Minnesota Council for HIV/AIDS Care and Prevention

Technical Assistance for HIV Planning

June 2021

Assessment and report provided by HealthHIV

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BACKGROUND

In February 2021, HealthHIV began an assessment process to evaluate the effectiveness of the Minnesota Council for HIV/AIDS Care and Prevention (MCHACP) structure, bylaws, responsibilities, and function. The process included documentation review, implementation of a comprehensive assessment, and a formal presentation to the MCHACP membership to discuss improvements to the planning group's membership, structure, and policies/procedures.

Logistics & Responsibilities

HealthHIV is a technical assistance (TA) provider for the Integrated HIV/AIDS Planning TA Center (IHAP TAC), funded by the Health Resources and Services Administration's HIV/AIDS Bureau. HealthHIV assists state and local health departments, HIV planning groups, AIDS service organizations (ASOs), community-based organizations (CBOs), and healthcare organizations improve community engagement, organizational development, program integration, integrated HIV prevention and care planning, high-impact prevention, clinical integration in prevention, public-private partnerships, and much more.

HealthHIV created and tailored the HIV planning body assessment tools then fielded and analyzed data from members of MCHACP. With support from MCHACP leadership, HealthHIV managed the engagement and communication with MCHACP members during the six-month assessment process.

Objectives

The goal of the HIV planning body assessment was to assess the effectiveness of the planning body structure, bylaws, policies, and procedures, and how MCHACP's operations allow it to achieve its goals for 'Ending the HIV Epidemic' in Minnesota. The key objectives of the assessment process were to:

- Assess the effectiveness of MCHACP's structure, membership, community engagement, and tracking to improve health outcomes.
- Identify opportunities for best practice application and share recommendations to improve the MCHACP's operations.
- Present implications and findings from assessment with full MCHACP membership to encourage consideration, adaptation and/or implementation of recommendations.

DOCUMENT SCOPE

The following report provides a summary of the information gathering process, as well as the data and recommendations for MCHACP structure and process improvement. While HealthHIV may have identified areas for TA, the assessment process did not include delivery of follow-up TA. HealthHIV will facilitate TA to MCHACP at their request.

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INFORMATION GATHERING

HealthHIV implemented information gathering activities via key MCHACP stakeholders, including the Part A, Part B, and CDC recipients, the Council Coordinator, and the Council Co-Chairs. HealthHIV conducted numerous calls with these stakeholders to discuss the scope of activities, outline objectives and intended outcomes, review requests for documentation, gain clarification on policies and procedures, and ensure full cooperation and clear communication with members regarding the assessment. MCHACP documentation was collected remotely via email, and included:

- Minnesota and TGA Integrated HIV Prevention and Care Plan 2017-2021
- MCHACP practices and procedures
- MCHACP bylaws
- MCHACP goals, objectives, and activities
- MCHACP application form
- New member orientation materials
- Annual meetings calendar
- Meeting minutes
- Recruitment brochure and flyer

HealthHIV also implemented two assessment modalities simultaneously between February and April 2021, which included an anonymous, online survey of the full membership and key informant interviews by phone with a diverse group of members and stakeholders.

Review MCHACP's Documents

Membership Survey & Key Informant Interviews

Present Findings to Members & Provide Final Report

Overview of MCHACP Member Survey

The purpose of the online survey was to provide MCHACP with information for reflection, discussion, planning, and development to improve the group's structure, policies and procedures. HealthHIV asked survey participants to provide thorough, thoughtful, and truthful

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answers. Responses to the survey are de-identified and reported all together to protect the confidentiality of MCHACP members.

The survey included 37 questions (27 quantitative and 10 qualitative/open-ended) related to: membership demographics and skills; effectiveness of MCHACP structure; MCHACP recruitment and orientation activities, relationship with external stakeholders, and key successes and areas for improvement. HealthHIV and MCHACP leadership reached out to all MCHACP members and a total of **23 individuals responded to the survey, which included 90% of the current MCHACP members**.

Overview of MCHACP Key Informant Interviews

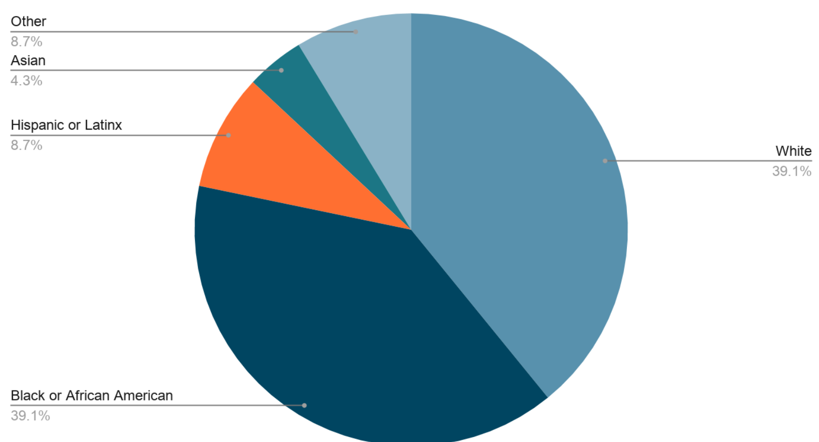
HealthHIV also conducted key informant interviews (KIIs) by phone to further the involvement of MCHACP members in the assessment process. A diverse group of members with varying perspectives were asked to participate, including both new and seasoned members. HealthHIV ultimately spoke with five members. All qualitative information from the interviews was de-identified and combined. The interview tool consisted of open-ended questions and was administered throughout a 60-minute phone call. Interviews included a discussion of: member background, current engagement and role with MCHACP, HIV planning purpose and effectiveness, MCHACP recruitment and orientation, community engagement, and future aspirations/anticipated challenges.

Summary of Findings

The following is a narrative summary of the survey data from 23 members of the MCHACP and key informant interview data from five MCHACP members.

Member Demographics

An equal number of respondents identify as white (39.13%) and Black or African American (39.13%). 8.70% of respondents identified as Hispanic or Latinx, while 4.35% of respondents identified as Asian and 0% of respondents identified as either American Indian or Alaska Native or Native Hawaiian or Pacific Islander. Most respondents identify as male (60.87%), with 34.78%



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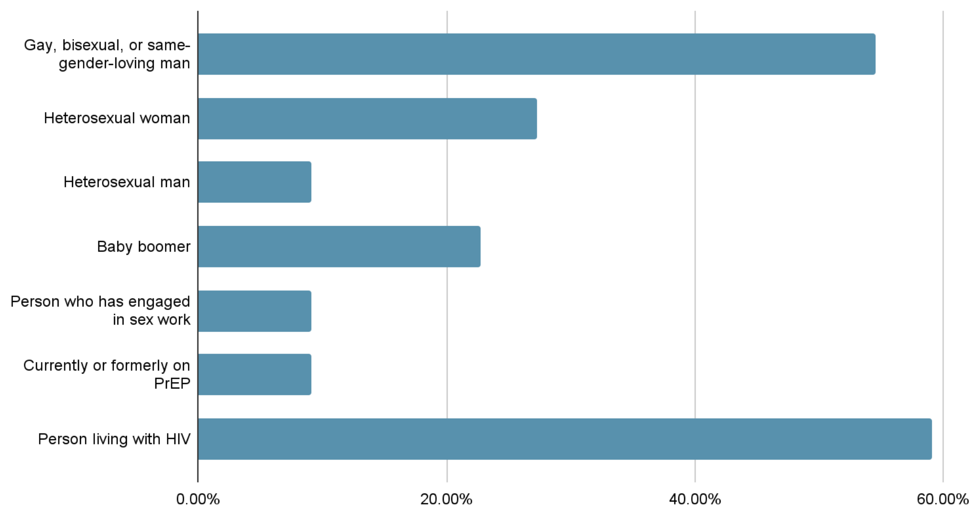
of respondents identifying as female and 4.35% identifying as gender non-conforming or non-binary.
Among respondents, 54.55% are gay, bisexual, or same-gender-loving men; 27.27% are heterosexual women, and 22.73% are Baby Boomers. Over half of respondents (68.18%) identify as LGBT, and 59.09% are people living with HIV (PLWH). A slightly larger percentage of respondents reside in urban areas than reside in suburban areas, with 52.17% living in urban areas and 43.48% living in suburban areas. Only 4.35% of respondents reside in a rural area, and 0% live on a Native American reservation.



A major strength of MCHACP is the diversity of its membership. All fourteen of the demographic categories asked about in the survey tool are represented by at least one member. Groups that are more difficult to engage, but still represented within MCHACP's membership, include people who currently inject or formerly injected drugs, people currently or formerly experiencing homelessness, people who have engaged in sex work, and people with viral hepatitis. The diversity of MCHACP's membership allows the Council to better represent the various communities affected by HIV in Minnesota.

Member Satisfaction

Many members are satisfied with MCHACP and plan to finish out their membership term (79%). Some members are not satisfied, but are planning to finish out their term (21%). No members are planning to end their term early.

Skills and Perspectives Among Members

Respondents reported that the following skills, people, or perspectives should be expanded within the current membership:

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Skills	People/Perspectives
• Epidemiology • Virtual conference platform etiquette • Policy work • Harm reduction • Trans-specific health care • Social media	• Teachers • Law enforcement • Youth • Transgender individuals • Lawyers • American Indians/Alaskan Natives • Medicaid representatives

Desired Training

Respondents expressed a desire to receive additional training related to the following topics:

- Funding streams
- The relationship between government entities involved in the integrated HIV planning process
- Parliamentary procedures
- Equity and inclusion
- Conflict resolution
- Epidemiology

MCHACP Structure and Processes

HealthHIV explored several areas of the current MCHACP structure through review of documentation, the online survey, key informant interviews, and conversations with the MCHACP leadership to understand strengths, areas for improvement, and how the structure currently contributes (positively or negatively) to the effectiveness of the group.

Meeting Format

Survey respondents were asked about their meeting format preferences in a COVID-19 and post-COVID-19 context. In the context of the current pandemic, 65.22% of respondents reported that they preferred meeting via Microsoft Teams with video conferencing over Microsoft Teams without video conferencing. When given the opportunity to choose their preferred virtual meeting platform, 43.48% indicated a preference for Zoom, while 26.09% of respondents preferred Microsoft Teams.

Post-pandemic, 50% of respondents reported that they would prefer in-person meetings if possible. 45% of respondents preferred in-person meetings with the option to join virtually. Pre-COVID, survey respondents and KII participants seemed to enjoy the ways in which the in-person meeting format allowed for organic and informal conversations with fellow Council members. Some expressed how these “side conversations" were often very productive and

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allowed for clarification of confusing content and generation of new ideas. While continuing in the all-virtual format, MCHACP may want to incorporate opportunities for less formal interaction and conversation among members.

Meeting Facilitation

Several questions in both the survey and KIIs touched on members' satisfaction with MCHACP meeting facilitation. Overall, MCHACP does an excellent job balancing a huge number of competing priorities in each meeting, and meetings are well-organized. Distribution of relevant documents by the Council Coordinator well in advance of meetings allows members to adequately prepare.

When asked about barriers to successful meetings, the main concern raised was that meeting time could be more engaging and meetings could more effectively utilize the expertise of planning body members. Respondents reported that some activities performed during meetings could be completed at home or more quickly/less formally, and that there is insufficient time within the agenda for thoughtful discussion, brainstorming, or decision-making. Additionally, a quarter of respondents (26%) indicated that too many off topic conversations posed a barrier to meeting efficiency.

Recommendations for Enhancing Meeting Facilitation
● Begin each meeting with a conversational, community building activity (e.g., ask a fun question, go over current events) ● Encourage members to turn their cameras on (at least for the first 15 minutes of the meeting) ● Incorporate breakout group-based discussions whenever possible ● Be transparent and acknowledge that meetings are very full ● Reexamine which policies and procedures actually contribute to efficiency and which are just rules that can be removed ● Consider switching the meeting platform to Zoom ○ If in Zoom, utilize polling questions and breakout groups for discussion ● Consider distributing a survey to determine if the current meeting time is really the best option for members ● Celebrate members' accomplishments (e.g., member shoutouts)

Committees

About a third (30.43%) of respondents reported that no barriers interfere with *committee* meeting efficiency. The most commonly reported barriers to committee meeting efficiency relate to uneven distribution of speaking time and unclear meeting purpose. 30.43% of respondents reported that committee meetings are dominated by a small number of people and 21.74% of respondents indicated that the purpose of committee meetings is unclear.

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When asked about recommendations to improve committee structure and function, the majority of respondents did not provide concrete recommendations. However, some recommendations were offered to bolster the Community Voices Committee (CVC) through more frequent meetings, additional training, and mission clarification.

MCHACP Recruitment

Recruitment of new members was an area in which all survey respondents felt that MCHACP could improve. The most commonly reported barriers to new member recruitment included lack of broad outreach (43.48%), insufficient member compensation (47.83%), and inaccessibility of recruitment information to the general public (52.17%). Nearly half of survey respondents (47.83%) also indicated that potential new members often do not understand what MCHACP is and do not understand what responsibilities MCHACP membership would entail.

The Community HIV/AIDS Technical Assistance and Training for Planning project (Planning CHATT) has several publicly available offerings related to recruitment that may be of interest to MCHACP members:

- Recruitment & Retention of New Planning Council/Planning Body Members (webinar)
- Best Practices for Consumer Recruitment and Retention (document)

Role of MCHACP

Purpose

Several survey and KII questions focused on the extent to which members understood the purpose of the MCHACP, and/or felt that the work they did with the Council was effective. Less than half (43.48%) of members reported that they were “very” familiar with the objectives of the Minnesota and TGA Integrated HIV Prevention and Care Plan, while 17% reported being “not familiar.” This suggests that it may be beneficial to revisit the clarity of training materials, ensure that meeting activities are clearly explained, and ensure that leadership is communicating the purpose of various Council activities to the membership. Relatedly, only about a third (30.43%) of members reported that the planning Council evaluates the effectiveness of its own HIV planning activities, though 65.21% of respondents reported that MCHACP was either “somewhat” or “very effective” in meeting/working towards its objectives.

MCHACP Contribution to Ending the HIV Epidemic

When asked how the MCHACP impacts the HIV epidemic, many respondents pointed to the importance of the MCHACP in making sure that government entities understand where HIV dollars are most needed in the community. Likewise, many members mentioned how crucial the diverse voices of the Council are in discussions and focused on the role of the MCHACP in promoting genuine representation as key decisions are made. Members also talked about the

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importance of the MCHACP in helping them bring up-to-date information on the epidemic back to the community.

MCHACP Representation and Equity

Accessibility

A number of survey respondents and KII participants expressed concern regarding the accessibility of MCHACP meeting content. 21.74% of respondents reported lacking confidence in their understanding of how the Council operates and this sentiment was echoed qualitatively as well. Members expressed frustration with excessive jargon and acronyms used in MCHACP activities as well as the over-intellectualization of meeting topics and processes. Furthermore, given the complexity of integrated HIV planning, respondents expressed that a single orientation does not sufficiently prepare them to understand the process. It was recommended that additional trainings take place beyond orientation to enhance new members' understanding of the HIV planning process. Some respondents indicated that these trainings would be most helpful if facilitated by members who are not affiliated with the government and can better explain the HIV planning process in layman's terms. If that is not possible, members suggested that training materials be revised to be more clear to people unfamiliar with the processes.

Equity and Power

Survey and KII respondents reported instances in which they felt that members did not have equal power in the Council, or that more could be done to promote equity. About half of members (47.83%) reported that meetings are "dominated by a few voices," and noted that it can be difficult for members who are less knowledgeable about the planning process to speak up. Additionally, about a third (30.43%) of members reported feeling condescended to. Coupled with additional trainings, limiting the use of excessive jargon and acronyms could help newer, less experienced members feel more comfortable contributing to the Council's discussions.

Recommendations for Equalizing Power in MCHACP Meetings
● Create an anonymous post-meeting evaluation that includes the following questions: ○ "How well did you understand the meeting activities today?" ○ "Were there terms or concepts that were confusing in the meeting today? If so, which?" ● Use feedback from post-meeting evaluations to develop additional trainings related to confusing content ● Ensure that all acronyms are defined on presentation slides ● Brainstorm ways to give other members genuine ownership over parts of the agenda ● Facilitate discussions related to how members' race, socioeconomic status, and educational attainment affect their influence on the Council and the speaking time they afforded

Connection to Community

Another area of improvement identified by the survey and KIIs is related to the connection between the MCHACP and the community at large. Only 21.74% of members said that the

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planning body communicates effectively with the communities impacted by the epidemic. Some noted that the only option for community member input was if individuals attend meetings. Because attending meetings is a substantial time commitment, it might be helpful to identify other ways for community members to engage or share input with the Council.

Various respondents also indicated that improvements could be made related to the CVC. When asked how well concerns raised by the CVC are integrated into the Council's planning priorities, some (21%) said somewhat well. Around half (43.48%) of members said that CVC concerns were integrated either poorly or somewhat poorly. Many members mentioned the need for MCHACP leadership to make clearer requests of the CVC and be more transparent about ways that the CVC can be involved in setting planning goals and allocations.

Recommendations for Enhancing Connection to Community
● Set up non-formal, non-meeting ways to engage community members, including cookouts, pop-up events, trivia, etc ● Establish community ambassadors to attend events and represent the council ● Hold paid satellite sessions that solicit community feedback, use these sessions to pose explicit questions re: allocations, etc. to community ● Link with other community organizations for outreach and promotion of MCHACP (e.g., join newsletters, radio shows, webinars, etc) ● Explicitly welcome new community members to meetings ● Create a plain-language writeup of the MCHACP's purpose etc ● Engage a graphic designer ● Hold roundables of local leaders, organization leaders, etc. ● Clarify the purpose of the CVC meetings ● Hold more time for CVC members to report back about activities to council

Race

Less than half of members (39.13%) said that the planning Council addresses disparities linked to social determinants of health like poverty, unequal access to health care, lack of education, stigma, and racism. Related to this data point, several members expressed that there is an opportunity for growth related to the MCHACP's engagement in dialogue about race and equity. These individuals felt that MCHACP could have more explicit conversations around race, gender, and sexuality, as well as the intersection between racial justice and HIV. Members expressed a desire to acknowledge whiteness head-on, and to conduct focused and interactive programming related to white fragility, privilege, and whiteness in the public health sector. More broadly, respondents expressed wanting to lean into difficult and uncomfortable conversations as a Council and make sure not to just "check the box" on a diversity and inclusion training.

As part of the organization's training and capacity building offerings, HealthHIV has hosted several webinars on topics related to race, social justice, and equity. Below are links to HealthHIV's publicly available offerings that might be of interest to SAPG's members:

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- Roots of Racism in Healthcare: Creating a Climate for Culturally-Responsive Care (webinar)
- Achieving Health Equity: Countering Racism and Implicit Bias in Healthcare (webinar)
- Racial Justice & Meaningful Involvement of People Living with HIV (webinar)

In August of 2021, HealthHIV will also be hosting a webinar entitled "Fostering Equity in HIV Planning." This webinar will discuss the ways in which power imbalances can manifest in HIV planning bodies, how other planning bodies have sought to address implicit bias and promote equity, and strategies that MCHACP can apply to their own council to foster equity and mitigate power imbalances based on race, education, age, and socioeconomic status. HealthHIV will share the link to this webinar with MCHACP leadership at a later date.

Next Steps

Findings from the review of documentation, online survey, and key informant interviews point to several areas for improvement, as well as highlight the success and effectiveness of MCHACP and its HIV and viral hepatitis planning efforts. For the purposes of this initial assessment report, recommendations focused on areas for improvement summarized by HealthHIV from the online survey and KII data. MCHACP is encouraged to request technical assistance via the IHAP TAC to further define priority areas for improvement and practical solutions over the next three to six months.

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