Ending HIV/AIDS in Southwest Minnesota

SUMMARY OF REGIONAL STAKEHOLDER INPUT

July 2018
Prepared by Wilder Research

MINNESOTA

Ending HIV/AIDS in Southwest 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 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 southwest region. The workshop was conducted on June 6, 2018, in Worthington, Minnesota. This summary also includes findings from the web survey respondents.

Participants

Workshop participants

Eleven 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=11)	
Role or area of work	**N**	**%**
Advocate for, or member of, high-risk population[a]	2	18%
Chemical dependency provider	0	0%
City or county public health or human services professional	4	36%
HIV services provider	0	0%
Medical provider	3	27%
Mental health provider	0	0%
Social service provider	1	9%
Youth advocate/youth worker	1	9%
Other	3	27%
Unspecified or not pre-registered	1	9%

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 never to daily, with 8 of the 11 responses being sometimes.

Survey participants

Fourteen 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=14)	
Role or area of work	**N**	**%**
Advocate for, or member of, high-risk population[a]	1	7%
Chemical dependency provider	0	0%
City or county public health or human services professional	4	29%
Faith leader	0	0%
HIV services provider	0	0%
Housing provider	0	0%
Medical provider	1	7%
Mental health provider	0	0%
Social service provider	0	0%
Youth advocate/youth worker	0	0%
Other	4	29%
Prefer not to answer	0	0%
Missing	5	36%

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 southwest 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 southwest 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, seven 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 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 2.2: Engage community leaders, non-profit agencies, people living with HIV (PLWH), and other community members to identify and to address barriers that prevent testing and person-centered care.
Strategy 3.2: Ensure person-centered strategies that support long-term retention in care.
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 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.

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 southwest 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 14)	%
Strategy 1.1: Increase HIV education and awareness for all Minnesotans, especially health professionals, students, and high-risk populations.	8	57%
Strategy 3.4: Identify and reduce barriers to accessing mental health and substance use services and care.	6	43%
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.	4	29%

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.	▪ [Provide] formal training for health providers (all fields) and local public health staff. A lot is old. Pre-exposure prophylaxis (PrEP) education. Ob/Gyns are uninformed. Update continuing medical education. ▪ [Inform] community members; more PSAs about good tests [and] good drugs. Do a campaign to educate; dovetail with screening. ▪ [Teach] sexual health in settings including at schools. Education in schools [varies].* ▪ Provide education. Clinics should explain screening criteria: how often, who is tested, age limits. ▪ [Provide] more education to culturally specific communities. Think about cultural needs and consult the community or a community leader when developing educational activities.*
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.	▪ Conduct focus groups or public forums. Identify trusted leaders in the community, churches, and tribes to take the lead. Identify local care providers willing to participate.* ▪ Involve case managers to connect with people living with HIV. Involve key stakeholders. Start with a generalized approach to identify champions. Create safe-places discourse appointments. ▪ Identify trusted leaders as champions for integrated care that minimizes stereotyping. Include youth as leaders.* ▪ [Improve] messaging. Use social media/PSAs. [Ensure] accurate information is disseminated. Share basic HIV-101 education. Use appropriate social media platforms.

Table 5. Brainstormed tactics from workshop participants (continued)

Prioritized strategies	Potential tactics
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.	▪ Ask JBS (a large, local employer) to add screening. ▪ Develop a relationship with schools; find out their sex education curriculum. Start a conversation about how HIV prevention could be implemented in schools. [Offer] basic education about HIV (e.g., transmission, etc.). ▪ [Provide] state support to try to get schools talking about HIV and standardized sex education.* ▪ Develop relationships across sectors and have conversations. Frame it in a way so that it matters to others like JBS.* ▪ Host a meeting with people from different sectors to talk about resource lists and ensuring that people within each organization know how to navigate them. ▪ Get undocumented people connected to telemedicine at Hennepin County Medical Center (HCMC) via the HCMC Positive Care Clinic. ▪ [Conduct an] advertising campaign to increase awareness of HIV/AIDS across all sectors.

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.	▪ [Implement] media campaigns, continuing education for professionals, education by community leaders and trusted messengers so they can get the message out. ▪ Provide regional updates and training to health professionals. ▪ Offer HIV education in public and private schools. Also provide education in community organizations such as the YMCA. ▪ [Confirm that physicians] in greater Minnesota are up to date as far as current HIV care (medications and follow up). [This may] perhaps make doctors think about HIV. [Greater Minnesota HIV] rates are often a lot lower than metro [rates], [it is] hard to sustain programs in these areas. ▪ [Implement] testing for new immigrants coming from other countries [to understand] how many are coming here with the disease. ▪ Use social media to get an updated message out. ▪ Implement local classes or programs that are part of an already existing system or require health professionals and students to attend classes.
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.	▪ [Identify] a community outreach worker who is trained and can bring the message to their own community and be the liaison with the medical community. ▪ [Improve] education, translation, and patient advocacy. [Implement] audio/visual services since many patients cannot read or write in their own language. ▪ [Hire] well-trained staff able to offer empathy and support in a caring non-judgmental way.
Strategy 3.4: Identify and reduce barriers to accessing mental health and substance use services and care.	▪ [Address the] long wait to be seen by a therapist and lack of affordable mental health services. ▪ [Implement] more incentives for mental health providers and substance abuse help. There is often a lack of resources in greater Minnesota--namely the number of providers able to help due to burnout and low numbers of this profession graduating with degrees in this field. ▪ Provide statewide percentage reimbursement of student loans for those who are trained as counselors and will serve within this capacity for a set amount of time. ▪ Develop mental health and substance abuse programs and facilities for southwest Minnesota.

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

Participants shared additional input related to the cultural diversity of residents in the region, the need to involve the private sector in the work to end HIV, geographic challenges in the region, housing, and general concerns about infrastructure.

- Participants discussed how there are many diverse, non-English speakers in the region. Approximately 54 languages or dialects are spoken in the region. There is a need for both on-site and language line services; people like different choices. Additionally, stigma is a major issue in cultural communities that creates a barrier to care. People don't want others in their community to discover they're HIV positive; they worry that if the translator knows their status the rest of the community might find out.
- Participants expressed a need to improve access to basic health care and preventative care among the diverse community members. They acknowledge that the best approach for connecting to these communities and sharing information is through churches/faith based communities.
- Participants stressed that employers and the private sector need to be involved. In Worthington, JBS is a major employer. Some of JBS's policies are not well understood by employees and result in barriers to care. For example, many people believe that JBS will deduct "points" from employees for missing work, even for doctor's appointments. So people don't go to the doctor because if they lose enough points, they will lose their jobs. Additionally, participants recommended reaching out to JBS to help them understand why the issue is important and to request that they help share information about HIV and/or help conduct HIV screenings.
- Participants shared some of the particular challenges related to the geographic location of their counties. Because they are near the state border, HIV-positive individuals frequently move to bordering states, then back. People are lost from the system of care with these moves.
- Participants indicated that there is a big housing problem in area. The new tenants union may help. There is a need for City involvement to enforce laws and rules for landlords.
- Participants had an overall concern about infrastructure in the region and potential implications for the feasibility of their suggested tactics. They noted that there is a higher incidence of HIV than tuberculosis in Nobles County, but there is much more education about tuberculosis.

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.