Ending HIV/AIDS Among Injection Drug Users in Minnesota

SUMMARY OF COMMUNITY STAKEHOLDER INPUT

July 2018
Prepared by Wilder Research

MINNESOTA

Ending HIV/AIDS Among Injection Drug Users in Minnesota

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Contents

Introduction

The Minnesota Departments of Health (MDH) and Human Services (DHS) convened 15 facilitated workshops around Minnesota to develop tactics for implementing the Minnesota HIV Strategy. The Minnesota HIV Strategy is a comprehensive plan to end HIV/AIDS. It includes five goals supported by 22 total sub-strategies (strategies) focused on how the goal will be achieved. The Minnesota HIV Strategy is available here: Minnesota HIV Strategy report (www.health.state.mn.us/divs/idepc/diseases/hiv/strategy/reportfeb2018.pdf).

Each facilitated workshop focused on a specific region of the state or high-risk community. Workshop participants included stakeholders and community members with knowledge, connections, and insights about challenges and opportunities to support the success of this strategy. Wilder Research facilitated each workshop.

This is a summary of the facilitated workshop focused on ending HIV/AIDS among injection drug users (IDU). A workshop focused on IDU was held because new infections among IDU – particularly IDU who are also men who have sex with men -- have increased over the last few years. While the numbers remain relatively low compared to other modes of exposure, with the growing opioid epidemic, the potential for an HIV outbreak among IDU in Minnesota is concerning. The workshop was conducted on May 29, 2018, in Minneapolis, Minnesota. This summary also includes findings from a survey that was offered to individuals who were invited to participate in the workshop, but unable to attend.

Participants

Workshop participants

Fifteen people participated in the facilitated workshop. Table 1 shows the roles or areas of work participants identified when registering for the workshop. Participants could select multiple roles or areas of work.

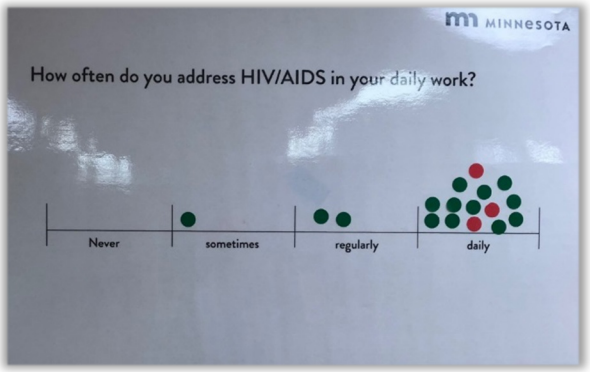
Table 1. Roles of workshop participants

	Workshop participants (N=15)	
Role or area of work	**N**	**%**
Advocate for, or member of, high-risk population[a]	8	53%
Chemical dependency provider	3	20%
City or county public health or human services professional	1	7%
HIV services provider	11	73%
Medical provider	1	7%
Mental health provider	2	13%
Social service provider	5	33%
Youth advocate/youth worker	2	13%
Other	4	27%
Unspecified or not pre-registered	0	0%

Note. The numbers above may not sum to the total number of participants because each participant was able to select multiple roles. Staff from MDH, DHS, and Wilder Research also attended each facilitated workshop to present data on HIV in Minnesota, describe the Minnesota HIV Strategy, facilitate activities, answer questions, and take notes during small group discussions. The staff are not included in the table.

[a] High-risk populations include men who have sex with men, people who inject drugs, people experiencing homelessness, African-born men and women, African American women, Latina women, and transgender people.

Workshop participants were asked to complete a visual survey question at the start of the workshop in which they answered the following question: "How often do you address HIV/AIDS in your daily work?" Responses ranged from sometimes to daily, with a majority of the responses being daily.



Survey participants

Eight people provided input via the survey. Table 2 shows survey participants' roles or areas of work. Again, participants could select multiple roles or areas of work.

Table 2. Roles of survey participants

	Survey participants (N=8)
Role or area of work	N
Advocate for, or member of, high-risk population[a]	1
Chemical dependency provider	1
City or county public health or human services professional	3
Faith leader	0
HIV services provider	0
Housing provider	0
Medical provider	1
Mental health provider	0
Social service provider	0
Youth advocate/youth worker	0
Other	2
Prefer not to answer	0
Missing	2

Note. The numbers above may not sum to the total number of participants because each participant was able to select multiple roles.

[a] High-risk populations include men who have sex with men, people who inject drugs, people experiencing homelessness, African-born men and women, African American women, Latina women, and transgender people.

Processes

Facilitated workshop process

Each workshop began with a presentation by MDH and DHS about the incidence and prevalence of HIV in Minnesota, a description of the Minnesota HIV Strategy, and a review of themes identified during a needs assessment conducted in 2017. The remainder of the workshop consisted of facilitated activities, led by Wilder Research, which helped participants to:

- Prioritize strategies that are most important for ending HIV/AIDS among injection drug users in Minnesota
- Develop tactics that would support implementation of high priority strategies

Throughout the workshop, note-takers documented participants' insights and ideas. This summary describes the strategies prioritized by participants and the tactics they identified.

Survey process

Individuals who were unable to participate in the workshop were able to contribute via a web-based survey. The survey asked respondents to identify the three strategies that they feel are most important for the population of interest, to recommend a tactic that addresses each strategy, and to identify barriers to implementing the tactic as well as resources that could support it. Survey responses are described alongside the feedback captured during the facilitated workshops.

Prioritized strategies

Strategies prioritized in the facilitated workshop

The goal of the first facilitated activity was to identify a set of high-priority strategies from the full set of 22 that are included in the Minnesota HIV Strategy. The activity included two rounds of prioritization. First, each small group of participants identified the four strategies they thought were most important for making progress toward ending HIV among injection drug users.

Second, after each small group shared their four selected strategies, all participants were able to vote for the one(s) they felt should advance to the tactic development stage of the workshop. Each participant was allowed four votes that could be distributed in any manner across any strategy that had been prioritized by at least one small group.

Across the four small groups working together during this workshop, 11 strategies were prioritized at least once. These are listed in Table 3. The four strategies that received the largest number of votes and advanced into the tactic development stage of the workshop are in bold.

Table 3. Prioritized strategies

Strategies
Strategy 1.4: Increase availability, access and use of evidence-based interventions that prevent HIV infections, such as pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), syringe services programs, and partner services.
Strategy 2.1: Protect and enhance advancements in health care policies, including Minnesota Health Care Programs expansion, coverage for people with pre-existing conditions, and access to preventative treatments without cost sharing.
Strategy 2.2: Engage community leaders, non-profit agencies, people living with HIV (PLWH), and other community members to identify and to address barriers that prevent testing and person-centered care.
Strategy 2.3: Dedicate adequate resources to populations of color hardest hit by HIV to eliminate health inequities.
Strategy 2.4: Reduce HIV-related stigma, systemic racism, and other forms of structural discrimination that prevent people from accessing HIV care and prevention services.
Strategy 3.2: Ensure person-centered strategies that support long-term retention in care.
Strategy 3.4: Identify and reduce barriers to accessing mental health and substance use services and care.
Strategy 4.3: Ensure that PLWH and those at high risk of HIV infection have access to necessary supports that maintain their housing stability.
Strategy 4.4: Secure long-term, sustainable resources to meet the growing need for affordable housing and supportive services.
Strategy 5.3: Identify, research, and replicate new, effective interventions through partnerships between local public health and state governments, tribal nations, HIV providers, community-based and religious organizations, the University of Minnesota and other academic institutions, research partners, and others.
Strategy 5.4: Establish policies that encourage an innovative culture and delivery of comprehensive statewide services. An innovative culture includes recognizing that prevention and treatment options evolve and leadership must be willing to respond to new technologies to reduce HIV burden.

Note. The strategy numbers (e.g., 1.4) correspond to the numbering system used in the Minnesota HIV Strategy. Some strategies may have received a large number of votes, but ultimately did not have enough participants interested in developing tactics to progress. These strategies are not in bold.

Strategies prioritized by survey respondents

Web survey respondents were also asked to identify strategies that they thought were most important for ending HIV/AIDS among injection drug users. Each survey respondent could identify up to three strategies they thought were most important. The most commonly selected strategies are shown in Table 4.

Table 4. Prioritized strategies from survey participants

Strategy	N (out of 8)
Strategy 1.4: Increase availability, access and use of evidence-based interventions that prevent HIV infections, such as PrEP, PEP, syringe services programs, and partner services.	6
Strategy 1.1: Increase HIV education and awareness for all Minnesotans, especially health professionals, students, and high-risk populations.	3
Strategy 1.3: Immediately link newly diagnosed individuals to person-centered HIV care and treatments.	3
Strategy 3.4: Identify and reduce barriers to accessing mental health and substance use services and care.	3

Note. The strategy numbers (e.g., 1.4) correspond to the numbering system used in the Minnesota HIV Strategy. Only strategies that were selected by at least three people are included in the table; some strategies were prioritized by a smaller number of respondents.

Tactics

Tactics identified in the facilitated workshop

First, participants worked in small groups to brainstorm possible tactics for the four highest priority strategies highlighted in Table 3. Table 5 lists the tactics that were brainstormed for each of the strategies. The eight starred tactics (*) are the ones that participants recommended for integration in the Minnesota HIV Strategy.

Table 5. Brainstormed tactics from workshop participants

Prioritized strategies	Potential tactics
Strategy 1.4: Increase availability, access and use of evidence-based interventions that prevent HIV infections, such as PrEP, PEP, syringe services programs, and partner services.	▪ Expand AIDS Line services to provide safe consumption services preferably by phone. Could be a call in connection to a peer, [there are] safety issues [with this]. ▪ Integrate syringe services programs (SSP) into other services (e.g., primary care, treatment agencies, and emergency rooms). Imbed this in places like Positive Care. This will improve retention in care and this would also help [address] transgender needs. [Increase number of] safe disposal sites; [implement] syringe take back at pharmacies, community incinerator, and community visible disposable sites (like in Denver). Need more licensed alcohol and drug counselors and Rule 25 assessors integrated at SSPs.* ▪ [Implement] peer delivery of syringes. More money is needed for supplies. [Implement] secondary exchangers (replicate Washington Heights model) and drug user organizing. Engage drug consumers in design and delivery.* ▪ [Make] Syringe Access Initiative (SAI) required. It should be changed to say that a pharmacy/pharmacist MUST (not may) sell up to 10 syringes without a prescription. This should be legally challenged. ▪ [Educate] medical providers and agencies about what is harm reduction and why/how it works. Reframe recovery to "any positive step" and away from just treatment and/or abstinence.
Strategy 2.4: Reduce HIV-related stigma, systemic racism, and other forms of structural discrimination that prevent people from accessing HIV care and prevention services.	▪ [Decrease] structural discrimination. Decriminalize possession of syringes and narcotics through legislation.* ▪ [Address] systemic racism. Go where people are to exchange needles—do not just do the service at white agencies or by white people. Go to agencies of color [to implement] needle exchange. Bring people to the table to make better decisions.* ▪ Increase access to health care for people of color. Provide translation; [improve] health literacy for people from different countries. Incorporate non-western medical models into western models.

Table 5. Brainstormed tactics from workshop participants (continued)

Prioritized strategies	Potential tactics
Strategy 3.4: Identify and reduce barriers to accessing mental health and substance use services and care.	▪ Offer ongoing mental health/substance use care and supports to people living with HIV (PLWH) regardless of exposure category. Provide comprehensive assessment and immediate referrals for integrated care.* ▪ Increase peer supports and case management for PLWH with mental health and substance use issues.* ▪ Eliminate insurance barriers (especially to treatment); explore the Certified Community Based Health Clinics (CCBHC) concept. ▪ [Make] clinicians available to do assessment and follow up services rather than relying on referrals.
Strategy 4.4: Secure long-term, sustainable resources to meet the growing need for affordable housing and supportive services.	▪ [Implement] looser eligibility requirements (Housing first, harm reduction housing). Increase flexibility in funding. Have tighter network of housing resources and increase [their] congruence.* ▪ [Eliminate] sobriety requirements attached to housing. ▪ [Provide] support services attached to housing support to increase retention. [Start] "de-siloing services" and making them more accessible.* ▪ Implement "sticky services" [as done by the] Hearth Connection, [where] services are attached to individual not the type of housing they have. ▪ Increase flexibility [of funding]. Prioritize state funding to pay for support services.

Tactics identified by survey respondents

Each survey respondent was invited to recommend a tactic that should be used to implement each of the strategies they selected as most important. Table 6 lists the tactics that they recommended.

Table 6. Recommended tactics from survey participants

Prioritized strategies	Recommended tactics
Strategy 1.1: Increase HIV education and awareness for all Minnesotans, especially health professionals, students, and high-risk populations.	▪ Offer more conferences and webinars to professionals. [Use] more PSAs to reach high-risk populations.
Strategy 1.3: Immediately link newly diagnosed individuals to person-centered HIV care and treatments.	▪ [Implement] same-day initiation of antiretroviral therapy (ART) upon diagnosis. This may require adding access to ART in testing locations so people do not fall between the cracks when referred elsewhere. ▪ Develop an easy to use referral system to link individuals to a provider who specializes in HIV treatment.
Strategy 1.4: Increase availability, access and use of evidence-based interventions that prevent HIV infections, such as PrEP, PEP, syringe services programs, and partner services.	▪ Educate about options in at-risk populations. Often persons who may have risks for certain diseases don't understand options in prevention of that disease. ▪ Offer more education to providers regarding PrEP and PEP. Expand syringe services programs to rural areas. ▪ Work with pharmacies to reduce the stigma around purchasing syringes. At most pharmacies it's up to the pharmacist if they want to sell them or not.
Strategy 3.4: Identify and reduce barriers to accessing mental health and substance use services and care.	▪ Integrate on-demand treatment into HIV care.

Note. The strategy numbers (e.g., 1.1) correspond to the numbering system used in the Minnesota HIV Strategy. Only strategies that were selected by at least three people are included in the table; some strategies were prioritized by a smaller number of respondents. Some respondents did not provide a tactic for their chosen strategies. Some responses that were provided to the question about tactics were non-responsive and thus not included above.

Additional participant contributions

Workshop participants offered additional input throughout the facilitated activities. These insights are listed below.

- Participants indicated that the fundamental question that we should ask is, "Why are people falling out of care (i.e., not retained)? What are the demographics of these people?"
- Participants provided feedback about many aspects of the Minnesota HIV Strategy.
  - They recommended that the Strategy be more focused on person-centered and culturally appropriate care and that it be driven by impacted populations.
  - Four elements of the Strategy that were specifically identified as important were: early intervention, referral and follow-up (warm handoff), access to care, and linkage to care.
  - The Strategy should articulate the overlap with substance abuse disorder and the overdose crisis.
  - The Strategy should focus on harm reduction and treatment access. Some specific ways this could be integrated include:
    - Strategy 2.3 should include key populations like injection drug users (especially those of color).
    - Strategy 3.4 should specify "evidence-based" substance use services, and the strategy should reference retaining in care in addition to just access.
    - Strategy 4.4 should include harm-reduction resources such as wet housing.
- There are important barriers to accessing HIV care and information, including individual barriers and policy barriers.
  - There is an inequity in access to HIV information. While white men who have sex with men have access to HIV information, members of the black and Latino communities do not.
  - IDU stigma is very high, and because of this, some choose not to access services due to shame.
  - Professionalization and lack of support are also barriers; some PLWH need more hands on or supportive care, especially when they have co-occurring issues like mental health or substance use.
  - There are insurance barriers for IDU to access PrEP and PEP; especially for those who have Medicare.
  - The Syringe Access Law is inefficient and creates shame. It actually legitimizes use, is stigmatizing, and should be abolished.
    - Participants recommend renaming syringe services to include harm reduction, possibly by renaming to Drug User Care Services and including overdose prevention measures.
    - Expand strategy to cover all IDU/drug users to create human-centered approach.
- There is a need for Harm Reduction Housing, which provides harm reduction supports and supervised injection.

Next steps

Using the information from this summary, as well as other regional and community summaries and a statewide report of synthesized results, the Minnesota HIV Strategy Advisory Board will prioritize a set of tactics to be implemented. In fall 2018, MDH, DHS, and Wilder Research will prepare an implementation plan (including a fiscal analysis which describes the anticipated cost) and an evaluation plan to guide and monitor these efforts.

An updated Minnesota HIV Strategy will be submitted to the Minnesota Legislature by January 1, 2019. The update will include the most current data about the status of HIV/AIDS in Minnesota, information related to the outcomes of the facilitated workshops and web-based survey, the prioritized tactics, and the implementation and evaluation plans.

DHS is creating a new position to coordinate and report on the progress of the implementation and evaluation plans as well as progress in reaching the outcomes and indicators included in the Strategy. As tactics are successfully implemented in coming years, additional tactics will be prioritized and added to the implementation and evaluation plan.

At the end of the workshop and survey, participants were able to sign up to stay involved with, or support future work on, their recommended tactics if they are selected for the Minnesota HIV Strategy. Participants were also able to indicate other organizations or individuals who were unable to attend but should be included if the tactic moves forward. MDH and DHS will reach out to these individuals to request further input on or assistance with the tactic, as appropriate.

Lastly, workshop participants were encouraged to stay in touch with individuals they met during the workshop. They were invited to move forward with any promising tactics they identified that could be implemented with existing resources.

For additional information about developments in the Minnesota HIV Strategy, please visit Minnesota HIV Strategy (www.health.state.mn.us/divs/idepc/diseases/hiv/strategy/index.html) or email Health.HIV.Strategy@state.mn.us.