

Results from a Qualitative Assessment for the Minnesota HIV Strategy

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Introduction

The Minnesota Department of Health (MDH) conducted a series of focus groups and key informant interviews as part of the Minnesota HIV Strategy development process. During the summer and early fall of 2017, focus groups and key informant interviews were conducted in seven of eight regions in Minnesota. The findings from these activities identified important areas of need to help accomplish the goals of the Minnesota HIV Strategy.

Additional stakeholder input during 2018 will help to develop the tactics. Utilization of information from the focus groups and key informant interviews provide the perspective of people living with HIV (PLWH), communities affected by HIV, and providers for the next steps in process. Facilitated meetings in greater Minnesota, with tribal nations, and with populations most impacted by HIV in the metropolitan area will provide an opportunity for participants to discuss and prioritize tactics and to develop action plans for implementation of tactics that are locally-based, as well as maintaining a focus on specific sub-populations identified as most impacted by HIV in Minnesota.

Below is a brief overview of the Minnesota HIV Strategy and information about HIV standards of care and HIV prevention strategies to provide context to the important areas participants reflected on during the focus groups and key informant interviews.

The Minnesota HIV Strategy provides a plan for coordinating efforts and resources to help address HIV and lead towards the ultimate goal of eliminating HIV/AIDS in Minnesota. The ultimate goal of antiretroviral therapy (ART), or the medications used to treat HIV, is viral suppression. Viral suppression means that the amount of HIV in the body is very low or undetectable, allowing PLWH to live long, healthy lives and substantially lower the risk of HIV transmission. Critical steps towards reducing new HIV infections in Minnesota include ensuring that PLWH are aware of their HIV status, are rapidly linked to care and begin HIV treatment, remain in care over time, and achieve viral suppression.

The vision of the Minnesota HIV Strategy is that by 2025, Minnesota will be a state where new HIV diagnoses are rare and all people living with HIV and those at high risk of HIV infection will have access to high quality health care and resources they need to live long healthy lives, free from stigma and discrimination.

To achieve health equity and to end the epidemic, the Minnesota HIV Strategy has five goals:

1. Prevent new HIV infections
2. Reduce HIV-related health disparities and promote health equity
3. Increase retention in care for PLWH
4. Ensure stable housing for PLWH and those at high risk for HIV infection
5. Achieve a more coordinated statewide response to HIV

Each of the goals has several strategies for achieving the goal. Progress toward reaching the goals of the Minnesota HIV Strategy will be measured through four legislatively-mandated outcomes and nine indicators.

Rapid linkage to care includes competent HIV medical care within 30 days of HIV diagnosis and starting ART early, which lowers the possibility of developing AIDS and other illnesses, as well as reducing the risk of transmitting HIV to others. Since HIV has no cure, treatment is a lifelong process that requires PLWH to receive ongoing HIV medical care. It is critical that PLWH stay in care over time (retention in care), which is key to becoming virally suppressed.

Pre-exposure prophylaxis (PrEP) is a highly effectively HIV prevention strategy. PrEP is a daily pill taken by people who do not have HIV in order to prevent HIV infection. Post-exposure prophylaxis (PEP) medication can reduce the risk of infection in a HIV negative person exposed to HIV during sex, sharing injection drug equipment, sexual assault, or through work if taken within 72 hours of a possible exposure to HIV.

Minnesota faces growing health inequities and HIV health disparities in many communities across the state. Data show that HIV disproportionately affects historically marginalized populations. The populations hardest hit by HIV in Minnesota are the following:

- Gay, bisexual and other men who have sex with men (MSM)
- Injection drug users (IDU)
- Populations of color and American Indians
- Transgender people

Social determinants of health play a role in HIV infection and the ability of PLWH to seek treatment, care, and support. Social determinants of health include the following factors: socioeconomic status, education, physical environment, employment, social support networks, and access to health care. PLWH may experience stigma and discrimination related to their HIV status. Stigma from societal attitudes, practices, policies, and services; in addition to HIV-related discrimination from unfair treatment can marginalize PLWH.

Table 1 on the following page outlines four of the goals of the Minnesota HIV Strategy and their accompanying strategies as associated to the major themes identified through the focus groups and key informant interviews.

Please see the [Minnesota HIV Strategy](http://www.health.state.mn.us/divs/idepc/diseases/hiv/strategy/reportfeb2018.pdf) (<http://www.health.state.mn.us/divs/idepc/diseases/hiv/strategy/reportfeb2018.pdf>) for more information.

Table 1. Minnesota HIV Strategy Goals and Strategies by Focus Group Themes*

	Prevention Education	Provider Training	HIV Testing and Counseling	Initial HIV Diagnosis/Linkage to Care	HIV Medication	Case Management	Retention in HIV Care/Re-engagement in HIV Care	Specialized Services	HIV Services	Socio-economic and Environmental Needs	HIV Resources	Media Communications	Team Approach, HIV Health Care
Goal 1: Prevent New HIV Infections													
Strategy 1.1: Increase HIV education and awareness for all Minnesotans, especially health professionals, students, and high risk populations	x	x											x
Strategy 1.2: Increase routine opt-out HIV testing and early intervention services		x	x										
Strategy 1.3: Immediately link newly diagnosed individuals to person-centered HIV care and treatment		x		x		x		x	x				
Strategy 1.4: Increase availability, access and use of evidence-based interventions that prevent HIV infections such as PrEP, PEP, and syringe exchange programs		x							x		x		
Goal 2: Reduce HIV-related Health Disparities and Promote Health Equity													
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, PLWH, and other community members to identify and to address barriers that prevent testing and person-centered care													
Strategy 2.3: Dedicate adequate resources to populations of color hardest hit by HIV to eliminate health inequities									x				
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		x											x
Goal 3: Increase Retention in Care for People Living with HIV													
Strategy 3.1: Employ high-impact public health approaches to identify and re-engage individuals who are out of HIV care and treatment							x						
Strategy 3.2: Ensure person-centered strategies that support long-term retention in care				x	x	x		x					x

	Prevention Education	Provider Training	HIV Testing and Counseling	Initial HIV Diagnosis/Linkage to Care	HIV Medication	Case Management	Retention in HIV Care/Re-engagement in HIV Care	Specialized Services	HIV Services	Socio-economic and Environmental Needs	HIV Resources	Media Communications	Team Approach, HIV Health 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		X							X				
Strategy 3.4: Identify and reduce barriers to accessing mental health and substance use services and care							X			X			
Strategy 3.5: Ensure access to services that meet the basic needs of PLWH		X					X	X		X	X		
Goal 4: Ensure stable housing for PLWH and those at high risk for HIV infection													
Strategy 4.1: Identify gaps in affordable housing statewide													
Strategy 4.2: Build partnerships that increase the supply of safe, affordable housing units for PLWH and those at high risk of HIV infection										X			
Strategy 4.3: Ensure that PLWH and those at high risk of HIV infection have access to necessary supports that maintain their housing stability										X			
Strategy 4.4: Secure long-term, sustainable resources to meet the growing need for affordable housing and supportive service											X		
* Goal 5: 'Achieve a more coordinated statewide response to HIV' of the HIV Strategy was not addressed by the questions in the focus groups and key informant interviews. Additional stakeholder input during 2018 may address and develop tactics toward a coordinated response to HIV.													

Methods

Between June and September 2017, the Minnesota HIV Strategy team conducted 36 focus groups and 15 key informant interviews within seven regions of the state (Northeast (2), Northwest (3), Central (2), Southeast (2), South Central (1), Southwest (1), and Twin Cities Metropolitan (27)). There were no focus groups or key informant interviews conducted in the West Central part of the state even though there was outreach to agencies within the region to recruit participants.

The Minnesota HIV Strategy Coordinator at MDH coordinated with partner agencies that provide HIV/AIDS services for PLWH across the state to recruit HIV clinical and non-clinical providers, PLWH, and community members in populations disproportionately affected by the HIV epidemic to participate in focus groups and key informant interviews.

Minnesota HIV Strategy Advisory Board (Advisory Board) members provided assistance with development of questions for the focus groups, identification and recruitment of key stakeholders for key informant interviews and focus groups, as well as facilitation of focus groups in some locations.

Focus Group/Key Informant Development of Questions

The Minnesota HIV Strategy Coordinator worked with Advisory Board members and other experts to develop questions for the focus groups/key informant interviews. Findings from early focus groups informed the development of additional and revised questions asked in subsequent focus groups. *(Appendix B contains the focus groups questions asked during the focus groups and key informant interviews.)*

The focus group discussion gathered the following information from participants who were PLWH to reflect on their experiences prior to and after their HIV diagnosis:

- To understand their experience with HIV education
- To understand their experience with HIV testing and counseling
- To understand their experience with service providers and clinics
- To understand their experience with mental health and substance abuse services, including syringe exchange
- To understand their experience with sexually transmitted diseases (STDs) and viral hepatitis
- To understand their experience with addressing basic needs (e.g., income/employment, transportation, housing, food, and child care)
- To understand their experience with post-exposure prophylaxis (PEP) and pre-exposure prophylaxis (PrEP)
- To understand what factors impact HIV treatment for PLWH
- To understand what barriers PLWH may have to being retained in care and to being virally suppressed
- To understand experiences of people at high risk when it comes to HIV prevention services and what helps or hinders their success in preventing transmission and staying healthy
- To gather information about how to reduce HIV stigma and discrimination in their community

The focus group discussion gathered the following information from participants who were community members from HIV high-risk populations:

- To understand their experience with HIV education
- To understand their experience with HIV testing and counseling
- To understand their experience with service providers and clinics
- To understand their experience with PEP and PrEP
- To understand experiences of people at high risk when it comes to HIV prevention services and what helps or hinders their success in preventing transmission and staying healthy
- To gather information about how to reduce HIV stigma and discrimination in their community

The focus group discussion and key informant interviews gathered the following information from participants who were HIV clinical and non-clinical providers and local public health staff:

- To understand their challenges as service providers
- To understand their needs for HIV education and training
- To understand their experience/needs related to HIV testing and counseling
- To understand clinical providers' feelings about routine HIV testing and anticipated challenges if routine testing were to be implemented in their clinic
- To understand their experience/needs related to PEP and PrEP
- To understand what impacts HIV treatment for PLWH
- To understand the process they use for newly diagnosed clients/patients
- To understand what motivates health professionals to provide services to PLWH
- To understand how health professionals perceive the needs of PLWH

Focus Group/Key Informant Interview Sessions

Each focus group and key informant interview included a facilitator and note taker. Several focus groups with a larger number of participants included a co-facilitator to help with the process. Participants provided information in two ways, written responses answered individually at the beginning and group discussion of questions presented during the focus group.

The consent to participate information read aloud to participants at the beginning of each group and interview allowed participants to refuse to participate by signifying that they did not want to participate and leaving the session. (*'Consent & Recording Release Form'* for adults or *'Consent to Participate in a Focus Group (Teens)'* for adolescents. One agency required signed parental permission for adolescents to participate in the focus group *'Parent/Guardian Consent for Child to participate in a Focus Group'*). Focus group participants received compensation between \$20 - \$40 (gift cards) along with food and refreshments provided during the meeting. To protect participant confidentiality, staff excluded names of participants', clinics, physicians, and other healthcare personnel mentioned during the sessions from transcripts.

Data Coding Process

Transcribed data from notes and recordings from focus groups and key informant interviews used a thematic analysis process where themes and sub-themes were developed. The process included three analysts reviewing the data to organize and determine topical thematic areas. The group of analysts met at least weekly to compare results. During the meetings, analysts discussed similarities and differences in findings to determine final themes and sub-themes for each focus group/key informant interview. Agreement between themes and sub-themes among different analysts was high. At the end, the team met with a group of content experts to finalize the topical thematic areas.

The major themes include the following areas:

1. Prevention, Education, Training, and Testing
 - a. Education
 - b. Provider Training

- c. Testing and Counseling
2. HIV Care Services
 - a. Initial HIV diagnosis/linkage to care
 - b. HIV medication
 - c. Case management
 - d. Retention in HIV care/Re-engagement in HIV care
 - e. Specialized services
3. Resources and Services
 - a. Services
 - b. Resources
4. Advocacy
 - a. Media communications
 - b. Team approach, HIV health care

Participants

Focus Groups

Table 2 shows that a total of 252 individuals participated in the focus groups across the state, including HIV clinical and non-clinical providers, local public health staff, Minnesota state government staff, PLWH, and community members from populations disproportionately affected by the HIV epidemic. Clinical providers included infectious disease physicians, primary care physicians, academic medical physicians, nurses, nurse practitioners, case managers, HIV counselors, and mental health therapists who worked in a clinic environment. Non-clinical providers included community health workers, case managers, HIV counselors, HIV testers, and syringe exchange workers who worked in a non-clinical environment. The majority of participants were PLWH (n=112, 44 percent). About one-quarter were community members from populations disproportionately affected by the HIV epidemic (n=66, 26 percent). The remainder were HIV clinical (n=18, 7 percent) and non-clinical (n=21, 8 percent) providers, as well as local public health/state government staff (n=35, 14 percent).

There were 16 PLWH focus groups. Most of the focus groups had a mixture of PLWH who did not belong to a specific sub-population (n=9). For the remaining groups (n=7), MDH worked with organizations serving specific communities to schedule focus groups and invite members from their communities that were PLWH. Focus group participants were not asked to provide racial/ethnic or sexual orientation/gender identity information about themselves.

The strategy of participants attending a select focus group for a specific sub-population was useful to help participants feel more comfortable in discussing sensitive topics related to HIV/AIDS and their personal encounters related to HIV treatment and care. Community organizations serving the following populations participated in recruiting PLWH for select focus groups:

- MSM
- Women
- Hispanic/Latino
- American Indian

- Transgender
- Youth

Seven focus groups of community members recruited by agencies that serve populations disproportionately affected by the HIV epidemic included the following communities:

- African-born black
- African-American
- Youth

Please note: There was preliminary engagement and contact with organizations from other communities affected disproportionately by the HIV epidemic. It was determined at the time by the organizations that it would be better for community members to not participate in focus groups due to the lack of trust related to stigma and sensitivity of HIV in the community (i.e. Asian/Asian American, West African).

The remaining focus groups included participants representing clinical providers (n=5), non-clinical providers (n=3), and local and state governmental staff (n=6).

Table 2. Minnesota HIV Strategy Focus Group Participation*

Number of participants	City	Focus groups were scheduled to include persons:		
		Living with HIV/AIDS	Providers/ Government staff	High-risk Community
North East Region				
10	Duluth	U		
3	Duluth		P	
North West Region				
1	Moorhead		P	
10	Moorhead	U		
9	Bemidji	U		
Central Region				
6	St. Cloud	U		
1	St. Cloud		P	
South Central Region				
8	Mankato	U		
South West Region				

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Number of participants	City	Focus groups were scheduled to include persons:		
		Living with HIV/AIDS	Providers/ Government staff	High-risk Community
3	Worthington		G	
South East Region				
15	Rochester		C	
5	Rochester	U		
Metropolitan Region				
2	St. Paul		C	
2	Minneapolis		C	
4	St. Paul, Minneapolis		P	
7	Minneapolis		P	
4	St. Paul		P	
7	Minneapolis			Y
6	Minneapolis			Y
6	Minneapolis			Y
8	Minneapolis	U		
11	Brooklyn Park			AO
2	St. Paul	MSM		
6	Minneapolis			AA
15	Minneapolis	W, U		
10	St. Paul	H		
3	Minneapolis	AI		
14	Minneapolis			AO
7	Minneapolis	U		
16	Minneapolis			AA, AOM
11	Minneapolis	U		

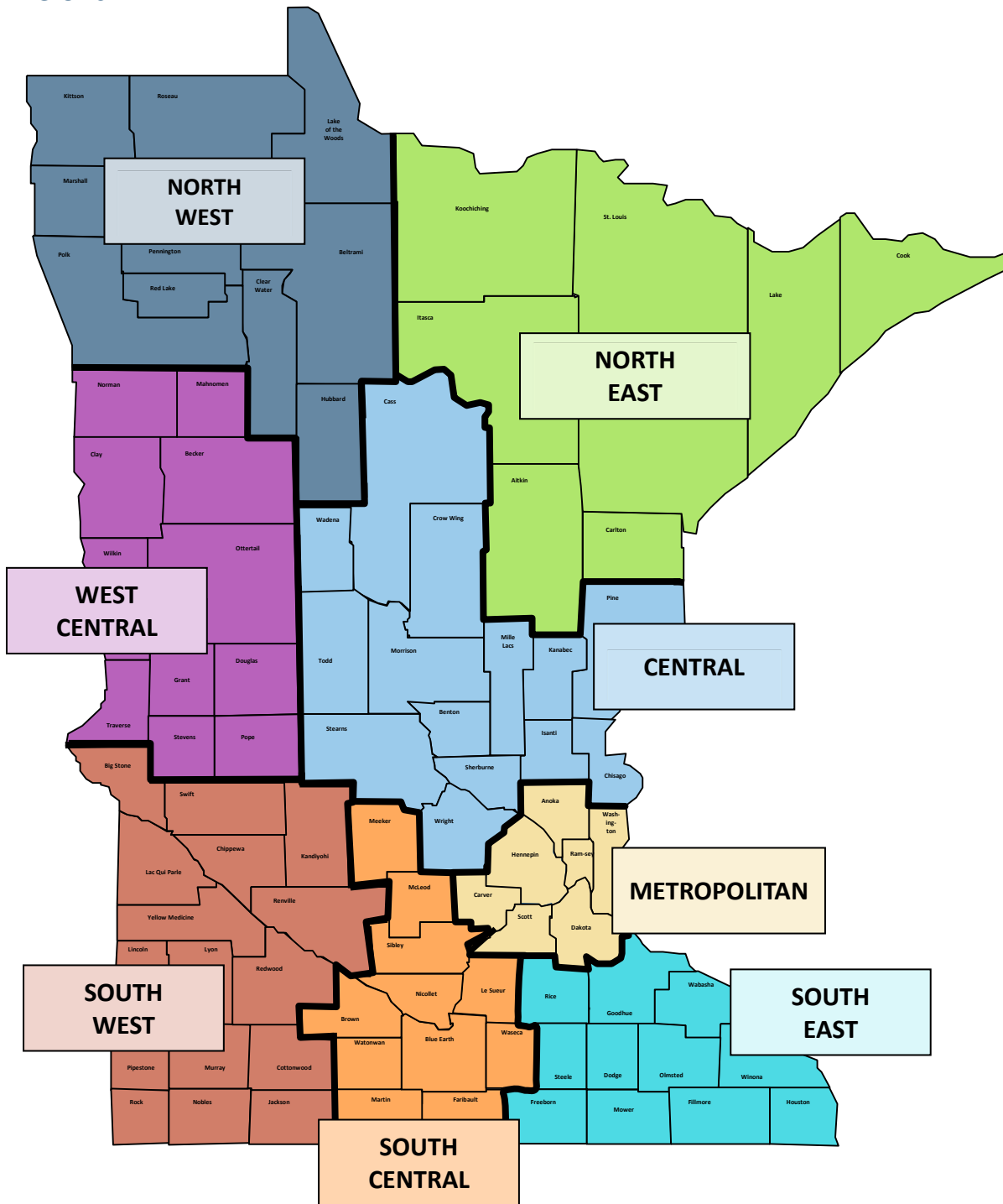
Number of participants	City	Focus groups were scheduled to include persons:		
		Living with HIV/AIDS	Providers/ Government staff	High-risk Community
6	Minneapolis	Y		
1	Minneapolis	T		
1	Minneapolis	T		
6	St. Paul		G	
3	St. Paul		G	
10	St. Paul		G	
9	St. Paul		G	
4	St. Paul		G	
252		112 3 AI 74 U 10 H 15 W 2 T 6 Y 2 MSM	73 18 C 20 P 35 G	66 25 AO 16 AOM 6 AA 19 Y

* MDH worked with organizations serving specific communities to invite members from their communities. Focus group participants were not asked to provide racial/ethnic or sexual orientation/gender identify information about themselves.

DEFINITIONS:

- AA= African American
- AO= African origin (who are black)
- AOM= African origin men (who are black)
- AI= American Indian
- H= Hispanic (of any race)
- W= Women
- T= Transgender
- Y= Youth
- MSM= Men who have sex with men
- U= Persons unidentified based on race and sexuality
- C= Participants who work for providers in a clinical setting
- P= Participants who work for providers in a non-clinical setting
- G= Participants who work for Minnesota State Government, Local Public Health

REGIONS:



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02/20/2018

Key Informant Interviews

There were 15 key informant interviews that included clinical providers (n=5), HIV non-clinical providers (n=2), Tribal Health and Indian Health Services providers (n=3), MDH Center for Health Equity staff (n=3), and community leaders (n=2).

Focus Group/Key Informant Interview Limitations

A limitation of the focus groups/key informant interviews was a reliance on qualitative comments from a select group of participants. Generalizations to all PLWH, community members, and health care providers cannot be made from the results. Revised and additional focus group questions were included based on findings from earlier focus group sessions, which used a constant-comparative qualitative method. There were some differences in staff and Advisory Board members who helped in facilitation of the groups/interview. The initial focus groups/interviews were not recorded. The researchers attempted to be unbiased in the analysis of the results. However, the nature of qualitative research allows for the posing of different questions and differing data collection methodologies.

Results

The following sections summarize the major themes present in each topic area and include quotes from focus group/key informant interviews. The goals and strategies of the Minnesota HIV Strategy to which the themes relate are presented above the themes.

[Appendix A contains a glossary for definition of different terms and abbreviations used in the report.]

Prevention Education, Training, and Testing

Education

Goal 1: Prevent New HIV Infections

Strategy 1.1: Increase HIV education and awareness for all Minnesotans, especially health professionals, students, and high risk populations

HIV Prevention Education

Across all regions, PLWH and community members discussed the need to educate the public about what HIV is, how transmission occurs, and how it is treated. Some focus groups talked about the current lack of HIV awareness as compared to the past. For example, several focus groups mentioned that HIV education has faded from the media. Several PLWH in different groups discussed that a lack of HIV awareness and education cause stigma and fear in the public. Yet several PLWH and providers discussed that past messages of overt fear and stigma about HIV masks safe sex messages. Further elaboration from providers suggests that there needs to be a shifting away from shame and blame to

messages that are more sex-positive. One provider mentioned there are fewer HIV prevention educational opportunities in greater Minnesota as compared those available in the metro region.

*'Education for the general public, because the lack of education is what is creating stigma'
PLWH Southeast MN*

PLWH, providers, and community members across most regions discussed the importance of HIV prevention education to youth in middle school and high school. A youth from the metro region discussed the need for more detailed HIV education, because in school it was very briefly talked about. A provider talked about the importance of attending school board meetings to advocate for comprehensive sex education. A PLWH from southern Minnesota discussed that parents do not want educators talking to their children about HIV; therefore, there is a need to educate parents who live in denial about the reality of HIV. A youth from the metro region talked about the option of sharing sex education curriculum with parents so they are aware of what their children learned. A provider talked about parents needing to opt out (as required in some states) of comprehensive sex education for their children. If Minnesota would adopt the opt-out provision, it would require schools in the state to provide comprehensive sex education to all children, unless a parent provides written permission for a student to opt out of instruction. A youth PLWH group suggested a need for more outreach workers/peer educators to talk about awareness and education. In Northeast Minnesota, a health educator shared sentiments discussed at a youth lesbian, gay, bisexual, transgender, queer (LGBTQ) social support group that provides HIV basic education and testing.

'It's about the parents who live in denial and don't want the educator to talk to their kids about sex' PLWH South Central MN

'We also had a program..., they would come down and get us information about HIV and other STDs and also recruit to help with outreach work as well. This is where I got most of my education and I feel like that we need more outreach workers and more campaigns.' Youth community member

Community members and PLWH from communities of color discussed the need for HIV prevention education tailored to each community. Hispanic/Latino PLWH and African-born community members discussed the stigma and lack of education about HIV in their community. Members of the African-born community stated that parents are afraid to talk to their children and suggested education is needed for parents to help educate their children. Several groups from communities of color discussed the need to find community leaders to provide HIV prevention education to help address the issues from within the community, such as spiritual leaders in the community.

'HIV needs to be taught differently in each community, for the gay community is different from how you would teach it in the Hispanic community. ...Different cultures where HIV exist is different so you cannot take a broad brush to it for everyone.' PLWH, person of color

'We don't have enough education, in East African [community] it's like a taboo, so people are not comfortable talking about that in the East African community.' Community member

Providers and local public health staff in several groups indicated that there is a need for more HIV prevention education for primary care providers, mental health providers, substance abuse counselors, nurses, social workers, local public health, and others who work with high risk populations or PLWH. For example, local public health staff in Southwest Minnesota talked about how information about HIV

has changed so much that they would like a refresher course. Mental health providers mentioned the need for more education and training in HIV prevention for mental health providers and staff.

[See provider training section for more information on HIV prevention education]

Other suggestions from PLWH included addressing HIV prevention education for senior networks and in the workplace for employers and co-workers. Another suggestion included use of creative methods of HIV education, such as games or storytelling. Several PLWH focus groups mentioned opportunities for PLWH to speak and educate youth in schools and the public about HIV and what it is like to live daily with HIV.

PrEP/PEP Education

In several of the focus groups across the state, PLWH and community members were unaware of PrEP/PEP. Therefore the majority of focus groups recommended enhanced community PrEP/PEP awareness and education across the state. Some focus groups discussed the need for culturally appropriate PrEP/PEP awareness and education in communities of color and for women. A HIV provider stated that different targeted PrEP/PEP messages were necessary for subpopulations most at risk. Some PLWH mentioned they were unaware of PrEP/PEP before their diagnosis and found out after it was too late. Several PLWH focus groups mentioned that people are afraid to use PrEP/PEP because of the sense of shame and stigma in taking the medication. A provider suggested an innovative idea of using community health trucks to distribute information and resources about PrEP/PEP.

'It depends on what subpopulation of HIV we are talking about because they all have different needs. For example, the young MSM, I think that safe sex practices and PrEP is really important message to get out there, but I don't think that would be the same message that will work at all for African-American heterosexual women or Latina women which are other populations affected. I don't think it's a one-message-fits-all, it has to be a targeted message.'
HIV provider

Providers talked about the lack of education about PrEP, especially for primary care providers and suggested education for providers in clinics serving high risk populations. A PLWH estimated that only one in three providers know about PrEP and noted it as a problem.

'There is a huge lack of education on [the] provider perspective on PrEP, especially in primary care settings. Many providers do not use PrEP at all or are afraid of it. I think this is a huge need.' HIV provider

[See Provider Training and Services sections for more information on PrEP/PEP]

Undetectable=Untransmittable (U=U), Viral Suppression, CD4 Education

Some PLWH focus groups discussed that education for PLWH needs to be broken down into simple terms. Medical terms, such as viral load and CD4, are complicated to understand. In addition, they talked about the need for more education about undetectable status and its importance to HIV care. A provider mentioned that clinicians do not focus on the concept of U=U. Focus groups that did mention the U=U campaign stated it so new that more awareness across the state is important.

A group of PLWH from a community of color suggested that newly diagnosed people need a class to learn about HIV and the effects of treatment along with a binder of information to take home.

Other Prevention Education

Some of the focus groups with PLWH and community members talked about the need for STD education and awareness in schools and for the public. Part of the education should include information about the long-term effects of syphilis. A couple of PLWH focus groups discussed raising awareness and education about hepatitis and the need for better testing.

Provider Training

HIV Workshop

Goal 1: Prevent new HIV infections

Strategy 1.1: Increase HIV education and awareness for all Minnesotans, especially health professionals, students, and high risk populations

Strategy 1.3: Immediately link newly diagnosed individuals to person-centered HIV care and treatment

Several provider groups and PLWH discussed the importance of HIV workshops for providers and clinics. Providers in greater Minnesota emphasized the need for more trainings for primary care providers to understand HIV transmission, testing and linkage to HIV care and treatment. In Northeast Minnesota, HIV providers suggested returning to more frequent local workshops and update meetings similar to what occurred in the past. Suggestions by providers included training focused on bridging the gap between infectious disease providers and primary care providers, specialists trained to care for PLWH, training more case managers to work with HIV, and offering webinar trainings via local public health.

'It will be good to have Duluth HIV providers meeting again like in the past where people can come and share what they are doing.' HIV provider, Northeast Minnesota

PrEP/PEP Training

Goal 1: Prevent new HIV infections

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 to and use of evidence-based interventions that prevention HIV infections such as PrEP, PEP, and syringe exchange programs

As mentioned in the PrEP/PEP education section, HIV providers and PLWH in several groups were surprised at the lack of awareness, education, and training of providers about PrEP/PEP in Minnesota. A medical school professor emphasized there needs to be curriculum and training about PrEP/PEP for residents, so it becomes part of practice. The professor continued that the PrEP/PEP training would

need to include training on screening patients seeking STD screening and/or upon diagnosis of an STD, which would be a good opportunity to talk about PrEP/PEP and testing for HIV.

'Providing education and decision support tools like questions to ask and the practical components of testing and delivering the medication.' Medical school professor talking about PrEP/PEP

'...we would need to have providers and locations where they can actually go and get PrEP and not all providers are comfortable offering that, especially in greater Minnesota.' Medical school professor talking about PrEP/PEP

'It is very rare that someone will come and say, 'I was exposed yesterday...'. I think the questions are not being asked. For example, in a clinic a common reason for coming in is for sexually transmitted disease screening. This would be a good opportunity to talk about PrEP.' Medical school professor talking about PrEP/PEP

[See Education and Services sections for more information on PrEP/PEP]

HIV Testing/Counseling Training

Goal 1: Prevent new HIV infections

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

In the Northwest region, PLWH emphasized that there was a lack of providers conducting HIV testing and the need for training primary care providers in the area. Community members from populations of color mentioned that community organizations would benefit from additional resources such as testing kits and HIV testing training.

HIV providers elaborated more on the necessary HIV testing and counseling training needs for providers, such as the following:

- Language used when talking to a patient about HIV testing to remove the stigma
- Practical skills on what to do when there is a positive test
- Practical skills on how to report a case
- Practical skills on what to tell a patient who is newly diagnosed
- HIV testing and counseling online learning modules
- Short video on what to do when a patient tests positive
- Provider life line (phone consult/hotline) when they don't know what to do
- Metro providers partner with clinics in greater Minnesota for telemedicine/telehealth

[See telemedicine/telehealth in Specialized Services for more information]

'Practical skills for providers when there is a positive test result; most providers do not know what to do.' HIV medical professor

'It is probably most efficient to have testing affiliated with HIV clinics, but then I also realize that is not going to be always feasible and practical if you want people tested. So having

designated areas where there are people trained to do counseling is going to be very important for the whole program. And, designated parts across the state, unfortunately most of that right now is located in the metro area.’ HIV provider

‘Physicians really respond to, ‘I do not know what to do, give me a life line.’ And, if the life line is a phone number where you can talk to somebody.’ HIV medical professor

[See HIV Testing and Counseling section for more information]

HIV Diagnosis/Encounter with Patient Training

Goal 1: Prevent new HIV infections

Strategy 1.1: Increase HIV education and awareness for all Minnesotans, especially health professionals, students, and high risk populations

Strategy 1.3: Immediately link newly diagnosed individuals to person-centered HIV care and treatment

HIV diagnosis and encounter with patient training is necessary to help the patient at initial HIV diagnosis that includes some HIV counseling training at initial diagnosis encounter. Almost every focus group of PLWH discussed their initial HIV diagnosis encounter with the provider and offered suggestions for improved communication skills needed by providers. Several PLWH had bad experiences when first told they had HIV. There were several comments that providers need to treat patients with respect, caring, and compassion when informing them of their HIV diagnosis. Some mentioned that they felt alone and needed emotional support and someone to stay with them for a while due to the fear and anxiety of the diagnosis. Others talked about the huge stigma they felt from the provider when given their initial diagnosis and suggested more anti-stigma training.

Several PLWH groups discussed needing more information during the initial HIV diagnosis. Yet one PLWH suggested patients need information given little by little, because too much information too quickly scares them so they drop out of care. Several groups suggested that communication of initial information should be in simple words and terms. In addition, another PLWH thought patients should receive the news in writing and orally.

‘If he would have sat with me and talked with me first more, before he started telling me everything.’ PLWH, talking about what could have helped during the initial HIV diagnosis

‘...or they could have just delivered it better, the doctor was just doing rounds for the day and just dropped in on me. Could have asked if I had family or support member or someone I could reach out to help me process the information, then set me up with some counseling.’ PLWH, talking about what could have helped during the initial HIV diagnosis

Cultural and Linguistic Competency Training

Goal 2: Reduce HIV-related health disparities and promote health equity

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

Goal 3: Increase retention in care for PLWH

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

Some PLWH groups discussed the training needs for providers to be comfortable with PLWH. Such training would be based on respecting the whole individual and to avoid being judgmental based on HIV status, along with the interconnected nature of race, class, sexual orientation, and gender identity. One group discussed issues with linguistically appropriate services, especially for Hispanic/Latino PLWH (discussed further in the services section). A few groups mentioned the need for the translation of educational materials for the public and PLWH into languages based on populations disproportionately affected by the HIV epidemic.

Some providers discussed training based on trauma informed care to help providers that work with patients from marginalized communities. Training can help providers to recognize the trauma and provide support and understanding to the patient.

'Implement trauma informed care to recognize, understand, and respond to the experienced effects of trauma when treating and caring for anybody who has a marginalized identity, because most people carry a certain level of trauma. Having an informed practice is necessary, especially for people of color [that are] LGBTQ and the intersection of all marginalized identities. There is serious mistrust and the distrust is real history; for example, Tuskegee syphilis experiment.' Provider

Mental Health Providers Training

Goal 1: Prevent new HIV infections

Strategy 1.1: Increase HIV education and awareness for all Minnesotans, especially health professionals, students, and high risk populations

Goal 3: Increase retention in care for PLWH

Strategy 3.5: Ensure access to services that meet the basic needs of PLWH

As previously mentioned, mental health providers suggested the need for more education and training in HIV prevention. Several focus groups of PLWH emphasized the need for immediate therapy services at HIV diagnosis and mental health providers that have training associated with the interrelationship between HIV and mental health.

'I have a small amount of HIV education, I think as providers in mental health and having the population that we serve, we need more intense training on it and know from the beginning to the end what it entails. ... I have a small amount [of education]...just through pamphlets and

reading.... But, all of our staff will benefit from knowing a little bit more about HIV' Mental health provider

'Therapists who understand people living with HIV and the impact of stigma.' PLWH talking about the need for more mental health therapist

'Stressing the importance of mental health with people of color living with HIV.' PLWH

[See HIV Prevention Education section for more information]

Testing and Counseling

HIV Testing and Counseling

Goal 1: Prevent new HIV infections

Strategy 1.2: Increase routine opt-out HIV testing and early intervention services

In regions of greater Minnesota, several PLWH groups discussed the need for more awareness and accessibility of HIV testing services. Several PLWH groups mentioned that people are unaware of free testing locations and talked about the need for resource guides of HIV testing locations in greater Minnesota. PLWH suggested the need for immediate counseling when testing positive to help them process the news better. Community groups suggested HIV testing at more community events.

The following were more suggestions for increased HIV testing from PLWH groups:

- Incentive testing in communities disproportionately affected by the HIV epidemic
- Awareness campaigns for people at risk who do not know their HIV status
- Mobile clinics with laboratory testing equipment

Several HIV provider groups talked about making HIV testing the norm for all sexually active people. Making HIV testing part of the routine annual visit or during a walk-in visit would help limit the stigma associated with testing. Several HIV provider groups made the suggestion of using an electronic medical record flag system to indicate whether a patient has had an HIV test in the past year. Several HIV provider groups mentioned using the opt-out system for HIV testing, which would require patients to receive an HIV test unless a patient decided to opt out of the test. Other areas mentioned by providers included the use of interpreters for routine HIV testing, recommendation guidelines, and referral networks for HIV positive patients.

Several non-clinical providers discussed that they provide HIV testing without counseling but referred HIV positive clients to specific clinics for follow-up. Some mentioned that they need a better tracking system to follow up with clients to see if they went to the clinic.

The following were other suggestions for increased HIV testing from HIV providers:

- HIV testing at syringe exchange programs
- HIV testing during home visits by medical case managers
- HIV testing in and out of prison
- 24 hour clinic that includes comprehensive HIV testing

'Profiling, I did not look like someone who might have HIV and I was not tested....That was two years of not feeling well and several physician follow-up appointments...' PLWH, talking about when they were first diagnosed with HIV

'Ideally, we should not let a person's behavior tell who should be testing or not.' HIV provider

'Our electronic medical records flags to check if the patient has received testing in the past year. If the patient gets tested, the flag does not ding. But, if the patient says 'no', the flag will ding again after a year to offer the test. Within the first four months of the electronic medical record pilot program, we found two new cases. The electronic medical record increases screening by 30 percent and controls the HIV epidemic and we find new cases.' HIV provider

[See Provider Training section for more information about HIV testing training needs]

STD Testing

Some PLWH groups discussed that the need for better STD testing, information, and awareness, especially in greater Minnesota.

HIV Care Services

Initial HIV Diagnosis/Linkage to Care

Goal 1: Prevent new HIV infections

Strategy 1.3: Immediately link newly diagnosed individuals to person-centered HIV care and treatment

PLWH focus groups reflected on their experiences with their initial HIV diagnosis and what suggestions they would make to improve the process to link newly diagnosed people to HIV care and treatment. Some PLWH mentioned that people diagnosed with HIV are lost and confused in the process for initial treatment. Some groups mentioned a peer educator or support group would help people newly diagnosed to navigate better HIV care and treatment. Several groups suggested a resource packet/notebook of information about HIV care and treatment and local resources. PLWH in greater Minnesota mentioned there are fewer options for HIV providers and stated that the Twin Cities provides the best care.

Several PLWH groups reiterated that if PLWH receive medical care right away, they will remain engaged in their care. In order to reduce time for connection to medical care, some PLWH groups emphasized that providers need to work as a team. Besides HIV medical providers, several PLWH suggested that connecting with a case manager and mental health therapist early are vital for linkage to HIV care. A few PLWH groups mentioned the need to become your own advocate.

'People who are newly diagnosed have no clue of what to do next.' PLWH

'Welcoming class for first diagnosis. This to learn about what you are going through. If you can get a binder. There is so much learning that happens once you are diagnosed.' PLWH

'Faster linkage to case manager after HIV diagnosis.' PLWH

'Team-social worker, doctor, pharmacist, dietitian, mental health counselor all to work as a team.' PLWH

'It took a while for me to get comfortable and get the care I needed in order for me to speak my mind.' PLWH talking about relationship with HIV provider

'Offering the opportunity with others-connectedness. Having to go to all the appointments and having people around me is what keep me alive. Having other people who are going through the same thing. It is important for those people who are newly diagnosed to have a chance to connect and not feel alone.' PLWH

Providers from some networks discussed the importance of a team approach to providing HIV care to patients. As discussed in the HIV testing and counseling training section, when a patient tests positive, HIV providers suggested the use of a life line/hotline (phone consult) and/or telemedicine/telehealth as innovative methods to help connect people newly diagnosed with HIV into care.

'It is a group collaborative practice. Before the patient comes [to the appointment], we sit together as a group and the patient receives a well-rounded multidisciplinary approach.' HIV provider

'To immediately link people into care, you would need to have providers immediately available. Providers available in a more rapid immediate basis but that takes funding to allow providers to do that.' HIV provider

'HIV treatment services, I think are widely available in urban Minnesota, developing telehealth services to offer HIV consultation in rural Minnesota where providers are not well versed in treatment services. As far as I know, I do not know of any providers in Minnesota using telemedicine for HIV services. A question for rural providers would be if they have the support to provide HIV treatment and services and if telemedicine would be a solution.' Provider

[See HIV Diagnosis/Encounter with Patient section for more information]

HIV Medication

Goal 3: Increase retention in care for PLWH

Strategy 3.2: Ensure person-centered strategies that support long-term retention in care

Many PLWH groups discussed wanting to know more information about the medications that they take, such as side effects, importance of medication, what happens when not taken regularly, long-term effects of medication, and medication resistance. A few PLWH revealed that they were unsure why their medication regimen was changed and since they were not involved, lost trust with their HIV provider. Some PLWH groups gave tips on creating a routine for taking medications that included use of different types of pill reminders, and meeting with a pharmacist to personalize care.

'Compliance to medication increased when patients understand why they taking the medications, what it is for, why it is important to take it—providing medication information in detail at the patient's knowledge-base.' HIV Provider

'Meeting with the pharmacist. The pharmacist asks how it is like taking the medication, tried to find what will work and works with you to find an alternative, plus they inform you about the medication.' PLWH

Case Management

Goal 1: Prevent new HIV infections

Strategy 1.3: Immediately link newly diagnosed individuals to person-centered HIV care and treatment

Goal 3: Increase retention in care for PLWH

Strategy 3.2: Ensure person-centered strategies that support long-term retention in care

Most PLWH connected to a case manager felt the relationship with their case manager was excellent. Some PLWH who did not have a case manager mentioned they were unaware of the services and thought that having a case manager would be helpful for them. Several groups discussed that there was a lot of turnover and most case managers had overburdened caseloads and needed assistance. Several groups suggested connecting with a case manager right away after diagnosis as helpful for linkage to HIV care. Some groups talked about the need for non-medical case managers as well.

Some of the provider focus groups had case managers who suggested training on HIV testing and the need for a resource guide of all available services locally and statewide for case managers to use with their clients. Some provider groups recommended regular follow-up with patients, as well as high priority follow-up with patients who miss appointments to help with retention in care.

'Case manager helps me with any possible need.' PLWH

'Love my case manager.' PLWH

'People genuinely out here to help and actually really care and not just doing their job. People who are taking the time with you to check if you are getting the help that you need or that you are taking your medication or whatever.' PLWH talking about their case manager

'There is a lot of times when I am in trouble and I call (case manager) and even if she cannot be with me physically, she tries to help as much as she can. It's good to have a person who is just a phone call away.' PLWH

Retention in HIV Care

Goal 3: Increase retention in care for PLWH

Strategy 3.1: Employ high-impact public health approaches to identify and re-engage individuals who are out of HIV care and treatment

Strategy 3.2: Ensure person-centered strategies that support long-term retention in care

Strategy 3.5: Ensure access to services that meet the basic needs of PLWH

PLWH reflected on their HIV care and treatment over the years; mentioning areas that have been positive in their HIV care, barriers they have encountered during the years, and suggestions on ways to improve HIV care in Minnesota.

Some groups talked about working with HIV providers to personalize care, where the provider works with the patient to find what works and is helpful. Groups noted that providers needed to listen to their needs and address their complaints. The PLWH youth group discussed the importance of information about all services and programs available to them. A group of PLWH of color emphasized that being part of a community helps them to feel that they belong, which gives them motivation to take better care of themselves. Several groups emphasized how crucial getting into HIV care at initial diagnosis is to staying in care over time, as was also noted by many HIV providers. As discussed previously, knowledge and education for PLWH around the significance of taking HIV medication helps keep PLWH in care.

[See *HIV Medication* section for more information.]

The following were suggestions from PLWH to improve long-term retention in HIV care:

- Mobile clinics to provide medication to patients (homeless)
- Home visits
- Mobile app for medication reminder
- System of support from PLWH who are in care for PLWH who are out of care
- Support groups
- Street outreach workers
- Case manager
- Better access to HIV provider
- More time with HIV provider during clinic visit
- Financial incentives for viral suppression

PLWH indicated many reasons why PLWH fall out of care, which included the following:

- Loss of health insurance coverage
- Mental health issues
- Substance abuse issues
- Life-changing events
- Stressors

PLWH discussed in detail the experience of falling through the cracks due to major life-changing events that cause emotional stress. Situations where PLWH switch jobs or lose Medicaid or other health

insurance came up in several groups as reasons PLWH fall out of care. The majority of PLWH groups mentioned the need for mental health services, especially in greater Minnesota. Mentioned in several groups were issues such as homelessness that can cause problems with medication compliance, missing medical appointments, mental health, and substance abuse problems.

'The support group is a great support....The support of people in the group is important.' PLWH talking about what helps them stay in care

'When I first started I had a harder time with compliance – with my school schedule, my work schedule, and my family. It has been hard to find a time that works every day...The pharmacy really worked with me to find alternatives. I now carry my medication everywhere I go.' PLWH

'We waste too much time from when a person is diagnosed to when they are connected with services. After HIV diagnosis, there needs to be faster linkage – medications – linkage in case managers right away, immediately. It creates relationships and retention [and] creates trust right away' PLWH

Some groups recommended that providers need to find out why PLWH drop out of care and suggested that after a couple of missed appointments there needs to be follow-up by the clinic. Another suggestion was to evaluate clinics that have small numbers of PLWH out of care to examine what makes the difference.

'Contact individuals that leave and ask why they left or those who are in care, why they are still in care.' PLWH talking about PLWH that fall out of care

HIV providers in one group talked about the challenges they face with PLWH patients with substance abuse and other issues, where providers need to stay with the patient despite their life challenges. In greater Minnesota, providers and PLWH mentioned traveling long distances for clinic appointments and taking time off from work as barriers.

'The big issue in Minnesota is retention in care, patients show up, they get diagnosed, they go to clinic and they have a bad experience with health care system, with stigma, with insurance and they drop out of care.' HIV provider

'Element of storytelling, folks who were out of care and are now in care – making those folks visible and tell their stories. Normalizing that conversation, you were out of care and we can get you back in care.' HIV Provider

'From my experience, one of the biggest barriers in getting my HIV patients well controlled and well managed is substance abuse – it is a huge issue and challenge.' HIV Provider

Specialized Services

Mental Health Care

Goal 1: Prevent new HIV infections

Strategy 1.3: Immediately link newly diagnosed individuals to person-centered HIV care and treatment

Goal 3: Increase retention in care for PLWH

Strategy 3.4: Identify and reduce barriers to accessing mental health and substance use services and care

The majority of PLWH groups highlighted the importance of mental health services. PLWH discussed the need for early connection to mental health following initial diagnosis of HIV. PLWH from greater Minnesota all agreed that there was an urgent need for more access to mental health services in their region. Some groups also talked about the difficulty accessing mental services, referring to wait periods that are long for referrals, as well as health insurance limitations. As mentioned previously, it was felt that therapists need more education and training to better understand PLWH and the impact of stigma. HIV providers talked about the challenges of dealing with patients' psychosocial issues and the need for more mental health support. Some providers indicated there was a need for a resource guide on making mental health referrals.

'...is very difficult to find a mental health therapist in greater Minnesota to understand someone living with HIV.' PLWH

'Mental health therapist who is focused on the HIV population....A HIV medical case manager to help adjust in the ways HIV impact your mental health and support them and someone who really knows and understands the stigma.' PLWH

'A mental health therapist would help with adherence to medication.' HIV provider
'Routine access to mental health counselors, psychologists, and therapists are important in any setting where people with HIV are getting any medical care. I think that's the responsibility of those settings to implement mental health services into their clinical care....I would go back to the consumer and ask how they would like to see it improved.' HIV provider

'Focus on mental health. More comprehensive care not just physical care should include mental health and these should happen together. It is not just HIV that you are dealing with it is HIV and other problems.' PLWH

[See Education, Provider training and Retention in HIV care sections for more information]

Substance Abuse Care**Goal 3: Increase retention in care for PLWH**

Strategy 3.4: Identify and reduce barriers to accessing mental health and substance use services and care

Several PLWH groups mentioned provider stigma associated with patients using drugs and the need for more provider anti-stigma training. A PLWH group considered the connection between mental health and substance abuse a cycle, where substance abuse can turn into a mental health issue. Several PLWH groups in greater Minnesota mentioned the need for more substance abuse support resources for their region. A HIV provider group brought up the idea of more frequent follow-up to help to decrease substance use problems among users. Several provider groups noted the challenges related to patients

with alcohol or substance use issues, which included mention about the long and complicated process to connect patients with treatment services.

'Your substance abuse can turn into mental health and then the system is not in for you, so then you go to substance abuse or whatever and [you are] stuck with a permanent problem.' PLWH

'...need to understand that many individuals with HIV have issues with mental health and substance use, instead of creating a more stigmatized environment, we need to support these individuals through their usage and allow them to work towards sobriety or managed usage at their own pace.' PLWH

'...have providers contacting HIV patients every two weeks, as it helps patients to decrease the amount of substance used.' HIV Provider

[See Education, Provider training and Retention in HIV care sections for more information]

Telemedicine/Telehealth

Goal 3: Increase retention in care for PLWH

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 PLWH

In several key informant interviews with providers, there were discussions about the possibilities of using telemedicine/telehealth in treating HIV patients as part of the solution for the need for HIV care services in greater Minnesota. In the Northeast region, providers mentioned the use of telemedicine for mental health services for PLWH in their region. One provider suggested that HIV providers carve out or set aside a percentage of their time to dedicate to telemedicine/telehealth. The discussion turned to the management of telemedicine/telehealth in the state since currently there is no infrastructure platform for telemedicine/telehealth in Minnesota.

'I think partnering with specific clinics and I think some part of telehealth programs. I think this is something you can do very well via telehealth; because it is a conversation....I think other states are way ahead of us in terms of telemedicine, I think if HIV paved the way, I think that other areas of health in general would piggy back and get the ball rolling. I think the patients would also appreciate the privacy of it too, go sit in a corner and talk to a physician and not feel the stigma of walking into a particular location where they might be targeted, especially in a small town.' HIV provider

[See Provider Training, HIV Testing, and HIV Care Services sections for more information]

Resources and Services

Services

Interpreters

Goal 2: Reduce HIV-related health disparities and promote health equity

Strategy 2.3: Dedicate adequate resources to populations of color hardest hit by HIV to eliminate health inequities

Goal 3: Increase retention in care for PLWH

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.

Across the state, providers and local public health highlighted the need for interpreters. For example, in Southeast Minnesota there are more than 50 languages spoken in the region. HIV providers from a large clinic in greater Minnesota mentioned the use of laptops and tools to help with translation. Yet most groups stressed that in-person interpreters were most helpful. A group of Hispanic/Latino PLWH felt there was a need for more interpreters that were literate in HIV to help provide information.

In addition, the group of Hispanic/Latino PLWH discussed a need for more bicultural and Spanish-speaking personnel at clinics across greater Minnesota. The same group suggested replicating the model of a Twin Cities clinic that specializes in treating the Hispanic/Latino population in greater Minnesota to help increase access to care for Spanish-speaking people.

'The amount of interpreting needed, we tried to recruit as many interpreters as possible, in-person interpreters are better but [there are] few of them, so we have to use the phone line. We need to find appropriate materials for education, find ways to translate these material and we cannot really know if it is at the right literacy level.' Local Public Health nurse

'For our non-English speakers, we use translators a lot. We have the iPod translator and in-person translators.' HIV Provider

'...lack of interpreters and then even when I had one, a bill came to my house for the cost. I was not told I would have to pay.' PLWH

Support Groups

Goal 2: Reduce HIV-related health disparities and promote health equity

Strategy 2.3: Dedicate adequate resources to populations of color hardest hit by HIV to eliminate health inequities

Goal 3: Increase retention in care for PLWH

Strategy 3.2: Ensure person-centered strategies that support long-term retention in care

Statewide, PLWH groups voiced the importance of support groups for PLWH and the need for more groups in greater Minnesota, such as the Northwest and Southeast regions of the state. PLWH expressed that support groups are critical when first diagnosed, as well as helpful in long-term maintenance of HIV care with continued participation. Several PLWH groups talked about the need for support groups for special populations, such as women, heterosexual men, substance abusers, and Hispanic/Latino PLWH. Participants believed that having some separate support groups based on a specific population of PLWH would help PLWH feel more comfortable in discussing sensitive topics related to their personal encounters with HIV treatment and care in a support group setting. Another suggestion in one group was to have support groups for family members of PLWH.

'A lack of stability in some programs. ...it takes time to get a support group going. Just because the numbers are not there yet, you should not stop the program....You cannot start something and take it away, because you leave people behind, you do not want to leave people behind.'
PLWH Northwest MN, talking about the need for support groups

'Support groups are important especially when you are first diagnosed.' PLWH

'The support group meeting brings a lot of support, knowing that other people are going through the same thing, is good.' PLWH

'With us, if we did not have our support group, we will be lost to navigate the healthcare system.' PLWH

'I started out listening. Some of it was release of fear. There was a new [person] who came in who had the same questions I had and the same outlook I had and to me that is helpful.' PLWH talking about support group experience

'For me it was important to hear about people's experiences at different stages. I do not think there is enough support groups. I was excited to hear about peoples' stories.' PLWH talking about support group experience

Peer Educators/Outreach Workers/Community Health Workers

Goal 1: Prevent new HIV infections

Strategy 1.3: Immediately link newly diagnosed individuals to person-centered HIV care and treatment

Goal 3: Increase retention in care for PLWH

Strategy 3.2: Ensure person-centered strategies that support long-term retention in care

Several groups of PLWH talked about peer educators to help answer questions and share their experiences, which helps to keep PLWH engaged in HIV care. Another suggestion was the use of peer educators to help newly diagnosed PLWH navigate the health care system for HIV care and treatment. A group of PLWH in the metro region mentioned the use of street outreach workers to help reach out of care PLWH who are homeless.

'Peer educator to coach, to help guide individuals in the various programs and to answer questions that one may not want to discuss with an agent of the state.' PLWH

'Peer to peer support...I think when you are HIV positive there are times of crisis when you are not feeling well, I think when you have other people who are positive that relate to you and talk to you and share with you – I think it keeps you involved in care. I think that is essential....'
PLWH

Another area discussed by a group of state government staff focused on community health workers. The group gave the example of a community-based clinic that uses community health workers to reach out to their high risk patients. Re-engagement in HIV care for PLWH was possible using a holistic approach to remove stigma by connecting PLWH with community health workers.

'Community health workers go out and sit down with the patients and ensure information is delivered, because after initial diagnosis, things might have been fuzzy. They are culturally competent and the patient address barriers that they might be facing.' State government worker

HIV Prevention Services

Goal 1: Prevent new HIV infections

Strategy 1.4: Increase availability, access to and use of evidence-based interventions that prevent HIV infections such as PrEP, PEP, and syringe exchange programs

PrEP/PEP

Several provider groups talked about the need for more clinics to provide PrEP/PEP services, especially in greater Minnesota. As mentioned previously in the report, there is a need for more provider training across the state to help increase availability and access to PrEP/PEP services. Non-clinic providers in some groups emphasized support for more agencies to help with PrEP/PEP linkage, which would include training and building partnerships with local clinics to provide the services.

In discussion about PEP services, one provider noted that the process for insurance approval and medication availability is cumbersome. PEP is a time sensitive problem where the earlier there is access to PEP, the less likely the patient will become HIV positive. The provider suggested the need for funding for clinics to stock PEP so it can be readily available.

Due to the stigma around PrEP/PEP, providers in some groups recommended that more information needs to be distributed to people such as where to go to get a prescription, who to talk to about PrEP, and how to pay. A provider in a key informant interview suggested finding champions to help increase availability in regions that are lacking PrEP/PEP services by finding providers who are comfortable prescribing PrEP/PEP.

'[Name of health care system] needs to brush up with what to do. It can take up to four hours to find out what to do in the emergency room for something that can be done in 20 minutes.'
Provider talking about PEP access

'Get people excited about it. If you can find a champion to get people excited on how well it works and how safe it is....So, identifying champions and individual clinics would be effective in getting the word out about PrEP/PEP.' Provider

'It is expensive for a clinic to purchase PEP and leave them on the shelf, in order to be readily available for patients. I would like to see funding for such clinics to stock PEP, so that it can be readily available.' Provider talking about PEP access

Most PLWH groups mentioned the lack of information about PrEP/PEP, especially in some high-risk communities, for example African-American, Hispanic/Latino, and African-born black communities. Most community of color group participants were not aware of PrEP/PEP, which emphasizes the need for more education and awareness. Several PLWH groups suggested that a resource guide of PrEP/PEP providers would be useful to people.

'Our community does not know about this.' Hispanic/Latino PLWH, talking about PrEP/PEP

'I did not know what PrEP was in the beginning, and my care provider right away told me this was something you might look into. She said, look into it, if you want it we can start you on it, if not and you do not want to, it is fine, we can start you on it when you are more sexually active.' Community member

Condom Distribution

Some provider groups mentioned building more partnerships in greater Minnesota for condom distribution locations at bars. A clinic provider talked about a condom box at the clinic, where staff educate patients on how to use condoms.

Syringe Exchange

Several provider groups pointed out the need for more access to syringe exchange services and supplies to meet the need across the state, especially in greater Minnesota. Several providers suggested a reference list on syringe exchange resources, and one provider went even further and recommended that the clinic could provide clean needles. In Northwest Minnesota, a provider that runs a syringe exchange service discussed the option of home delivery. People find out about the syringe exchange services via information cards distributed at gay bars, substance abuse treatment centers, and homeless shelters. The same provider expressed an interest in providing HIV testing.

'In terms of needle exchange, I actually do not know where to access the needle exchange services for my patients' Provider

'Working with pharmacies or community-based organizations to encourage them in some way or another to provider harm reduction services.' HIV Provider

Socio-economic and Environmental Needs

Goal 3: Increase retention in care for PLWH

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 PLWH

Goal 4: Ensure stable housing for PLWH and those at high risk for HIV infection

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 4.3: Ensure that PLWH and those at high risk of HIV infection have access to necessary supports that maintain their housing stability

Housing Affordability

Most PLWH groups commented on the lack of affordable housing in all regions of the state. Discussion focused on more subsidized and permanent housing for PLWH. PLWH homeowners suggested special loans to help with home improvements to help them stay in their homes. Groups mentioned specialized housing such as transgender PLWH housing options, safe shelters for transgender PLWH, daytime shelters, youth PLWH housing, and more HIV-specific housing options. Some groups suggested working together with agencies in different regions to help with finding housing for PLWH. Some groups wanted help in knowing how to access housing resources.

'Dedicated representatives to assist with finding housing in greater Minnesota, case managers do not have time to do this.' PLWH

Food Security

Most PLWH in greater Minnesota favored the elimination of the food voucher 'lottery' program for the Ryan White Part B Supportive Services through which PLWH send in requests for vouchers monthly. If there are more requests than available funding, there is a random selection of recipients until the funding runs out for the month. Several groups spoke about the need for more nutrition awareness education and nutrition counseling.

'Eliminate the lottery, we need stability' PLWH talking about the Ryan White food voucher program

Transportation Access

Several PLWH groups discussed the need for more transportation options. Several groups of PLWH and providers spoke about the long distances traveled by some PLWH in greater Minnesota for medical appointments due to the lack HIV providers in their region. The following were suggestions given for access to transportation for PLWH:

- Improve network for ride share and volunteer drivers
- More public transportation options
- Need for emergency medical appointment transportation
- Financial assistance with car repair/purchase
- Metro mobility eligibility
- Transportation to attend support groups

'Clients need to know that services are available.' PLWH talking about transportation access

Childcare Access

Some PLWH groups talked about the need for childcare when attending medical appointments, support groups, or other appointments related to their HIV care and treatment that lasted more than two hours.

Employment Opportunities

Some PLWH groups discussed the need for better job opportunities, such as job training, part-time jobs, and paths for college degrees. Another suggestion was job fairs for the transgender community to help find employers that are trans-friendly. One area of need related to employment is the lapse of health insurance when switching jobs, causing PLWH to fall out of care waiting for the new health insurance to be effective.

Resources

Goal 1: Prevent new HIV infections

Strategy 1.4: Increase availability, access to and use of evidence-based interventions that prevention HIV infections such as PrEP, PEP, and syringe exchange programs

Goal 3: Increase retention in care for PLWH

Strategy 3.5: Ensure access to services that meet the basic needs of PLWH

Goal 4: Ensure stable housing for PLWH and those at high risk for HIV infection

Strategy 4.4: Secure long-term, sustainable resources to meet the growing need for affordable housing and supportive service

Financial Assistance

Clinical and non-clinical provider groups discussed financial assistance in terms of funding in the following areas:

- If HIV services were to be provided via telecommunications, management of telemedicine/telehealth should include funding to compensate providers for a fixed percentage of provider time;
- Need more funding for harm reduction supplies;
- Increase funding allocation to programs that are already working; and
- Funding to support agencies to do PEP linkage

Clinical and non-clinical providers and PLWH identified insurance as a barrier to HIV care treatment, and preventative services. Among providers, the paperwork involved with insurance companies to cover HIV medications pose challenges to the provider and the patient.

'Insurance is a huge issue. Flat out. There is so much paperwork....the vast majority of people who have HIV are uninsured.' Provider

In addition to the paperwork involved, obtaining insurance to cover PrEP is also a challenge for providers and those at risk for HIV infection.

'Some people come in and they are uninsured and they have three to six months of medication but once those three to six months are up they have to sign up for insurance and that is something we've struggled with...that step to get insurance is hard for some people.' HIV Provider

'Contractual requirements around PrEP are the most difficult. You have to do a lot before you can connect to PrEP. You have them come in, fill out paperwork, get tested...' HIV case manager

'Clients have a lot of anxiety surrounding insurance (always on their minds because it affects their ability to remain undetectable)' HIV case manager

Advocacy

Goal 1: Prevent new HIV infections

Strategy 1.1: Increase HIV education and awareness for all Minnesotans, especially health professionals, students, and high risk populations

Goal 2: Reduce HIV-related health disparities and promote health equity

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

Media/Communications

The majority of the PLWH participants and those from communities of color mentioned the use of public campaigns to raise HIV awareness to the general population and to reduce HIV stigma and discrimination in their community. Public campaigns include advertisements in television, radio, social media platforms, magazines, and billboards to increase awareness of HIV prevention education and U=U (Undetectable=Untransmittable) messaging.

'My family is from Chicago and on the buses, and the billboards there are some awesome campaigns about HIV, knowing your status targeting the whole population. I wish that was something we had here.' Provider

PLWH and some clinical and non-clinical providers mentioned that HIV television advertisements should be positive representations of HIV marketed during popular television programs in local networks.

'We need broad education campaigns...dominate your sex life campaigns. It is all about empowering images and all about encouraging people to get tested.' Provider

Among youth, HIV positive representations supported by celebrity activists.

'The media, finding out who are the celebrity supporting HIV campaigns, like Rihanna, I am obsessed with her. And get the big names speak on it.' PLWH

In addition to increasing public consciousness about HIV, public awareness campaigns will decrease HIV stigma and discrimination according to PLWH, youth, and communities of color.

'We have nothing on billboards about HIV and somehow it is scrubbed out of the country's consciousness, nobody knows what HIV is and that creates stigma and misunderstanding because nobody knows what HIV is. The stigma is unbearable and it is because of things people are not aware of.' PLWH

According to PLWH, HIV advertisements in magazines should not be just in LGBTQ magazines but also in magazines targeting the general public to change the perception that HIV is only in the MSM population. This relates to input from other PLWH who mentioned that HIV awareness should be for everybody who is sexually active. Both PLWH and community members said that HIV needs to resurface in the public's consciousness to portray that HIV exists and is still an issue today.

'I think people are not thinking about HIV specifically and people don't think it is still an issue because things have improved. We need to educate the general public. I am educated and all the consumers are educated about HIV. We need to educate the general public so that they understand it is an issue.' PLWH

HIV-related stigma and discrimination is a barrier to many PLWH.

'I am stable, well managed and have excellent health. My main issue in life is the ever-present stigma. My biggest obstacle in life is the ignorance of the public of what HIV actually is. The stigma that arises from it is almost unbearable.' PLWH

Suggestions from PLWH to decrease stigma and discrimination included changing the public's perception of HIV as a manageable chronic disease, and more public knowledge of HIV facts such as 'what is HIV' and its modes of transmission.

'There need to be more knowledge about the disease, because people are so funny about it. If they find out that you have it, they might think "oh my God, they gonna touch you" people are so funny about it still and they still gonna put you in a category. I am not going in no category.' PLWH

'The media, the propaganda behind having HIV needs to change, the culture around it needs to change. We need to get the word out. What HIV was back then is not what it is today. The culture around it needs to change. If people just see it like any other disease like cancer, and diabetes they will be more open to get tested and not be so afraid to get tested because a lot of people are so afraid to get tested. People can actually survive HIV better than they can survive with cancer.' PLWH

Similar to increasing HIV awareness, the majority of focus group participants discussed increasing awareness about PrEP/PEP through advertisements in television, social media platforms, and light rail and bus stops targeted to populations at risk for HIV infection and in locations with the least amount of resources and information.

'Making sure we are getting the message out to the high risk group. For most of the general population, they are most likely not going to feel that they need it...but for the high risk groups that we know, then targeted messaging for them-magazines, online, social media is going to be really important.' Provider

HIV Care Team Approach

Goal 3: Increase retention in care for PLWH

Strategy 3.2: Ensure person-centered strategies that support long-term retention in care

Almost all PLWH groups prefer personalized care and want to be included in their care early on in treatment. A PLWH group in southern Minnesota added that a team approach is crucial because the care team knows about them and are working collectively to address their needs. The professionals included in a team approach are physicians, mental health therapists, pharmacists, and case managers/case workers. Having a case manager/case worker as part of the team is important because they assist with housing, childcare, transportation, and employment. Some PLWH prefer meeting with all the providers in one room at the same time in contrast to individually meeting with each provider at separate times during the same visit. Regardless of preference for a team approach, most PLWH would like to have an array of services in one location, described as a one-stop shop.

'Team care is what matters. When everybody knows about you and allow you to participate to include us is very important. Working together to include us. PLWH

'They think that they have to sit down with us individually but we all talk about the same things so having team care means that we are not going in and out and repeating it with every provider. The team approach prevents that back and forth.' PLWH

'I understand the timeframe and having everyone at one time but my visit is just a plan of my day, because I do not work. I prefer the individual time with each provider. I see my case manager first, then I see my doctor then I see my pharmacist. I feel like it gives me a little bit more personal attention with each person. It is all preference to me because I appreciate the separate times with each provider' PLWH

Conclusion

In conclusion, the focus groups and key informant interviews sought to understand and identify important areas of need that will be utilized in the development of tactics for accomplishing the Minnesota HIV Strategy.

Focus group participants made the following recommendations to address their identified needs:

- Increase the public's awareness of HIV
- Increase the public's awareness of PrEP/PEP
- Provide more HIV education and training for providers (primary care providers, mental health providers, substance abuse counselors, nurses, social workers, local public health and others that work with high risk populations or PLWH)
- Provide more PrEP/PEP education and training for providers
- Provide more training in HIV diagnosis and patient encounter for primary care providers
- Provide more HIV testing and counseling services in greater Minnesota

- Provide early connection to mental health services at initial HIV diagnosis and throughout HIV care and treatment
- Provide early connection to case managers at initial HIV diagnosis and throughout HIV care and treatment
- Provide patient education about HIV medications
- Explore the possibilities of telemedicine/telehealth in treating HIV patients
- Provide support groups for PLWH
- Provide peer educators to assist newly diagnosed PLWH in navigating health care and social services systems

The next steps will involve use of the findings from the focus group and key informant interviews to help inform the development of tactics for implementing the Minnesota HIV Strategy. Facilitated meetings in various regions of greater Minnesota, with tribal nations, and with populations most impacted by HIV in the metro area will provide an opportunity for participants to review the findings from the focus group and key informant interviews. Stakeholders will discuss and prioritize tactics and will develop action plans for implementation of tactics that are locally-based and focus on specific sub-populations identified as most impacted by HIV in the state.

Appendices

Appendix A: Glossary, Acronyms and References

AIDS or Acquired Immunodeficiency Syndrome, is the most advanced stage of HIV infection. HIV destroys the CD4 T lymphocytes (CD4 cells) of the immune system, leaving the body vulnerable to life-threatening infections and cancers. To be diagnosed with AIDS, a person with HIV must have an AIDS-defining condition or have a CD4 count less than 200 cells/mm³ (regardless of whether the person has an AIDS-defining condition).

CD4 count (or T-cell count) is the measure of white blood cells that play a role in immune system response in HIV-infected persons. Usually CD4 count increases as the HIV virus is controlled with effective HIV treatment. People living with HIV who do not have a CD4 or viral load test conducted during a calendar year are considered out of care.

Cultural competence refers to behaviors, attitudes, and policies that are present in a system, agency, or individual to enable that system, agency, or individual to function effectively in interactions with people from a variety of cultural backgrounds.¹

Culturally and linguistically appropriate services (CLAS) consist of 14 standards organized by the themes of culturally competent care, language access services, and organizational supports for cultural competence. The standards are primarily directed at health care organizations but individual providers are also encouraged to use the standards to make their practices more culturally and linguistically accessible. Some of the standards are requirements for all recipients of federal funds. CLAS is a way to improve the quality of services provided to all individuals, which helps reduce health disparities and achieve health equity. CLAS is about respecting the whole individual and responding to the individual's health needs and preferences.

Clinical providers as defined by participants in the focus groups and key informant interviews included infectious disease physicians, primary care physicians, academic medical physicians, certified nurse practitioners, nurses, mental health therapists, and HIV counselors who worked in a clinical setting.

Disease investigators (DI), also known as Disease Intervention Specialists [DIS], are specially trained to conduct voluntary interviews with patients to obtain the names and contact information of their sexual partner(s) and then use that information to contact a patient's sexual partner(s) and inform them of their potential exposure to HIV or an STD. This work breaks the chain of disease transmission and protects the community's health.

Food security is the condition in which all people, at all times, have physical, social and economic access to sufficient safe and nutritious food that meets their dietary needs and food preferences for an active and healthy life [World Food Summit, 1996].

Goal is the desired result toward which effort is directed.

Housing affordability, also referred to as affordable housing, consists of policies designed to decrease housing cost burden to ensure that households can afford housing below 30 percent of their income.

Harm reduction: a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm reduction refers to policies, programs and practices that aim primarily

to reduce the adverse health, social and economic consequences of the use of legal and illegal psychoactive drugs without necessarily reducing drug consumption.²

Health disparity is a population-based difference in health outcomes.

Health equity is when everybody has the opportunity to realize their health potential—the highest level of health possible for that person—without limits imposed by structural inequities. Health equity means achieving the conditions in which all people have the opportunity to attain their highest possible level of health.

Healthy food includes lower calorie beverages, healthier essentials (e.g., whole wheat bread, canned tuna in water, frozen vegetable) and healthier snacks (e.g., fruits, baked chips) compared to items higher in salt, fat, and sugar.

Health inequity is a health disparity based in inequitable, socially-determined circumstances. Because health inequities are socially-determined, change is possible.

Hepatitis the inflammation of the liver often caused by a virus. The most common types of viral hepatitis are hepatitis A, hepatitis B, and hepatitis C.

HIV awareness campaigns include accurate information about HIV, how the virus is transmitted and the importance of HIV testing to all adults, especially those populations most at risk for HIV infection.

HIV (human immunodeficiency virus) is the virus that can cause AIDS (acquired immunodeficiency syndrome). HIV is most commonly transmitted during anal and vaginal sex, while sharing syringes or equipment to inject drugs or other substances, and less commonly during oral sex, pregnancy, childbirth, or breastfeeding.

HIV counselling is based on client-centered guidelines tailored to the behaviors, circumstances and needs of the person being served for those infected with HIV as recommended by the Centers for Disease Control and Prevention (CDC).

HIV education is the provision of basic information and knowledge about HIV transmission and infection, and prevention strategies to reduce the risk of HIV infection.

HIV medications, also known as antiretroviral therapy, are used to effectively manage HIV infection in order to reduce the risk of HIV transmission and live longer and healthier lives.

HIV prevention involves public health approaches that include practices, strategies, and policies aimed at reducing the spread of HIV/AIDS at an individual and population level.

HIV-related stigma refers to the “negative beliefs, feelings and attitudes towards PLWH, groups associated with PLWH (e.g., the families of people living with HIV) and other key populations at higher risk of HIV infection, such as people who inject drugs, sex workers, men who have sex with men and transgender people.”³

HIV testing is the process of obtain objective evidence of the presence or absence of HIV antigen/antibodies.

HIV workshops are typically 90- to 150-minute programs of collaborative learning and skill building used to enhance response to the HIV epidemic.

Medical case management services are a range of client-centered services that link clients with health care, psychosocial and other services to insure timely, coordinated access to medically appropriate levels of health and support services, continuity of care, ongoing assessment of the client's and other family members' needs and personal support systems, and inpatient case management that prevents unnecessary hospitalization or that expedite discharge, as medically appropriate, from inpatient facilities.

New HIV diagnoses refers to HIV-infected Minnesota residents who were diagnosed in a particular calendar year and reported to MDH. This includes persons whose first diagnosis of HIV infection is AIDS (AIDS at first diagnosis).

Non-clinical providers as defined by participants in the focus groups and key informant interviews included community health workers, medical and non-medical case managers, HIV counselors, HIV testers, syringe exchange providers who work in a non-clinical setting.

Non-medical case management provides assistance to obtain medical, social, community, legal, financial, and other needed services. This includes referral information to Legal Aid, food banks, and Housing Opportunities for Persons with AIDS (HOPWA), and eligibility determination in Ryan White programs and other benefits.

Opt-out testing means telling a person an HIV assay will be performed unless they specifically decline HIV testing.

Outreach worker is a person whose efforts are to engage, educate, and connect specific audiences to resources to improve health status. Most outreach workers are community health workers (CHW), health educators, and/or health promoters.

Partner Services include a variety of related services that are offered to persons with HIV or other sexually transmitted diseases (STDs) and their sexual or needle-sharing partners. By identifying infected persons, confidentially notifying their partners of their possible exposure, and providing infected persons and their partners a range of medical, prevention, and psychosocial services, partner services can improve the health not only of individuals, but of communities as well.

Peer navigators are defined as medication-adherent role models living with HIV who have a shared experience and a shared community membership as the populations with which they work. Peers are trained and are often paid professional staff members rather than volunteers.

Person-centered HIV care involves keeping the person at the center of their HIV care, using individualize intervention and honoring the person's preferences.

Pre-exposure prophylaxis (PrEP) involves taking specific HIV medicines daily to lower a person's risk of getting infected. PrEP can stop HIV from taking hold and spreading throughout the body. It is highly effective if used as prescribed and can reduce someone's risk of infection by up to 92 percent. A person's risk of getting HIV from sex can be even lower if PrEP is combined with condoms and other prevention methods.⁴

Post-exposure prophylaxis (PEP) means taking antiretroviral medicines (ART) after a potential HIV exposure to prevent becoming infected. PEP must be started within 72 hours after a potential exposure to HIV. If a person thinks they have been recently exposed to HIV during sex or through

sharing syringes or works, they should talk with a health care provider or an emergency room doctor about PEP right away.⁵

Retention in care is the ongoing medical care for people living with HIV to maximize positive health outcomes. In Minnesota, this is defined as the receipt of one or more labs indicative of HIV infection within a 12-month period, frequently represented in publications as within a calendar year.

Telemedicine/Telehealth is the use of telecommunications technology to allow health care professionals to evaluate, diagnose and treat patients in remote locations. Telemedicine allows patients in remote locations to access medial expertise quickly, efficiently without travel.

Training is the action of teaching a particular skill or type of behavior.

Trauma informed care is an organizational and treatment framework to understand and respond to the experienced effects of trauma when treating and caring for anybody who has a marginalized identity.

Ryan White HIV/AIDS Program is a federally funded comprehensive system of care that includes primary medical care and essential support services for people living with HIV who are uninsured or underinsured. The program distributes funds to cities, counties, states, and local community-based organizations and clinics to provide HIV care and treatment services to more than half a million people in the United States each year.

Strategy is the approach taken to achieve a goal. Strategies are broadly-stated activities required to achieve the goals.

Structural discrimination (also known as structural inequality or systemic discrimination) is an unintentional form of discrimination resulting from policies that were enacted with the intent to be neutral with regard to characteristics such as race and gender. Structural discrimination occurs when these policies, despite apparently being neutral, have disproportionately negative effects on certain groups. Some structural discrimination is a result of past policies that continue to impact present-day inequality, while other policies still exist today and with disproportionately negative effects on minority groups.

Structural racism is the normalization of an array of dynamics—historical, cultural, institutional and interpersonal—that routinely advantage the majority population while producing cumulative and chronic adverse outcomes for populations of color and American Indians. Structural racism is deeply embedded in American society and is a potent factor leading to inequities in all major indicators of success and wellness.

Syringe Services Programs are an umbrella term for services to clients who use injection drugs, including hormones. Most syringe services programs offer other prevention materials (e.g., alcohol swabs, vials of sterile water, condoms) and services, such as education, on safer injection practices and wound care; overdose prevention; referral to substance use disorder treatment programs including medication-assisted treatment; and counseling and testing for HIV and hepatitis C.⁶

Undetectable = Untransmittable (U=U) As of October 23, 2017, Minnesota became the third state to endorse the U=U consensus statement and sign on as a community partner. With this endorsement, Minnesota joined more than 400 organizations from 60 countries to endorse the U=U Campaign, which describes the scientific consensus that people living with HIV who take antiretroviral therapy daily and

achieve and maintain an undetectable viral load have effectively no risk of transmitting HIV to their sex partners.²¹ The U=U campaign destigmatizes HIV because it removes fear of PLWH as “risky” and “infectious” to their sexual partners thus dismantling HIV stigma on the community, clinical, and personal level further improving the lives of people living with HIV.

Viral load refers to the number of copies of HIV per mL of blood. In other words, it's the amount of virus in the blood.

Viral suppression is when the level of circulating virus in the blood is reduced to a very low level of ≤ 200 copies/mL.

Acronyms

AIDS: Acquired Immunodeficiency Syndrome

CBO: Community-based organization

HIV: Human Immunodeficiency Virus

LGBTQ: Lesbian, gay, bisexual, transgender, and queer

MSM: Men who have sex with men

PEP: Post-exposure prophylaxis

PrEP: Pre-exposure prophylaxis

PLWH: People living with HIV

STD: Sexually transmitted disease

U=U: Undetectable = Untransmittable

References

¹ Minnesota Department of Health. Moving Along the Cultural Competence Continuum: An Ongoing Journey; 2017. <http://www.health.state.mn.us/communityeng/multicultural/moving.html>

² Harm Reduction International. What is Harm Reduction? <https://www.hri.global/what-is-harm-reduction> . Accessed 10 November 2017.

³ UNAIDS. (2014). Guidance Note. Reduction of HIV-related Stigma and Discrimination. Accessed 10.27.2017 from http://www.unaids.org/sites/default/files/media_asset/2014unaidsguidancenote_stigma_en.pdf

⁴ Minnesota Department of Health. Pre-Exposure Prophylaxis (PrEP); 2017. <http://www.health.state.mn.us/divs/idepc/diseases/hiv/prep.html> . Accessed 18 October 2017

⁵ CDC. PEP; 2017. <https://www.cdc.gov/hiv/basics/pep.html> . Accessed 18, October 2017

⁶ CDC. HIV and Injection Drug Use; 2017. <https://www.cdc.gov/hiv/risk/idu.html> . Accessed 18 October 2017

Appendix B: Focus Group/Key Informant Interview Questions

Focus Group Questions that PLWH Completed Individually in Writing

Your experience with...	Reflection: What needs improvement?	Solutions: Your suggestions to improve it?
HIV prevention education		
HIV testing and counseling		
HIV diagnosis		
First entry into HIV care and treatment		
Relationship with your HIV/AIDS provider		
Taking HIV medication on schedule/time		
Relationship with case manager		
Substance use care		
Mental health care		
Income and/or employment		
Housing		
Food		
Transportation		
Childcare		
Syringe Exchange		

Your experience with...	Reflection: What needs improvement?	Solutions: Your suggestions to improve it?
Sexually Transmitted Diseases (STDs) (Chlamydia, Gonorrhea, Syphilis)		
Co-infection Ex: Hepatitis B Hepatitis C Herpes		
Post-exposure Prophylaxis (PEP) Pre-exposure Prophylaxis (PrEP)		
Other Please state the issue(s)		

1. Please give us some suggestions on how to reduce HIV stigma and discrimination in your community.
2. How can we improve two-way communication between provider and patient?

Focus Group Questions that Community Members Completed Individually in Writing

Your experience with...	Reflection: What needs improvement?	Solutions: Your suggestions to improve it?
HIV prevention education		
HIV testing and counseling		
Relationship with your health care provider		
Relationship with your clinics or hospital		
Mental health care		
Income and/or employment		

Your experience with...	Reflection: What needs improvement?	Solutions: Your suggestions to improve it?
Housing		
Food		
Transportation		
Childcare		
Stigma in your community		
Sexually Transmitted Diseases (STDs) (Chlamydia, Gonorrhea, Syphilis)		
Viral infection Ex: Hepatitis B Hepatitis C Herpes		
Post-exposure Prophylaxis (PEP) Pre-exposure Prophylaxis (PrEP)		
Other Please state the issue(s)		

1. What will make you more comfortable to talk to your doctor about HIV prevention and testing?
2. HIV stigma keeps people from being tested and treated. What should be done to decrease HIV stigma and discrimination in your community?
3. How can we improve the two ways communication between provider and patient?

Focus Group Questions that Providers Completed Individually in Writing

As a provider, please give us your experience with...	Reflection: What needs improvement?	Solutions: Your suggestions to improve it?
HIV prevention education		

As a provider, please give us your experience with...	Reflection: What needs improvement?	Solutions: Your suggestions to improve it?
HIV testing and counseling		
HIV testing treatment services		
Harm reduction services		
Mental health services		
Chemical/substance abuse treatment		
Post-exposure Prophylaxis (PEP) Pre-exposure Prophylaxis (PrEP)		

Questions for Clinicians:

1. Tell us about your role and patient population you serve.
2. As an HIV provider, what is the easy part of your job?
3. What are the parts of your job that challenge you? What things that you are dealing with that you can't really solve?
4. What are your patients'/clients' greatest needs?

The following questions are related to routine HIV testing. (The intent is that routine HIV testing increases the probability to find people who are not aware of their HIV status or to find people who are out of care and who should be link to care)

5. As a clinic, if you were going to do routine HIV testing, how would you feel about that?
6. What challenges would you expect to face with implementation of routine HIV testing at your clinic/organization?
7. What else would you like us to add as we formulate the tactics to implement the Minnesota HIV Strategy?

Questions for Case Managers and HIV Counselors and Testers

1. Tell us about your role and patient population you serve
2. What are the parts of your job that challenge you?
3. What things that you are dealing with that you can't really solve?
4. As a community-based organization, what challenges do you have with targeted HIV testing?
5. When you have a positive what do you do? Where do you try to refer your newly diagnosed client/patient? Are you able to get the patient into care within 30 days?
6. Tell us about the process you use for your newly diagnosed client or patient?
7. Do you refer right away? Why?
8. How do you narrow the time of someone ready to receive PrEP or HIV treatment?
9. What else in HIV prevention or treatment service would you like us to add as we formulate the tactics to implement the Minnesota HIV Strategy? Or in an ideal world, what kind of things would you like to see happen?

Questions for Government Employees

1. What is your title and your role and what department do you work for?
2. How do you see your job?
3. What is rewarding about your job?
4. What are your concerns and frustrations?
5. What is stopping you to better do your job?
6. What is getting in the way to have complete data?
7. Tell us more about your system of communication with different partners
8. What else in HIV prevention or treatment services would you like us to add as we formulate the tactics to implement the Minnesota HIV strategy plan? Or, in an ideal world, what kind of things would you like to see happen?

Appendix C: Regional Themes Identified through Focus Groups and Key Informant Interviews

Colored and italicized font indicates that a theme was specifically mentioned in the region under which it is listed.

Acronyms

CEU: Continuing education unit

CLAS: Culturally and linguistically appropriate services

CM: Case manager

DI: Disease investigator

Dr: Doctor

EMR: Electronic medical record

GM: Greater Minnesota

ID: Infectious Disease

LPHN: Local public health nurse

MH: Mental health

PPL-EFL: Project for Pride in Living - Education for Life

SW: Social worker

North West Region

1. **Prevention Education, Training & Testing**
 - a. HIV prevention education (who, how, what)
 - b. HIV testing and counseling (*in and out of prison, incentives for testing*)
 - c. STD awareness, education, and testing
 - d. Culturally appropriate PrEP/PEP (*more info to black community*)
 - e. Viral infection (hepatitis B, hepatitis C, herpes) (*education and testing*)
2. **HIV Care Services**
 - a. Initial HIV diagnosis
 - b. HIV medication
 - c. Retention in care
 - d. Re-engagement in care
 - e. Medical case management
 - f. Non-medical case management
 - g. Mental health therapists trained to provide services to PLWH
 - h. Health providers who understand PLWH and transgender
 - i. Health providers who are culturally competent (CLAS)
3. **Resources and Services**
 - a. Mental health care
 - b. Chemical/substance abuse treatment (*equitable referral, treatment facility for heterosexuals*)
 - c. Affordable housing (*for all HIV+, for transgender, subsidized shelter for homeless HIV+ people*)
 - d. Nutritional food
 - e. Transportation options
 - f. Childcare reimbursement to attend appointments (MH, medical, support groups, dental)
 - g. Condoms (*for men in prisons*)
 - h. Employment programs (*to get people back to work, restart PPL-EFL*)
 - i. Support groups (*none in Bemidji*)
4. **Advocacy**
 - a. HIV health care team approach (Dr, MH, dietician, SW or CM, pharmacist)
 - b. Stigma awareness (fear and stigma, whore stigma)
 - c. HIV workshops

North East Region

1. **Prevention Education, Training & Testing**
 - a. HIV prevention education (who, how, what)
 - b. HIV testing and counseling (*for any walk-in patient*)
 - c. STD awareness, education, and testing
 - d. Culturally appropriate PrEP/PEP
 - e. Viral infection (hepatitis B, hepatitis C, herpes)
2. **HIV Care Services**
 - a. Initial HIV diagnosis
 - b. HIV medication
 - c. Retention in care
 - d. Re-engagement in care
 - e. Medical case manager
 - f. Non-medical case manager
 - g. Mental health therapists trained to provide services to PLWH
 - h. Health providers who understand PLWH and transgender
 - i. Health providers who are culturally competent (CLAS)
3. **Resources and Services**
 - a. Mental health care (*more providers, support existing programs*)
 - b. Chemical/substance abuse treatment
 - c. Affordable housing
 - d. Nutritional food
 - e. Transportation options
 - f. Childcare reimbursement to attend appointments (MH, medical, support groups, dental)
 - g. Condoms
 - h. Employment program
 - i. *Publications about CD4, viral load, PrEP*
 - j. *Resource guides (HIV, domestic violence, harm reduction, mental health)*
 - k. *Peer educators*
4. **Advocacy**
 - a. HIV health care team approach (Dr, MH, dietician, SW or CM, pharmacist)
 - b. Stigma awareness (*ads in magazines targeting LGBTQ community and general public*)
 - c. HIV workshops
 - d. *Seminars on STDs*
 - e. *HIV research*

West Central Region

No focus groups conducted in this region

Central Region

1. Prevention Education, Training & Testing

- a. HIV prevention education (who, how, what)
- b. HIV testing and counseling
- c. STD awareness, education, and testing
- d. PrEP/PEP
- e. Viral infection (hepatitis B, hepatitis C, Herpes)
- f. *U=U*

2. HIV Care Services

- a. Initial HIV diagnosis
- b. HIV medication
- c. Retention in care
- d. Re-engagement in care
- e. Medical case manager
- f. Non-medical case manager
- g. Mental health therapists trained to provide services to PLWH
- h. Health providers who understand PLWH and transgender
- i. Health providers who are culturally competent (CLAS)

3. Resources and Services

- a. Mental health care
- b. Chemical/substance abuse treatment
- c. Affordable housing
- d. Nutritional food
- e. Transportation options (*for clients*)
- f. Childcare reimbursement to attend appointments (MH, medical, support groups, dental)
- g. Condoms
- h. Employment programs
- i. PrEP providers
- j. *Resource guide for GM*
- k. *Telemedicine for GM*

4. Advocacy

- a. HIV health care team approach (Dr, MH, dietician, SW or CM, pharmacist)
- b. Stigma awareness
- c. HIV workshops
- d. *Immediate linkage to care (MH, HIV care)*

South West Region

1. **Prevention Education, Training & Testing**
 - a. HIV prevention education (who, how, what)
 - b. HIV testing and counseling (*place for free screening*)
 - c. STD awareness, education, and testing
 - d. PrEP/PEP culturally appropriate
 - e. Viral infection (hepatitis B, hepatitis C, herpes)
2. **HIV Care Services**
 - a. Initial HIV diagnosis
 - b. HIV medication
 - c. Retention in care
 - d. Re-engagement in care
 - e. Medical case management
 - f. Non-medical case management
 - g. Mental health therapists trained to provide services to PLWH
 - h. Health providers who understand PLWH and transgender
 - i. Health providers who are culturally competent (CLAS)
3. **Resources and Services**
 - a. Mental health care
 - b. Chemical/substance abuse treatment (*needle exchange*)
 - c. Affordable housing
 - d. Nutritional food
 - e. Transportation options
 - f. Childcare reimbursement to attend appointments (MH, medical, support groups, dental)
 - g. Condoms
 - h. Employment programs
 - i. *Human resources (LPHN for HIV)*
 - j. *Interpreters*
 - k. *HIV curriculum approved by school and community*
 - l. *Resource guide*
 - m. *Funding*
4. **Advocacy**
 - a. HIV health care team approach (Dr, MH, dietician, SW or CM, pharmacist)
 - b. Stigma awareness
 - c. HIV workshops, *HIV webinars, CEUs*

Metropolitan Region

1. **Prevention Education, Training & Testing**
 - a. HIV prevention education (who, how, what)
 - b. HIV testing and counseling (*mobile unit, EMR*)
 - c. STD awareness, education, and testing
 - d. PrEP/PEP culturally appropriate
 - e. Viral infection (hepatitis B, hepatitis C, herpes)
 - f. *U=U*
2. **HIV Care Services**
 - a. Initial HIV diagnosis (*DI, resource guide for newly diagnosed*)
 - b. HIV medication
 - c. Retention in care
 - d. Re-engagement in care
 - e. Medical case management
 - f. Non-medical case management
 - g. Mental health therapists trained to provide services to PLWH
 - h. Health providers who understand PLWH and transgender
 - i. Health providers who are culturally competent (CLAS)
3. **Resources and Services**
 - a. Mental health care
 - b. Chemical/substance abuse treatment
 - c. Affordable housing
 - d. Nutritional food
 - e. Transportation options
 - f. Childcare reimbursement to attend appointments (MH, medical, support groups, dental)
 - g. Condoms
 - h. Employment programs
 - i. *Support groups*
 - j. *Interpreters*
 - k. *Providers who can prescribe PrEP*
4. **Advocacy**
 - a. HIV health care team approach (Dr, MH, dietician, SW or CM, pharmacist)
 - b. Anti-stigma/stigma awareness
 - c. HIV workshops; *advocacy for the voiceless*
 - d. Immediate linkage to care
 - e. *Telemedicine for metro ID physicians to support ID physicians in GM*
 - f. *PrEP campaign; U=U campaign*
 - g. *First entry into HIV care*

South Central Region

1. Prevention Education, Training & Testing

South Central Region

- a. HIV prevention education (who, how, what)
(bug chasers, parents in denial)
- b. HIV testing and counseling
- c. STD awareness, education, and testing
- d. PrEP/PEP
- e. Viral infection (hepatitis B, hepatitis C, herpes)

2. HIV Care Services

- a. Initial HIV diagnosis
- b. HIV medication
- c. Retention in care
- d. Re-engagement in care
- e. Medical case manager
- f. Non-medical case manager
- g. Mental health therapists trained to provide services to PLWH
- h. Health providers who understand PLWH and transgender
- i. Health providers who are culturally competent (CLAS)

3. Resources and Services

- a. Mental health care
- b. Chemical/substance abuse treatment
- c. Affordable housing
- d. Nutritional food
- e. Transportation options
- f. Childcare reimbursement to attend appointments (MH, medical, support groups, dental)
- g. Condoms
- h. Employment programs
- i. *More literature on CD4, viral load tests*
- j. *Financial assistance*
- k. *Peer educators/navigators*

4. Advocacy

- a. HIV health care team approach (Dr, MH, dietician, SW or CM, pharmacist)
- b. Stigma awareness
- c. HIV workshops/*seminars*
- d. *Providers knowledgeable about LGBTQ*

South East Region

1. Prevention Education, Training & Testing

- a. HIV prevention education (who, how, what)
- b. HIV testing and counseling *(mobile unit, incentives, free HIV testing)*
- c. STD awareness, education, and testing
- d. PrEP/PEP
- e. Viral infection (hepatitis B, hepatitis C, herpes)

2. HIV Care Services

- a. Initial HIV diagnosis
- b. HIV medication *(personalized care, home visits)*
- c. Retention in care
- d. Re-engagement into care
- e. Medical case manager
- f. Non-medical case manager
- g. Mental health therapists trained to provide services to PLWH
- h. Health providers who understand PLWH and transgender
- i. Health providers who are culturally competent (CLAS)

3. Resources and Services

- a. Mental health care
- b. Chemical/substance abuse treatment (syringe exchange)
- c. Affordable housing *(navigation of resources)*
- d. Nutritional food
- e. Transportation options *(expand the budget)*
- f. Childcare reimbursement to attend appointments (MH, medical, support groups, dental)
- g. Condoms
- h. Employment programs
- i. *Support groups*
- j. *Youth outreach workers*
- k. *Updated resource guide*
- l. *Providers who can prescribe PrEP*

4. Advocacy

- a. HIV health care team approach (Dr, MH, dietician, SW or CM, pharmacist)
- b. Stigma awareness
- c. HIV workshops
- d. *Education around trauma-informed care*
- e. *Social media campaigns*