood donor	22	10.0%	13	5.4%
Military recruit	--	--	3	1.2%
Jail or prison screening	6	2.7%	3	1.2%
Offered at clinic	3	1.4%	10	4.1%
Pregnancy testing	4	1.8%	9	3.7%
Other	23	10.5%	36	14.9%
No answer or missing	2	0.9%	16	6.6%
Total	220	100.0%	242	100%

**SITE WHERE TESTED POSITIVE.** Participants in this needs assessment were also asked to identify the kind of facility or location where they first tested positive for HIV.

<b>FACILITY/TYPE:</b>	<b>1999 Frequency</b>	<b>1999 Percent</b>	<b>2003 Frequency</b>	<b>2003 Percent</b>
HIV testing/counseling site (like Red Door, Room 111)	53	24.1%	87	36.0%
Family planning/prenatal clinic	7	3.6%	5	2.1%
Other medical clinic	19	8.6%	11	4.5%
Private physician	24	10.9%	31	12.8%
Hospital	73	33.2%	44	18.2%
Emergency Room	3	1.4%	6	2.5%
Correctional Facility	11	5.0%	2	0.8%
Blood bank	8	3.6%	15	6.2%
Chem dep treatment program	15	6.8%	4	1.7%
Other	4	1.8%	34	14.0%
Missing or no answer	3	1.4%	3	1.2%
Total	220	100.0%	242	100

**REFERRALS AT TESTING POINT.** We also asked a number of questions about the connections between testing and getting into medical care. The following table summarizes these responses:

<b>QUESTION ABOUT REFERRALS:</b>	<b>Frequency</b>	<b>Percent</b>
When you were first told that you were infected with HIV, were you told where you could go for health care?	<b>168</b>	<b>69.4%</b>
Were you given printed materials?	<b>136</b>	<b>56.2%</b>
When you first tested positive, were you referred for any of the following services?		
Health insurance	<b>96</b>	<b>39.7%</b>
Case management	<b>111</b>	<b>45.9%</b>
Substance abuse treatment	<b>45</b>	<b>18.6%</b>
Mental health services (other than for substance abuse)	<b>51</b>	<b>21.1%</b>
Medical care for a condition other than HIV	<b>57</b>	<b>23.6%</b>
Prevention program or services	<b>55</b>	<b>22.7%</b>
Peer counseling and support group	<b>80</b>	<b>33.1%</b>
Other	<b>19</b>	<b>7.9%</b>

**KNOWLEDGE AND USE OF SERVICES.** We asked about knowledge and use in the past year for about 25 services, some of which are currently funded by Ryan White dollars. **Short Term Intervention has been part of the Primary Medical Care area and was not broken out as a separate service in either of the assessments.** [Please note, also, that because someone indicated "yes" about knowledge and use of a service does not necessarily mean that they used a Ryan White funded service. For example, outstate participants, reporting "yes" about use of a food shelf typically did not (could not) involve a Ryan White funded service.]

Service:	1999 - Know about this service?		1999 - Have used in the past year?		2003 - Know about this service?		2003 - Have used in the past year?	
	#	%	#	%	#	%	#	%
Primary Medical Care	218	99.1%	189	85.91%	196	81.0%	166	68.6%
Pharmacy/ADAP	163	74.1%	149	67.73%	109	45.0%	49	20.2%
Dental Care	138	62.7%	94	42.73%	152	62.8%	92	38.0%
Medication Adherence					145	59.9%	66	27.3%

**MET AND UNMET NEEDS.** We asked participants in 1999 whether their needs were met in each of the service areas. In 2003, we asked the same question but using a 5-point scale, with the opportunity to cite a need *completely, well, adequately, poorly* or *not at all met*. For 2003, the figures represent those who said their needs were *completely, well* or *adequately met*, versus those who said their need was *poorly* or *not at all met*.

Service:	1999 – Currently need met		1999 – Currently need NOT met		2003 – Currently need completely/well met		2003 – Currently need met poorly/not at all	
	#	%	#	%	#	%	#	%
Primary Medical Care	195	88.6%	16	7.3%	168	69.4%	5	2.1%
Pharmacy/ADAP	187	85.0%	22	10.0%	93	38.2%	5	2.1%
Dental Care	136	61.4%	70	31.8%	117	48.3%	19	7.8%
Medication Adherence					117	48.3%	4	1.6%

**FUTURE NEEDS.** In both 1999 and 2003, we asked each person interviewed if they thought they might need a service in the future. The following table summarizes these results for both years. In 2003, 88% of those interviewed indicated they **might need primary medical care** in the future.

SERVICE:	1999 Might need in the future		2003 Might need in the future	
	#	%	#	%
Primary Medical Care	207	94.1%	202	83.5%
Pharmacy/ADAP	201	91.4%	172	72.1%
Dental Care	198	90.0%	181	74.8%
Medication Adherence			166	68.6%

**RANKING OF SERVICES.** When consumers participating in the Needs Assessments are asked to rank services (by choosing five cards out of 24 or 25 services as the most important to preserve). The ranking for primary medical care was:

- In 1999, Primary Medical Care was ranked 1<sup>st</sup> out of 24 services.
- In 2003, Primary Medical Care was ranked 3<sup>rd</sup> of 25 services.

SERVICES	1999 RANKINGS			2003 RANKINGS		
	Rank (of 24)	# or Top Five Votes	% of Top Five Votes	Rank (of 25)	# of Top Five Votes	% of Top Five Votes**
Ranking of Top Services [where comparable services]						
Emergency Financial Assistance	4	68	6.62%	1	135	12.1%
Case Management	3	84	8.18%	2	127	11.3%
<b>Primary Medical</b>	<b>1</b>	<b>143</b>	<b>13.93%</b>	<b>3</b>	<b>117</b>	<b>10.4%</b>
ADAP	2	100	9.74%	4	95	8.4%
Transportation	8	60	5.84%	5	86	7.6%

Indicates tie in rank order. \*\*Total number of votes: 1125 From **Comprehensive Needs Assessment Report, 2003**,

**SERVICE ACTIVITY: MEDICAL NUTRITION THERAPY**

**HRSA Core Medical Service: K. Medical Nutrition Therapy**

**Service Activity Definition:**

**Medical Nutrition Therapy** is provided by a licensed registered dietitian outside of a primary care visit and includes the provision of nutritional supplements. (Medical nutrition therapy provided by someone other than a licensed registered dietitian should be recorded under psychosocial support services.)

*Formerly Nutritional Supplements, a service activity under Food and Nutrition..*

*Definition:* Provision of natural and nutritional supplements for people who are experiencing or at risk of HIV/AIDS-related wasting/metabolic changes. Products covered include enteral supplements (i.e. Ensure, Sustacal), multi-vitamins, and lactase enzyme.

**2006-08 PRIORITY: 13 out of 23** (part of Food Bank/Home Delivered Meals)

**2004-05 PRIORITY: 7 out of 15** (part of Nutritional Services)

2006-7 Allocation	2006-7 Expenditure	Activity	2007-8 Post Award Allocation
\$30,700	\$12,299.48	Nutritional Therapy	\$40,600

In 2006, 85 **people** used Nutritional Supplements (Medical Nutritional Therapy), according to MDH services utilization data. This is % of all HIV+ people, and % of all HIV+ people in services.

*Demographics	Epi #	Epi %	ALL Service Use #	ALL Service Use %	Med Nutritional Therapy Service Use #	Med Nutritional Therapy service Use %
All	5566	100%	3888	100%	<b>85</b>	<b>100%</b>
Male	4300	77.3%	2838	73.0%	<b>76</b>	<b>89.4%</b>
Female	1266	22.7%	1027	26.4%	<b>9</b>	<b>10.6%</b>
Transgender			23	0.6%	<b>0</b>	<b>0%</b>
<b>Race:</b>						
American Indian	97	1.7%	123	3.2%	<b>1</b>	<b>1.2%</b>
Asian/Pacific Islander	83	1.5%	119	3.1%	<b>1</b>	<b>1.2%</b>
Black	1889	33.9%	1241	31.9%	<b>27</b>	<b>31.8%</b>
Caucasian	3035	54.5%	1727	44.4%	<b>47</b>	<b>55.3%</b>
Other*	35	0.6%	427	11.0%	<b>5</b>	<b>5.9%</b>
<b>Ethnicity:</b>						
Hispanic/Latino	427	7.7%	251	6.5%	<b>4</b>	<b>4.7%</b>

<b>*Demographics</b>	<b>Epi #</b>	<b>Epi %</b>	<b>ALL Service Use #</b>	<b>ALL Service Use %</b>	<b>Med Nutritional Therapy Service Use #</b>	<b>Med Nutritional Therapy service Use %</b>
<b>Transmission:</b>						
MSM	2844	51.1%	1493	38.4%	<b>44</b>	<b>51.8%</b>
IDU	394	7.1%	218	5.6%	<b>2</b>	<b>2.4%</b>
MSM/IDU	289	5.2%	117	3.0%	<b>1</b>	<b>1.2%</b>
Heterosexual	662	11.9%	1054	27.1%	<b>11</b>	<b>12.9%</b>
Perinatal	50	0.9%	27	0.7%	<b>0</b>	<b>0%</b>
Blood/hemophilia	45	0.8%	45	1.2%	<b>1</b>	<b>1.2%</b>
Unknown	1282	23.0%	034	24.0%	<b>26</b>	<b>30.6%</b>
<b>Age*:</b>						
<13	27	0.5%	17	0.4%	<b>0</b>	<b>0%</b>
13-19	43	0.8%	27	0.7%	<b>0</b>	<b>0%</b>
20-24	169	3.0%	152	3.9%	<b>0</b>	<b>0%</b>
25-29	398	7.2%	352	9.1%	<b>1</b>	<b>1.2%</b>
30-34	507	9.1%	395	10.2%	<b>9</b>	<b>10.6%</b>
35-39	846	15.2%	604	15.5%	<b>13</b>	<b>15.3%</b>
40-44	1235	22.2%	834	21.5%	<b>20</b>	<b>23.5%</b>
45-49	1030	18.5%	669	17.2%	<b>14</b>	<b>16.5%</b>
50+	1303	23.4%	838	21.6%	<b>28</b>	<b>32.9%</b>
Unknown	8	0.1%	0	0%	<b>0</b>	<b>0%</b>
<b>Geography:</b>						
Hennepin	3175	57.0%	2273	58.5%	<b>58</b>	<b>68.2%</b>
Ramsey Co.	991	17.8%	692	17.8%	<b>10</b>	<b>11.8%</b>
Other 7 counties#	625	11.2%	359	9.2%	<b>10</b>	<b>11.8%</b>
Other 13 counties^	65	1.2%	26	0.7%	<b>1</b>	<b>1.2%</b>
Greater Minnesota	741	13.3%	386	9.9%	<b>6</b>	<b>7.1%</b>
Unknown	34	0.6%	11	0.3%	<b>0</b>	<b>0%</b>
<b>Country of Origin:</b>						
United States	2444	43.9%	2064	53.1%	<b>16</b>	<b>18.8%</b>
Other	1005	18.1%	588	15.1%	<b>6</b>	<b>7.1%</b>
Unknown	2117	38.0%	1235	31.8%	<b>63</b>	<b>74.1%</b>

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 Data from \*Persons Living with HIV/AIDS by Exposure Category, etc. Minnesota 2006, by MDH, n.d.

Epi data does not include Wisconsin counties. 9 uninfected clients were served in 2006.

Transgender identity is not collected in surveillance/epi. All transgender people reported through CLRS is 2006 (N=23) were male-to-female.

"Other" race/ethnicity category "Unknown," "Other," "refused," and "More than 1 race"

Hispanic ethnicity is reported separately from race for surveillance/epi and services.

#Other 7-county metro includes clients living in Anoka, Carver, Dakota, Scott and Washington counties (7-county metro area excluding Hennepin and Ramsey counties).

^Other 13—county metro includes clients living in Chisago, Isanti, Sherburne, and Wright counties in MN and Pierce and St. Croix counties in WI (13 county EMA excluding the 7 county metro area).

Unknown for services geography includes 11 out-of-state clients.

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### **SERVICE ACTIVITY UTILIZATION HISTORY:**

<b>Year</b>	<b>Nutritional Supplements/Med Nutritional Therapy</b>	<b>Total Epidemiology</b>	<b>Percent of Epidemiology</b>	<b>Total in HIV Services</b>	<b>Percent of those in HIV services</b>
2006	<b>85</b>	5,566	<b>1.5%</b>	3888	<b>2.2%</b>
2005	<b>127</b>	5,233	<b>2.4%</b>	3752	<b>3.4%</b>
2004	<b>120</b>	5,002	<b>2.4%</b>	3,838	<b>3.1%</b>
2003	<b>187</b>	4,895	<b>3.8%</b>	3,399	<b>5.5%</b>

## 2006 NEEDS ASSESSMENT INFORMATION

### Assessing the Needs of Minnesotans Living With HIV or AIDS: Results of a Community Survey

Positive Outcomes, Inc. and Community Consulting Group, LLC August 2006

The Hennepin County Human Services and Public Health Department funded a voluntary survey of Minnesota HIV-infected residents to assess access to HIV clinical and psychosocial support services, evaluate the impact of recent changes in Minnesota State health insurance programs, measure unmet need, and help to plan the allocation of HIV services funds. Residents of Minnesota counties included in the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act Title I Eligible Metropolitan Area (EMA) were surveyed. These counties include Anoka, Carver, Chisago, Dakota, Hennepin, Isanti, Ramsey, Scott, Sherburne, Washington, and Wright Counties. Residents of other Minnesota counties also were surveyed. The survey was designed and conducted by Positive Outcomes, Inc. (POI) and Community Consulting Group (CCG).

A voluntary survey of 379 HIV-infected Minnesota residents was conducted in Spring 2006. The survey administered by HIV program staff assessed respondents' health insurance coverage, use of HIV clinical and support services, and unmet need.

**Other Services** 19% of respondents (n=59) reported needing but not getting another service during the six months before the interview. Affordable housing and related housing services were identified as being needed in the six months before the interview. Table 3 summarizes specific services needed but not received.

<b>Table 3. Services Needed But Not Received By Survey Respondents in the Six Months Before the Survey</b>			
<b>Housing, rental assistance, or rental services</b>	25.4%	<b>Emergency assistance</b>	1.7%
<b>Financial assistance</b>	11.9%	<b>Heating assistance</b>	1.7%
<b>Transportation</b>	6.8%	<b>Injections to fill out sunken cheeks in face</b>	1.7%
<b>Employment assistance</b>	5.1%	<b>Job skills training</b>	1.7%
<b>Food or food vouchers</b>	5.1%	<b>Medical insurance</b>	1.7%
<b>Child care assistance</b>	3.4%	<b>More services for kids and women with kids</b>	1.7%
<b>Driving lessons</b>	3.4%	<b>Neuropsychiatric testing</b>	1.7%
<b>Home repair assistance</b>	3.4%	<b>Permanent legal status</b>	1.7%
<b>Nutrition or nutritional supplements</b>	3.4%	<b>Physical therapy</b>	1.7%
<b>SSDI</b>	3.4%	<b>Podiatry</b>	1.7%
<b>Computer to access internet</b>	1.7%	<b>Public health assessment for PCA</b>	1.7%
<b>Delivered meals</b>	1.7%	<b>Supportive services</b>	1.7%
<b>Assistance w/ activities of daily living due to back surgery</b>	1.7%	<b>Tax service</b>	1.7%
		<b>Disability benefits</b>	1.7%

## CONSUMER RANKING OF SERVICES FROM 2003 NEEDS ASSESSMENT:

This information is based on interviews with 242 HIV+ Minnesota conducted during 2003 (where applicable comparison is made with the 1999 needs assessment). The people interviewed may or may not have been in services, or at the time using case management services.

After asking each person four questions about each service, we asked each participant to choose the top five (or most important) services, and the bottom five, (or least important) services – as they saw them.

[Imagine that we are looking at a theoretical 1210 votes – @ 242 people x 5 votes. In actuality, there were 1125 votes cast in ranking the five highest services, and 1041 for the ranking of the five lowest services. The service which gets the most votes is ranked highest (for top ranked services) or lowest (for bottom ranked services).] The results are on the following tables.

SERVICES	1999 RANKINGS			2003 RANKINGS		
	Rank (of 24)	# or Top Five Votes	% of Top Five Votes	Rank (of 25)	# of Top Five Votes	% of Top Five Votes**
<b>Ranking of Top Services</b> [where comparable services]						
Emergency Fin Assist	4	68	6.62%	1	135	12.1%
Case Management	3	84	8.18%	2	127	11.3%
Primary Medical	1	143	13.93%	3	117	10.4%
ADAP	2	100	9.74%	4	95	8.4%
DHS Insurance program	7	61	5.94%	7	61	5.4%
Dental	5	66	6.43%	8	54	4.8%
Food Shelf	10	44	4.28%	11	34	3.0%
Meals On-site				12	28	2.5%
<b>Nutritional Services</b>	<b>20</b>	<b>14</b>	<b>1.36%</b>	<b>24</b>	<b>10</b>	<b>0.8%</b>

## KEY POINTS FOR MEDICAL NUTRITION THERAPY

This program has been administered by DHS, as the nutritional supplement program. Use of the service currently requires a doctor's prescription. This program is now on auto-enroll, which means that any client enrolled in any DHS HH program (ADAP, insurance, or oral health/dental) is automatically enrolled in this program. Note that this is separate from Food and Nutrition, which is a separate support service including food shelf, food vouchers, on-site meals and home-delivered meals.

### ***From the SAR Data:***

According to the most recent needs assessment [*Assessing the Needs of Minnesotans Living With HIV or AIDS: Results of a Community Survey by Positive Outcomes, Inc. and Community Consulting Group, LLC August 2006*], 3.4% of case-managed clients who were interviewed indicated an unmet need for nutrition or nutritional supplements. [Note that we cannot determine whether this means use of nutritional supplements is the unmet need, or if this refers to nutrition in general.]

According to earlier needs assessment data (not limited to case managed clients) (*NEEDS ASSESSMENT OF HIV POSITIVE MINNESOTANS; CLEAR MARCH 2004*): 67% of those interviewed indicated that they regularly take vitamins, minerals, herbs or other nutritional supplements.

### **From the NA&E Committee discussion:**

Committee members indicated they felt the utilization rates for this service were low (85 clients in 2006), given the potential need and benefits of nutritional supplements. Committee members pointed out that it may be difficult for consumers to make use of this service, for several reasons.

- Changes in the treatments available have resulted in few consumers experiencing wasting – on the other hand, providers report that basic financial pressures do create a need for supplements to simply maintain a basic level of calories.
- It is difficult to physically obtain and carry the prescribed nutritional supplements – one pharmacy service which delivered these in the past no longer does so. [For example, it isn't very feasible to carry heavy shopping bags of nutritional supplements on public transportation.]
- A major pharmacy chain can create barriers to using nutritional supplements, due to billing and reimbursement requirements. The largest public clinic's pharmacy also does not provide the nutritional supplements.

Several clinics have registered dietitians available for consultation with patients. However, the committee noted that although any patient could have access to a registered dietitian by physician referral, this creates one more appointment plus added difficulties in obtaining and transporting the prescribed supplements.

Committee members also noted that a review of the formulary, or what would be available through this program would also help address some of the consumer barriers. For example, coverage of energy bars (which are more transportable and easier to store without refrigeration) would be better particularly for patients who are working for pay.

*The new HRSA definition does present some issues which the grantees need to consider, e.g.: the need for a registered dietitian to be involved to make use of this service, and for it to be provided outside of a primary care visit (or clinic, depending on the interpretation).*

- *The Committee would advise the grantee to investigate additional or alternate ways to provide this service, to assure it is in keeping with the new HRSA definitions but addresses the current client barriers (particularly pharmacy access and delivery). This might involve, for example, exploring mail order pharmacies, or working with a service provider which already delivers meals to eligible clients, and does have a registered dietitian supervise creation and delivery of food to clients.*
- *The Committee endorses the value of engaging a nutritional specialist in assessment and focus on optimal nutrition, given that people are living longer (and facing in some clinics, for example, obesity rates that parallel rates for the general population). The Committee also noted comments made on previous consumer surveys about the challenges of accessing healthy food with limited financial resources.*

Drafted after NA&E Committee discussion, August and October, 2007. Approved 11/27/2007

## APPENDIX A: INFORMATION FROM 2003 NEEDS ASSESSMENT RE MEDICAL NUTRITIONAL THERAPY/NUTRITIONAL SUPPLEMENTS

This information is based on two needs assessments conducted with people who are HIV+ Minnesota. The first assessment was conducted in 1999 with 220 people; the second in 2003 with 242 people. The people interviewed may or may not have been in services, or at the time using case management services. The following provides information from those assessments relevant to DHS HIV Programs.

**FOOD AND NUTRITION QUESTIONS.** Participants in the 2003 needs assessment were asked a number of questions about their diet and nutrition. Under questions about income, we asked if people had received help in the form of food shelf or free meals in the prior six months.

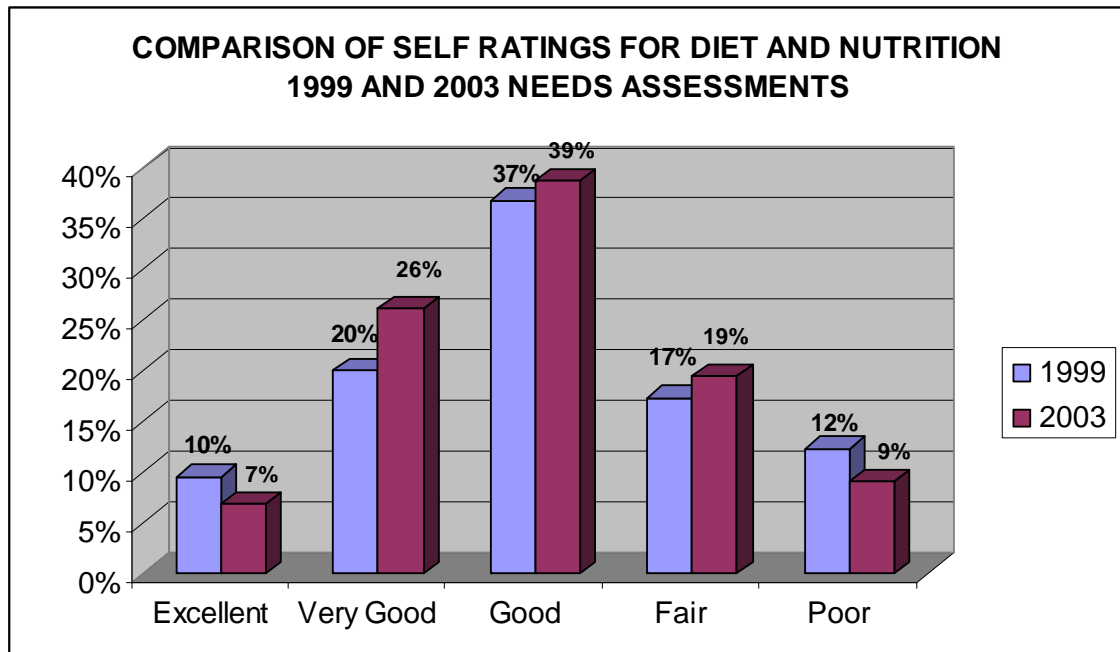
HAVE YOU RECEIVED ANY OF THE FOLLOWING KINDS OF HELP IN THE PAST SIX MONTHS?	Frequency	Percent
Food shelf	137	61.2%
Free meals	122	54.5%

We also asked a series of questions about eating habits – questions which could be answered “yes” or “no.” The results are presented below for both 1999 and 2003.

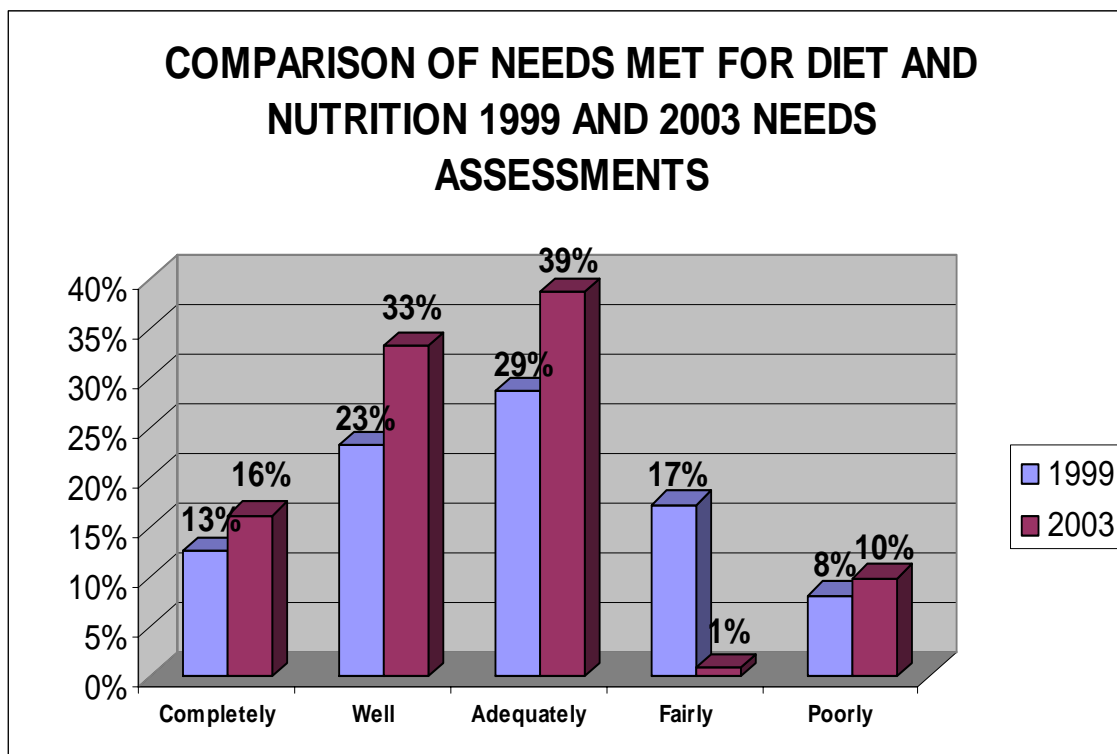
STATEMENT:	ANSWERING “YES”:	1999 Frequency	1999 Percent	2003 Frequency	2003 Percent
I eat at about the same time from day to day.		131	59.5%	138	62.2%
I eat pretty much the same types of food from week to week.		164	74.5%	163	73.4%
I eat about the same amount of food from week to week.		130	59.1%	157	70.7%
I eat about the same amount of food from day to day.		121	55.0%	139	62.6%
I regularly eat breakfast.		99	45.0%	122	55.0%
I regularly eat lunch.		178	80.9%	175	78.8%
I regularly eat dinner.		191	86.8%	204	91.9%
I eat snacks.		186	84.5%	191	86.0%
I have concerns or worries about my diet.		95	43.2%	88	39.6%
I follow a special diet/try to include or exclude foods to stay healthier.		90	40.9%	100	45.0%
<i>I take vitamins, minerals, herbs or other nutritional supplements.</i>		<b>134</b>	<b>60.9%</b>	<b>149</b>	<b>67.1%</b>
There are some food/beverages I can't tolerate because I'm allergic or have trouble digesting them.		92	41.8%	92	41.4%
Ever talked to a dietitian or nutritionist about diet?				108	48.8%
Ever participated in an education program or workshop about the importance of diet and nutrition?				73	32.9%
If yes, was this an HIV-specific program?				54	23.3%
I have to budget money pretty carefully to have enough for food				176	79.3%
I usually shop for my own groceries.		179	84.0%	199	89.6%
I usually do my own cooking.		171	77.7%	191	86.0%
I have trouble getting food at the end of the month.		158	71.8%	88	39.6%
I eat at Aliveness or another congregate meal program.		137	62.3%	120	54.1%
I have meals delivered to my home.		58	26.4%	35	15.8%
In the past 30 days, there were two or more days when I didn't have anything (or barely anything) to eat.				43	19.4%

**SELF RATING OF DIET AND NUTRITION.** Participants were also asked to rate their diet and nutritional needs, as well as to indicate how well they feel their diet and nutritional needs are being met. The next two tables summarize these results.

SELF RATING OF DIET AND NUTRITION	1999 Frequency	1999 Percent	2003 Frequency	2003 Percent
Excellent	21	9.5%	15	6.8%
Very Good	44	20.0%	58	26.1%
Good	81	36.8%	86	38.7%
Fair	38	17.3%	43	19.4%
Poor	27	12.3%	20	9.0%
Missing/no answer	9	4.1%	0	0.0%
<b>Total</b>	<b>220</b>	<b>100.0%</b>	<b>222</b>	<b>100%</b>



SELF RATING OF DIET AND NUTRITION NEEDS MET	1999 Frequency	1999 Percent	2003 Frequency	2003 Percent
Completely	28	12.7%	36	16.2%
Well	51	23.2%	74	33.3%
Adequately	63	28.6%	86	38.7%
Fairly	38	17.3%	2	0.9%
Poorly	18	8.2%	22	9.9%
Not at all	6	2.7%	2	0.9%
Missing/No answer	16	7.3%	0	0.0%
Total	220	100.0%	222	100%



**INFORMATION SPECIFIC TO DHS NUTRITIONAL SUPPLEMENT PROGRAM**

DHS NUTRITIONAL SERVICES	1999 Frequency	1999 Percent	2003 Frequency	2003 Percent
Know about this service?	115	52.3%	127	57.2%
Have used this service in the past year?	72	32.7%	53	23.9%
Need for this service (completely) met*	139	63.2%	86	38.7%
Need for this service NOT being met at all	44	20.0%	5	2.3%
Might need in the future?	160	72.7%	149	67.1%

## KNOWLEDGE AND USE OF SERVICES (IN CONTEXT/COMPARISON TO OTHER SERVICES)

Service:	1999 - Know about service?		1999 - Used in the past year?		2003 - Know about service?		2003 - Used in the past year?	
	#	%	#	%	#	%	#	%
Primary Medical Care	218	99.1%	189	85.9%	196	81.0%	166	68.6%
Pharmacy/ADAP	163	74.1%	149	67.7%	109	45.0%	49	20.2%
Dental Care	138	62.7%	94	42.7%	152	62.8%	92	38.0%
Food shelf	139	63.2%	108	49.1%	209	86.4%	143	59.1%
Insurance assistance	97	44.1%	61	27.7%	144	59.5%	85	35.1%
<b>Nutritional services</b>	<b>115</b>	<b>52.3%</b>	<b>72</b>	<b>32.7%</b>	<b>140</b>	<b>57.9%</b>	<b>60</b>	<b>24.8%</b>
On-site Meals					197	81.4%	133	55.0%

## MET AND UNMET NEED:

Service:	1999 Currently need met		1999 Currently need NOT met		2003 Currently need completely/well met		2003 Currently need met poorly/not at all	
	#	%	#	%	#	%	#	%
Primary Medical Care	195	88.6%	16	7.3%	168	69.4%	5	2.1%
Pharmacy/ADAP	187	85.0%	22	10.0%	93	38.2%	5	2.1%
Dental Care	136	61.4%	70	31.8%	117	48.3%	19	7.8%
Insurance assistance	136	61.8%	48	41.8%	120	49.6%	9	3.7%
Food shelf	167	75.9%	19	8.5%	170	70.2%	5	2.1%
<b>Nutritional services</b>	<b>139</b>	<b>63.2%</b>	<b>44</b>	<b>20.0%</b>	<b>105</b>	<b>43.4%</b>	<b>6</b>	<b>2.5%</b>
On-site Meals					173	71.5%	11	4.5%

FUTURE NEEDS	1999 Might need in the future		2003 Might need in the future	
	#	%	#	%
Primary Medical Care	207	94.1%	202	83.5%
Pharmacy/ADAP	201	91.4%	172	72.1%
Dental Care	198	90.0%	181	74.8%
Insurance Assistance	159	72.3%	176	77.2%
Food shelf	159	72.3%	199	82.2%
<b>Nutritional services</b>	<b>160</b>	<b>72.7%</b>	<b>159</b>	<b>65.7%</b>
On-site Meals			197	81.4%