Minnesota HIV Strategy Advisory Board Retreat
Meeting Minutes, April 17, 2017.

MINNESOTA DEPARTMENT OF HEALTH, 9:30 A.M. - 3:00 P.M

Present

Co-Chairs
- Chuck Peterson

Members
- Cheri Booth
- Abiel Gebrehiwat = Sharon Day Proxy (phone)
- Mady Ekue-Hettah
- Roger Ernst
- Mary Johnson
- Meghan Rothenberger
- Mary St Marie (phone)
- Matt Toburen

Government Staff
- Colleen Bjerke (DHS)
- Jonathan Hanft (HCPH)

MN HIV Strategy Staff
- Dr. Alvine Laure Ekame

Guests
- Jake Maxon
- Bridge McKye

Absent
- Roxane Anderson
- Kyle Dulgar
- Reneka Evans
- William Grier
- Chryssie Jones
- Mary Johnson
- Mary St. Marie
- Mario Villeda Maldonado
- Anthony Stately
Welcome and Introduction
There was expressed concern about the low attendance at the meeting, as well as expressed concerns about the lack of reflective representation from communities that need to be included. Many on the board have demanding jobs and might not be able to block off chunks of time for long meetings. However, they may still be invested in the project and willing to put in more time for the community meetings. The planning stage can become tedious even though it is necessary and board members may lack clarity on their role in this process and what level of commitment is expected of them. There also may be a sense that this process is not necessary if plans from other places could be used, but this process is key to ensuring community ownership of the plan. We should take advantage of technology in the future to cut down on in-person meetings if possible. Alvine will call all the Advisory board members who were not present to find out what barriers they faced preventing them to attend the scheduled advisory board meetings.

Why another survey? Consumers will feel that this is not necessary. We need new data to stay current, and need to explain that. Want to see highlighted more in the planning process how we are using what already exists. We maybe have not clarified how this is different from the past.

The Board should be as fluid and transparent as possible, without a lot of structure that gets in the way of moving forward. The Board needs to make key decisions along the way, but meetings are open to non-board members. Guests are always welcome but they can't make key decisions.

Q: How do we advertise meetings? A: The board received the meeting information and it is up to the board members to invite community members. The meetings’ agendas are posted online and the calendar will be posted online by the end of the month.

Review of the Agenda

Review of Minutes

Practical Vision Report
The vision is built on the five principles that were identified last month during the practical vision exercise.

Vision Statement – DRAFT
By 2025 Minnesota will be a state where new HIV infections are rare and when they do occur, every person regardless of age, gender, race/ethnicity, sexual orientation, gender identity or socio-economic circumstance, will have access to high quality, life-extending care, free from stigma and discrimination.
Our vision is built on the following principles:

- We have systems and funding in place that assures health equity for people living with and at risk of HIV infection.
- We strive to eliminate the inequities and burden of the epidemic in our most marginalized and underserved communities.
- We create opportunities for meaningful Government and Private Sector collaboration that empowers communities to implement new ideas and programs to end the epidemic.
- We reduce stigma and create opportunities for community healing.

Below is the feedback received to enhance the vision statement.

- Equity in action should promote opportunities for collaboration that empowers communities to implement new ideas, not necessarily what government says we should do, and to identify funding sources for these new ideas that the plan promotes.
- We should add country of origin to the vision because of disparities among foreign-born communities.
- Since this word “rare” is not measurable, should we use it? However, it may be appropriate for the broader vision statement.
- One alternative, bringing the number of new cases down below the number of deaths—not increasing prevalence. Should this be broken down by community, rather than a reduction for the population overall?
- Stigma is a subjective word, not sure how it is meant to be interpreted or how it is meant to be reduced. Internal? External? How much stigma? We can never reduce stigma enough. We should define it.
- However, leaving the words open to definition will give the state plan room to grow in the future, can be fine-tuned into the future and depending on the community.
- Does the first bullet imply that funding is available? “Have” maybe is not the right word to use.
- Third bullet: Systems will not empower communities, maybe they can facilitate empowerment. Solutions for the communities most impacted by HIV will come from the communities, the system and government and funders can provide resources and facilitation.
- The word “partnership” should be added. “We create opportunities for meaningful Government and Private Sector partnerships that facilitate communities’ empowerment to implement new ideas and programs to end the epidemic.”

The vision statement will guide work moving forward. The co-chairs and the Statewide Coordinator will edit the vision statement and present final revision at the May meeting.
Underlying Contradictions
In Minnesota, there has been a plateau in HIV cases. What is blocking us from moving toward this vision? Today, we will focus on analyzing underlying contradictions, as this is an important step on the road to developing a realistic strategic plan.

Underlying Contradictions are blocks and barriers that prevent us from realizing our vision. They are like boulders in our path to the future. They are sometimes recently arrived, sometimes longer-term realities in our organizations. Contradictions are to be found in historic and societal trends, in our images and attitudes, and in the structures and patterns we create and out of which we operate.

Contradictions are not problems. Problems are things you fix and you cannot fix an underlying contradiction. You may respond to, affect or go around contradictions. Contradictions are existing realities and may be either internal or external factors that block the way forward. Frequently contradictions are not obvious. They are like cataracts. You do not see them directly. Yet they cloud your vision and over time blind you to what is there.

Activity
From the group activity, the following six contradictions that could block our vision are:

1. Social Determinants of Health
2. Disempowered Communities
3. Government Inertia
4. Institutional Barriers
5. Resource Prioritization

Lunch

Advisory board responsibilities in terms of facilitating community events

Facilitating a Meeting Guest Speaker:
Community Engagement is a set of activities or a set of approaches/meetings. An approach means that all actions are conducted as a member of a community. These community meetings engage the community and give them a space for their voice to be heard while also offering a chance to give them new information. The meeting should expand both the facilitator and communities ideas on the topic.
Keys points

▪ Review questions beforehand. If using a set questionnaire introduce the question set and explain why.
▪ Introduce question in context.
▪ Follow-up: Ask if they are interested in receiving the results. If so, collect contact information.
  ▪ Get their contact info.
  ▪ Be clear about use of info that will be collected: How will participants be informed of how the information gathered will be used? This needs to be very clear.
▪ Record only if all the participant(s) agree.

Review Timeline

By January 30, 2018, the complete strategy plan should be sent to legislators. The board needs to collect any data from community meetings before then.

▪ Some Advisory Board members will not necessarily facilitate community meetings.
▪ We will schedule a town hall meeting in September. This will be an opportunity to share the MN HIV Strategy process, vision, goals and objectives and get community members’ feedback.
▪ A small group will work on drafting the mains goals, and present it to the Advisory Board members in May. The group may need to prioritize which communities we need to have meetings with and need to focus on communities that have not had a chance to share their voice yet.
▪ For example, immigrant communities in southern MN. In order to determine what the community meetings should look like, we should look at what meetings have been held in the past. These meetings are intended to be more focused than past community meetings.
▪ While planning the community meetings, keep in mind to involve the most marginalized community members.
▪ In some cases, the facilitator at some of these meetings might not be advisory board members.
▪ How many meetings will the budget allow for?
▪ What communities will be important for us to hear from African; African American; Latino; youth; Trans; rural area?
▪ What communities we want to reach and how to reach them.
▪ Think about accessing people who are struggling to stay in care.
▪ Meet with consumer at the planning council.
▪ The meeting should focus on underserved hard to reach communities.
▪ Each community should determine if community meetings are the best approach or if individual interviews would work better.
Use snowball sampling; that will enable us to spread out to population that matters?

From the literature review, found out how other states engage with people in care who are struggling to stay in care and with people who are out of care. Also, how other states tackle HIV stigma.

The group went then on to identify some of the existing groups.

- African American Same Gender Loving Men’s Group (Working on projects and new ways to reach that community)
- African Faith Leaders Group
- MN Trans Health Coalition (Roxanne Anderson)
- Long Term Survivors Group (Chris Larson)
- AA Same Gender Loving (Dennis & Kevin)
- YAP Support Groups - Trans; HIV positive; High Risk (Val)
- Reclaim Support Groups
- MAP Support Groups - Women Living with HIV; Gay/Bi Men Living with HIV; IDU community; Young MSM
- Sex Trafficking Support Groups in Greater MN
- MN Girl trans (Swift County)
- 16-24 years old girls from Wilmer, Blue Earth County, North Minneapolis youth, street outreach (St Steven) – (Yasmine)
- Rural MN (RAAN)
- CAIR - Council on American Islamic Relations
- Intimate partners violence

**Review of Questionnaire**

More in depth analysis to be done at the June meeting.

Questions are broken into sets for stakeholders, consumers, etc. Ask each community if they need a facilitator, all will use the same question set, and gift cards are for community members that attend. This is an opportunity to demonstrate that we are overcoming the contradiction identified of government inertia and structural rigidity, but instead valuing flexibility and innovation and new information. Do we need to separate the community meetings by those who are HIV positive or not? It does not seem to make sense, but we should let the community decide.

There is concern that community meetings will not draw out more information that is new. How do we reach people who are not connected to care or a support group? Street outreach? Shelter system? What about rural MN?
Q: Ask clinics to send info to patients who have fallen out of care.

A: These patients often do not want to be found and this is a very labor-intensive process. Generally, patients fall out of care because of mental health, substance abuse, and/or poverty with too many demands from life.

Service providers can’t necessarily take this on top of their workload, could potentially see about DIS and MDH and Red door who are contacting patients who are out of care –could maybe ask them to add questions.

We should focus more on patients who are in care, but who have trouble staying in it may be a good resource for information.

We are interested in transfer points.

Perhaps we need a literature review on how to engage with people who are not staying in care.

Developing systems to engage people who are out of care to evaluate their needs could be a part of the report.

The issues that are keeping people out of care are the same pretty much for everyone. We need to look at what is actually working to keep people in care and do more of that. Once we have identified what is working, then have community conversations to run these methods by the community. Should there be a meeting to go over other state strategies? Mental health care and housing should also be looked at as well as different strategies to reduce stigma. We should maybe be reluctant to copy what is working because what is defined as “working” is keeping us at a steady rate of infections. We need to look at what other states are doing that we are not.

Are we looking to seek community input? Or focus on best practices? Do we have reason to believe that our community may be different and best practices from other community may not work in our community? The questions were drafted to make people think differently about these issues, and in combination with sharing data with community members and discussing the care continuum, we will hopefully get information that we have not gotten in the past.

This plan guides all of our work towards a common goal. This dictates where we put funding; communities are not told what to do with the funding, but success is measured based on outcomes that aligns with the statewide plan. The plan maybe does not need to go deeply into the “how,” but we need to get government to have the flexibility to respond to what’s working in the community.

The national HIV strategy first defined goals, then drafted the document outlining what each player will do.

The group needs clarity on the process of creating the plan, and the role of the group. Alvine has been leading us through the process, and the group is creating the plan.
What has been done already is valid, and the main issue to focus on is how we address these barriers uniquely in MN.

- **First Step:** Finalizing the vision, create broad goals and objectives, and then create strategies & outcomes.

- **Next step:** Community meetings are held to address how to reach the goals in the plan. How do state agencies change funding to meet the “how” needs. The “how” is how we address the contradictions identified this morning. How do we address these barriers in our own microsphere? How do we deal with social determinant of health that affect the continuum of care?

When this process started, the desire was that the group would own the plan and that a certain process would be followed to get the plan formulated, which would then be taken to the community for feedback. Alternatively, based on this meeting discussion, this group would draft out goals and outcomes based on best practices around the country, then in May finalize and in June through October start conversations in the community to discuss how to get to these goals. In October and November this feedback would be used to create the “how” section of the plan to take to the legislature in January. A different set of players may need to be included—the “how” should also include which groups should be included.

When looking for best practices: New York, Seattle, and San Francisco are often compared, but we need to look at areas what have a large geographic area. Our unique challenge is that we have an urban area and a large rural area with diverse populations. Not necessarily looking at the “how” from the other states, but looking at their goals. It might be beneficial to look at data based on zip code to identify areas to focus on.

**Current reality/Strategic Direction**

Added to the May meeting agenda

**Next meeting date, time, location, agenda**

- **Next Meeting date/time:** Monday May 22, 2017
- **Location:** Clare Housing, 929 Central Avenue NE, Minneapolis, MN 55413
- **Agenda**
  - Approve revised vision statement
  - Strategic Direction-Review Draft goals/objectives/outcomes
  - Share new MDH data 2016 breakout by goals
  - June Meeting: Current Reality
  - July-October focus on
    - How, Community Input, Town Hall