2017- 2021 Montana Integrated HIV Prevention and Care Plan and the Statewide Coordinated Statement of Need

Prepared by:

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and

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Montana 2016
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Linda Gryczan – HPG Coordinator
Cara Murolo – STD Coordinator
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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ADAP	AIDS Drug Assistance Program (under Ryan White Part B)
AETC	AIDS Education and Training Center (Montana associated with Mountain West AETC)
AI	American Indian (formerly Native American or NA)
BRFSS	Behavioral Risk Factor Surveillance System
CBO	Community-Based Organization
CDC	The Centers for Disease Control and Prevention, Atlanta, GA
HPG	HIV Planning Group
CSA	Community Services Assessment
CRCS	Comprehensive Risk Counseling Services
CTRS	Counseling, Testing & Referral Services
DPHHS	MT Department of Public Health and Human Services
EIP	Early Intervention Program (under Ryan White Part C)
EPI	Epidemiological Profile (of STD/HIV/Hep)
FSR	Final Status Report (fiscal) to CDC
GLI	Group Level Intervention (Type of prevention activity)
GMTF	Gay Men's Task Force
HCV	Hepatitis C Virus
HE/RR	Health Education/Risk Reduction (Broad interventions category)
HIV	Human Immunodeficiency Virus
HOPWA	Housing Opportunities for Persons with HIV/AIDS
HPG	HIV Planning Group
HRSA	Health Resources Services Administration; Ryan White CARE Act
HRTF	Harm Reduction Task Force
IDU	Injection Drug User (target population)
IHS	Indian Health Service
ILI	Individual Level Intervention (Type of prevention activity)
LGBTI	Lesbian, Gay, Bisexual, Transgender, Intersex
MMWR	Morbidity and Mortality Weekly Report (from CDC)
MSM	Men Who Have Sex With Men (target population)
NAPWA	National Association of Persons Living with HIV/AIDS
NASTAD	National Association of State & Territorial AIDS Directors
NMAC	National Minority AIDS Council, Washington DC
NNAPC	National Native American Prevention Center
NPIN	National Prevention Intervention Network
OPI	Office of Public Instruction, State of Montana
ORW	Outreach Worker
PS	Partner Services
PIR	Parity, Inclusion and Representation (HPG Membership Composition)
PLWA	People Living With HIV/AIDS
PSE	Public Sex Environment
PWID	Persons Who Inject Drugs
RFP	Request for Proposals (Formal method of attaining services providers)
STD/STI	Sexually Transmitted Disease/ Sexually Transmitted Infection
TA	Technical Assistance
YRBS	Youth Risk Behavior Survey

Montana Integrated HIV Prevention and Care Plan
including the
Statewide Coordinated Statement of Need

2017 - 2021

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Section I: Statewide Coordinated Statement of Need/Needs Assessment

Introduction

Montana is a large, sparsely populated state, famous for dinosaur bones and good hunting and fishing. An interesting mix of farming/ranching and a small business economy catering to tourists sustains this politically conservative state. In terms of HIV, Montana is very low incidence, with an average of 20-22 new identified cases annually over the last fifteen years. With little change over the decades, the HIV epidemic in Montana has remained fueled by the risks of male-to-male (MSM) sex and the combined risk of MSM and injection drug use.

Montana's population is mostly white; its largest minority being American Indian (nearly 7%). Most persons living with HIV (PLWH) are white males; the native population is not over-represented.

Approximately 600 persons with HIV live in Montana. ADAP and the two Ryan White Part C programs in the state served over 400 PLWH in 2015.

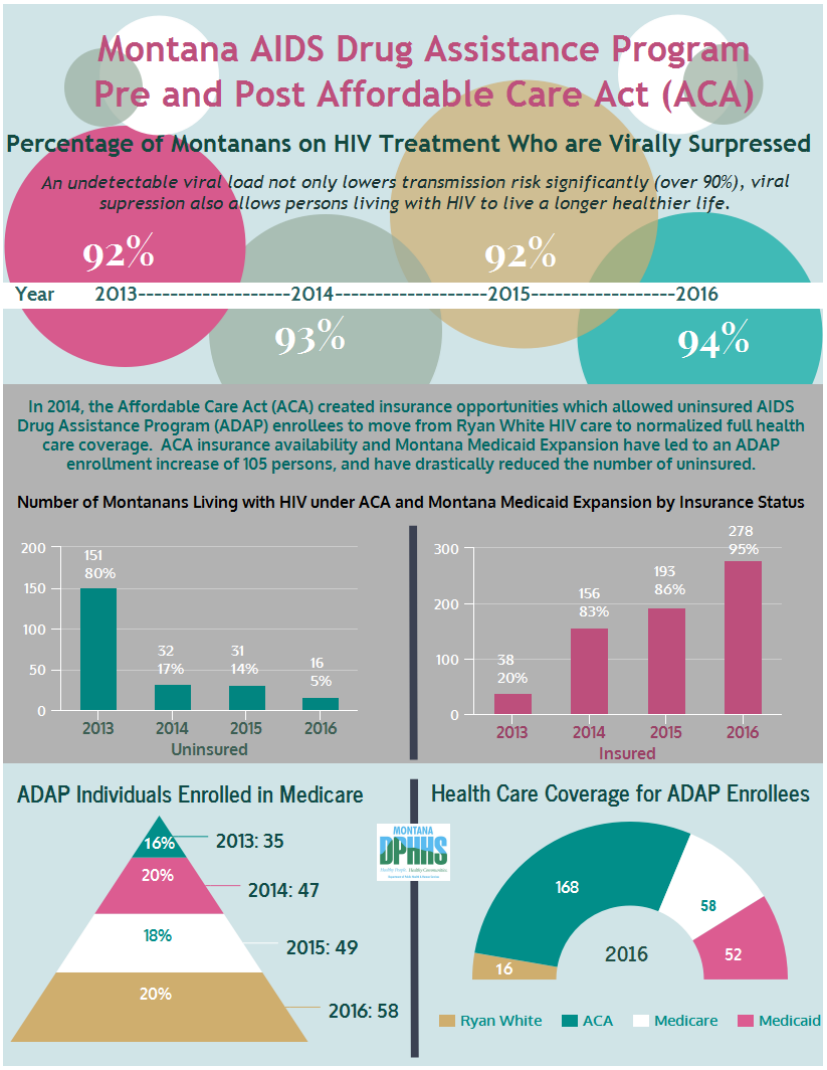
Montana has one of the highest poverty rates in the nation. About half of Ryan White clients have incomes less than 100% of the federal poverty level (FPL) and an additional 16% are below 138% FPL. Expansion of Medicaid effective in January of 2016 has allowed many of these persons to access Medicaid. Even with the additional payer source, needs for services such as housing and case management continue.

Low incidence in terms of disease prevalence equates with low resources in terms of funding. Montanans are resourceful, and independent, always managing to provide at least the basics for those in need. The AIDS Drug Assistance Program (ADAP) struggled with waiting lists from 2002 to 2012, but clients were never left without medication. The Ryan White program utilized various methods to alleviate the problem, including drug manufacturer's compassionate use programs that provided free medication, the generosity of the Flowers Heritage Foundation (charitable giving arm of Ramsell Corporation), and President Bush's Presidential Initiative which allowed ADAPs with waiting list to apply for extra federal monies. When Ryan White federal funders enacted the Emergency Shortfall Relief funds in 2012, Montana efficaciously accessed those funds and has done so annually since that time, successfully ending wait lists.

Also in 2012, Montana ADAP began to employ the use of a pharmacy benefits management company to increase access to drug manufacturer rebates, which is supplementing revenue for the ADAP program. Previously able to fund only medical case management because of the need to subsidize ADAP with Part B base funds, increased rebate funds, along with ADAP Emergency Shortfall Relief Funds, have permitted the use of Part B base funds to finance outpatient ambulatory care and to provide support services, including housing, along with medical case management .

While Montana historically has always been able to help with insurance premium payment when clients had access to insurance, ADAP has utilized Affordable Care Act Market Place opportunities to increase access to care for Montanans living with HIV. Continually evolving and growing, enrollment in ADAP has increased from 113 in 2012 to 312 as of September 2016.

The Montana Ryan White Part B program recently applied for Part B Supplemental funds, successfully adding over $700,000 to its resource pool. These monies will be used to meet the needs and services gaps identified through the needs assessment conducted for the Statewide Coordinated Statement of Need.

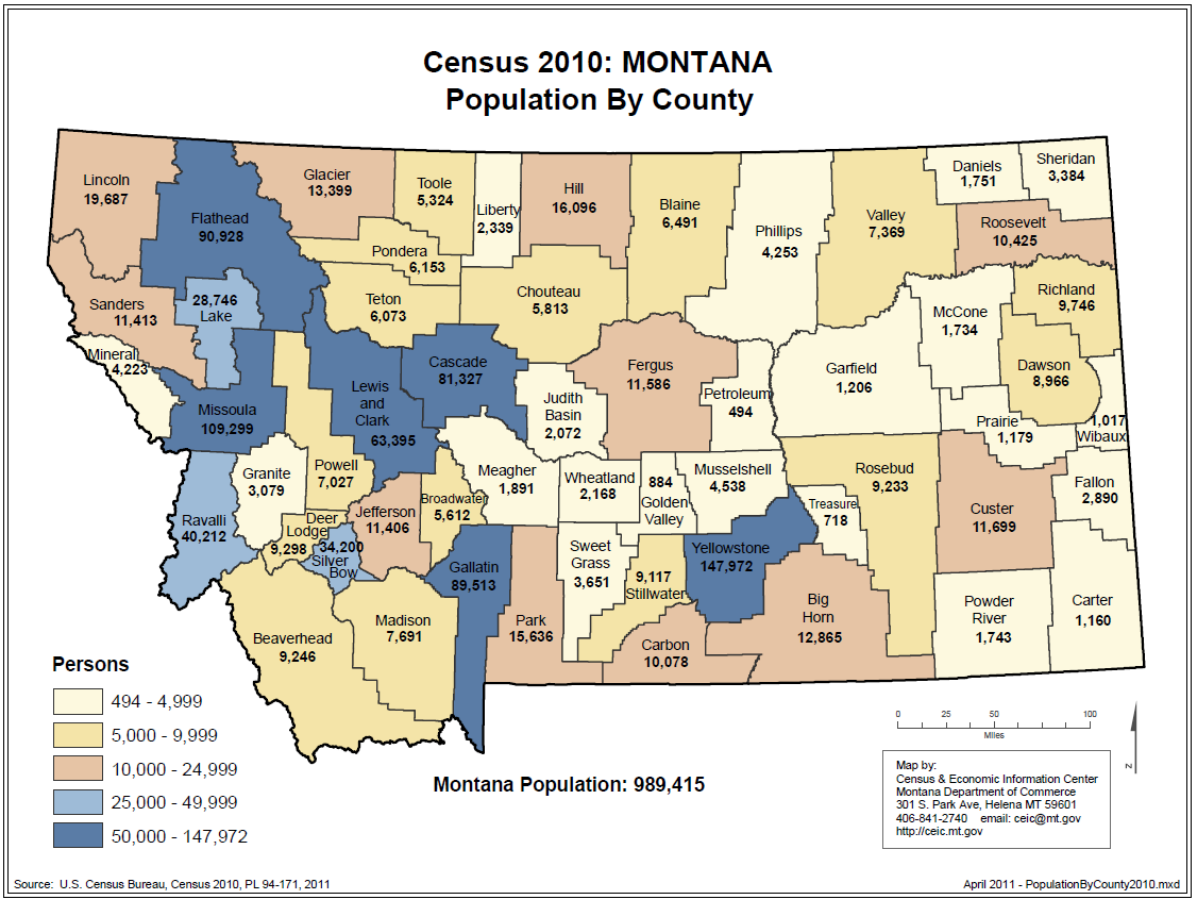


The Epidemiology of HIV in Montana

Also See Annual Report, Appendix A

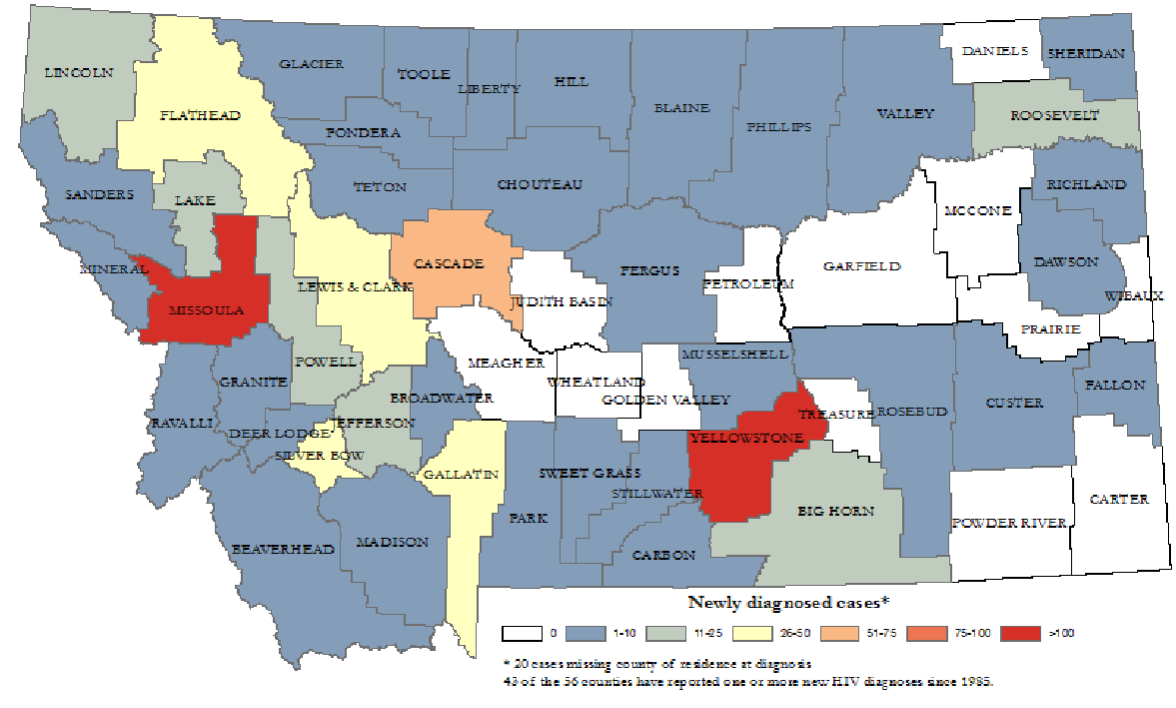
A. Epidemiologic Overview

Montana is a large state, but houses only just over one million residents. Montana has a 545-mile border with three Canadian provinces: British Columbia, Alberta, and Saskatchewan, the only state to do so. It also borders the frontier states of North Dakota and South Dakota to the east, Wyoming to the south, and Idaho to the west and southwest. Montana is ranked 4th in size, but 44th in population and 48th in population density of the 50 United States. The eastern third of Montana is one of the most sparsely populated areas in the United States.



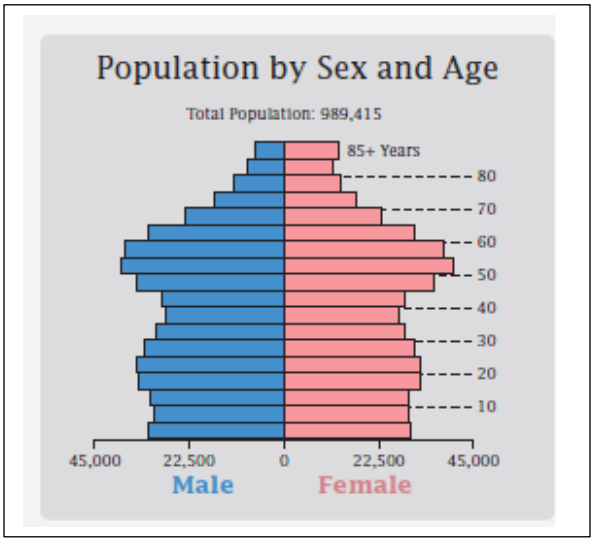
As of the end of 2015, 595 persons were reported to be living with HIV in Montana. HIV disease in the state follows the population centers. Most of the resident cases (68% are from the six most populous counties of Cascade, Flathead, Gallatin, Lewis and Clark, Missoula and Yellowstone. See darker colored counties on the above map.

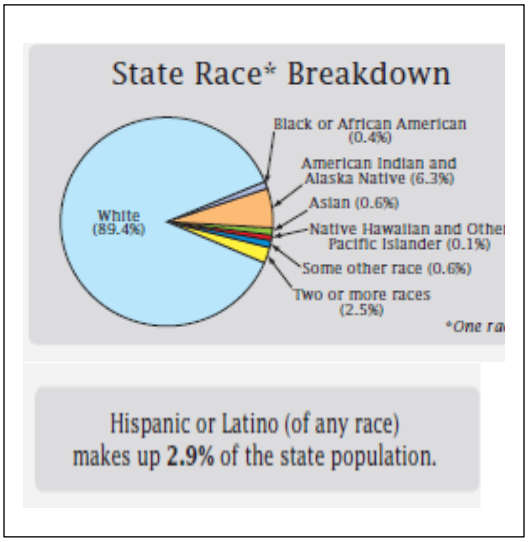
New HIV infection diagnoses by county of residence — Montana, 1985–2015



The geographic distribution of persons living with HIV/AIDS in Montana reflects the population distribution in Montana. Since 1985, nearly 70% of the reported newly diagnosed cases of HIV infection resided in one of the seven most populated counties of Montana. The most populous counties in Montana are also the counties with the greatest number of PLWH (See Figure 10 in attached Annual Report.)

Most HIV infections reported in Montana have historically been non-Hispanic, White males.

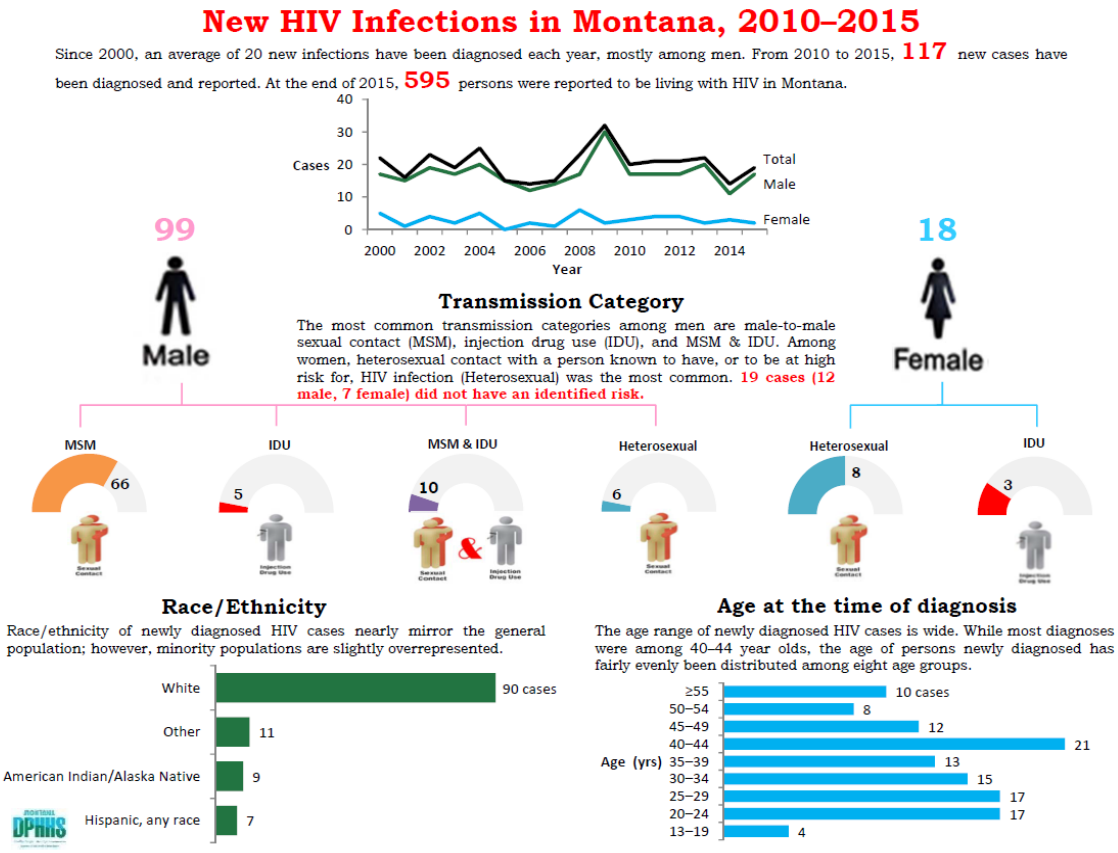




The leading transmission categories among men are male-to-male sexual contact (MSM) and users of injection drugs (IDU). Among women, high-risk heterosexual contact (HRH), sexual contact with a person known to have, or to be at high risk for, HIV infection, is the leading transmission category followed by IDU.

In 2015, men accounted for 17 or the 18 new infections reported, and 14 were non-Hispanic white. Among men, MSM and IDU were the most common transmission categories. Thirteen of the 17 men reported MSM or IDU as their risk.

See Figures 1 – 4 of attached HIV Report



Year of diagnosis	2011	2012	2013	2014	2015	1982–2014
Total	21	21	22	14	18	706
			Sex			
Male	17	17	20	11	17	607 (86%)
Female	4	4	2	3	1	99 (14%)
Age at HIV diagnosis						
<13	--	--	--	--	--	4 (1%)
13–24	2	3	3	2	5	98 (14%)
25–34	3	6	7	6	5	252 (36%)
35–44	7	5	5	4	4	208 (29%)
45–54	5	7	4	2	1	94 (13%)
≥55	4	--	3	--	3	50 (7%)
Race			**Ethnicity - Non-Hispanic**			
White	19	14	13	11	15	592 (84%)
American Indian/Alaska Native	1	3	2	1	--	51 (7%)
Black/African American	--	1	1	--	1	21 (3%)
Other	--	2	5	1	--	17 (2%)
Hispanic, any race	1	1	1	1	2	25 (4%)
Transmission category Male only						
Male/Male sex (MSM)	11	10	17	5	8	369 (61%)
Injection drug use (IDU)	2	1	--	1	1	61 (10%)
MSM/IDU	1	1	1	2	4	65 (11%)
Heterosexual contact †	1	2	--	1	1	29 (5%)
Other §	--	--	--	--	--	16 (3%)
No identified risk	2	3	2	2	3	67 (11%)
Transmission category Female only:						
Heterosexual contact †	2	--	2	3	--	55 (56%)
Injection drug use (IDU)	1	1	--	--	--	20 (20%)
Other §	--	--	--	--	--	6 (6%)
No identified risk	1	3	--	--	1	18 (18%)

The characteristics of persons living with HIV infection in Montana have not changed significantly over time. HIV infection continues to impact men who have sex with men (MSM) and/or individuals reporting injection drug use (IDU). American Indians/Alaska Natives represent 6.6% of the prevalent population.

See Figures 6 – 8 in attached report, Appendix A

Indicators of Risk

According to the Montana Youth Risk Behavior Survey, more than 60% of high school students report having had sexual intercourse by 12th grade and 41% did not use a condom the last time they had sex. As a group, Native American and Hispanic students were more sexually active than white students. (58.2%, 52% and 42% respectively).

The 2015 Montana Youth Risk Behavior Survey indicates that among high school students:

- 44% ever had sexual intercourse.
- 3% had sexual intercourse for the first time before age 13 years.
- 13% had sexual intercourse with four or more persons during their life.
- 32% had sexual intercourse with at least one person during the 3 months before the survey.
- 41% did not use a condom during last sexual intercourse. (1)
- 9% did not use any method to prevent pregnancy during last sexual intercourse. (1)
- 16% were never taught in school about AIDS or HIV infection. (2)

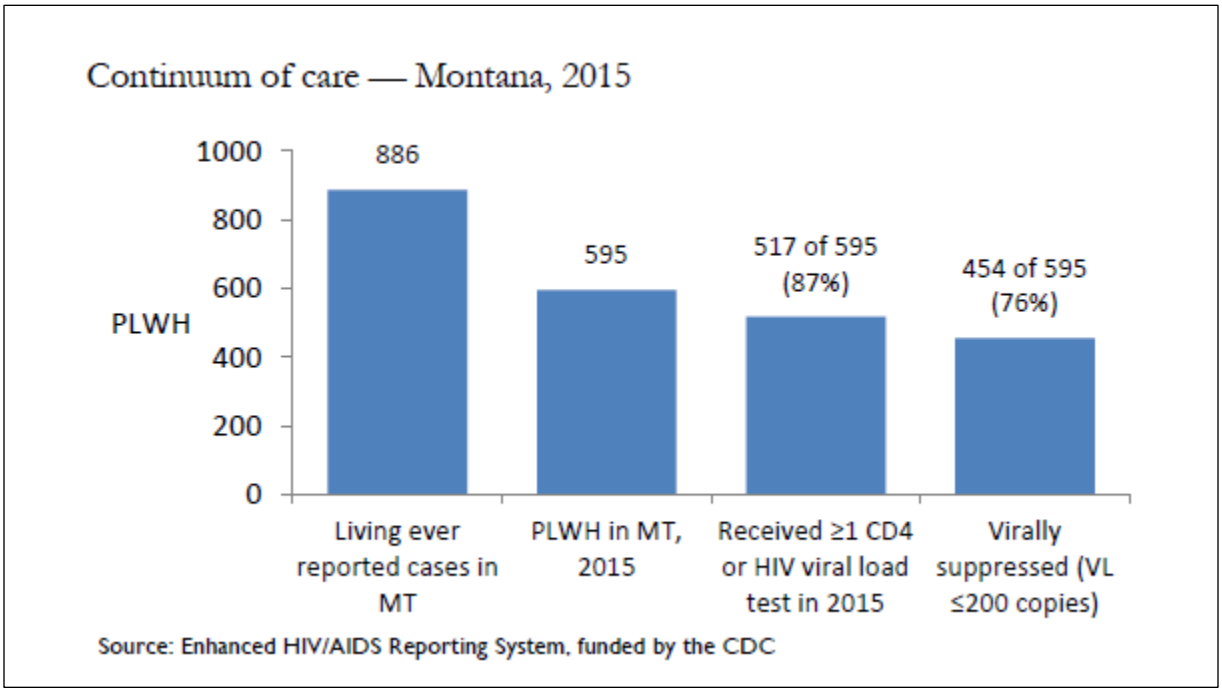
HIV Testing

According to 2014 Montana Behavioral Risk Factor Surveillance System (BRFSS) 2014 Annual Report, 37% of all Montana adults have been tested at some point for HIV. More women than men have been tested and a majority are age 25-54.

In spite of American Indians (AI) being tested at a higher percentage than the percentage of whites testing for HIV as noted in the 2014 Behavioral Risk Factor Surveillance System, https://dphhs.mt.gov/publichealth/BRFSS/Publications the percentage of AI with HIV is lower than the proportion of American Indians (7.1%) in the overall Montana population. Of the 595 persons reported to be living with HIV in Montana 32 were Native Americans (5.8%).

B. HIV Care Continuum

The HIV continuum of care is a series of steps from a person's HIV diagnosis to successful treatment to achieve viral suppression. Montana's continuum progress from the number of persons ever reported in Montana and alive (n=886) to PLWH who had a suppressed viral load (n=454). A suppressed viral load significantly reduces the chance of HIV transmission.



The above graph represents the 2015 Montana HIV care continuum. The largest figure on the left (n=886) represents all HIV-infected persons who were ever reported in Montana and are known to be alive. Of the 886 persons, 595 persons were reported to be living in Montana as of the end of 2015. And of those 595 persons, 517 persons (87%) received at least one CD4 or HIV viral load test reported in 2015. Of persons who had an HIV viral load test result in 2015, 76% (n=454) had a suppressed viral load.

Of the 595 PLWH, 352 (60%) ever had an AIDS diagnosis. The demographic profile of PLWH is similar to that of persons diagnosed in Montana (See Table 2 of Annual Report, Appendix A).

Over the last three years (2013-2015) Montana has been successful in linking newly diagnosed persons to care within three months. Montana's HIV Planning Group has been focused on increasing the number of persons who are in care and have a suppressed viral load. Montana defines "in-care" as a person who has one CD4 or viral load result within a calendar year and virally suppressed as a person with an HIV viral load less than or equal to 200 copies/mL.

The demographics of persons living with HIV in Montana, but not in care, mirror the demographics of the prevalent infected population. The Montana care continuum has been just recently created. With this new information, HIV prevention planners will assess the demographics of those in care but not virally suppressed. Already, funds have been secured to increase referrals to social and medical services for persons struggling with adherence issues, and to reach out to those not in care.

C. Financial and Human Resources Inventory

Funding Sources	Total Funds	% of funds available	Services Delivered	Care Continuum Impact
Ryan White Part C Eastern Region	$173,000	100%	Early Intervention Services. HIV treatment clinic, medical case management	Access to Care, Treatment, Medication, Viral Suppression
Ryan White Part C Western Region	$157,000	100%	Early Intervention Services. HIV treatment clinic, medical case management	Access to Care Treatment, Medication, Viral Suppression
ADAP Earmark and Supplemental	$368,817	100%	Health Insurance Purchase	Access to Care Treatment, Medication, Viral Suppression
Emergency Shortfall Relief Funds	$688,002	100%	Health Insurance Purchase, Prescription Benefit Management, Drug Purchase	Access to Care Treatment, Medication, Viral Suppression
ADAP Drug Rebates	$133,725	100%	Health Insurance Purchase, Prescription Benefit Management (PBM)	Access to Care Treatment, Medication, Viral Suppression
Part B Base funds	$500,000	100%	Health Insurance Purchase, PBM, Drug Purchase	Access to Care Treatment, Medication, Viral Suppression
Part B Supplemental	$769,122	100%	Housing assistance, Early Intervention Services, Medical transportation Case Management	Access to Care Treatment, Medication, Viral Suppression
Mountain West AIDS Education and Training Center (AETC)	$80,000	100%	Provider training	Treatment, Medication, Viral Suppression
Mountain West AETC Tribal Bear Project	$89,000	60% 40%	Provider training. Prevention education	Treatment
CDC HIV Prevention	$750,000	46%	Counseling and Testing, Comprehensive Risk Counseling Services Social Marketing	Access to Care

TriState HELP (HOPWA)	$591,788	100%	Housing, Utility assistance	Access to Care Viral Suppression
MT Medicaid	$3,383,762	100%	Medication, Medical care Transportation assistance	Access to Care Treatment Viral Suppression
Office of Women's Health	$2,284,817	5%	Education	Access to Care
Bureau of Primary Health Care	$864,468	5%	Education	Access to Care
Flex Rural Veteran Health Access Program	$6,000	2%	Telehealth for mental health services or other health care	Treatment Viral Suppression
SAMHSA (CSAP)	$300,000	100%	Integrated Community Empowerment to reduce HIV and HCV transmission	Linkage to Care Patient Retention

b. Shortfalls in the healthcare workforce.

- Shortage of specialty providers such as psychiatrists, and infectious disease doctors.
- Provider time constraints
- Lack of cultural competency
- Mental health provider shortage
- Dentists who will accept Medicaid
- Greater access to affordable chemical dependency treatment

Montana medical specialists are not reimbursed at a rate as high as in larger populated areas, and specialists can sometimes not find enough specific disease incidence to sustain a practice. Some providers actually travel to smaller cities in Montana to provide specialty care in places where none is available.

c. Coordination with Other Programs

HIV/AIDS Care Programs

HIV prevention services for individuals infected with HIV/AIDS occur in the state through various means. The Ryan White Part B program manager is located in the STD/HIV Prevention Section and attends HPG meetings, providing expertise based on knowledge, skills, and abilities as appropriate to the situation. Currently, the Ryan White program manager is also the administrator of the CDC prevention grant. The HPG has assumed the responsibilities of HIV treatment planning by creating a standing workgroup with a focus on HIV treatment. This workgroup provides input toward decision-making about services, and develops and maintains a continuum of care plan for Montanans living with HIV/AIDS.

Linkages between HIV primary prevention and the secondary prevention activities accomplished by the Ryan White Part B and Part C case managers occur in several ways. All but one of the eight local health departments that provide Ryan White case management also provide HIV primary prevention services. The clients are able to access a continuum of care for their health needs within these organizations.

Substance Abuse Prevention and Treatment Programs

CTR contractors conduct counseling and testing in several of the few available treatment centers. HIV prevention contractors implement interventions for staff and clientele consistent with community planning priorities in their local communities. Educational materials are offered during intervention implementation.

Corrections

The STD/HIV Prevention Section staff members encourage all HIV Prevention contractors to collaborate with correctional services by implementing individual level and group level interventions, counseling, testing and referral services within the correctional system. Community collaboration and capacity building, as well as distribution of materials is also supported. These activities occur at juvenile detention centers; male and female pre-release centers; and local jails. Yellowstone City-County Health Department and the Yellowstone AIDS Project implement a group level intervention at the Montana Women's Prison. Topics covered include identifying risk behaviors as well as benefits of healthy behaviors.

American Indians

American Indians comprise the largest minority population within Montana. The STD/HIV Prevention Section currently contracts with one tribal facility, but is implementing a process to expand partnerships with more Native American entities. The HPG has prioritized American Indians as a community for representation in the community planning process. Currently there are four representatives from this group on the HPG. The Department attempts to collaborate and coordinate HIV prevention services with the tribal entities whenever possible.

Hepatitis

The state Immunization Section, which houses the Hepatitis B program, is located in the same bureau as the STD/HIV/Viral Hepatitis Prevention Section. The two programs are physically located next to each other.

The STD program supervisor and State Community Planning Chair is also the Hepatitis C Coordinator. Montana HIV community planning has been integrated with the Hepatitis C Program for several years.

Collaboration between the sections also occurs in data tracking and chart review activities. Immunization section staff members audit hospital birthing records to assess compliance with Hepatitis B immunization and testing requirements, and concurrently audit for prenatal HIV

testing. The Hepatitis B coordinator shares the birthing facilities' chart audit data with the STD/HIV Prevention Section.

Tuberculosis/HIV

Ongoing collaboration between the HIV surveillance epidemiologist, the TB Program Manager and the HIV treatment program manager assures that suspected and confirmed cases of dual HIV/TB are recognized both for reporting and case management purposes. In addition, an HIV/AIDS/TB case registry match is performed on an annual basis. Organizationally, the HIV/AIDS prevention program and the TB program are located within the same bureau, which facilitates ease of collaboration and communication as needed. Weekly disease meetings are held in which staff from both programs participate, providing collaboration, interaction, and updates as necessary.

Women and Men's Health Section

The STD/HIV Prevention Section staff and the Women's and Men's Health Section Staff continue to meet on a routine basis to discuss programmatic issues and over-arching goals and objectives. Regular collaboration between occurs on a state level with Family Planning, which is training providers in cultural sensitivity. State level Family Planning program administrators were guests at two HPG meetings in 2015.

d. Securing Services.

Ryan White has resorted to paying dentists full rate, rather than Medicaid rates, in order to get HIV positive clients accepted as patients. At least one community health center, which also has a Ryan White Part C HIV clinic on site, has expanded its public health oral health program.

While a long-established policy to prioritize HIV positive patients for admission into the state-sponsored Montana Chemical Dependency Center remains in place, the number of patients that it facility serves has been reduced. Increased Ryan White Part B resources are being shared with the Part C case management programs to allow a limited amount of inpatient substance abuse treatment assistance.

D. Assessing Needs, Gaps, and Barriers

This section specifically speaks to the prevention and care service needs, gaps and barriers of people at higher risk for HIV as well as PLWH, both diagnosed and undiagnosed. Those needs have been identified primarily as temporary and/or emergency housing and utility assistance, increased peer involvement and medical transportation. Both Housing Opportunities for Persons with AIDS (HOPWA) programs in the state frequently have fiscal year end waiting lists for short term and transitional housing

Evidence shows that housing assistance improves HIV health outcomes along each stage of the HIV Care Continuum. Housing supports have proved to increase stability and connection to care for PLWH experiencing homelessness or unstable housing. This consistency leads to improved HIV treatment access, uninterrupted care, better health outcomes, and reduced risk of ongoing HIV transmission. Yet, this assessment revealed the housing needs of PLWH in Montana are not being met. The collective input from the HPG and public meetings that were conducted in early 2016 both named temporary/emergency housing assistance as a primary service need.

Participants recurrently voiced concerns surrounding the lack of available funds to assist with temporary and emergency housing. These concerns were further validated and demonstrated by the most recent data and reports submitted by Ryan White Part Cs and the state's HOPWA programs. Montana Ryan White Part C grantees reported 22 out of 367 persons to be in unstable and/or homeless situations on the 2015 RSR, while both of the state's Housing Opportunity for Persons with HIV/AIDS (HOPWA) programs reported having waiting lists for short term housing as of April, 2016. HOPWA waiting lists included 6 homeless persons, 28 persons currently unstably housed or homeless, two homeless justice-involved persons awaiting housing as a condition of parole and three disabled or persons with debilitating health issues.

Increased peer involvement

The recent needs assessment revealed a universal need for more peer involvement surrounding the daunting and confusing experience of early diagnosis and treatment challenges. In addition, peer advocates could provide people living with HIV the confidence they need to advocate for themselves. Focus group participants honed in on the importance of peer support, as seen in the form of advocates and other people living with HIV, as a means toward empowerment.

Participants also suggested that empowerment can come from case managers assisting their clients in learning to navigate the HIV-related services. As one key informant stated, "That's where it kind of becomes important to have a good case manager that can actually help a person get through those systems because they're not necessarily easy to navigate if you're not familiar with them."

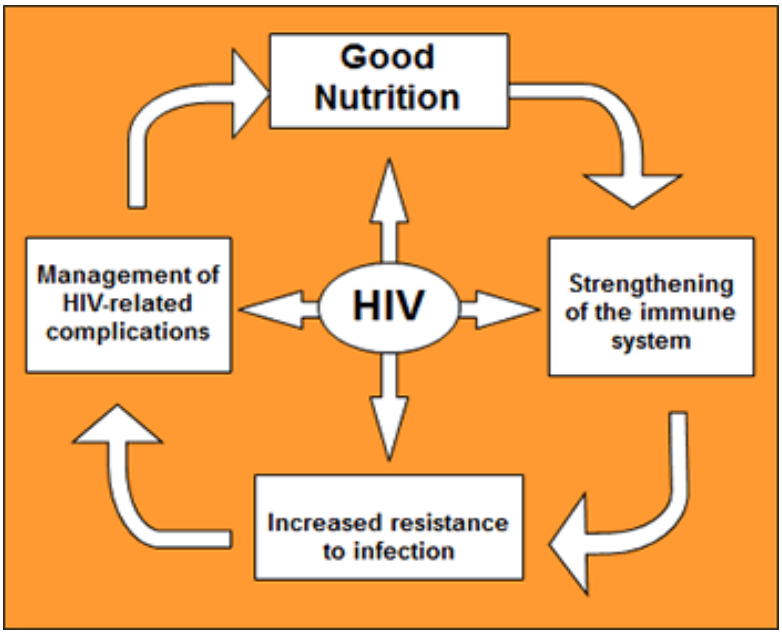
Medical Transportation.

Transportation is a service need that has held a prominent place in the research literature and in past needs assessments conducted in Montana. Because Montana is America's 4th largest state with a small population of one million that is widely dispersed, the lack of available medical transportation has proven to be a chronic problem in this state. About 30 percent of our Ryan White clients have to drive a significant distance to see HIV medical providers. Even those living within city limits are forced to drive or find a ride because public transportation is virtually non-existent.

Increase Public Education/Awareness about HIV:

An additional important prevention and treatment service need that arose from the interviews was a strong belief that HIV needs to be de-stigmatized within communities, across the state, and at a national level. Assessment participants believed that increased public education through comprehensive sex education in schools and increasing visibility through strategies such as social marketing would contribute greatly to reducing the stigma that currently surrounds HIV and sexual minorities. Comprehensive sex education was viewed as a way to reduce risky sexual behavior and increase the visibility of HIV leading to a decreased stigma associated with HIV.

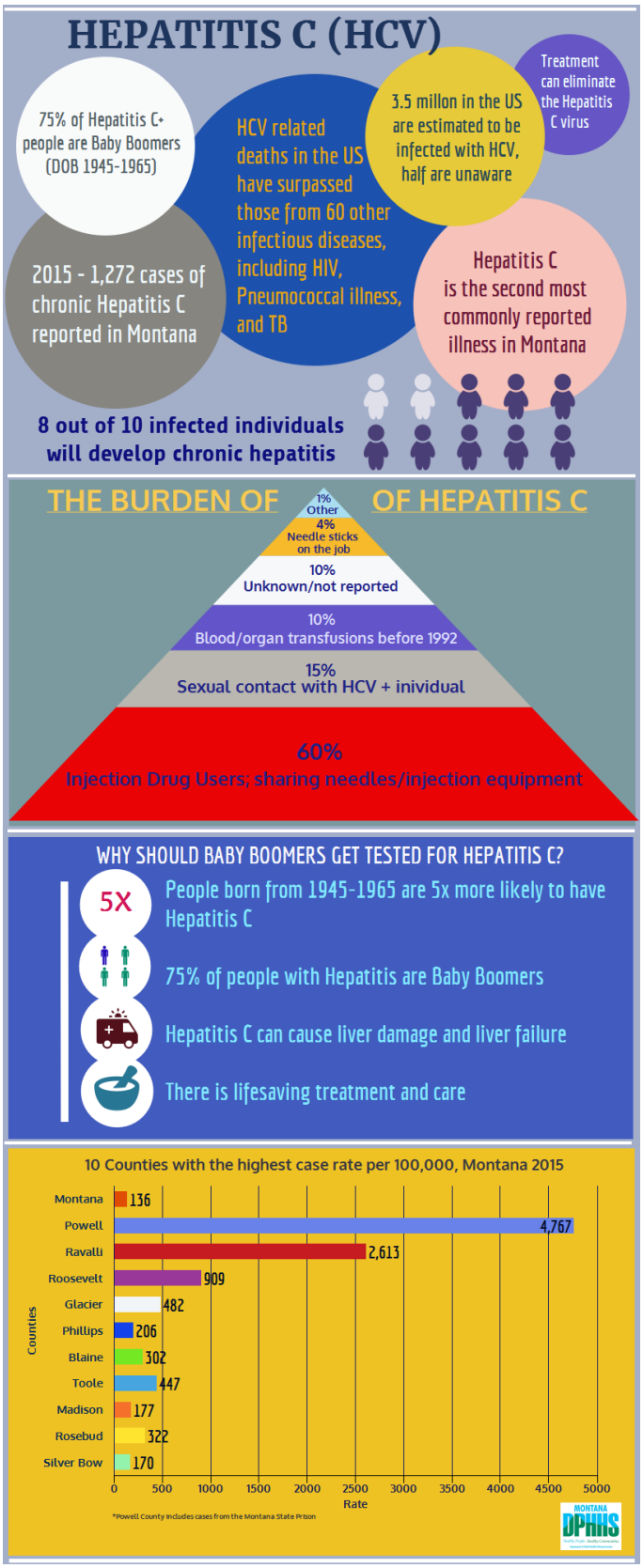
Nutrition Services



Nutrition Services (counseling and education) is another service need that has been recently identified as an important part of our client's unique needs and overall health. Because nutrition counseling services are not always covered or not fully covered by ACA plans or Medicaid, the service needs of PLWH, for whom good nutrition is paramount, remain.

Hepatitis C medication/treatment assistance.

Another significant service need is Montana's lack of available funds to assist with Hepatitis C treatment. Co-infection of HIV and Hepatitis C is common in Montana, with 15% of active Ryan White clients reported to be co-infected with HCV. Funding for Hepatitis C medications has not been previously available through the ADAP formulary in Montana and therefore not on the ADAP formulary. At the time of this assessment, there were 6 persons across the state the Ryan White Program identified as being in need of immediate Hepatitis C treatment. Yet, the estimated cost for Hepatitis C co-pay assistance alone is about $25,200 per person.



Rural Case Management

In Montana, the Ryan White program relies heavily on its rural case managers to effectively assist clients in remote regions. This requires case managers to be able to devote a significant amount of time towards assisting clients in meeting their needs. However, Ryan White case management is only a small part of the work that our rural case managers perform. They have many other responsibilities, which can include being city-county public health nurses and health educators. At the location of at least one site, this situation has created a deficiency in billable time and a lack of ability to reach out-of-care clients in an area that has several PLWA who have lost contact with the case management site.

Barriers

Barriers frequently mentioned in focus group and key informant interviews as obstacles to seeking services included stigma, discrimination and lack of transportation. These barriers have held a prominent place in the research literature and in past needs assessments conducted in Montana.

When considering barriers to services, it is important to discuss the barriers to testing. Many Ryan White clients were diagnosed with AIDS at the same time they discovered they were infected with HIV. When asked about their barriers to being tested earlier, the most frequent responses were that they thought they were at low or no risk for infection, and they were in a monogamous relationship at the time. It should be noted that these barriers are particularly salient for women, although the small number of women who responded to this question make generalizations difficult.

Fear also played a role in postponing an HIV test – fear of the test itself and fear of the discrimination that could accompany a positive diagnosis. One key informant spoke to this fear, stating, "I think in some ways even though we're an open-minded place in a very conservative zone, sometimes there's a real fear that there'll be kind of dramatic forms of backlash and, you know, even violence or risk-to-life that happen occasionally and so I think it creates an environment of fear even though there's sort of a quality of openness in the local community. I think it creates tension for people, being able to resolve those two."

Fear of discrimination, being unaware of improved HIV treatment and perception of low risk are barriers that frequently are mentioned in the research literature (Bravo et. al, 2010; Schwartz et. al, 2011). However, the perception of "low or no risk" appears to be particularly prevalent in low incidence states like Montana, indicating the need to address this barrier as a priority.

Other barriers to treatment and services appear to be connected with the poor economic status of people living in Montana with HIV. Poor economic status is directly related to uncertainty about how to pay for prevention and treatment services and how to pay for medications. One focus group participant said, "This is the last month I'm being covered [by private insurance]. I make $950 per month. My medication is twice that."

An additional barrier to access services is transportation. The lack of available medical transportation has proven to be a chronic problem in this state. About 30 percent of Ryan White clients have to drive a significant distance to see HIV medical providers. Even those living within city limits are forced to drive or find a ride because public transportation is frequently non-existent.

And finally, as in many rural areas, fear of lack of confidentiality was cited as a barrier to accessing services. The lack of anonymity in small rural communities in Montana was perceived to decrease the likelihood of confidentiality and increase the risk for discrimination. This was highlighted by one focus group participant who stated, "I always feel that I'm walking to the doctor's office, they've got the camera, I sign my name, okay it's recorded somewhere, ya know? So I mean it's kind of a joke on some of the confidentiality."

E. Data: Access, Sources, and Systems

a. Part C RSR data served as a valuable resource for Needs Assessment data. Ryan White case managers provided qualitative information, as did formal needs assessment narrative. Client input is received at client meetings and through HIV positive persons serving on the HPG. State quality performance measures were also used to identify testing issues.

CAREWare, and pharmacy claims data provide a picture of client level insurance coverage and treatment and care needs.

State disease surveillance data from MIDIS is used for Hepatitis C data.

The state HIV surveillance epidemiologist uses HARS data in the development of the HIV Care Continuum and the Annual HIV Report.

b. The Montana HIV Care Continuum took some time to develop. The HIV surveillance epidemiologist had to determine starting points (definitions of measures and their denominators). Researching the unmet need percentage, or out of care data involves correlation with several databases, and must be continually updated.

Ryan White case managers and the ADAP coordinator assist in the effort to clean data for who is in care or which clients had moved away. The state uses Lexus Nexus for addressing information.

Section II: Montana Integrated HIV Prevention and Care Plan

History of Integrated Planning in Montana

Montana proactively combined its HIV prevention and HIV treatment statewide planning groups in 2009. In addition, Montana took the initiative for the 2012-2016 plan to submit an integrated document in terms of HIV prevention and treatment. This move brought greater emphasis on finding persons not in care and getting them into treatment by focusing prevention funds on outreach to persons with unmet need. In 2011, the Montana Community Planning Group (before the name change to HIV Planning Group) began to formulate ideas to align its HIV prevention and treatment planning goals with the National HIV/AIDS Strategy.

The public planning body in Montana has also embraced the principles of High Impact Prevention. In 2016, the Montana HIV Planning Group collectively chose objectives to best meet current CDC goals.

The Montana STD/HIV/Hepatitis C Prevention Section within the state Department of Public Health and Human Services, and the Montana HIV Planning Group are united in their commitment to achieving the National HIV / AIDS Strategy goals within the next five years:

Reduce new HIV infections

Improve access to care and health outcomes for people living with HIV

Reduce HIV-related disparities

A. Montana Integrated HIV Prevention and Care Plan

Montana is supporting the theory that reducing some of life's barriers will, in turn, reduce conditions which can lead to disease transmission. Going forward, counseling and testing contractors will be spending more time making referrals to meet needs such as lack of insurance coverage, unstable housing, hunger, syringe services and harm reduction, substance abuse treatment and mental health counseling. Counseling will go beyond handing out condoms to helping people access life changing processes such as employment counseling and application to higher education.

Montana is committed to the concepts of CDC High Impact Prevention and holistic care to reduce health disparities and socio-economic injustice and has instilled these precepts throughout its 2017 – 2021 Integrated HIV Prevention and Treatment Plan. In doing so, Montana will expect to see improvement in the metrics of the Montana Continuum of Care.

2017 – 2021 National Prevention Goal #1: **Prevent new HIV infections**

Montana Goal 1.1: By 2021, increase awareness and knowledge of HIV transmission among target populations.

2017-2019 Objective: Office of Public Instruction (OPI) recommends all Montana schools implement CDC National Health Education Standards

Strategy: After 2016 election, work with newly elected Superintendent of Public Instruction to implement policy

2017-2019 Objective: Increase testing by 10% in target populations

Strategy: Increase number of contracts for RW Early Intervention Services (EIS) and increase number of new non healthcare testing sites.

Strategy: Implement RW EIS to complement HIV prevention counseling, testing and referral

Strategy: Implement CDC new guidance for Counseling and Testing in non-healthcare settings

2017-2019 Objective: Reduce Stage 3 HIV diagnosis by 25% by 2021

Strategy: Increase RW Part B Supplemental funds for EIS

2017-2019 Objective: Modify Montana law to exempt certified outreach workers in the drug paraphernalia law.

Strategy: HIV Prevention Group will lobby for change in law during 2017, 2019 and 2021 legislative sessions.

Timeframe	Responsible Parties	Activity	Target Populations	Data Indicators
By the end of 2019	University of Montana Community Health and Prevention Graduate program; MT Education Association; HPG members	Increase knowledge of transmission risk by engaging the Montana Office of Public Instruction (OPI) on ways to ensure state sexual health curricula is inclusive of LBGTQ students	Young LGTBQ+ (Sexual and gender minority youth)	OPI recommends all Montana schools implement CDC National Sexual Health Education Standards
2017 - 2019	Ryan White (RW) Part B Supplemental funds program	Increase outreach and testing of target populations in non-healthcare settings by 10%	MSM, young MSM, MSM/IDU	-Number of new contracts for RW Early Intervention Services (EIS) -Number of new non-healthcare testing sites
Annual Measure 2017 - 2019	Ryan White Part B program; EIS contractors	Implement Ryan White Early Intervention Services (EIS) to complement HIV prevention counseling, testing and referral services	MSM, young MSM, MSM/IDU	-Total number of PLWH newly identified at new EIS sites annually
Annual Measure 2017 - 2019	RW Part B supplemental funds program; EIS contractors	Through increased outreach, decrease the number/percentage of late stage diagnosis	MSM, MSM/IDU, HRH, IDU, Native American MSM and MSM/IDU	-Total number of PLWH newly identified by EIS contractors annually -Number of newly identified PLWH diagnosed with Stage 3 disease within three months of positive test
2017	Open AID Alliance (AIDS Service Organization) State STD/HIV/HCV Section	Develop HIV and hepatitis prevention plan after successful submission of Determination of Need to supply syringe services	HIV Positive IDU Negative IDU	Implementation of HIV and HepC prevention plan for provision of syringe services if needed

National Prevention Goal #1: **Prevent new HIV infections**

Montana Goal 1.2: **By 2021, increase Montana HIV Continuum of Care linkage to care measure to 95%.**

2017-2019 Objective: Increase Montana HIV Continuum of Care linkage to care measure to 95%

Strategy: Implement Early Intervention Services (EIS) for target populations to identify new positives and link them to care

Strategy: Implement new CDC testing guidance in non-healthcare settings.

2017-2019 Objective: Refer 100% of newly identified PLWH to Ryan White (RW) case managers

2017-2019 Objective: Increase linkage to HIV medical care for each high risk category of HIV+ Montanans to at least 85%

Strategy: Increase number of EIS and CTRS contractors

Timeframe	Responsible Parties	Activity	Target Populations	Data Indicators
By the end of 2019	RW Part B; EIS contractors	Implement Early Intervention Services (EIS) to increase identification of new positives and link them to care	MSM Young MSM MSM/IDU	-Number of PLWH newly identified by EIS contractors -Number of PLWH newly identified by EIS contractors who attended first medical appointment within three months of positive test
2017-2021	HIV Prevention Program; HIV prevention Counseling, Testing and Referral (CTR) contractors	Implement new CDC testing guidance in non-healthcare settings	MSM Young MSM MSM/IDU HRH IDU	-Number of PLWH newly identified by HIV prevention contractors -Number of PLWH newly identified by HIV prevention contractors who attended first medical appointment within three months of positive test
Annual measure 2017-2021	State HIV prevention and treatment programs EIS contractors; CTR contractors	Refer 100% of newly identified PLWH to Ryan White (RW) case managers	All newly identified PLWH	-Number of PLWH newly identified by state contractors referred to RW case management; -Number of PLWH newly identified by state contractors who completed Ryan White case management visit within two months
By the end of 2021	EIS contractors; HIV Prevention CTRS contractors	Increase linkage to HIV medical care for each high risk category of HIV+ Montanans to at least 85%	All newly identified PLWH	-Number of newly identified PLWA per risk category -Number of newly identified PLWH per risk category who attended their first medical

				appointment within 90 days.

CDC Prevention Goal #1: **Prevent new HIV infections**

Montana Goal 1.3: **By 2021, increase by ten percent the percentage of PLWH who have undetectable viral loads.**

2017-2019 Objective: Increase by 10%, the percentage of PLWH who have undetectable viral loads

Strategy: Implement Data to Care Program by 2018

Strategy: EIS and CTRS contractors and RW case managers will refer PLWH with adherence issues to substance abuse counseling or treatment

Timeframe	Responsible Parties	Activity	Target Populations	Data Indicator(s)
Annual measure 2017-2021	HIV surveillance program; RW Part B; RW medical case managers	Implement Data to Care Program by 2018 to decrease unmet need percentage	PLWH who know their status but are not in care	Annual Unmet Need percentage (number of prevalent population who are not in care divided by the total number of persons reported to be living with HIV in Montana)
Annual measure 2017-2019	Ryan White Part B supplemental funds manager; Early Intervention Services (EIS) contractors	Increase housing assistance referrals through EIS personnel	Unstably housed persons living with HIV	-Number of unstably housed PLWH who successfully accessed stable housing through EIS -Percent of stably housed Ryan White clients
Annual measure 2017-2021	EIS Contractors; RW case managers; HIV prevention CTRS contractors	Identify adherence issues on individual client level	PLWH with adherence issues	-Number of PLWH with adherence issues referred to substance abuse counseling or treatment -Number of PLWH with adherence issues referred to mental health counseling

National Prevention Goal #2: **Improve access to care and health outcomes for people living with HIV**

Montana Goal 2.1**: By 2021, increase the percent of Ryan White clients who are stably housed by 5%**

2017-2019 Objective: Increase the number of Ryan White and other HIV positive individuals who are permanently housed by 5% by the end of the grant period.

Strategy: Increase housing referrals through EIS personnel

Strategy: Increase availability of housing assistance

Strategy: RW case managers create care plans, including housing if appropriate, for all RW clients

Timeframe	Responsible Parties	Activity	Target Populations	Data Indicators
By the end of 2019	Ryan White Part B Program EIS contractors	Implement Early Intervention Services (EIS)	Unstably housed persons living with HIV	-Number of unstably housed PLWH who successfully accessed stable housing.
2017 - 2019	Ryan White Part B supplemental funds program	Increase availability of housing assistance	Unstably housed Montanans with HIV	-Number of EIS contracts awarded that include housing assistance -Number of EIS clients provided with housing assistance
Annual measure	RW Part B; RW case managers	RW case managers create care plans, including housing if appropriate, for all RW clients	Ryan White clients	-Percent of stably housed Ryan White clients -Number of PLWH with adherence issues provided with housing services

National Prevention Goal #2: **Improve access to care and health outcomes for people living with HIV**

Montana Goal 2.2**: Annually, all newly diagnosed PLWH are referred to Ryan White case managers**

2017-2021 Objective: All new identified PLWH referred to RW case manager

Strategy: Identify new positives through EIS or CTR contractors

Strategy: EIS and CTR personnel encourage attendance at first case management visit.

2017-2021 Objective: 90% of newly diagnosed PLWH have a care plan developed within 30 days of first case management visit

Strategy: Care plans developed for all newly diagnosed positives in a timely manner

Timeframe	Responsible Parties	Activity	Target Populations	Data Indicators
Annually	RW case managers; EIS contractors; HIV prevention CTR contractors	Refer all newly identified PLWH to Ryan White case manager	Newly identified through EIS or CTR contractors	-Annual number of PLWH newly identified by contractors -Number of newly identified referred to case management
Annually	RW case managers; EIS contractors; HIV prevention CTRS contractors	Ensure attendance at first case management visit	Newly identified through EIS or CTR contractors	-Annual number of PLWH newly identified annually by contractors -Number of newly identified who attended first case management visit within two weeks.
Annually	RW program; RW case managers	Care plans, including housing for all newly diagnosed HIV positive are developed in a timely manner	Newly diagnosed	90% of newly diagnosed PLWH have a care developed within 30 days of first case management visit

National Prevention Goal #3: **Reduce HIV-related disparities**

Montana Goal 3.1: **By 2021, increase HIV prevention services targeted to Native Americans.**

2017-2021 Objective: Award three Early Intervention Services contracts to tribal entities

Strategy: Directly award interested tribes for Early Intervention Services (EIS)

2017-2019: Increase testing of high priority individuals in Native American communities by 25%

Strategy: EIS contractors will increase outreach and referrals for at-risk Native Americans to social services and insurance purchase assistance

2019-2021 Objective: Increase testing of high priority individuals in Native American communities by 10%

Strategy: Increase number of EIS contractors on reservations

Strategy: EIS contractors will increase outreach and counseling and testing

Timeframe	Responsible Parties	Activity	Target Populations	Data Indicators
2017	RW Part B supplemental funds program	Directly award interested Native American tribal entities to perform Early Intervention Services (EIS)	Native American with HIV or at risk for acquiring HIV	-Number of Native American providers with EIS contracts
By the end of 2019	EIS contractors;	Increase testing of high priority individuals in Native American communities by 25% by the end of the EIS funding cycle	Native American MSM, IDU, MSM/IDU HRH	-Number of annual EIS testing events with reported AI race -Annual number of CDC-funded testing events with reported AI race
By the end of 2019	EIS contractors;	Increase outreach and referrals for at-risk Native Americans to social services and insurance purchase assistance	Native American MSM, IDU, MSM/IDU HRH	Number of successful referrals instituted through EIS
By the end of 2021	HIV prevention CTRS contractors	Increase testing of high priority individuals in Native American communities by 10% by the end of the funding cycle	Native American MSM, IDU, MSM/IDU/HRH	- Annual number of CTR events with reported AI race -Annual number of all testing events

B. Collaborations, Partnerships and Stakeholder Involvement

Community Planning in Montana

Montana is a sparsely-populated state of one million people scattered over 147,000 square miles. It is a low-incidence state in terms of HIV infection, reporting 595 persons with the disease living in Montana at the end of 2015, and averaging 20-22 new infections per year. The demographics of the state's epidemic have changed little over the decades: men who have sex with men and men who have sex with men and also inject drugs comprise 76 percent of new infections. Most Montanans classify their race as either non-Hispanic White (89.2%) or American Indian (6.6%). HIV disease demographics in the state closely mirror the general demographic composition of the state's population. *(population information from* *http://factfinder.census.gov/faces/nav/jsf/pages/community_facts.xhtml*

The Montana HIV Prevention Planning Group currently consists of four representatives of each targeted and prioritized population including persons living with HIV, men who have sex with men and representatives of the injecting drug community. Two additional communities included are four representatives of American Indians and tribal health, and service providers such as Ryan White case managers, community-based AIDS service organization representatives, and providers of housing, mental health services and harm reduction services. Members represent most geographic areas of the state.

Coordination and integration is innate in low-population areas where service organizations often perform multiple services. Local health departments frequently provide both HIV treatment and prevention services. Integration of STD, hepatitis and HIV services is common in Montana, as not only are local entities delivering integrated services, the prevention programs at the state health department are integrated as well. The STD/HIV/Hepatitis C Prevention Section administers the federally-funded programs for Hepatitis C, Ryan White Part B, HIV prevention, in addition to the STD Prevention program. Similarly, the state's planning group has integrated with HIV treatment, Hepatitis C and STDs.

A lesser-populated state with a corresponding limited number of providers not only necessitates that Montana entities deliver multiple services, but also leads to inherent collaboration and partnerships. Montana HIV program agencies routinely work together, as resources are too scarce to duplicate services.

HPG engagement plans include intentional collaboration with other community social services entities as well as tribal health and American Indian Health Services facilities.

a. Specific contributions of stakeholders and key partners

Collaborative partners include HPG consultation with a state substance program administrator. One successful HIV partnership endeavor led to prioritized entry for HIV-positive persons into the Montana State Chemical Dependency Center.
Another fruitful stakeholder partnership is the involvement of the Mountain West AIDS Education and Training Center (AETC) Tribal Bear Project.

Tribal BEAR Project

The Tribal BEAR Project is a program of the Mountain West AIDS Education and Training Center, funded through the Minority AIDS Initiative of the Ryan White Care Act. The project provides a broad spectrum of HIV/AIDS training to tribal health clinics and Native substance abuse treatent centers in Washington, Oregon, Montana, Idaho, Colorado, Utah, North and South Dakota, Wyoming and Alaska.

This program is geared exclusively toward HIV education of providers serving Native Americans in Montana, and gives a solid voice to HIV statewide planning. Specific contributions have been leadership for the Native American planning community, cultural sensitivity training, and presentations on historical trauma. Most recently, AETC personnel have drawn attention to a void in Indian Country of resources for STD and Hepatitis C epidemics.

While Native Americans with HIV in Montana are not disproportionately impacted by HIV, and have the same risks as the majority of cases in the state, Montana natives do suffer from high gonorrhea and Hepatitis C rates. (In 2015, there were about 1400 probable and confirmed HCV cases reported. 64% were among whites and 21% were among AI. AI comprise about 7% of the state population.)

The combination of STD impact with the socio-economic disadvantages of many reservation areas is cause for concern. The Native Americans serving on the HPG bring trepidations such as these to the forefront. Their contribution has led to the use of new Ryan White funds to make Early Intervention Services (outreach, counseling, testing and referral, and navigation through the health care system) easily available to tribal entities.

The main AETC program for the state is also represented in the public planning body. This collaboration allows HPG members to receive immediate feedback when questions on specific past provider trainings and possibilities for new trainings are brought forth.

An HIV prevention contractor that has connections with many corrections facilities throughout the state serves on the HPG. This indigenous IDU outreach worker conducts HIV and hepatitis C

trainings for both corrections staff and inmates. The contractor's perspective and past experience allows the planning body great insight to IDU and corrections issues.

Ryan White case managers serving on the HPG allow planning body members to understand client needs and medical issues. These medical case managers are also the contact persons for accessing care through the Veterans Administration.
The HIV surveillance epidemiologist presents updated HIV and hepatitis C epi-data at every HPG meeting, which provides the information needed for prioritizing target populations. The HIV surveillance coordinator aggregates risk factors and demographic information for planning purposes. This coordinator develops the HIV Epi Profile and also generates the Montana HIV Continuum of Care which the planning group uses to set objectives.

Because STD infection can be a precursor to HIV infection, the state STD Prevention Coordinator provides consultation on STD rates and brings specific epidemiologic concerns to HPG meetings. Input from HPG members who perform partner service for STD contact tracing is used to remind members of the complete interventions package available to interrupt disease transmission and to provide anecdotal information on human behavior.

At least one Ryan White Part C representative is present at every planning meeting. Montana has two Part C grantees and both are also Ryan White Part B contractors. These two federally qualified health centers are also promoting and prescribing PrEP.

HIV prevention providers are at the Montana prevention planning table. Examples are AIDS Service Organizations, a community based organization with a mission to keep gay men safe and healthy, local health department partner service providers and counseling and testing providers. Each provides insight from the field.

AIDS housing providers are usually present at HPG meetings. They have notified planning body members of their financial need to establish waiting lists for short term and transitional housing near the end of almost every fiscal year. This concern prompted new Ryan White funds to be allocated to fill this service gap.

The Ryan White Part B/AIDS Drug Assistance Program (ADAP) Coordinator attends HPG meeting as the treatment consultant. This regular attendance allows immediate recognition of concerns such as the housing waiting lists. This prompt recognition led to a timely response.

A behavioral scientist has served as the HPG evaluator since the inception of the Montana public planning body. Her historical perspective and experience as an evaluator, as well as her insight as a member of the LGTB community, provides valuable continuity. Not mired in history, the evaluator researches new ideas about human behavior, and aids the group to understand new prevention concepts and meet CDC requirements.

b. Stakeholders and partners needed to help improve outcomes along Care Continuum

The identification of stakeholders not currently engaged has evolved over the past years. The HIV Planning Group (HPG) and the HIV Prevention staff have long considered those that could be partners in HIV prevention whether it is an occasional or long-term engagement process, and although the list is not long, it is significant.

- Montana Office of Public Instruction (Department of Education)
- Montana School Board Association
- Medicaid
- Private providers
- Infectious disease physicians
- Montana Medical Association
- Montana Primary Care Association
- Montana Nurses Association
- Urban Indian Clinics
- Montana Board of Pharmacy
- Montana Mental Health Association
- Tribal Substance Abuse treatment facilities

Montana has, for one of its objectives to increase awareness, a plan to engage the Montana state Office of Public Instruction (OPI) to meet the objective of OPI recommending that all Montana schools adopt CDC National Sexual Education Standards.

While Medicaid is on the above list, some collaboration does occur at state program levels. The ADAP coordinator has a Medicaid liaison who shares data on Medicaid medication and medical care outlays for HIV positive persons. The state medical director for public health and the state Department of Public Health STD/HIV/Hepatitis Prevention Section are working together to loosen restrictions on Hepatitis C treatment in Medicaid and in the state Department of Corrections. The section supervisor successfully appealed to the Medicaid Drug Utilization Review board to allow the provision of Truvada in the absence of an HIV diagnosis code in an effort to support PrEP.

Together with a state Family Planning administrator, the Chief of the Communicable Disease Bureau, which houses the STD/HIV/Hepatitis Prevention Section, met with the state Board of Pharmacy requesting that EPT be allowed in all medical facilities, not just STD clinics. To date, that request has not been enacted upon.

c. **Letter of concurrence to the goals and objectives of the Integrated Plan**. See Appendix B.

C. People Living with HIV and Community Engagement

a. The Montana HIV Prevention Planning Group consists of 20 public members who represent five different communities of four members each:

HIV positive persons
Men who have sex with men
Persons who inject drugs
Native Americans
Service providers of the above populations

The first three communities on the list above represent the Montana target populations in order of the prioritization given by the HPG. Men who have sex with men (MSM) and MSM/IDU combined risk comprise the majority of the state's epidemic (72% of all males and 61% of all cases reported over the last five years). 17 of 18 persons newly diagnosed with HIV/AIDS in Montana in 2015 were male.

Persons who inject drugs and high risk heterosexuals comprise a considerably smaller percentage of the prevalent (each comprise 12% of all cases in the last five years). Women represent 15 percent of those living with HIV in Montana.

The vast majority of Montanans are white and its largest minority is Native American (6.6%). Most HIV infections reported in the state continue to be non-Hispanic White males with MSM and MSM/IDU risk. While American Indian (AI) HIV positive persons follow the same risk patterns as their white counterparts, the HPG has given natives a special place at the planning table because of their extreme socio-economic disadvantages and disparate rates of STD, especially gonorrhea.

b. Both male and female members of the HIV positive population participate in the public planning process. They provide input on stigma, access to medical care and insurance access, financial burdens, and other life experiences related to living with HIV.

c. Representatives of men who have sex with men provide HPG members with information about sexual risk taking, experience with stigma and suggest target areas for prevention intervention. Members of the IDU community share personal experiences and provide an understanding of chemical dependency.

d. The HPG recruits and selects its own members from the prioritized populations through a self-declared risk applicant pool. Members govern through bylaws created by themselves. Leadership is comprised of three community co-chairs who serve in a progressive line over three years: co-chair elect, current co-chair, and immediate past co-chair. Members not elected to leadership roles also serve three year terms.

All of the above members are encouraged to, and indeed, do participate actively, during HPG meetings. In 2016 over the course of three meetings, members developed the Montana Integrated Treatment and Care Plan goals and objectives, and selected state-appropriate prevention activities. Their candid conversations in addition to the input gleaned from client participation in the Statewide Coordinated Statement of Need meetings assure the state that prioritized needs are being met.

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Section III. Monitoring and Improvement

a. Plan Updates for planning body members

Measures listed in the statewide plan are updated and presented at an HPG meeting every one to two years. State staff gather the data for the measures and prepare a presentation, allowing time for discussion. HPG member input is taken surrounding progress on measures. Explanations for both positive and negative results are discussed.

b. Monitoring and evaluating activities related to objectives

Every one to two years, state HIV treatment, prevention and epi staff collect and analyze the data used to monitor progress in meeting plan objectives. Reviewing the data as a group ensures that the proper data was used regarding timeframes, demographics, etc. Staff compare new outcome measurement result with previous data measurements and monitor for outlying results. Adjustments in data collection methods or sources are made as deemed desirable.

c. Describe use of surveillance and program data to assess and improve health outcomes as related to HIV Care Continuum

In terms of treatment, Montana evaluation plan questions begin with asking if this activity will positively impact the measures in the Care Continuum. Will increased outreach and the implementation of updated guidelines on non-health care setting counseling and testing increase our sero-positivity rate? Will referring all newly identified positive persons to a Ryan White case manager within two weeks of identification increase linkage to care? Will the new Early Intervention Services increase the percentage of stably housed persons with HIV who have adherence problems?

In terms of prevention, will new Early Intervention Services allow more persons to access PrEP and/or insurance? Will users of injection drugs be tested for hepatitis and referred to syringe services? Will more frequent STD and HIV screening for persons infected with syphilis in the last year either prevent or catch early HIV disease?

The Evaluation Plan includes increasing the sero-positivity rate, and monitoring the outcomes within the Care Continuum for improvement and flattening of the cascade.

Other evaluation measures include successful development of an HIV and hepatitis prevention plan; the number of persons successfully accessing syringe services, and an increase in the number of HIV positive Native Americans receiving housing services.

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