Partner Engagement Survey

September 2020

Overview

Through the Partner Engagement Survey, staff at community-based organizations who are doing on-the-ground work to end HIV in Minnesota had the opportunity to provide input to the HIV Supports Section at the Minnesota Department of Human Services (DHS), the STD/HIV/TB Section at the Minnesota Department of Health (MDH), and the Hennepin County Public Health Ryan White Program (Hennepin County) on how to more effectively engage them as partners. Because these staff members are experts who work closely, on a daily basis, with people living with HIV, they are in a position to also advise state and local agencies on how to more effectively engage community members in decision-making about funding and programming, as described in END HIV MN Priority Tactic 6.

The input gathered through the Partner Engagement Survey will be used to create a community engagement plan, inform implementation of others parts of END HIV MN, and to inform other strategies to improve partnerships between administrative partners and the organizations they collaborate with and fund.

The survey was open from June 6 through July 31, 2020. A link to the survey was shared through grantee and subrecipient email lists, the END HIV MN Advisory Board email list, other listservs (e.g., Syringe Service Provider, Community Collaborative Campaign), and directly with organizations (e.g., Midwest AIDS Training and Education Center). The survey was also promoted during grantee and subrecipient calls, and through individual outreach.

Respondent demographics

A total of 66 people responded to the survey. Of those, 56 completed all questions and 10 answered at least one question. Twenty-five respondents voluntarily provided the name of their organization. Among respondents who provided the name of their organization, one organization was identified seven times, two organizations were identified four times each, and nine organizations were identified two or fewer times each.

Most respondents represent AIDS service organizations. There were no respondents from state or tribal government agencies, pharmaceutical companies, or faith-based organizations. None of the respondents who

selected “other” further specified their organization type. One respondent who selected “culturally specific organization” described it as an organization that primarily serves people of African descent.

Table 1. Organization type

Organization type	Number of respondents
AIDS service organization	31
Medical clinic, medical provider, or other organization in the health system	8
Other type of nonprofit or social service organization	6
Local government agency	4
Other	4
Advocacy organization	2
Culturally specific organization	2

Additionally, most respondents indicated that they are front-line staff. Those two who indicated “other” reported having roles of a program coordinator and a social worker.

Table 2. Role in organization

Role	Number of respondents
Organization leadership	13
Manager or supervisor	13
Front-line staff	28
Other	2
Volunteer	1

The majority of respondents work primarily with people living with HIV and generally work with those individuals daily. The respondent who selected “other” indicated that their organization primarily works with people who use drugs.

Table 3. Individuals served

Client type	Number of respondents
My organization primarily works with people who are **living with HIV**	31
My organization primarily works with people who are **not living with HIV**	6
My organization works about equally with **both** people who are living with HIV and those who are not	19
Other	1

Client type	Number of respondents
I'm not sure	0

Table 4. Frequency with which respondents work directly with people living with HIV or who are otherwise impacted by HIV

Frequency	Number of respondents
Every day	37
A few times a week	7
A few times a month	5
A few times a year	7
Hardly ever or never	1

Most respondents indicated that their organizations are located in the Twin Cities metropolitan area. Similarly, respondents most commonly reported the Twin Cities metropolitan area as the location where the people they serve live. Six respondents noted that they serve individuals outside of Minnesota and 19 respondents indicated that they serve people in multiple regions.

Table 5. Organization and client locations

Location	Number of respondents who selected as an organization location	Number of respondents who selected as a a client location
The Twin Cities metropolitan area	47	50
Northeast Minnesota	5	18
Central Minnesota	4	18
Southeast Minnesota	4	16
Southwest Minnesota	3	16
Northwest Minnesota	2	14
Outside of Minnesota	0	6

About equal numbers of respondents said their organization currently receives, or has received in the past, funding from DHS, MDH, or Hennepin County.

Table 6. Current and past funders of HIV-related work

Funder	Number of respondents who selected as a current funder	Number of respondents who selected as a past funder
DHS	31	34
MDH	39	37
Hennepin County	32	34
None of the above	2	3
I'm not sure	8	11

Engaging communities most impacted by HIV

The survey included questions about how to better engage communities most impacted by HIV in decision-making about HIV-related programming and funding.

Respondents were asked about how they had engaged communities in the past year on behalf of DHS, MDH, and Hennepin County. Most frequently, respondents said they had shared information with consumers or others about community engagement opportunities hosted by DHS, MDH, or Hennepin County, followed by sharing information with consumers or others about END HIV MN stakeholder events, and encouraging consumers to participate in the needs assessment survey.

Fewer respondents reported encouraging consumers to participate in the dental health assessment. A similar number of respondents said they had not participated in any of the listed engagement efforts. The respondent that indicated "other" engagement efforts noted that they had promoted the Medical Case Management Survey and the COVID-19 Client Survey.

Table 7. Community engagement efforts in the past 12 months[1]

Engagement method used	Number of respondents
Shared information with consumers or others about community engagement opportunities hosted by DHS, MDH, or Hennepin County	34
Shared information with consumers or others about END HIV MN stakeholder events	33
Encouraged consumers to participate in the needs assessment survey	32
Encouraged consumers to participate in the dental health assessment survey	10

[1] Respondents could select more than one answer option.

Engagement method used	Number of respondents
Other	1
None of the above	14

Respondents were also asked about the best ways for DHS, MDH, and Hennepin County to engage with communities regarding HIV-related funding and programming. Most respondents said they prefer in-person meetings, online surveys or "comment box" opportunities, and virtual meetings.

Table 8. Preferred methods of community engagement[2]

Engagement method preferred	Number of respondents
In-person meetings (e.g., town halls, forums, etc.)	50
Online surveys or "comment box" opportunities	42
Virtual meetings	41
Other	8
None of the above	2

Reflected below (in direct quotes) are other suggested methods for DHS, MDH, and Hennepin County to engage with communities regarding HIV-related funding and programming.

One theme that emerged was direct outreach to individuals to engage them one-on-one, especially if they have not previously engaged in other opportunities.

- Incentivized one-on-one outreach.
- Individual phone calls.
- Reach out directly to those who are the least likely to participate in any of these other modes. A majority of those who complete any of the modes of communication above are generally the same HIV-positive persons over and over. So, reaching out directly to others who to not will give you a more true and realistic needs assessment.
- Media is the best way to reach people.
- Better hiring practices that highlight lived experience (both with HIV and of the communities you are trying to reach). Create a paid ongoing think tank of experts from the communities you are trying to reach.
- Support groups.
- Community events.
- Participate in community events that aren't "meetings"—no one likes meetings.

Finally, respondents were asked if there was anything else they would like to share about what DHS, MDH, and Hennepin County could do to engage community members most impacted by HIV. A total of 28 people provided answers to this question.

[2] Respondents could select more than one answer option.

Broad themes were related to communication and awareness, continued learning opportunities, culturally- and community-appropriate approaches, increasing accessibility through incentives, and housing. Direct quotes have been organized into these themes. In some cases, suggestions involve multiple themes but have been organized into the most prevalent theme.

Communication and awareness:

- Reach out directly to those who do not partake in the modes above. Many of the same clients provide feedback year after year, need to reach out to those that are not regular participants of these activities to get a true and more honest assessment of needs.
- Mass mailing to all PLWHA that are in CareWare to inform them of community engagement opportunities.
- There is no media for to link people into care or to stay into care. We need to do better. There are people who lost their jobs and have no clue there is a Ryan White system to help them. Word of mouth is not working or flyers.
- I think all agencies involved should be doing to a lot more as far as public relations so that people are aware that such a plan exists. I can't remember seeing any billboards or signs on buses or in the bus shelters.
- Advertise on gay hookup apps like Grindr and Jack'd. Also, during the application process for Ryan White services, offer clients opportunity to provide input.
- As a grantee, I don't often know when stakeholder events are happening—meaning community members also are likely not well-informed about when they are asked to participate. When I have attended events, it is mostly other grantees/staff from agencies working directly in HIV. Additionally, communicating follow-up and next steps have been poor after stakeholder events—which has led me to rarely attend meetings as they often seem like meeting for the sake of meeting (not doing). I know that is something that government agencies struggle with. Recommendations—hire cultural/community liaisons to advertise to communities, compensate community members when they come to meetings, have a very clear plan regarding how you will communicate follow-up and action plans to community members.
- Advertisement in the community such as buses, billboards, flyers, etc. The HIV community is aware but outside of that needs more community involvement.
- Find a way to ensure they maintain a contact list that they can send info to when needing to engage community.

Continued learning opportunities:

- It would be nice for grantees from across the state to have a summit and meet and learn from one another.
- Include risk reduction/syringe exchange teams as part of the conversation.
- More challenging now with COVID, in-person meetings are often the best approach but challenging with restrictions.
- Create a budget for community engagement events and more programmatic experiences (e.g., art and HIV intersections, learning seminars open to public, HIV public forums, etc.).
- I think in the era of COVID, smaller in-person meetings or virtual meetings with lots of different community groups impacted by HIV would be very beneficial.

Culturally- and community-appropriate approaches:

- Community engagement involves culture, tradition and language, plan to end HIV should focus community awareness. African immigrant agencies are power to engage with community to provide high level of awareness through outreach to the grassroots. It is wise to [include] youth African immigrant HIV grantees for awareness than HIV testing. African communities are eager to receive HIV and related infections education from their own people but not much interested to get tested with them.
- I think you will need to do several different types formats given that we have such a wider variety of patients or clients. This will be difficult with persons from Africa and English as a second language.
- Specifically engage in communities of color, and trans communities. Those most impacted by HIV.
- Infuse everything we do with anti-racism and equity principles.
- Stop being stuffy old white folks.
- Truly offering accessible opportunities for folks to engage with the institutions deciding their fates. The three options I selected are a great start, and I think paying community members an ethical and just wage to investigate the ways their communities want to engage is where you will gather your best data. Hire, train, and employ with benefits people from the community to do the work for the community. If education or experience is a barrier, provide those skills (we know PLWHIV are disproportionally under-educated, under-employed, and under-compensated as a result of systemic and systematic barriers) to liberate the community from the barriers killing them.
- Must prioritize targeting individuals from marginalized communities, specifically BIPOC.
- Most of the discussion opportunities about HIV that were conducted by MDH, DHS, and Hennepin County did provide less chance or less representation to minority communities most impacted by HIV.

Increasing accessibility through incentives:

- Incentivize participation. Many folks are focused on basic survival and need support and encouragement to be able to participate and give feedback.
- Incentivize input and include marginalized community members. Even as someone working at a partner agency, I feel as though I rarely hear about, or even more rarely get invited, to community events by DHS, MDH, and/or Hennepin County; please ensure that all staff (front line or otherwise) are on your mailing list.
- Encourage consumers to participate on the Council and join committees like “community voice”, make gift cards available to compensate consumers for their time.
- The most surefire way to get involvement from community members is to offer some kind of incentive. Really from my experience when we were able to have in-person meetings, if there were something as simple as a Subway sandwich and chips, you could get people who would provide input to come.

Housing:

- I would like to see more of a budget towards outreach to help impact people’s lives that are housing insecure, housing is the first step in HIV prevention. We need more funding for housing, if people have to worry about where they are going to sleep and live all the time, HIV risk is going to happen. It is hard to take care of yourself when you are homeless.
- Offer linkage to housing/employment/benefits opportunities.
- The need for services in the encampments especially in Minneapolis is greater than the current organizations are able to provide. Significantly increasing funding in order to dedicate more staff resources, services and supplies to these populations is necessary. Only when basic needs of shelter,

food/nutrition and safety are met can these individuals seriously focus on the importance of their health with harm reduction methods, HIV testing and linkage to care.

Engaging partner organizations

Respondents were also asked how to best engage organizations like theirs in decision-making about HIV-related funding and programming.

Respondents were asked about activities they had engaged in or attended in the past 12 months. Most commonly, respondents said they engaged in All Provider meetings, grantee or subrecipient partner site visits, and END HIV MN stakeholder events. Those who answered "other" said they participated in AIDS Action Day and Syringe Service Provider Network meetings.

Table 9. Partner organization engagement methods[3]

Engagement method used	Number of respondents
All Provider meetings	35
Grantee or subrecipient partner site visits	27
END HIV MN stakeholder events	26
Grantee or subrecipient check-in meetings (ex. Ryan White COVID-19 subrecipient calls)	23
Minnesota Council on HIV/AIDS Care and Prevention (MCHACP) or subcommittee meetings	18
Hennepin County annual contracted provider meeting	17
Early Identification of Individuals Living with HIV/AIDS (EIIHA) meeting	11
Fetal and Infant Mortality Review (FIMR) Board meetings	10
Quality improvement committees (QMAC or QMN) meetings	10
Provider meetings for input on Ryan White service standards	9
Community Collaborative Campaign (photo shoot project) meetings	8
Ryan White service standards review meetings	8
Medical case management acuity scale revision workgroup	7
Minnesota HIV Strategy/END HIV MN Advisory Board meetings	7
Grants RFP proposal reviewer	6
Other	3

[3] Respondents could select more than one answer option.

Engagement method used	Number of respondents
None of the above	7

Among respondents who said they had not attended or engaged in any of the above listed activities, the most common reason for not participating was not knowing about the opportunity.

None of the respondents cited physical or technological barriers, lack of interest, or not feeling welcome as reasons for not participating. The respondent who selected "other" noted that they had been recently redeployed.

Table 10. Reasons respondents did not participate in any of the above engagement opportunities

Reason for not participating	Number of respondents
I didn't know about them	3
I was not invited	1
I did not have time to attend	1
They weren't held at times that are convenient for me	1
Other	1

Respondents were also asked about the best ways for DHS, MDH, and Hennepin County to engage with partner organizations regarding HIV-related funding and programming. Methods favored most often included virtual meetings, in-person meetings, and attending community or collaborative group meetings.

The respondent who selected "other" noted that "in-person meetings would work post COVID-19." None of the respondents felt that the options for engagement listed were not suitable for engaging partner organizations.

Table 11. Preferred methods of partner organization engagement[4]

Engagement method preferred	Number of respondents
Virtual meetings	49
In-person meetings (e.g., town halls, forums, etc.)	44
Attending community or collaborative group meetings	42
Online surveys or "comment box" opportunities	34
Other	1

When asked if there was anything else they would like to share about what DHS, MDH, and Hennepin County could do to engage partner organizations, 11 respondents provided input.

[4] Respondents could select more than one answer option.

Respondents touched on the potential success of surveys (or lack thereof), interest in in-person meetings, equity and inclusion, communication, and incentives.

Success of surveys:

- Surveys don't always capture the needs due to response options are not the best selection. Surveys are predetermined set of questions seeking a certain outcome; therefore, they are not as helpful for partnering organizations that are working with PLWHA.
- My hunch is that things being as they are now, an online survey that seems tailored in some way to the organization would get the most successful engagement.

In-person meetings:

- In person meetings would be great, but we are living in a COVID world.
- Would be very interested in participating in collaborative group meetings that include consumers and those who serve/provide care for PLWH.

Equity and inclusion:

- Be more transparent and equitable about opportunities and acknowledge the expertise and ability of cultural providers.
- MDH and Hennepin County have more contact with African Communities on HIV than DHS. I suggest DHS should have more representation with African Communities during decision making or discussion about HIV.

Communication:

- I think all the above options are important as long as there is clear communication about what the events achieved/next steps after the meetings.
- Reach out directly to front-line workers who have their finger on the beat of the city vs. program directors, ED's etc.

Incentives:

- Incentives for hitting goals.
- I'm [redacted] BUSY. I need an incentive to take the time out of my busy schedule to attend these things.

Partnership feedback

Respondents were offered the opportunity to provide feedback on their partnership(s) with DHS (n = 30), MDH (n = 31), and Hennepin County (n = 24).

The same questions were asked about each organization, including levels of agreement on engagement opportunities, areas of progress, satisfaction with the partnership, and how the partnership could be improved.

DHS HIV Supports Section

Engagement

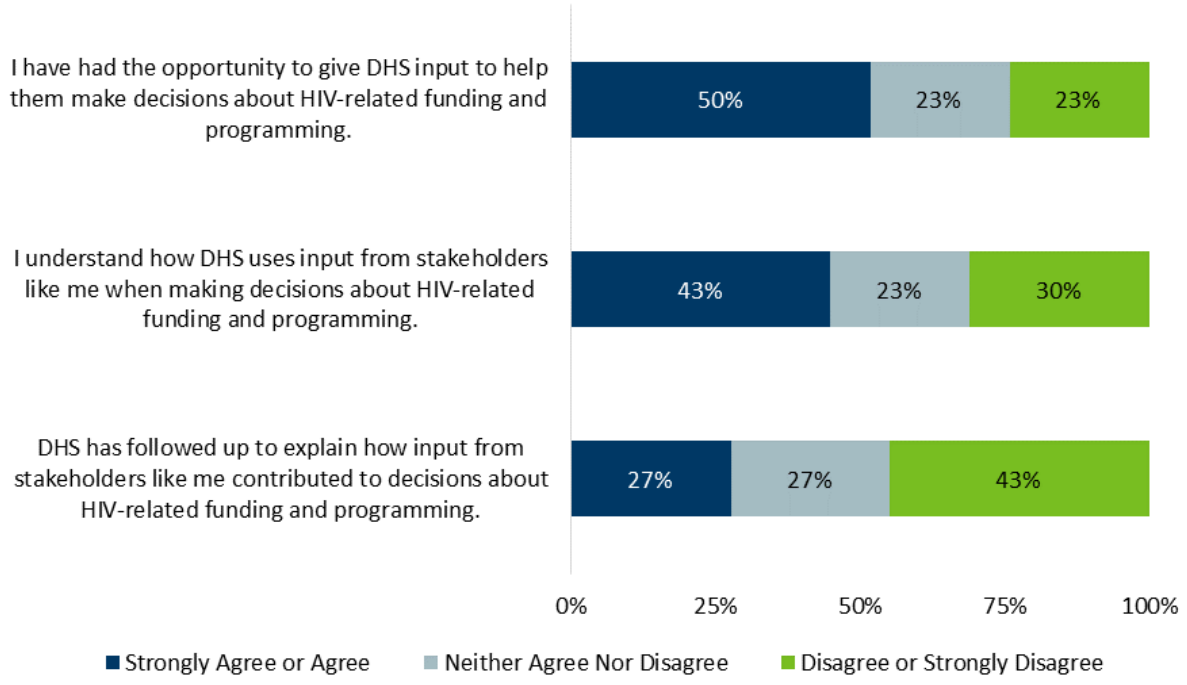
Figure 1 illustrates levels of agreement regarding different types of engagement. Data tables with numbers (rather than charts with percentages) are available in the Appendix: Data Tables Represented as Charts in Narrative (page 23).

Half of the respondents who provided feedback about DHS felt they had the opportunity to provide input that would help DHS make decisions about HIV-related funding and programming. Nearly one-quarter were neutral about this statement, with the same proportion disagreeing.

Less than half of the respondents agreed that they understand how DHS uses input from stakeholders such as themselves when making decisions about HIV-related funding and programming. Nearly one-quarter were neutral about this statement and nearly one-third disagreed.

Just over one-quarter of respondents agreed that DHS follows up to explain how input from stakeholders contributes to decisions about HIV-related funding and programming. A similar number of respondents were neutral about this statement, with nearly half disagreeing.

Figure 1. Levels of agreement regarding engagement with DHS[5]



[5] One respondent who indicated they would like to provide feedback on the partnership between DHS and their organization did not answer these questions.

Progress

According to respondents, the top areas of progress that DHS has helped contribute to in recent years included: funding agencies or organizations that provide HIV services, increasing access to HIV medical care, and increasing access to other core medical and support services.

The areas least selected by respondents as areas of progress by DHS included community-based organization capacity building, training, and technical assistance. Respondents could select all choices that they felt applied.

Table 12. Areas where DHS has helped make the most progress in recent years to end HIV in Minnesota

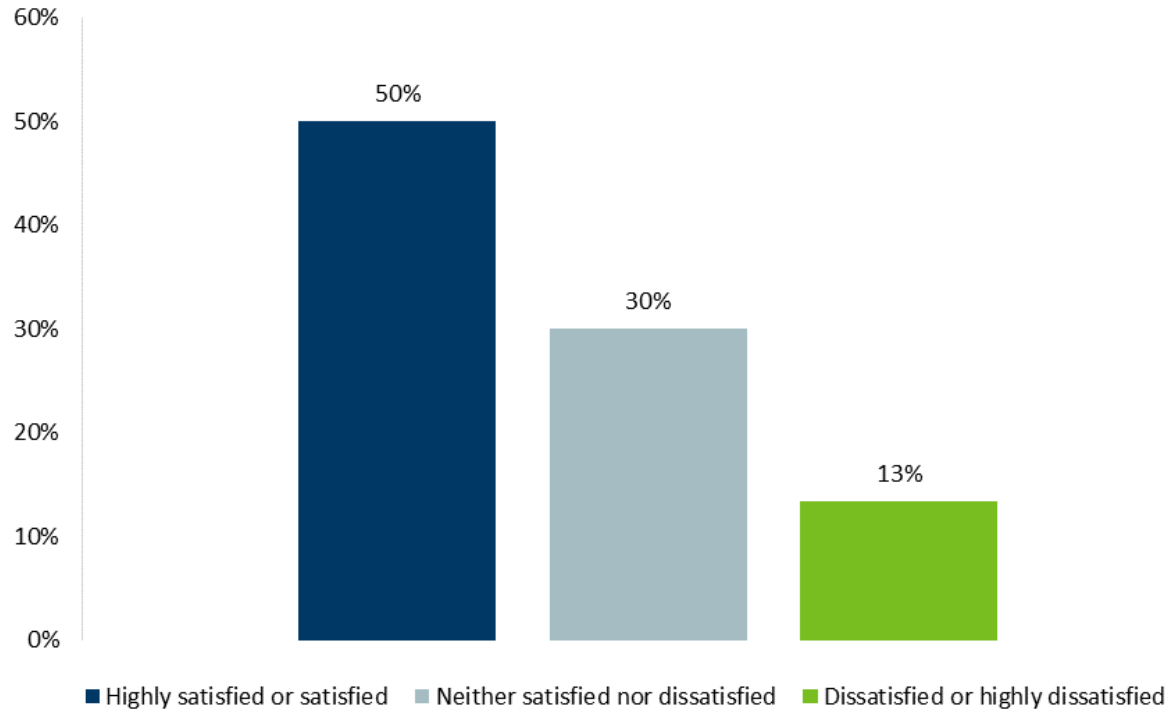
Area of progress	Number of respondents
Funding agencies or organizations that provide HIV service	17
Access to HIV medical care	15
Access to other core medical and support services	15
Data collection and sharing	10
Stable housing	9
Eliminating HIV-related health disparities	7
Harm reduction	7
Testing	6
Prevention education	6
I don't know	6
Community-based organization capacity building	5
Training	4
Technical assistance	2

Satisfaction

Figure 2 illustrates respondent satisfaction with the partnership they have with DHS. Data tables with numbers (rather than charts with percentages) are available in the Appendix: Data Tables Represented as Charts in Narrative (page 23).

Half of the respondents said they are satisfied with their partnership between their organization and DHS. Nearly one-third are neutral about their partnership, and a few respondents are dissatisfied.

Figure 2. Satisfaction with partnership with DHS[6]



Opportunity for improvement

Respondents were also asked what DHS could do to improve their partnership with the respondent's organization. A total of 13 people answered this question, and themes emerged around additional support and engagement, funding, and data.

Additional support and engagement:

- It seems like one of the only people I hear from regularly are Mariah Wilberg and Darin Rowles.
- Improved communication about how people's input is being used, targeted outreach to BIPOC communities. More technical support and training. Tech support around QI is needed. The relationship is concerning and feel it is not conducive to success of smaller organizations. Very little information or support given.
- I don't have a formal contract with DHS to do business related to HIV. Even though I run a program funded by a rebate money, I am contracted with Hennepin County. Probably if I have a contract directly with DHS, that working environment will improve my partnership and increase my involvement in decision making.
- More in person communication.

[6] One respondent who indicated they would like to provide feedback on the partnership between DHS and their organization did not answer this question. Another respondent selected the following, which is not reflected in this chart: My organization does not have a relationship with DHS, or I do not know enough about it to say.

- It could work much more diligently to engage the people who are the boots on the ground, including doctors, medical personnel, and, especially, outreach workers. Those are the people who have the knowledge and experience of what is happening in the communities as far as MSM, sex workers and drug users. But I don't hold much hope because the absence of the officials devising public health policy in settings at the street level is a massive fail on the part of public health officials at every level, from internationally (WHO and UNAIDS) to locally (syringe exchange programs).

Funding:

- Make sure that funding is appropriately disbursed to culturally specific ASO's. Limit or cap dollars to the larger ASO's and provide technical assistance to smaller ASO's.
- Additional funding.
- We would appreciate a little more time to respond to requests about funding changes, etc. It's challenging when we're strapped for time and have to redirect to fulfill a request. Understandable because of timing challenges but thought it bore mentioning.
- Further funding for harm reduction supplies and grants—again more program and engagement events opportunities to create lasting community engagement. Would also like to see more publicity with U=U.

Data:

- Create a way to do ADAP applications online for clients and case managers. So often I hear stories of case managers having to double and triple check and send applications. Better ongoing engagement and create better policies to adapt to changes that may occur during the grant cycle.
- With regard to the Data to Care program that we have found the fact that each agency seems to be held to different eligibility guidelines (what is expected or permitted of the MDH program vs the program at the Red Door Clinic) causes difficulty when attempting to work with or compare/contrast with our Data to Care colleagues at MDH. It's like two different, not fully related programs in a way. Some uniform clarity would be helpful.
- It would be helpful to get the results from site visit in a timely manner.

Miscellaneous:

- I think some of the difficultly is participation is from my organization and COVID. We are short staffed, COVID, no travel policy at the moment.

MDH STD, HIV, and TB Section

Engagement

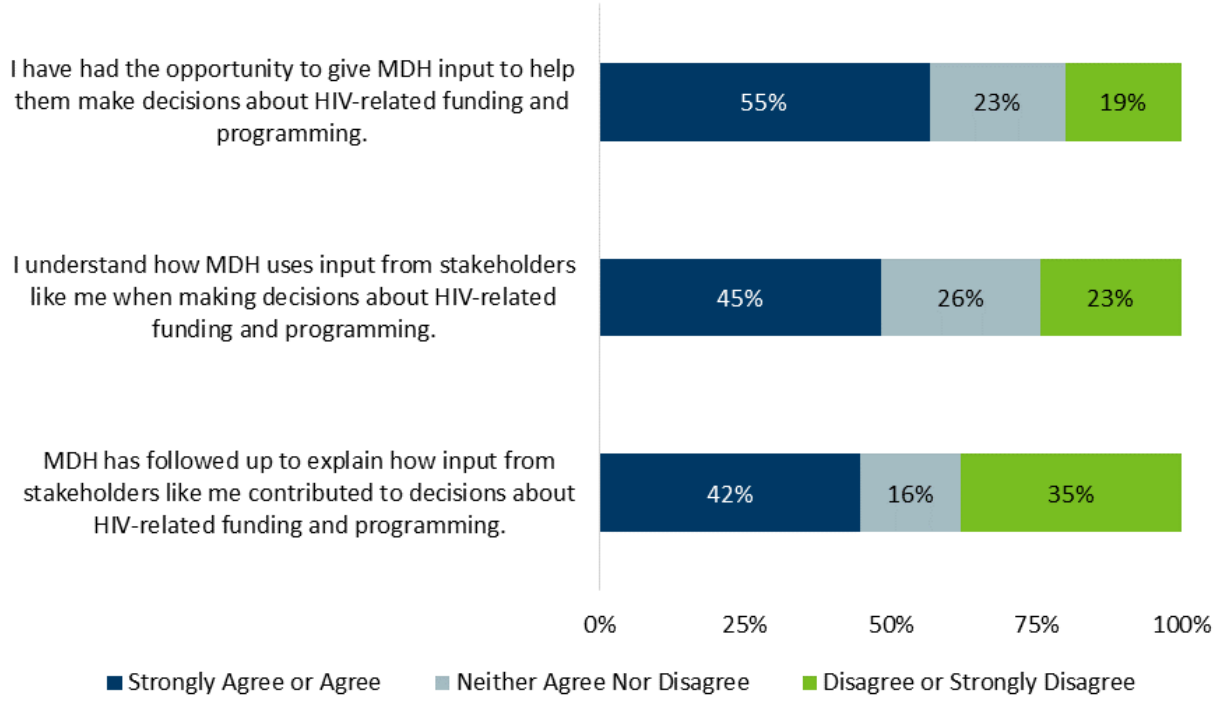
Figure 3 illustrates levels of agreement regarding different types of engagement. Data tables with numbers (rather than charts with percentages) are available in the Appendix: Data Tables Represented as Charts in Narrative (page 23).

Just over half of the respondents who provided feedback about MDH felt they had the opportunity to provide input that would help MDH make decisions about HIV-related funding and programming. Nearly one-quarter were neutral about this statement, with nearly one-fifth disagreeing.

Nearly half of the respondents agreed that they understand how MDH uses input from stakeholders when making decisions about HIV-related funding and programming. Just over one-quarter were neutral about this statement, with a similar proportion disagreeing.

Less than half of the respondents agreed that MDH follows up to explain how input from stakeholders contributes to decisions about HIV-related funding and programming. A few respondents were neutral about this statement, with over one-third disagreeing.

Figure 3. Levels of agreement regarding engagement with MDH[7]



Progress

According to respondents, the top areas of progress MDH has helped contribute to in recent years included funding agencies or organizations that provide HIV services, prevention education, and testing.

The areas least selected by respondents as areas of progress by MDH included increasing access to other core medical and support services, stable housing, and technical assistance. Respondents could select all choices that they felt applied.

[7] One respondent who indicated they would like to provide feedback on the partnership between MDH and their organization did not provide an answer for the first or last statement; two respondents did not provide an answer for the second statement. One respondent selected "Don't know or N/A" for the third statement, which has been excluded from this chart.

Table 13. Areas where MDH has helped make the most progress in recent years to end HIV in Minnesota

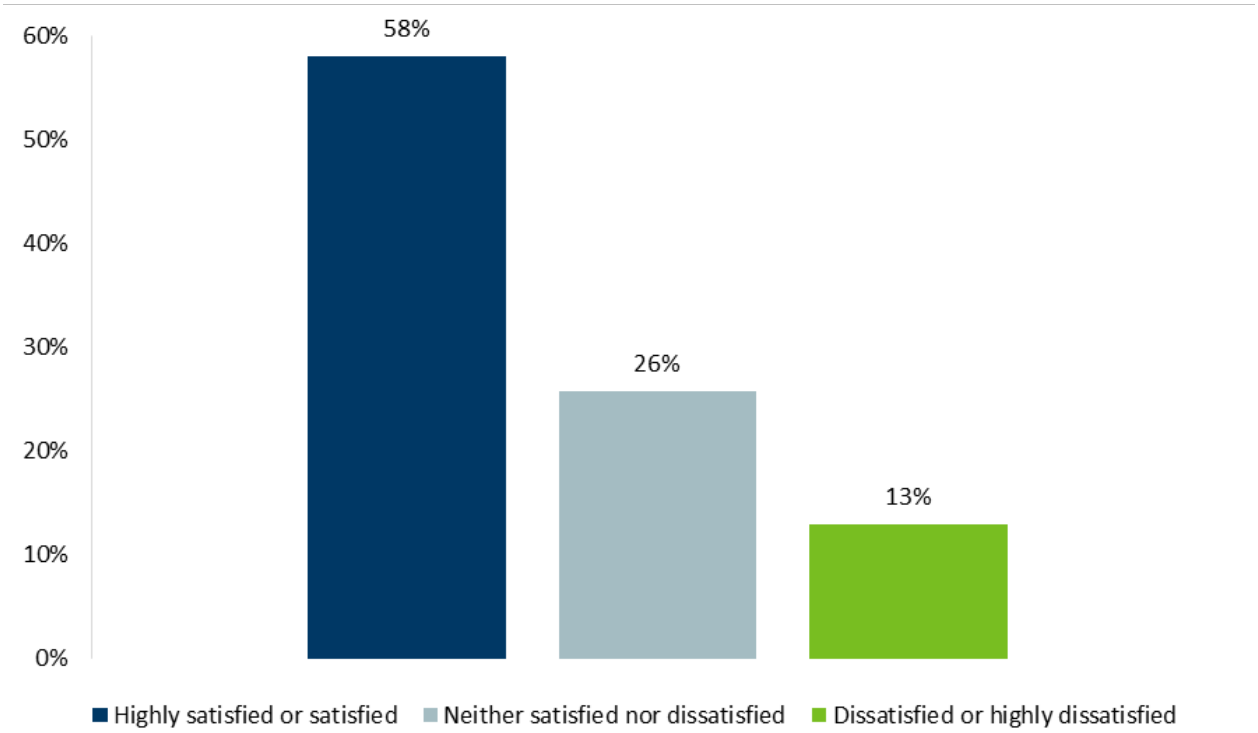
Area of progress	Number of respondents
Funding agencies or organizations that provide HIV service	17
Prevention education	15
Testing	15
Data collection and sharing	12
Harm reduction	12
Training	10
Access to HIV medical care	9
Community-based organization capacity building	6
Eliminating HIV-related health disparities	6
Access to other core medical and support services	4
I don't know	4
Stable housing	1
Technical assistance	1
None of the above	1

Satisfaction

Figure 4 illustrates respondent satisfaction with their partnership with MDH. Data tables with numbers (rather than charts with percentages) are available in the Appendix: Data Tables Represented as Charts in Narrative (page 23).

Over half of the respondents said they are satisfied with their partnership between their organization and MDH. One-quarter are neutral about their partnership, and a few respondents are dissatisfied.

Figure 4. Satisfaction with MDH partnership[8]



Opportunity for improvement

Respondents were also asked what MDH could do to improve their partnership with the respondent's organization. A total of 14 people answered this question, and themes emerged around relationship building and engagement, programming and capacity building, and communication.

Relationship building and engagement:

- Create spaces for us to build relationships with other organizations.
- Help with community engagement.
- They could give me a job and hire me to bring the voices of the streets to the HQ and to the conference tables at the HQ.
- Introduce yourselves! Even when I've worked on MDH grants, the only time I really see the grant managers is for site visits. Also, for site visits PLEASE get the results back to organizations sooner. It is IMPOSSIBLE to take corrective action for the next site visit because the communication comes so late—this practically ensures a negative site visit the next year.
- Decisions seem to be made from a top-down structure. Provider and community input in the decision-making process would more effectively address client needs.

[8] One respondent who indicated they would like to provide feedback on the partnership between MDH and their organization did not answer this question.

- I sometimes feel like MDH could be better at working collaboratively on projects. It seems sometimes like they tend to keep things to themselves, which may be completely unintentional. Maybe more proactive outreach to organizations that are working in conjunction or collaboration with them on a project.

Programming and capacity building:

- This is more of an overall observation (not limited to my organization), but being better at not spreading monies so thin that organizations cannot create meaningful programming. Have grant managers that are not so far removed from the front-line to have a better understanding of struggles on the ground. Often times I feel my grant manager is worried more about numbers than trying to serve the community (which can be difficult when I don't have the funds to create meaningful programming to engage them).
- MDH is trying to do its best. It needs to improve its action towards increasing capacity building for small organizations.
- Would like to see more harm reduction funding in light of the HIV outbreak among IDU folks. Would also like to see more funding around community-based capacity building and funding for outreach events within the community.
- Allow for more autonomy and support to change, improve, participate in, or develop innovative approaches to support the End HIV mission. There seems to be a lot of barriers MDH places that organizations need to be overcome to work towards common interests and goals.

Communication:

- Better communication, we don't hear many updates unless they are program relevant and come from contract managers. COVID has upset everyone's apple cart but this is not really new. As a former member of CCHAAP, I haven't heard a peep about prevention plans or what's going into them as an example. The only updates of that nature that I'm aware of are at planning council meetings and not everyone can attend those.
- Clear, direct communication --> even if they don't know the answer...
- Talking to the front-line workers face to face.

Hennepin County Public Health Ryan White Program

Engagement

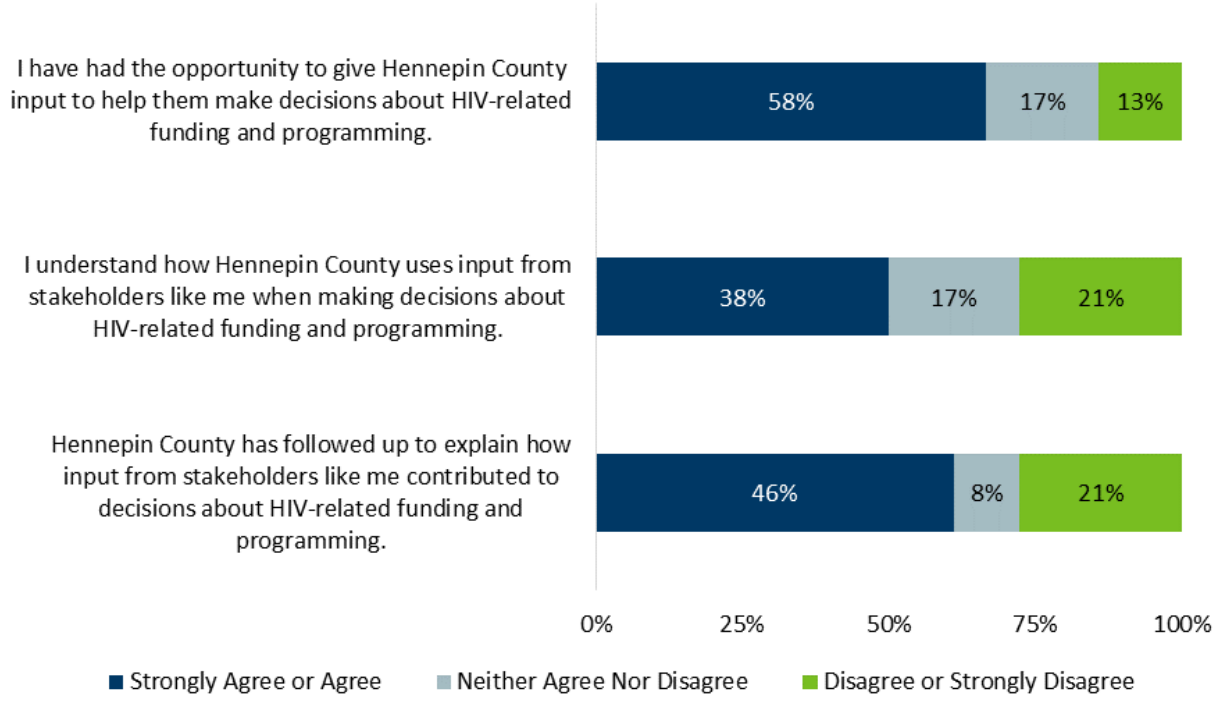
Figure 5 illustrates levels of agreement regarding different types of engagement. Data tables with numbers (rather than charts with percentages) are available in the Appendix: Data Tables Represented as Charts in Narrative (page 23).

Over half of the respondents who provided feedback about Hennepin County felt they had the opportunity to provide input that would help Hennepin County make decisions about HIV-related funding and programming. A few were neutral about this statement, with a similar number disagreeing.

Over one-third of respondents agreed that they understand how Hennepin County uses input from stakeholders when making decisions about HIV-related funding and programming. A few were neutral about this statement, with one-fifth disagreeing.

Nearly half of the respondents agreed that Hennepin County follows up to explain how input from stakeholders contributes to decisions about HIV-related funding and programming. A few respondents were neutral about this statement, with one-fifth disagreeing.

Figure 5. Levels of agreement regarding engagement with Hennepin County[9]



Progress

According to respondents, the top areas of progress Hennepin County has helped contribute to in recent years included data collection, funding agencies or organizations that provide HIV services, increasing access to HIV medical care, and access to other core medical and support services.

The areas least selected by respondents as areas of progress by Hennepin County included harm reduction, technical assistance, and eliminating HIV-related disparities. Respondents could select all choices that they felt applied.

[9] Three respondents who indicated they would like to provide feedback on the partnership between Hennepin County and their organization did not provide an answer for the first statement; six respondents did not provide an answer for the second and third statements.

Table 14. Areas where Hennepin County has helped make the most progress in recent years to end HIV in Minnesota

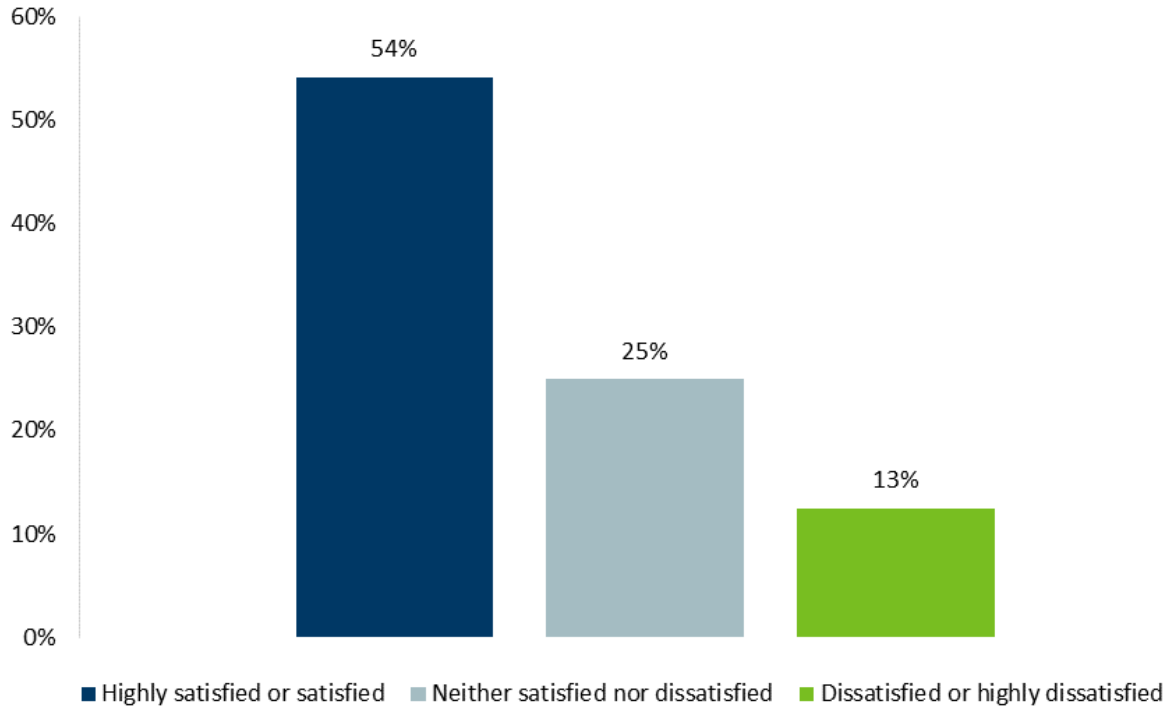
Area of progress	Number of respondents
Data collection and sharing	15
Funding agencies or organizations that provide HIV services	14
Access to HIV medical care	12
Access to other core medical and support services	12
Community-based organization capacity building	7
Stable housing	6
Testing	6
Training	6
Prevention education	5
Harm reduction	3
Technical assistance	3
Eliminating HIV-related health disparities	3
I don't know	3

Satisfaction

Figure 6 illustrates respondent satisfaction with their partnership with Hennepin County. Data tables with numbers (rather than charts with percentages) are available in the Appendix: Data Tables Represented as Charts in Narrative (page 23).

Over half of the respondents said they are satisfied with their partnership between their organization and Hennepin County. One-quarter are neutral about their partnership, and a few respondents are dissatisfied.

Figure 6. Satisfaction with partnership with Hennepin County[10]



Opportunity for improvement

Respondents were also asked what Hennepin County could do to improve their partnership with the respondent's organization. A total of eight people answered this question, and themes emerged around relationship building and funding.

Relationship building:

- Be better listeners and not always just go with the agenda they want or think it should be. Let the planning council do their job and stop controlling them.
- Again, talk to the boots on the ground. I find it appalling that the first End HIV MN roll-out didn't even address the role of syringe exchange in the midst of an opioid injecting epidemic. In fact, a quick word search on "syringes" returned 0/0 results. That is reprehensible.
- Talk to and work with the front-line workers.

Funding:

- Be more transparent about funding opportunities when funding is available outside of the competitive grant process. Not expect providers to carry programs when they run out of money before the contract

[10] Two respondents who indicated they would like to provide feedback on the partnership between Hennepin County and their organization did not answer this question.

ends. It would be helpful if unspent dollars from other programs were made available. We know that Hennepin County does this but has not done this for our particular programs.
- Update the RFP process to make sure everything is clear, understandable and accurate.
- Would like to see more funding available for Syringe exchange services as well as community engagement opportunities/funding for outreach and community events.

Miscellaneous:

- Improve communication, support from contract managers. The relationship is concerning and feel it is not conducive to success of smaller organizations. Very little information or support given.
- I think Hennepin County tends to usually be pretty responsive whenever there is a concern and is pretty good at checking in through surveys and the like. With regard to the Data to Care program, we have found the fact that each agency seems to be held to different eligibility guidelines (what is expected or permitted of the MDH program vs the program at the Red Door Clinic) causes difficulty when attempting to work with or compare/contrast with our Data to Care colleagues at MDH. It's like two different, not fully related programs in a way. Some uniform clarity would be helpful.

Additional qualitative data

At the end of the survey, respondents were asked if there was anything else they would like to share. Eight people answered this question. In general, respondents reiterated responses to previously asked open-ended questions.

The most common theme was related to relationship building and support, though respondents also touched on programming and factors outside of DHS, MDH, and Hennepin County's control.

- Better support and outreach to Greater MN needed.
- Strengthen the partnership continue what you are doing.
- I strongly believe in a good working partnership to do effective and efficient work.
- Meeting up with and talking to the front-line workers needs to happen more. I feel like we are not as in the loop as we should be and as a result we are not being as effective as we could be.
- Disparities in access to new sterile syringes are horrible. Syringes need to be available to anyone anywhere any time anyone walks into a pharmacy to purchase syringes. People deserve better than being held hostage to someone's skewed morals.
- Case managers need to be paid better—this job is hard and people burn out fast. A higher salary would be a good way to keep people in the job. Our salaries are ridiculously low and it's time for Minnesota to step up and lead the way to paying people livable wages.

Appendix: Data tables for figures

Table 15. Levels of agreement regarding engagement with DHS[11]

Statement	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Don't Know or N/A
I have had the opportunity to give DHS input to help them make decisions about HIV-related funding and programming.	4	11	7	5	2	0
I understand how DHS uses input from stakeholders like me when making decisions about HIV-related funding and programming.	4	9	7	7	2	0
DHS has followed up to explain how input from stakeholders like me contributed to decisions about HIV-related funding and programming.	2	6	8	11	2	0

Table 16. Satisfaction with partnership with DHS[12]

Level of satisfaction	Number of respondents
Highly satisfied	5
Satisfied	10
Neither satisfied nor dissatisfied	9
Dissatisfied	4
Highly dissatisfied	0
My organization does not have a relationship with DHS, or I do not know enough about it to say	1

[11] One respondent who indicated they would like to provide feedback on the partnership between DHS and their organization did not answer these questions.
[12] One respondent who indicated they would like to provide feedback on the partnership between DHS and their organization did not answer these questions.

Table 17. Levels of agreement regarding engagement with MDH

Statement	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Don't Know or N/A
I have had the opportunity to give MDH input to help them make decisions about HIV-related funding and programming.[13]	2	15	7	4	2	0
I understand how MDH uses input from stakeholders like me when making decisions about HIV-related funding and programming.[14]	1	13	8	6	1	0
MDH has followed up to explain how input from stakeholders like me contributed to decisions about HIV-related funding and programming.[15]	3	10	5	8	3	1

Table 18. Satisfaction with MDH partnership[16]

Level of satisfaction	Number of respondents
Highly satisfied	4
Satisfied	14
Neither satisfied nor dissatisfied	8
Dissatisfied	4
Highly dissatisfied	0
My organization does not have a relationship with MDH, or I do not know enough about it to say	0

[13] One respondent who indicated they would like to provide feedback on the partnership between MDH and their organization did not answer this question.
[14] Two respondents who indicated they would like to provide feedback on the partnership between MDH and their organization did not answer this question.
[15] One respondent who indicated they would like to provide feedback on the partnership between MDH and their organization did not answer this question.
[16] One respondent who indicated they would like to provide feedback on the partnership between MDH and their organization did not answer this question.

Table 19. Levels of agreement regarding engagement with Hennepin County

Statement	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree	Don't Know or N/A
I have had the opportunity to give Hennepin County input to help them make decisions about HIV-related funding and programming.[17]	3	11	4	2	1	0
I understand how Hennepin County uses input from stakeholders like me when making decisions about HIV-related funding and programming.[18]	2	7	4	4	1	0
Hennepin County has followed up to explain how input from stakeholders like me contributed to decisions about HIV-related funding and programming.[19]	2	9	2	3	2	0

Table 20. Satisfaction with partnership with Hennepin County[20]

Level of satisfaction	Number of respondents
Highly satisfied	2
Satisfied	11
Neither satisfied nor dissatisfied	6
Dissatisfied	3
Highly dissatisfied	0
My organization does not have a relationship with Hennepin County, or I do not know enough about it to say	0

[17] Three respondents who indicated they would like to provide feedback on the partnership between Hennepin County and their organization did not answer this question.
[18] Six respondents who indicated they would like to provide feedback on the partnership between Hennepin County and their organization did not answer this question.
[19] Six respondents who indicated they would like to provide feedback on the partnership between Hennepin County and their organization did not answer this question.
[20] Two respondents who indicated they would like to provide feedback on the partnership between MDH and their organization did not answer this question.