Ending HIV/AIDS in South Central Minnesota

SUMMARY OF REGIONAL STAKEHOLDER INPUT

July 2018
Prepared by Wilder Research

MINNESOTA

Ending HIV/AIDS in South Central Minnesota

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Minnesota HIV Strategy (www.health.state.mn.us/divs/idepc/diseases/hiv/strategy/index.html)

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Adults HIV/AIDS information (https://mn.gov/dhs/people-we-serve/adults/health-care/hiv-aids/)

Upon request, this material will be made available in an alternative format such as large print, Braille or audio recording. Printed on recycled paper.

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, and offered a web survey to individuals who were unable to participate in the workshop.

To ensure geographic representation across Minnesota in this process, feedback was sought through workshops and web surveys in each of eight regions of the state. This is a summary of the facilitated workshop focused on ending HIV/AIDS in the south central region. The workshop was conducted on May 31, 2018, in Mankato, Minnesota. This summary also includes findings from the web survey respondents.

Participants

Workshop participants

Twenty 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.

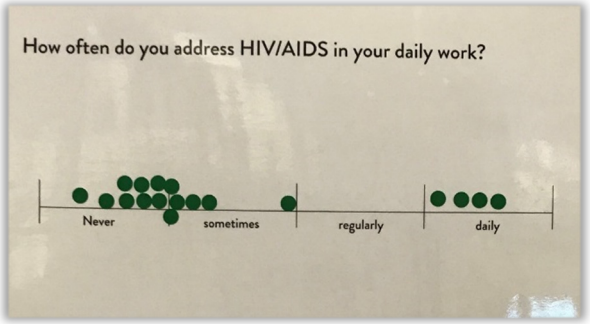
Table 1. Roles of workshop participants

	Workshop participants (N=20)	
Role or area of work	**N**	**%**
Advocate for, or member of, high-risk population[a]	1	5%
Chemical dependency provider	1	5%
City or county public health or human services professional	10	50%
HIV services provider	3	15%
Medical provider	0	0%
Mental health provider	2	10%
Social service provider	2	10%
Youth advocate/youth worker	0	0%
Other	2	10%
Unspecified or not pre-registered	2	10%

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 MN 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?" The 18 responses ranged from never to daily, with the largest share of responses being never.



Survey participants

Ten 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=10)	
Role or area of work	**N**	**%**
Advocate for, or member of, high-risk population[a]	0	0%
Chemical dependency provider	0	0%
City or county public health or human services professional	5	50%
Faith leader	0	0%
HIV services provider	0	0%
Housing provider	0	0%
Medical provider	0	0%
Mental health provider	0	0%
Social service provider	0	0%
Youth advocate/youth worker	0	0%
Other	2	20%
Prefer not to answer	0	0%
Missing	3	30%

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 in the south central region
- Develop tactics that would support implementation of high priority strategies

Throughout the workshop, note-takers documented participant's 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 in the south central region.

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 five small groups working together during this workshop, 13 strategies were prioritized at least once. These are listed in Table 3. The five 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 from workshop participants

Strategies
Strategy 1.1: Increase HIV education and awareness for all Minnesotans, especially health professionals, students, and high-risk populations.
Strategy 1.2: Increase routine opt-out HIV testing and early intervention services.
Strategy 1.3: Immediately link newly diagnosed individuals to person-centered HIV care and treatments.
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 2.4: Reduce HIV-related stigma, systemic racism, and other forms of structural discrimination that prevent people from accessing HIV care and prevention services.
Strategy 3.1: Employ high-impact public health approaches to identify and to re-engage individuals who are out of HIV care and treatment.
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 3.5: Ensure access to services that meet the basic needs of people living with HIV (PLWH).
Strategy 4.4: Secure long-term, sustainable resources to meet the growing need for affordable housing and supportive services.
Strategy 5.2: Integrate HIV prevention, care and treatment throughout all sectors of government (e.g., health, human services, education), health care systems, and social 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.

Note. The strategy numbers (e.g., 1.1) 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 in the south central region. 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 10)	%
Strategy 1.1: Increase HIV education and awareness for all Minnesotans, especially health professionals, students, and high-risk populations.	6	60%
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.	4	40%
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.	3	30%
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.	3	30%
Strategy 3.2: Ensure person-centered strategies that support long-term retention in care.	3	30%
Strategy 3.4: Identify and reduce barriers to accessing mental health and substance use services and care.	3	30%

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.

Tactics

Tactics identified in the facilitated workshop

First, participants worked in small groups to brainstorm possible tactics for the five highest priority strategies highlighted in Table 3. Table 5 lists the tactics that were brainstormed for each of the strategies. The ten 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 1.1: Increase HIV education and awareness for all Minnesotans, especially health professionals, students, and high-risk populations.	▪ [Host a] regional conference with breakout sessions for differing levels of knowledge. [Invite a] comprehensive group – school staff, police officers, etc. This could be a webinar.* ▪ [Create a] regional hotline to link people living with HIV (PLWH) to resources. ▪ Provide an HIV-specific education session or outreach to local schools serving students age 13 and older through local public health. This could be paired with existing presentations that focus broadly on sexual health.* ▪ Conduct education or outreach at chemical dependency treatment facilities. This could be done by the regional drug task force. ▪ Host a “day in the life" session where PLWH share stories and describe day-to-day life to students. ▪ [Have the] state HIV specialist conduct visits to rural/greater Minnesota’s small communities to do monthly outreach and testing at clinics where people with high-risk visit. ▪ Identify and engage with cultural community leaders to ensure they have accurate information about HIV and can serve as a liaison between providers and cultural communities.
Strategy 3.1: Employ high-impact public health approaches to identify and to re-engage individuals who are out of HIV care and treatment.	▪ Develop a referral process to local public health by the Minnesota Department of Health (MDH).* ▪ [Increase] public health’s involvement with individuals doing Directly Observed Therapy (DOT) until [they reach an] undetectable viral load. ▪ Educate providers about processes for referral, access to medication, and funding. ▪ Provide person-centered, holistic education to patients with HIV via public health. Education does not always translate to behavior change but unless you educate you won't be able to impact behavior. ▪ [Provide] holistic nurse case management with medication administration, education, referral to services, and care coordination.* ▪ [Provide] provider education around routine testing (i.e., pregnancy with syphilis, tuberculosis). ▪ Offer testing in office and at community events by public health.

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.	▪ [Implement an] outcome-based payment [system]. ▪ [Increase] cultural competence. Work with community organizations and populations from high-risk populations. ▪ [Address] understanding discrepancy. [Provide] focused education for true need and misunderstanding. ▪ Reduce stigma through a provider outreach initiative. Link providers to groups who are not accessing care.* ▪ [Improve] access to care. ▪ [Increase] availability to bed space/programs. [Implement] dual programs [for mental health and substance abuse]. ▪ Increase awareness among providers. Educate [to improve] provider competency. [Teach providers to use a] standardized screening process [for mental health and substance abuse issues].* ▪ [Change] government rules and regulations. Licensing rules need to be integrated. Regulations need to be loosened up. ▪ [Provide] treatment in the emergency department specifically for mental health and substance use disorders.
Strategy 5.2: Integrate HIV prevention, care and treatment throughout all sectors of government (e.g., health, human services, education), health care systems, and social services.	▪ [Provide] ongoing professional education through webinars and conferences.* ▪ Build on existing coalitions and networks.* ▪ Integrate HIV and sexually transmitted disease (STD) education in schools and communities. ▪ Refine referral networks.
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.	▪ Develop an inventory of best practices in other states. MDH/DHS take the lead to collect and or compile these resources/best practices.* ▪ Offer training for professionals. MDH/DHS conduct regional training on the best practices, specifically for interventions that have worked in similar geographic regions (rural) and for particular communities. ▪ Identify successful programs to model hands-on experience. [Look to] programs that have worked (e.g., King County, Seattle). ▪ Build a large collaboration within the region to maximize limited resources. (e.g., social networking, sharing what works, building relationships with gatekeepers in community/governments). ▪ [Provide] capacity funds for public [messaging] of prevention, care, and treatment services. [Conduct] outreach to other service providers.*

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.	▪ Develop online education programs and webinars. ▪ Provide communication content and tools to local public health and community partners to deliver in their settings and in any outreach work they do. ▪ [Conduct] outreach activities within schools, community events, and clinics to ensure all are aware of prevention and appropriate testing.
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.	▪ [Increase] education. [Ensure] private access.
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.	▪ Lobby for legislative action and [provide] education for elected officials. ▪ [Implement] legislation to secure that pre-existing conditions are always covered.
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.	▪ Attempt to normalize the conversations.
Strategy 3.2: Ensure person-centered strategies that support long-term retention in care.	▪ Provide resources and support around individually personalized strategies to providers and their support staff that accept the care of HIV positive clients.
Strategy 3.4: Identify and reduce barriers to accessing mental health and substance use services and care.	▪ MDH and insurance carriers need to provide coverage for [mental health and substance abuse] services. Offer incentives to caregivers if they provide services. ▪ Recruit additional mental health providers for rural Minnesota even if through tele-medicine. ▪ [Implement] legislation and [provide] funding to support this important area.

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 which is summarized below.

- Participants made connections between the work with HIV and that with tuberculosis (TB). They suggested that testing for and management of HIV should be done like TB. They indicated that they know the numbers of TB cases, but don't have the same records for people living with HIV. Because it's a reportable infectious disease like TB, they recommended that it be treated like that, but the care coordinator position to do so is missing.
- Participants inquired as to whether MDH informs regional public health about new HIV cases in the region, and if not, suggested that this happen.
- Participants recommended collaborating with established systems to this work (e.g., have probation officers conduct HIV tests while doing drug testing).

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.