Ending HIV/AIDS in Northwest Minnesota

SUMMARY OF REGIONAL STAKEHOLDER INPUT

July 2018
Prepared by Wilder Research

MINNESOTA

Ending HIV/AIDS in Northwest 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 northwest region. The workshop was conducted on May 23, 2018, in Bemidji, Minnesota. This summary also includes findings from the web survey respondents.

Participants

Workshop participants

Ten 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.

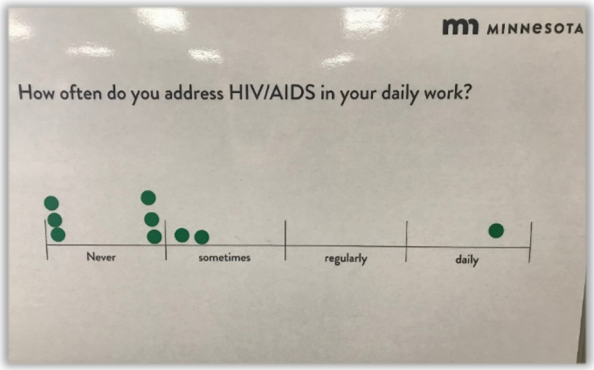
Table 1. Roles of workshop participants

	Workshop participants (N=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	3	30%
HIV services provider	1	10%
Medical provider	0	0%
Mental health provider	0	0%
Social service provider	2	20%
Youth advocate/youth worker	0	0%
Other	2	20%
Unspecified or not pre-registered	4	40%

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?" Responses ranged from never to daily, with 6 of the 9 responses being never.



Survey participants

Fifteen 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=15)	
Role or area of work	**N**	**%**
Advocate for, or member of, high-risk population[a]	1	7%
Chemical dependency provider	1	7%
City or county public health or human services professional	4	27%
Faith leader	0	0%
HIV services provider	1	7%
Housing provider	0	0%
Medical provider	0	0%
Mental health provider	2	13%
Social service provider	2	13%
Youth advocate/youth worker	0	0%
Other	0	0%
Prefer not to answer	0	0%
Missing	7	47%

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 northwest 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 northwest 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 three small groups working together during this workshop, eight 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 1.4: 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 2.4: Reduce HIV-related stigma, systemic racism, and other forms of structural discrimination that prevent people from accessing HIV care and prevention services.
Strategy 3.4: 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 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 northwest 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 15)	%
Strategy 1.1: Increase HIV education and awareness for all Minnesotans, especially health professionals, students, and high-risk populations.	11	73%
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.	6	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	27%
Strategy 2.2: Engage community leaders, non-profit agencies, PLWH, and other community members to identify and to address barriers that prevent testing and person-centered care.	4	27%

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.

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.	▪ Develop public service announcements (PSAs): provide information, reduce stigma, inform people rates are going down, tell people they can reduce their viral loads, share where to be tested in the region, get celebrities involved, and have MDH take the lead on development of messaging. Present information on TVs in social service waiting rooms. Use social media strategies to reach youth.* ▪ Identify information and referral numbers for people to contact at the regional level.* ▪ [Conduct] information sessions with a medical doctor or people with HIV. This is not going to work for rural areas, but is still a good idea. ▪ Simplify public access to online resources including MDH website. ▪ [Offer] provider education through rural health conferences offering Continuing Education Credits (CEUs) to providers, as well as education for patients about what is included in STD testing. This could be included in provider training to clarify with patients what is included and what is not when they come in for labs.
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 healthcare professionals about PrEP (pre-exposure prophylaxis).* ▪ Normalize point of care HIV testing.* ▪ Provide training for service navigators at point of care. ▪ Educate professionals, especially healthcare, about PrEP and other preventative interventions. ▪ [Provide] funding for point of care testing. ▪ Identify available local resources; get an intern/student to conduct an inventory of services in the area.
Strategy 4.2: Build partnerships that increase the supply of safe, affordable housing units for PLWH and those at high risk of HIV infection.	▪ Create/standardize housing codes across the region (particularly in rural areas) to support safe housing for families/individuals, and support landlords to make changes (partner with Habitat construction companies, work programs, etc.). ▪ Build relationships with/educate landlords and property managers around low-income housing to create flexibility for tenants (e.g., lower requirements for credit if people can show they are working on it).* ▪ Create incentives for landlords to dedicate housing for low-income (e.g., more housing subsidies). ▪ Build/renovate/utilize tax credit housing to increase housing supply through Minnesota Urban and Rural Homesteading Program (MURL) type programs, Habitat or other rehab/building programs. Allow tax credit housing projects in greater Minnesota.* ▪ Educate renters about housing and skills for moving into better housing.

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.	▪ [Host] one-day seminars with continuing education credits. ▪ Hold groups and informational meetings in all communities. Provide county human services, public health, mental health, housing authorities, and church communities or others that will listen with information to give to their clients. ▪ Work with professionals to bring the issue forward. ▪ [Offer] e-learning for all health professionals, including mental health professionals. Highlight easy to understand statistics and education on locations to obtain help. ▪ [Run] ads on local TV regarding HIV. ▪ Make up-to-date education available on YouTube that local public health agencies could use for educating staff and the public as needed.
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.	▪ Encourage and give incentives to clinics to provide services. ▪ [Offer] needle exchange programs and [provide] rural HIV treatment access with insurance coverage. ▪ [Implement an] ad campaign or news reports. [Offer] local education updates related to HIV with no charge to attend. ▪ Educate primary care providers on PrEP -- most don't know about it or use it. ▪ Utilize northwest local public health departments who offer HIV testing to begin offering PrEP. ▪ Offer opportunities for syringes to be turned in (i.e. drop off locations). Needle exchange is not universally supported by policy makers in the northwest region, currently, and this is a beginning tactic they may be amenable to.
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.	▪ Make sure our legislators are aware of health care barriers. ▪ [Use] inclusive language with minimal "red tape" for all sexual health services.
Strategy 2.2: Engage community leaders, non-profit agencies, PLWH, and other community members to identify and to address barriers that prevent testing and person-centered care.	▪ [Host a] one-day seminar with continuing education credits for attending.

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 additional input which is described below.

- There are limited mental health providers and treatment options in the northwest region. This is an important piece of ending HIV.
- Information is very empowering to people. It is cheaper to provide information and prevention than to treat the problem once it occurs.
- There are important barriers to housing in the northwest region.
  - There are rental vouchers, but fair market rate is above the voucher so clients have to come up with the difference.
  - There is limited housing stock. Even though there are vouchers, people can't find housing; people are sometimes on the waitlist for five years.
  - Good safe housing is also needed; landlords can have terrible housing, but they don't feel they have to fix it because if someone doesn't want to rent from them, they'll find someone else.

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.