MONTANA INTEGRATED HIV PREVENTION AND CARE PLAN AND THE STATEWIDE COORDINATED STATEMENT OF NEED

2022-2026

Prepared by

HIV/STD/Hepatitis Prevention Section, Montana Department of Public Health and Human Services and Montana HIV Planning Group

Acronyms

ADAP	AIDS Drug Assistance Programs
ADR	AIDS Drug Assistance Program Data Report
AETC	AIDS Education and Training Center
AIAN	American Indian Alaskan Native
AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
CBO	Community Based Organization
CDC	Centers for Disease Control and Prevention
CDEpi	Communicable Disease Epidemiology
CQM	Clinical Quality Management
DIS	Disease Intervention Specialists
DPHHS	Department of Public Health and Human Services
ECHO	Extension for Community Healthcare Outcomes
eHARS	Electronic HIV/AIDS Reporting System
EIS	Early Intervention Services
ELR	Electronic lab reporting
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Centers
HCV	Hepatitis C
HIV	Human Immunodeficiency Virus
HOPWA	Housing Opportunities for Persons with AIDS
HRH	High Risk Heterosexual
HRSA	Health Resources and Services Administration
IHS	Indian Health Services
IRB	Institutional Review Board
LHJ	Local Health Jurisdictions
MCA	Montana Code Annotated
MIDIS	Montana Infectious Disease Information System
MSM	Men who have sex with men
PBM	Prescription Benefit Management
PEP	Post-Exposure Prophylaxis
PrEP	Pre-Exposure Prophylaxis
PWID	People who Inject Drugs
RW	Ryan White
RWHAP	Ryan White HIV/AIDS Program
RSR	Ryan White Services Report
SAMHSA	Substance Abuse and Mental Health Services Administration
SCSN	Statewide Coordinated Statement of Need
SDOH	Social Determinants of Health
SGRX	ScriptGuideRX
SOR	State Opioid Response
STI	Sexually Transmitted Infections

MONTANA INTEGRATED HIV AND CARE PLAN

Table of Contents

Acknowledgements

Completing this inclusive plan could not have been possible without the participation and assistance of the Montana HIV Planning Group (HPG), the Rural Institute for Inclusive Communities within the University of Montana, and the Montana Department of Public Health and Human Services. Their continued commitment, expertise, and involvement in HIV care and prevention to ensure a better quality of life for people living with HIV and AIDS in Montana are unmatched.

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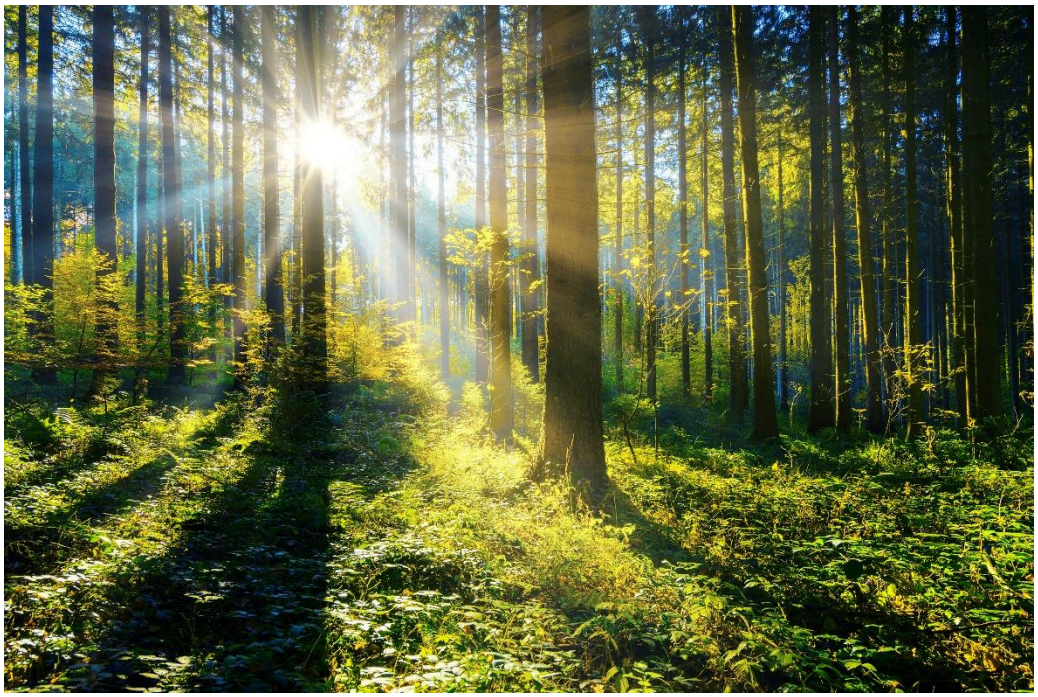
Our overarching target is to decrease new HIV diagnoses to 10 by the end of 2026



SECTION 1- Executive Summary of Integrated Plan and the Statewide Coordinated Statement of Need (SCSN)

This Integrated Plan builds on the first iteration of Montana's 2017-2021 Integrated Plan, and advances HIV prevention and treatment during 2023-2026. The plan fulfills a funding requirement of the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA), as well meeting the federal requirement regarding HIV prevention and care planning activities and the Statewide Coordinated Statement of Need (SCSN), a legislative requirement for grantees of the Ryan White HIV/AIDS Program.

Throughout this strategic plan, we have strived to center the work and voices of those affected by human immunodeficiency virus (HIV), hepatitis C virus (HCV), and sexually transmitted infections (STIs) in Montana. Our overarching target is to decrease new HIV diagnoses to 10 by the end of 2026. Stakeholders were given the opportunity to comment, provide feedback, and share recommendations on ending the epidemic through a series of community forums and survey.

The HIV Integrated Plan for the state of Montana is divided into six sections, including the executive summary.

- Section II discusses how we engaged and included community members throughout the integrated planning process.
- Section III describes our data sharing agreements, a five-year epidemiological snapshot, resource funding inventory, and the needs assessment results.
- Section IV dives deeper into the situational analysis of HIV prevention and care within Montana. This section discussed strengths, weaknesses, gaps, and priority populations. It also includes a breakdown of the four pillars: Diagnose, Treat, Prevent, and Respond.
- Section V is the section that outlines the eight goals and the 30 objectives based on the information found within the Needs Assessment and the feedback from Montana HIV Planning Group (HPG).
- Lastly, section VI of the plan discusses how Montana will implement and monitor elements of the plan. The Montana HIV Integrated plan is a living document that will be modified and improved over the course of the plan. The responsibility to implement, monitor, and improve the plan is shared by the HPG, Montana DPHHS, and the Ryan White Program recipients. The plan will be reviewed annually.

New HIV diagnoses have remained stable from 2015 to 2021 with an average of 22 cases per year. The Montana rate of new HIV diagnoses has been maintained at 3.3 per 100,000 people…

SECTION 2- Community Engagement and Planning Process

Jurisdictional Planning Process

Montana has a low prevalence of HIV as compared to other parts of the nation. New HIV diagnoses have remained stable from 2015 to 2021 with an average of 22 new cases per year. The Montana rate of new HIV diagnoses has been maintained at 3.3 per 100,000 people, while the United State rate was 12.6 per 100,000 people. Because Montana is a low morbidity state, the jurisdictions and state department can work diligently together on new HIV diagnoses and partner services. These factors guided our planning process and the needs assessment, as well as provide a promising framework to end the HIV epidemic in Montana. Planning and the assessment for the second integrated plan began in 2021 and has continued throughout 2022.

Key to the planning process has been the Montana HIV Planning Group (HPG), Clinical Quality Management (CQM) Group, representatives from agencies receiving Ryan White funding, community partners, disease intervention specialists (DIS), people living with HIV (PLWH), Ryan White clients, and populations that have been placed at higher risk of HIV.

Entities Involved in Process:

HIV Planning Group

One of the most significant driving forces for ending the epidemic in Montana is the HPG. This group consists of 10 individuals from each targeted and prioritized population, including persons living with HIV, men who have sex with men (MSM), persons who inject drugs (PWID), and American Indian and tribal health community representatives. Additionally, the HPG has a variety of representatives providing healthcare and other services to PLWH or vulnerable to HIV, including Ryan White (RW) case managers, a mental health therapist providing care to the LGBTQ+ youth and adults, a DIS, harm reduction services, and an AIDS Education and Training Center (AETC) program coordinator.

Many HPG members represent multiple populations, geographic areas, and service providers. A representative from the Rocky Boy Tribal Health Center provides HIV care and prevention services, representing not only our tribal partners but also a rural part of the state, which is located hours away from specialty care. In addition to rural and tribal representatives, there are members representing the south-central region of the state and the largest city, Billings, who are Ryan White case managers and the AETC program coordinator at Riverstone Health. Riverstone Health is a health jurisdiction that includes a local health department and a federally qualified health center, which offers HIV care and treatment to a large percentage of PLWH in Montana. Additionally, Riverstone Health provides HIV testing and counseling, a harm reduction program, and a syringe services program. Representing the north-western region of the state, a clinical social worker working with LGBTQ+ youth and adults is a member of HPG. Lastly, one HPG member is a disease intervention specialist (DIS) in one of the fastest-growing western cities in Montana, Missoula. The DIS conducts communicable disease investigations and interventions for their population. Each member is vital to providing expertise and input to Montana's efforts to support PLWH and efforts to eradicate HIV in Montana.

The group is governed through bylaws voted on by the membership. Leadership is comprised of three community co-chairs who serve in a progressive line: co-chair elect, current co-chair, and immediate past co-chair. To maintain continuity, each member agrees to serve a minimum of three years, though many have served much longer. Starting in 2009, HPG has met in person twice per year, with exception of 2020-21 due to the COVID-19 Pandemic. The goal of HPG meetings is collaboration to make a collective impact in improving access to care and health outcomes for people living with HIV, reducing HIV transmission and health disparities. HPG meetings feature presentations on the state HIV epidemic, HIV prevention, medical and non-medical service delivery for PLWH, as well as any special projects. Participants provide input about gaps, barriers, and disparities in HIV prevention and treatment services, and recommendations for strategies to address identified disparities and gaps through facilitated discussions. In addition to bi-annual HPG in-person meetings, HPG participated in monthly virtual workshops to collaborate in writing the 2022-2026 Integrated HIV Plan.

The goal of HPG meetings is collaboration to make a collective impact in improving access to care and health outcomes for people living with HIV, reducing HIV transmission and health disparities

Clinical Quality Management Workgroup

The Ryan White Clinical Quality Management (CQM) workgroup meets regularly to provide input and feedback on the clinical quality of the Montana Ryan White Program. The HIV Treatment goals in the HIV Integrated Plan were based on the input and feedback of the CQM. The workgroup includes three Ryan White clients, four Ryan White medical case managers, and one Ryan White non-medical case manager.

University of Montana

The University of Montana completed on the HIV and Viral Hepatitis Needs Assessment, which was utilized in setting strategies and goals in the HIV Integrated Plan. The following groups were included in the needs assessment process: PLWH, persons testing positive for hepatitis C, licensed healthcare providers (MD, DO, NP, PA), and DIS. Focused interviews and surveys were completed by people working in healthcare, public health, community-based organizations focused on HIV prevention and/or treatment, entities that provide HIV/HCV-related education, testing, and treatment, and tribal or county health departments.

Evidence suggests that RWHAP assistance is linked with increased retention in care, greater receipt of antiretroviral therapy, and improved viral suppression

Role of the RWHAP Part B Planning Council

The RWHAP Part B Planning Council provided fundamental data and information regarding the welfare of people living with HIV in Montana. Evidence suggests that RWHAP assistance is linked with increased retention in care, greater receipt of antiretroviral therapy, and improved viral suppression (Diepstra et al., 2017). As such, Montana clients served by the RWHAP have been shown to have better HIV-related health outcomes compared to people living in Montana with HIV who do not receive services through RWHAP.

Collaboration with RWHAP Parts

Montana has two Part C grantees which are also Ryan White Part B subrecipients. A Ryan White Part C representative is present at every planning meeting. The RWHAP Part B contractors assisted in developing the resource inventory, situational analysis, and creating the treatment and prevention goals. They provided information on client's HIV care service utilization, prevention gaps and strengths, clients who have been lost to follow-up, and new client's CD4 count and viral load results.

Qualitative data from RWHAP clients collected through the annual satisfaction survey was utilized in the creation of the integrated plan. Our approach throughout the plan was guided by client and case manager feedback about services provided and barriers clients experience.

Engagement of People with HIV

Montana's engaged PLWH through each stage of the planning process, as well as through surveys, HPG meetings and CQM meetings. Both groups assisted in developing the goals and objectives and provided feedback about both successes and challenges their region has experienced in HIV prevention and treatment.

Over the last five years, Montana's top three populations with the highest new HIV diagnoses were MSM, MSM/PWID, and PWID. Based on this data, both HPG and CQM focus on recruiting their members from these populations. The HPG recruits and selects its members from the prioritized populations through a self-nomination and declaration.

RWHAP clients that serve on the CQM workgroup committee agree to serve a minimum of two years. Clients provide vital input as they receive Ryan White services in Montana. During each quarterly meeting, they give constructive feedback to case managers and DPHHS to help identify areas of improvement.

There is no maximum term limit for both workgroups. If a member has a desire and is an active participant, they can serve longer than the minimum term. Having term minimums has helped attract active and involved community members who cannot make a long-term commitment to an organization. Our term minimums also allow for new fresh ideas and ensure more people with real-world experience from all walks of life have an opportunity to share their insights on living with HIV in Montana, including risk behavior, testing, treatment, and stigma.

Priorities

To end the HIV epidemic, Montana will focus on early diagnosis, linkage to care and treatment for PLWH, prevention of new cases of HIV, and responding to outbreaks or clusters. Early diagnosis is critical to identify and link individuals to HIV treatment and care to reduce the risk of further transmission. Montana will prioritize increasing linkages and access to HIV care and treatment for all Montanans. Due to the geography and population of Montana, many rural residents do not have access to care nearby. To increase access, Montana will improve access to HIV care through telehealth, increased training opportunities for healthcare providers, and Ryan White services. Additionally, Montana will collaborate with partners to prevent future cases of HIV by increasing access to PrEP, increase PrEP utilization through education of priority populations vulnerable to HIV transmission, and provide training to the public health workforce to increase HIV screening. To improve response to HIV outbreaks and clusters and prevent further transmission, Montana will focus on increasing the capacity of local and tribal public health departments to conduct comprehensive HIV investigations.

Priority populations include those most vulnerable to HIV in Montana, which include gay, bisexual, and other men who have sex with men, particularly adolescents and young adults aged 13-24; people who inject drugs, and men who have sex with men and inject drugs.

Priorities revolve around ensuring that providers receive more project ECHO trainings and additional educational training on PrEP, HIV testing, and linkage to care through AETC resources.

Appendix A is a letter of concurrence for the Integrated Plan signed by the Co-Chairs of the HPG and a representative from the Ryan White HIV/AIDS Program (RWHAP) Part B Planning Council.

Section 3: Contributing Data Sets and Assessments

Data Sharing and Use

The Montana Public Health and Human Services, Communicable Disease Control rules define the process of reporting diseases and follow through with confirmed cases. The department works with the Centers for Disease Control and Prevention and federal sources to measure and specify control measures for communicable diseases. Although, Montana is a decentralized state, and each tribe and county operate as its own jurisdiction. State laws still requires each jurisdiction to share data with the state regarding specific reportable diseases including HIV and hepatitis (Administrative Rules of Montana, 2022). One method of sharing data includes the electronic lab reporting system, Montana Infectious Disease Information System (MIDIS) that stores HIV test results (Viral Load/CD4 count).

The HIV Treatment program has data sharing agreements with its six contractors for contiguous treatment. This agreement is used for ADAP and the Ryan White program through CAREWare, a free, scalable software program provided by HRSA. CAREWare is used to track ADAP services to generate two federal reports, the Ryan White Services Report (RSR) and the AIDS Drug Assistance Program Data Report (ADR). All data about ADAP, such as prescriptions and insurance, comes from the Prescription Benefit Management (PBM) company, ScriptGuideRx (SGRX). Each of the two-Part C's also utilizes CAREWare for managing and monitoring HIV clinical and supportive care. CAREWare and pharmacy claims data provide a picture of client-level insurance coverage, treatment, and care needs.

The HIV Prevention program also has data sharing agreements in place with each of its nine contractors and four additional testing sites whom the program provides tests and controls for. Each of these 13 sites enter data directly into Evaluation Web in addition to the data they share monthly and annually with the program. The purpose of these data sharing agreements is to gather information needed for HIV Prevention reporting including test numbers, condom distribution, PrEP and Post-Exposure Prophylaxis (PEP) referrals, and social media reach. The information helps the program determine areas of the state that need additional HIV Prevention services.

The state HIV surveillance epidemiologist uses the CDC electronic HIV/AIDS Reporting System (eHARS) data to maintain and update the HIV Care Continuum and the Annual HIV Report. The epidemiologist and subject matter experts use MIDIS to collaborate with local health jurisdictions on investigations and labs for the reported disease. The HIV Surveillance Program systematically collects, analyzes, interprets, and disseminates data to characterize trends in infection, detect active transmission, analyze care and viral suppression, and implement public health interventions.

Epidemiologic Snapshot

State Demographic Data

Montana is the fourth largest state geographically in the United States (U.S.) covering ~147,028 square miles, with a population of ~1,080,577. Of the 56 counties, the smallest has a population of approximately 500 (Petroleum County) and the largest county has a population approximately 167,000 (Yellowstone County). Montana is also home to 8 sovereign tribal nations and American Indians make up about 7% of the total population. Montana's overall population has been steadily increasing.

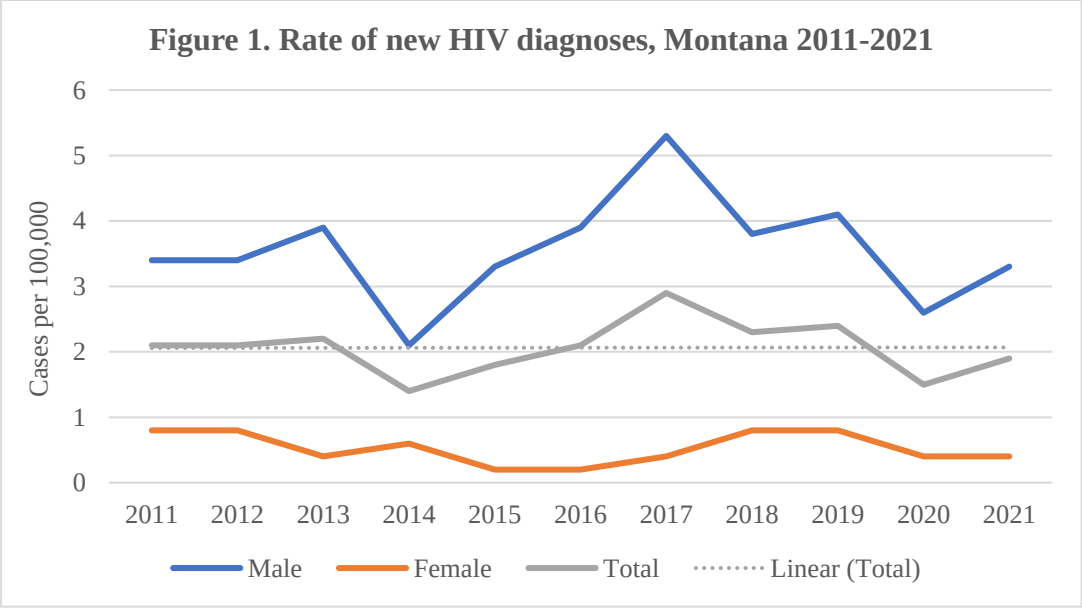
Montana's gender distribution is 50% male (544,101) and 50% female (536,476). Like other western states, Montana has an aging population. Between 2011-2020, Montana experienced its biggest population growth between the ages of 65-69 (1.88%) and 70-74 (1.73%), and its biggest decline between the ages of 45-49 (-1.31%) and 50-54 (-2.33%).

Current Epidemiologic Profile

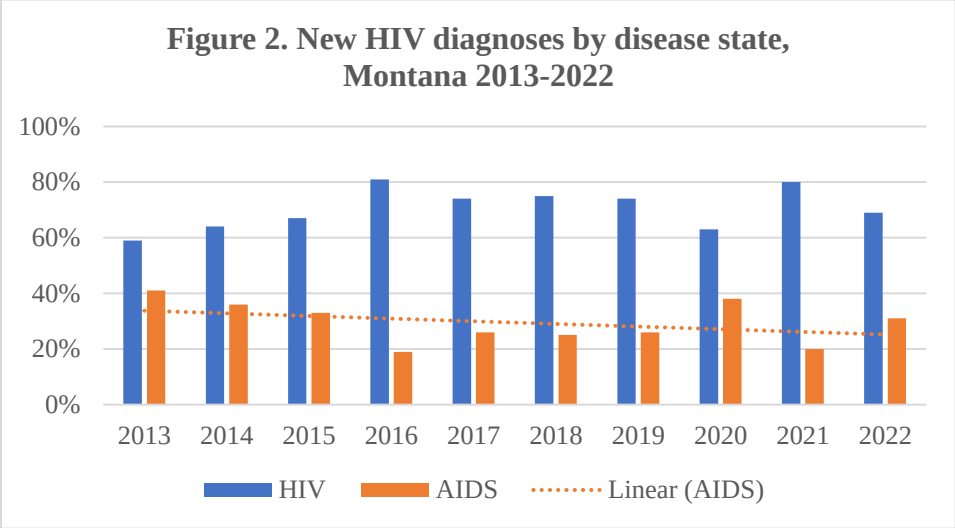
The HIV Surveillance Program has completed the HIV/STI Epi profile for the 2017-2021 period. This report includes HIV/STI epidemiology, trends, and vulnerable populations. Categories are often a small number of events and should be interpreted with caution.

Persons Newly Diagnosed with HIV

Montana is a low-morbidity state in terms of new HIV diagnoses. While the US rate of new HIV diagnoses decreased by 8% in 2019, the rate in Montana has remained stable for the past 10 years as shown by the trend line in Figure 1.



The percent of persons with AIDS at the time of diagnosis in Montana has steadily declined since 2013 (Figure 2). However, in 2020, there was a significant increase in the number of late HIV diagnoses (defined as a person whose disease has progressed to AIDS at the time of diagnosis). The number of late diagnoses declined in 2021, continuing the overall downward trend line between 2013 and 2021.



Persons newly diagnosed with HIV/AIDS in Montana are not representative of the statewide demographics. Table 1 shows that most new diagnoses in 2021 were male (90%) and those who reported as white (80%). This greatly exceeds the percentage of Montana residents that are male (50%). Unlike other diseases such as chlamydia and Hepatitis C, HIV is not over-represented in the American Indian population. In contrast, approximately 7% of Montana's population is American Indian, and only 5% of people newly diagnosed with HIV in 2021 were American Indian.

Table 1. New HIV diagnoses by gender, race/ethnicity, Montana 2021

New HIV diagnoses by gender, Montana 2021		
Male	18	90%
Female	2	10%
Total	**20**	**100%**
New HIV diagnoses by race/ethnicity, Montana 2021		
American Indian	1	5%
White	16	80%
Multi-race	1	5%
Other	1	5%
Hispanic, all races	1	5%
Total	**20**	**100%**

When a person becomes diagnosed with HIV, they may qualify for RWHAP B or C services. The qualifications to receive these services includes the client having a diagnosis of HIV/AIDs, having a household income which does not exceed 500% of the Federal Poverty Level (FPL), live in Montana, and provide proof of insurance coverage. Of the 20 people who were diagnosed with HIV in 2021, 10 became RW clients.

Table 2 summarizes the ages and transmission risk for new diagnoses in 2021. Sixty percent of new diagnoses in 2021 were in the 25–34-year age group and most cases reported MSM as the transmission risk factor (70%).

Table 2. New HIV diagnoses by age and transmission risk category, Montana 2021

New HIV diagnoses by age, Montana 2021						
Age	**Male**		**Female**		**Total**	
<13	0	0%	0	0%	0	0%
13-14	0	0%	0	0%	0	0%
15-24	5	28%	0	0%	5	25%
25-34	6	33%	1	50%	7	35%
36-44	2	11%	0	0%	2	10%
45-54	2	11%	1	50%	3	15%
55-64	3	17%	0	0%	3	15%
>=65	0	0%	0	0%	0	0%
Total	**18**	100%	**2**	100%	**20**	**105%**
New HIV diagnoses by transmission risk, Montana 2021						
Risk Factor	**Male**		**Female**		**Total**	
MSM	14	78%	0	0%	14	70%
PWID	1	6%	1	50%	2	10%
MSM/PWID	0	0%	0	0%	0	0%
High-risk heterosexual (HRH)	0	0%	1	50%	1	5%
No reported risk	3	17%	0	0%	3	15%
Total	**18**	**100%**	**2**	**100%**	**20**	**100%**

Of the 20 people who were diagnosed with HIV in 2021, 10 became Ryan White clients

Most new HIV diagnoses in Montana are in the most populous parts of the state (Figure 3). Five counties made up nearly 70% of all new diagnoses.

- Yellowstone county = 22%
- Missoula county = 18%
- Gallatin county = 11%
- Cascade county = 10%
- Flathead county = 8%

Figure 3. New diagnosed HIV/AIDS cases by county, Montana 2013-2021

Persons Diagnosed with HIV- Linkage to Care

Montana defines timely linkage to care as the percentage of people newly diagnosed with HIV who receive a CD4 or viral load laboratory test within 30 days of diagnosis. Table 3 shows that 87.5% of persons newly diagnosed in 2020 had a CD4 test within 30 days. The percentage of persons with a viral load test within 30 days of diagnosis was higher at 93.8%. Both measures exceed the CDC benchmark that 85% of persons receive HIV care within 30 days of diagnosis.

Table 3. Percent of newly diagnosed HIV cases with a CD4 or viral load test within 30 days of diagnosis, Montana 2018-2020

Year	CD4	Viral load
2018	83.3%	87.5%
2019	71.4%	82.2%
2020	87.5%	93.8%

Persons living with HIV/AIDS (PLWH)

In 2021, there were approximately 800 persons living with HIV in Montana (PLWH) shown in Table 4. Of note, the percentage of PLWH who report PWID as a transmission risk are more likely to currently have AIDS (60%) than any other risk group, particularly when compared to MSM (49%). Furthermore, American Indians are more likely to be living with AIDS (65%) compared to the entire cohort (51%).

Table 4. People living with HIV, by select demographics, Montana, 2021

Characteristic	HIV	%	AIDS	%	Total
Sex					
Male	336	49%	351	51%	687
Female	60	53%	53	47%	113
Mode of Exposure					
MSM	225	51%	216	49%	441
PWID	19	40%	29	60%	48
MSM&PWID	45	46%	52	54%	97
HRH	13	46%	15	54%	28
Other*/Risk Not Specified	34	47%	39	53%	73
Age					
Less than 13	0	0%	2	100%	2
13-24	7	70%	3	30%	10
25-34	91	83%	19	17%	110
35-44	115	70%	50	30%	165
45-54	75	42%	104	58%	179
Over 55	106	32%	225	68%	331
Race					
White	313	49%	327	51%	640
American Indian	12	35%	22	65%	34
Hispanic, any race	38	69%	17	31%	55
Other	31	46%	37	54%	68
Total	394	49%	403	51%	797

*Transfusion/transplant, Perinatal transmission, Hemophilia

Frequency missing = 3

Equivalent to national data, the average age of PLWH is older than persons newly diagnosed with HIV (Table 5).

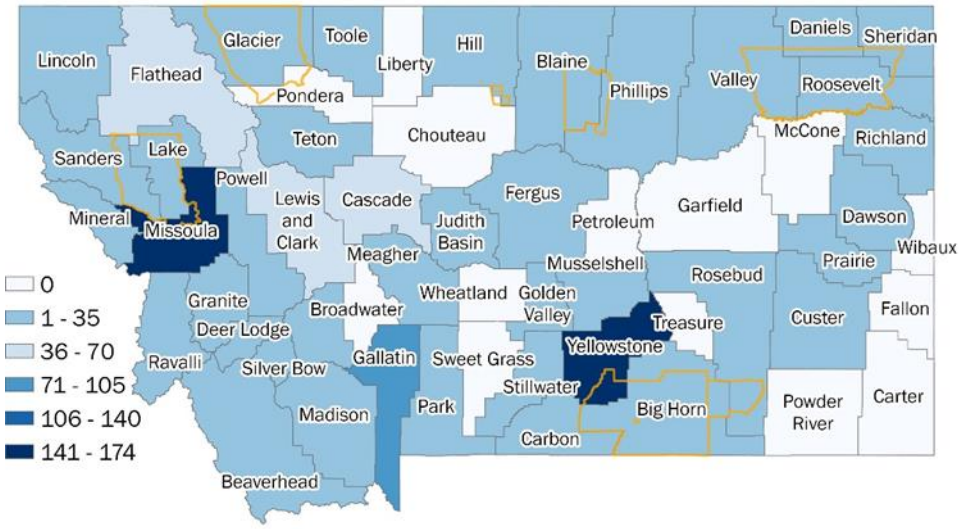
In 2021, 85% of PLWH were 35 and older, while most persons with new HIV diagnoses in the 2018 to 2021 duration were under age 35 (56%). Due to the small number of events, data for new HIV diagnoses is shown in an aggregate form.

Table 5. Percent of new HIV diagnoses and PLWH, by age category, Montana

	New HIV Diagnoses 2018-2021	PLWH 2021
<13	0%	0%
13-24	18%	1%
25-34	38%	14%
35-44	20%	21%
45-54	13%	22%
55 and over	11%	42%
Total	100%	100%

Figure 4 below shows the number of persons living with HIV by county. As the most populous counties, Yellowstone, Gallatin, and Missoula have the largest number of PLWH in residence. These counties also have the largest number of infectious disease providers.

Figure 4. People living with HIV by county, Montana 2021



Persons who are Unaware of their HIV Status

At this time, Montana DPHHS cannot accurately track data on individuals who are unaware of their HIV status as our statute and administrative rules do not require reporting on negative test results.

HIV Continuum of Care

As of December 31, 2021, about 800 persons were living with HIV in Montana (PLWH). Of those, lab data indicates that 82% were in care that same year (defined as having at least one HIV-related lab in the previous 12 months (Table 6). This exceeds the percentage of PLWH receiving care in the United States (66%). In addition, the rate of PLWH in Montana who were virally suppressed in 2021 is higher when compared to national data (76% vs. 57%).

There was a decrease in the percentage of PLWH in Montana who were virally suppressed between 2019 to 2021. This may result from delayed medical usage and laboratory testing during the COVID-19 pandemic. The number of HIV labs reported to DPHHS decreased during 2020-2021.

Table 6. Continuum of care, Montana, 2019-2021

	2019		2020		2021	
PLWH in MT	728		731		801	
PLWH in care	615	84%	600	82%	659	82%
PLWH who are virally suppressed (VL <200 copies)	579	80%	536	73%	609	76%

However, when looking at those in care who are virally suppressed, the benefits of being linked to care are evident. In 2021, of those program participants who were in care, 92% achieved viral suppression and were no longer able to transmit HIV through sexual contact (Table 7).

Table 7. Continuum of care, persons in care who are virally suppressed, Montana, 2019-2021

	2019		2020		2021	
PLWH in care	615		600		659	
PLWH in care who are virally suppressed (VL ≤200 copies)	579	94%	536	89%	609	92%

The Montana continuum of care differs when comparing PLWH reporting specific transmission risks (Table 8 and Figure 7). Persons who report as MSM most often report being in care (92%) when compared to the total PLWH (82%) and PWID (87%). Persons who inject drugs have the lowest levels of viral suppression (72%).

Table 8. Continuum of care by transmission risk category, Montana, 2021

	All		MSM		PWID	
PLHW in risk category	801		403		78	
PLWH in care	659	82%	372	92%	68	87%
PLWH who are virally suppressed (VL <200 copies)	609	76%	309	77%	49	72%

Priority Populations

While any person may be a risk for HIV, data point to specific priority populations on which to focus prevention efforts.

Men who have Sex with Men

Men who have sex with men make up the largest percentage of new HIV diagnoses in Montana (Figure 5) and represent a clear priority population for prevention and care efforts. This trend is also seen when looking new diagnoses between 2017 and 2022 (Figure 6).

FIGURE 5. NEW HIV DIAGNOSES BY TRANSMISSION CATEGORY, MONTANA 2021-2022

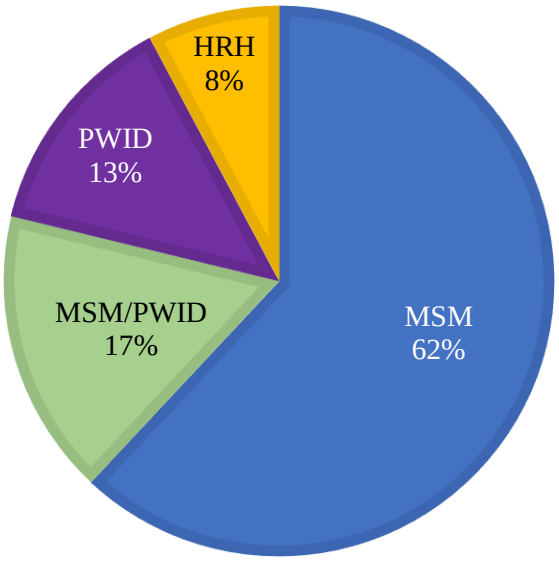
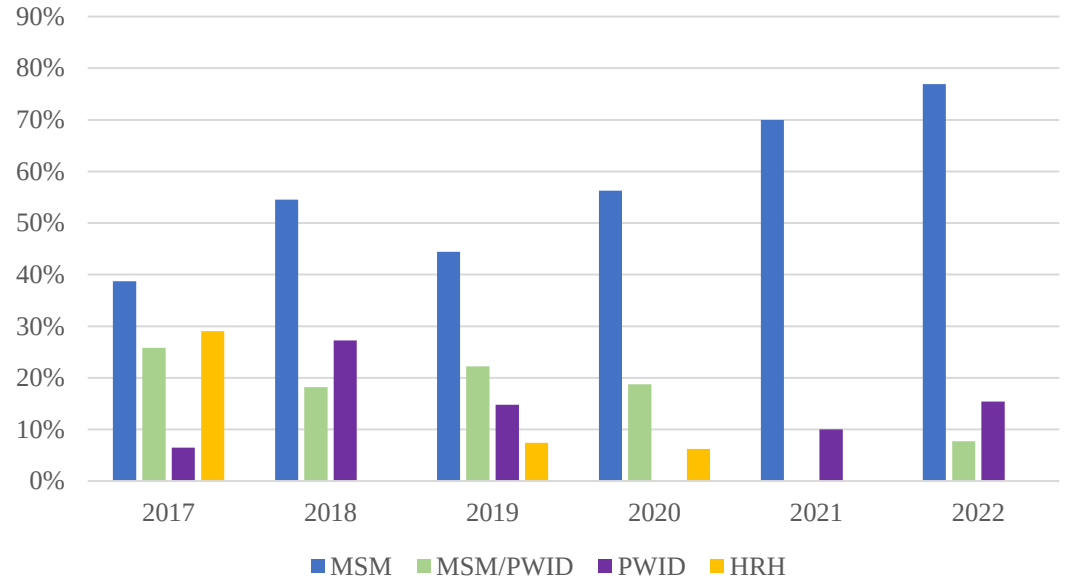


Figure 6. HIV diagnoses by year and transmission category, Montana 2021-2022

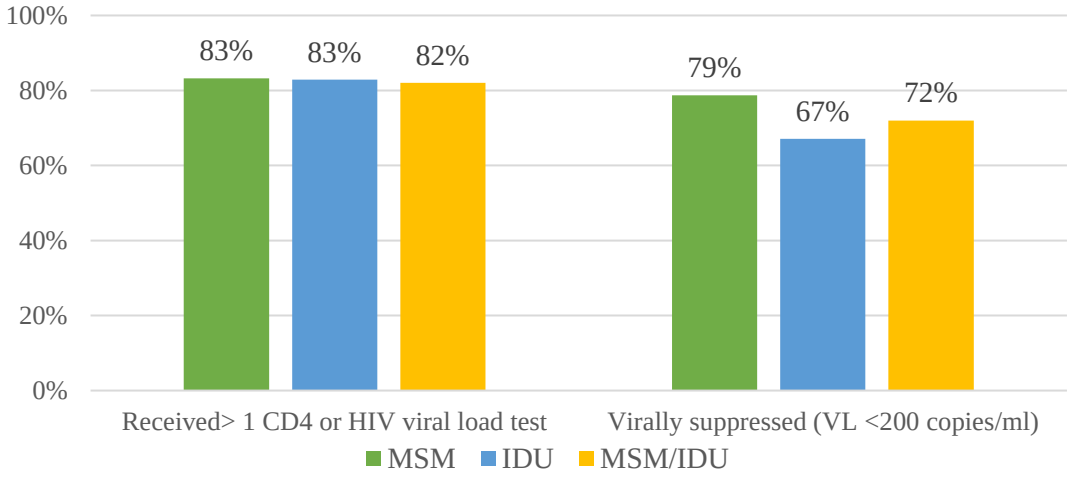


People who Inject Drugs

Following MSM, injecting drug use is the second most common transmission risk in Montana. Cases where injecting drug use is a least one transmission risk made up 32% of new diagnoses in Montana in the 2017-2021 timeframe (Figure 6).

The impact of injection drug use negatively impacts sustained viral suppression. The percent of people who inject drugs is 67% compared to 79% of all PLWH in Montana.

Figure 7. Continuum of care by select transmission risk, Montana 2019-2021



The Montana continuum of care differs when PLWH reporting specific transmission risks (Table 8 and Figure 78). Persons who report as MSM have the highest percentage of being in care (92%) when compared to the total PLWH (82%) and PWID (87%). Persons who inject drugs have the lowest levels of viral suppression (72%).

Young Adults Aged 13-34 Years

Youth less than 24 years made up 25% of new diagnoses in Montana from 2018-2021. Young adults between 25 and 34 made up another 35% of new cases. Together, 60% of cases were among Montanans less than 34 years of age.

Figure 8. New HIV diagnoses by age category, Montana 2018-2021

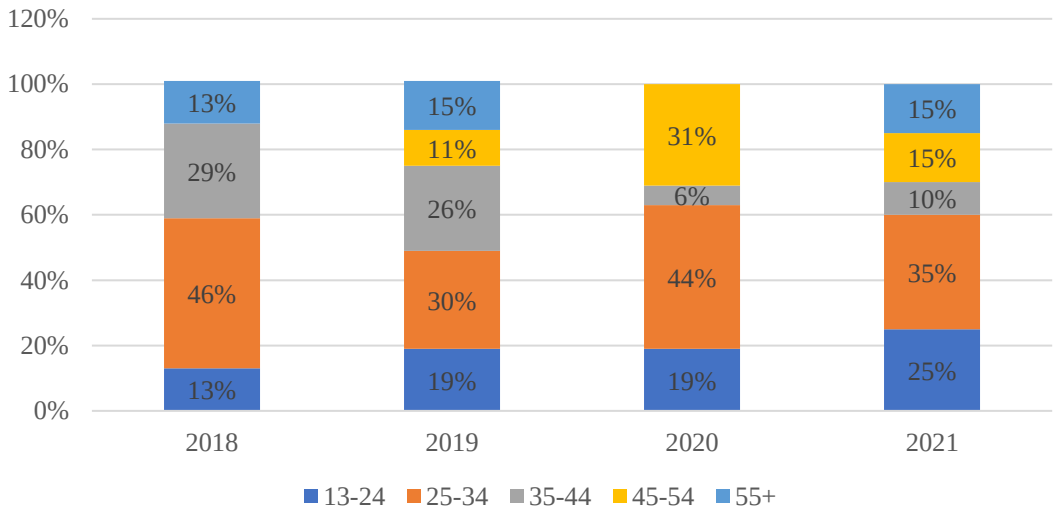
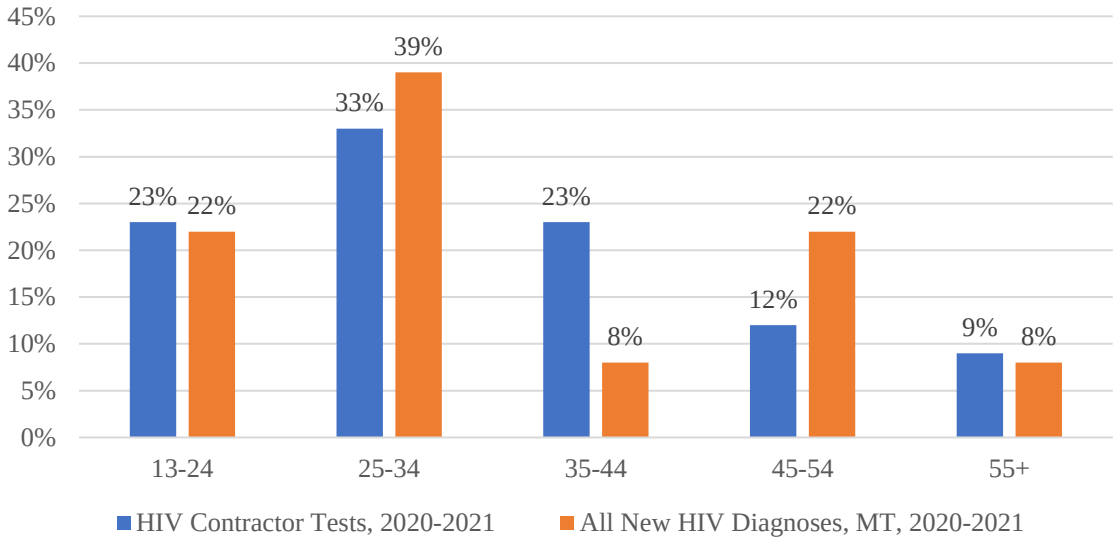


Figure 8 compares the percent of DPHHS HIV contractor testing with the percent of new HIV diagnoses by age category during 2020-2021. Because of the small number of events, this figure will use aggregate data for new diagnoses. While the percentage of contractor testing and the percentage of new diagnoses is similar in the 13-24 and the 55+ age groups, the percentage of testing versus new diagnoses are discordant for other age groups. Thirty-nine percent of new diagnoses occurred in the 25-34 age group, while 33% of testing was conducted in that cohort. The difference is a more drastic in the 34-44 age group where 8% of new HIV diagnoses were identified in the 35–44-year-old group, and 23% of contractor-supported testing was conducted in that group.

It should be noted that, collectively, the percent of testing in the 13-34 age group is comparable the percent of new diagnoses (56% vs 61% respectively).

Figure 9. Percent of testing compared to percent of new HIV diagnoses by age category, Montana, 2020-2021



HIV Clusters

In Montana transmission clusters are identified through:

1. Surveillance data
2. Partner services and contact investigations
3. Molecular HIV data
4. Reports from Local Health Jurisdictions (LHJ), laboratories and/or health care providers

All new reports of HIV diagnoses are reviewed at a weekly disease meeting with representatives from the Communicable Disease Epidemiology, HIV/STI/HCV prevention, TB control, Immunization, MT Public Health Laboratory, together with the MT Refugee Coordinator, State Epidemiologist, and State Medical Officer. The data is analyzed to determine if there is a higher-than-expected number of cases by specific demographics or geographic regions. In addition, striking patterns of HIV transmission rate by county, risk factor, gender, or race/ethnicity are reviewed and reported as appropriate.

The HIV Prevention, Surveillance, and Ryan White Coordinators meet bi-weekly to review reports of new HIV diagnoses and cases diagnosed elsewhere and moved into the state. This includes analysis of case reports, laboratory data, partner services, and Ryan White utilization. Partner data, molecular sequence, and time-space analyses are reviewed every month. Based on this data, the group investigates as needed to determine if there is a potential cluster.

HIV nucleotide sequence data is uploaded to secure HIV-Trace and is analyzed monthly to identify chains of partners whose viral genetic relatedness implies direct or indirect epidemiological connections. Linkage in HIV-Trace does not demonstrate the direction of transmission. Yet, two cases could have both been infected by a third source. Because of this, HIV sequence data and partner identification should work together to identify transmission clusters.

Using molecular data, a transmission cluster must meet the following characteristics:

- A genetic distance threshold of 0.5% and
- Identified clusters with at least 3 cases diagnosed within the most recent 12-months

Using these tools, Montana has not identified any clusters meeting the definitions outlined above.

HIV Prevention, Care and Treatment Resource Inventory

The following table describes the Montana jurisdictional HIV financial resources inventory. It specifies the public and private funding sources for HIV prevention, care, and treatment services; the dollar amount and the percentage of the total available funds for each funding source; the services delivered; and the components of HIV prevention programming and the HIV Care Continuum are impacted. The inventory does not include Indian Health Services (IHS), Medicare, and Veterans Administrations (VA) funding since this information could not be obtained.

Funder	Funding Source	Org Receiving the Funding	Annual Award Amount	Subrecipients	Services Delivered	HIV Prevention Strategies
HRSA	HRSA	MT DPHHS	$870,130	SGRX, Partnership Health Center, Riverstone Health	ADAP, Early Intervention Services (EIS), Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals, Medical Case Management, including Treatment Adherence Services, Oral Health Care, Emergency Financial Assistance, Food Bank/Home Delivered Meals, Housing, Non-Medical Case Management Services, Outreach Services	• HIV Diagnosis • Linkage to Care • Engagement or Retention in Care • Prescription of ART • Viral Suppression
HRSA	HRSA	MT DPHHS	$481,779	ScriptGuideRX	ADAP, Health Insurance Premium and Cost Sharing Assistance for Low-Income Individuals	• Prescription of ART • Viral Suppression
CDC	Immunization and Vaccines	MT DPHHS	$50,000	Butte-Silver Bow HD, Partnership Health Center, Riverstone Health, Flathead City-County HD, Lewis and Clark City-County HD	Medical Case Management, including Treatment Adherence Services	• Engagement or Retention in Care
CDC	HIV Prevention and Control Grant	MT DPHHS	$1,029,059	AIDS Outreach, Butte-Silver Bow HD, Cascade HD, FDH, Flathead	Health Education/Risk Reduction, Outreach Services,	• HIV Diagnosis • Linkage to Care

Funder	Funding Source	Org Receiving the Funding	Annual Award Amount	Subrecipients	Services Delivered	HIV Prevention Strategies
				City-County HD, Lewis & Clark HD, Open Aid Alliance, Partnership Health Center, Riverstone Health	Referral for Health Care and Support Services, Condom Distribution, HIV Transmission Cluster and Outbreak Identification and Response, Partner Services, Perinatal HIV Prevention and Surveillance, PrEP Delivery, Prevention for Persons Living with Diagnosed HIV, Social Marketing Campaigns	
Montana State	Fund 01100 General Fund	MT DPHHS	$54,999	Planned Parenthood Montana, Butte-Silver Bow HD, Lewis & Clark City-County HD, Flathead City-County HD, Bridgercare, Partnership Health Center	PrEP Delivery	• Linkage to Care • Engagement or Retention in Care
CDC	Immunization	MT DPHHS	$63,672	AIDS Outreach, Butte-Silver Bow HD, Cascade HD, FDH, Flathead City-County HD, Open Aid Alliance, Partnership Health Center, Riverstone Health	Immunization Promotion	• Linkage to Care
HRSA	Rebates	MT DPHHS	$752,095	ScriptGuideRX, RiverStone Health, Butte-	ADAP, EIS, Housing, Outreach Services	• HIV Diagnosis

Funder	Funding Source	Org Receiving the Funding	Annual Award Amount	Subrecipients	Services Delivered	HIV Prevention Strategies
				Silver Bow HD, FDH & Associates, HRDC, Missoula City-County HD, Open Aid Alliance		• Linkage to Care • Engagement or Retention in Care • Prescription of ART • Viral Suppression
SAMHSA	State Opioid Response Grant	MT DPHHS	$200,000	Alluvion Health, Butte-Silver Bow HD, RiverStone Health, Flathead City-County HD, Open Aid Alliance	Referral for Health Care and Support Services, Syringe Service Programs, Testing, Harm Reduction Services	• HIV Diagnosis • Linkage to Care
HOPWA	Housing Opportunities for Person with AIDS	HRDC District 7	$121,054	HRDC District 7	Housing, Intensive Case Management, Supportive Services, Nutritional Services, Transportation Services	• HIV Diagnosis • Linkage to Care • Engagement or Retention in Care
HUD/MT DPHHA	HOPWA Regular HOPWA Plus	MT DPHHS	$251,224	Open Aid Alliance	Housing, Non-Medical Case Management Services	• Linkage to Care • Engagement or Retention in Care • Viral Suppression
HRSA	HRSA	University of Washington & Mountain West AETC	$3,098,654	RiverStone Health	Provide training and technical assistance to providers treating patients with or at risk for HIV	• HIV Diagnosis • Linkage to Care • Engagement or Retention in Care • Prescription of ART • Viral Suppression

Approaches and Partnerships

The data compiler tool includes public and private funding sources for HIV prevention, care, and treatment services. The HIV Prevention and Treatment program managers completed the data inventory on behalf of their subrecipients. In addition, private and DPHHS entities who are funded by organizations like Housing Opportunities for Persons with AIDS (HOPWA) and Substance Abuse and Mental Health Services Administration (SAMHSA) were contacted, and their program managers provided their funding information. All resources shown on the table above play a pivotal part in the HIV Care Continuum and assist in preventing and treating HIV.

Strengths and Gaps

The HIV Inventory indicates HIV Prevention and Treatment services are primarily provided in the most populous cities in Montana. Additionally, several other moderately populated towns are served by these providers located less than one hour drive away. Montana is a large state geographically, while small in population with slightly more than 1,000,000 people total. As a result, providing HIV testing and treatment services in our significant and moderate populations is both a strength and a gap. While many rural residents do not have access to state-funded prevention and treatment services in their community, many are located in nearby populous communities where rural residents often travel for specialty care, groceries, and other services. Additionally, many rural residents travel to other communities for healthcare services due to comfort and privacy concerns.

Another strength of Montana's HIV Prevention and Treatment services is that they are provided by local public health departments, federally qualified health centers, and a variety of Community-Based Organizations (CBOs). The diversity of service providers allows individuals to choose a particular setting or organization based on their level of comfort with staff and other services provided.

Geographically, the HIV Prevention Inventory indicates a gap in contracted HIV Prevention and Treatment providers in Montana's north-central and eastern regions. Despite Hill County, in north-central Montana, and Custer County, in south-eastern Montana, being one of the top 15 most populous counties, neither has a contracted HIV Prevention or Ryan White provider. Additionally, both counties are located more than two hours away from a contracted provider, meaning many Montanans must travel significant distances to receive HIV prevention or treatment services.

Needs Assessment

The University of Montana (UM) contracted with the Montana Department of Public Health and Human Services (DPHHS) to complete a needs assessment of the care continuum. The authors of this needs assessment, Kaitlin Fertaly Ph.D., and McKenzie Javorka M.A, provided a comprehensive report that included the perspectives of Montanans living with HIV, providing care to people living with HIV, as well as people providing services across the HIV continuum of care. The perspectives included both strengths and gaps in the HIV continuum of care in Montana. The care continuum, shown below, provides an integrated process that follows the client through their HIV health care needs.

The research design included surveys and interviews of priority populations along the HIV care continuum. The research team followed human subject research protocols and protections and subject application material and consent were reviewed by the University of Montana Institutional Review Board (IRB). The process included qualitative and quantitative research with surveys and interviews with key stakeholders; people living with HIV (PLWH) and living with HCV, Disease Intervention Staff (DIS), Ryan White Case Managers, Montana state DPHHS communicable disease staff, healthcare providers, and staff at community-based organization serving PLWH and PWID. Recruitment for the assessment included Montana counties with the highest rates of HIV and HCV. As Montana is a low-morbidity state for HIV, five counties with the highest rates for HIV diagnoses were identified by analyzing ten years of data (2011-2021).

The study applied a sequential, mixed methods approach to accomplish the following objectives:

1. Understand the current prevalence, populations at risk, and risk factors for HIV and HCV in Montana using available epidemiological data

2. Understand how people living with HIV and/or HCV in Montana navigate and experience HIV/HCV care in the state

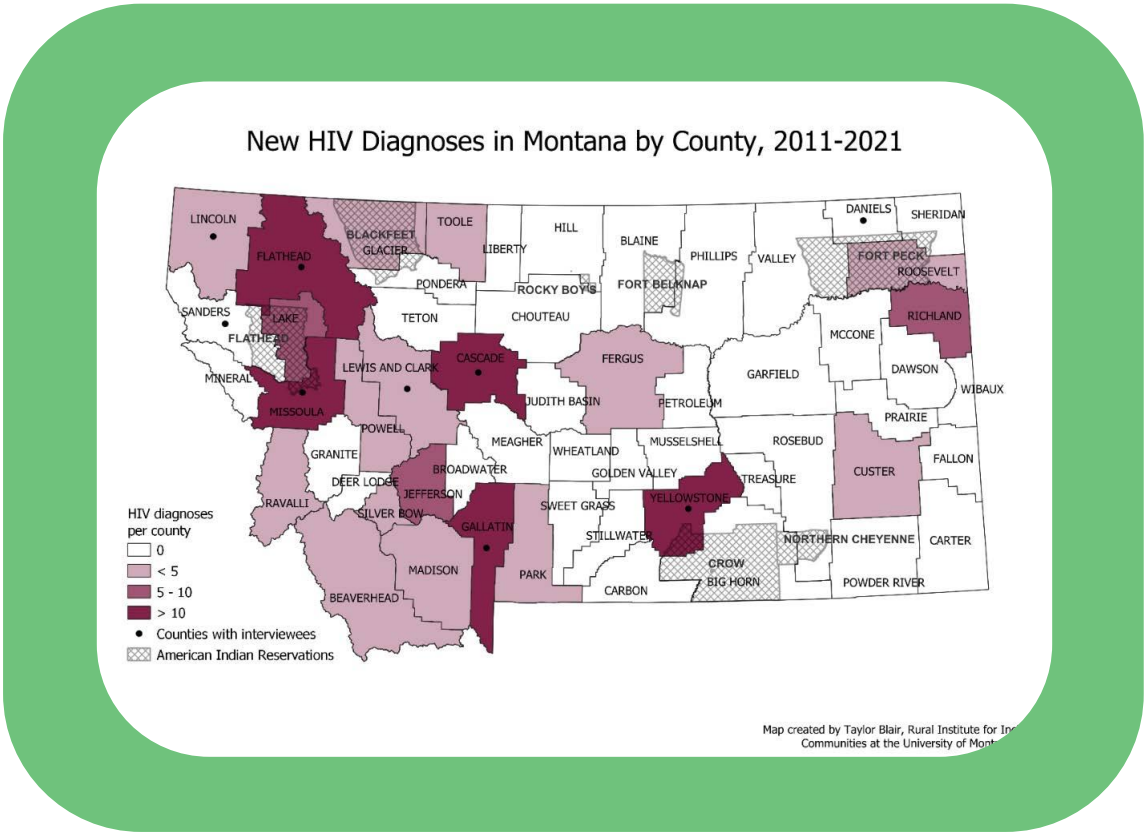
3. Assess healthcare provider knowledge and comfort level with risk factors, testing, treatment, and resources/services for HCV and HIV

4. Assess the role, knowledge, and comfort level of local public health staff at county and tribal health departments in conducting prevention, testing, reporting, and referral services.

Respondents and Research Method

Semi-structured Interviews with People Living with HIV/HCV

The research team recruited People Living with HIV through the Ryan White program and used a semi-structured interview guide. Each participant was asked to share their experiences navigating the HIV or HCV care continuums, describe interactions with healthcare providers, and identify any barriers or challenges they faced. Interview questions and guiding prompts were adapted from relevant literature on barriers and facilitators to care for HIV and HCV. Overall, there were 20 semi-structured interviews with seventeen participants being PLWH, and of those, eight participants had a co-infection with HCV at some time. Participants were from nine counties in Montana, including urban and rural areas across the state. Interviews were transcribed using Otter.ai, an automated transcription services, and were reviewed and cleaned by a research assistant to ensure accuracy. Transcripts were then analyzed in NVivo using a general inductive approach to identify barriers, facilitators, and recommendations for HIV care across the care continuum. Interviews included representation of at least one participant from all counties with the highest number of new HIV diagnoses in the state, as shown in the map below.



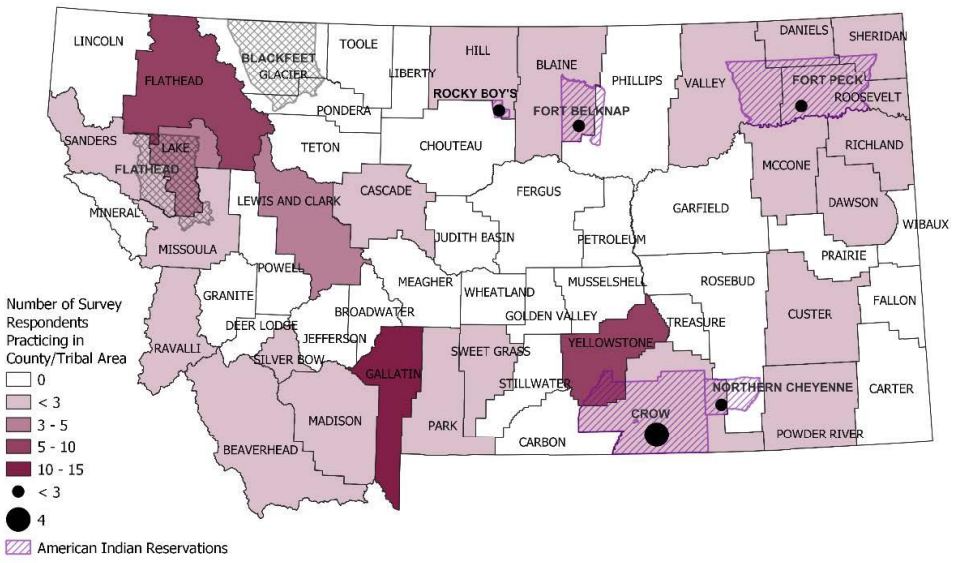
Source: Montana Department of Public Health and Human Services. eHARS system. Access August 17, 2022

Participants were predominantly male (85%), and most identified as gay, queer, or bisexual/pansexual (75%). Fifty-five percent (55%) of participants identified as White. Other participants identified as American Indian/Alaska Native (10%), Asian/Pacific Islander (5%), Black/African American (5%), Hispanic (5%) and Mixed Race (5%).

Survey of Healthcare Providers

Sixty-three medical providers were recruited and interviewed through Qualtrics surveys. Respondents were predominantly (75%) physicians (MDs and DOs); 18% were physician assistants; and 8% were nurse practitioners. The location and provided service areas were in 31 of the 56 counties in Montana, see figure below, and the health care setting ranged from, Critical Access Hospitals (33%), Federally Qualified Health Centers (27%), and private practices (25%). Four providers (6%) provided care at IHS or Urban Indian Health Centers. Respondents represented both rural and urban areas.

Provider Survey: Respondents' Areas of Practice in Montana, 2022



Map created by Taylor Blair, Rural Institute for Inclusive Communities at the University of Montana, 2022

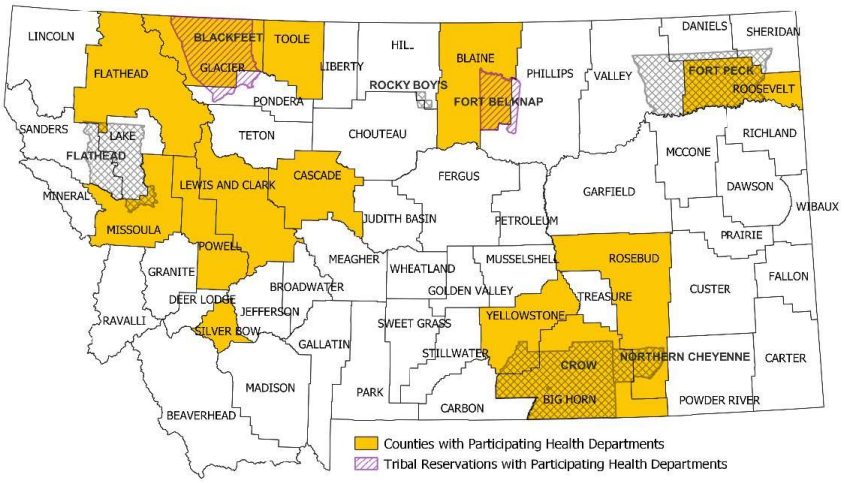
Source: 2022 Montana HIV/HCV Needs Assessment

Data from healthcare providers was cleaned and analyzed using SPSS statistical software. Analysis included conducting basic summary and descriptive statistics (e.g., frequencies, percent, and measures of central tendency).

Structured Interviews with Local Health Department Staff

Additionally, fifteen county and tribal health departments (71% response rate) participated in a structured interview. Local (county and tribal) public health staff are at the forefront of preventing and controlling communicable disease, including sexually transmitted infections, HIV, and HCV. Their work entails case identification, contact tracing, and connecting individuals to appropriate medical and social services. Structured interviews were conducted with local public health staff at tribal and county health departments in Montana to understand their current role in reporting HIV and HCV cases and their knowledge and comfort in conducting prevention, testing, and referral services. A purposive selection method was used to capture less populous counties with high rates of HCV and HIV, given their populations and more populated counties with higher reported cases.

Health Department Interviews: Participating County/Tribal Health Departments in Montana, 2022



Map created by Taylor Blair, Rural Institute for Inclusive Communities at the University of Montana, 2022

Source: 2022 Montana HIV/HCV Needs Assessment

Detailed notes were taken by the interviewers during structured interviews using a Qualtrics form. Interviews were audio recorded to ensure accuracy of notes. Interview notes were reviewed and cleaned by a research assistant using audio recordings as needed for corrections. Each interview question was then analyzed using content analysis to document the topics and themes described by local health department staff.

Data Triangulation

After analyzing data from each data source and method independently, multiple strategies to synthesize and triangulate findings across sources and methods were employed. Data triangulation refers to the practice of bringing together data using multiple methods (i.e., surveys, interviews, archival records), methodologies (i.e., quantitative, and qualitative approaches), and data sources or stakeholder groups, which can enhance the validity of findings and help to illuminate areas of convergence and divergence. In the needs assessment, triangulated data was used across all three levels, as seen in Table 9 below.

Matrix of Data Sources and Methods		
	Qualitative	**Quantitative**
Data Source	Interviews	Surveys
People Living with HIV	X	
Medical Providers		X
Local Health Department Staff	X	X

Of the 25 persons in Montana newly diagnosed with HIV, 68% were identified at earlier stages of disease, 16% were diagnosed with AIDS, and 16% were unknown

Required HIV Services

Currently there is no cure for HIV. However, effective treatment with antiretroviral therapy (ART) is available, and when taken as prescribed medication can reduce the amount of HIV in the blood (also known a viral load) to a very low or undetectable level. People living with HIV who take HIV medications as prescribed and maintain viral suppression can live long and healthy lives and will not transmit HIV to HIV-negative partners through sexual contact. Additionally, PrEP medication can prevent HIV transmission due to sexual contact or injection drug use in HIV-negative people.

Early diagnosis is critical to controlling HIV transmission in the U.S., yet rates of HIV screening are low. Nationally, only 39% of the U.S. population has ever been tested for HIV based on data from 2016-2017. Data from the Behavior Risk Factor Surveillance Survey over the same period indicated that approximately 34% of Montana's have ever been tested for the HIV virus. In 2019, the CDC reported that of the 25 persons in Montana newly diagnosed with HIV, 68% were identified at earlier stages of disease, 16% were diagnosed with AIDS, and 16% were unknown.

Access to treatment through linkage to care and retention in care are critical steps of the HIV care continuum. ART can reduce viral levels to low or undetectable rates. Individuals who have achieved viral suppression through treatment cannot transmit the virus to partners through sexual contact. Among persons diagnosed with HIV in the U.S. in 2019, 81% were linked to HIV medical care less than one month after diagnosis. Montana was among the top 25% of states in the U.S. for linkage to care. Of the 25 people diagnosed with HIV that year, 88% of persons diagnosed were linked to HIV medical care within one month and 96% within three months. Nationally, within six months of diagnosis, viral load was suppressed in 68% of persons with an HIV diagnosis in 2019. In Montana, 64% of people diagnosed with HIV that year achieved viral suppression within six months of diagnosis.

Of the population of PLWH in Montana during 2021 (approximately 801 individuals), data from MT DPHSS indicates that 82% were in care for that same year, a higher rate than the U.S. average (66%). Being "in care" means having at least one HIV-related lab in the previous 12 months. Additionally, 76% of people living with HIV in Montana were virally suppressed in 2021, higher than the national average of 57%. Montana data indicates the benefits of being linked to care. In 2021, of 92% of PLWH and in care achieved viral suppression.

An identified gap in the HIV prevention care continuum is PrEP coverage among those eligible. PrEP is an important prevention strategy for reducing HIV transmission and is a significant component of the national initiative to end the HIV epidemic. According to the CDC, between 2019-2021, Montana fell into the lowest 25% of states for PrEP coverage, with only 12% of individuals indicated for PrEP received it.

Key Findings

There were several key themes around barriers and facilitators in accessing and navigating the HIV care continuum that emerged in the needs assessment. Regarding prevention, sources consistently indicated that there is limited awareness of, availably of, and access to PrEP as a prevention strategy in Montana. Although there were not significant barriers to HIV testing described across data sources, both PLWH and providers indicated that HIV testing is not standardized or consistently offered to all clients. Additionally, Montanans may face internal barriers to HIV testing (e.g., fear of HIV, stigma, or the perception that they are not at risk for HIV).

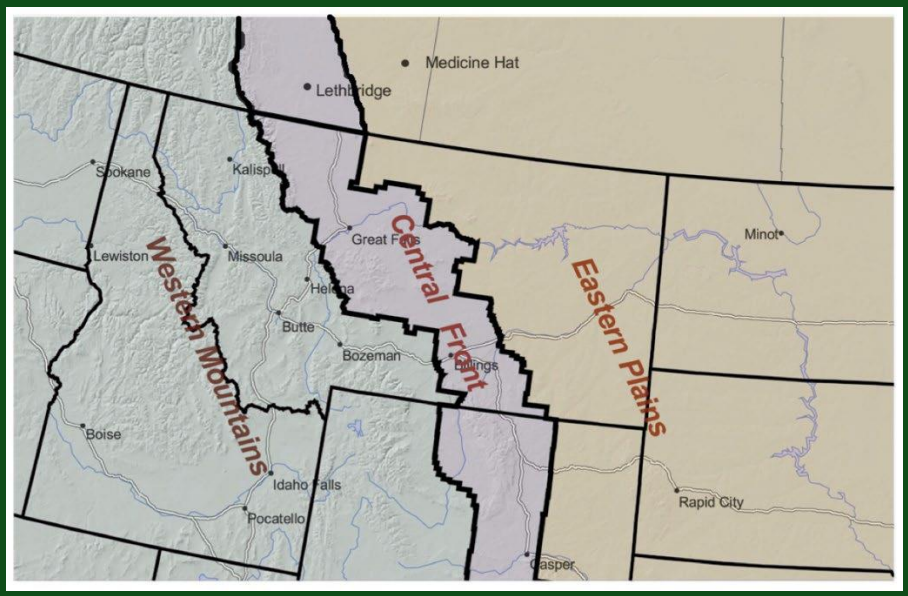
Of the population of PLWH in Montana during 2021 (approx. 801 individuals), data from MT DPHHS indicates that 82% were in care for that same year, a higher rate than the US average (66%)

As a low-prevalence state, Montana's healthcare providers and local health department staff often had limited experience or training on HIV diagnosis and treatment. PLWH indicated that they often had to educate their providers on their HIV treatment needs and struggled to access HIV specialty care. Several barriers to engagement in HIV care were noted across data sources and included the following: the distance PLWH must travel to access HIV specialty care, healthcare providers' lack of experience and knowledge of HIV treatment, pharmacy-related barriers to treatment, and lack of statewide care coordination which made healthcare system navigation challenging for high-need clients.

Although lack of awareness/availability/access to PrEP was consistent across rural and urban areas, for all other key themes, there were notable discrepancies between rural and urban areas. Specifically, while urban areas were often described as having robust testing and treatment options for HIV, more rural areas did not provide the same access across the care continuum.

Actions Taken

The final needs assessment report was completed at the end of August 2022. Since then, the University of Montana research team has presented findings at stakeholder meetings. The 2022-2026 HIV Integrated Plan builds on the identified strengths and addresses identified gaps in the HIV care continuum.



Section IV- Situational Analysis

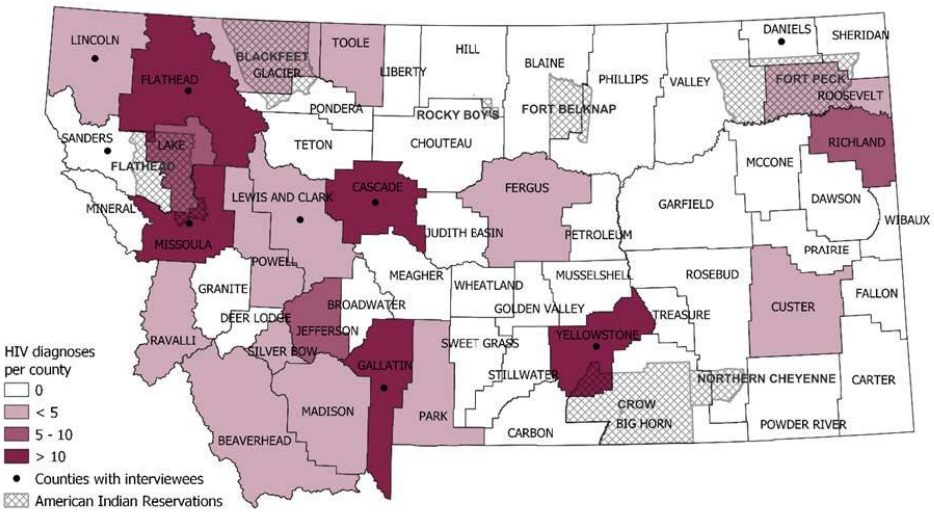
The situational analysis utilizes an assessment of priority and vulnerable populations and Montana's recent Needs Assessment, described previously. The HPG provided consumer driven data regarding the strengths, barriers, gaps, and needs within the state. This information assisted in developing the Integrated Plan goals and objectives.

Montana Demographics

Montana contains diverse regions with vast variations in terrain, vegetation, climate, land use, economies, and population density. The continental divide runs throughout Montana from north to south, dividing the state's waterflow from east to west. Despite the importance of the continental divide, it does not provide a clear regional divide in Montana. Montana's mountain ranges in the west and rolling grasslands in the east provide more insight on travel patterns, land use, economy, and population density. Western Montana is marked by expansive, interconnected mountain ranges with low-lying valleys and abundant water sources, as well as population dense cities. Eastern Montana is marked by rolling grasslands, fields planted with grains, and smaller cities and towns. Between eastern and western Montana lies a smaller distinct region, the central front, extending north-by-northwest from Wyoming through the largest Montana city, Billings, and further northwest to the Great Falls area and up to the Canadian border (Swanson, n.d.).

Twenty-one of the state's 56 counties largely lie in the Western Mountain region, with another 21 in the Eastern Plains, and 14 within the Central Front (Swanson, n.d.). Utilizing these three groupings, one can see that Montana's population varies from west to east. Although, the most populated city in Montana resides in the Central Front, the western counties have a larger population than the central and east sides of the state. The western region is made up of roughly 60% of the state's total population, the central region has about 30% of the total population and the eastern has the remaining 10% (Swanson, n.d.).

New HIV Diagnoses in Montana by County, 2011-2021



Map created by Taylor Blair, Rural Institute for Inclusive Communities at the University of Montana, 2022

Montana has a population of about 1.1 million people, and which has increased annually in the last decade, according to the United States Census Bureau. The population is a predominantly white, 89%, while American Indian/Alaskan Native (AIAN) is approximately 7% of the population. In 2020, 60% of Montana's population aged between 18 to 64 years old, 20% aged under 18 years old, and roughly 19% of the population were older than 64 years of age, the median age is 40 years of age (U.S. Census Bureau, 2020). In Montana, there were approximately 800 PLWH in 2021, the majority are 35 years and older. However, 65% of newly HIV diagnoses between 2018 to 2021 were under the age of 35. Although many people who are diagnosed with HIV live in the Western Mountain and the Central Front regions, there are areas throughout the Eastern Plains as well. Needs assessment data indicates that PLWH on the eastern side of the state report decreased access to HIV testing, treatment, and specialized care, which leads to long travel distances for care.

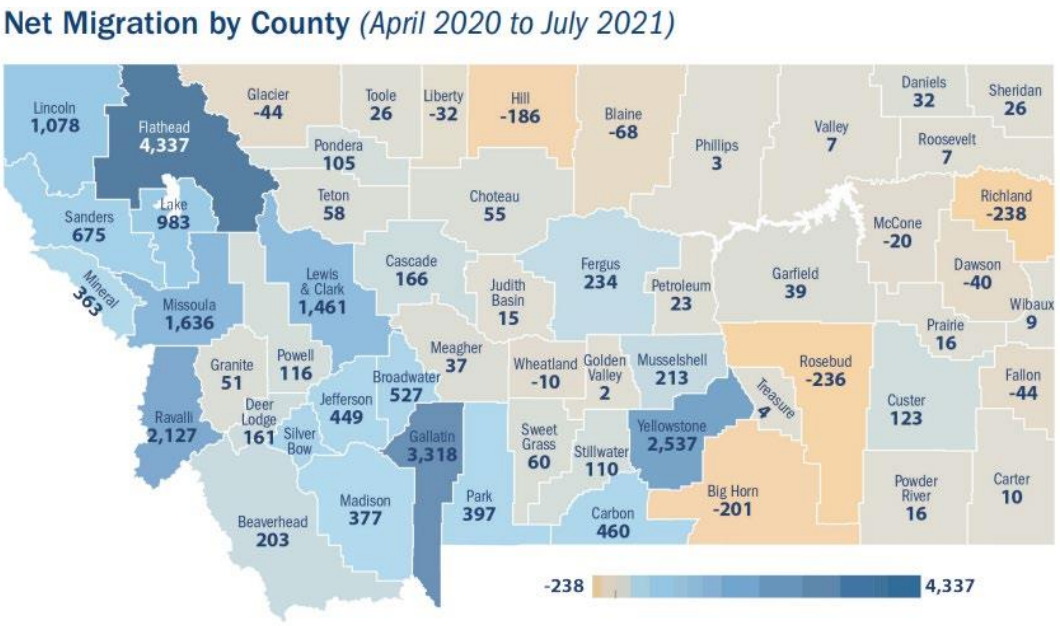
Social Determinants of Health

The social determinants of health (SDOH) include the conditions in the environments where people are born, live, work, and play that affect their health and quality of life, which include economic stability, access to education, access to healthcare, quality of healthcare, and built environment. Some examples of SDOH are safe housing, transportation, education, job opportunities, access to nutritious foods, clean air and water, and income.

Many people in Montana experience poverty. Montana ranks 31st in the nation for overall poverty. Disparities in poverty are seen between race and ethnicity in Montana. The poverty rate for American Indian/Alaska Native is 31.9% as compared to Latino (20.5%), white (10.8%), and Asian American (8.3%) populations. Median household income in Montana ranges from $35,859 for American Indian families to $58,291 for white households. Women also experience income inequality in Montana, making just 77.8¢ for every dollar their male counterparts earn, ranking 39th compared to other states (Center for American Progress, 2022). Poverty and low income also affect access to healthcare. Montanans report they cannot afford healthcare even with health insurance, the percentage of adults who do not have a personal doctor or health care provider in Montana exceeds the overall national rate by 4%.

Access to affordable housing has become more challenging in the last several years. During the COVID-19 pandemic, there was a significant migration of people to Montana and the population grew 1.8%. Montana was third in the nation for increased growth between April 2020 and July 2021.

Montanans report they cannot afford healthcare even with health insurance, the percentage of adults who do not have a personal doctor or health care provider in Montana exceeds the overall national rate by 4%



Source: U.S. Census Bureau. Components of Population Change. 2021.

The figure above shows net migration in Montana counties between April 2020-July 2021.

This growth has led to an increased in-home price and a reduction in affordability. Montana's home prices increased 44.3% between the first quarters of 2021 and 2022 (Wagner et al., 2022). This report further states that housing affordability has placed a constraint on lower wage workers' and their ability to live in areas that are experiencing rapid growth. In contrast, Montana's average wages/incomes are lower than the U.S. average, suggesting homeownership is less affordable in Montana than in other parts of the nation (Wagner et al., 2022). Rising home prices and the limited housing supply affects renters as well. Across the U.S., rent has increased by 7% in the first six months of 2022 compared to with two years prior (Wagner et al., 2022).

Just as with rising house costs, food today is 8% more expensive on average than it was a year ago in all cities across the country. For Montana a family of four can expect to spend an average of $9,782 on food in 2022, the 24th highest among states, according to the EPI's Family Budget Calculator (Stebbins, 2022). Additionally, many Montanans experience food insecurity due to accessibility and affordability. Out of the 56 counties, 30 counties with nearly 72,000 residents contain areas considered food deserts. While those living in food deserts face food insecurity, others in Montana face barriers related to the consumption of wholesome foods. Furthermore, about 1 in 9 people, or 116,120 Montanan residents, are struggling with hunger (Eat Right Montana, 2020). The rise in food prices and the food insecurity issue Montana faces can pose a greater threat to PLWH than people who are not living with HIV. Studies show that when food prices rise and food insecurity occurs PLWH are greatly affected because when PLWH go without proper nutritious food, adherence to their medication dwindles, viral suppression rates go down, and poor health outcomes ensue (Weiser et al., 2013).

[HIV transmission in Montana], PWID occupy 13% of the population, MSM occupy 59% of that population, and 32% has injection drug use as at least one risk factor

Vulnerable and Priority Populations and HIV Diagnoses in Montana

HIV can infect anyone regardless of their sexual orientation, race, ethnicity, age, gender, or where they reside. However, according to the most recent data for HIV transmission in Montana, PWID occupy 13% of the population, MSM alone occupy 59% of that population, and 32% of people living with HIV has injecting drug use as at least one risk factor. New HIV diagnoses among age groups also helps identify the priority populations in Montana. The data also shows the following list includes the most vulnerable populations for HIV transmission in Montana.

1. Gay, bisexual, and other men who have sex with men
    - Youth aged 13-24
2. PWID
3. MSM/PWID

This information allows Montana to position HIV prevention and treatment resources that are centralized on these three priority populations. This focus is essential to succeed the nation's goal of ending the HIV epidemic by 2030.

Strengths, Challenges, and Identified Needs

As a low-incidence state, Montana has many strengths in linking and retaining PLWH in care. However, as a frontier state, Montana also experiences many challenges and barriers to providing care for people at higher risk for HIV and PLWH, diagnosed and undiagnosed.

Strengths

Since 2019, on average, 90 percent of PLWH in Montana actively in care and receiving treatment are virally suppressed. Members from the HPG and the needs assessment indicated Montana has built an effective infrastructure for supporting individuals with HIV, including timely linkage to care. Due to low numbers of HIV clients, case managers can build relationships with each client and ensure that they feel included in their medical treatment.

An additional strength for Montana's American Indian residents is an updated Indian Health Service (IHS) formulary that allows IHS pharmacies to order and dispense PrEP through a cooperative agreement with a healthcare provider. This recent change increases access for IHS beneficiaries to receive PrEP for HIV prevention.

Lastly, the Montana Department of Public Health and Human Services provides support and technical assistance to support local and tribal public health in conducting case investigations and case management for people recently diagnosed with HIV.

Barriers and Challenges

Although Montana is making progress in improving HIV outcomes, significant barriers and challenges remain. The ongoing and emerging barriers and challenges that Montana faces fall within four categories: Montana's geography and rurality, PrEP uptake, HIV screening, HIV care and treatment.

Frontier State

Many existing gaps in the availability of services are due, in part, to the rurality of Montana, which is considered a frontier state. Health disparities and challenges to accessing health care persist in rural and frontier areas. People must often travel significant distances to access needed health care services. Public transportation is limited or unavailable in most communities, making transportation to healthcare more difficult for those without reliable vehicles. Furthermore, harsh Montana winters cover roads in sheets of snow and ice, making travel dangerous, particularly in mountainous and remote areas.

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Since 2019, on average, 90 percent of PLWH in Montana actively in care and receiving treatment are virally suppressed. Members from the HPG and the needs assessment indicated Montana has built an effective infrastructure for supporting individuals with HIV, including timely linkage to care. Due to low numbers of HIV clients, case managers can build relationships with each client and ensure that they feel included in their medical treatment.

An additional strength for Montana's American Indian residents is an updated Indian Health Service (IHS) formulary that allows IHS pharmacies to order and dispense PrEP through a cooperative agreement with a healthcare provider. This recent change increases access for IHS beneficiaries to receive PrEP for HIV prevention.

Lastly, the Montana Department of Public Health and Human Services provides support and technical assistance to support local and tribal public health in conducting case investigations and case management for people recently diagnosed with HIV.

Barriers and Challenges

Although Montana is making progress in improving HIV outcomes, significant barriers and challenges remain. The ongoing and emerging barriers and challenges that Montana faces fall within four categories: Montana's geography and rurality, PrEP uptake, HIV screening, HIV care and treatment.

Frontier State

Many existing gaps in the availability of services are due, in part, to the rurality of Montana, which is considered a frontier state. Health disparities and challenges to accessing health care persist in rural and frontier areas. People must often travel significant distances to access needed health care services. Public transportation is limited or unavailable in most communities, making transportation to healthcare more difficult for those without reliable vehicles. Furthermore, harsh Montana winters cover roads in sheets of snow and ice, making travel dangerous, particularly in mountainous and remote areas.

PrEP Utilization

Many Montanans are not limited aware of PrEP. For those who are aware, they may also experience limited access to PrEP to prevent HIV in Montana. Of healthcare providers surveyed, 29% indicated that they did not routinely offer information about PrEP to their clients and felt less comfortable discussing PrEP with clients compared to other sexual health and HIV-related topics.

Screening and Testing

HIV testing and screening procedures are not standardized or consistently offered to all clients. Only 35% of healthcare providers indicated that they implement "opt-out" HIV screening, in which an HIV test is automatically included in standard preventive screening tests unless declined by the client.

HIV Care and Treatment

Montana health care providers have limited experience in HIV diagnosis and treatment. Of the healthcare providers surveyed, only 33% indicated that their clinic follows a protocol for HIV treatment, and 51% responded that they do not provide HIV treatment at their clinic. Additionally, nearly half of providers (44%) answered that they do not have a referral process in place for HIV clients for specialty care, and 40% are not familiar with the Ryan White program and its services. People living with HIV indicated that they struggled to access HIV specialty care and often had to educate their providers regarding their HIV treatment needs.

Of the healthcare providers surveyed, only 33% indicated that their clinic follows a protocol for HIV treatment, and 51% responded that they do not provide HIV treatment at their clinic

The needs assessment also showed that only five of the 15 local health department staff who participated in the evaluation had experience with a new HIV diagnosis in their county or tribal area. Local and tribal health department staff are resources in the community and often the some of the first people who interface with people newly diagnosed with HIV, and one of the key roles a DIS performs is to identify community resources and referrals to link them and partners to needed testing and treatment. When DIS are unsure or lack the needed experience to accomplish these essential tasks, clients are often lost to follow-up and do not receive timely treatment.

Another barrier to HIV care is retention in care, as those clients linked to care often disengage due to a variety of reasons. One reason clients leave care is the distance they must travel to access HIV specialty care. Some healthcare providers lack experience and knowledge in providing HIV treatment. Additionally, some PLWH experience pharmacy-related barriers that make accessing their medications more challenging. Montana does not have statewide care coordination, which can make navigating the healthcare system challenging for PLWH.

Identified Needs

The identified needs to improve the HIV care continuum include the following: increased awareness of PrEP, improved HIV medication refill procedures, more HIV peer support services, and medical transportation alternatives. Increased HIV training opportunities for healthcare professionals to ensure they understand the health needs of PLWH, needed specialty care, and how to access Ryan White services will improve the health outcomes for PLWH. Peer support services, improved medication refill procedures, and alternative to travel for health care appointments, such as telehealth, could also increase the number of PLWH who continue in care and improve health outcomes for PLWH.

Analysis on the Four Pillars

Montana aims to achieve national goal of reducing new HIV diagnoses 75% by 2025 and 90% by 2030. To do so, Montana will utilize Ending the HIV Epidemic (EHE) strategies and create goals and objectives under the following four pillars:

- Diagnose
- Treat
- Prevent
- Respond

Diagnosis is the first step in the HIV Care Continuum and, as such, is the first pillar under the EHE strategies. Early diagnosis is critical to identify and link undiagnosed individuals to HIV care to reduce the risk of transmission. For this pillar, Montana's plan focuses on educating healthcare professionals about the HIV and HCV testing algorithms and screening guidelines. To achieve the goals and objectives, DPHHS will partner with infectious disease providers, the Primary Care Association of Montana, AETC, primary care providers, the University of Montana, Federally Qualified Health Centers (FQHCs), contractors, local and tribal public health departments, Emergency Departments and Urgent Care Centers.

The second pillar is to provide linkage to care and treatment for people diagnosed with HIV. The goals and objectives under the treat pillar include increasing rapid linkage to care after diagnosis, access to HIV care via telehealth, increased training opportunities for healthcare providers, and Ryan White services.

Pillar number three is designed to prevent new HIV transmissions by using proven interventions, including PrEP and Syringe Services Programs (SSP). Montana's goals and objectives are to increase access to PrEP; increase PrEP utilization; and provide training to the local and tribal public health workforce regarding HIV screening, HIV treatment resources, and PrEP.

The final pillar, respond, addresses the jurisdiction's ability to quickly react to potential HIV outbreaks. For this pillar, Montana will focus on increasing the capacity to conduct comprehensive HIV case investigations at local and tribal public health departments and increase the number of providers who order the drug resistance/sequencing lab test for new HIV diagnoses and for clients who have not achieved viral suppression.

Goal #1

By the end of 2026, increase awareness of HIV and HCV testing algorithm and screening guidelines

Diagnose

Objectives/Strategies

1. Provide at least two training opportunities annually to cover testing algorithms and screening guidelines
    a. Conduct outreach to Emergency Department
    b. Conduct outreach to Urgent Care Centers
    c. Conduct outreach to Federally Qualified Health Centers
    d. Provide HIV Prevention & HCV Prevention ECHOs
    e. Collaborate with the AIDS Education and Training Center (AETC) to provide provider education
    f. Provide training to HIV Prevention & SSP Contractors
2. Provide outreach at least two medical conferences annually
3. Identify a HIV/HCV physician champion by 31 December 2024
4. Provide training opportunities to tribal and local health jurisdictions
    a. Disease Intervention Specialist module
    b. Disease Intervention Specialist ECHOs
    c. Provide outreach at Montana Public Health Association conference

Key Partners

Infectious disease providers, Primary Care Association of Montana, primary care providers, University of Montana, FQHCs, contractors, local and tribal public health departments, AETC, Medical Board of Directors of Emergency Departments, and Urgent Care Centers

Potential Funding Resources

CDC HIV Prevention and Surveillance Programs, RWHAP, DIS programs, and Viral Hepatitis Program

Estimated Funding Allocation (Annually)

$391K RWHAP funds, $25K CDC HIV Prevention funds, $4K Viral Hepatitis funds, and $20K DIS funds

Outcomes *(reported annually, locally monitored more frequently)*

- Provide at least two training opportunities
- Provide outreach at two medical conferences annually
- Obtain a HIV/HCV physician champion

Monitoring Data Source *(Local databases, medical records, surveillance data, etc.)*

Moodle, surveillance data, and ECHO contractor reports

Expected Impact on the HIV Care Continuum

Increase provider and health department worker's knowledge on HIV and HCV testing algorithms and screening guidelines to ensure early diagnosis

Objectives/ Strategies

1. Ensure at least 40% of clients who are accessing SSPs are tested for HIV every six months or more frequently by 31 December 2026
    a. Monitor and evaluate testing data
    b. Provide quarterly reports to SSP contractors
2. Provide at least two training opportunities annually to educate providers on universal testing for HIV
3. Increase the number of HIV screening tests performed by HIV Prevention subrecipients to 2500 per year by 31 December 2026

Key Partners

Syringe service providers, Infectious disease providers, Behavioral Health and Developmental Disabilities Division (BHDD), Viral Hepatitis program, DIS, community-based organizations, State Opioid Response (SOR), and HPG

Potential Funding Resources

CDC HIV Prevention and Surveillance, BHDD, Viral Hepatitis program, and the DIS program

Estimated Funding Allocation

$20K CDC HIV Prevention and Surveillance, $10K BHDD, $5K Viral Hepatitis funding, $45K DIS funds

Outcomes *(reported annually, locally monitored more frequently)*

- The percentage of clients accessing SSP services who are tested for HIV every 6 months
- The number of training opportunities annually educating providers on universal HIV testing
- The number of HIV screening tests reported by HIV Prevention contractors in Evaluation Web annually

Goal #2

Increase the number of people diagnosed early before disease progression/ AIDS status from 80% to 90% by 31 December 2026

Monitoring Data Source *(Local databases, medical records, surveillance data, etc.)*

Contractor reports and local databases

Expected impact on the HIV Care Continuum

Identify new HIV cases earlier to lessen the number of people being diagnosed with AIDS

Treat

Goal #1

Increase viral suppression in people diagnosed with HIV statewide from 76% to 85% by 31 December 2026

Objectives/ Strategies

1. Increase by 3% the number of people with new HIV diagnosis who have either a CD4 count or viral load test within 30 days of diagnosis
2. AETC will provide at least one educational opportunity annually to educate providers about HIV antiviral medications, HIV specialty care, and/or Ryan White services
3. Increase access to HIV specialty care via telehealth

Key Partners

FQHCs, RW Program data medical providers, Infectious Disease providers, people living with HIV, health departments, and public health professionals

Potential Funding Resources

RWHAP and state local funding

Estimated Funding Allocation

$2.1 million RWHAP

Outcomes *(reported annually, locally monitored more frequently)*

- Percentage of people with new HIV diagnosis who have a CD4 count or viral load test within 30 days of diagnosis
- Number of training opportunities annually to educate providers about HIV antiviral medications, HIV specialty care, or Ryan White services
- Number of providers offering HIV care via telehealth

Monitoring Data Source *(Local databases, medical records, surveillance data, etc.)*

eHARS, MIDIS, SGRX, CAREWare, and contract data

Expected Impact on the HIV Care Continuum

Improve viral suppression rates by 9% and increase access to care

Objectives/Strategies

1. Increase the percentage of Ryan White Medical Case Management (MCM) clients with one or more MCM visits per year from 73% to 85% by 31 December 2026
2. Increase the percentage of clients receiving RW housing assistance served during the measurement period who are virally suppressed from 81% to 86% by 31 December 2026
    a. Establish a state quality improvement report demonstrating the percentage of clients receiving RW housing assistance who are virally suppressed
    b. Provide the quality improvement report to local sites
    c. Case managers will provide more intensive case management to those clients receiving housing assistance who are not virally suppressed
3. Work with Ryan White case managers to develop two strategies to ensure annual HCV and STI screening and confirmatory testing as needed for clients who have current high- risk behaviors (PWID, multiple sex partners)

Key Partners

Infectious disease providers, RW program providers, medical care providers, viral hepatitis program, STI programs, and people living with HIV

Potential Funding Resources

RWHAP, Viral Hepatitis funding, DIS funding, and state local funding

Estimated Funding Allocation

$391 K RWHAP funds and $3K DIS funds

Goal #2

Achieve optimal health for Ryan White clients

Outcomes *(reported annually, locally monitored more frequently)*

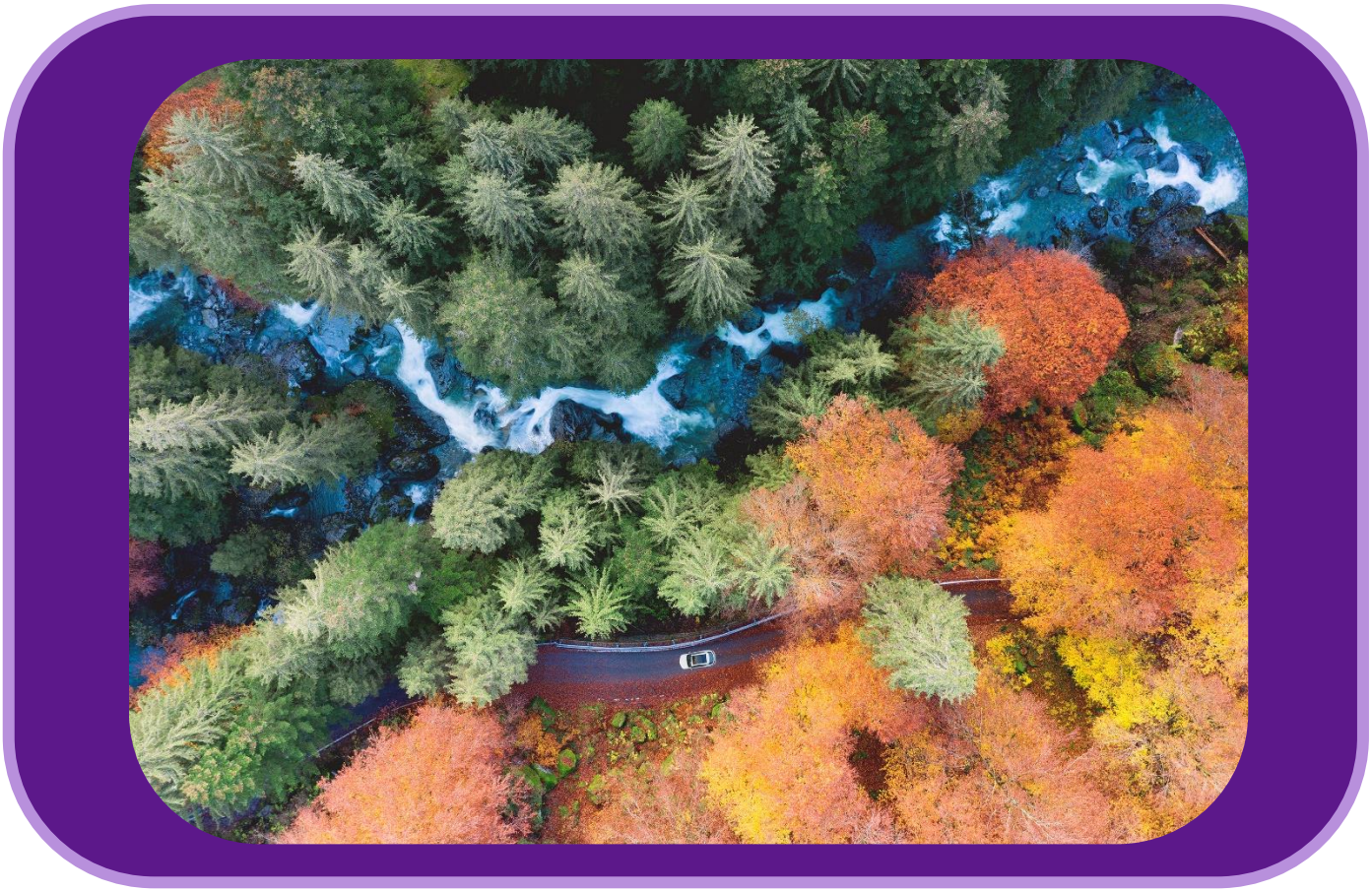
- Percentage of RW MCM clients with 1 or more MCM visits per year
- Percentage of RW clients receiving housing assistance who are virally suppressed
- Development and implementation of two strategies to promote annual HCV and STI screening in Ryan White clients

Monitoring Data Source *(Local databases, medical records, surveillance data, etc.)*

MIDIS, CAREWare, RW program data, and contract data

Expected Impact on the HIV Care Continuum

Improve the overall health and well-being of all of Montana's RW clients by increasing their MCM visits one or more times a year by 12 %. Thus, improving Montana's care continuum. Also, to strengthen viral suppression amongst RW clients receiving housing assistance and the relationship between RW MCMs, non-RW medical providers, and housing organizations.



Prevent

Goal #1

Reduce new HIV diagnoses in Montana by 75% by 31 December 2026

Objectives/ Strategies

1. Increase the eligible population the utilizes PrEP from 11.9% to 50% by 31 December 2026
    a. Increase providers who utilize the PrEP assistance program by 50% by 31 December 2026
    b. Provide Project ECHO training on PrEP
    c. Conduct outreach to Emergency Departments, Urgent Care Centers, and private providers to provide training and resources on PrEP
    d. Provide direct outreach and/or marketing to people who are eligible for PrEP
2. Provide at least four educational opportunities annually for medical providers on a status neutral approach to identifying individuals at risk for HIV and connecting them to prevention and treatment services, including PrEP
    a. Provide outreach at medical conferences
    b. Education through the college programs (PA, nurses, doctors, medical professionals) for HIV/STI/HCV
    c. Provide Project ECHO sessions on PrEP
3. Implement three strategies per year to provide HIV treatment and prevention resources to local and tribal public health workforce
    a. Disease Intervention Specialist module
    b. Provide Disease Intervention Specialist Project ECHO
    c. Update state website to include HIV prevention resources for local and tribal public health including PrEP providers, SSPs, housing, insurance, and financial assistance
    d. Provide training at Ryan White Case Management meetings
    e. Provide outreach at public health conferences and events

4. Partner with Montana family Planning to ensure at least 85% of Montana Family Planning Clinics offer HIV screening to clients
5. Partner with local and tribal health departments to ensure at least 40% of Health Departments offer HIV screening onsite
6. Conduct outreach to local and tribal health departments to ensure at least 80% of those who do not offer onsite HIV screening have a referral network for free and confidential testing
7. Ensure 85% of STI cases are provided a referral for a HIV test
    a. Data collection in MIDIS
    b. Data quality training
    c. DIS HIV module

Key Partners

Infectious disease providers, FQHCs, University of Montana, Emergency Departments, hospitals, Urgent Care Centers, and pharmacies, HIV Prevention contractors, local and tribal health departments, IHS, primary care providers, and AETC

Potential Funding Resources

CDC HIV Prevention and Surveillance Programs, state and local funding, AETC, and Indian Health service

Estimated Funding Allocation

$800K of HIV Prevention funding, $30K state funds, and $20K DIS funding

Outcomes *(reported annually, locally monitored more frequently)*

- Percentage of the eligible population the utilizes PrEP
- Number of annual education opportunities annually for medical providers discussing status neutral approach to HIV screening
- Number of strategies per year to provide HIV prevention and treatment resources to local and tribal public health
- Percentage of family planning clinics offering HIV testing to clients
- Percentage of local and tribal health departments offering onsite HIV screening
- Percentage of local and tribal health departments not offering onsite HIV screening who have a referral network for free and confidential testing
- Percentage of STI cases provided a referral for HIV testing

Monitoring Data Source

MIDIS, Evaluation Web, eHARS, Moodle, and PrEP program data

Expected Impact on the HIV Care Continuum

Decrease the number of HIV/AIDS diagnoses annually within Montana and improve retention in care

Respond

Objectives/ Strategies

1. Conduct annual reviews and updates of the Montana HIV and Viral Hepatitis Cluster Detection and Outbreak Response Plan
2. Provide at least one training on HIV clusters and outbreaks to local and tribal public health
3. Present the Montana HIV and Viral Hepatitis Cluster Detection and Outbreak Response Plan during biannual HPG meetings

Key Partners

CDEpi, HPG members, local and tribal health departments, and public health professionals

Potential Funding Resources

CDC HIV Prevention and Surveillance Programs

Estimated Funding Allocation

$20K CDC HIV Prevention and Surveillance funds

Outcomes *(reported annually, locally monitored more frequently)*

- Annual review and update of the Montana HIV and Viral Hepatitis Cluster Detection and Outbreak Response Plan
- Number of trainings annually on HIV Clusters and Outbreaks provided to local and tribal public health
- Review of the Montana HIV and Viral Hepatitis Cluster Detection and Outbreak Response Plan with HPG

Monitoring Data Source

Surveillance data, MIDIS, and local databases

Expected Impact on the HIV Care Continuum

Improve linkage to medical care and viral suppression for people in counties affected by rapid transmission

Goal #1

Increase capacity and execution of activities for detecting and responding to counties where HIV clusters and outbreaks are more likely to occur by 31 December 2026

Goal #2

Increase the capacity of local and tribal public health to conduct comprehensive HIV case investigation

Objectives/ Strategies

1. Provide at least one training opportunity per year to tribal and local health jurisdictions
    a. DIS module
    b. DIS ECHOs
    c. MIDIS office hours
2. Update the State websites annually to provide resources that local health departments need to conduct HIV case investigations
    a. Funding sources
    b. CDC guidelines
    c. Partner services resources

Key Partners

Infectious disease providers, local and tribal health departments, DIS, University of Montana, Communicable Disease Epidemiology Section, and public health professionals

Potential Funding Resources

CDC HIV Prevention and Surveillance Program and DIS program

Estimated Funding Allocation

$20K CDC HIV Prevention and Surveillance Program and DIS program

Outcomes *(reported annually, locally monitored more frequently)*

To provide HIV training to our local public health workforce to better their understanding of HIV case investigation procedures. This will help ensure we identify clusters and outbreaks quicker and more efficiently.

Monitoring Data Source

Moodle, Surveillance data, and ECHO contractor reports

Expected Impact on the HIV Care Continuum

Identify HIV cases, clusters, and/or outbreaks quicker and ensure the HIV investigations are completed properly and in a timely manner

Objectives/ Strategies

1. Establish a baseline of providers who are ordering the drug resistance/sequencing lab tests by 31 January 2023
2. Determine a baseline of people newly diagnosed with HIV who receive the drug resistance/sequencing lab tests by 31 January 2023
3. Develop a baseline of PLWH who have been tested for drug resistance/sequencing lab test at least once by 31 January 2023
4. Provide at least one educational opportunity per year to educate providers on the importance of the drug resistance/sequencing lab tests starting in 2023

Key Partners

Infectious disease providers, local health jurisdictions, ordering physicians

Potential Funding Resources

CDC HIV Prevention and Surveillance Programs

Estimated Funding Allocation

$25K CDC HIV Prevention and Surveillance Programs

Outcomes *(reported annually, locally monitored more frequently)*

- Baseline of providers ordering drug resistance/sequencing lab tests by 31 January 2023
- Baseline of people newly diagnosed with HIV who receive drug resistance/sequencing lab tests by 31 January 2023
- Baseline of PLWH who have been tested for drug resistance/sequencing lab tests by 31 January 2023
- Number of educational opportunities per year on the importance of drug resistance/sequencing lab tests starting in 2023

Goal #3

Increase the number of providers who order the drug resistance/sequencing lab test for new HIV diagnoses and for cases who are not virally suppressed

Monitoring Data Sources *(Local databases, medical records, surveillance data, etc.)*

MIDIS and eHARS

Expected Impact on the HIV Care Continuum

Increase the percentage of PLWH who are virally suppressed and improve their medical care

Section VI- 2022-2026 Integrated Planning Implementation, Monitoring, and Jurisdictional Follow Up

Implementation

Implementation of the 2022-2026 HIV Integrated Plan is critical to ending the HIV epidemic and will require the collaboration of many entities, including AETC, RWHAP Part B Planning Council, Ryan White case managers, HPG, and the Viral Hepatitis Advisory Council.

The Montana Communicable Disease Control and Prevention Bureau within the Department of Public Health and Human Services (DPHHS) will regularly convene stakeholders and planning bodies to inform them of the progress of the plan's implementation and solicit feedback. Implementation updates to stakeholder groups will include an overview of the goals, strategies, and activities outlined in the previous sections, as well as outcomes of the goals and objectives measured by the data indicators. Additionally, updated surveillance and epidemiological data will also be presented to the HPG, Planning Council, and VHAC to assist in monitoring trends and planning further activities and initiatives.

DPHHS will collaborate with stakeholders on HIV implementation of strategies and will keep stakeholders informed of upcoming and ongoing activities and interventions. Stakeholders will be asked to provide feedback on activities to ensure the strategies are appropriate in reaching the priority population and align with the plan's goals and objectives.

Monitoring

Ongoing monitoring and feedback are critical to ensure that desired health outcomes are achieved. DPHHS will evaluate the plan every 12 months based on available data and feedback from stakeholders. The HIV Integrated Plan is a living document that will be updated throughout the period of implementation based on emerging trends, data, and stakeholder feedback. Feedback will be solicited from AETC, HPG, RWHAP Part B Planning Council, and the Viral Hepatitis Advisory Council (VHAC).

Data to monitor performance will be obtained from CAREWare, MIDIS, and other electronic systems used by the contracted providers. This data will then be aggregated by the recipients for use in reports and for the purposes of the progress assessment.

Evaluation

Consistent periodic evaluation of the effectiveness of the Integrated Plan will ensure that the activities are making changes that positively affect outcomes. This evaluation will include assessing whether the plan activities have been implemented as prescribed by the plan and whether it is moving towards meeting the stated goals and objectives. The plan will be presented each year during the fall HPG meeting.

The implementation of the Integrated HIV Prevention and Care Plan will be evaluated both quantitatively and qualitatively. Quantitative evaluation will consist of annual measurement of the plan objectives and key data indicators described in each section of the plan. Qualitative input will be obtained both formally and informally.

Surveillance reports are developed for HIV, hepatitis C, and STIs every six months. These reports will be used to evaluate both implementations of the plan and progress toward the overall plan objectives. Reports will also continue to be used to develop new strategies, policies, and procedures, especially as they relate to the overall goals and objectives of the Montana Integrated HIV Prevention and Care Plan.

Improvement

Montana intends to update the Integrated Plan each fall. New results can be compared with prior years to study areas of improvement and areas where disparities persist.

Reporting and Dissemination

Reporting and disseminating the Integrated HIV Prevention and Care Plan will occur digitally and by posting the plan on DPHHS's website. An electronic version will be sent to HPG members, RWHAP Planning Council members, and other stakeholders annually to ensure they have the most up-to-date version. Additionally, DPHHS will create a brief Integrated HIV Prevention and Care Plan synopsis to help inform stakeholders and the public more efficiently.

Appendix A

Letters of Concurrence *(HPG Co-Chairs)*

To Whom it May Concern,

The HIV planning group ***concurs*** with the following submission by the Montana Department of Public Health and Human Services in response to the guidance set forth from health department and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need (SCSN) for calendar year (CY) 2022-2026.

The planning body has reviewed the Integrated HIV Prevention and Care Plan submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas with high rates of HIV. The planning body ***concurs*** that the Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the CDC's Notice of Funding Opportunity for Integrated HIV Surveillance and Prevention Programs for Health Departments and the Ryan White HIV/AIDS Program legislation and program guidance.

The fall HPG meeting allowed time for the planning body to review the Integrated Prevention and Care Plan and provide their input to DPHHS.

The signature(s) below confirms the ***concurrence*** of the planning body with the Integrated HIV Prevention and Care Plan.

Andrew Hardison Digitally signed by Andrew Hardison
Date: 2022.12.05 09:57:14 -07'00'

Andy Hardison, HPG Member Co-Chair

Kristi Aklestad Digitally signed by Kristi Aklestad
Date: 2022.12.05 10:51:03 -07'00'

Kristi Aklestad, HPG Member Co-Chair

Letters of Concurrence *(RWHAP Part B)*

To Whom it May Concern,

The RWHAP Part B Planning Council ***concurs*** with the following submission by the Montana Department of Public Health and Human Services in response to the guidance set forth from health department and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need (SCSN) for calendar year (CY) 2022-2026.

The planning body has reviewed the Integrated HIV Prevention and Care Plan submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas with high rates of HIV. The planning body ***concurs*** that the Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the CDC's Notice of Funding Opportunity for Integrated HIV Surveillance and Prevention Programs for Health Departments and the Ryan White HIV/AIDS Program legislation and program guidance.

The fall HPG meeting allowed time for the planning body to review the Integrated Prevention and Care Plan and provide their input to DPHHS.

The signature(s) below confirms the ***concurrence*** of the planning body with the Integrated HIV Prevention and Care Plan.

Robert Elkins Digitally signed by Robert Elkins
Date: 2022.12.05 11:00:22 -07'00'

Robert Elkins, HIV Treatment Coordinator

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