Ending HIV/AIDS in Northeast Minnesota

SUMMARY OF REGIONAL STAKEHOLDER INPUT

July 2018
Prepared by Wilder Research

MINNESOTA

Ending HIV/AIDS in Northeast Minnesota

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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 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 northeast region. The workshop was conducted on May 7, 2018, in Duluth, Minnesota. This summary also includes findings from the web survey respondents.

Participants

Workshop participants

Twenty-one 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.

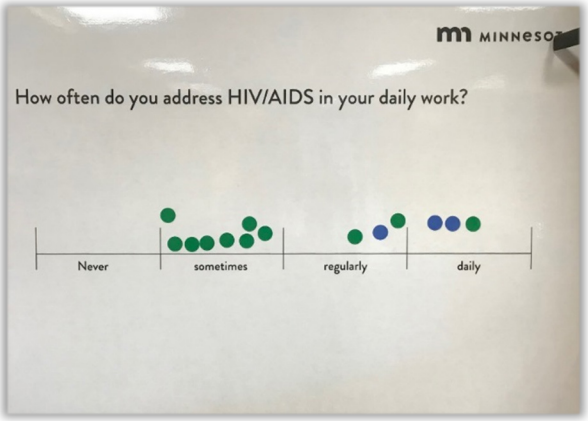
Table 1. Roles of workshop participants

	Workshop participants (N=21)	
Role or area of work	**N**	**%**
Advocate for, or member of, high-risk population[a]	3	14%
Chemical dependency provider	0	0%
City or county public health or human services professional	9	43%
HIV services provider	4	19%
Medical provider	2	10%
Mental health provider	2	10%
Social service provider	4	19%
Youth advocate/youth worker	2	10%
Other	4	19%
Unspecified or not pre-registered	1	5%

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 8 of the 14 responses being sometimes.



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]	1	10%
Chemical dependency provider	0	0%
City or county public health or human services professional	2	20%
Faith leader	1	10%
HIV services provider	0	0%
Housing provider	1	10%
Medical provider	0	0%
Mental health provider	0	0%
Social service provider	2	20%
Youth advocate/youth worker	1	10%
Other	1	10%
Prefer not to answer	0	0%
Missing	5	50%

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 northeast 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 northeast 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, nine 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 from workshop participants

Strategies
Strategy 1.1: Increase HIV education and awareness for all Minnesotans, especially health professionals, students, and high-risk populations.
Strategy 1.4: 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 3.3: Provide culturally and linguistically appropriate services, as well as gender appropriate and sexual orientation appropriate services in clinical and/or community support settings.
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 4.2: Build partnerships that increase the supply of safe, affordable housing units for PLWH and those at high risk of HIV infection.
Strategy 4.4: Secure long-term, sustainable resources to meet the growing need for affordable housing and supportive services.

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 northeast 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.	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.	4	40%
Strategy 3.4: Identify and reduce barriers to accessing mental health and substance use services and care.	4	40%
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.	3	30%
Strategy 2.3: Dedicate adequate resources to populations of color hardest hit by HIV to eliminate health inequities.	3	30%
Strategy 4.4: Secure long-term, sustainable resources to meet the growing need for affordable housing and supportive services.	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 four 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.	▪ Talk about available services at University of Minnesota-Duluth (UMD) Bull Dog welcome week orientations. ▪ Develop statewide school standards for sex education and put into mandate through Board of Education. Health people develop and education people implement. Require at all levels and have specific guidelines for levels.* ▪ Develop a succinct messaging campaign (including ideas on ongoing danger, hope, and treatment) that is in all sorts of materials (social media, print, messages, etc.). Go beyond HIV, include all sexually transmitted diseases (STDs).* ▪ Research and talk with organizations beyond grand rounds. Table out incentives for providers to move time in their day to attend. ▪ Have the Minnesota Department of Health (MDH) be a continuing medication education (CME) provider or coordinate with organizations for CMEs. Make learning about HIV through CMEs a requirement. ▪ Connect with medical residency programs. Re-emphasize training for sexually transmitted infections (STDs) section on boards. Contact curriculum development bodies to see what is being taught. ▪ Educate providers. Essentia should be at the table. Providers are the in-roads for message delivery. Have conversations about messaging and reaching rural populations. Connect/collaborate with Office of Rural Heath, UMN, MN Association for Rural Health, Wilderness Health. Educate and talk with health care organizations serving teens. Use temporary doctors, traveling doctors and nurses, and transportation vans. Possibly begin this tactic with a one-day summit. ▪ Target campaigns at jails, homeless shelters (e.g., Union Gospel Mission, CHUM, Lighthouse), churches, Salvation Army, and food shelves. Include information pamphlets delivered with food or other services. Have community conversations with community leaders. ▪ [Conduct] additional research on Hepatitis C and other comorbidities. These are more prevalent and could be a good place to get more data to identify populations that could be high-risk. ▪ Connect with dental providers, mental health [providers], treatment [providers], etc. ▪ Get walk-in clinics in rural areas.

Table 5. Brainstormed tactics from workshop participants (continued)

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.	▪ Educate providers (including physicians' assistants, medical doctors, registered nurses) on PrEP reporting services. ▪ [Create a] mobile regional HIV coordinator.* ▪ [Provide] mobile units for syringe exchange, PrEP, testing, and beyond.* ▪ Include law enforcement and emergency medical services for buy in. ▪ Incentives for people who test and testing events (could be combined with Hepatitis C events). ▪ Routine testing for medical personnel.
Strategy 3.3: Provide culturally and linguistically appropriate services, as well as gender appropriate and sexual orientation appropriate services in clinical and/or community support settings.	▪ Educate medical professionals on issues [faced by LGBT people and people of color] so people can see a doctor and get tested without having to educate our providers. ▪ Move beyond the 101 and box checking for training. ▪ Do tracking around micro aggressions.
Strategy 4.4: Secure long-term, sustainable resources to meet the growing need for affordable housing and supportive services.	▪ Advocate for changes in policy.* ▪ Obtain long-term funding for established programs and services.* ▪ Turn empty buildings into affordable housing with supportive services in the buildings. ▪ Turn empty houses into affordable housing. ▪ Coordinate among social services to avoid competition for funding. ▪ [Develop] a funding stream that avoids competition between social agencies. ▪ [Provide] services for youth before they get evicted rather than after. Preventive versus triage.

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.	▪ Educate students and high-risk populations about transmission and the importance of being tested and treated if engaged in risky behaviors. ▪ [Provide] strategies for making wise choices like abstinence or one partner. [Do so in] health classes, gym classes, biology classes, homeless shelters, gyms, YMCAs, bars, community events. ▪ Have a messaging campaign that is consistent and applicable across the population.
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.	▪ None provided
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 make this just HIV specific. This should be general public policy to maximize health equity.
Strategy 2.3: Dedicate adequate resources to populations of color hardest hit by HIV to eliminate health inequities.	▪ Connect with organizations that are representative of and responsive to populations of color.
Strategy 3.4: Identify and reduce barriers to accessing mental health and substance use services and care.	▪ None provided
Strategy 4.4: Secure long-term, sustainable resources to meet the growing need for affordable housing and supportive services.	▪ Put public monies into affordable housing and relationship education. ▪ Educate everyone, but particularly policy makers, about the real scope of the challenge. For example, there are 665 households on waiting lists for affordable housing in Duluth, but due to lack of resources, we build about 12 units a year. Enlist the private builders who know about cost control in the construction phase. Use cost control mechanisms in the private market and in the subsidized market (use modularized/panelized systems; build with metal frame instead of wood, etc.). Plan for scale - figure out how to build 10, 50-unit buildings over 5 years and fund that rather than a building every other year.

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

- Participants would love to see continuum of care statistics for Greater Minnesota and/or the northeast region. MDH cannot disaggregate the data this way at this at this point, but they are looking at statistics on the mode of transmission in rural vs. metro areas and for different demographic groups.
- There are limited resources available in greater Minnesota (e.g., social and support services). Providers want to know what is available in their area.
- There is huge stigma around HIV in greater Minnesota. We need to have that person-to-person contact between a patient and a provider. The phone is not as personable; clients have expressed not liking the phone. We need "best practices" for clinicians/providers.
- The point of infection is more important than diagnosis—medical diagnoses seem frivolous because it seems like the last straw.
- There is a problem with the disease focus; basic needs and stability are important. However, even if people have their needs met, people avoid the doctor (e.g., transgender individuals). Transgender people don't want to have to educate their doctors. Doctors don't even know what cis-gender means. We need a billboard campaign to create awareness and start conversations.
- The tactics that are selected for the Strategy need to have multiple bangs for the buck, local government buy-in, consistency and strong messages, and balance a one-size-fits-all approach with specific needs in specific areas.
- This work requires us to broaden stakeholder perspectives (e.g., include education, criminal justice, etc.).
- We need an HIV/AIDS lobbyist. There is low morale, faith, confidence, and knowledge about the system/administration and where funding is coming from. There is low faith that anything that needs to be funded will.

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.