Ending HIV/AIDS in Central Minnesota

SUMMARY OF REGIONAL STAKEHOLDER INPUT

July 2018
Prepared by Wilder Research

MINNESOTA

Ending HIV/AIDS in Central Minnesota

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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 central region. The workshop was conducted on May 22, 2018, in St. Cloud, Minnesota. This summary also includes findings from the web survey respondents.

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.

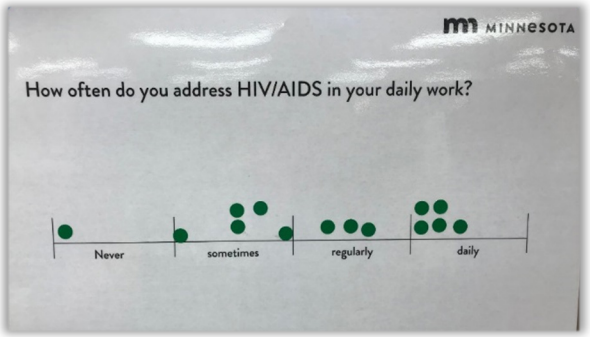
Table 1. Roles of workshop participants

	Workshop participants (N=15)	
Role or area of work	**N**	**%**
Advocate for, or member of, high-risk population[a]	4	27%
Chemical dependency provider	2	13%
City or county public health or human services professional	6	40%
HIV services provider	3	20%
Medical provider	3	20%
Mental health provider	2	13%
Social service provider	2	13%
Youth advocate/youth worker	0	0%
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?" The 14 responses ranged from never to daily.



Survey participants

Thirteen 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=13)	
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	3	23%
Faith leader	0	0%
HIV services provider	0	0%
Housing provider	0	0%
Medical provider	1	8%
Mental health provider	2	15%
Social service provider	1	8%
Youth advocate/youth worker	0	0%
Other	1	8%
Prefer not to answer	1	8%
Missing	4	31%

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 central region
- 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 in the 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 four small groups working together during this workshop, 10 strategies were prioritized at least once. These are listed in Table 3. The three 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 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 3.2: 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 4.4: 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 5.5: Create effective information sharing partnerships and systems that produce reliable data and that inform decision-making, strategy development, and program accountability.

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 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 13)	%
Strategy 1.1: Increase HIV education and awareness for all Minnesotans, especially health professionals, students, and high-risk populations.	4	31%
Strategy 1.3: Immediately link newly diagnosed individuals to person-centered HIV care and treatments.	7	54%
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.	7	54%
Strategy 2.3: Dedicate adequate resources to populations of color hardest hit by HIV to eliminate health inequities.	6	46%
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	31%

Note. The strategy numbers (e.g., 1.3) correspond to the numbering system used in the Minnesota HIV Strategy. Only strategies that were selected by at least four 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 three highest priority strategies highlighted in Table 3. Table 5 lists the tactics that were brainstormed for each of the strategies. The six 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.	▪ Utilize public health as one platform to distribute information. ▪ Educate health providers on minor consent law. ▪ Advocate for changes in state education policies around sex education. Incentivize comprehensive sex education instead of abstinence-only.* ▪ Teach bedside manner to physicians. ▪ Normalize testing. Offer programs or seminars for medical professionals about questions they should be asking during a medical visit. Centers for Disease Control (CDC) has recommendations around sexual health. ▪ [Create] visibility - more advertisements, more billboards, advertisements on buses. There are so many advertisements about everything else, why not more about HIV (e.g., from MDH for testing)?* ▪ [Provide] incentives to get tested. ▪ Figure out how insurance companies decide what people should be tested for and how often, and get it changed. ▪ Get CDC involved in providing a formal recommendation that HIV testing happen annually and increasing education among providers about what they should be doing.

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.	▪ Identify culturally sensitive providers. The State should reach out to them to provide technical assistance around Minnesota's AIDS Drug Assistance Program (Program HH) and billing as well as to provide education (i.e., provider resources). ▪ Create provider directory/network that is maintained and updated (make lists localized for each area/region). ▪ Set minimum benefits for mental health and substance abuse. [Ensure they are] provided, seamless, and uniform.* ▪ Explore ways to allow consistency with case management services/case workers for individuals [to help] build relationships and trust. ▪ [Host] regular provider network meetings to share information and identify gaps. ▪ [Provide] trauma-informed care training for providers. ▪ Look at increasing reimbursement rates for psychiatry, mental health services, and health rehabilitation services. Revenue does not cover cost and there have not been increases in many years. Dental [reimbursement] is also very low. This can lead to lower quality services and lower availability. ▪ [Have] navigators (health, basic needs, etc.) for persons living with HIV while using a person-centered approach. This person can address individual needs and connect them to appropriate 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.	▪ [Offer] routine testing for new immigrants/students/visa holders in Minnesota.* ▪ Talk to insurance companies about making HIV testing confidential on Explanation of Benefits (EOB) (i.e., don't explicitly list HIV testing on EOB so parents/policy holders can't identify tests conducted). ▪ Create a regional HIV coordinator [position] and have state link reported cases to regional HIV coordinator. This would be a resource for patients and providers--one HIV contact number for each region.* ▪ Investigate data about characteristics of people who are not linked to care within 30 days.

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.	▪ [Improve] HIV education and awareness in public schools. It has slipped [and needs to] at least get back to where we were 20+ years ago. We could potentially replicate some of the awareness campaigns of the past. ▪ Require specific trainings for health professionals. [Have] an outreach program for students and high-risk populations. [Implement] marketing strategies utilizing media to get the information to all individuals. ▪ [Have] training, education materials, and tools for agencies to help educate employees.
Strategy 1.3: Immediately link newly diagnosed individuals to person-centered HIV care and treatments.	▪ Let clinics know where to refer patients by providing regularly updated information. There are online resources, but at the clinic level, we need easy and immediate access for patients and staff. ▪ Have a task force that has resources available in one spot so any health professional can click on a link, get answers, send referrals, etc. ▪ Connect people living with HIV to a provider that has experience in treating HIV and connect them to Rural AIDS Action Network for additional support.
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.	▪ Engage CentraCare in assisting with this work. Educate providers in evidence-based interventions and prevention strategies. Assist public health agencies in accessing funding for evidence-based programs such as syringe services. Help reduce the stigma in central Minnesota. None of this will happen until people can talk about HIV. ▪ [Provide] low- to no-cost transportation to the client and easy availability.
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.	▪ Do not gut the ACA - address this with lawmakers.
Strategy 2.3: Dedicate adequate resources to populations of color hardest hit by HIV to eliminate health inequities.	▪ Include those that are hardest hit in advisory group capacities.

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 four 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 shared several additional comments throughout the process that are listed below.

- It is important to find the 1,100 people [estimated by the state epidemiology data] who are living with undiagnosed HIV.
- A few things were missing from the Strategy.
  - Strategy 1.3 is missing the notion that newly diagnosed people need to be linked to mental health resources (support groups) and social services. People get a lot of information at once and might not be mentally ready to take everything in.
  - Goal 3 should acknowledge a need for judgement free health care. We need to normalize sexual health, because it is still taboo to talk about sexual health. Open, frank conversations do not happen as much with providers, they are more common to have in college health clinics.
  - Strategy 5.2 should involve the Department of Commerce because they regulate the private health care market.
- We need to normalize HIV testing. There is no need for opt-out testing anymore (except for cost reasons). Everyone should be tested. We should offer STI testing and HIV testing as if it should be something everyone should do.
- Data about income bracket would be useful; it may be higher income individuals that are infected. They may not be as connected to social services and this may explain some of the percentage of individuals who are not connected to care (17%).
- Due to abstinence-only funding for schools, some counties, such as Wright County Public Health, teach sex education because schools cannot.

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.