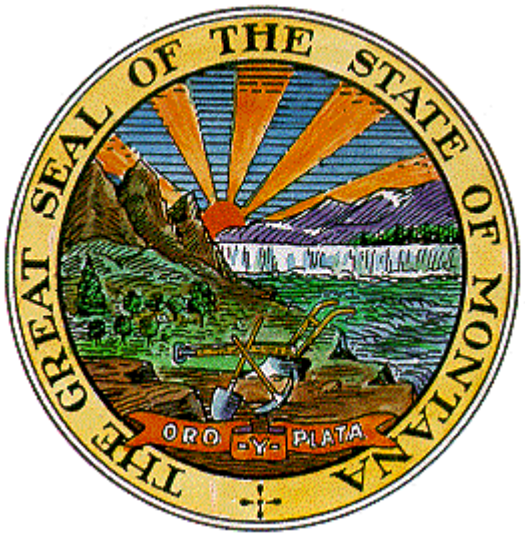

STATE OF MONTANA

Montana 2012 - 2016
Integrated HIV Prevention and Treatment Plan

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September 2012

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ACRONYMS

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

2012-2016 Montana Integrated HIV Prevention Plan

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Montana Integrated HIV Prevention and Treatment Plan

Executive Summary

Montana combined its HIV prevention and HIV treatment statewide planning groups in 2009. Also integrated into planning activities are the persons at risk for or infected with Hepatitis C. This move is bringing greater emphasis on finding persons not in care and getting them into treatment by focusing prevention funds on outreach to persons with unmet need.

In 2011, the Community Planning Group for the State of Montana began to formulate ideas to align its HIV prevention and treatment planning goals with the National HIV/AIDS Strategy. Following the guidance of the Centers for Disease Control and Prevention (CDC), the planning body re-prioritized its targeted populations and chose interventions proven to have the most impact upon the disease. Already integrated in terms of combined treatment and prevention planning, as well the inclusion of STD and Hepatitis C prevention, the group was in an ideal position to implement CDC's new approach toward high impact HIV prevention.

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

Reduce transmission of HIV in the state

Improve health outcomes for persons living with HIV

Expand the network of care, leverage external resources, and reduce duplication of efforts

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To achieve the overarching goals, the newly-renamed HIV Planning Group (HPG) has developed specific HIV prevention and treatment program goals, strategies and action steps. The HPG has also identified possible partners to assist the state's HIV prevention and treatment programs to aid in the quest for reduced transmission and improved health outcomes for Montanans infected with HIV. The planning group has identified specific populations most at risk either for transmission of or for becoming infected with STDs, HIV and Hepatitis C, and will provide appropriate supportive services intended to help at-risk individuals stay uninfected.

The Montana HIV prevention and treatment continuum of care includes activities that focus on both uninfected persons at risk for infection as well as persons living with HIV.

- Social marketing/public information messages and internet outreach activities will attempt to educate and increase awareness of risk behaviors.
- Evaluated and evidence-based interventions will include skills-building training and education to prevent HIV, hepatitis C and sexually transmitted diseases.
- HIV prevention providers will target and test those at risk by performing rapid testing in non-health care settings.
- Intervention facilitators and testing counselors will identify those most at risk and make referrals to appropriate community services and prevention activities
- Testing counselors will link identified positives to care, refer to Ryan White case managers and monitor attendance at first medical appointments.
- Ryan White case managers will ensure access to care, and strive for increased retention in care.
- Both treatment and prevention providers will be asked to refer the highest risk persons, both negative and positive, to Comprehensive Risk Counseling Services.
- Follow-up services will offer persons living with HIV education in disease self-management to facilitate retention in care.
- Prevention providers and case managers will be requested to provide medication adherence counseling and to refer to substance abuse treatment, if necessary.
- All of the above activities will include condom distribution.

These are the main tenets included in the Montana Integrated 2012 HIV Prevention and Treatment Plan, a blueprint for the implementation of Montana's high-impact prevention activities.

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Chapter One is an overview of the diverse membership of the Montana HIV Planning Group and the group's program objectives and action steps to accomplish objectives. It
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demonstrates the collaborative nature inherent among the programs of this rural, low-population state where specialization is rare.

Chapter Two contains the 2011 Epidemiologic Profile. Montana's HIV epidemic is comprised mainly of white males whose risks are having sex with men, sharing injection equipment or both.

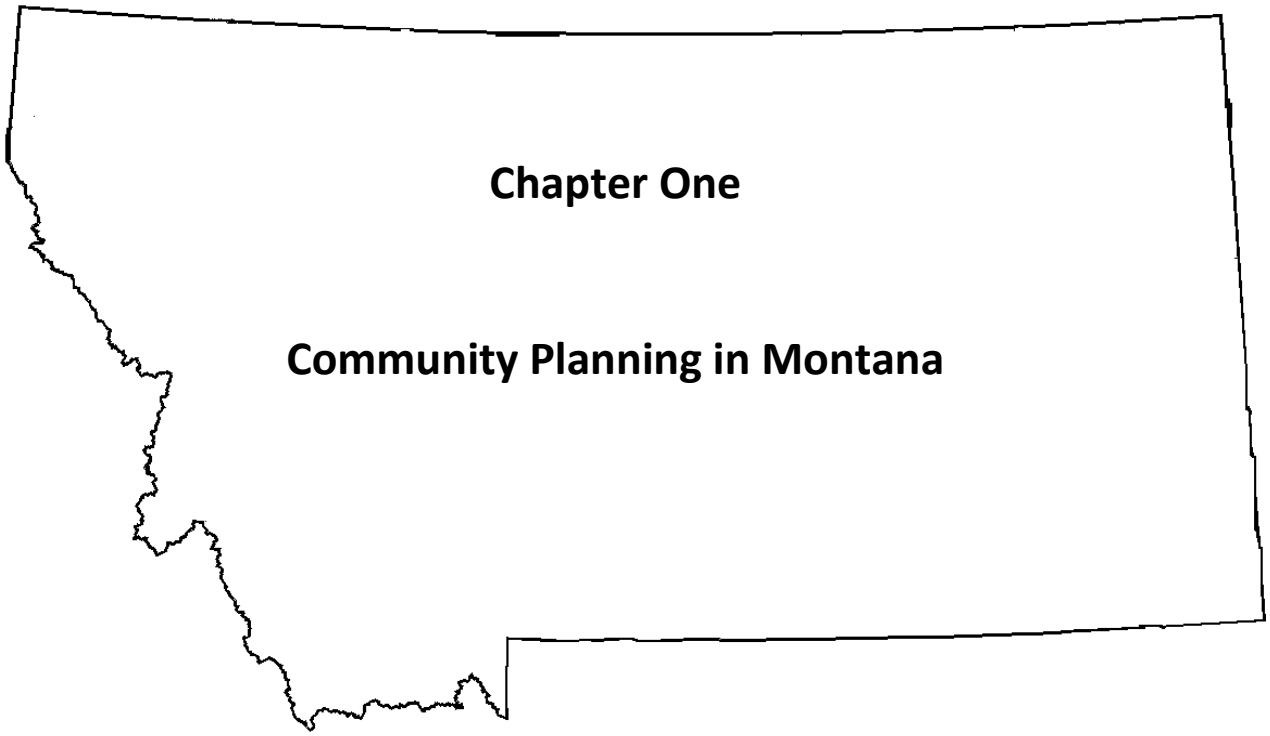
Chapter Three outlines the results of needs assessments conducted for target populations, the 2011 community services assessment and the resulting services gap analysis that guided the planning group's intervention choices. It also lists the objectives set to address identified gaps and needs, in part by providing services that were not being implemented elsewhere.

Chapter Four details the interventions and prevention activities that will be implemented to attain desired outcomes. Counseling, testing and referral programs, support groups and educational retreats, and Comprehensive Risk Counseling Services have been funded. Resource-intensive interventions were reserved for those at highest risk. Social media, such as internet outreach and social marketing/public information messages will be utilized to reduce stigma. Task forces to address policy issues will meet regularly.

Chapter Five features the Statewide Coordinated Statement of Need (SCSN) which will focus on the treatment aspects needed to attain national and statewide goals. Similar to the CDC mandates for HIV prevention programs, Ryan White legislative components of the SCSN include a focus on the needs of individuals who are unaware of their HIV status, bringing all HIV positive persons into care and include referral of HIV negative individuals into services to help keep them HIV-negative. The statewide HIV treatment plan and SCSN developed strategies for addressing the unmet needs of HIV positive persons who know their status but are not in care, and the needs of special populations.

Chapter Six lays out the Engagement Plan which expands the state's HIV treatment and prevention network by enlisting service-delivery partners to aid in comprehensive holistic care, by leveraging services in light of diminishing federal dollars, and through collaboration with medical providers.

And finally, Chapter Seven details the Montana HIV Comprehensive Program Monitoring and Evaluation Plan which will measure progress toward goals using specific performance measures for both treatment and prevention.



Chapter One

Community Planning in Montana

Chapter One

Community Planning in Montana

Montana is a sparsely-populated state of less than one million people scattered over 147,000 square miles. It is a low-incidence state in terms of HIV infection, reporting 545 persons with the disease as of the end of 2011. The demographics of the state's epidemic have changed little over the decades: men who have sex with men and men who have sex with men and also inject drugs comprise 76 percent of the infected male population. Of the prevalent total, 15% are female whose reported risk factors were predominately (77%) heterosexual. Most Montanans classify their race as either non-Hispanic White (89.5%) or American Indian (6.2%). HIV disease demographics in the state closely mirror the general demographic composition of the state's population.

The Montana HIV Prevention Planning Group currently consists of representatives of each targeted and prioritized population including persons living with HIV, men who have sex with men and representatives of the injecting drug community. Also included are American Indian and tribal health representatives, and service providers such as Ryan White case managers, community-based AIDS service organization representatives, and providers of housing, mental health services and harm reduction services.

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

A lesser-populated state with a corresponding limited number of providers not only necessitates that Montana entities deliver multiple services, but also leads to inherent collaboration between entities. Montana HIV program agencies routinely work together, as resources are too scarce to duplicate services. HPG engagement plans for 2012 include expanded and intentional collaboration with other community social services entities as well as tribal health and American Indian Health Services facilities. While one successful HIV prevention endeavor has led to prioritized entry for HIV-positive persons into the Montana State Chemical Dependency Center, and collaboration with the Veterans Administration has recently been increased, more work remains to be done to help clients obtain community services such substance abuse counseling.

Montana is committed to the national efforts to decrease the rate of HIV transmission, to increase access to care, to improve health outcomes for persons living with HIV and to reduce

HIV-related health disparities. In November 2011, the Montana HIV prevention integrated Planning Group developed statewide prevention and treatment goals that are in alignment with the National HIVAIDS Strategy (NHAS). This diverse group also listed barriers, and strategies and action steps relative to their HIV prevention goals. Additionally, in an effort to leverage appropriate community services, ensure holistic care for persons at risk at transmitting HIV or for contracting the infection, and to intensify prevention efforts, the planning group identified possible external partners with which to engage.

Vision for the National HIV/AIDS Strategy

"The United States will become a place where new HIV infections are rare and when they do occur, every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity or socio-economic circumstance, will have unfettered access to high quality, life-extending care, free from stigma and discrimination"

Using the NHAS goals as a guide, the HIV Planning Group (HPG) has set six prevention goals and two treatment goals. Each goal is designed to have an ultimate effect on reducing the transmission of STD, HIV and Hepatitis C, to improve health outcomes for persons living with HIV, and to reduce health disparities in Montana.

The Montana Integrated HIV Prevention Planning Group met a total of four times beginning July 2011 to identify gaps and develop programmatic goals and strategies to meet the goals. On August 3 and 4, 2012, the group met for a fifth time to finalize and prioritize action steps to meet their goals of:

- reducing the number of Montanans who become infected with HIV disease,
- reducing risky behavior,
- increasing the number of persons who know their status,
- linking all positives to care, and,
- providing supportive services which lead to retention in care and undetectable viral loads.

Many of the suggested actions steps are currently being implemented and have been in place in Montana for some time. The group is committed to improving and expanding services, even as funds decrease.

The need for more education emerged as an overwhelming theme in the HPG action steps for the 2012 - 2016 plan. Identified education needs extended across all targeted populations. Listed as possible action steps were:

- cultural sensitivity training for medical providers, corrections personnel, counseling and testing staff, and policy makers;
- health education to empower persons living with HIV and those at risk for acquiring the disease;
- education and training for peers to extend outreach; and,

- education geared toward the general public to fight stigma and to promote testing.

Montana Prevention Goal #1: Reduce the number of Montanans who become infected. Through increased awareness and augmented education, the state's rate of infection will maintain or decrease.

Measure: Maintain or decrease the state infection rate of 2.4 cases per 100,000 by 2016.

Objective: Reduce the number of Montanans who become infected through increased awareness of risk

Barriers to reaching the goal:

- Need for increased sense of responsibility among HIV positive persons
- Need for enhanced public communication strategies

Needed Engagement--Responsible Parties:

- HIV Treatment Case Managers
- Medical providers with emphasis on those who are considered HIV medical providers
- Mental Health Counselors/Chemical Dependency professionals
- State and county health departments
- Prevention and Treatment Contractors/ Support group sponsors
- Hospitals and clinics, and urgent care centers
- Youth organizations, churches, schools and universities and other educational entities
- Social marketing entities
- Partners who may not know they are at risk
- Peers of persons at risk
- HIV-positive clients

Current Activities to Enhance:

- Intensify efforts to engage HIV positive individuals who can act as peer leaders
- Continue social marketing efforts to reduce stigma
- Through education, empower persons living with HIV to make healthy choices
- Increase cultural competency of policy makers and service providers

2013-2016 Key Strategy

Reduce transmission by increasing the proportion of HIV-infected individuals in Montana who are linked to prevention and care by reaching out with a core message to partners, entities, agencies, and others who encounter positive and potentially positive persons.

2013 Action Steps:

- The 2013 strategic action step for reducing the number of infected Montanans is the development of a generalized "core message" which could be distributed in several forms of media. Delivering a consistent message from a reliable source which is designed to increase the awareness of clients, service providers and the general public as to the importance of treatment may assist in reaching a measureable goal of 90% of infected persons in Montana at the appropriate level of care.
  Responsible party: HIV Prevention Program

- Design educational campaign to disseminate core message
  a. Identify those to educate (peer educators, CBOs, health care providers including mental health, school counselors, student groups, etc.)
  b. Determine who will do the educating and how, specifically in regard to treatment, prevention, stigma, dos and don'ts, etc.
  c. Develop and train potential peers and educators with already trained educators, i.e., AETC.
  d. Develop MOUs with people/organizations already engaged as educators and peers
  e. Core messaging – develop a core message "slide set" so that providers, educators, and outreach workers have accurate, consistent resource information available to use based on their audience

Possible Future Action Steps:

- Continue reaching out to HIV individuals and as for their assistance in sharing the core message in a positive way
- Review, evaluate and continue to implement the educational program steps that are already working and are effective.
- Increase cultural competency of service providers
- Brainstorm new ways to educate the public on high risk behaviors, etc. Implement a screening process with the educators to ensure that the core message is being adhered to and delivered.

Montana Prevention Goal #2: DECREASE RISKY SEXUAL AND DRUG-USING BEHAVIORS AMONG PERSONS AT RISK FOR ACQUIRING HIV, STD AND HEPATITIS C.

Measure: Decrease the percentage of those responding to a needs assessment survey that report engaging in unprotected sex by 5% by the end of 2016.

Montana Objectives:

- Implement risk reduction strategies to decrease risky sexual and drug-using behaviors among persons at risk for acquiring HIV, HCV and STDs
- Actively involve community partners to conduct prevention and to identify positives and link them into long-term care and support systems.

Barriers to reaching the goal:

Enlisting cooperation of already over-burdened entities.
Limited funding for outreach activities

Needed Engagement--Responsible Parties:

- Corrections
- Mental health providers
- CBOs
- Hospitals, emergency rooms, clinics
- Montana Nurses Association
- Tribal entities
- Harm Reduction Task Force
- Gay Men's Task Force
- State and local health departments
- AIDS Service Organizations
- Outreach Workers
- Media
- Political entities
- Office of Public Instruction
- Peers, parents, individuals

Current Activities to Enhance:

- Integrate harm reduction into prevention and treatment services.
- Offer high quality counseling and testing training. All counselors/testers will provide or refer clients to integrated testing facilities.
- Identify, prioritize and engage appropriate partners.
- Provide continual education to public on integrated risks, prevention, testing and treatment.
- Recruit "champions" (popular opinion leaders) to promote collaboration.
- Increase cultural competency of corrections/prison staff
- Educate policy leaders on the benefits of harm reduction. Use social marketing to reduce stigma.

2013 – 2016 Key Strategy
Reduce risky behavior through support of outreach systems and enhanced training of testers and harm reduction workers.

Action Steps for 2013

- Support outreach systems and training of harm reduction workers through the development of an "outreach tool box" including guidelines and protocols; safety strategies; communication approaches for street outreach; overdose procedures; education on legal guidelines. Responsible party(s): State staff/Harm Reduction TF
- Engage with Open Aid Alliance to update the MTAP manual. Responsible Party: State, Open Aid Alliance

Possible Follow up Action Steps

- Distribute the updated manual to entities willing to add outreach workers to their list of duties
- HIV Prevention contractors seek peer leaders to conduct outreach
- Pursue political change and create awareness around syringe disposal and exchange.
- Actively utilize media to increase awareness regarding prevention and risky behaviors.
- Explore ways to move ahead with legislation. (Research into other exchange programs pre-existing and previous research on this topic – Harm Reduction Task Force).
- IDU - Needle Exchange Implementation

Montana Prevention Goal #3: Increase the proportion of HIV-infected individuals across Montana who know they are infected.

Measure: Increase sero-positivity rate by .1% annually

Objective:
Increase the number of Montanans who know they are infected by extending targeted testing for HIV, HCV and STDs in Montana to identify those who are infected.

Barriers:

- Lack of involvement, collaboration with non-designated health providers
- Need for more social marketing
- Limited opportunities for HIV-positive individuals to access information and testing.

Needed Engagement - Responsible Parties:

- Counseling and testing contractors
- HIV-positive community
- Non-designated healthcare providers and other health care providers
- Social marketing specialists
- School educators
- Political entities
- Outreach workers
- State health department
- Groups working with families/youth
- Health care providers

Current Action Steps on which to improve/enhance:

- Enhance the skills of counseling and testing personnel through cultural sensitivity trainings. Responsible party: Gay Men's Task Force.
- Identify areas needing CTR; develop appropriate plans and action steps. (State)
- Continue and improve education about routine and targeted testing statewide.
- Continue and improve education/awareness programs about risky behavior and preventions.
- Implement evidence-based risk reduction interventions.
- Train and support testers. Create user-friendly areas and guidelines for testing and data collection.
- Distribute condoms at testing sites. Create user-friendly areas for testing.

2013 – 2016 Key Strategy

Increase the number of infected persons who know their status by strengthening and extending the reach of counseling and testing.

2013 Action Steps

Enhance counseling and testing training system:

- Create user-friendly areas and guidelines for testing and data collection. Explore having follow-up training for tester support (testing and counseling), to stay current, and for certification/updates. (State; contractors; local health departments)
    - NWAETC –web based training for rapid oral test

    - Design strategies to provide tester support, to meet specific tester needs: i.e., web resources (Project MORE)
- Monitor/follow evolving protocol to meet needs of various areas of the state (urban, rural) so that every testing agency has a protocol. (State; contractors; HPG)
- Support testers: conduct a needs assessment
    - Responsible Party – Annie Sondag
- Create a standardized template/policy for post-test counseling
    - Responsible Party – State
- Invite testers from Billings and Missoula and one small site to present at HPG

<u>2014 Action Steps</u>

- Electronic resources: Web-based or electronic refresher course(s) available: i.e. interactive webinars – collaborate, identify trends across the state, incorporate in future trainings
- Programs for parents and youth: disseminate slide set with core message
- Evaluate changes and continue to identify needs

<u>Possible Action Steps for Years 3-4:</u>

- Explore having follow-up training to stay certified. (State; contractors; local health departments)
- Identify areas needing CTR; develop appropriate plans and action steps. (State)
- Implement F/U or post-test counseling. Monitor/follow evolving protocol. (State; contractors; HPG)
- Identify and continue to build partnerships and working relationships to meet clients where they're at.
- Add internet tools
- Disseminate the consistent core message
- Explore the possibility of a web-based counseling and testing refresher course
- Fund useful advocacy programs.
- Legalize/de-criminalize needle exchange. Make available and educate on user-friendly syringe disposal
- Implement comprehensive programs for parents and youth. Education, outreach,
    - Assess what programs/activities exist in communities
    - Identify the needs that can be worked on
- Identify the partners:
    - High risk youth – located in: youth detention centers, youth groups, other programs we can identify and partner with
    - Train parents – how to work with a- risk youth: utilize consistent web-based resources to bridge geographic gap and funding shortage
- Work with partners to make certain they are finding the right people and that they're talking to them via the best communication style (expand cultural sensitivity training).

MONTANA PREVENTION GOAL #4:
Increase the proportion of HIV-infected individuals in Montana who are linked to prevention and care by engaging with informed entities/people who encounter them.
Through the implementation of secondary prevention efforts, Montana has set a measurable objective of increasing the number of HIV positive individuals in care (reducing unmet need), as effective treatment reduces transmission risk.

Measure: By 2016, 90% of infected persons in Montana will be in an appropriate level care.

Objective: Decrease unmet need by increasing awareness of HIV within appropriate entities.

Barriers:

- Need for increased sense of responsibility among HIV positive persons
- Need for updated education as information constantly changes – both the disease and treatment options.

Needed Engagement - Responsible Parties:

- Peers
- Medical providers; chemical dependency providers; other clinical providers including IHS and VA
- Pertinent facilities and social service entities
- CBOs
- State health department
- Professional organizations in the State representing providers

Current Action Steps to improve or enhance:

- Case managers must perform initial counseling for all newly diagnosed HIV positive persons which includes general information about HIV and prevention of transmission; treatment options; continuum of care; community resources and partners in linkage to care, including housing.
- State provides contractual requirement for CBOs to use social networking and internet sites which will include:
    - Social networking outreach
    - Prevention as treatment; education about HIV's effect on the body without treatment
- Include contractual points for training and education of medical providers, clinical providers, HIV positive persons and community partners.

2013-2016 Key Strategy
Reduce unmet need through the development of formal steps that would advance partnerships with entities that might serve HIV positive persons.

Action step for 2013

In conjunction with a possible restructure of the statewide HIV Planning Group, develop a set of criteria for identifying the most effective persons/entities to whom an invitation for engagement should be extended and follow through with those invitations.

Responsible Party: The HPG and the department will implement the engagement plan

Action Step for 2014

- State provides contractual incentive to CBO's for the use of social marketing and internet sites which will include:
    - Social networking outreach
    - Prevention as treatment; education about HIV's effect on the body without treatment (State)

Possible action steps for years 3 – 4

- Include contractual points for training and education of medical providers, clinical providers, HIV positive persons, and community partners; recruit chemical dependence counselors. (State)
- Develop and distribute a useful, up-to-date HIV/AIDS fact sheet (core message).
- Conduct an HIV-positive "boot camp" including 2 hours of personal one-on-one counseling after diagnosis.
- Require state prevention contractors do follow-up to make sure HIV-positive individuals are seeking/receiving appropriate levels of care.
- Recruit chemical dependency counselors; redefine the HPG provider list to include medical, chemical dependency and clinical providers in a membership work group.
- HPG to seek opportunities to engage with the Montana Nurses Association, infectious disease practitioners, AIDS Education and Training Centers and corrections personnel in the state.

Montana Treatment Goal #1:

Increase the proportion of Ryan White clients in continuous care and on antiretroviral therapy who have undetectable viral loads. Through education of clients and service providers, the importance of treatment and knowledge about the progression of HIV in the body among the asymptomatic can be imparted.

Measure: Increase the proportion of Ryan White clients with undetectable viral loads to 95% percent by 2016.

Objective: Reduce transmission through reduction in the community viral load.

Barriers to reaching the goal:

- Separation of case managers and medical providers; limited access to medications
- Montana communities without support; people moving and losing their care.
- Lack of understanding of importance of treatment; some with undetected viral load who are seeking "hookups" believe unprotected anal sex is accepted behavior.
- Lack of transportation to appointments
- Inefficient, ineffective internet searches

Needed Engagement - Responsible Parties:

- State and county health departments
- AIDS Education and Training Centers
- HIV Prevention and treatment Contractors (case managers)
- Social marketing specialists
- Counselors/testers
- Medical providers, including Indian Health Service and tribal health
- Hospitals, urgent care centers and emergency departments and other medical facilities

Current Activities to improve/enhance:

Ryan White Case Managers provide consistent adherence counseling requesting client reports of viral load, cd4 count, and issues of concern.

2013 – 2016 Key Strategy

Engage with prevention and treatment providers to empower clients in self-care.

2013 Action Steps

- Engage with medical providers regarding the importance of treatment and the knowledge of the progression of HIV in the body among the asymptomatic.
- Working with state and prevention contractors, create a "letter of invitation" for potential partners such the AIDS Education and Training Center
- Invite Project MORE staff to do a presentation on internet outreach
- Annually invite AETC to update HPG on updated treatment and testing guidelines

Responsible parties: HPG, Health Department, AETC

2014 – 2016 Possible Action Steps:

- Leverage and nurture all treatment options by expanding the burden shared among potential partners (e.g., CBOs, case managers, providers, client support
- Engage CBOs for training standardized medical guidelines such as when to be tested, how often to be tested, what to be tested for and when to start treatment/types of treatment)
- Expand statewide social marketing messages to target HIV positives not in care. Push "being proud of getting tested." (Explore the Lupus commercial process related to funding, etc.)
- Develop and use a unique ID form for testers, but maintain a checklist with names and telephone information and develop protocols for following up.
- Hand out pill boxes to clients to help remind them about taking medications.

Montana Treatment GOAL #2:

Increase the proportion of Ryan White clients and other HIV positive individuals needing the services, who are permanently housed. Believing that permanent housing increases medication adherence, the HPG will engage with entities that offer housing services.

Measure: The proportion of Ryan White clients who are permanently housed will increase from 85% to 90% by 2016.

Objective: Ensure that the vast majority of HIV positive persons have a safe place to reside.

Barriers to reaching the goal:

- Communication between case managers and HOPWA needs to expand in order to increase support for housing.
- Medical providers are not involved in solving housing issues.
- Unavailability of housing:
    - Need for more stigma-free housing statewide
    - HOPWA has a waiting list and is not available in Bozeman and western Montana

Needed Engagement - Responsible Parties:

- State Health Department
- Contractors
- Case managers
- Local social networks such as churches, non-profits, etc.
- Tri-State HELP (HOPWA)

Current Activities to Enhance

- Connect and build linkages between/among HOPWA, Section 8, identified partners through contractors and case managers to increase housing opportunities.

2013-16 Key Strategy

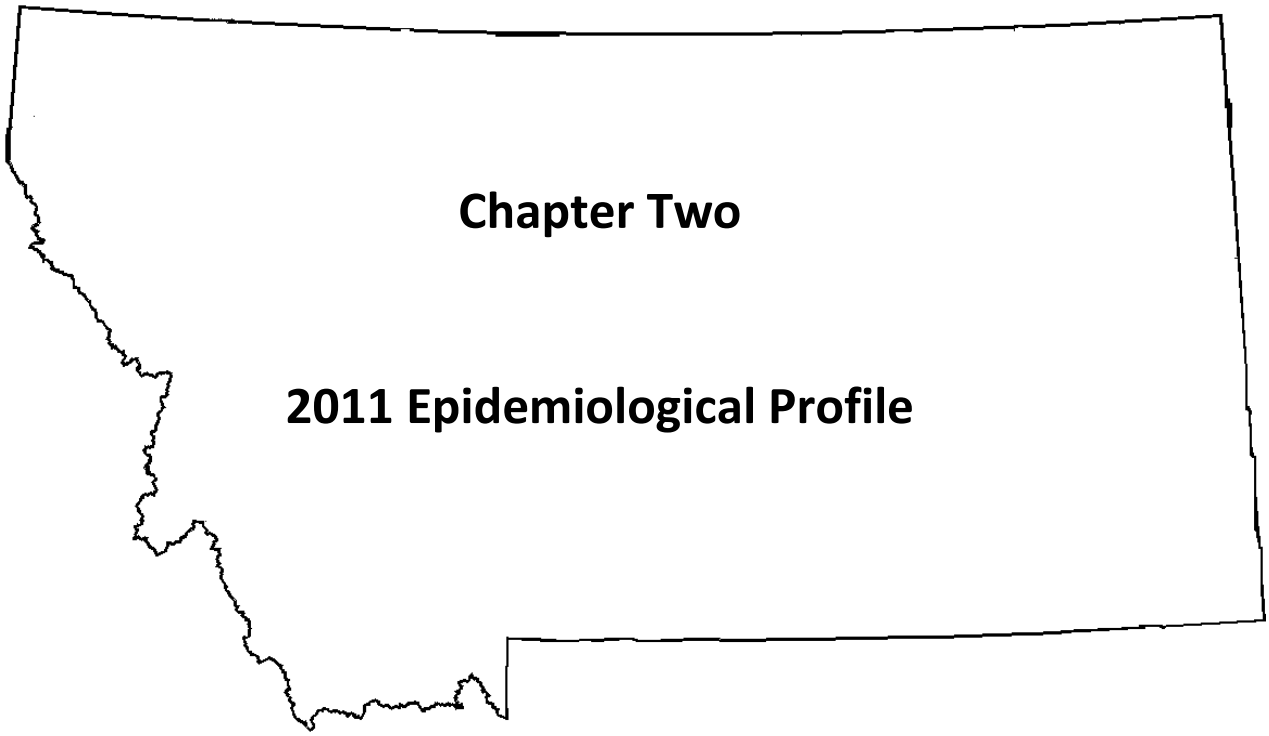
Create and implement a housing resource list, expand appropriate linkages and connections with the goal of empowering clients through education.

2013 Action Step:

- Ask prevention and treatment contractors to develop a list of organizations that offer housing assistance.
- Develop and update a resource list for "regional" housing; engage contractors in updating and expanding on a regular basis. Responsible Party: HPG Treatment Work Group

2014-2016 Action Steps

- Through collaboration between case managers and contractors, advocate for clients to eliminate stigma related to housing. Educate public housing entities and landlords about the "no discrimination" law related to housing.
- Expand statewide social marketing messages to decrease stigma.
- Expand contractors' role to include a clearinghouse related to housing.
- Create MOUs and other formal agreements related to housing.



Chapter Two

2011 Epidemiological Profile

Chapter Two

2011 Epidemiologic Annual Report

(See Attachment 1)

HIV/AIDS Summary

- From 1985, when AIDS reporting was initiated in Montana, to December 31, 2011, a total of 1,070 cases of human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) have been reported to the Montana Department of Public Health and Human Services (DPHHS).

- As of December 2011, 529 persons were known to be living with HIV infection (PLWH) in Montana.

- From 2000–2011, there were 16 - 31 newly diagnosed cases of HIV infection reported each year. Montana is considered a "low incidence" state.

- Nearly 9 of every 10 reported cases of HIV infection have occurred in men.

- The most frequently reported risk characteristic for HIV infection reported by newly diagnosed males is men who have sexual contact with men (MSM). The most frequently reported risk characteristic for HIV infection reported by newly diagnosed females is heterosexual contact.

- Approximately 85% of reported cases of HIV infection occurred in persons classified as non-Hispanic white, a classification that represents about 90% of Montana's population.

- Approximately 7% of the reported cases of HIV infection occurred in persons classified as American Indian/Alaska Native (AI/AN), a classification that represents about 7% of Montana's population.

- Since 2000, the average age at HIV diagnosis is approximately 37 years.

- In 2011, among persons known to be living with HIV infection in Montana, nearly 80% are reported to be receiving medical care.

- Cases of other sexually transmitted diseases (STDs) were reported from 48 of the 56 counties in 2011. *Chlamydia trachomatis* infection (chlamydia; 3,406 cases in 2011) remains the most commonly reported STD followed by *Neisseria gonorrhea* infection (gonorrhea; 85 cases in 2011).

- In 2011, the chlamydia reported incidence rate was 1,206 cases/100,000 population among American Indian/Alaska Native persons, compared to 243 cases/100,000 population among non-Hispanic white persons.

- In 2011, the majority of chlamydia and gonorrhea infection cases were reported among persons 20 - 24 years of age.

- Nine cases of *Treponema pallidum* infection (syphilis) were reported in Montana in 2011.

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The highest risk populations among Montana's prevalent HIV population are men who have sex with men (MSM), MSM who inject drugs, and injection drug users. The population of MSM alone comprises 62% of the infected male populace; the MSM/IDU population adds an additional 14% and male users of injection drugs compose 10% of the infected male population. Thus, the MSM plus MSM/IDU population comprises 76% of Montana's male prevalent cases. Nearly nine of every ten reported cases of HIV have occurred in men.

Ryan White Part C data reflect similar percentages of persons in care. See table below.

Region Ryan White Clients	**Age 13-24**	**Age 25-44**	**Age 45-and over**	**Non-Hispanic White race**	**American Indian**	**Black/AA**	**Other Race,** including Hispanic, mixed and not reported	**Gender**	**Reported Risks for males in RW care**
West **% of 177**	5% (8)	40%	55%	85%	4% (7)	3% (5)	8%	85% male 15% female	MSM 72% MSM/IDU 9% IDU 12% (of 141 males)
East **% of 193**	4% (8)	43%	53%	81%	11% (21)	4% (8)	4%	82% male 18% female	MSM 75% MSM/IDU 6% IDU 6% (of 158 males)
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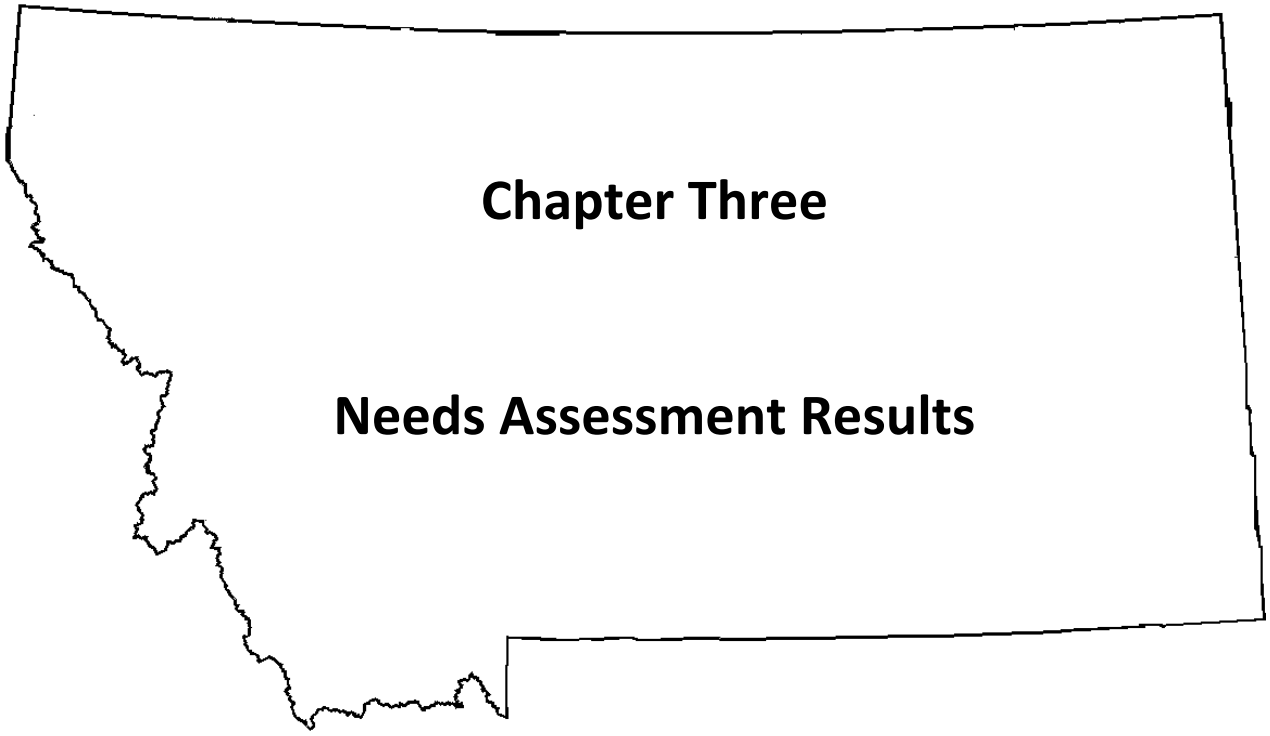
An analysis of Montana HIV surveillance data was completed in an attempt to discern any significant risk factor differences between the eastern region prevalent cases and the western region cases. Statistically, 80% of PLWH in the eastern region are White, 13% are American Indian, and 6% are Black. On the western side of the state, 92% of PLWH are White, 4% AI and 2% are Black. Hispanics comprise 3% of the infected in each of the regions.

See attached Montana 2011 Epidemiologic

HIV/AIDS Annual Report



Chapter Three

Needs Assessment Results

Chapter Three

Needs Assessment: Key Findings

Introduction

As people infected with HIV are living longer lives due to effective treatment it is important for them to access care immediately after infection and to continue in care to protect their health and to reduce their potential of transmitting the virus to others. Key to the success of this "treatment as prevention" focus is identifying barriers to HIV testing, barriers to accessing treatment, and to continuing treatment. Identifying and addressing these barriers is an important step in assuring that people living with HIV are well-supported in a regular system of care that will ultimately improve the quality of their lives and reduce their chances of reinfection or of transmitting the virus to others.

Thus, the purpose of this assessment was to explore the HIV testing, prevention, and treatment needs of people living in Montana who are infected with HIV. Specifically, information from this assessment was used to describe the demographic characteristics of people living with HIV; the behaviors that contribute to reinfection and/or transmission of the virus to others; and barriers to accessing and maintaining HIV testing, prevention and/or treatment services.

Epidemiology of HIV in Montana

Montana is considered a low-HIV-incidence state, with only 16 - 31 newly diagnosed cases of HIV reported each year (Montana DPHHS, 2012). Montana has reported 1025 cases of HIV infection since 1985, with the majority of people living with HIV residing in Yellowstone, Missoula, Gallatin, Flathead, Cascade, Lewis & Clark, and Ravalli counties at the time of diagnosis (Montana DPHHS, 2012). As of December 2009, there were 532 people living with HIV in Montana (Montana DPHHS, 2012). Although women are affected by HIV, men constitute 88% of the 1025 reported cases, making men more at-risk in Montana than women. The greatest percentage of HIV infection was seen in persons classified as White non-Hispanic (90%), representing 90% of the population. However, 7% of reported cases occurred in AI/AN, constituting 6% of Montana's population (Montana DPHHS, 2012).

According to the Montana Department of Public Health and Human Services (Montana DPHHS), most persons in Montana living with HIV were between 30 and 39 years of age at the time of diagnosis, with nine of every 10 reported cases occurring in men. Risk factors that were identified for people living with HIV were heterosexual contact, injection drug use, men

having sex with men (MSM), and no risk factor specified (NRS). MSM accounted for 66% of infections in males, with the second being MSM who inject drugs at 13% (Montana DPHHS, 2012). In 2007, 35% of respondents aged 18 - 65 to the Montana Behavioral Risk Factor Surveillance System (BRFSS), reported previous HIV testing as compared to 42% of the US population (Montana DPHHS, 2010).

Assessment Methods

This assessment utilized a mixed methods design to examine the prevention needs of people who are living with HIV in Montana. Ten interviews with key informants and four focus group interviews with individuals living with HIV were conducted across the state. A total of 32 individuals were involved in the interviews. In addition, a questionnaire was distributed to 346 individuals who are living with HIV. Approximately half of the questionnaires were completed and returned.

Assessment Participants: Although the demographic characteristics of the individuals represented in this assessment varied broadly, there were significant similarities among individuals living with HIV who agreed to participate in a focus group or respond to a questionnaire. The vast majority of participants in this assessment were white males who identified as gay. While there was a broad range of socio-economic and education levels, over half of the individuals earned under $20,000 per year, and most had not graduated from college. A majority of questionnaire respondents reported being unemployed or on disability and approximately a third were receiving housing assistance. Nearly all of the assessment participants (95%) had a case manager, and, therefore were connected to HIV-related services.

The following discussion represents a synthesis of data collected, both qualitatively through interviews and focus groups, and quantitatively through a questionnaire. The researchers explored quality of life issues, behaviors that put individuals at risk for reinfection or transmission of the virus to others, physical and mental health issues, prevention and treatment needs, and barriers to accessing or continuing treatment.

Key Issues:
Quality of Life Issues and Health Problems

People living with HIV suffer from a number of quality of life and health issues that previously have been well-documented in the literature. Participants in this assessment identified stigma, fear of discrimination, loss of personal relationships, and poverty as issues that affect the quality of their lives. Similar quality of life issues were identified by Bravo et al. in 2010 who found that an HIV diagnosis can cause avoidance of previously established social contracts with family, friends, health care systems, and public services due to a fear of stigmatization and discrimination, leading directly to lowered self-esteem, and increased social isolation (Bravo et al., 2010). One key informant summed up the experience of many people living with HIV when they said, "So many clients do not have any other person in their life that they feel they can talk openly to, except their case manager."

> *"So many of our clients, along with their diagnosis, they face poverty which really limits their ability to get the medications they need, to get the resources they need, transportation, so many other things come out of that poverty issue."* –*KI*

> *"As far as depression goes, we have a double-edged sword because most of our population are MSM and gay men on the whole; gay/bi men are four times more likely to be depressed than the general population."* –*KI*

As might be expected, nearly half the individuals who completed the questionnaire identified depression and stress as major health issues. It seems plausible that a diagnosis of HIV infection may propel an otherwise mentally healthy person into depression. Qualitative interview data, however, shed light on the fact that HIV infection may have simply exacerbated a pre-existing condition of depression and not necessarily caused it. One focus group member summed up the feelings of many participants when he said, "I mean, depression has always been a part of my life and it's so not because I am HIV-positive. It's one complicated thing or the other." A second focus group participant related a similar message when he said, "The depression one is a big one,

because when you are first diagnosed you have depression along with probably 100 other things that weren't quite right in your life. None of us were probably doing the healthy and positive things [prior to diagnosis]."

Table 1. Emotional Concerns (n=169)

Emotional Concern	Percent	(n)
Stress	46%	(77)
Depression	43%	(73)
Worry/Fear	37%	(63)
Loneliness	33%	(56)
Anger/Resentment	23%	(39)
Suicidal Tendencies	11%	(19)
Guilt	10%	(17)

In addition to depression, over half of the questionnaire respondents reported having at least one medical issue aside from HIV infection. The list of medical issues ranged from bronchitis to seizures to cancer. No one illness was reported by more than a fifth of the survey respondents and thus, no illness stood out as being particularly prevalent. HCV, however, was the most commonly reported medical condition aside from HIV. While nationwide, approximately 35% of people living with HIV are co-infected with HCV (Proeschold-Bell et al., 2010), the number of individuals reporting co-infection was substantially lower (17%) in this assessment.

Risky Behaviors

Drug and Alcohol Use:

As has been frequently noted in the literature, the use of drugs and alcohol as a mechanism for coping with low self-esteem and depression can lead to unsafe sexual practices and contribute to mental health issues. Studies have found that although individuals are aware of the consequences of their risky sexual behaviors and the effects of those behaviors on their health, depression and hopelessness may lead them to cope in unhealthy ways (Rao et al., 2008, Schwarz et al., 2011). As one key informant stated, "A lot of our positive patients smoke and drink alcohol and do all sorts of things to cope with the trauma of being stigmatized in this society."

Relatively few study participants reported problems associated with drug and alcohol use/abuse.

138 (84%) respondents reported having no problem or a small problem that does not negatively affect their family, social life or work.

While alcohol and other drug use may have contributed to risky behaviors prior to infection with HIV, it is important to note that less than 10% of participants in this assessment reported alcoholism and less than 5% reported addiction to other drugs. Indeed, when asked if drug and alcohol use was a problem, over 80% of questionnaire respondents reported that they did not perceive themselves to have problems associated with drugs and/or alcohol.

Condom Use:

In regards to sexual risky behaviors, almost two-thirds of the participants in this assessment report having stopped sexual relations or report always using condoms. Unfortunately, however, nearly a third of individuals reported "sometimes" or "never" using condoms. One focus group participant summed up many individuals' feelings about condom use when he said, "Nonetheless, safe sex is still not practiced enough within our own community and within any community; with HIV-positive people especially."

Courtenay-Quirk et al. (2009) found 30% of people living with HIV who were also unstably housed or homeless reported some or no condom use during sexual activity. While the rationale for not using condoms is not known, one key informant described it this way, "The reality is fucking is fun. And people do it. And sex is fun. If it didn't feel good, we wouldn't do it, and we have to get to that point of recognizing the excitement of it all and we have to get to the point of recognizing that we sometimes make really stupid decisions when we're sexually excited."

Study participants reported relatively high levels of inconsistent condom use

(sometimes or never use condoms)

- *29% (n=49) of survey respondents reported inconsistent condom use*
  - *37 (38%) of the 96 gay respondents*
  - *21 (22%) of the 96 individuals who identify as single*
  - *17 (41%) of the 41 individuals in a monogamous relationship*
  - *12 (23%) of individuals who identify as heterosexual*

Preferred Prevention and Treatment Services

> *"I've had really good services with the doctors. They all take lots of time with you and any questions that you have they want to give you answers, so at least I want to say that the services I've had here are really good." –FG*

Health Care Providers:
A key purpose of this study was to identify prevention and treatment services that people living with HIV found most helpful. Not surprisingly, interview participants as well as questionnaire participants identified health care providers as key to maintaining both their physical and mental health. Providers who are caring, take time to answer questions, and do not stigmatize their HIV-positive patients are integral to keeping their patients connected to care and treatment. This concept was reinforced by a focus group participant who said, "Sometimes I think that my best healthcare provider was not a doctor; my best healthcare providers were physician assistants and licensed practical nurses because they took the time. They understood my knowledge and my health and my own body in a way that we have some doctor culture that is hard to get through."

Case Managers:
Many participants expressed their appreciation for the assistance, prevention, and treatment services that are currently provided for people living with HIV in Montana. Although barriers do exist that hinder access for some services, case managers were commended for their hard work and continued diligence in offering services that meet the needs of people living with HIV. One participant summed up many individuals' feelings about case management by saying, "I think that there's this sense with case managers at <local clinic>, that people are listened to and they seem to have a positive connection with their case managers. And I think that there's an openness to feel tension or difficulty. People seem like

> *"I feel I am fortunate to have a case worker who does care and who does ask those questions." –FG*

they can go back to their providers when there's problems or questions and they can feel heard, that's really good."

> *Not only does it [retreat] help with the treatment and prevention, but also helps us with our isolation and all that." –FG*

HIV Positive Retreats:

A third important existing service identified by many individuals was the HIV-positive retreats. In comparison to all current prevention interventions-- including support groups, individual counseling, peer counseling, and education--retreats were by far the most popular with nearly two-thirds of survey respondents affirming their importance. One focus group participant stated, "The good thing about treatment and prevention services that we've received is the fall retreat up at <Montana retreat location>. Not only does it help with the treatment and prevention, but also helps us with our isolation and all that." The retreats were identified as opportunities to enhance social interactions with other people living with HIV as well as a means to increase their knowledge-base about other issues related to HIV that might not always be accessible during routine visits to their health care provider. As mentioned by one focus group participant, "I learned more about my meds and how they interact and stuff like that [while attending the retreat]. He just brought up things I never even thought to ask about."

Table 2. Preferred Services Reported Overall and by Gender (n=162)

Preferred Services	All (=162)	Male (n=136)	Female (n=26)
I don't need any services	**28.4%**	**28.2%**	**29.6%**
HIV+ weekend retreats	**32.5%**	**32.4%**	**33.3%**
Group counseling	**18.9%**	**21.1%**	**7.4%**
Group education workshops	**13.6%**	**12.0%**	**22.2%**
Peer counseling	**13.6%**	**14.1%**	**11.1%**
Counselor led HIV+ support groups	**16.0%**	**16.2%**	**14.8%**
Education offered by your primary care provider	**16.0%**	**16.2%**	**14.8%**

Individual counseling	**26.6%**	**27.5%**	**22.2%**

Prevention and Treatment Unmet Needs

Train Professional/Peer/Self Advocates:

A second key purpose of the assessment was to identify important prevention and treatment services that were needed, but not necessarily available. Needs that were identified by focus group and key informant interviewees revealed three main areas of focus. First, was the recognition that people living with HIV should be empowered to advocate for themselves. As one focus group member said, "We still need to remain vigilant. And we are the experts, we know what's going on with our bodies, we feel them. Be proactive." This issue rose to the forefront, in part, because of a recognition that as HIV has transitioned from an acute and deadly disease to one that is chronic and not immediately life threatening, the resources and services designed to assist people living with the infection have both declined and been stretched to their limits as people require services for the long-term.

> *"I would like to see HIV positive people given the tools to help advocate for HIV positive folks."*
> *–KI*

Participants suggested that empowerment can come from case managers assisting their clients in learning to navigate the HIV-related services. As one key informant stated, "That's where it kind of becomes important to have a good case manager that can actually help a person get through those systems because they're not necessarily easy to navigate if you're not familiar with them." In addition, peer advocates could provide people living with HIV the confidence they need to advocate for themselves. One focus group participant identified this need by stating, "What about advocates for people…what if I'm really ill and I don't feel like my doctor is hearing me, what about a person who is available to call them up and say I need you to go to the doctor with me, this person is just not hearing me, you know?" Participants honed in on the importance of peer support, as seen in the form of advocates and other people living with HIV, as a means toward empowerment.

Increase Public Education/Awareness about HIV:

The second important prevention and treatment service need that arose from the interviews was a strong belief that HIV needs to be de-stigmatized within communities, across the state, and at a national level. Assessment participants believed that increased public education through comprehensive sex education in schools and increasing visibility through strategies

such as social marketing would contribute greatly to reducing the stigma that currently surrounds HIV. Comprehensive sex education was viewed as a way to reduce risky sexual behavior and increase the visibility of HIV leading to a decreased stigma associated with HIV.

> *"I just want to solve it all by making comprehensive sex ed. mandatory from a young age and letting that be our guide, knowing and trusting that once people have this comprehensive sex ed. and aren't stigmatized by their bodies or their sexuality or it might be their curiosity, it wouldn't be so hard for folks to access those services."* –KI

The idea of increased visibility was explained by this focus group participant, "I think in places like Montana and smaller populated states it's even more important to have that visibility because it's going to keep creeping. That's all there is to it."

Improve Physicians' Expertise in HIV Care:

The third important need was to improve physicians' expertise in treating people with HIV and to treat them more holistically. Suggestions for improving health care providers' expertise ranged from mandatory HIV trainings, to bringing in expert speakers, to employing an HIV care specialist who is a "circuit rider" and whose job it is to visit each major city in Montana every week. One key informant spoke to the importance of expert speakers, which are currently used at some HIV-positive retreats, "We're really fortunate in our retreats that we tend to bring in national experts on treatment issues… HIV-positive individuals really want to make sure that they have the most up to date education on treatment because we know that single-handedly has made the biggest difference in quality of life issues, for people are the new treatments."

> *"I would've just loved to have seen an HIV care specialist who is a circuit rider who went and had a clinic once a week in every town, like in five major towns in Montana, and that's what they did."* –KI

Treat the Whole Person:

Physicians' expertise was described not only in regard to HIV, but also in regard to a need for comprehensive holistic treatment of HIV including mental and emotional, as well as physical needs. Rao et al. (2008), Bravo et al. (2010), and Hergenrather et al. (2005) also found that they should be treated as integral parts of each other when accessing health care services. One key informant spoke to this idea of holistic care by stating, "I think that people kind of get their mental health needs met on a sort of individual basis, where there's a need for that, but I'm talking about more of an integration of mental health and prevention efforts and also treatment would be great."

PREVENTION AND TREATMENT UNMET NEEDS

- Heighten public awareness of the existence of HIV in Montana and decrease stigma
- Increase knowledge about how to navigate HIV services
- Empower people living with HIV to advocate for themselves and for others living with HIV
- Improve time and location of services/events
- Improve physicians' expertise in treating people with HIV
- Treat the whole person. Address mental and emotional as well as physical needs

Barriers to Testing

A third key purpose of this assessment was to identify barriers to testing. Approximately 21% of questionnaire respondents were diagnosed with AIDS at the same time they discovered they were infected with HIV. When asked about their barriers to being tested earlier, the most frequent responses were that they thought they were at low or no risk for infection, and they were in a monogamous relationship at the time. It should be noted that these barriers are particularly salient for women, although the small number of women who responded to this question make generalizations difficult.

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

Table 3. Barriers to Testing Overall and by Gender among Individuals who were Diagnosed with AIDS when They Tested Positive for HIV (n=162)

	Overall n=50	Male n=45	Female n=5
I thought I was at low or no risk	32.0% (n=16)	28.9% (n=13)	60.0% (n=3)
I was in a monogamous relationship	16.0% (n=8)	13.3% (n=6)	40.0% (n=2)
I was afraid of being discriminated against if I was HIV+	20.0% (n=10)	20.0% (n=9)	20.0% (n=1)
I was too scared to get the test done	16.0% (n=8)	17.8% (n=8)	--
Too scared to find out the results of the test	24.0% (n=12)	26.7% (n=12)	--

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

> *"The stigma comes up again… it's just hard to call a doctor to get a mammogram much less an HIV test. It's just hard to do."* –FG

Barriers to Accessing Services

Cost of Services/Lack of Insurance:

Other barriers to treatment and services appear to be connected with the poor economic status of people living in Montana with HIV. Poor economic status is directly related to uncertainty about how to pay for prevention and treatment services and how to pay for medications. One focus group participant said, "This is the last month I'm being covered [by private insurance]. So at the end of this month, we're gonna have to try to, and they already told me I don't qualify for ADAP because I'm working, that I don't qualify for some other program because I make too much money. I make $950 per month, I don't really see how that's too much money. My medication is twice that." Concern about how to pay for services is not unique to Montana. These barriers mirror those found in previous studies, showing that a lack of health insurance and lack of money to pay for services create barriers that hinder access and continued linkage to services (Schwarz et al., 2011; Wohl et al., 2011).

> *"I don't get travel [money] anymore and I didn't get a raise and I don't know what happened there but they all of a sudden decided I make too much money to get paid travel anymore and my copay for a specialist visit is $50 and I have to drive 225 miles one way to get there and between the copays and the mileage and everything, it mounts up."* –FG

Stigma and Lack of Confidentiality

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

Quality of Medical Care:
While every focus group and a few key informant interviews identified the lack of experienced and knowledgeable health care providers as a barrier to accessing assistance, prevention, or treatment services, this issue was not cited frequently by questionnaire respondents. Similarly, focus group participants and key informants emphasized the lack of positive relationships with health care providers and organizations that provide HIV services; however, lack of positive relationships was not an issue that was cited by questionnaire respondents. Questionnaire respondents' most frequently cited barriers are displayed in tables 4 and 5 below.

Table 4. Questionnaire Respondents' Top 3 Barriers to Accessing Treatment and Services (n=169)

Barriers	Big Barrier	Small Barrier	Not a Barrier
Not having enough insurance coverage	30% (n=51)	25% (n=42)	40% (n=68)
The cost of assistance or treatment	22% (n=37)	27% (n=46)	46% (n=78)
Fear/Stigma	18% n=30	28% n=48	50% (n=85)

Table 5. Questionnaire Respondents' Top 3 Barriers to Accessing Services Reported by Income (n=169)

Income	#1 Big Barrier	#2 Big Barrier	#3 Big Barrier
$35,001-$50,000 (n=12)	Cost of Care (42%)	Lack of Insurance (42%)	Fear and Stigma 25%
$20,001-$35,000 (n=34)	Lack of Insurance (24%)	Cost of Care (18%)	Fear and Stigma (12%)
$10,001-$20,000 (n=45)	Lack of Insurance (27%)	Cost of Care (22%)	Fear and Stigma (16%)
$6,000-$10,000 (n=27)	Fear and Stigma (30%)	Burn Out (30%)	Lack of Insurance (22%)
Less than $6,000 (n=32)	Lack of Insurance (50%)	Cost of Care (30%)	Not knowing what services are available (22%)

Inconvenient Times and Locations of Services

Another barrier to accessing assistance, prevention, and treatment services was identified as the inconvenience of scheduled time and place of services and/or events. Focus group participants felt that most organized events interfered with work schedules or were not accessible due to a lack of transportation due to location. One focus group participant echoed the feelings of others when he said, "All functions here are through the <local CBO> and they're all in the afternoon. I go to work at 2:00 p.m. and I don't get off until 2 o'clock in the morning, they're not on weekends, so unless I want to get up at 6:00 a.m. to get there at 9:00 a.m., that's about the only time I can see them."

> *"Extending the hours, doing some of the functions on weekends, would be nice. All the group meeting and stuff are all Monday-Friday" –FG*

On the other hand, it is interesting to note the issues that questionnaire respondents did not perceive as barriers. Table 6 illustrates the items that were checked as "not a barrier."

Table 6. Top Seven Issues that were Not Barriers to Treatment and Services (n=169)

Not a Barrier	*Percent (n)*
The amount of time I had to wait to get an appointment	81% (n=137)
Discrimination I experience by the persons or organizations providing the service	73% (n=124)
Not having transportation	72% (n=121)
The location of the organization providing services	66% (n=112)
Lack of experience of the person providing services to me	66% (n=112)
My physical health	66% (n=111)
The quality of assistance or treatment	66% (n=111)

> *Over two-thirds of questionnaire respondents did NOT perceive discrimination, transportation, location of services, or inexperienced providers to be barriers to accessing services.*

Linkage to Treatment or Related Services

The most important aspect to accessing services after initial HIV diagnosis is being linked to the proper services. Only one individual in this study had never been linked to treatment services for HIV. The greatest percentage of respondents identified their doctor or health care provider as the person who initially connected them to HIV treatment or related services. The table below describes how HIV-positive people were initially linked to services.

Table 7. Linkage to Treatment or Related Services of Questionnaire Respondents (n=165)

Means by which the Individual was Linked to Services	Percent (n)
My personal doctor/health care provider connected me with treatment and services	36.4% (n=60)
The person who did my HIV test linked me to treatment services	20.6% (n=34)
The person who did my HIV test referred me to a Ryan White case manager	16.4% (n=27)
I have never been linked to treatment or related services for HIV	.6% (n=1)
I looked on the internet to find out where to get treatment and services	3.0% (n=5)
I have an HIV positive friend/acquaintance who helped me find services	7.9% (n=13)
Other	15.1% (n=25)

Not Linked to a Case Manager

Although only 14 respondents identified as never had or no longer have a case manager, 23 respondents answered the question pertaining to the reason why they no longer or have never been connected to a case manager. Respondents were asked to identify all reasons that applied to their neglecting to connect to a case manager or discontinuing the relationship with their case manager; therefore, the total percentage was more than 100%. Table 8 demonstrates the top four reasons for no longer or never having been connected to a case manager.

Table 8. Reasons for Not Connecting or Discontinuing Connection to a Case Manager (n=23)

Reason	Percent (n)
I live too far away	21.7% (n=5)
I don't know how a case manager could help me	17.4% (n=4)
I don't need services	17.4% (n=4)
I can get services myself	30.4% (n=7)

Limitations of the Assessment

A number of limitations exist in this assessment. When interpreting findings it is important to note that only 190 of the 532 individuals known to be living with HIV in Montana are represented by this data. Over ninety percent of questionnaire respondents had a case manager and only one individual was not linked to treatment or other HIV related services. It seems reasonable to assume, therefore, that individuals who did not participate in the assessment represent a wide range of individuals living with HIV; some of whom are in possession of all the services they need, while at the other end of the spectrum there are individuals who may be so impoverished or isolated that they are not aware of or able to access much needed HIV-related services. Furthermore, while HIV-positive Native Americans and women living with HIV were represented among the questionnaire respondents in proportion to their numbers statewide, they were not represented in the focus groups or interviews. As such, the information in this assessment does not fully represent all people living with HIV in Montana. It also is important to note that data analysis was limited by the project directors' abilities and biases.

Conclusions

Currently, the goal of the National HIV/AIDS Strategy (2010) is to offer every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity or socioeconomic circumstance, unfettered access to high quality, life-extending care, free from stigma and discrimination (National HIV/AIDS Strategy, 2010). However, as HIV has shifted from an acute death sentence to a chronic, yet treatable disease, many barriers continue to hinder proper care and treatment for people living with HIV.

This assessment was an attempt to explore quality of life issues and examine the barriers that inhibit HIV-related prevention and treatment for people in Montana living with HIV. Approximately 190 HIV-positive individuals took part in focus group interviews and/or completed a questionnaire, with 10 key informants participating in one-on-one interviews. Although HIV-positive individuals participating in this assessment represented great diversity in regard to gender, age, income, and education level, the majority of participants were single, middle-aged, white men with limited income. Most assessment participants reported being infected with HIV through sex with a man and have been living with an HIV diagnosis for over 5 years.

Quality of life for the majority of the individuals in this assessment was affected in large part by poverty, stress and depression. The vast majority of participants reported incomes below $20,000 per year and indicated that worry about the future, loneliness, and isolation were major concerns for them. Foremost among the needs uncovered in this assessment were the need to have access to health care providers who are holistic, caring and current in their knowledge about treating HIV; the need to feel empowered to advocate for themselves and for others living with HIV; and, the need to decrease the stigma and discrimination associated with being HIV-positive.

Lack of insurance coupled with the high cost of prevention and treatment services were cited most frequently as barriers to accessing HIV-related treatment and services. Concern about the cost of services came to the forefront in focus groups, interviews and questionnaires, and held true regardless of income, gender or region of the state. Other barriers frequently mentioned in focus group and key informant interviews as obstacles to seeking services included stigma, discrimination and lack of transportation. These barriers have held a prominent place in the research literature and in past needs assessments conducted in Montana. Interestingly, however, only a small percentage of questionnaire respondents indicated that these issues were significant barriers.

Because testing for HIV is a critical component of prevention, individuals who were diagnosed with AIDS at the same time they received their HIV test were asked their reasons for postponing testing. Assessment participants' number one barrier to seeking a test was the belief that they were "at low or no risk of infection." This barrier was especially true for women, and is not particularly surprising given Montana's low HIV incidence rate. This finding does, however, highlight the importance of confronting the on-going challenge of realistically addressing the risk of infection in rural, low incidence states.

Recommendations

Given the quality of life issues and barriers to services faced by many individuals living with HIV in Montana, it is no surprise that the majority of assessment participants felt strongly that Montana should continue to support HIV-positive retreats, maintain and possibly increase the availability of case management services, and continue to offer support groups and individual counseling. All of these services help to combat feelings of loneliness and isolation and also have been shown to decrease depression. Many HIV-positive individuals also spoke about the need to be empowered and to learn to serve as advocates for themselves and for other people living with HIV. And finally, participants repeatedly stressed the need to decrease stigma by increasing the general public's awareness of HIV through comprehensive sexuality education in public schools and increasing the use of social marketing and social networking strategies.

Information gathered in this assessment supports the perspective of the National HIV/AIDS Strategy that states, "HIV disproportionately affects the most vulnerable in our society—those Americans who have less access to prevention and treatment services and, as a result, often have poorer health outcomes." It became clear through the course of this assessment that, for many people in Montana who are living with HIV, issues such as poverty, lack of suitable employment, stigma regarding being gay, and lack of access to services for mental health issues like anxiety and depression, were factors that were present prior to infection with HIV and therefore complicated efforts to address prevention both before and after an HIV diagnosis. For many years prevention specialists ignored or attempted to address these broader social and emotional issues with individual-level interventions. There is, however, a growing awareness that although some individual-level interventions have been successful in reducing risk behavior, their success is substantially improved when interventions address the broader structural factors that influence risk behaviors, such as poverty, policy and power (Dean and Fenton, 2010).

> HIV disproportionately affects the most vulnerable in our society—those Americans who have less access to prevention and treatment services and, as a result, often have poorer health outcomes.
>
> *National HIV/AIDS Strategy (2010)*

Prevention specialists in Montana have answered the call to address these broader structural interventions. Specifically, they have made significant strides toward improving program coordination and service integration; they have established task forces for the purpose of examining opportunities for policy and legislative approaches to prevention; they are in the process of shifting to prevention approaches that include community-level as well as individual-level interventions; and, they are investing in research that helps in understanding the social and structural barriers to prevention. While progress has been made, it is clear that more work needs to be done. The issues identified in this assessment reinforce the need to increase efforts to approach HIV treatment and prevention from a holistic perspective. Thus, Montana prevention specialists should remain vigilant and continue their pursuit of prevention approaches that address, not only the individual's physical health needs, but also emotional, social and economic needs.

Community Services Assessment

Needs Assessment Review and Findings

July 8 and 9, 2011 HPG Meeting

Summary by Ginny Tribe

Target Population – MSM (out)

1. Incidence and prevalence
   - 62% MSM
   - 14% MSM/IDU

2. Demographic characteristics: majority are white men living in Billings and Missoula areas who have sex with men

3. Specific behaviors contributing to transmission
   - Bareback
   - Alcohol/drugs
   - Internet – anonymous

4. Aspects of the social and physical environment contributing to spread of
   - Smaller communities
   - Alcohol/drugs
   - Social isolation

5. Behaviors and/or social and environmental aspects most important to address
   - Bareback
   - Drugs/alcohol
   - Sex education

6. 1, & 6. 2. Factors having the most influence on those behaviors/aspects…most important and changeable
   - Bareback – Social skills
   - Drugs/alcohol- Inhibitions
   - Sex education – politics/educating educators

7. Existing resources and services already addressing factors

8. Gaps between needs and services
   - East vs. west in the State
   - Age disparity

Target Population – MSM (closeted)

1. and 2. Incidence and prevalence… Demographic characteristics
    - No scientific data; suspicions but not verifiable; unknown

3. Specific behaviors contributing to transmission
    - Partner non-communication
    - Unprotected sex
    - Self-medication (substance abuse, addiction)
    - Travel
    - Lying or failure to disclose
    - Anonymity
    - Self-isolation

4. Aspects of the social and physical environment contributing to spread of
    - Stigma
    - Peers; social groups
    - Professionalism; job security; status
    - Attitudes and beliefs
    - Lack of real or perceived family support
    - Safety; lack of safe space

5. Behaviors and/or social/environmental aspects most important to address
    - Poor communication
    - Unprotected sex
    - Self-medication
    - Frequency of hookups

6. 1. Factors having the most influence on those behaviors/aspects
    - Unprotected sex (ignorance, laziness, preference, narcissism, no condoms, excitement)
    - Partner communication (anonymity, role-playing, adrenaline junkies, shame, judgment, society, excitement)
    - Self-medicating (shame, fear, fun, excitement)

6.2. Most important and changeable
    - Excitement – need to address this – anonymity as fun
    - Ignorance – marketing knowledge – real facts

7. Existing resources and services already addressing factors
    - Ignorance – Social marketing
    - Excitement – Social circles; online communities; porn

8. Gaps between needs and services
   - Knowledge – at least in planning, sexual excitement
   - Marketing information to persons who are not self-identified MSM
   - Address denial, empowerment.
   - How do we address the fact that health education rarely acknowledges how sex is exciting, fun, and dangerous – all things most teenagers are drawn to - we need to empower without judgment.

Target Population – Heterosexuals

1. Incidence and prevalence
   - 76 total

2. Demographic characteristics
   - 25-54 in age; 8/14 – female; 6/14 male; Region 3/5 : Missoula/Billings

3. Specific behaviors contributing to transmission…
   - Unprotected heterosexual intercourse – no condom use
   - Substance abuse/IDU
   - Tattooing/branding/vampire
   - Down low population

4. Aspects of the social and physical environment contributing to spread of
   - Lack of education on risk
   - Providers – time; failure to routinize
   - Cost – “goddamn insurance”; lack of resources
   - “Montana mentality”; anti-gay attitudes/religious right/”Christian”
   - Stigma – not wanting to know/be labeled
   - Small community – confidentiality

5. Behaviors and/or social/environmental aspects most important to address
   - Education of providers/public (kids and parents)
   - Increasing testing
   - Increasing awareness against stigma/societal attitudes

6. Factors having the most influence on those behaviors/aspects
   - Provider/public education (Knowledge, policy, outdated/incorrect information; lack of incentive to keep up-to-date; cost; personal values)
   - Increasing testing (Access, i.e., offsite, Health Fairs; cost and time of staff; fear of process of testing; knowledge of anonymous testing; education to staff/public; wanting status unknown/fear)
   - Stigma/societal attitudes (Education/lack of knowledge; policy; desensitizing – media; more testing in any atmosphere)

Most important and changeable
- Access
- Education
- Policy

7. Existing resources and services already addressing factors…
   - Access but need outreach
   - Education – but more
   - Policy – routinized testing (CDC); RFP guidance but more local

8. Gaps between needs and services
   - Social marketing
   - Branching out education to non-traditional high risk groups (i.e., elderly)
   - Advocating (policy)

Target Population – IDU

1. Incidence and prevalence
   - 20% diagnosed cases since 1985
   - 5 newly diagnosed cases for 2010
   - 261 total since 1985

2. Demographic characteristics
   - White non-Hispanic
   - Heterosexual identity
   - Average age – 30
   - Primarily Regions 4 and 5

3. Specific behaviors contributing to transmission
   - Multiple sexual partners
   - Sharing equipment
   - Not getting tested
   - Lack of knowledge or access to clean supplies
   - Lack of harm reduction methods (lack of knowledge of risk behavior and options; lack of adequate education in schools; lack of comprehensive sex education)

4. Aspects of the social and physical environment contributing to spread of
   - Ignorance of incidence in Montana
   - Poor self-esteem
   - Stigma
   - Isolation

- Idea that there are no resources available
- Getting high feels good – self-medication
- Idea that there are no outlets for harm reduction
- Community support outside of treatment/rehabilitation; generational

5. Behaviors and/or social and environmental aspects most important to address
   - Education/testing
   - Access to risk reduction supplies
   - Advocate for policy change (i.e., risk reduction supplies; needle exchange; getting into schools)

6. Factors having the most influence on those behaviors/aspects
   - Education
     - Safety
     - Trust
     - Fear of isolation

   - Access to risk reduction supplies
     - Fear of law enforcement policy
     - Not enough supplies
     - No knowledge where to get supplies

   - Advocate for policy change
     - Stigma
     - Conservative climate in Montana
     - Misinformation

   Most important and changeable
   - Access to supplies
   - Access to education and risk reduction
   - Access to counseling and testing

7. Existing resources and services already addressing factors
   - Limited underground exchange
   - Limited risk reduction services
   - Some outreach
   - Limited HIV/HCV tests/supplies

8. Gaps between needs and services
   - Access to treatment
   - Lack of funding
   - Lack of positive media messages
   - Lack of political/social support
   - Comprehensive education in schools

Target Population – HIV Positive

1. Incidence and prevalence
   - 20 cases in 2010; 31 cases in 2009
   - Total in Montana – 532 HIV/AIDS

2. Demographic characteristics
   - 53% under 35 years of age but the population is aging
   - White – non-Hispanic
   - Native Americans (number one minority)
   - Male
   - Urban (Billings/Yellowstone County, Missoula/Missoula County, Cascade County, Flathead County, Gallatin County)
   - Low income (as listed in Needs Assessments)

3. Specific behaviors contributing to transmission
   - MSM
   - Unprotected anal sex
   - Lack of condom use
   - Not asking partners' status and not disclosing personal status
   - Two positive have unprotected sex with partners with STD
   - Non-adherence
   - Substance abuse

4. Aspects of the social and physical environment contributing to spread of
   - Stigma (anti-gay)
   - Mental health
   - Rural – travel to and from urban areas
   - Substance abuse (pressure to use)
   - Lack of communication (lack of face-to-face; sexting)
   - Social norms
   - Lack of empowerment (particularly women)
   - Internet – quick hookups
   - (Identify reasons why some are not in care - needs assessment needed)

5. Behaviors and/or social/environmental aspects most important to address
   - Unprotected anal sex – lack of condom use
   - Partner denial (with positives)
   - Not getting tested/late testing
   - Adherence to medications

6. 1, 2. Factors having the most influence on those behaviors/aspects
   - Lack of negotiation skills, knowledge, access; low perception of risk (LPOR)
   - LPOR; lack of communication skills; undetectable viral load; fear of rejection
   - Stigma; transportation; confidentiality; LPOR
   - Transportation; mental health; substance use; support systems; medication side effects; communication/bonding with physicians/provider)

6.2. Most important and changeable

- Low perception of risk
- Skills to negotiate (partner, providers); empower and education
- Lack of knowledge/risk
- Stigma – normalize testing

7. Existing resources and services already addressing factors
   - AETC – Tribal Bear Project
   - YAP; MAC; BASS, etc. (Prevention sites)
   - Ryan White Case Managers
   - GYT/Internet

8. Gaps between needs and services
   - Mental health services
   - Outreach
   - Work with area representatives (lobby)
   - Large media campaign across the entire State
   - Retreats are missing people
   - Access to care – transportation
   - Document like a wallet card = women and men's chart of healthcare exams (like an immunization chart) to include an "Adult health maintenance checklist"

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Ranking Populations

With the acknowledgement that CDC recognizes HIV+ as the top ranked population, Planning Group members agreed unanimously on the following ranking of remaining target populations:

1) MSM

2) IDU

3) Heterosexual
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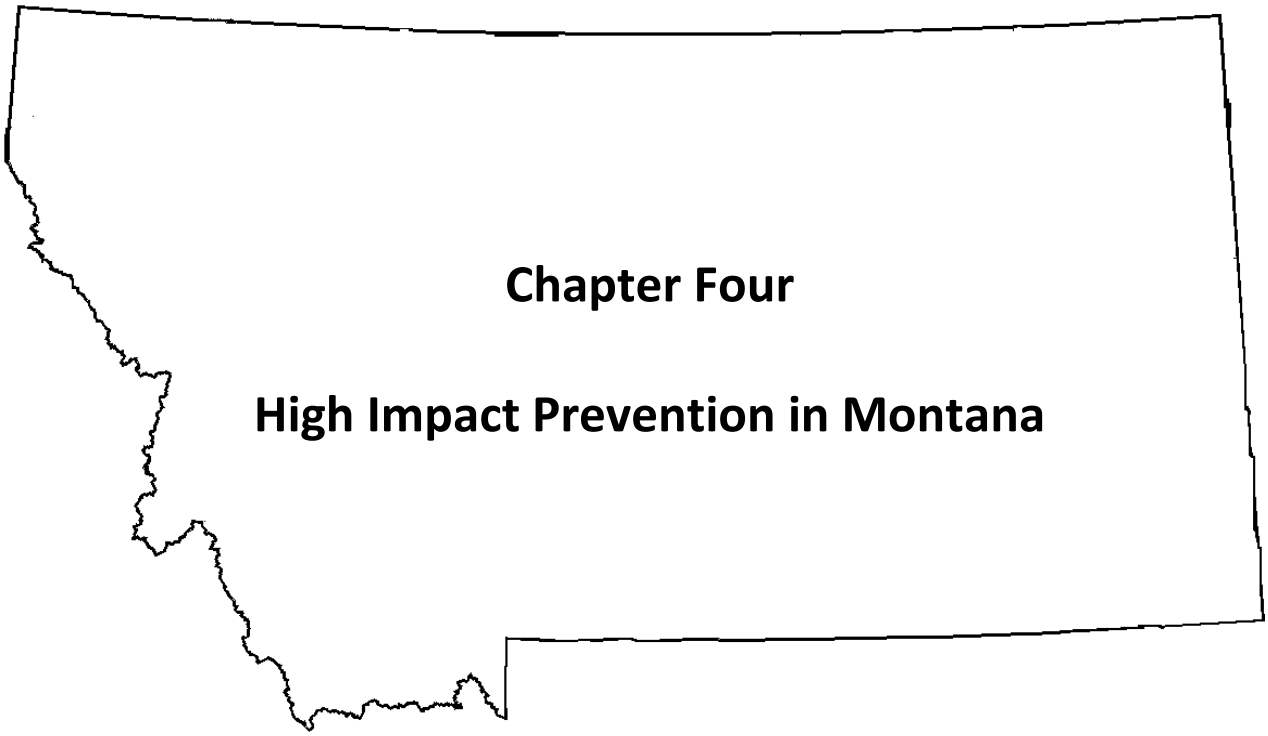


Chapter Four

High Impact Prevention in Montana

Chapter Four
The Montana High Impact Prevention Program

Counseling, Testing, and Referral

Montana's current prevention program is broadly distributed, and includes 22 contractors that perform prevention activities in the state's nine largest cities and on four Indian reservations. An additional contractor provides social marketing/public information services statewide. Four groups--HIV-positive persons, men who have sex with men, persons who inject drugs and heterosexuals of highest risk--are prioritized for 2013 prevention services. Counseling and testing is performed through 18 contracted sites that test in dozens of locations including corrections facilities and youth detention centers, gay bars, migrant worker camps, domestic violence centers, homeless shelters, chemical dependency treatment sites, adult book stores, AIDS service organization, college student union buildings, and local health departments and American Indian health facilities.

All counseling and testing and referral (CTR) contractors are required to use rapid tests and provide results during the testing events. Contractors are to have a referral system in place to obtain confirmatory testing and to assure entry into care.

CTR sites have developed good working relationships with local medical providers. Contractors without medical facilities will be required to have letters or memos of understanding with local medical providers to set up arrangements for confirmatory testing blood samples to be sent to the state public health lab.

2012 prevention contractors are required to deliver targeted CTR services in non-healthcare settings frequented by persons at risk. Such sites are corrections facilities and youth detention centers, gay bars, homeless shelters and adult book stores. Community health centers who serve those of highest risk will be also utilized as these facilities serve populations who participate in risky behaviors.

Counseling and testing contractors will be required to work with neighborhood birthing facilities to ensure availability of rapid testing for untested women in labor. Testers must counsel pregnant women regarding perinatal transmission of HIV and recommend testing.

Funded providers are contractually required to particularly target MSM. Data from counseling and testing forms will be analyzed to ensure that testing events focus on those of highest risk.

Testing consent in Montana is an opt-out procedure. While informed consent is required, no written consent is needed. Even if testing is refused, clients should receive help to identify the specific behaviors putting them at risk for acquiring or transmitting HIV and commit to

steps to reduce this risk. CTR contractors are also required to deliver information to clients regarding HIV transmission and prevention and the meaning of HIV test results.

Two of the goals of CTR services are that all newly identified positive individuals are given confirmed test results in person, and are then referred to medical care and attend their first appointment. All positive test results are individually followed once the testing form is received at the state health department. Each tester is contacted by health department prevention personnel to ensure that a confirmatory test was accomplished, that the client was informed of the results and that the client entered care.
CTR sites will be required to strive to increase their past sero-positivity rate by 10 percentage points. Each preliminary positive test result is to be delivered at the time of the testing event. Testing contractors will be expected to assist local health department personnel with partner contact services and to coordinate care entry with the nearest Ryan White case manager.

Five of the six largest anticipated testing sites have in-house referral systems in place. CTR entities that do not have HIV providers would be required to have referral systems in place for their proposal to be successfully funded. CTR contractors must have a detailed procedure that would ensure that the client would receive confirmatory testing and the results of that confirmatory test.

All counseling and testing contractors will be required to follow clients through the linkage-to-care process from preliminary positive results to assuring confirmatory testing, delivering confirmatory tests results, linkage to care and attendance at first appointment. A form will be developed for testers to complete, and a follow-up call from the grantee will be made once the form is received by the state. Partnerships will have to be formed and memorandums of understanding will be developed to ensure a seamless process at each testing site.

Contractors will be responsible to ensure that the transition from confirmed-positive client to a fully-enrolled patient in HIV care is accomplished. Clients will be given priority assistance to ease them through the process.

Montana law requires that confirmatory testing be conducted by the Montana Public Health Laboratory. Contractors/local health department personnel/private providers are required to send a specimen (blood draw) to the lab, and results are given to the requesting agency as well as to the state HIV Prevention Program and HIV Surveillance Coordinator.

Funded testing contractors are required to have policy and/or letters of understanding in place between the contractor and the corrections facility to accomplish entry into care when the newly-identified are tested while still in custody. Ryan White sites in Montana are required to maintain relationships with local corrections facilities to allow transition to HIV case management upon release. The state's AIDS Drug Assistance Program prioritizes the newly discharged and holds enrollment slots for those incarcerated for relatively shorter periods.

Montana contractually requires that testers offer partner services after a preliminary positive test. They are also required to assist the local public health department with partner notification.

Testing Outcomes. In addition to individual contractor goals of increasing their sero-positivity rates and striving to see that all confirmed newly-positive persons attend their first HIV medical appointment, the prevention grantee will set the objective of increasing the percentage of persons diagnosed with HIV at earlier stages of the disease by 5% in 2012.

Counseling, Testing and Referral Goals

Goal: Prevent New Infections

Objective 1: By 2013, increase by 2% percent the number of persons diagnosed with HIV at earlier stage of disease

Strategy: Intensify outreach efforts to reach younger HIV positive MSM

Objective 2: 100% of newly identified, confirmed-positive results will be returned to clients

Strategy: All CTR contractors will have policy and procedures in place to follow clients with preliminary positive test results through the confirmatory testing process

Objective 3: 95% of newly identified confirmed-positive persons with HIV will attend their first medical appointment

Strategy: All CTR contractors will develop policy and procedures to ensure that newly identified, confirmed-positive clients attend their first medical appointment

Prevention for Positives Program

From Testing to Care. All counseling and testing contractors will be required to follow clients through the linkage-to-care process from preliminary positive results to assuring confirmatory testing, delivering confirmatory tests results, linkage to care and attendance at first appointment. A form will be developed for testers to complete, and a follow-up call from the grantee will be made once the form is received by the state. Partnerships will have to be formed and memorandums of understanding will be developed to ensure a seamless process at each testing site. Plans to handle off-hours confirmatory testing will have to be explicitly designed.

Contractors will be responsible to ensure that the transition from confirmed-positive client to a fully-enrolled patient in HIV care is accomplished. Clients will be given priority assistance to ease them through the process. This process at both of the two largest CTR sites, which are the AIDS service organizations (ASO) in the two cities with more than 30% of the HIV population in the state, is already fully developed and being successfully implemented. One of the sites calls the medical provider site when a preliminary positive is received; a

prevention specialist goes to the ASO, draws the confirmatory blood, and spends as much time as needed conducting prevention counseling with the client with a preliminary positive. This prevention specialist would be the same person that notifies the client about the confirmatory and sets up the first HIV care appointment as well as a visit with the Ryan White case manager.

The other CTR site has a similar process, except they physically walk a client with a preliminary positive to the medical provider where the confirmatory blood test is drawn and the client meets with a Ryan White case manager. Thus a relationship with the HIV clinic and the Ryan White case management system is immediately established at both of the most active sites where the vast majority of HIV positive persons in the state are provided specialty care.

As demonstrated above, in the relatively small cities of Montana, the move from testing to care is within easy reach, often in the same building; sometimes just a short walk away. Some testing sites without HIV specialty providers personally transport clients to care facilities.

Once a newly-identified person is established in care, Ryan White case managers have regular visits to monitor care and treatment adherence and to assess social needs. Assessments are accomplished at the Ryan White sites to determine individual needs such as housing and substance abuse counseling.

Newly-identified clients are given a list of resources at the testing sites. Case managers are also knowledgeable about prevention services that are available locally to each Ryan White client. Prevention and treatment services are often delivered out of the same facility.

All funded prevention activities will include emphasis on the need for care and treatment within the scheduled curricula. Peer leaders will be enlisted to encourage those out of care to re-engage. The use of Ryan White case managers is to be strongly encouraged.

HIV prevention services providers are required to have resource lists available to those they reach. The resource list is provided by the state. In addition, Ryan White case managers are skilled in making appropriate referrals. Prevention service providers are to make referrals to the local case manager and the state's HOPWA program, as well as to the providers of CRCS.

Comprehensive Prevention for Positives Goals

Goal: Increase Linkage to and Impact of Prevention Care and Services

- Objective 1: By 2013, increase by 2% the percentage of HIV–diagnosed persons in care whose most recent viral load test in the past 12 months was undetectable
- Strategy 1: Prevention contractors will include within each intervention activities and education that emphasize the importance of treatment
- Strategy 2. Enlist the aid of peer leaders to bring to intervention activities to those who are aware of their HIV positive status, but are not in care

Objective 2: After baseline is established, reduce by 5% the percentage of HIV positive persons in care who report unprotected anal intercourse in 2014.

Strategy 1: Include education and support for condom use in all comprehensive prevention for positives activities

Strategy 2: Collaborate with Ryan White case managers to include education and support for condom use during case management visits

Strategy 3: Collaborate with Ryan White case managers to include adherence counseling during case management visits

Other Health Education/Risk Reduction Interventions

Because the majority of Montana HIV cases are MSM or MSM/IDU, the Montana HIV Planning Group (HPG) has chosen men who have sex with men and MSM who also inject drugs as their second priority population behind HIV-positive persons. The Effective Intervention Workgroup recommended to the full HPG at the September 2011 meeting to fund MpowerMT, MSM support group activities and MSM retreats, including an HIV Positive Partners Retreat which is specially designed for sero-discordant couples.

Three contractors were funded for retreat-type interventions designed for persons with HIV, and three contracts include weekend retreats for PLWH. Three sites are funded for HIV positive support groups and four are funded to sponsor MSM support groups. These ongoing interventions provide HIV prevention education as well as social networking opportunities. Two community-based organizations implement MpowerMT, which reaches young MSM in various venues across the state. The cost for delivering these interventions in six different cities is estimated at $136,453 or 12% of the total budget.

Recruitment for these group level interventions is accomplished through social marketing websites targeted to gay/ bisexual men and MSM such as ManHunt, Adam4Adam, Craigslist, Facebook and other websites to promote group level interventions. The numbers of high risk negative MSM who are currently using such social marketing sites as ways to meet other men in Montana is increasing, as there are very few gay bars and other social venues. As such, advertising is used on these sites to promote prevention activities. Word of mouth also proves to be an effective way to promote group level interventions, especially within existing social networks.

These interventions have been practiced in Montana for some time and are either DEBIs or proven effective by the state's contracted evaluator. Providers of these group-level prevention activities are required to administer behavioral risk screenings to determine client need for more intensive intervention. Condom distribution is included in all activities.

Those at highest risk would be contacted after the activity and followed with more intensive prevention services, as those at highest risk often have much instability in their lives. Those in need of services such as housing or mental health or substance abuse counseling could be

referred to Comprehensive Risk Counselors and offered other referrals as necessary to increase self-efficiency.

To recruit even more persons of highest risk, and to combat the distrust such persons frequently have, clients of highest risk could be offered incentives to bring one or two new friends to group level interventions. In this manner, prevention providers may be able to break into the high risk social networks.

Goals for MSM and MSM/IDU Health Education and Risk Reduction Activities

Goal: Reduce HIV-Related Disparities

Objective: After baseline is established, reduce by 5% the percentage of MSM who report unprotected anal intercourse in 2014.

Strategy 1: Include education and support for condom use in all comprehensive prevention for positives activities

Strategy 2: Develop community through group level intervention in an attempt to change social norms

Strategy 3: Increase number of persons at risk who attend prevention activities by developing peer recruitment activities

Policy

In keeping with the need for integrative services and integrated thinking, the Montana Gay Men's Task Force and the Harm Reduction Task Force will be hosting several regional training events for providers.

Experts in Hepatitis C, drug addiction, HIV and STD will be present to increase awareness of risk.

The Gay Men's Task Force and the Harm Reduction Task Force enlist community members who in turn participate in Task Force efforts to build support for and involvement in HIV prevention efforts, and assist in trying to end HIV stigma.

Policy Initiative Goals

Goal: Task Force members will impart their knowledge and skills about HIV prevention, local IDU communities, and IDU risks related to HIV / STDs, to help enact a change in social norms.

Harm Reduction Task Force Objective: Develop and direct integrated training and education on Hepatitis C, STD and HIV for medical providers.

Gay Men's Task Force Objective: Develop and direct state and local for policy makers at least one written communication annually that imparts the need for increased availability of chemical dependency treatment in the state.

Social Marketing

Montana has budgeted $79,238 dollars to continue its public information/social marketing activities. In a large rural state with a sparse and scattered population, public media is a cost-effective method of disseminating information about HIV transmission. Montana social marketing activities target HIV positive persons, men who have sex with men, and men who have sex with men and also use injecting drugs in regions of the state most heavily affected.

A key component of the current HIV Prevention Social Marketing Project is the "Get Checked" campaign. In order to understand demographics, beliefs, preferences, knowledge and attitudes of the target populations, formative research during campaign development took place in form of focus groups and interviews. In 2011, research-based strategies were used to promote a branded website called "GetCheckedMT" which was designed to increase HIV testing. The site lists reasons to be tested and other information such as statistics regarding HIV/AIDS in Montana, testing site locations and links to services.

In general, all Montana social marketing activities attempt to either raise HIV awareness, or to encourage HIV risk reduction and testing, or to fight stigma. Montana has supported the creation of HIV prevention public education and social marketing media for years. The media are matched with the prioritized populations of the state's HIV Prevention Planning Group. Dissemination of such products is an ongoing commitment of the STD/HIV/Hepatitis C Prevention Section.

Social Marketing Goals

Goal**:** To increase awareness and perception of HIV risk, decrease HIV & sexual stigma, and increase testing among in Montana's at-risk populations

Objective**:** From 2012 to 2017, billboards, commercials, text messages, a HIV Testing web site, and other media targeting HIV prevention will be marketed annually in Missoula, Bozeman, Helena, Billings, Great Falls, Butte, & Kalispell to at-risk populations including MSM, IDU, HIV positive, and Native youth.

Outcome: From 2011 to 2016, HIV testing in Montana's urban areas (Missoula, Bozeman, Helena, Billings, Great Falls, Butte, & Kalispell) will increase by *3%-5%.

* Baseline: In 2010, 4874 HIV tests were conducted in Montana

Treatment (See also Statewide Coordinated Statement of Need Chapter Five)
Montana has two Ryan White Part C programs with HIV specialty clinics, one on each end of this large state and they are located in the two communities which have more than 30% of the disease burden. The vast majority of HIV positive persons are served at these two sites. The community health center pharmacies connected with these facilities are the ADAP dispensing pharmacies. Ryan White case managers at both sites perform medical case management for

Part B. These two entities are also HIV prevention contractors, which results in inherent and often seamless transitions from testing to care. Likewise, the more rural sites in the smaller cities have provided both prevention and HIV medical case management for years.

Medical Case Management Goals

Performance measures for 2012 for the case management clients are:

- 60% of case-managed clients will have had a new or updated medical case management care plan or acuity assessment in the measurement year.
- 75% of case-managed clients enrolled for at least twelve months will have had one substance and tobacco use assessment during the measurement year.

Statewide Annual Clinical Quality Management Goals

Goal 1: Annually, 50% of female clients will have had a gynecological visit in the measurement year.

Action Plan: Provide clients with yearly appointment reminders; notify providers of need and utilize follow-up checks.

Goal 2: Annually, 50% of clients will have had a dental visit in the measurement year.

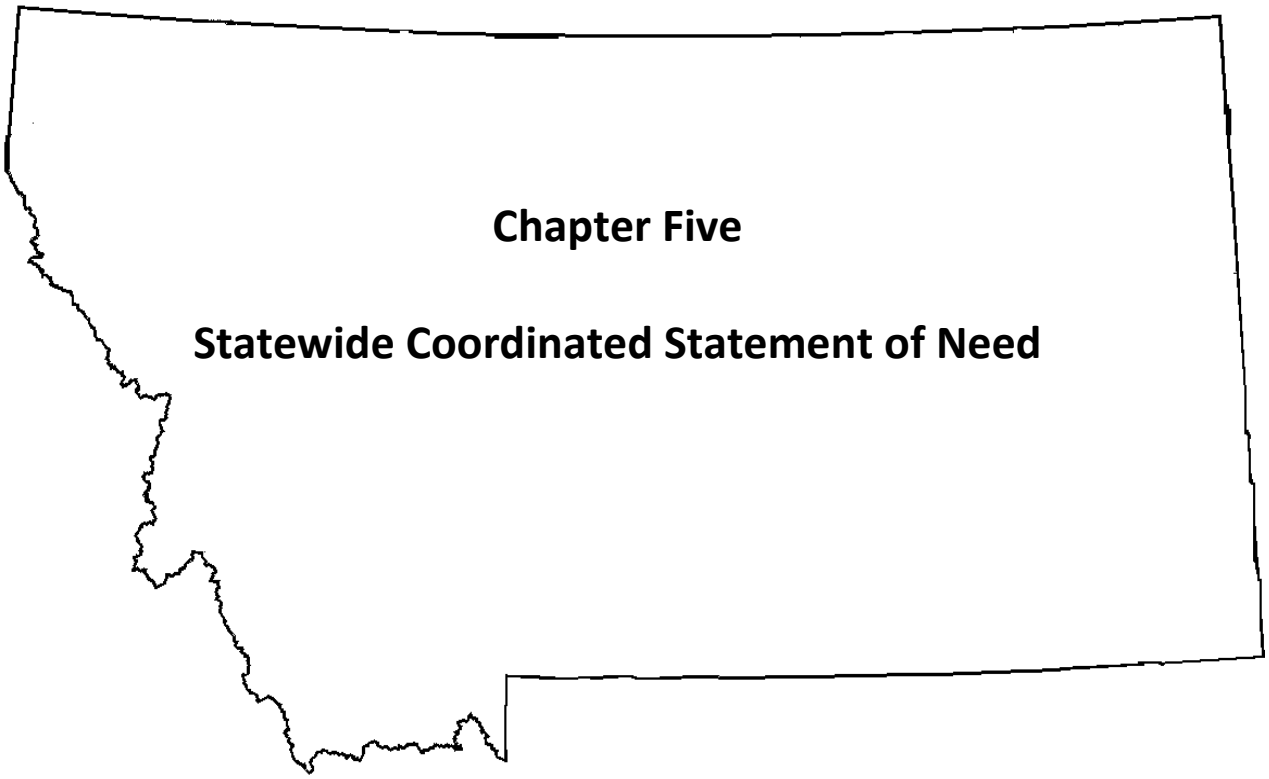
Action Plan: Provide clients with yearly appointment reminders; notify providers of need and utilize follow-up checks.

Goal 3: Annually, 95% of active clients Ryan White clients will have been screened for Hepatitis C.

Action Plan: Conduct chart audits, notify providers of need and utilize follow-up checks.

Data for the above indicators are gathered through chart audits, patient reports and through CAREWare reports of medical services paid by Ryan White Part C.

(See SCSN Chapter Five for additional treatment goals.)



Chapter Five

Statewide Coordinated Statement of Need

Chapter Five

Statewide Coordinated Statement of Need

In 2011, the Montana Integrated HIV Prevention Group updated its community services assessment and subsequent services gap analysis. In early 2012, a survey of approximately one third of the PLWH in Montana was conducted, focus groups discussions held and a formal needs assessment was prepared. In April 2012, the Montana Ryan White programs held a statewide public meeting for the purposes of creating the 2012 Statewide Coordinated Statement of Need. The ultimate planning goals for the Integrated HIV Prevention Group were later finalized using the results of the Statewide Coordinated Statement of Need (SCSN) as a resource. Montana's HPG is committed to the aims of the National HIV/AIDS Strategy and has set parallel strategies for the state.

SCSN Participation

In addition to participation in the triennial SCSN, Ryan White Part B and Part C administrators meet every year to standardize services across the state, to set review policies and to set common quality management goals. 2012 SCSN attendees included HIV treatment and prevention services providers, Ryan White Part B and Part C program administrators, Ryan White case managers and AIDS Education and Training Center program personnel, PLWH, representatives of persons who inject drugs, men who have sex with men, representatives of transgendered persons, persons with connections to the corrections system, Native Americans and a behavioral scientist, a mental health counselor and a professional evaluator. The race mix matched the general population and the HIV epidemic in terms of Native American participation.

SCSN agenda

The statewide meeting began with a presentation on the results of the latest Needs Assessment of HIV Positive Persons Living in Montana, and an updated epidemiology report from the state's HIV surveillance coordinator. Using that data and the Community Services Assessment (see Chapter Three)and the resultant gap analysis as resources, the planning group then listed needs, barriers and goals, following the suggested SCSN format. (See notes at end of Chapter.) The discussions that follow are the result of the 2012 SCSN meeting.

Epidemic Demographics (see EpiProfile in Chapter Two)

Over the decades, the HIV epidemic in Montana has retained much of the same demographics. Affecting a low-incidence proportion of mainly white men who have sex with men, the disease in Montana, until fairly recently, remained almost hidden. The state's conservative culture leads to stigma. The low population creates confidentiality concerns. Stigma, confidentiality issues and a low disease prevalence leads to lack of awareness, a reluctance to test, hesitation to seek treatment and failure to disclose.

While state HIV prevention messages are attempting to increase awareness, two Northwest AIDS Education and Training Center (AETC) programs in Montana reach hundreds of medical providers yearly. Over the span of the last five years, and with the advent of the gradually rising number of infected persons living in the state, HIV testing is slowly becoming more routine within the Montana medical community. More physicians are trained and willing to accept patients with this complex condition. More routine testing is being accomplished, including routine prenatal testing. While HIV prevention education is prohibited in many schools, more doctors, dentists, nurses and nurse practitioners are willing to be trained to detect the disease and to treat it.

Montana's two largest cities each have at least 30% of the state's prevalent cases residing in their areas. Billings on the eastern side of the state has 32% of the state's total, and Missoula on the western end has 37% residing in that surrounding area. Conveniently, those two cities each have a Ryan White Part C grantee and connected HIV specialty clinic within their community health centers. Each facility also houses an AIDS Drug Assistance Program (ADAP) dispensing pharmacy.

Needs Assessments (see Chapter Three)
The Montana HIV Planning Group (HPG) performs community planning for the state's HIV prevention and HIV treatment programs. Among planning components performed are the conduction of needs assessments and surveys of affected targeted populations, inventories of community resources and the development of a services gap analysis. Ryan White case managers serve on the HPG, offer input, and help develop planning goals to fill service gaps. The Ryan White Part B Coordinator is also present at all HPG meetings and shares the results of planning body efforts with the two Part C administrators in the state.

Unmet Need

Epidemiologic research and analysis by Montana HIV surveillance personnel show that persons who fall in the Unmet Need category have similar demographics to the epidemic. A state-sponsored survey for HIV-positive individuals and needs assessment reveals that reasons for not being in care in spite of being aware of an HIV positive status seem to fall into three basic categories: chemical dependency, distrust of governmental and health care systems and/or the inability to navigate those systems for a variety of reasons. Failure to understand the true consequences of being infected is also felt to be a reason why some HIV-positive persons do not seek care.

Upon review of data on PLWHA in Montana, demographic characteristics of persons not in care were assessed. It appears as though persons with HIV (non-AIDS) are male and of races other than American Indian, and persons aged 20-29 were less likely to be in care.

The demographics of persons not in care mirror the epidemic in Montana. In the most recent Needs Assessment of HIV Positive Montanans, the needs of persons not in care have been determined to include:

- *Knowledge of available resources*
- *Knowledge of the real consequences of contracting HIV*
- *Access to mental health and addiction services*
- *Social support system*
- *Increased emergency financial assistance from CBOs such as housing services*

Barriers to Linkage to Care

Barriers include lack of access to medical providers and transportation issues, a shortage of alcohol and substance abuse treatment providers, and stigma in a very conservative environment. Compounding factors are the lack of a sense of community and isolation, access to current information about available resources and confidential places to access services.

In collaboration with Montana HIV prevention planning, activities to address the above barriers include: 1) greater emphasis on peer education: enlist clients who are doing well with conventional treatment to reach out to those not in care; 2) impart outreach messages in as many settings as possible; and 3) increase collaboration between treatment and prevention contractors to create activities designed to engage HIV-positive persons not in care.

Strategies for Reducing Unmet Need

An HIV-friendly resource directory is posted on the state website. Ongoing social marketing campaigns attempt to reduce stigma. HIV prevention outreach workers carry the contact information for Ryan White case managers. The state's Addictive and Mental Disorders Division has prioritized persons with HIV for available chemical dependency treatment slots. Support groups and retreat-style education events for PLWH/A teach the benefits of treatment and are accessible statewide. Montana HOPWA housing projects have a policy that their housing clients are entered into care; collaboration between HOPWA case managers and Ryan White case managers occurs on a regular basis in Montana. Ryan White case managers maintain connections with corrections facilities and homeless shelters in their local areas. Ryan White providers work with prevention outreach workers to find persons with HIV/AIDS who are not in care. AIDS service organizations are helping to pay for transportation to HIV specialty physicians.

Beginning in 2012, all Montana counseling and testing prevention contractors are required to follow clients through the linkage-to-care process from preliminary positive results to assuring confirmatory testing, delivering confirmatory tests results, linkage to care and attendance at first appointment. Partnerships are to be formed and memorandums of understanding developed to ensure a seamless process at each testing site.

Contractors will be responsible for ensuring that the transition from confirmed-positive client to a fully-enrolled patient in HIV care is accomplished. Attendance at the first HIV medical care appointment will be tracked. Clients will be given priority assistance to ease them through the process.

In June 2012, the Part C Eastern Region Program received a HRSA grant to identify and locate persons out of care, to enroll those persons into care programs and work to keep them in care. This is a statewide project that has already reduced the percentage of unmet need by nearly ten percent.

Corrections and Unmet Need Strategies

Funded testing contractors are required to have policy and/or letters of understanding in place between the contractor and area corrections facilities to ensure entry into care when the newly-identified are tested while still in custody. Ryan White sites in Montana are required to maintain relationships with local corrections facilities to allow transition to HIV case management upon release.

The state's AIDS Drug Assistance Program prioritizes newly discharged individuals and holds enrollment slots for Ryan White clients incarcerated for relatively shorter periods. Even though Montana ADAP has a waiting list, the program reserves enough funds to provide one month of medications while other medication assistance is being set up.

Unmet Need and Montana American Indians

While the unmet need percentage of Native Americans in Montana is less than the state's average unmet need percentage, Native Americans, in general, enter care later than their white counterparts. Collaboration with the health centers of nearby reservations will be required of both treatment and prevention contractors. The state will conduct regional trainings, making a concerted effort to reach providers of Native Americans. The state also collaborates heavily with an AIDS Education and Training Center program in Montana called Tribal Bear. Staff members from Tribal Bear serve on the HIV Planning Group.

Expanding Outreach to Reduce Unmet Need

Online outreach is being expanded. Three prevention contractors were awarded contracts for increased MSM contact through internet chat rooms and social networking sites. Internet outreach is considered a vital element to educate and inform Montanans not in care, especially those in the rural areas. The use of new technology and the youth focus on texting has opened other avenues of communication and education.

Early Identification of Individuals with HIV/AIDS

Barriers to Testing

Two major barriers and challenges that inhibit the identification of Montanans with HIV are stigma in a conservative state, and the physical distances of a large rural state which isolate people and make the dissemination of prevention messages difficult. Driven underground by a conservative political climate and a social norm of discrimination against gays, married men who have sex with men and who identify as heterosexual (men on the "down-low"), are not uncommon in Montana. It is challenging to focus outreach efforts toward these men who do not normally frequent the same venues as openly gay men.

The main barrier for unaware individuals not post-test counseled after either confidential or anonymous testing is the use of conventional testing, which requires that the patient take an initiatory and active role in communicating with providers for results that may take as long as ten days to be reported to providers. Those testing anonymously are at even higher risk of not receiving results, as no contact information may be available for providers.

To meet the priority needs of unaware individuals who have tested either confidentially or anonymously, but have not received post-test counseling, Montana has changed the requirements for the use of CDC HIV prevention funds. Prevention contractors funded for 2012 are now required to conduct rapid tests only and to deliver preliminary results within the same testing event. Community-based organizations are required to have plans for confirmatory testing and written agreements with other entities to ensure that a confirmatory blood draw is performed at the time of a preliminary positive test result.

A barrier that prevents preliminary-positive individuals from receiving confirmatory testing results is a lack of a specific plan/procedure for testing entities to arrange confirmatory blood draws during the rapid testing event, and/or to arrange for confirmatory tests to be communicated.

Two barriers which prevent closeted men who have sex with men from seeking testing are stigma and a perceived lack of confidentiality. Montana's conservative political climate and prevalent homophobia force men who have sex with men to hide their sexual preferences. These closeted men will often not test in their local areas, as most cities in Montana are small.

Meeting the Needs of the Unaware

Care Activities

The state of Montana has a fully integrated STD/HIV/Hepatitis C program that includes both HIV treatment and HIV prevention. The Ryan White Part B coordinator administers both the CDC prevention awards and the HRSA Ryan White grant. Because of the rural nature of the state, local health departments inherently have integrated systems, sometimes as refined as having the same personnel perform both prevention and treatment services.

Part B has contractual arrangements for HIV medical case management with both of Montana Ryan White Part C programs. Both Part C programs have also received CDC prevention monies through the state for targeted testing activities and are thus aware of CDC counseling and testing guidelines. Both Part C facilities conduct targeted routine HIV screening for their general patient population.

Montana HIV treatment and prevention programs have been working collaboratively for years in an effort to increase the state number of newly-identified positive persons and to increase the number of HIV positive persons who are in care. The statewide plan is integrated in terms of both treatment and prevention and in terms of disease prevention integration which includes Hepatitis C, STDs and HIV.

Prevention Activities

To meet the priority needs of stigma and discrimination against injection drug users and sexual minorities, Montana is using CDC funds to sponsor anti-discrimination social media and public information campaigns.

To meet the needs of closeted gay men, a website with testing information and HIV prevention information will be continued with the use of CDC HIV prevention funding. To perform additional cost-effective outreach for this large rural state, Montana has applied to CDC for funding for expanded internet outreach services.

A cultural challenge for MSM, no matter what their age and whether they were tested but not post-test counseled, or if they were not tested at all, is the sexual minority stigma that is present in this conservative state. The rural nature and long distance between providers is another. When individuals test in a locale other than their place of residence, another long distance trip is necessary to obtain confirmatory results. The rural nature also results in a lack of community or social support networks.

Young MSM are affected by the same barriers as their older closeted counterparts. Through the state's prevention surveys and client questionnaires, it has been learned that young MSM are also more likely to receive inaccurate information on HIV and STDs, to feel peer pressure, to be too embarrassed to purchase or use condoms, and maintain typical youthful feelings of invincibility. To meet the needs of young MSM, a face-to-face group level intervention geared specifically toward that population has been expanded to ensure that education and support reaches young men on both sides of this large state.

IDU and the Unaware

Men who have sex with men and also inject drugs are, of course, dually impacted by risk. Stigma is compounded when a person is using illicit drugs and of a minority sexual orientation. Stigma drives users underground; drug use can increase paranoia. Outreach workers report

that both of the above occurrences can lead to rejection of the option to be tested through traditional entities.

While prevention education and some harm reduction efforts are being directed toward inmates, more education and chemical dependency treatment needs to occur within the corrections system. The availability of supportive programs after release is limited.

HIV risk is complicated by an epidemic Hepatitis C in Montana's IDU population. Cultural challenges for incarcerated users of injectable drugs follow in the same vein. The prevailing cultural attitude of the status quo to "put them in prison," rather than to provide treatment, does little to educate or break the cycle of addiction. Incarcerated individuals who inject drugs also face discrimination and avoid testing.

To meet the needs of injection drug users, Montana has applied for extra CDC funding to expand the implementation of an intervention called "Taking it to the System/Population" which educates corrections staff and inmates on HIV, STD and Hepatitis C. A team of indigenous outreach workers trains prison employees as well as presenting HIV, STD and Hepatitis C prevention programs to inmates in numerous corrections facilities across the state. In addition to training, this team is also allowed to conduct testing in various pre-release facilities, chemical dependency centers, in private prisons and in local jails. The team also helps released felons to reintegrate into society as part of their privately-funded business. Because of the nature of persons incarcerated in Montana, this CDC-funded intervention concurrently reaches MSM of all ages and injection drug users at risk.

Native Americans and the Unaware

In terms of cultural race/ethnicity challenges, Montana's only statistically significant minority (7% of the state's one million people) is American Indians (AI), and their challenges to becoming aware of their status are the same as their white counterparts. However, AI within Montana high risk groups are more prone to unemployment and subsequent low poverty levels, and injection drug use which compounds their ability to seek testing and care in a confidential setting. There is a disproportionate population of incarcerated American Indians. The limited chemical dependency treatment that is available in prison does not include American Indian traditional healing methods.

Timetable for newer strategies

The use of new technology and the youth focus on texting has opened other avenues of communication and education. Mentoring Ryan White clients to be advocates for others living with HIV and to make care referrals for their peers is an intriguing idea that is being explored within the HIV Planning Group treatment workgroup. A foreseeable barrier is the lack of training funds.

Goals

In conjunction with prevention activities, the progress to promote testing and increase awareness of HIV issues are listed below.

Goal 1**: Eliminate legal barriers to routine testing**.

Rationale: Cumbersome requirements for counseling and testing and written consent were barriers to routine testing.

Objective: Allow HIV testing to become part of routine medical care.

Progress: New statute eliminating barriers to routine testing implemented in October of 2009.

Goal 2: **Disseminate media messages designed to:**

1) Increase the number of the MSM, HIV Positive, IDU, and Youth at risk populations who engage in HIV protective risk behaviors and who participate in HIV testing and counseling, and,
2) Decrease overall HIV positive and sexuality stigma.

Rationale: The availability of an easily identifiable "brand" that is associated with social marketing activities and corresponds to a **getcheckedmt.org** website that will list, among other information, all testing sites in the state, will increase testing.

Action Plan: Implement Social Marketing strategies by developing innovative HIV/AIDS prevention "messages" and disseminating these messages among the HIV priority populations utilizing multiple media channels.

Progress: "Getcheckedmt.org" was implemented as of October 2010 and will be evaluated for its impact in 2012.

Goal 2 Objective: Communicate HIV/AIDS prevention messages to increase HIV/AIDS knowledge and perceptions of HIV risk, decrease at-risk behaviors, and to decrease barriers to HIV counseling and testing among risk populations.

Objective measure: By December 31, 2011, the Social Marketing strategies in Montana will increase overall testing in the targeted risk populations. (Evaluation underway in 2012.)

Goal 3. **Ensure that all clients tested by HIV prevention contractors are informed of results.**

Objective 1: Encourage all counseling and testing contractors to use rapid tests.

Action Step 1: Actively assist CDC-funded HIV prevention contractors to convert from the use of conventional testing to all rapid testing in 2012.

Action Step 2: Work with HIV prevention counseling and testing contractors to eliminate anonymous conventional testing

Objective 2: All contractors' preliminary positive test results are confirmed through a conventional confirmatory test

Action Step: Contractually require Montana HIV prevention contractors to have an easily-accessible referral system in place for confirmatory testing.

Goal Measure: 100% of persons tested will be informed of their test results.

Current statewide treatment goals in Montana are to annually reduce the percentage of unmet needs and to increase annually: 1) the percentage of women accessing gynecologic care, 2) the percentage of all Ryan White clients who have annual oral health visits, and, 3) the percentage of clients screened for Hepatitis C.

Summary: The Assimilation of the SCSN and the Montana High Impact HIV Prevention Plan

Statewide Strategic Planning Goals

The number one goal of the Montana Statewide HIV Planning Group (HPG) is to reduce the number of Montanans who become infected with HIV. The remaining goals of decreasing risky behavior, increasing the proportion of Montanans who know their status and who are linked to and retained in care, all support this first main goal.

The HPG worked for two years to assess needs and service gaps, to set goals that were in alignment with the National AIDS Strategy and to plan strategies that could help reduce the spread of HIV in Montana. The work the group accomplished at the SCSN brought relevance to the saying of "treatment is prevention." Once the SCSN was completed, the HPG, at their August 2012 meeting, finalized action steps to meet their goals. See Chapter One.

In response to needs discussed at the Statewide Coordinated Statement of Needs meeting, the statewide planning group has created action steps to empower clients, increase knowledge and awareness of HIV, enhance their collaboration with AIDS Education and Training Center programs and to leverage support services through a formal engagement plan.

Montana now has a long term Integrated Statewide HIV Prevention Plan that strives to improve an already well-functioning HIV prevention and treatment system. The HPG will annually review the measures now set in place to assess the effectiveness of Montana high-impact prevention activities.

Notes from the Montana Statewide Coordinated Statement of Need Meeting April 2012

After a presentation of the results of the HIV positive needs assessment, meeting participants responded to the following questions:

What obstructs access to care for HIV positive individuals, including gaps and overlaps in care, as well as priorities in addressing underserved populations?

Needs:

- Access – Education; transportation; money
- Advocacy – self and peer
- Mental health – holistic care
- Provide education and networking of providers
- Resistance to change
- Obstructions may be different whether before or after diagnosis.

Barriers:

- Data and money over "heart", we pay more attention to data
- Resistance to change

Suggestions:

- Dig deeper when doing needs assessments
- Outreach work
- Holistic care-referral to appropriate social services

What are the needs of individuals who are aware of their HIV positive status but are not in care, with an emphasis on outreach, referral and linkage to care needs?

Needs:

- Education regarding the importance of care
- Advocacy
- Self empowerment
- Continuity of information, resources and referrals
- Support for outreach workers and their efforts – including community efforts
- More and diverse case workers
- Case workers to holistically empower the client for self advocacy

Barriers:

- Money
- Stigma
- Inconsistency of treatments

Suggestions:

- Training volunteer case workers, though confidentiality problems in small communities
- Assistance from DPHHS to better address the conclusions of the study

What are the needs of individuals who are unaware of their HIV status with an emphasis on outreach, counseling and testing, referral and linkage to care needs?

Needs:

- Public awareness raised regarding HIV and STD in Montana – "It could be you."
- Risk reduction strategies
- Education on risky behaviors – what it is and targeting
- Make counseling and testing routine for those at risk while making sure clients don't feel singled out.
- Transportation and access to transportation
- Better communication between patient and provider
- Coordinated care access

Barriers:

- Funding
- The health care system and limitations

Suggestions:

- Utilize alternate resources for transportation ie; The Salvation Army, United Way
- Teach patients techniques on how to talk to the doctor
- Have referral and resource data available to patients

What are the needs of special populations including but not limited to adolescents, injection drug users, homeless and transgender persons?

Needs:

- Education to meet the special needs of all populations – There is a lack of educated trainers for Providers
- Needle exchange
- Training and licensing of outreach workers
- Traveling long distances to providers

Barriers:

- Poverty
- Lack of public transportation
- Lack of trained outreach workers

Suggestions:

- More routine testing in ER's and other medical facilities
- Increase in provider training with PCP's

The rural nature of this geographically large state results in social isolation for sexual minorities. For more information on special populations such as men on the down-low and men who have unprotected sex with men, see Chapter Three.

What shortfalls exist in the healthcare workforce?

Needs:

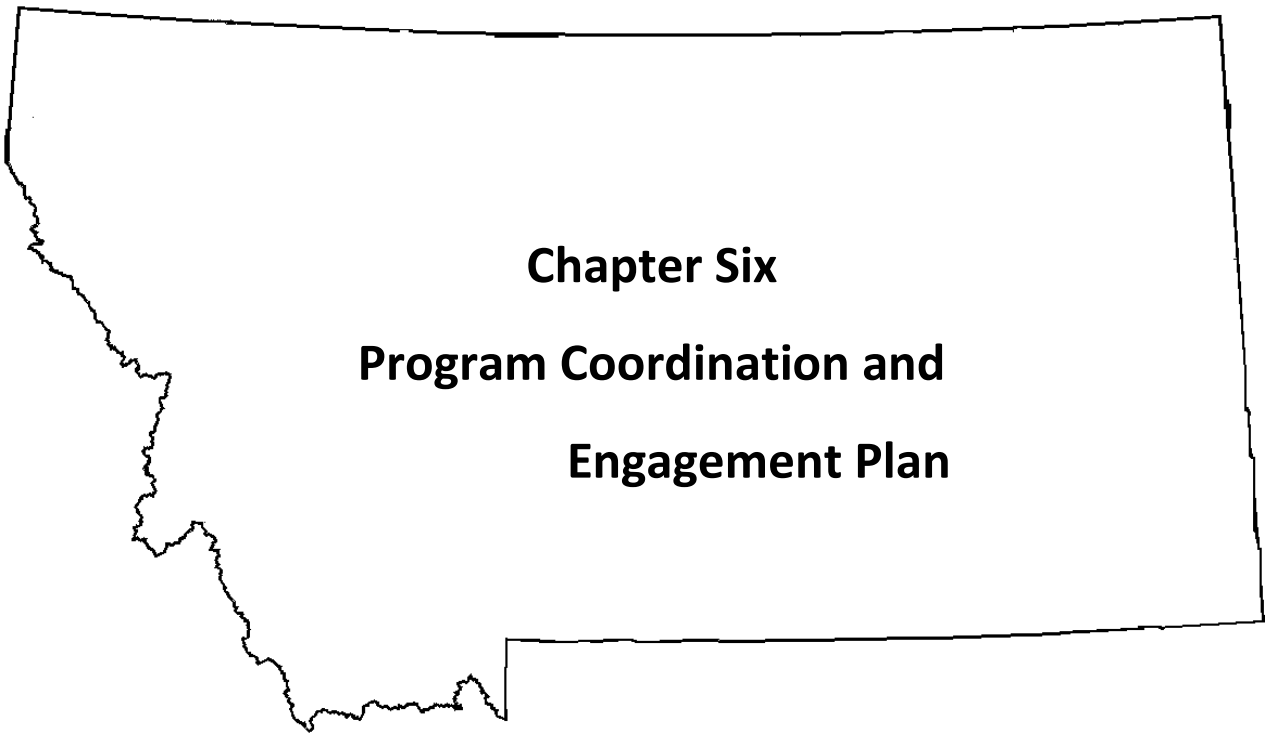
- Disconnect between mental health and medical health
- Time constraints
- Lack of cultural competency
- Perception of what services are available and access to the services
- Education on how the health care system works
- Mental health provider shortage
- Dentists who will accept Medicaid
- Greater access to affordable chemical dependency treatment

Barriers:

- Fear of asking
- Geographical isolation
- HIV as an isolated medical problem, not a holistic approach

Suggestions:

- Making resources available
- Mentors and advocating to others
- AECT training



Chapter Six

Program Coordination and Engagement Plan

Chapter Six

PROGRAM COORDINATION

Individual community planning group members provide invaluable information to the HIV Prevention Planning Group (HPG) based on their local resources, culture, and community norms and values. Coordination recommendations are intended to maximize the use of local and state resources in order to strengthen prevention efforts and stop the spread of HIV in Montana.

Coordination with CBOs Directly Funded by CDC

The relationship between directly funded Community Based Organizations (CBOs) and the local Health Departments (HDs) is crucial to ensure a comprehensive provision of services, including HIV care, treatment, prevention, and support, to persons living with HIV/AIDS, and individuals at-risk of infection in the community. Currently, Montana does not have a CDC directly-funded CBO.

Coordination with CBOs not funded by CDC

The state health department contracts directly with CBOs which are not directly funded by CDC to provide services and coordinate HIV/AIDS prevention activities to maximize funding sources and impact the maximum number of individuals in our efforts to decrease the spread and transmission of HIV/AIDS and encourage HIV+ individuals to access appropriate services.

Coordination with Other Programs

HIV/AIDS Care Programs

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

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

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

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

American Indians
American Indians comprise the largest minority population within Montana. The STD/HIV Prevention Section currently contracts with four tribal entities as well as one urban Indian center. The HPG has prioritized American Indians as a community for representation in the community planning process. Currently there are five (5) representatives from this group on the HPG. The Department attempts to collaborate and coordinate HIV prevention services with the tribal entities whenever possible.

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

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

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

Tuberculosis/HIV
Ongoing collaboration between the HIV surveillance epidemiologist, the TB Program Manager and the HIV treatment program manager assures that suspected and confirmed cases of dual HIV/TB are recognized both for reporting and case management purposes. In addition, an

HIV/AIDS/TB case registry match is performed on an annual basis. Organizationally, the HIV/AIDS prevention program and the TB program are located within the same bureau, which facilitates ease of collaboration and communication as needed. Weekly disease meetings are held in which staff from both programs participate, providing collaboration, interaction, and updates as necessary.

Women and Men's Health Section

The STD/HIV Prevention Section staff and the Women's and Men's Health Section Staff continue to meet on a routine basis to discuss programmatic issues and over-arching goals and objectives.

Laboratory support

Laboratory Services staff members and the STD/HIV Prevention Section staff members attend weekly disease meetings. The HIV/STD Prevention Section contracts with the state lab to perform HIV serum testing, quality assurance work for the rapid test, and training on rapid test technology implementation. The HIV/AIDS Prevention Section utilizes CDC funds to support the cost of HIV testing for specimens obtained via counseling and testing activities. Support is provided for the Virology Supervisor to attend the ASTPHLD Retro Virology Conference.

Program funds are used to pay for, on a fee-for-service basis, HIV testing that is submitted to the MT Public Health Laboratory (MTPHL) from counseling and testing sites up to the capped allotment. Currently, HIV-1 EIA screening is performed daily at the MTPHL, and Western Blot confirmation testing is performed on a STAT basis, rather than batch tested once a week. This provides same day turn around time (TAT) for negative specimens received in the morning, and 2-3 working day TAT for positive specimens. The MTPHL is a CLIA certified laboratory, and subscribes to the CAP proficiency for HIV testing as well as the CDC Model Performance Evaluation Program (MPEP). Laboratory performance on these check samples has been excellent. The MTPHL does not perform CD4 or viral load testing.

In addition, the MTPHL is actively participating with the HIV rapid test program. The MTPHL Technical Supervisor designed a quality assurance program, exposure control plan, and all necessary documentation for rapid testing (OraQuick).

The MTPHL Quality Assurance (QA) Committee oversees the testing performed and serves as a technical consultant to the rapid test sites. The sites submit their QA documentation on a monthly basis for review by the QA Committee. These sites are currently enrolled in the rapid testing CDC MPEP. Because of the impact of rapid HIV testing on the MTPHL, the HIV program is directly supporting a small portion of the QA activities associated with the HIV rapid test program.

HIV/AIDS Epidemiologic and Behavioral Surveillance

The HIV Disease Surveillance Epidemiologist develops the epidemiologic profile. This document is posted onto the State of Montana DPHHS web page. The epidemiologic profile is updated yearly and distributed to HPG members. The HIV Disease Surveillance Epidemiologist responds to the surveillance data needs of HIV prevention contractors and to HPG members. This individual attends every HPG meeting and is available to provide information regarding analysis, interpretation, and presentation of surveillance data. This individual also prepares and updates the epidemiologic profiles and other reports for use by the HPG and contractors. The HIV Disease Surveillance Epidemiologist undertakes other related activities that directly improve and support the implementation and evaluation of HIV prevention activities on a case-by-case basis. Collaboration occurs to ensure data from other surveillance programs and CDC is incorporated into the epidemiologic profile.

Northwest AIDS Education and Training Center (NWAETC)

The Yellowstone City-County Health Department, through a grant from the Northwest AIDS Education and Training Center (NWAETC), offers HIV treatment education, clinical consultation, capacity building and technical assistance to health care professionals and agencies in Montana. In addition, Montana also has a NWAETC grant for tribal providers.

The purpose of the AETC is to increase providers' capacity to provide high quality HIV/AIDS care within the region's health care systems. AETC target audiences includes physicians, physician assistants, nurse practitioners, nurses, dental professionals, clinical pharmacists, and other members of the health care team. Providers from Ryan White CARE Act funded agencies, federally-funded community and migrant health centers, tribal health clinics, state and local health departments, corrections facilities and private practice settings serving persons with HIV and AIDS are targeted for training. The NWAETC is part of a network of regional AETCs that covers the United States, Puerto Rico and the U.S. Virgin Islands. Funded through the Health Resources and Services Administration, the national AETC network is the professional training arm of the former Ryan White Comprehensive AIDS Resource Emergency (CARE) Act now called the Ryan White Treatment Modernization Act of 2006.

There are a variety of educational opportunities for health care providers and organizations offered in Montana to meet specific HIV/AIDS education needs.

Some of the opportunities include didactic lectures and seminars, interactive workshops, case-based presentations, clinical preceptorships, e-mail, phone and on-site clinical consultations, capacity building, and web-based learning modules. For more information regarding the NWAETC or to inquire about trainings, please contact Molly Hale, program coordinator, at 406-247-3320.

Housing Opportunities for Persons With AIDS (HOPWA)

Tri-State HELP HOPWA (Housing Opportunities for Persons with AIDS) is a partnership between one State agency and four private agencies serving Montana, North Dakota and

South Dakota, and its service area is the entirety of all three states. Tri-State HELP represents the first multi-state model for delivery of HIV/AIDS housing and related social services. It provides a continuum of housing and related support service opportunities for people living with HIV/AIDS and their families such as long term and emergency rental assistance as well as utilities assistance and housing coordination services.

Montana HIV Prevention Engagement Plan

Given the rural nature of the state, Montanans are accustomed to working together for a common cause, and reaching out to as many other state agencies, community agencies, and engaged individuals as possible. This strategy will continue as the HIV Prevention Program moves forward through the current funding cycle.

As an integrated section for the past five years, the HIV, STD, Hepatitis C and Ryan White/ADAP Programs have worked very collaboratively on many overlapping objectives and issues, including epidemiology of HIV/STD/HCV in targeted populations, testing and counseling training and services for HIV/STD/HCV clients, partner services and referrals for HIV and STD, linkage to care for those testing positive for HIV/STD/HCV, condom distribution, and prevention education for all disease areas.

Within the Montana Department of Public Health and Human Services (DPHHS), the HIV/STD/HCV Section engages with the Communicable Disease and Epidemiology Program, with Women's and Men's Health Section, with Maternal and Child Health Programs, with the Immunization Program, with the Public Health Laboratory, with Senior and Long Term Care Programs, with Addictive and Mental Disorders Division, with the Director's Prevention Resource Center, with the Rape and Sexual Assault Program, with BRFSS staff, and with Medicaid/Medicare Programs. While collaboration with some of these programs occur on an infrequent basis, the majority of the programs meet routinely with the Section to discuss epidemiological data, programmatic issues and concerns, programmatic strategies and activities that cross-cut several programs, similar prevention interventions, testing modalities, and cost-saving measures, specifically with meetings, site visits and laboratory costs.

Current collaborative agencies outside of DPHHS include correctional institutions (youth and adult), substance abuse treatment programs, mental health agencies, tribal clinics, IHS clinics, reproductive health agencies, STD clinics, HIV contractors, Ryan White/ADAP contractors, local public health departments, community health centers, community-based organizations, AIDS-service organizations, and nurses' associations.

Engagement and retention of the agencies and organizations listed above have been successful due to defining common ground, understanding beneficial results of collaboration, exchanging complementary products via trainings, educational materials, media campaigns, understanding the need to work together due to the vastness and rurality of the state and the

decreased amount of resources, and the success of working as a team versus individual entities in overcoming challenges and creating solutions that work for all.

Engagement Process: In collaboration with current HPG members:

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

- Montana Office of Public Instruction (Department of Education)
- Montana School Board Association
- Montana Parent Teacher Association
- Private providers
- Infectious disease physicians
- Montana Medical Association
- Montana Primary Care Association
- Montana Nurses Association
- Legislators
- Urban Indian Clinics
- Montana Dental Association
- Montana Board of Pharmacy
- Montana Chemical Dependency Center
- Montana Mental Health Association
- Tribal Substance Abuse Treatment Facilities
- Montana Tri-state HOPWA
- State Prisons
- Montana Pride Foundation
- Churches, non-profits

2. Develop and Document

Engagement of these entities is challenging primarily due to a lack of time and resources, lack of interest, and turf issues.

a. Determine appropriate contact for each organization, agency and/or individual. The state and community co-chairs will meet in-person with the stakeholder to provide history, common ground, benefits, and logistics of engaging with the HPG.

b. If the first meeting is not successful, a search will continue for other opportunities for recruitment and collaboration, including contacting other individuals, other organizations working with specified partner to determine steps to collaboration, contact another agency conducting same services.

c. Retention of HPG members is not a significant issue. In cases of losing a stakeholder, HIV Prevention Program staff and the HPG executive team will work together on a case-by-case basis to determine if there are measures that can be taken to retain the member or if it is in the best interest of the group, not retain the member and determine a potential replacement.

d. All HPG meetings occur in person primarily due to the desire of the group to continue to meet in-person, and as there are only 2 or 3 two-day meetings, it works well. Occasionally, members who cannot attend the meeting will be able to conference call in to the meeting. If necessary, and agreed upon by the HPG, access to meetings via teleconference, phone calls or Skyping are options that HIV Program staff will enable.

e. Documentation regarding recruitment measures will be conducted in written form and sent to all HPG members to assure continuity and equity. Since both HPG co-chairs will be involved in the recruitment process, it will be incumbent upon them to make certain all aspects of recruitment are included.

3. Convening HPG Meetings

a. Dates and locations of HPG meetings are determined via mutual agreement among members, HIV Prevention staff, and the meeting facilitator.

b. The by-laws/written protocols include parameters of HPG meetings, logistical information, ground rules, and the use of technology.

c. Orientation of HPG members will occur every first meeting in a new year. New HPG members are required to attend; other members are invited to attend. Orientation includes the mission of the HPG, roles and responsibilities of members and state staff, explanations of documents (by-laws, policy and procedures, populations, workgroups, etc.), expectations of attendance, structure of meetings, and role of the facilitator.

4. Information

All HPG members will receive current information and up-to-date documents regarding meetings, by-laws, policy and procedures, meeting minutes, evaluation results, projects, assessments, Jurisdictional Plan, grant applications, and other information pertinent to the work of the HPG.

HPG members will receive information regarding HIV treatment and care, referral, and linkage to care as well as the latest information regarding STDs and HCV.

5. Opportunities and Challenges

A needs assessment and gap analysis will be conducted each year of the grant cycle. Conclusions will be addressed, especially if there are deficiencies and/or weaknesses in programmatic or HPG functions. The workgroups include all members of HPG, and have the responsibility to engage in solution-oriented processing with the knowledge that they are representing a population as well as their community.

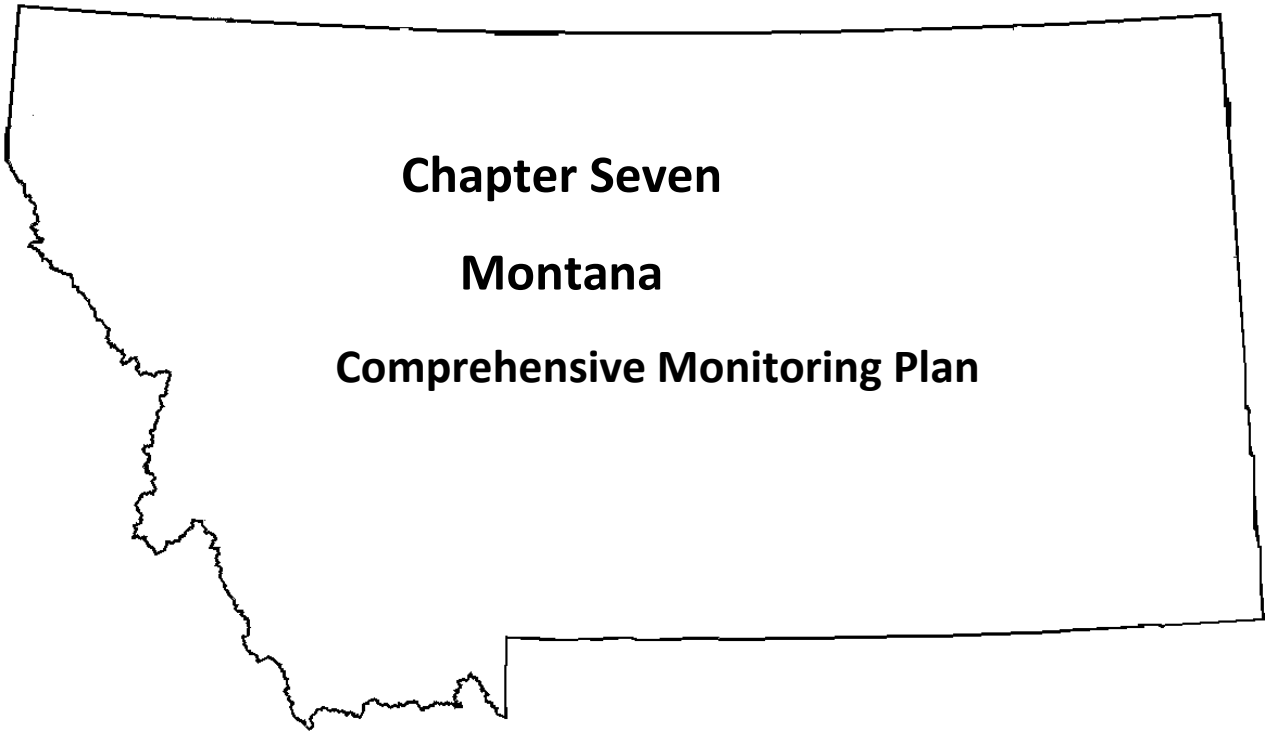
Programmatic issues specifically tied to the HPG will be addressed by state staff with input from the HPG. These issues could include, but are not limited to: high-impact interventions targeting appropriate populations, counseling and testing, condom distribution, referrals, treatment, linkage to care, partner services, STDs and Hepatitis C.

6. Monitoring and Evaluation

HPG members will be apprised of results of quality assessments, evaluations, monitoring of programmatic activities, epi data, and strategies for linking HIV-positive individuals to treatment and care that occur throughout the year. Report-outs will occur at each meeting, and HPG members will be requested to comment, share innovative strategies and ideas to improve areas, and assist in determining avenues to use in addressing populations most at risk for transmission of HIV/STD/HCV.

7. Review and Update

Each HPG meeting will provide the opportunity to discuss the engagement process to determine the efficacy of the process, what areas need to be revised to gain proficiency, new methods of engagement, other stakeholders that could/should be included, and to ascertain that the diversity of the group meets the requirements stated in the by-laws.
Progress reports will be provided to the HPG members by state staff regarding successes, improvements and weaknesses occurring in moving forward with the Jurisdictional Plan.



Chapter Seven

Montana

Comprehensive Monitoring Plan

HEALTH DEPARTMENT CONTACT INFORMATION					
Award Number:	Ps12-1201				
Health Department:	Montana				
Mailing Address:	P.O. Box 202951 Cogswell Bldg C-211				
City:	Helena	**State:**	MT	**Zip Code:**	59620
Phone Number:	406-444-4744			**Fax:**	406-444-6842

Contact Information for this program plan	**Title/Position**	**Name**	**Phone** **Fax**	**E-mail Address**
Primary Contact	HIV Prevention Coordinator	Judy Nielsen	Ph: 406-444-4744 F: 406-444-6842	jnielsen@mt.gov
Secondary Contact	HIV Prevention Supervisor	Laurie Kops	Ph: 406-444-2457 F: 406-444-6842	lkops@mt.gov

HEALTH DEPARTMENT FUNDED CATEGORIES
Please select the required core components and recommended program components implemented with the jurisdiction:
Category A: HIV Prevention Programs for Health Departments
Required core components *(required for all funded grantees):*
☒ HIV Testing ☒ Comprehensive Prevention with Positives ☒ Condom Distribution ☒ Policy Initiatives
Recommended program components:
☒ Evidence-based HIV Prevention Interventions for HIV-Negative Persons at Highest Risk ☒ Social Marketing, Media and Mobilization ☐ Pre-Exposure Prophylaxis and Non Occupational Post-Exposure Prophylaxis Services
Category B: Expanded HIV Testing for Disproportionately Affected Populations
☒ *Not Applicable/Not Funded*
Program components:
☐ HIV Testing in Healthcare Settings (required) ☐ HIV Testing in Non-Healthcare Settings (optional) ☐ Service Integration (optional)
Category C: Demonstration Projects for Innovative, High-Impact Prevention
☐ *Not Applicable/Not Funded*
Program focus areas:
☐ Structural, Behavioral, and/or Biomedical Interventions ☐ Innovative HIV Testing Activities ☐ Enhanced Linkage to and Retention in Care ☒ Advanced Use of Technology ☐ Programmatic use of CD4, viral load and other surveillance data

PS12-1201 Resource Allocation

One of the goals of this FOA is to reduce HIV transmission by building capacity of health departments to focus HIV prevention efforts in communities and local areas, where HIV is most heavily concentrated, to achieve the greatest impact in decreasing the risks of acquiring HIV. Grantees should monitor the HIV/AIDS epidemic within the jurisdiction for program planning, resource allocation and monitoring and evaluation purposes. Grantees should utilize the most current epidemiological and surveillance data and other available data sources to assist in program planning and evaluation.

To ensure that resources are reaching the areas of greatest need, grantees will be required to report annually to CDC on the amount of funding allocated to the areas with 30% or greater of the HIV epidemic and how the funds were used.

Please identify each city/MSA with at least 30% of the HIV epidemic within the jurisdiction. For directly-funded cities, please report areas or zip codes within the MSA with at least 30% of the HIV epidemic within the jurisdiction. If no area represents at least 30% of the HIV epidemic, then identify the top three MSA/MDs, cities, or areas within the jurisdiction that have the greatest burden of disease.			
CITY	**Percentage of HIV Epidemic**	**Percentage of PS12-1201 Funds Allocated**	**Components and Activities Funded**
Missoula and Service Area	**51%**	**52.3%**	**Comprehensive Prevention with Positives, Interventions for High-risk Negatives and CTR**
Billings and Service Area	**49%**	**47.8%**	**Comprehensive Prevention with Positives, Interventions for High-risk Negatives and CTR**

PS12-1201 Category A

HIV Prevention Programs for Health Departments *(core funding)*

Required Component: HIV Testing $196,191

The following are the National-Level Objectives and Performance Standards that will be used for HIV testing and linkage to care activities funded under Category A. Category A goals and objectives should be developed in relation to the National-Level Objectives and Performance Standards while also addressing elements of each program component as listed in the FOA.

National Goal: CDC expects approximately **two** million HIV tests will be provided annually, among all funded jurisdictions, when the program is fully implemented.

Performance Standards: CDC expects each funded jurisdiction to achieve the following performance standards, when the program is fully implemented:

- ❑ For targeted HIV testing in non-healthcare settings or venues, achieve at least a 1.0% rate of newly-identified HIV-positive tests annually.
- ❑ At least 85% of persons who test positive for HIV receive their test results.
- ❑ At least 80% of persons who receive their HIV-positive test results are linked to medical care and attend their first appointment (within 90 days of the positive HIV test).
- ❑ At least 75% of persons who receive their HIV-positive test results are referred to and interviewed for Partner Services (within 30 days of having received a positive test result).

Required Elements for HIV Testing:

A. Implement and/or coordinate opt-out HIV testing of patients ages 13-64 in healthcare settings.

B. Implement and/or coordinate HIV testing in non-healthcare settings to identify undiagnosed HIV infection using multiple strategies and the most current recommendations for HIV counseling, testing and referral.

C. Support HIV testing activities in venues that reach persons with undiagnosed HIV infections.

D. Ensure the provision of test results, particularly to clients testing positive.

E. Promote routine, early HIV screening for all pregnant women, according to current CDC recommendations.

F. Encourage and support health department and non-health department providers to increase the number of persons diagnosed with HIV through strengthening current HIV testing efforts or creating new services.

G. Facilitate voluntary testing for other STDs (e.g., syphilis, gonorrhea, chlamydial infection), HBV, HCV, and TB, in conjunction with HIV testing, including referral and linkage to appropriate services, where feasible and appropriate and in accordance with current CDC guidelines and recommendations. *(This activity may be implemented in collaboration with STD, hepatitis, and/or TB programs).*

H. Ensure that testing laboratories provide tests of adequate quality, report findings promptly, and participate in a laboratory performance evaluation program for testing. *(This activity may be done in conjunction with surveillance and/or laboratory services).*

I. Incorporate new testing technologies, where feasible and appropriate.

HIV Testing Goals: Increase sero-positivity rate.

HIV Testing Objectives and Annual Targets

In an effort to monitor progress toward meeting the PS12-1201 Category A national objectives, please submit your jurisdictional proposed objectives for number of HIV test events, number of newly-identified HIV-positive test results, and new HIV-positive test rate for years 1-5 of the project period. For each year, enter the projected number of HIV test events that will be conducted and the anticipated new HIV-positive test rate.

	Targets Per Year					
Objectives	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
# of HIV testing events	2600	2300	2100	2100	2100	11,200
# of HIV positive test results	7	7	8	9	9	40
# of newly-identified HIV-positive test results	7	7	8	9	9	40
New HIV-positive test rate (%)*	0.27	0.3	0.38	0.43	0.43	
% of newly identified HIV-positive test results returned to clients	95%	95%	95%	95%	95%	
Additional local objectives: % of total tests administered to individuals reporting high risk behaviors such as MSM or IDU	55%	60%	65%	70%	70%	

**# of newly-identified HIV-positive test results (numerator)/ # of HIV testing events (denominator) = Target rate for new HIV positivity*

Outcome Objective(s): Increase the proportion of HIV-infected individuals across Montana who know they are infected	**Responsible for implementation**
Process Objective 1: 95% of newly identified, confirmed-positive results will be returned to clients	**CTR contractors**
Process Objective 2: implement three new outreach programs based on use of electronic media that are designed to increase the number of high risk MSM who get tested	**Open Aid Alliance, Yellowstone AIDS Project and FDH and Associates**
Process Objective 3: implement social marketing campaign targeted toward increasing testing among high-risk MSM.	**Social Marketing contractor**

Capacity Building Activities Planned for HIV Testing:

1) Survey and interview CTR contractors throughout the state to solicit information regarding their challenges and successes in recruiting high risk individuals for HIV testing. Synthesize and share results with contractors in order to build on strengths and overcome challenges.

2) Offer refresher CTR training courses for individuals who received their training 3 or more years ago.

Monitoring and Evaluation question	**Indicator(s)/Measure(s)**	**Data Source**	**Timeline**
Are CTR contractors targeting Montana's highest risk populations for HIV testing?	• **Increase in % of total HIV tests that are administered to MSM and IDU.** • **Increase in sero-positivity rate.**	• **CTR data**	**Annually**

Required Component: **Comprehensive Prevention with Positives $120,807**

Required Elements for Comprehensive Prevention with Positives:

A. Provide linkage to HIV care, treatment, and prevention services for those persons testing HIV-positive or currently living with HIV/AIDS.

B. Promote retention or re-engagement in care for HIV-positive persons.

C. Offer referral and linkage to other medical and social services such as mental health, substance abuse, housing, safety/domestic violence, corrections, legal protections, income generation, and other services as needed for HIV-positive persons.

D. Provide ongoing Partner Services (Recommendations for Partner Services Programs for HIV Infection, Syphilis, Gonorrhea, and Chlamydial Infection, 2008. http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5709a1.htm) for HIV-positive persons and their partners: Collaborate and coordinate with STD programs, and HIV and/or STD surveillance programs to utilize data to maximize the number of persons identified as candidates for Partner Services. (2) Partner with non-health department providers, including CBOs and private medical treatment providers, to identify more opportunities to provide Partner Services.

E. Assure that HIV-positive pregnant women receive the necessary interventions and treatment for the prevention of perinatal transmission.

F. Conduct sentinel event case review and community action to address local systems issues that lead to missed perinatal HIV prevention opportunities by utilizing the Fetal and Infant Mortality Review (FIMR)-HIV Prevention Methodology, including CDC's web-based data system (see www.fimrhiv.org), where appropriate and based on local need and the availability of resources.

G. Support behavioral and clinical risk screening followed by risk reduction interventions for HIV-positive persons and HIV-discordant couples at risk of transmitting HIV.

H. Support implementation of behavioral, structural, and/or biomedical interventions (including interventions focused on treatment adherence) for HIV-infected persons.

I. Support and/or coordinate integrated hepatitis, TB, and STD screening (STD Treatment Guidelines, 2010), and Partner Services for HIV-infected persons, according to existing guidelines.

J. Support reporting of CD4 and viral load results to health departments and use of these data for estimating linkage and retention in care, community viral load, quality of care, and providing feedback of results to providers and patients, as deemed appropriate.

K. Promote the provision of antiretroviral therapy (ART) in accordance with current treatment guidelines. (CDC funds may not be used to purchase antiretroviral therapy).

Comprehensive Prevention with Positives Goal: Identify and reduce the percent of persons with HIV who are out of care through increased outreach, and enhanced prevention and treatment services.

Comprehensive Prevention with Positive Objectives and Annual Targets

Objectives	Targets					
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
Newly-identified HIV-positives						
# HIV-diagnosed clients (new and previous positives) linked to HIV medical care	7	7	8	9	9	40
# of clients with a newly-identified HIV-positive test result linked to medical care and attended their first medical appointment	7	7	8	9	9	40
# of newly-identified HIV-positive clients who were referred and linked to prevention services	6	6	7	8	8	35
# of clients with a newly-identified HIV-positive test result referred to and interviewed for Partner Services	7	7	8	9	9	40

Outcome Objective(s): 1) 95% of newly identified confirmed-positive persons with HIV will attend their first medical appointment. 2) Positive clients at high risk for transmitting HIV/STD/HepC will be referred to CRCS and other supportive services as appropriate.	**Responsible for implementation:**
Process Objective 1: CTR contractors will pre-arrange confirmatory testing agreements for persons with preliminary positive test results **Process Objective 2:** CTR contractors will ensure confirmed positive persons are assisted to attend first medical appointment **Process Objective 3:** All prevention providers will maintain established referral arrangements with CRCS providers	**1) CTR contractors.** **2) Ryan White case managers and prevention services providers** **3)CRCS contractors**

Capacity Building Activities Planned for Prevention with Positives:
Provide prevention providers with a written "referral protocol" and with an electronic means for recording and submitting clients' actual follow through with recommended referrals.

Monitoring and Evaluation question	Indicator(s)/Measure(s)	Data Source	Timeline
How many newly confirmed clients attend their first medical appointment?	**Percent of newly confirmed positive persons that attended their first medical appointment**	**Referral form completed by prevention provider**	**Form completed and submitted when client completes the appointment or refuses the referral.**
Do HIV+ persons follow through with recommended referrals?	**Percent of HIV+ persons who make contact with recommended referral agencies**	**Referral form completed by prevention provider**	

Required Component: **Condom Distribution $12,750**

Required Elements for Condom Distribution:
A. Conduct condom distribution to target HIV-positive persons and persons at highest risk of acquiring HIV infection.

Condom Distribution Goal:
Provide sufficient access to prevention supplies targeted toward HIV positive persons and MSM.

Condom Distribution Objectives and Annual Targets						
	Targets					
Objectives	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
# of condoms to be distributed (overall)	57645	58000	58000	58000	58000	289,645
# of condoms to be distributed targeted to HIV-positive individuals	6,330	7000	7000	7500	7500	35,330
# of condoms to be distributed targeted to high-risk negatives/HIV unknown status	51,315	51,000	51,000	50,500	50,500	254,315

Outcome Objective(s): Include condom distribution in all prevention activities.	**Responsible for implementation**
Process Objective 1: Have condoms available at testing venues **Process Objective 2:** Distribute condoms at all ILI and GLI events **Process Objective 3:** Include education and support for condom use in all prevention activities	**Prevention services providers**

Capacity Building Activities Planned for Condom Distribution:
Distribute via the DPHHS web site an updated Power Point slide show depicting the epidemiology of HIV/HCV/STDs in Montana, and the efficacy of condoms in preventing diseases related to unprotected sex. All prevention specialists will be encouraged to use the slide show, or information gleaned from the slide show in their safer sex educational efforts.

Monitoring and Evaluation question	Indicator(s)/Measure(s)	Data Source	Timeline
Are MSM who are at high risk for infection using condoms?	**Percent of MSM who report condom use.**	**Survey conducted by the Gay Men's Task Force.**	**Every other year.**
Do contractors provide education and support for condom use in the course of their prevention activities?	**Number of educational sessions related to condom use.**	**QA monitoring forms completed by contractors.**	**Bi-annually**

Required Component: **Policy Initiatives $15,000**

Required Elements for Policy Initiative Strategies:
Support efforts to align structures, policies, and regulations in the jurisdiction with optimal HIV prevention, care, and treatment and to create an enabling environment for HIV prevention efforts. Policy efforts should aim to improve efficiency of HIV prevention efforts where applicable, and are subject to lobbying restrictions under federal law.

Policy Initiative Goals:
Identify structures, policies and regulations that hinder HIV prevention efforts.

Note: *When providing the Policy Initiatives objectives, please indicate at what stage the jurisdiction expects to be for each of their policy initiatives for each year, using the following categories: Identification (i.e., Identification/recognition of need, review of existing policies); Planning (i.e., policy formulation/preparation/development); Implementation; or Evaluation.*

Outcome Objective(s):	**Responsible for implementation:**
1) The Harm Reduction Task Force will develop and direct toward medical providers integrated training and education on Hepatitis C. 2) The Harm Reduction Task Force will identify existing financial, legal, and cultural barriers to establishing syringe exchange programs in Montana and present their findings to the HPG. 3) Gay Men's Task Force will develop and direct toward state and local policy makers at least one written communication annually that imparts the need for increased access to mental health and/or chemical dependency treatment for people living with HIV and MSM in Montana.	Contracted task forces.
Process Objective 1 (Implementation is ongoing): Harm Reduction Task force members will present information and conduct trainings for relevant community based organizations and health care facilities regarding HIV prevention, local IDU communities and IDU risk related to HIV/STDs. **Process Objective 2 (Identification Years one and two):** The Harm Reduction Task Force will utilize existing resources to explore the legal and cultural barriers to establishing syringe exchange programs in Montana. **Process Objective 3 (Planning Years two and three):** Gay Men's Task Force will research the factors that may facilitate or restrain efforts to increase access to mental health and/or chemical dependency treatment and formulate a policy initiative to increase access.	Contracted task forces

Capacity Building Activities Planned for Policy Initiative:
A speaker with expertise in the area of policy initiatives will attend an HPG meeting to which members of the task forces will be invited. This speaker will educate attendees about the process of policy change – including the specific cultural, political and legal considerations of expanded mental health, chemical dependency treatment and syringe exchange programs in Montana. The speaker also will address the challenges of changing policy in a conservative rural state such as Montana.

Monitoring and Evaluation question	Indicator(s)/Measure(s)	Data Source	Timeline
What are the structures, policies and regulations that impede HIV prevention efforts in Montana?	**List of factors that need to be addressed in order for HIV prevention to have maximum effectiveness.**	**Written reports from the Harm Reduction and Gay Men's Task Forces.**	**End of fiscal year.**
What practical and realistic initial steps can be undertaken in regard to changing policy and/or regulations that negatively affect HIV prevention?	**List of potential first steps in the process of policy and/or regulation change.**	**Written reports from the Harm Reduction and Gay Men's Task Forces.**	**End of fiscal year.**

Recommended Component: **Evidence-based HIV Prevention Interventions for HIV-Negative Persons at Highest Risk of Acquiring HIV $100,040**

Not applicable ☐

Recommended Elements for Evidence-based HIV Prevention Interventions for HIV-Negative Persons at Highest Risk:

A. Provide behavioral risk screening followed by individual and group-level evidence-based interventions for HIV-negative persons at highest risk of acquiring HIV, particularly those in an HIV-sero-discordant relationship.

B. Implement community evidence-based interventions that reduce HIV risk.

C. Support syringe services programs (SSPs), where allowable, and according to HHS and CDC guidelines. Programs that use federal funding for SSPs should adhere to state and local laws, regulations, and requirements related to such programs or services. Programs must have a certification signed by an authorized official. Funded grantees must, in turn, have documentation that local law enforcement and local public health authorities have agreed upon the location for the operation of the SSPs.

HIV Prevention Intervention Goals:
Reduce risk behaviors among at-risk populations through the implementation of individual and group level interventions that deliver risk reduction education, provide social support and reduce stigma and discrimination toward MSM and people infected with HIV.

EBIs for High-Risk Negatives Objectives and Annual Targets						
	Targets Per Year					
Objectives	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
# of high-risk HIV negative clients who enroll in individual and group level evidence-based interventions (ILIs and GLIs)	1647	0	0	0	0	0
# of community evidence-based interventions conducted	0	0	0	0	0	0
# of people reached by community evidence-based interventions	0	0	0	0	0	0

Outcome Objective(s): Reduce by 2.5% annually the percentage of MSM who report unprotected anal intercourse	**Responsible for implementation**
Process Objective 1: Increase number of persons at risk who attend prevention activities and receive prevention supplies by developing peer recruitment activities **Process Objective 2:** Include education and support for condom use in all prevention activities **Process Objective 3:** Use community based interventions to foster positive social norms regarding consistent use of condoms.	**EBI providers**

Capacity Building Activities Planned for HIV Prevention Interventions:
At regularly scheduled state contractors meetings, provide a formal process for each contractor to talk about the successes and challenges he or she faces in recruiting participants, implementing their intervention(s) and collecting monitoring data. Allow adequate time for discussion and problem solving.

Monitoring and Evaluation question	Indicator(s)/Measure(s)	Data Source	Timeline
Do HIV prevention interventions targeted toward HIV negative persons increase condom use?	**Number of intervention participants that report consistent condom use.**	**Administration of brief behavioral risk questionnaire given to participants at the end of an intervention (when feasible).**	**Summary of behavior risk questionnaire data submitted bi-annually.**
Do HIV prevention interventions targeted toward HIV negative persons reduce risk behaviors such as drug and alcohol use.	**Number of intervention participants that report a decrease in drug and alcohol use**	**Administration of brief behavioral risk questionnaire given to participants at the end of an intervention (when feasible).**	**Summary of behavior risk questionnaire data submitted bi-annually.**

Recommended Component: **Social Marketing, Media, and Mobilization $78,188**

Not applicable ☐

Recommended Elements for Social Marketing, Media, and Mobilization:

A. Support and promote social marketing campaigns targeted to relevant audiences (e.g., providers, high risk populations or communities) including the use of campaign materials developed and tested by CDC.

B. Support and promote educational and informational programs for the general population based on local needs, and link these efforts to other funded HIV prevention activities (e.g., pamphlets, hotlines, or social marketing campaigns).

C. Support and promote the use of media technology (e.g., Internet, texting, and web applications) for HIV prevention messaging to targeted populations and communities.

D. Encourage community mobilization to create environments that support HIV prevention by actively involving community members in efforts to raise HIV awareness, building support for and involvement in HIV prevention efforts, motivating individuals to work to end HIV stigma, and encouraging HIV risk reduction among family, friends, and neighbors.

Social Marketing, Media, & Mobilization Goals:

Increase awareness and perception of HIV transmission risk, encourage protective behaviors, establish healthy social norms, decrease HIV and sexual stigma, and increase testing among Montana's at-risk populations.

Social Marketing, Media, & Mobilization Objectives and Annual Targets

	Targets Per Year					
Objectives	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
# of social marketing/public information campaigns to be conducted	2	2	2	2	2	
# of people to be reached (exposures)	412,825 households thru TV; 14.4 million billboard traffic counts;	No change	No change	No change	No change	
# of media placements for marketing campaigns	630 TV ads; 29 billboard months; 9,480 SWAG items	No change	No change	No change	No change	

Outcome Objective(s): Increase overall testing in targeted risk populations	**Responsible for implementation**
Process Objective: Track longitudinal annual trend testing data	**Social Marketing Coordinator and DPHHS**

Capacity Building Activities Planned for Social Marketing, Media, & Mobilization:
Continued collaboration with HIV Planning Group through attendance at planning meetings.

Monitoring and Evaluation question	**Indicator(s)/Measure(s)**	**Data Source**	**Timeline**
Does Montana's social marketing campaign increase awareness about HIV and increase HIV testing?	**Number of hits on GetCheckedMT.org website**	**Website**	**Track counts annually**

Recommended Component: Pre-Exposure Prophylaxis and Non-Occupational Post-Exposure Prophylaxis Services

Not applicable ☒

PS12-1201 Category C

Demonstration Project

Project **MORE (Montana Outreach, Referral and Education) $90,000**

Not applicable ☐

Focus Area (Choose at least one)

☐ Structural, behavioral, and/or biomedical interventions or a combination that will have a high impact on reducing HIV incidence

☐ Innovative testing activities that increase identification of undiagnosed HIV infections and/or improve the cost effectiveness of HIV testing activities

☐ Enhanced linkage to and retention in care for persons with new and prior diagnosis of HIV infection

☒ Advanced use of technology

☐ Programmatic and epidemiologic use of CD4, viral load and other surveillance data to assess and reduce HIV transmission risk

☐ Other (specify):

Please include goals for the demonstration project. Goals should be specific and linked to the appropriate focus area(s).

Goals of Project MORE, Internet-based Outreach to gay, bisexual and men who have sex with men:

Initiate personal contact with target population to deliver appropriate health messages, offer medical and social services referrals, and promote HIV testing via internet channels and other social media.

Outcome Objective(s): Increase the number of the target population who are given risk reduction and positive health-behavior messages.	**Responsible for implementation**
Process Objective 1: Develop social media strategic plan **Process Objective 2:** Train peer outreach workers **Process Objective 3:** Implement the plan	**Three Project MORE service providers.**

Capacity Building Activities Planned for Demonstration Project, Specify Focus Area:
Training of peer leaders to offer health education via internet and social media channels

Monitoring and Evaluation question	Quantitative/Qualitative Measures	Data Source	Timeline
Does the MORE Project increase the number of MSM who receive information about HIV prevention, social services and HIV testing?	**Number of contacts will be maintained;** **Number of new contacts will increase by 50% by 2014.**	**Records of online contacts** **Subscribers of E-newsletter and users of social media tools**	**Annually**

MONTANA Quality Assurance (QA) Plan for Part A and C Categories

The Montana Quality Assurance Plan is applicable to all activities and categories. The HIV Prevention Coordinator will be responsible for implementation of the Quality Assurance Plan. The HIV Planning Group will yearly assess progress toward planning goals.

Technical performance: The degree to which the tasks carried out by health workers and facilities meet expectations of technical quality (i.e. adhere to standards).

1) **Quality Assurance Objective for Technical Performance:** Contractors will enter data and submit reports at least quarterly
2) **Quality Assurance Objective for Technical Performance:** Quarterly, the Department will compare submitted contractor data to ensure progress toward statewide goals.
3) **Quality Assurance Objective for Technical Performance:** Department staff will conduct site visits to each contractor at least yearly.

The HIV Prevention Planning Coordinator will conduct annual site visits and compare contractor data to ensure progress toward goals.

Access to services: The degree to which healthcare services are unrestricted by geographic, economic social, organizational or linguistic barriers.

1) **Quality Assurance Objective for unfettered access to services**: Funding for medical transportation assistance remains in place.
2) **Quality Assurance Objective for unfettered access to services:** A "core message" to understand HIV disease in Montana is developed and disseminated to appropriate service providers.
3) **Quality Assurance Objective for unfettered access to services:** Cultural sensitivity trainings for appropriate entities such as medical providers, testing counselors and corrections personnel is provided as requested.

The Department HIV treatment coordinator will ensure medical transportation funds are available for rural clients. The HPG will take responsibility for developing a "core message" to be disseminated as a PowerPoint slide set and other forms for media. HIV prevention contractors will be responsible for dissemination of the core message to appropriate entities. The contracted task forces will be asked to help with cultural sensitivity training.

Effectiveness of care: The degree to which desired results (outcomes) are achieved.

1) **Quality Assurance Objective for effectiveness of care:** Percentage of persons with undetectable viral loads is maintained or increased.

The HIV Treatment Coordinator will annually collaborate with the two Montana Ryan White Part C sites to monitor viral load percentages and report to HPG.

Continuity of services: Appropriate and timely referral/linkage and communication between providers.

1) **Quality Assurance Objective for linkage to care:** Percentage of newly identified positive persons who attend their first appointment is maintained or increased.
2) **Quality Assurance Objective for linkage to care:** All counseling and testing contractors will have agreements in place for confirmatory testing.

The HIV Prevention Coordinator will monitor counseling and testing data of individual contractors to ensure that testing contractors are following newly-identified positive persons through clients' first HIV medical appointment. Formal linkages for confirmatory testing must be in evidence at site visits.

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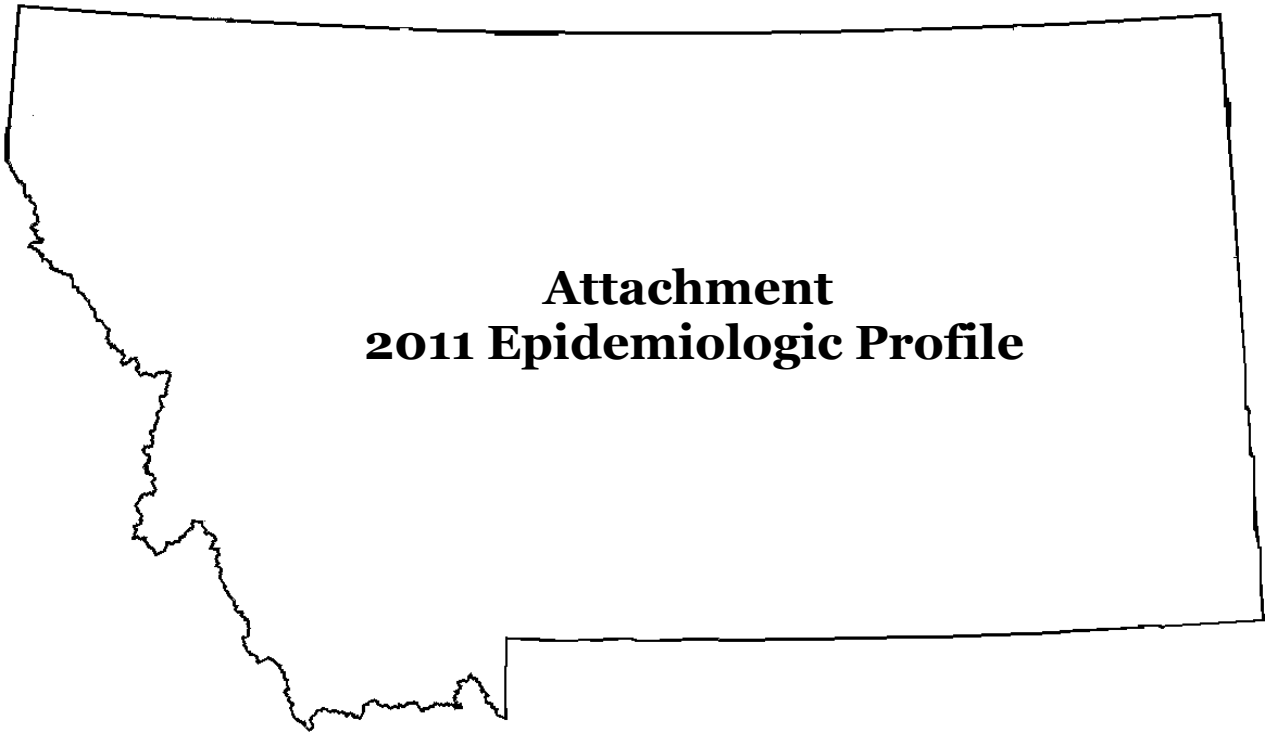

Attachment
2011 Epidemiologic Profile