Statewide Coordinated Statement of Need
and
Integrated HIV Prevention and Care Plan

State of Maine
2016

A collaborative effort of:

- **Maine's HIV, STD and Viral Hepatitis Program**
- **People living with diagnosed HIV/AIDS in Maine**
- **Maine's Ryan White Part C Programs**
- **Maine's AIDS Education and Training Center**
- **Key stakeholders, including State partners and HIV organizations**

Submitted by Maine's HIV Prevention and Ryan White Part B Programs

Paul R. LePage, Governor Mary C. Mayhew, Commissioner

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Executive Summary

Current surveillance records indicate that there were 1,766 people living with diagnosed HIV in Maine at the end of 2015.

Maine is a sparsely populated state with a low prevalence of HIV. Although there is a huge geographic divide within the state and many generally stated needs, the HIV prevention and care communities have a history of working together to address Maine's needs. There is a broad array of both medical and support services available to people living with HIV in Maine; in 2015, there was more than $22.7 million spent on HIV/STD-specific services in the state.

Most of the services assessed and described in this document are publicly-funded and supplied through MaineCare (MaineCare), Ryan White, HIV Prevention 12-1201 and Housing Opportunities for People with AIDS (HOPWA) grants. MaineCare, HOPWA, and AIDS Drug Assistance Program (ADAP) services are available throughout the state; Ryan White Part C services are available through three strategically located regional providers; and HIV case management is available through community-based agencies throughout the state. Other key medical providers also contribute to the Continuum of Care.

From 2015-2016, an extensive needs assessment process was conducted statewide to address the current resources available and the gaps that exist in services for a representative sample of people living with diagnosed HIV and those at highest risk for contracting HIV in Maine. A synthesis of data collected through the needs assessment served as a guide in the creation of this Integrated HIV Prevention and Care Plan.

This document contains the Statewide Coordinated Statement of Need (SCSN), which reports on the findings from the needs assessment and the Integrated HIV Prevention and Care Plan, which illustrates programming strategies to meet specific objectives for HIV Prevention and Care services over the next five years.

Section I: Statewide Coordinated Statement of Need/Needs Assessment

A. Epidemiologic Overview

As of December 31, 2015, there were an estimated 1,766 people living with HIV (PLWH) residing in Maine. In 2015, 48 newly diagnosed HIV cases were reported to Maine CDC. Ten newly diagnosed cases (21 percent) received an AIDS diagnoses within one month of testing positive for HIV.

Maine is a sparsely populated state with a low prevalence of HIV. In 2014, Maine's population was an estimated 1.3 million. More than 36 percent of Maine residents lived in its two southern-most counties, York and Cumberland.

In 2015, the estimated rate of reported HIV disease in Maine was 132.8 per 100,000, a significant increase from the 2005 rate of 70.4 per 100,000. This increase in HIV prevalence may be due to several factors, including increased HIV testing, improved disease reporting and data collection and longer lifespans among PLWH.

Maine's Ryan White Part B Program funds payer of last resort financial assistance and medical case management programs to help low-income people living with HIV in Maine to obtain or maintain access to appropriate health care and services. In 2015, the Part B Program provided some form of assistance to a total of 882 unduplicated people living with HIV, approximately half of all PLWH in the state. Ryan White Part B demographic data are presented in this section to bridge gaps in surveillance data.

Geography

Surveillance data are not always complete with regard to residence and do not indicate when PLWH move within the state. Therefore, the regional distribution of utilizing Ryan White Part B members may provide a more accurate picture of current residence among PLWH.

Table 1. Utilizing Ryan White Part B members by region of residence, 2015

Region	n	%
Southern (Cumberland and York counties)	457	52%
Central (Oxford, Franklin, Androscoggin, Somerset, Kennebec, Sagadahoc, Lincoln, Knox and Waldo counties)	271	31%
Northern (Piscataquis, Penobscot, Hancock, Washington and Aroostook counties)	154	17%
Total	882	100%

Source: CAREWare

Sex

Surveillance data refer to an individual's assigned sex at birth. At this time, Maine is unable to thoroughly and accurately report on current gender identity, which may be different than sex at birth. Aligning with national and historic trends, the majority of new diagnoses in Maine in 2015 were among individuals whose sex at birth was male. Of the 48 individuals diagnosed with HIV in 2015, 38 were male (79 percent), and 10 were female (21 percent). Males also make up the majority (82 percent) of all Maine PLWH.

The Ryan White Part B Program records members' self-identified gender. As of December 31, 2015, approximately one percent of Ryan White Part B members identified as transgender.

Age

In 2015, the majority of new HIV diagnoses in Maine were among individuals age 30 and older (71 percent). New diagnoses were reported in people ages nine through 70, including four pediatric cases. In 2015, approximately 95 percent of all Maine PLWH were age 30 and older and more than half (58 percent) were age 50 and older. The table below provides a breakdown by age group of new HIV diagnoses, existing HIV cases and utilizing Ryan White Part B members for comparison.

Table 2. New HIV diagnoses, all PLWH and utilizing Ryan White Part B members by age group, 2015

	New HIV diagnoses		Existing HIV cases (PLWH)		Utilizing Ryan White Part B members	
Age group	**n**	**%**	**n**	**%**	**n**	**%**
under 13	2	4%	13	1%	7	<1%
13-19	2	4%	8	<1%	2	<1%
20-29	10	21%	67	4%	28	3%
30-39	13	27%	225	13%	120	14%
40-49	9	19%	433	25%	217	25%
50-59	7	15%	657	37%	340	39%
60 and older	5	10%	363	21%	168	19%
Total	**48**	**100%**	**1,766**	**100%**	**882**	**100%**

Source: Maine Electronic HIV and AIDS Reporting System (eHARS), CAREWare

Race and Ethnicity

Of the 48 new adult HIV diagnoses in Maine in 2015, 23 (48 percent) were among non-Hispanic White individuals, 14 (29 percent) were among Black/African-American individuals and 4 (8 percent) were among individuals of Hispanic/Latino ethnicity.

The table below provides a breakdown of all Maine PLWH by race/ethnicity.

Table 3. Number and distribution of Maine PLWH by race/ethnicity, 2015

Race/ethnicity	n	%
White*	1,356	77%
Black/African-American*	237	13%
Hispanic/Latino(a)	108	6%
Other or multi-race*	44	2%
Asian*	10	1%
American Indian/Alaska Native*	10	1%
Native Hawaiian/Pacific Islander*	1	<1%
Total	**1,766**	**100%**

** Non-Hispanic*
Source: Maine Electronic HIV and AIDS Reporting System (eHARS)

While 77 percent of PLWH in Maine are White, HIV disproportionately affects Black/African-American and Hispanic/Latino(a) residents. The rate of Black/African-Americans living with HIV in Maine is 12 times higher than that of Whites. The rate of Hispanic/Latino(a) residents living with HIV is five times higher than that of Whites. The table below provides a breakdown of the distribution and rate of HIV infection in Maine by race/ethnicity.

Table 4. Estimated rate of diagnosed HIV infections in Maine by race/ethnicity, 2015

Race/ethnicity	n	Rate per 100,000
White*	1,356	109.0
Black /African-American*	237	1,296.1
Hispanic/Latino(a)	108	516.2

** Non-Hispanic*
Source: Maine Electronic HIV and AIDS Reporting System (eHARS)

The rate of Black males living with HIV is almost seven times higher than that of White males and the rate of Hispanic/Latino males living with HIV is almost four times higher than that of White males. The rate of Black females living with HIV – at 1,312.2 per 100,000 – is the highest rate per 100,000 population and more than 47 times higher than that of White females (27.7 per 100,000). The rate of Hispanic/Latina females is more than 10 times that of White females.

Region of Birth

According to the U.S. Census, in 2014 approximately 3.7 percent of Maine residents were born in a country other than the U.S. This sub-population is identified as 'New Mainers'. In 2014, almost ten percent of Maine PLWH were born outside the U.S. This suggests that Maine residents born outside the U.S. may be disproportionately impacted by HIV.

Sixteen percent of PLWH utilizing Ryan White Part B services in 2015 were born in countries other than the U.S. The top three countries of origin for new Mainers with HIV who utilized Ryan White Part B services in 2015 were Burundi, Rwanda and Congo. Almost three-quarters (72 percent) of new Mainers with HIV who utilized Ryan White Part B services in 2015 were from African countries, with 12 percent from North America, five percent from South America and four percent each from Europe and Asia.

The population of new Mainers enrolled in Ryan White Part B services in 2015 was more racially diverse than the general population of people living with HIV in Maine. Only eight percent identified as White and approximately 79 percent as Black/African-American.

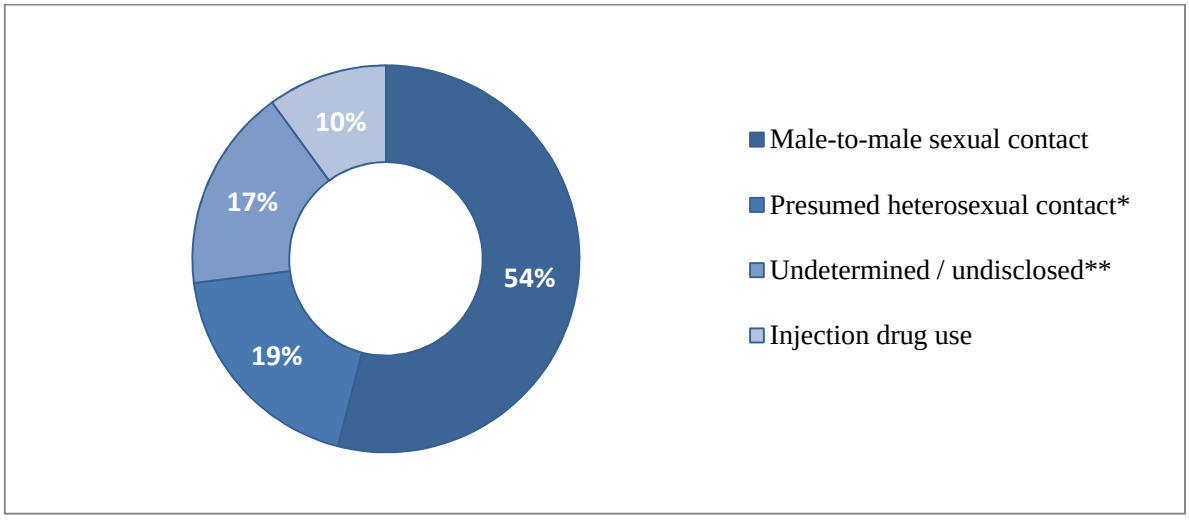
The Ryan White Part B program collects data related to immigration status and interpretation needs. According to the data on file, more than one-third of new Mainers (36.5 percent) who utilized Ryan White Part B services in 2015 met the immigration qualifications for federal benefits by being naturalized citizens, asylees or refugees and almost as many (35.8 percent) had pending asylum cases; almost one-quarter (23.4 percent) were lawful, permanent residents who are required to wait five years from the time their residency is granted to qualify for federal benefits; the remaining 4.4 percent includes those with a temporary visa and two individuals whose information was not complete at the time the data were analyzed. More than half (58 percent) of new Mainer enrollees did not need interpreters while approximately 40 percent needed an interpreter at least sometimes.

Heterosexual contact was the most commonly reported mode of transmission among new Mainer enrollees (58 percent), followed by male-to-male sexual contact (13 percent).

Mode of HIV Transmission

The figure below displays the distribution of new HIV diagnoses in 2015 by mode of transmission.

Figure 1. Distribution of new HIV diagnoses by mode of transmission, 2015



** Includes those who did not disclose at-risk partners*
*** Includes transmission via clotting factor, transplant/transfusion, other confirmed risks and those with no identified (NIR) or no reported risk (NRR).*
Source: Maine Electronic HIV and AIDS Reporting System (eHARS)

Among all PLWH in Maine in 2015, the majority were likely to have been infected through unprotected male-to-male sexual contact. High-risk heterosexual contact accounted for 11 percent of all known infections but was the most frequent mode of transmission for female PLWH (40 percent).

Table 5. Total number and distribution of Maine PLWH by mode of transmission and sex, 2015

Mode of transmission	Female		Male		Total	
	n	%	n	%	n	%
Male-to-male sexual contact	n/a	n/a	996	69%	996	56%
Injection drug use	61	19%	112	8%	173	10%
Male-to-male sexual contact & injection drug use	n/a	n/a	65	4%	65	4%
High-risk heterosexual contact	128	40%	65	4%	193	11%
Perinatal transmission (diagnosed at any age)	5	2%	10	0%	15	1%
Other*	127	40%	197	14%	324	18%
Total	**321**	**100%**	**1,445**	**100%**	**1,766**	**100%**

**Includes transmission via clotting factor, transplant/transfusion, other confirmed risks, presumed heterosexual contact (no at-risk partners disclosed) and those with no identified (NIR) or no reported risk (NRR).*
Source: Maine Electronic HIV and AIDS Reporting System (eHARS)

People infected through contaminated blood products represent less than one percent of Maine PLWH. Additionally, there have been no documented or reported instances of occupationally-acquired HIV infection in the state.

The Ryan White Part B Program collects mode of transmission data by self-report from enrollees and advocates (health care providers and case managers) and therefore may diverge slightly from surveillance data. Among utilizing members, the Ryan White Part B Program has an over-representation of individuals identifying heterosexual contact as their primary HIV risk factor compared to the overall population of PLWH in the state with corresponding under-representations of all other populations except perinatal transmission.

Table 6. Percentage of utilizing Ryan White Part B members by mode of transmission compared to all PLWH in Maine, 2015

Mode of transmission	Percent of Ryan White Part B utilizing members	Percent of PLWH in Maine
Male-to-male sexual contact	53%	56%
Heterosexual contact	23%	11%
Other	11%	18%
Injection drug use	9%	10%
Male-to-male sexual contact & injection drug use	2%	4%
Perinatal transmission	1%	1%

Source: CAREWare, Maine Electronic HIV and AIDS Reporting System (eHARS)

Deaths

Deaths among PLWH in Maine were considered to be those deaths that occurred in Maine, regardless of where the individuals were diagnosed. In 2014, ten PLWH were known to have died in Maine, but that figure is subject to change as additional death data are released by State and/or federal sources.

The number of deaths among people known to have HIV in Maine has remained relatively steady over the past ten years. During 2005 through 2014, the average number of deaths per year among PLWH was 19 and the average age at death was approximately 52 years-old.

In the 10-year period between 2005 and 2014, the majority of deaths (52 percent) that occurred in Maine among PLWH were due to causes other than those directly related to HIV. Among those with an HIV-related cause of death during this time period, the average age at death was 51 years-old, while the average age at death for those with a cause of death not directly related to HIV was 52 years-old. This aligns with national trends in average life-expectancy among HIV-positive individuals.

Socioeconomic Status

Maine's surveillance program does not collect nor maintain socioeconomic data for PLWH. Socioeconomic data for the general population in Maine and for the population utilizing Ryan White Part B and MaineCare services are used as a proxy.

In 2014, the estimated proportion of Maine residents living below the federal poverty level (FPL) was 14.1 percent—slightly below the national estimate of 15.5 percent.

Maine's median annual household income during 2009-2013 (the latest time period for which data are available) was approximately $4,500 lower than that of the U.S. overall ($48,458 per year versus $53,046 per year, respectively).

Maine's Ryan White Part B Program calculates income based on all members of the legal household. Members are required to verify their income every six months, providing documentation at least once per year. The Ryan White Part B Program has a household income cap of 500 percent of FPL.

Table 7. Percentage of utilizing Ryan White Part B members by Federal Poverty Level, 2015

Federal poverty level	%
0-100%	43%
101-250%	41%
251-300%	7%
301-400%	5%
401-500%	4%
> 500%	0%

Source: CAREWare

Since July of 2002, Maine's Office of MaineCare Services has operated the *Maine MaineCare Section 1115 Health Care Reform Demonstration for Individuals with HIV/AIDS*, often referred to as "the waiver." The waiver extends limited MaineCare coverage to PLWH at or below 250 percent of the FPL. Waiver benefits are based on a disease model with the goal to delay, prevent, and reverse the progression of HIV/AIDS. In addition to meeting eligibility requirements, waiver members must agree to be monitored and participate in medical treatment. Waiver members pay income-based premiums, pay co-pays for physician visits and have higher medication co-pays than those with traditional MaineCare benefits.

Approximately 44 percent of all PLWH were enrolled in MaineCare as of December 31, 2015. Of these approximately 772 enrollees, 311 (40 percent) were eligible for traditional Medicaid benefits.

In 2014, approximately 10 percent of Maine residents did not have health insurance, compared to approximately 12 percent of the U.S. population. A higher proportion of Maine young adults (age 19 to 25 years), American Indian/Alaska Native residents and Asian-American residents were without health insurance coverage compared to other subpopulations in the state. Additionally, a larger proportion of male residents in Maine were uninsured compared to female residents. According to data from the U.S. Census Bureau's American Community Survey, the majority of Maine residents—approximately two-thirds—were covered by private insurance plans, and nearly 38 percent were covered by publically-funded insurance. These insurance categories are not mutually exclusive; individuals may have multiple coverage types simultaneously.

Many Ryan White Part B members have multiple insurance types and experience intermittent changes to their insurance types throughout the year. Identification of members who are eligible for insurance and reduction and elimination of barriers to obtaining and maintaining insurance are among the highest priorities for the AIDS Drug Assistance Program (ADAP).

Table 8. Last reported primary insurance for utilizing Ryan White Part B members, 2015

Last reported primary insurance	%
MaineCare	40%
Medicare	33%
Private insurance	22%
No insurance	4%
VA, Tricare and other military	<1%

Source: CAREWare

Indicators for Risk

Testing Data

The State of Maine participates in yearly surveillance of health behaviors among adults, including HIV testing and risk behaviors via the Behavioral Risk Factor Surveillance System (BRFSS) survey. Information from the BRFSS provides a snapshot of HIV testing among the general adult population in Maine. In 2012, the last year for which data on HIV testing were available, 32 percent of Maine respondents indicated that they had been tested for HIV at least once, while 68 percent reported that they had never been tested for HIV.

In 2015, the HIV counseling, testing and referral (CTR) subgrantees funded by the Maine CDC HIV, STD and Viral Hepatitis Program performed 2,254 HIV tests; eight of these tests identified new positive cases (almost 17 percent of all new positive cases identified during the year). The table below shows CTR testing data for the past five years, including the percentage of new cases identified at CTR sites for each year.

Table 9. Maine CDC-funded Counseling, Testing and Referral site data, 2011-2015

Year	Total HIV tests*	Newly identified positive cases	% of new cases identified at CTR sites
2011	3,796	14	26%
2012	3,702	7	15%
2013	3,070	7	15%
2014	2,340	4	7%
2015	2,254	8	17%

Source: Evaluation Web

Decrease in total HIV tests annually correlates to decreased available funding

The distribution of tests by race and ethnicity is similar to the distribution of all PLWH in Maine, except for an under-representation of Hispanics and a corresponding over-representation of American Indian/Alaska Natives.

Table 10. Percentage of Counseling, Testing and Referral tests by race/ethnicity compared to all PLWH in Maine, 2015

Race/ethnicity	Percent of CTR tests conducted	Percent of PLWH in Maine
White	78%	77%
Black or African-American	11%	13%
Hispanic	2%	6%
Other or multi-race	2%	2%
American Indian/Alaska Native	5%	1%
Asian	2%	1%

Source: Maine Electronic HIV and AIDS Reporting System (eHARS), Evaluation Web

Male-to-male sexual contact is the most common HIV risk factor among those who tested at CTR sites as well as new cases in 2015 and all Maine PLWH. People who inject drugs (PWID) represent a larger percentage of CTR tests in 2015 than new or prevalent cases.

Table 11. New and prevalent cases compared to Counseling, Testing and Referral tests by risk factor, 2015

HIV risk factor	New cases		All PLWH		CTR tests	
	n	%	n	%	n	%
Male-to-male sexual contact	26	54%	996	56%	709	31%
Injection drug use	5	10%	173	10%	645	29%
Male-to-male sexual contact & injection drug use	0	0%	65	4%	92	4%
High-risk heterosexual contact	0	0%	193	11%	266	12%
Perinatal transmission (diagnosed at any age)	0	0%	15	1%	0	0%
Other/undetermined*	17	35%	324	18%	542	24%
Total	**48**	**100%**	**1,766**	**100%**	**2,254**	**100%**

Source: Maine Electronic HIV and AIDS Reporting System (eHARS), Evaluation Web

Risk Behaviors

According to the 2012 BRFSS (the most recent year in which the Maine survey included a question on HIV risk behaviors), an estimated three percent of Maine adults reported engaging in HIV risk behaviors in the 12 months prior to the survey. The 2012 BRFSS

defined being "at risk for HIV transmission" as including any of the following: used intravenous drugs in the past year; was treated for a sexually transmitted disease in the past year; had given or received money or drugs in exchange for sex in the past year; and/or had anal sex without a condom in the past year. The table below provides a breakdown of survey respondents by age group and gender.

Table 12. HIV risk behavior among Maine adults by age group and sex, Behavioral Risk Factor Surveillance System, 2012

	Number reporting HIV risk behaviors (weighted)	Percent reporting HIV risk behaviors (%)
AGE GROUP		
18-34	21,654	2.1% (CI: 1.6% – 2.6%)
35-54	9,470	0.9% (CI: 0.7% – 1.2%)
55+	2,160	0.2% (CI: 0.1% – 0.3%)
SEX		
Male	19,113	1.9% (CI: 1.4% – 2.3%)
Female	14,230	1.4% (CI: 1.1% – 1.7%)

Source: Behavioral Risk Factor Surveillance System (BRFSS), 2012
CI = Confidence Interval
Note: Cells in the same category with overlapping CIs are not statistically different from one another

HIV risk behaviors among Maine youth are not specifically addressed by statewide behavioral surveillance, however the Maine Integrated Youth Health Survey (MIYHS)—a biannual self-report survey of Maine kindergarten through 12th grade students—measures condom use among Maine middle and high school students. In the 2013 survey, 38 percent of Maine high school students responding to the survey reported they had not used a condom at their last sexual intercourse.

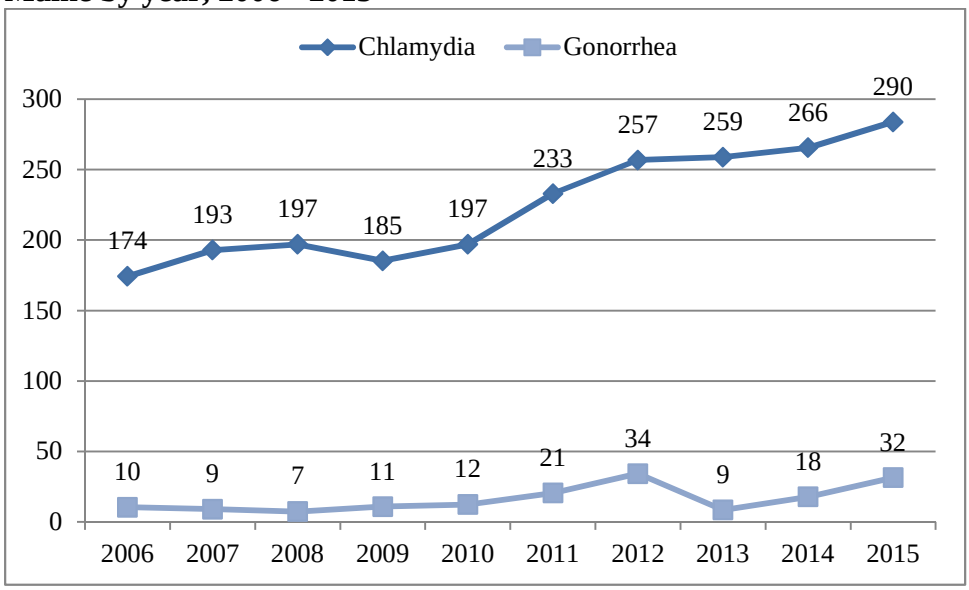
Chlamydia and Gonorrhea

Gonorrhea and chlamydia are notifiable conditions in Maine. Due to the large numbers of STD cases reported without data on race and/or ethnicity, comparisons by race/ethnicity are not included.

Chlamydia is the most frequently reported STD in the state. In 2015, there were 3,851 cases of chlamydia reported to Maine CDC, a case rate of 289.7 per 100,000. Rates were highest among women, adolescents and young adults. Rates were highest in Androscoggin and Somerset counties, with rates of 502.6 per 100,000 and 356.1 per 100,000 respectively.

As illustrated in the figure below, the yearly rate of reported cases of chlamydia in Maine has grown significantly and relatively steadily over the past decade. The rate of reported cases of gonorrhea has followed a less consistent trend.

Figure 2. Rate (per 100,000) of reported cases of chlamydia and gonorrhea in Maine by year, 2006 - 2015



*Source: Maine CDC, HIV, STD and Viral Hepatitis Program, STD*MIS*

In 2015, there were 422 cases of gonorrhea reported to Maine CDC, a case rate of 31.8 per 100,000. The rate was highest among men and young adults. Rates were highest in Androscoggin and Cumberland counties, with rates of 125.9 per 100,000 and 50 per 100,000 respectively. Approximately three percent of gonorrhea cases occurred in people previously diagnosed with HIV.

While chlamydia and gonorrhea co-infection with HIV is seemingly low, based on documentation of specimen source on positive gonorrhea labs reported to Maine CDC, many health care providers are failing to perform extra genital screening. Therefore, it is likely that chlamydia and gonorrhea are underdiagnosed and underreported. Additionally, in 2015, three Ryan White Part C clinics reported that only 34 percent of patients identified as males who have sex with males received an annual rectal gonorrhea test.

In addition, anecdotal evidence from gonorrhea case investigations suggests that health care provider awareness of the U.S. CDC-recommended treatment is not universal or universally applied. Additionally, many health care providers do not carry ceftriaxone on site, which must be provided through intramuscular injection, hindering correct timing of the dual therapy. Emergency room settings are reported to be the least likely to adhere to the recommended treatment regimen. While there have been no reported cases of antibiotic-resistant gonorrhea in Maine, cases are carefully monitored for signs of antibiotic resistance.

Syphilis

Fifty cases of early syphilis (primary, secondary and early latent) were reported to Maine CDC in 2015. Reported syphilis cases increased by 138 percent from 2014 to 2015 with notable geographic disparities. Syphilis numbers in Maine have remained relatively

constant in the past several years, averaging 19 cases annually over the past five years. In response to the surge in reported early syphilis cases, Maine CDC released a Health Alert Notice on December 1, 2015.

In 2015, the statewide syphilis rate was 3.7 per 100,000. Rates were highest in Somerset and Cumberland counties, with rates of nine per 100,000 and 11.7 per 100,000 respectively.

Of the reported cases, 61 percent were diagnosed in southern Maine (26 cases in Cumberland County, five cases in York County) and 22 percent of cases were diagnosed in central Maine (Kennebec and Somerset counties).

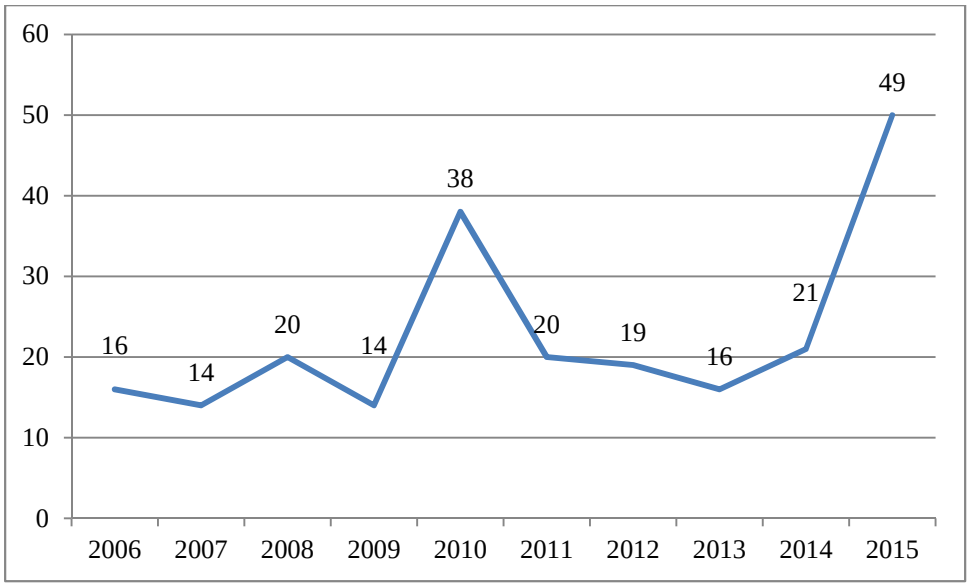
Most of the cases (72 percent) were among 30 – 54 year-olds. Since 2011, the proportion of syphilis cases in people age 40 and older has been increasing steadily from 30 percent in 2011 to 50 percent in 2015.

The majority of syphilis cases identified as male (40 cases or 82 percent). The number of early syphilis cases among females rose from one reported case in 2011 to nine reported cases in 2015.

The predominant mode of transmission associated with reported syphilis cases was male-to-male sexual contact (32 cases or 65 percent).

As with chlamydia and gonorrhea, comparisons by race/ethnicity are not included due to incomplete data.

Figure 3. Number of reported cases of syphilis by year, Maine, 2006-2015



*SOURCE: Maine HIV, STD and Viral Hepatitis Program, STD*MIS*

Hepatitis

In 2015, there were 30 confirmed cases of acute Hepatitis C Virus (HCV), a rate of 2.3 cases per 100,000. Twenty (67 percent) of the confirmed acute cases of HCV in 2015 identified injection drug use as a risk factor. As of 2015, approximately 11 percent of PLWH in Maine were co-infected with hepatitis C.

In 2015, Maine saw a spike in the number of chronic hepatitis C cases in people younger than 30 and conducted a six-month enhanced surveillance project to learn more. Among those interviewed, half thought they got hepatitis C from injection drug use. The median age of first injection was 18.5 years with a range of 15 to 21 years. The enhanced surveillance project shows a median starting age of 17.5 years for cocaine, 17 years for prescription opioids and 18 years for heroin.

The yearly reported cases of acute and chronic hepatitis B in Maine have remained relatively stable from 2010 through 2014. However, Maine CDC has noted a sharp increase in the number of acute hepatitis B cases reported in the first half of 2016. There were 15 confirmed cases of acute hepatitis B cases confirmed in Maine from January 1 through May 16, 2016, a rate of 1.1 cases per 100,000. There were no cases of acute hepatitis B during the same time period in 2015. The primary risk factor for new cases of acute hepatitis B in Maine in 2016 is injection drug use.

Hepatitis A is the least common form of hepatitis reported in Maine. The number of cases reported in Maine between 2010 and 2015 ranged from a low of six cases in 2011 to a high of 10 cases in 2013.

Injection Drug Use

As of the end of 2015, there were 173 PLWH in Maine who likely acquired the disease via injection drug use, representing approximately 10 percent of all Maine PLWH. An additional 65 individuals (four percent) were likely to have acquired HIV via a combination of male-to-male sexual contact and injection drug use. These counts are based on individual self-report through diagnostic interviewing and may underestimate the true number of PLWH in Maine who acquired HIV via sharing contaminated injection equipment.

In 2015, five new cases of HIV were attributed to injection drug use, the highest number for any single year in the last five years and more than double the five-year median of two cases. PWID accounted for approximately six percent of cumulative new cases of HIV diagnosed in Maine in the past five years.

From November 2014 through October 2015, the six certified needle exchange sites in Maine collected 545,475 contaminated needles from 4,264 individuals at 17,155 exchange events. The number of enrollees, contaminated needles collected and exchange events increased compared to the previous year. More than half (56 percent) of needle exchange enrollees were age 30 and older; 65 percent were male; and 95 percent were White.

Data reported to Maine's Office of Substance Abuse and Mental Health Services show that the number of individuals admitted to substance abuse treatment facilities reporting injection drug use has been increasing over the past decade. While this trend may represent improvements in availability of treatment rather than an increase in the prevalence of injection drug use, the proportion of injection drug users who also report needle sharing remains a particular concern.

In 2014, 1,117 of 4,390 PWID who were admitted for substance abuse treatment also reported sharing needles (25.4 percent).

The "County-level Vulnerability Assessment for Rapid Dissemination of HIV or HCV Infections among Persons who Inject Drugs (PWID), United States" published in 2016 in the *Journal of Acquired Immune Deficiency Syndromes* (JAIDS) identified Maine as the fourth-most vulnerable state for the rapid spread of HIV and hepatitis C virus among PWID. The four high-risk counties identified were Kennebec, Somerset, Washington and Waldo.

U.S. CDC clearly states that the assessment does not mean an outbreak of HIV or increases in HCV are imminent in the areas identified as high-risk, nor is it meant to be used to predict future events. Rather, its purpose is to alert states with relatively high rates of HCV and injection drug use and encourage them to think about detection and mitigation strategies that will help avert outbreaks and increases in disease. Maine CDC staff had multiple conversations with study investigators about how best to use the information from this study.

It is important to note that HCV is not reportable in 11 states, and acute and chronic HCV are not distinguished in many more, making it a questionable predictor of risk during a comparison of states. HCV is a notifiable disease in Maine with distinctions between acute and chronic HCV infection. Better reporting practices were established in 2014, resulting in surveillance capturing more cases of acute HCV.

Maine CDC staff does aggressive follow-up of electronic lab reports of HCV and elevated liver function tests, with direct outreach to providers and cases. Every suspected acute case of HCV and HIV is investigated. As a result, our surveillance systems for HCV and HIV are stronger and our data much more specific and complete than that available in other states.

In addition:

- Maine has six certified needle exchanges that provide HIV testing and have the ability to test for HCV.
- Maine supports a variety of HIV and HCV testing programs.
- Maine CDC is currently engaged in harm reduction activities.
- Maine has a basic infrastructure in place for outreach.
- The Virology Treatment Center at Maine Medical Center has started a telemedicine program (similar to Project ECHO) to train primary care providers in rural, low resource areas to treat hepatitis C.

- There is currently an initiative to establish electronic medical record prompts that identify individuals at high risk (specifically people who inject drugs and baby boomers) and prompt providers to offer screening and vaccination. This is an effective way to identify positive HCV cases and link to care. One health center initiated this change and increased screening from 11 tests in 2014 to approximately 800 in 2015.
- The Viral Hepatitis program trains 100 primary care providers and 30 substance use counselors every year.
- Maine CDC is currently working on an inventory of resources available to people with HIV and HCV.

Male-to-male Sexual Contact

In 2015, the majority of individuals in Maine who acquired HIV through male-to-male sexual contact (MSM) were 50 years-old or older (61 percent), reflecting an age distribution similar to Maine PLWH overall. While Black/African-American individuals account for 13 percent of all Maine PLWH, just four percent of PLWH with a male-to-male sexual contact mode of transmission are Black/African-American.

MSM also made up the largest proportion (48 percent) of cumulative new cases of HIV diagnosed in Maine in the past five years. Individuals aged 40-49 made up the largest proportion of cumulative diagnoses with an MSM mode of transmission, a pattern which diverges from national trends.

High-risk Heterosexual Contact

Approximately 11 percent of Maine PLWH acquired HIV via high-risk heterosexual contact. More than two-thirds of those with a high-risk heterosexual contact mode of transmission identified sex with an HIV infected partner as their likely risk factor. Individuals who acquired HIV via high-risk heterosexual contact are more likely to be Black/African-American than Maine PLWH as a whole.

Nine of the 48 new cases in 2015 (19 percent) had a presumed heterosexual mode of transmission but did not identify a high-risk partner and therefore were not classified as having a heterosexual mode of transmission. High-risk heterosexual contact and presumed heterosexual contact combined accounted for approximately 22 percent of cumulative new cases of HIV diagnosed in Maine in the past five years.

Qualitative Data

HIV Prevention Outreach Coordinators conducted online surveys with high-risk MSM and PWID in the spring of 2016. A total of 13 high-risk individuals were surveyed.

All PWID surveyed had used a needle exchange in the past year and all MSM surveyed had received education about pre-exposure prophylaxis (PrEP). Generally, respondents liked the HIV prevention services they have used, particularly the accessibility of services and education they received.

More than one-third of respondents (38 percent) had traded sex for drugs, money or shelter at some point. More than one-third of respondents (38 percent) had been under the influence of alcohol and/or drugs during most or all of their sexual encounters in the past year. Most (85 percent) reported using condoms for less than half of their sexual encounters in the past year. All of the PWID were actively injecting drugs and all indicated that they share injection equipment at least sometimes. Slightly more than half of all respondents (54 percent) considered themselves at risk for HIV and three-quarters of PWID considered themselves at risk for HCV.

While most (92 percent) respondents had been tested for HIV at some point, only 62 percent of respondents indicated that they had accessed CTR services in the past year. Less than half (46 percent) of respondents had utilized community testing for HCV in the past year. Only 15 percent had utilized community STD testing in the past year. Less than half (46 percent) of respondents have a primary care physician.

A key informant interview with the Minority Outreach Specialist in Southern Maine highlighted areas of concern related to new Mainers that may impact risk, including:

- Lack of information upon arrival in the U.S., including where to access safer sex supplies and education as well as needle exchanges
- Language barriers
- History of trauma
- Cultural norms that may lead to increased stigma about HIV, sex and drug use
- An aversion to testing because an HIV diagnosis may be seen as a death sentence
- A perception that condoms transmit HIV
- A finding that those who inject drugs are less likely to use needle exchanges due to shame and stigma

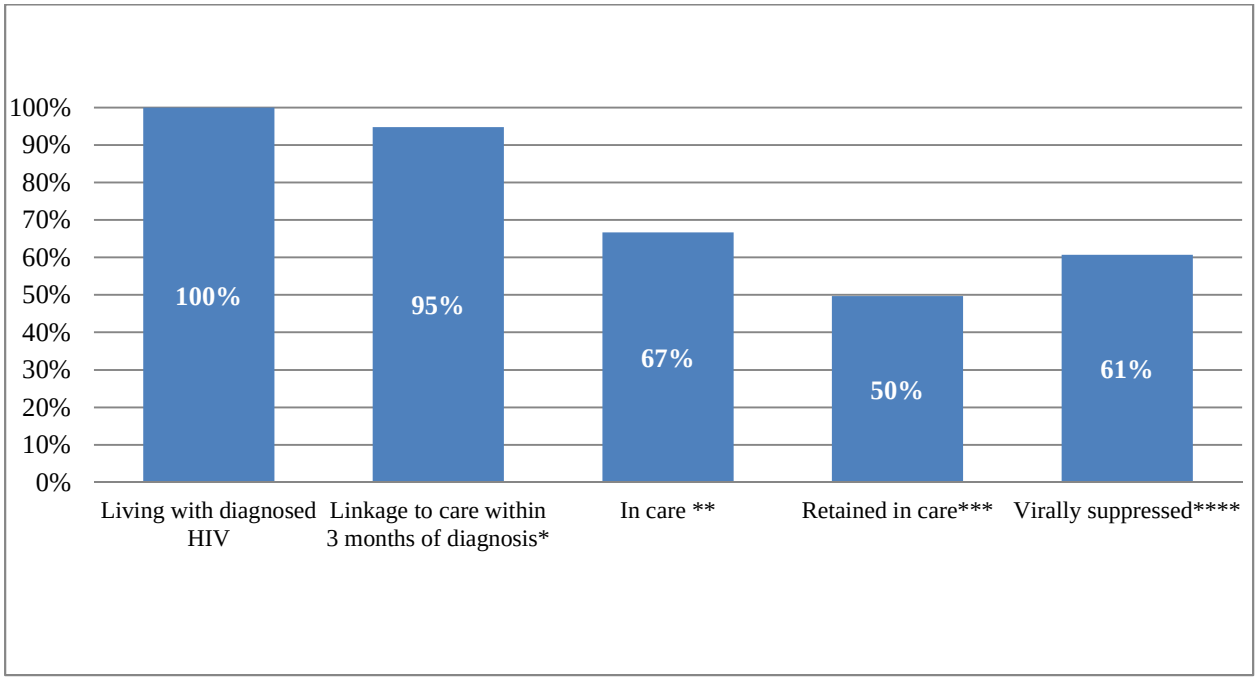
B. HIV Care Continuum

It is important to note that U.S. CDC does not recommend local jurisdictions use the national estimate of the percentage undiagnosed to estimate prevalence for the local continuum of care. National calculations are not applicable at the local level, where there may be more variation in HIV testing, reporting delays and under-reporting resulting in a larger or smaller percentage of persons undiagnosed. For local analyses of the continuum, U.S. CDC recommends jurisdictions use the number of persons living with diagnosed HIV infection (all stages of disease) as the overall denominator of the continuum of care.

As a result, direct comparisons between Maine's continuum of care cannot be made to the national continuum because underlying populations are different.

Below is Maine's continuum for calendar year 2014 for PLWH who were age 13 or older at the end of 2013 and resided in Maine, based on most recent residence.

Figure 4. Continuum of care among adult PLWH in Maine, 2014



**For individuals age 13 and older newly diagnosed in 2014 only (n=57)*
*** Defined as the number of PLWH age 13 and older who had* either *≥1 CD4+ or viral load test result during 2014. Percentage calculated as the number who received any care among diagnosed PLWH age 13 and older.*
**** Defined as the number of PLWH age 13 and older who had ≥2 care visits during 2014, at least 91 days apart. Multiple tests completed in the same month were considered as one care visit. This includes visits where different tests were completed (e.g., when one visit was a CD4 test and another visit was a viral load (or genotype) test). Percentage calculated as the number retained in care among diagnosed PLWH age 13 and older.*
***** Defined as the number of PLWH who had suppressed viral load (≤200 copies/mL) at most recent test during 2014. Percentage calculated as the number virally suppressed among diagnosed PLWH age 13 and older.*
Source: Maine Electronic HIV and AIDS Reporting System (eHARS)

Viral suppression leads to improved health outcomes, lower health care costs and a decreased likelihood of transmitting HIV to others. Individuals who have consistent access to their medications have an increased likelihood of following the required regimen, which leads to viral suppression.

The percentage of new cases linked to care within three months of diagnosis was slightly lower in 2014 (95 percent) than 2013 (97 percent). In 2015, six out of eight new cases identified through CTR (75 percent) were linked to medical care within three months of diagnosis.

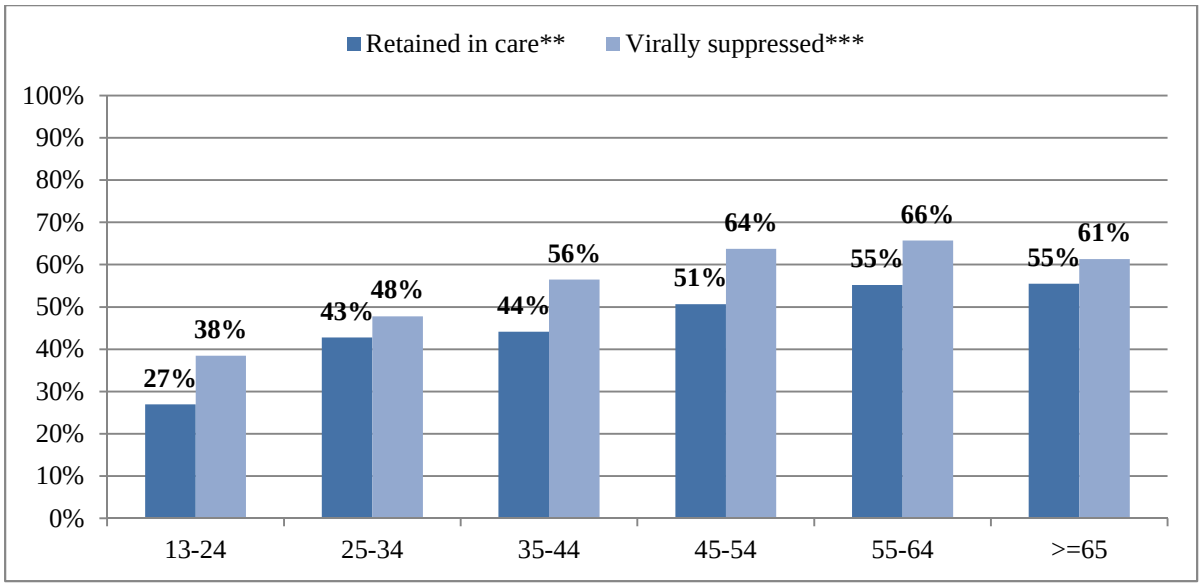
Viral suppression is quite high (92 percent) among those who had at least one viral load test (categorized as 'In care' in Figure 4) in 2014, but 33 percent of all Maine PLWH did not have even one viral load test in 2014.

Care Continuum Outcomes by Selected Characteristics

Age

As age increases, the percentage of PLWH who are virally suppressed also increases as illustrated below. In general, viral suppression is high (range of 81 percent to 97 percent) for those age 25 and older who had at least one viral load in 2014.

Figure 5. Retention in care and viral suppression by age group*, 2014



**Age as of December 31, 2013*
*** Defined as the number of PLWH age 13 and older who had ≥2 care visits during 2014, at least 91 days apart. Percentage calculated as the number retained in care among diagnosed PLWH age 13 and older.*
**** Defined as the number of PLWH who had suppressed viral load (≤200 copies/mL) at most recent test during 2014. Percentage calculated as the number virally suppressed among diagnosed PLWH age 13 and older.*
Source: Maine Electronic HIV and AIDS Reporting System (eHARS)

While the underlying population of HIV-positive 13-24 year-olds is relatively small (n = 26), they have the lowest proportions of PLWH who were retained in care, who had at least one viral load in 2014 and who were virally suppressed in 2014. This is consistent with national trends.

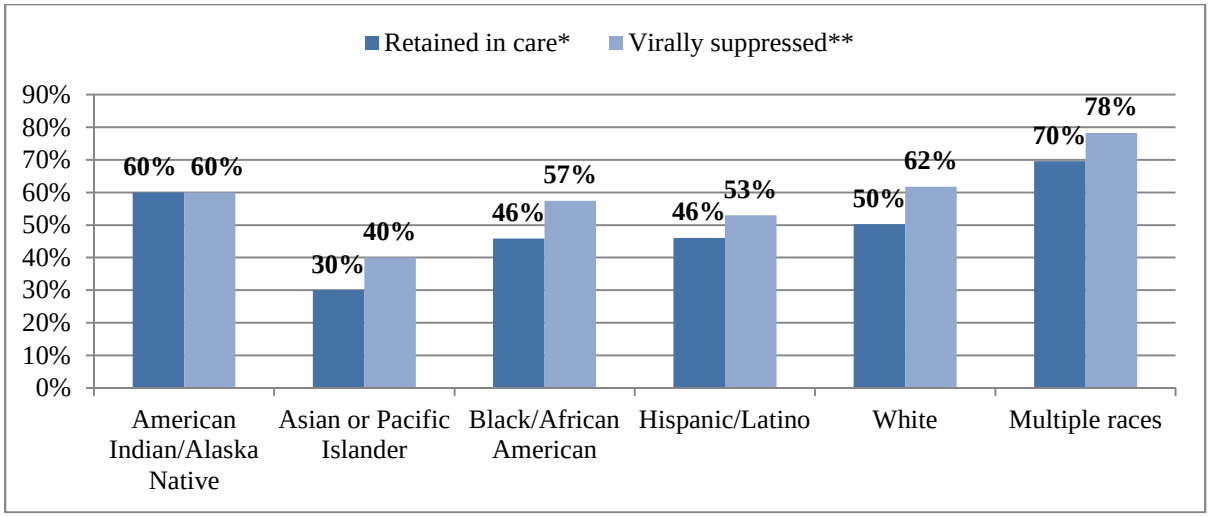
Race and Ethnicity

Although viral suppression was high among Black/African-American PLWH who had at least one viral load in 2014 (91 percent), only 46 percent of Black/African-American PLWH were retained in care.

In 2014, 30 percent of all Black MSM and 38 percent of all Black PWID were retained in care. While half of Black heterosexuals were retained in care, a greater proportion of Black heterosexual females were retained in care (57 percent) than Black heterosexual males (42 percent).

Hispanic/Latino(a) PLWH also have high viral suppression (93 percent) among those who had at least one viral load in 2014, but only 46 percent of Hispanic/Latino(a) PLWH were retained in care. Only 67 percent of Hispanic/Latina females who inject drugs who had a viral load reported in 2014 were virally suppressed.

Figure 6. Retention in care and viral suppression by race/ethnicity, 2014



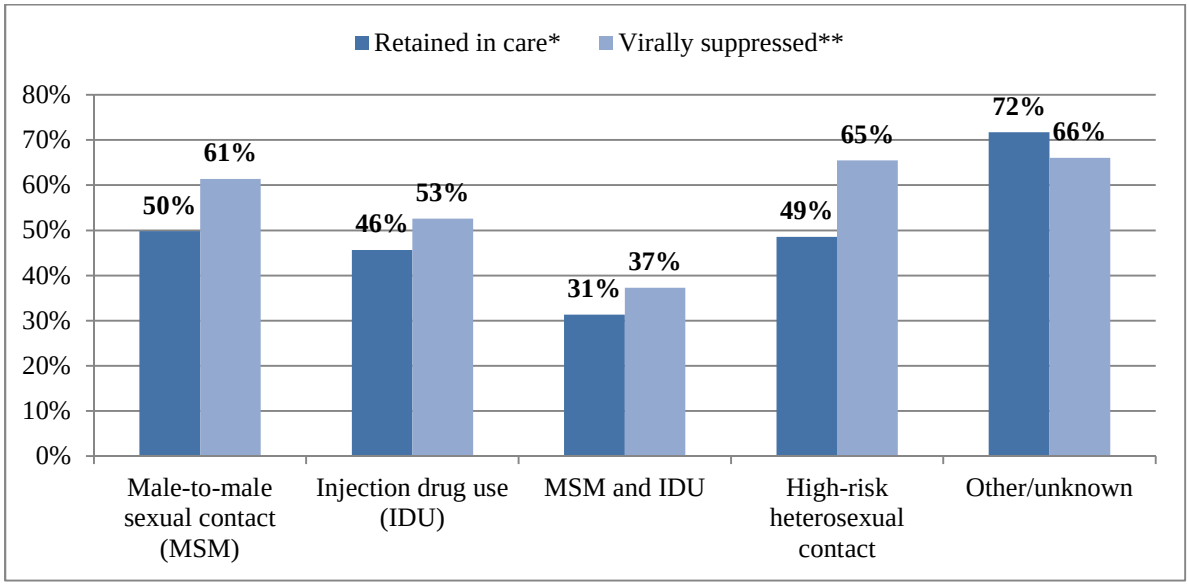
** Defined as the number of PLWH age 13 and older who had ≥2 care visits during 2014, at least 91 days apart. Percentage calculated as the number retained in care among diagnosed PLWH age 13 and older who reported a race/ethnicity.*
*** Defined as the number of PLWH who had suppressed viral load (≤200 copies/mL) at most recent test during 2014. Percentage calculated as the number virally suppressed among diagnosed PLWH age 13 and older who reported a race/ethnicity.*
Source: Maine Electronic HIV and AIDS Reporting System (eHARS)

Mode of Transmission

Those with an "other" or unknown mode of transmission had the highest proportion of PLWH retained in care and virally suppressed in 2014 when compared to other modes of transmission. However, this is also the only group to have a lower proportion virally suppressed than retained in care.

Viral suppression was high for nearly all transmission groups who had at least one viral load in 2014 (range of 89 percent to 95 percent for all groups except "other"). Only 75 percent of those with an "other" mode of transmission (includes hemophilia, blood transfusion and persons exposed perinatally) who had at least one viral load in 2014 were virally suppressed.

Figure 7. Retention in care and viral suppression by mode of transmission, 2014



** Defined as the number of PLWH age 13 and older who had ≥2 care visits during 2014, at least 91 days apart. Percentage calculated as the number retained in care among diagnosed PLWH age 13 and older.*
*** Defined as the number of PLWH who had suppressed viral load (≤200 copies/mL) at most recent test during 2014. Percentage calculated as the number virally suppressed among diagnosed PLWH age 13 and older.*
Source: Maine Electronic HIV and AIDS Reporting System (eHARS)

Care Continuum Outcomes and the Ryan White HIV/AIDS Program

Ryan White Part B

Of utilizing Ryan White Part B members with no viral load reported in 2015, 38 percent had a suppressed viral load at the end of 2014 and 24 percent had a suppressed viral load reported in the first six months of 2016; 29 percent have been lost to care.

Of the 137 new Mainers with HIV who utilized at least one Ryan White Part B service in 2015, 89 percent had a suppressed viral load at last test reported in 2015.

Maine's ADAP funds the full cost of medications to treat HIV and related conditions for eligible members without health insurance. In 2015, 38 members accessed this form of assistance only from ADAP. Only 68 percent of these were virally suppressed at last test reported in 2015, compared to 86 percent of those who had at least one insurance payment (premium, deductible and/or medication co-pay) paid on their behalf. This is consistent with data reported by other ADAPs nationally.

The proportion of virally suppressed PLWH is high among those who utilized Ryan White Part B-funded assistance with housing/utilities, dental care and/or food in 2015. Although three to four percent of those accessing assistance did not have a viral load reported in 2015, viral suppression was still 89 percent among those receiving

housing/utilities assistance, 89 percent among those receiving dental assistance and 90 percent among those receiving food assistance.

Ryan White Part C

Approximately 322 PLWH had at least one outpatient/ambulatory care service provided by one of the three Ryan White Part C recipients in Maine in calendar year 2015. Of those, 93.5 percent were virally suppressed at last viral load reported in 2015.

Care Continuum Outcomes and Housing

Frannie Peabody Center, Maine's Housing Opportunities for People with AIDS (HOPWA) grantee, was one of seven grantees nationally to participate in the Integrated HIV/AIDS Housing Plan (IHHP) from 2011 through 2015. Evidence shows that housing instability has an impact on each stage of the care continuum.

During the IHHP, Frannie Peabody Center found a positive relationship between length of time in the program and improved viral load. More than 80 percent of those who were stably housed had an improved viral load.

Utilizing the Care Continuum

This plan has been developed with a goal of improving outcomes along the Care Continuum for all PLWH in Maine. The Client Health Assessment survey was designed specifically to solicit information related to clients' experiences along the continuum. The Integrated Planning Body focused much of its discussions on the current retention in care and viral suppression data and evaluating activities and strategies to improve these two key areas. Attention was also paid to data limitations in these areas – particularly retention in care, where lab data may not be the best proxy for medical visits.

Future planning efforts should focus on Care Continuum data stratified by demographic characteristics to ensure that outreach, testing and care activities are aligned with those who are most vulnerable. In addition, strategies should be created to identify and reach out to those lost at each transition along the continuum. The effectiveness of services, testing and outreach should be analyzed annually in context of Care Continuum data to ensure that services and strategies are relevant and effective in improving health outcomes.

C. Financial and Human Resources Inventory

The following table illustrates all resources available statewide that serve people living with HIV. The resources that are managed by Maine CDC are identified with a triple asterisk (***) after the Funding Source name.

HIV Resources Inventory, FY 2016

Funding Source (Funding Recipient)	Funds available in FY16	% of total funds available	Funded Service Provider Agencies	Services Delivered	HIV Care Continuum Steps Impacted
Medicaid (State of Maine, Office of MaineCare Services)*	• $14,976,041	65.80%	• Any Provider with an executed Provider Agreement who properly bills claims	• Outpatient medical care • Inpatient care • Nursing home • Pharmacy • Limited vision care • Emergency dental care (for members with traditional MaineCare only) • Mental health services • Substance abuse services • Physical therapy	• Engaged or retained in care • Prescribed antiretroviral therapy • Achieved viral suppression
340B Drug Rebates from ADAP* **	• Estimated $1,900,000	8.35%	• Goold Health Systems: $818,412 • Medical Care Development: $646,743 • Frannie Peabody Center: $44,000	• Prescription drugs • Insurance premiums • Dental care and insurance • Food cards • Housing assistance • Interpreter services for medical case management	• Engaged or retained in care • Prescribed antiretroviral therapy • Achieved viral suppression
Ryan White Part B (State of Maine, Maine CDC)* **	• ADAP: $1,013,933 • Formula: $805,151	7.99%	• Goold Health Systems: $625,054 • Medical Care Development: $565,638 • Frannie Peabody Center: $135,241	• Prescription drugs • Insurance premiums • Dental care and insurance • Food cards • Medical case management	• Engaged or retained in care • Prescribed antiretroviral therapy • Achieved viral suppression

Funding Source (Funding Recipient)	Funds available in FY16	% of total funds available	Funded Service Provider Agencies	Services Delivered	HIV Care Continuum Steps Impacted
HUD/HOPWA (Frannie Peabody Center)	• HAVEN I: $346,515 • HAVEN II: $233,754 • HAVEN III: $328,500	3.99%	• None	• Rental subsidies • Short-term assistance with rent, mortgage and utilities • Permanent housing placement • Supportive services/case management	• Engaged or retained in care • Achieved viral suppression
CDC HIV Prevention (State of Maine, Maine CDC)* **	• $753,824	3.31%	• Down East AIDS Network/ Health Equity Alliance: $169,680 • City of Portland: $118,950 • Maine Family Planning: $71,050 • Frannie Peabody Center: $97,728	• Prevention with positives • Linkage to care • HIV testing • Condom distribution	• Diagnosed with HIV • Linked to care • Engaged or retained in care
State of Maine general funds	• HIV Care: $62,000*** • HIV/STD Prevention: $142,800*** • HIV prevention education: $150,000*** • Department of Corrections: $328,548** • Substance Abuse and Mental Health Services: $62,137	3.28%	• Medical Care Development: $62,000 • Down East AIDS Network/ Health Equity Alliance: $24,000 • City of Portland: $43,700 • Maine Family Planning: $34,300 • Frannie Peabody Center: $40,800	• Drug copays • Housing assistance • Integrated HIV/STD/HCV testing, including post-test counseling • HIV prevention education for tribal youth, special education students, high risk adolescents, GLBTQ youth, comprehensive sexuality education conference, revision and training for best practices for high school students • Medications for HIV-positive prisoners • HIV intervention services	• Diagnosed with HIV • Linked to care • Engaged or retained in care • Prescribed antiretroviral therapy • Achieved viral suppression

Funding Source (Funding Recipient)	Funds available in FY16	% of total funds available	Funded Service Provider Agencies	Services Delivered	HIV Care Continuum Steps Impacted
Ryan White Part C (Regional Medical Center at Lubec)	• $398,288	1.75%	• Community Health and Counseling Services: $14,000 • Down East AIDS Network/ Health Equity Alliance: $111, 377 • Eastern Maine Medical Center infectious disease specialists: $15,000 • Robert Pinsky, MD, infectious disease specialist: $3,750 • Wabanaki Health and Wellness: $3,000 • Maine Family Planning: $3,000	• Outpatient medical services • Oral health care • Mental health services • Treatment adherence counseling • Medical nutrition therapy • Medical case management • Medical transportation • HIV testing	• Diagnosed with HIV • Linked to care • Engaged or retained in care • Prescribed antiretroviral therapy • Achieved viral suppression
Ryan White Part C (City of Portland)	• $356,533	1.57%	• None	• Outpatient medical services • Early intervention services • Mental health services • Medical transportation	• Engaged or retained in care • Prescribed antiretroviral therapy • Achieved viral suppression
CDC STD Prevention (State of Maine, Maine CDC)* **	• $272,742	1.20%	• City of Portland: $90,660 • Maine Family Planning: $31,024	• Integrated DIS services, including linkage to care and partner services • STD testing	• Diagnosed with HIV • Linked to care • Engaged or retained in care
Ryan White Part C (Maine General Medical Center)	• $269,563	1.18%	• None	• Outpatient medical services • Health insurance / medications • Oral health care • Early intervention services • Mental health services • Medical transportation	• Engaged or retained in care • Prescribed antiretroviral therapy • Achieved viral suppression

Funding Source (Funding Recipient)	Funds available in FY16	% of total funds available	Funded Service Provider Agencies	Services Delivered	HIV Care Continuum Steps Impacted
CDC HIV Surveillance (State of Maine, Maine CDC)* **	• $165,307	0.73%	• University of Southern Maine: $20,000	• Disease surveillance activities	• Diagnosed with HIV • Linked to care • Engaged or retained in care • Achieved viral suppression
Ryan White Part F (New England AIDS Education and Training Center)	• $64,000	0.28%	• Down East AIDS Network/ Health Equity Alliance	• Professional development and training	• Engaged or retained in care • Prescribed antiretroviral therapy • Achieved viral suppression
United Way	• $64,310	0.28%	• Horizon Program: $16,000 • Frannie Peabody Center: $45,310 • Down East AIDS Network / Health Equity Alliance: $3,000	• Medical case management • Food pantry	• Engaged or retained in care • Prescribed antiretroviral therapy • Achieved viral suppression
AIDS United (Down East AIDS Network / Health Equity Alliance)	• $30,000	0.13%	• Maine General Community Cares: $4,000	• Syringe exchange	• Diagnosed with HIV • Linked to care • Engaged or retained in care
AIDS United Positive Organizing Project (Down East AIDS Network / Health Equity Alliance)	• $15,000	0.07%	• Voices Heard and Winter Gathering	• Social support and advocacy	• Linked to care • Engaged or retained in care
Broadway Cares / Equity Fights AIDS	• $15,000	0.07%	• Down East AIDS Network / Health Equity Alliance: $5,000 • Frannie Peabody Center: $10,000	• Housing and utilities assistance • Emergency food assistance	• Engaged or retained in care • Prescribed antiretroviral therapy • Achieved viral suppression

Funding Source (Funding Recipient)	Funds available in FY16	% of total funds available	Funded Service Provider Agencies	Services Delivered	HIV Care Continuum Steps Impacted
Comer Foundation (Down East AIDS Network / Health Equity Alliance)	• $5,000	0.02%	• None	• Syringe exchange	• Diagnosed with HIV • Linked to care • Engaged or retained in care
Total funds	**$22,758,946 (63% federal, 28% State, 8% drug rebates, 1% private funds)**				

** Actual claims data from FY2014 before pharmaceutical rebates, which would reduce costs by approximately $7 million.*

*** Actual costs for medications provided to HIV-positive prisoners in FY2015.*

The nature of available funding requires comingling of resources to ensure continuity of care. No frontline providers receive their funding from a singular source. For example, Maine's HOPWA grantee provides Ryan White Part B-funded medical case management, MaineCare-funded targeted case management and CDC-funded HIV prevention services. The ADAP utilizes State general fund dollars and drug rebates to augment its federal funding.

There is a variety of services available to PLWH and those at risk for HIV that are not specifically targeted to these populations. These services include community mental health and substance abuse services – both inpatient and outpatient – low-income housing programs, financial assistance programs and other health services.

Maine receives almost $19 million in federal grant awards from the Substance Abuse and Mental Health Services Administration in addition to the State funds earmarked for substance abuse and mental health services for HIV interventions noted in the table above. The Federal funds do not require a state match.

In addition to the medication costs reported above, the Maine Department of Corrections (DOC) also covers community-based consultations and follow-ups and lab testing at least quarterly for HIV-positive prisoners. HIV-positive prisoners are seen by a provider in the DOC chronic care clinics at least every six months. Total cost for these services was not available at the time this report was developed. In 2015, there were 28 off-site visits to infectious disease providers and 76 lab tests conducted. While the number of prisoners fluctuates, the FY2015 figures are similar to FY2014.

Approximately seven percent of PLWH who utilized Ryan White Part B services in 2015 identified as veterans of the armed forces, but it is unclear how many of these individuals accessed care through the Veterans Administration (VA). The full estimated budget for the VA in Maine for FY2015 was $964,588.

There are a number of private physicians who provide care to PLWH and those at risk for HIV (most of whom are reimbursed by public or private insurances for their services). The Virology Treatment Center treats about 340 PLWH and services are reimbursed by private insurance, public insurance and Free Care through the MaineHealth system.

Maine is home to 57 community health centers that can be found in areas and among populations in the state with the greatest needs. There are 40 rural health clinics throughout Maine. The majority of these clinics indicated that they serve a very small proportion of PLWH, with the exception of Portland Community Health Center, which serves approximately 50 PLWH.

The Maine Breast and Cervical Health Program offers free breast and cervical cancer screenings to low-income, uninsured or underinsured women, and the Maine Colorectal Cancer Control Program offers free colorectal cancer screenings to low-income, uninsured or underinsured men and women. Both programs are administered by Maine CDC.

Maine CDC's public health nursing program works with new Mainers to provide screening for tuberculosis, a nursing health assessment and education regarding the U.S. health care system.

MaineHousing, an independent State agency that bridges public and private housing finance to benefit Maine's low- and moderate-income people, provides homeless assistance grants to emergency shelters serving people who are homeless. Shelters are located in 12 of Maine's 16 counties.

Maine's Department of Health and Human Services administers the Bridging Rental Assistance Program (BRAP) through the Substance Abuse and Mental Health Services office. BRAP was established as a method to make sure that individuals who are housing unstable with severe mental health issues are able to live in the community among family, friends, and other natural supports. Although not targeted to people living with HIV/AIDS, those with an eligible mental health diagnosis can access BRAP assistance. Less than one percent of BRAP recipients in Maine are reported to have HIV, but these data may be incomplete.

The U.S. Department of Housing and Urban Development's Continuum of Care administers the Shelter Plus Care (SPC) program through Shalom House. SPC was created through the McKinney-Vento Act to provide communities with funding to house and support disabled, homeless individuals and families to get and remain off the streets and out of the shelters. PLWH are considered disabled for the purposes of program eligibility. Less than two percent of SPC recipients in Maine are reported to have HIV, but these data may be incomplete.

Other housing resources not specifically targeted to people living with or at risk for HIV but accessible to them are: Housing Choice Vouchers (Section 8), Public Housing, Low Income Housing Tax Credit (LIHTC) Programs and the Supported Housing Program.

People living with and at risk for HIV can access financial assistance through their local General Assistance programs, Temporary Assistance for Needy Families (TANF) and the Low Income Home Energy Assistance Program (LIHEAP). Many also qualify for food stamps and assistance from the Women, Infants and Children (WIC) program, which is administered by Maine CDC.

HIV Workforce Capacity

The following subsections describe the capacity of frontline staff members who work predominantly with PLWH and those at high risk for HIV in Maine. These subsections do not reflect the entire workforce serving PLWH and those at risk, which includes housing specialists, mental health and substance abuse counselors, prevention educators, grant administrators and administrative staff.

HIV Prevention Staff

The HIV Prevention workforce is comprised of disease intervention specialists (DIS), community outreach workers and staff at CTR sites, needle exchanges and STD clinics.

Two full-time DIS and the full-time Linkage to Care Coordinator provide Partner Services to individuals newly diagnosed with HIV, syphilis, gonorrhea and/or chlamydia and help partners named by diagnosed individuals obtain HIV/STD testing and treatment. DIS are professionals trained by U.S. CDC to provide Partner Services. Combined, these staff members have 17 years of experience in the field.

Outreach workers support and promote HIV, STD and HCV testing and regional, state and national prevention activities. Turnover among these staff has been high.

Maine CDC contracts CTR services to four community-based organizations. Maine CDC requires a comprehensive two-day training for all CTR staff.

Maine CDC contracts two community-based organizations to provide STD testing services in nineteen locations statewide. These services are provided by trained clinical staff.

Needle exchanges are located at six sites in all three regions of the state. All needle exchange staff are CTR trained.

Health Care Providers

A total of eight Maine health care providers are listed on the American Academy of HIV Medicine's referral link website, seven in Portland and one in Ellsworth (a small city in northern Maine). Of these, five are credentialed by the academy, all of whom practice in Portland. Four providers are members of the academy – three in Portland and one in Ellsworth.

The Office of MaineCare Services conducts an annual survey of physicians and nurse practitioners who provided medical care to MaineCare members with HIV who were enrolled that year. A total of 125 (out of 313) providers responded to the 2014 survey. The largest proportion of respondents identified as family/general practice (49 percent), 23 percent were internal medicine providers and 20 percent were infectious disease specialists.

Most respondents (65 percent) treated between one and ten patients with HIV. Among infectious disease respondents, 46 percent served more than 40 people living with HIV while 14 percent served between one and ten.

Only 35 percent of respondents indicated that they were always aware of current treatment guidelines and new HIV/AIDS recommendations; 56 percent indicated that they were sometimes aware of guidelines and recommendations; nine percent indicated that they were never aware of them. All respondents who indicated that they were never

aware of guidelines and recommendations belonged to family/general practices or internal medicine practices. Infectious disease providers were most likely to report always being aware of treatment guidelines and recommendations.

The majority (64 percent) of respondents indicated they were at least familiar with training opportunities through the Maine AIDS Education and Training Center (AETC), but 36 percent were not at all aware of the AETC.

A similar number of providers (35 percent) were not aware of Maine's MaineCare waiver for people living with HIV/AIDS. Slightly fewer (33 percent) were not aware of ADAP.

In February 2016, Maine's HIV, STD and Viral Hepatitis Program created an electronic survey for health care providers related to current treatment guidelines for HIV and STDs. The survey link was distributed to the Maine Primary Care Association's email listserv and via the Maine Medical Association's weekly e-newsletter. Six practices in Northern Maine (Aroostook, Penobscot, Piscataquis, Washington and Hancock counties) responded to the survey. According to the most recent epidemiological profile, approximately 16 percent of all people living with diagnosed HIV in Maine resided in this region at the time of their diagnosis. This region is characterized by its rurality and general health disparities.

Notable findings include:

- Of the two practices that indicate they served people living with HIV, one indicated that they were not following the current treatment guidelines (as updated in January 2016) and the other indicated that they were not familiar with ADAP.
- While all but one practice indicated they were using the current STD treatment guidelines, only one practice was familiar with the Disease Intervention Specialists (DIS).
- Four of the six practices offered routine HIV testing, five of the six offered routine STD testing and four of the six practices offered routine hepatitis C testing.
- Half of the practices were aware of PrEP, but none were prescribing it.
- Four of the six practices indicated that their practice had a referral system in place for patients newly diagnosed with HIV.

In late 2015, Maine's HIV, STD and Viral Hepatitis Program mailed a paper survey to health care providers related to knowledge of and experience with PrEP. A total of 36 responses were received. Notable findings include:

- While most respondents (83 percent) offered routine HIV, STD and hepatitis C testing and indicated that their practice serves high-risk populations, only 17 percent had experience prescribing PrEP.
- One responding practice was not even aware of PrEP as an intervention.
- Less than half (47 percent) of providers indicated a willingness to learn more about PrEP and prescribing it while an equal percentage of providers indicated that they would like to learn more about PrEP and prescribing it.

- One-quarter of respondents have referrals in place for patients interested in PrEP, but 67 percent said they would like information about where to refer patients to get PrEP.

The same survey was conducted by phone and fax in the summer of 2016 among the federally qualified health centers (FQHCs) in Maine. Thirty-one of the 57 FQHCs that were contacted completed the survey, including respondents from each of the State's public health districts. Notable findings include:

- While most respondents (90 percent) offered routine HIV, STD and hepatitis C testing and indicated that their FQHC serves high-risk populations, only six percent had experience prescribing PrEP.
- Nineteen percent of responding FQHCs were not aware of PrEP as an intervention.
- More than three-quarters of responding FQHCs were interested in learning more about PrEP and how to prescribe it.
- Most (84 percent) of responding FQHCs responded that they were interested in additional information on where to refer patients to receive PrEP.

HIV Case Managers

The Ryan White Part B Program funds medical case management in Central and Southern Maine for those who do not qualify for other forms of case management, such as targeted case management covered by MaineCare. The Regional Medical Center at Lubec funds medical case management in Northern Maine utilizing Ryan White Part C funds. Frannie Peabody Center utilizes HOPWA supportive services funds for case management. All community-based agencies in Maine that provide HIV case management provide targeted case management to MaineCare-eligible PLWH. Approximately 700 PLWH in Maine (40 percent) utilized HIV case management at some point in calendar year 2015.

The Ryan White Part B Program requires medical case managers to be a licensed nurse, nurse assistant, medical assistant or to be in pursuit of such certification. MaineCare requires case managers to have a minimum of:

1. A Bachelor's degree from an accredited four-year institution of higher learning with a specialization in psychology, mental health and human services, behavioral health, behavioral sciences, social work, human development, special education, counseling, rehabilitation, sociology, nursing or closely related field, OR
2. A Master's degree in social work, education, psychology, counseling, nursing or closely related field from an accredited graduate school, OR
3. A Bachelor's Degree from an accredited four -year institution of higher learning in an unrelated field and at least one year of full-time equivalent relevant human services experience, OR
4. A minimum of having had provided targeted case management on August 1, 2009, under previous rulemaking.

In early 2016, the Ryan White Part B Program collaborated with the Office of MaineCare Services (State MaineCare office) to develop a training assessment survey using the clinical guidelines for the treatment of HIV and questions related to access and insurance. The draft survey was also shared with the Maine AIDS Education Training Center. The online survey was designed to be anonymous and to highlight areas where competency training should be offered by Ryan White, MaineCare and the AETC for case managers in the future. Approximately 75 percent of all HIV case managers in the state completed the assessment.

Most respondents (80 percent or greater) noted that anti-retroviral therapy is recommended for all people diagnosed with HIV. Most respondents also correctly noted key eligibility requirements and processes for ADAP, MaineCare and Medicare.

Focused training is recommended for the following topics/areas:

- Treatment guidelines related to the frequency of viral load testing, frequency of CD4 testing, additional screenings recommended for people living with HIV, prophylaxis for opportunistic infections and inappropriate treatment regimens identified by the U.S. Public Health Service.
- Medicare Part D and the Medicare Savings Program (only one-third of respondents indicated even moderate familiarity with the Medicare Savings Program).
- Insurance premiums, who can pay for them, maintaining coverage and enrollment.

D. Assessing Needs, Gaps and Barriers

Needs Assessment Process

Maine CDC's HIV, STD and Viral Hepatitis Program developed and conducted a variety of surveys that were administered by mail and online. Service provider input was solicited through health care provider surveys, surveys specifically related to PrEP and the HIV case manager training assessment. High-risk individuals were surveyed online by regional outreach coordinators. Ryan White Part B and MaineCare members complete a satisfaction survey annually. A client health survey was conducted at two separate conferences for PLWH.

In addition, focus groups were held in each region of the state (Southern, Central, and Northern).

Surveillance and service utilization data that are already routinely collected were analyzed for trends and to complete epidemiologic profiles.

Planning Process

The Integrated Plan steering committee is comprised of Maine CDC staff from the Maine HIV, STD and Viral Hepatitis Program representing Ryan White Part B, HIV Prevention

and HIV Surveillance. Steering committee staff were required to participate in the planning process and lead the needs assessment process. The steering committee meets biweekly.

The full planning body was initially convened during the needs assessment phase. Key stakeholders from the following sectors were invited to participate:

- Ryan White Part C Programs
- Maine AIDS Education and Training Center
- Substance abuse
- Mental health
- MaineCare/Medicare
- Community health centers
- Veterans Administration
- Housing Opportunities for People with AIDS
- People at high risk for HIV infection
- People living with HIV/AIDS
- Service delivery providers and other community stakeholders
- Representatives from the federally-recognized American Indian tribes

PLWH and individuals at high risk for HIV were recruited from the membership of the State HIV Advisory Committee, focus group participants and attendees at two separate conferences for PLWH. These participants are offered incentives in the form of gas cards and food vouchers.

All key stakeholders were invited to a full-day meeting to explain the planning process in context of the National HIV/AIDS Strategy. The National Alliance of State and Territorial AIDS Directors provided technical assistance with presentations and facilitation.

Beginning in the spring of 2016, biweekly meetings were scheduled to complete the Integrated Plan. Meeting documents and notes have been shared with all key stakeholders to allow for participation among those who could not attend the meetings. Additional information from these stakeholders has been solicited via email and one-on-one meetings.

Service Needs

Needs assessments were conducted through traditional paper surveys, electronic surveys, focus groups, key informant interviews and by analyzing data already collected for program monitoring and evaluation purposes. Service providers were surveyed by the Office of MaineCare Services and the HIV, STD and Viral Hepatitis Program regarding general knowledge about treatment guidelines and best practices as well as services to high-risk individuals. People at high risk of HIV infection were surveyed by regional Outreach Coordinators. PLWH were surveyed at two separate conferences for PLWH and by mail. Focus groups were held in each region of the state (Southern, Central and Northern) and topic-focused small-group discussions were held at the initial integrated

planning meeting in April 2016. Findings from the needs assessment process are described below.

A total of 345 PLWH responded to MaineCare's annual satisfaction survey for 2015. Responses were generally similar to the 2014 survey. Highlights from the responses include:

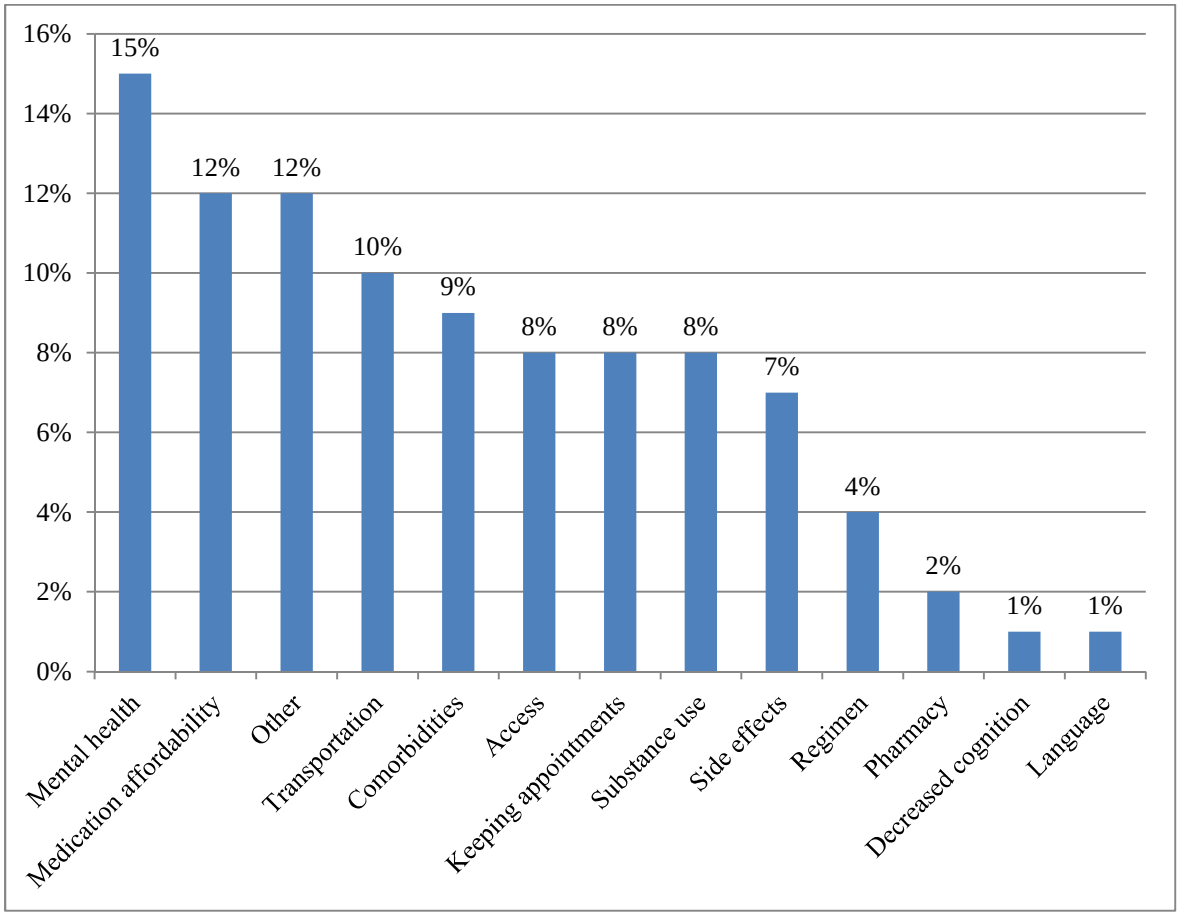
- 58 percent can afford their co-pays and premiums
- 93 percent can easily get their prescriptions filled
- 85 percent can get mental health services when needed
- 79 percent can get substance abuse services when needed
- 82 percent can get transportation for medical needs
- 96 percent see their infectious disease doctor as recommended
- 90 percent said that their case manager helped them find services they needed

MaineCare has very limited coverage for dental services in emergency situations and only for those with full traditional coverage. Still, 67 percent of respondents (compared to 64 percent for 2014) indicated that they could get dental services when needed.

Only 69 percent of respondents (compared to 73 percent for 2014) indicated that they feel healthy most of the time.

As part of its annual survey of health care providers serving PLWH, the Office of MaineCare Services asked about the most common barriers to treatment for their patients. The figure below illustrates provider responses, which followed a similar distribution pattern to the previous year.

Figure 8. Common barriers affecting treatment as identified by MaineCare providers, 2014



Generally, those who participated in focus groups are happy with case management, ADAP and dental care. Focus group participants across the state identified the following unmet needs:

- Transportation
- Eye care
- Opportunities for social support
- A solid communication network

Areas for improvement identified during focus groups included paperwork; education and training for providers, including health care providers and frontline staff at the Department of Health and Human Services; a list of friendly dentists; and additional resources for food.

Approximately one-quarter of respondents to the client health survey for PLWH indicated that they are engaging in behaviors that put themselves or others at risk for HIV/STDs. High recent STD rates, including co-infections with HIV, support the need for continuing prevention activities with PLWH.

Anecdotal reports from the Office of MaineCare Services may indicate that some PLWH are not aware of case management or the services it provides.

Service Gaps

Appropriate Care and Treatment

All CD4 and viral load tests are reportable by Maine law. Lab data indicate that many PLWH who are on antiretroviral therapy are not receiving CD4 or viral load tests as frequently as recommended in current treatment guidelines. While a gap obviously exists, it is unclear if health care providers are not ordering tests often enough, if PLWH are not following through on ordered tests or if the test results are not being reported as required.

Knowledge of Available Resources

A total of 425 PLWH responded to the Ryan White Part B Program's annual satisfaction survey for 2015. Responses were generally similar to 2014 with the vast majority of respondents indicating that it was easy to get help and that they were happy with ADAP and Ryan White Part B services (91 percent and 95 percent respectively). Most of the survey questions relate to services the Part B Program provides and whether or not PLWH know how to get help in those specific areas, if needed. Overall, responses improved compared to 2014 but still indicate gaps. For example:

- 21 percent did not know how to get help paying for medications at the pharmacy
- 44 percent did not know how to get help paying for health insurance
- 41 percent did not know how to get help paying with dental bills
- 55 percent did not know how to get help paying rent
- 56 percent did not know how to get help paying for heat and electricity
- 40 percent did not know how to get help paying for food

PrEP

Although PrEP is a prioritized intervention in the National HIV/AIDS Strategy, Ryan White HIV/AIDS Program funds and federal CDC prevention funds cannot be used to pay for PrEP. Some insurance programs may cover PrEP, but a gap exists for high co-pays and deductibles or individuals who lack insurance coverage. Consumers for Affordable Health Care is developing a resource to help individuals navigate the insurance system and identify out-of-pocket costs for PrEP. Currently, there is at least one health care provider prescribing PrEP in 14 of Maine's 16 counties.

Barriers

Social and Structural

A key informant interview with the Minority Outreach Specialist in Southern Maine highlighted areas of concern related to new Mainers, including:

- A need for culturally appropriate education and support

- Normalization of sexual health education and testing, because many new Mainers do not feel safe seeking this out
- Greater service accessibility, particularly for new arrivals

Transportation is repeatedly identified as a barrier, despite the fact that 82 percent of respondents to the MaineCare satisfaction survey indicated that they can get transportation for medical needs. MaineCare only covers transportation for covered services. Anecdotal reports indicate that allowable appointments cannot be accommodated at times due to a lack of available drivers. The Ryan White Program can support medical transportation only. Parts of Maine are extremely rural with no public transportation whatsoever.

Less than one percent of all Maine PLWH are known to be homeless at this time, but there are more than 160 households on wait lists for HOPWA rental subsidies and approximately 17 percent of PLWH accessing Ryan White Part B or C services in 2015 reported an unstable or temporary housing situation. It is important to recognize that many have stable housing as a result of housing assistance currently available through HOPWA, Ryan White or other housing assistance programs; PLWH who are not eligible for these programs or who meet utilization caps may face additional housing difficulties.

ADAP is seeing steadily increasing costs for both medications and insurance coupled with increasing program utilization. One of the primary insurance carriers on Maine's marketplace has requested a substantial rate increase for 2017 premiums (average increase of 22.9 percent with a range from 17.09 percent to 44.92 percent). The increase was pending regulatory approval at the time this report was developed.

Policy

While the Affordable Care Act has helped to make health insurance more accessible for many PLWH, it has also created a barrier in the form of the open enrollment period. The ADAP has reported situations where new enrollees have not had insurance for a length of time and because they have not had a recent qualifying event, they must wait for open enrollment (sometimes several months away) to apply for health insurance. This wait exists despite the fact that ADAP has the resources to pay for their insurance immediately. Similar problems arise when PLWH or advocates fail to report loss of insurance due to a qualifying event in a timely fashion. Members who fail to recertify for ADAP may lose insurance if they do not recertify by the time premium payments are due. In such situations, ADAP must pay the full cost of medications when they reenroll in the program and the member loses access to other health benefits until the following open enrollment period.

Program

Ryan White providers in Maine have been using CAREWare since 2004 and utilizing a statewide, networked version of the database hosted by the Part B Program since 2007. The Part B Program supports the costs of the server, remote access key fobs, database administration and limited technical support which total approximately $30,000 per year.

The shared CAREWare database has a number of advantages, including an ability to standardize and reduce redundant data collection. The software is free and updated to meet changing reporting requirements. However, upgrades are often released with little time to test or backfill necessary data before generating required reports and often well after announced release dates. Every recent upgrade has generated bugs ranging from minor inconveniences to ones that require significant staff time to address any major work-arounds.

Demographic data including race/ethnicity and sex are not always complete for reportable STDs and new HIV cases. Such data limitations can mask emerging trends and hinder planning efforts.

E. Data: Access, Sources and Systems

All surveillance data, including those used to generate the continuum of care, are obtained from the Maine Electronic HIV and AIDS Reporting System (eHARS). The Ryan White Part B Program has been using CAREWare since 2004, including support of a statewide network that includes all Ryan White HIV/AIDS Program recipients in the state since 2007.

No data policies impacted the needs assessment, including the development of the continuum of care.

The planning body identified several gaps in data that would have been useful during the planning process, including:

- Consistent and comprehensive housing status data for all PLWH in Maine
- An accurate estimate of those living with HIV in Maine who have not yet been diagnosed
    - As noted in the Care Continuum section, U.S. CDC does not recommend local jurisdictions use the national estimate of the percentage undiagnosed to estimate prevalence for the local continuum of care.
- More complete race and ethnicity data for HIV and STD cases
- Additional death data, including indicators of whether or not individuals were receiving HIV treatment prior to death
- Additional demographic data on Ryan White Part B satisfaction survey respondents to identify trends among those who reported unmet needs and no knowledge of services available to meet those needs (e.g. are they over income for assistance programs, do they have a case manager, is there a gap due to geography or are they newly diagnosed?)
- The HIV Prevention and Care Programs will now be part of the Maine CDC Division of Disease Control's Informatics Program, which will improve the consistency and reliability of HIV data collection and reporting for Maine

Section II: Integrated HIV Prevention and Care Plan

A. Integrated HIV Prevention and Care Plan

The plan below outlines Maine's response to the three main goals of the National HIV/AIDS Strategy (NHAS). The plan includes the benefits to PLWH and the State of Maine in general. Gaps in the HIV Care Continuum that are being monitored and addressed by specific strategies are identified as data indicators.

The strategies identified below cannot be completed without the dedication of key partners. These partners include:

- **HIV Services Organizations:** Community Health and Counseling Services, Down East AIDS Network/Health Equity Alliance, Frannie Peabody Center, Maine General Medical Center and St. Mary's Regional Medical Center.
- **HIV/STD Prevention Providers:** City of Portland, Down East AIDS Network/Health Equity Alliance, Family Planning Association of Maine and Frannie Peabody Center.
- **Ryan White Part C recipients:** City of Portland, Maine General Medical Center and Regional Medical Center at Lubec

NHAS Goal: Reduce new HIV infections

2017 – 2021 Objective 1: Annually, continue to ensure that 100 percent of people receiving a positive HIV diagnosis in Maine will be notified of their confirmed status

Benefits: Early diagnosis lowers lifetime medical costs and improves health outcomes. Knowledge of HIV status has been linked with risk reduction. Prevention education and partner services (PS) are associated with reduced risk of HIV transmission

Resources Committed: Federal funds from CDC, State general funds

Potential Challenges or Barriers: Funding availability for related activities, culturally competent providers with time for collaboration, accessing highest risk populations (compared to general screenings), Achieving positivity rates for rural settings in relation to funding requirements, disease reporting inconsistencies, travel burdens, acceptance of service and provider/community buy-in

Strategy	Timeframe	Responsible Parties and Key Partners	Activity	Target Population	Data Indicators
Annually ensure that all individuals tested through Maine CDC-funded testing sites statewide are notified of their status	Annually through 2021	**Responsible Parties:** Maine CDC HIV, STD, Viral Hepatitis (VH) Program **Key Partners:** HIV/STD prevention providers Health testing laboratories Health care providers	Integrated HIV, STD and VH testing among the highest risk populations for HIV in Maine who are under or uninsured	The highest risk populations for HIV in Maine based upon the HIV Epidemiological Profile	Percentage of newly diagnosed individuals who were tested who received their status

Strategy	Timeframe	Responsible Parties and Key Partners	Activity	Target Population	Data Indicators
Ensure that all newly diagnosed individuals are offered PS	Annually through 2021	**Responsible Parties:** Maine CDC HIV, STD, Viral Hepatitis Program **Key Partners:** Health testing laboratories	New diagnosis confirmed and results delivered to Maine CDC All newly diagnosed PLWH are notified of their status Linkage to Care Specialist will follow up with all newly diagnosed individuals and/or the reporting provider to offer PS	All individuals with confirmed HIV diagnosis reported to Maine CDC	Percentage of individuals with a positive HIV test result reported to the Maine CDC who are offered PS Percentage of newly diagnosed PLWH who are linked to medical care within three months
Increase PS education and utilization among all PLWH in Maine	Annually through 2021	**Responsible Parties:** Maine CDC HIV, STD, Viral Hepatitis Program	Update PS Interview requirements to include all new and existing PLWH Implement with all new cases Regional outreach coordinators will provide PS outreach and education opportunities for health care providers	PLWH and partners Health care providers who work with PLWH	Percentage of individuals with a positive HIV test result reported to Maine CDC who are offered PS Number of education opportunities delivered to health care providers annually Percentage of newly diagnosed PLWH

Strategy	Timeframe	Responsible Parties and Key Partners	Activity	Target Population	Data Indicators
					linked to care within three months Percentage of PLWH in care

NHAS Goal: Reduce new HIV infections

2017 – 2021 Objective 2: By 2021, reduce the number of new diagnoses by at least 25 percent, from 48 to 36

Benefits: Risk-reduction for people at high risk of acquiring HIV reduces the potential lifetime medical costs associated with HIV infection. People who know their HIV status are less likely to transmit the virus to others. Improved health care provider knowledge of PS will increase testing and linkage to care

Resources Committed: Federal funds from CDC, State general funds

Potential Challenges or Barriers: Adequate staff time and funding for new activities outside of the current responsibilities, database maintenance, culturally competent providers with time for collaboration, reaching highest risk populations and travel burdens in a large, rural state

Strategy	Timeframe	Responsible Parties and Key Partners	Activity	Target Population	Data Indicators
Intensify education and outreach efforts related to PrEP among the highest risk populations for HIV in Maine	Annually through 2021	**Responsible Parties:** Maine CDC HIV, STD, Viral Hepatitis Program **Key Partners:** Regional outreach coordinators	Create, maintain, and distribute 2,000 PrEP guides to consumers and providers Train and provide technical assistance regarding PrEP to providers	The highest risk populations for HIV in Maine based upon the HIV Epidemiological Profile Health care providers willing to prescribe PrEP	Number of materials distributed Number of PrEP providers added to the list annually

Strategy	Timeframe	Responsible Parties and Key Partners	Activity	Target Population	Data Indicators
		HIV/STD prevention partners	Establish and maintain a PrEP provider database that will be used to inform individuals interested in PrEP		
Target screening and testing events among the highest risk populations for HIV in Maine	Annually through 2021	**Responsible Parties:** Maine CDC HIV, STD, Viral Hepatitis Program **Key Partners:** HIV/STD prevention partners	Maintain an integrated HIV, STD and Hepatitis screening/testing program among the highest risk populations for HIV	The highest risk populations for HIV in Maine based upon the HIV Epidemiological Profile	Proportion of Maine CDC-funded tests that are delivered to high risk populations annually
Increase PS promotion and education among the highest risk populations for HIV in Maine	Annually through 2021	**Responsible Parties:** Maine CDC HIV, STD, Viral Hepatitis Program **Key Partners:** Regional outreach workers	Contract three regional outreach workers Create and implement procedure for PS, outlining partner engagement expectations and timelines Conduct regional/local education activities Implement regional and local screening/testing	Health care providers Identified partners of PLWH	Number of trainings delivered annually Percentage of individuals with a positive HIV test result reported to Maine CDC who are offered PS Percentage of newly diagnosed PLWH linked to care within three months Percentage of PLWH in care

Strategy	Timeframe	Responsible Parties and Key Partners	Activity	Target Population	Data Indicators
			events Promote linkage to care and PS regionally and locally		

NHAS Goal: Reduce new HIV infections

2017 – 2021 Objective 3: By 2021, reduce the percentage of new diagnoses among gay and bisexual men by at least 25 percent, from 54 percent to 30 percent

Benefits: These strategies improve collaboration, which results in time savings. Risk-reduction for people at high risk of acquiring HIV reduces the potential lifetime medical costs associated with HIV infection. People who know their HIV status are less likely to transmit the virus to others. Improved health care provider knowledge of PS will increase testing and linkage to care

Resources Committed: Federal funds from CDC, State general funds

Potential Challenges or Barriers: Adequate staff time and funding for new activities outside of the current responsibilities, culturally competent providers with time for collaboration, reaching highest risk populations and travel burdens in a large, rural state

Strategy	Timeframe	Responsible Parties and Key Partners	Activity	Target Population	Data Indicators
Intensify education and outreach efforts related to PrEP among the highest risk populations for HIV in Maine	Annually through 2021	**Responsible Parties:** Maine CDC HIV, STD, Viral Hepatitis Program **Key Partners:** HIV/STD prevention partners	Create, maintain and distribute 2,000 PrEP guides for consumers and providers Train and provide technical assistance to providers Establish and maintain a PrEP provider database that will be used to inform individuals interested in PrEP	The highest risk populations for HIV in Maine	Number of education and outreach materials distributed and providers trained
Intensify education and outreach efforts related to PrEP among Maine health care providers	Annually through 2021	**Responsible Parties:** Maine CDC HIV, STD, Viral Hepatitis Program **Key Partners:** HIV/STD prevention partners	Create a PrEP assessment tool Disseminate PrEP assessment tool to health care providers, analyze / report on data	Health care providers	Proportion of providers indicating that they are aware of PrEP Proportion of providers indicating that they are prescribing PrEP
Increase PS promotion and education among the highest risk populations for HIV in Maine	Annually through 2021	**Responsible Parties:** Maine CDC HIV, STD, Viral Hepatitis Program **Key Partners:** Regional outreach	Contract three regional outreach workers Create and implement procedure for PS outlining partner engagement expectations and	Health care providers Identified partners of PLWH	Number of trainings delivered annually Percentage of individuals with a positive HIV test result reported to Maine CDC who are

Strategy	Timeframe	Responsible Parties and Key Partners	Activity	Target Population	Data Indicators
		workers	timelines Conduct regional/local education activities Implement regional and local screening/testing events Promote linkage to care and PS regionally and locally		offered PS Percentage of newly diagnosed PLWH linked to care within three months Percentage of PLWH in care

NHAS Goal: Increase access to care and improve health outcomes

2017 – 2021 Objective 1: By 2021, increase the percentage of newly diagnosed persons linked to care within one month of their HIV diagnosis from 82 percent to at least 97 percent

Benefits: Early linkage to care leads to lower lifetime health costs and improved health outcomes. Linking PLWH to support services is demonstrated to improve treatment adherence and quality of life. The final strategy for this objective eliminates duplication of effort in verifying eligibility for Ryan White Part B enrollees and ensures labs and health care providers are complying with Maine's reporting laws

Resources Committed: Federal funds from CDC and HRSA/HAB, State general funds, drug rebates

Potential Challenges or Barriers: Adequate staff time and funding for new activities outside of the current responsibilities, culturally competent providers with time for collaboration, reaching highest risk populations and travel burdens in a large, rural state

Strategy	Timeframe	Responsible Parties and Key Partners	Activity	Target Population	Data Indicators
Increase the number of newly diagnosed PLWH linked to medical care	Annually through 2021	**Responsible Parties:** Maine CDC HIV, STD, Viral Hepatitis Program **Key Partners:** HIV medical case managers Ryan White Part C recipients and health care providers	Linkage to Care Specialist will follow up with all newly diagnosed PLWH and/or the reporting provider to determine if patient needs to be linked to medical care Linkage to Care Specialist will make a "warm handoff" to medical provider and assist in making the first appointment, as needed	Individuals newly diagnosed with HIV	Percentage of newly diagnosed PLWH linked to medical care within 3 months of diagnosis Percentage of PLWH in care
Intensify efforts to ensure that newly diagnosed PLWH understand the support services available to them and how to apply to them	By the end of 2018 then ongoing through 2021	**Responsible Parties:** Maine CDC HIV, STD, Viral Hepatitis Program Ryan White Part C recipients **Key Partners:** HIV medical case managers Health care providers	Linkage to Care Specialist will screen newly diagnosed PLWH for interest and enrollment in case management Linkage to Care Specialist assists newly diagnosed person with applications for benefits and services as appropriate Linkage to Care Specialist makes a	Individuals newly diagnosed with HIV	Percentage of newly diagnosed PLWH screened for service eligibility Number of resource guides distributed to newly diagnosed PLWH Percentage of newly diagnosed PLWH linked to medical care within 3 months of diagnosis Percentage of PLWH

Strategy	Timeframe	Responsible Parties and Key Partners	Activity	Target Population	Data Indicators
			"warm handoff" to a medical case manager, as requested Ryan White Part B Program will maintain a resource guide for distribution to newly diagnosed PLWH		in care
Improve communication and reporting between those who conduct HIV testing and Maine CDC	By the end of 2018 then ongoing through 2021	**Responsible Parties:** Maine CDC HIV, STD, Viral Hepatitis Program **Key Partners:** Health testing laboratories Maine hospitals Community-based testing providers	HIV Surveillance will conduct an assessment of labs used by health care providers and test facilities HIV Surveillance will compare findings with lab reports in eHARS to assess for completeness of reporting HIV Surveillance will follow up with labs as necessary and conduct an annual assessment of lab reporting completeness HIV Surveillance will conduct an annual cross-match with the Ryan White Part B	Health care providers and labs	Rate of lab reporting completeness Number of lab outreach sessions conducted Completion of annual data cross-matching between eHARS and CAREWare Number of trainings delivered to community-based HIV testing providers Percentage of PLWH in care Percentage of PLWH who are virally suppressed

Strategy	Timeframe	Responsible Parties and Key Partners	Activity	Target Population	Data Indicators
			Program to assess for completeness of lab reporting in both databases HIV Surveillance will work with HIV Prevention Program to ensure that community-based providers know reporting requirements for HIV testing results		

NHAS Goal: Increase access to care and improve health outcomes

2017 – 2021 Objective 2: By the end of 2021, increase the percentage of persons with diagnosed HIV infection who are retained in HIV medical care from 67 percent to at least 80 percent

Benefits: Engagement in care improves health outcomes and reduces health care costs. Individuals retained in care and more likely to be virally suppressed, leading to improved health outcomes, lower health care costs and a decreased likelihood of transmitting HIV to others. These strategies also eliminate duplication of effort in verifying eligibility for Ryan White Part B enrollees and ensures labs and health care providers are complying with Maine's reporting laws

Resources Committed: Federal funds from CDC and HRSA/HAB, State general funds, drug rebates, MaineCare

Potential Challenges or Barriers: Contacting PLWH who are out of care, willingness to be re-engaged in care, accessing PLWH who are not connected to case management or health care, Adequate staff time and funding for new activities outside of the current responsibilities, culturally competent providers with time for collaboration and labs and competing priorities among health care providers

Strategy	Timeframe	Responsible Parties and Key Partners	Activity	Target Population	Data Indicators
Intensify efforts to identify PLWH in Maine who are out of care and implement effective practices to re-engage them in care	By the end of 2017 then ongoing through 2021	**Responsible Parties:** Maine CDC HIV, STD, Viral Hepatitis Program	Identify PLWH who are out of care using eHARS and CAREWare data Outreach to PLWH out of care and assist with re-engagement in medical care	PLWH who are not currently retained in care	Percentage of PLWH in care Percentage of PLWH retained in care Percentage of PLWH out of care who were contacted and re-engaged in care
Increase the availability and accessibility of HIV support service information for new and existing PLWH in Maine	By the end of 2019 then ongoing through 2021	**Responsible Parties:** Maine CDC HIV, STD, Viral Hepatitis Program **Key partners:** HIV case managers HIV services organizations HIV/STD prevention providers Ryan White Part C recipients and health care providers Maine AIDS Education Training Center (AETC) MaineCare	Create an information packet for PLWH that provides a comprehensive list of support services available and tips to optimize their health and achieve viral suppression Identify ways to improve/ increase knowledge of RWB/ADAP and other available support services for PLWH in Maine Distribute information through all identified channels and provide to new RWB/ADAP clients and newly diagnosed PLWH	New and existing PLWH who are out of care All professionals working with PLWH	Percentage of PLWH who report knowledge of services available and how to access them on annual survey Percentage of providers who report knowledge of services available for PLWH on annual survey Number of PLWH directly given information packets annually by RWB/ADAP, LTC, and other HIV professionals Percentage of PLWH in care

Strategy	Timeframe	Responsible Parties and Key Partners	Activity	Target Population	Data Indicators
			Keep the information up to date, relevant and accessible for all PLWH		Percentage of PLWH retained in care Percentage of PLWH who are virally suppressed
Improve communication and reporting between those who conduct HIV testing and Maine CDC	By the end of 2018 then ongoing through 2021	**Responsible Parties:** Maine CDC HIV, STD, Viral Hepatitis Program **Key Partners:** Health testing laboratories Hospitals Community-based testing providers	HIV Surveillance will conduct an assessment of labs used by health care providers and test facilities HIV Surveillance will compare findings with lab reports in eHARS to assess for completeness of reporting HIV Surveillance will follow up with labs as necessary and conduct an annual assessment of lab reporting completeness HIV Surveillance will conduct an annual cross-match with the Ryan White Part B Program to assess for completeness of lab reporting in both	Health care providers and labs	Rate of lab reporting completeness Number of lab outreach sessions conducted Completion of annual data cross-matching between eHARS and CAREWare Number of trainings delivered to community-based HIV testing providers Percentage of PLWH in care Percentage of PLWH retained in care Percentage of PLWH who are virally suppressed

Strategy	Timeframe	Responsible Parties and Key Partners	Activity	Target Population	Data Indicators
			databases HIV Surveillance will work with HIV Prevention Program to ensure that community-based providers know reporting requirements for HIV testing results		
Increase participation and effort among health care providers to monitor their clients and promote care retention	By the end of 2019 then ongoing through 2021	**Responsible Parties:** Maine AETC **Key Partners:** Maine CDC HIV, STD, Viral Hepatitis Program MaineCare Ryan White Part C recipients and health care providers HIV case managers	Educate providers on current HIV treatment guidelines Administer annual provider survey that assesses knowledge of treatment guidelines	Health care providers who serve PLWH	Percentage of providers who indicate knowledge of current treatment guidelines on annual survey Total trainings delivered annually Percentage of PLWH in care Percentage of PLWH retained in care Percentage of PLWH who are virally suppressed

NHAS Goal: Increase access to care and improve health outcomes

2017 – 2021 Objective 3: By 2021, increase the percentage of persons with diagnosed HIV infection who are virally suppressed from 61 percent to at least 80 percent

Benefits: Viral suppression leads to improved health outcomes, lower health care costs and a decreased likelihood of transmitting HIV to others. Individuals who have consistent access to their medications have an increased likelihood of following the required regimen, which leads to viral suppression

Resources Committed: Federal funds from CDC and HRSA/HAB, State general funds, drug rebates, MaineCare

Potential Challenges or Barriers: Contacting PLWH who are out of care, willingness of PLWH to be re-engaged in care, accessing PLWH who are not connected to case management or health care, Adequate staff time and funding for new activities outside of the current responsibilities, completing a competitive bidding process to establish an online application and recertification system and implementation of new system

Strategy	Timeframe	Responsible Parties and Key Partners	Activity	Target Population	Data Indicators
Intensify efforts to identify PLWH in Maine who are not virally suppressed and implement effective practices to help them reach and maintain viral suppression, targeting higher risk populations first	By the end of 2021	**Responsible Parties:** Maine CDC HIV, STD, Viral Hepatitis Program **Key Partners:** HIV case managers MaineCare Ryan White Part C recipients and health care providers	Identify those who are out of care using eHARS and CAREWare data Consider any unique or helpful demographic characteristics to help target / reach high risk populations first Outreach to PLWH who are not currently virally suppressed Identify their needs and connect them to	PLWH who are not virally suppressed	Percentage of PLWH in care Percentage of PLWH retained in care Percentage of PLWH who are virally suppressed

Strategy	Timeframe	Responsible Parties and Key Partners	Activity	Target Population	Data Indicators
			services that will aid in viral suppression		
Create and implement procedures for monitoring Ryan White Part B/ADAP client enrollment and assist with program retention as needed	By the end of 2018 then ongoing through 2021	**Responsible Parties:** Maine CDC HIV, STD, Viral Hepatitis Program **Key Partners:** HIV case managers HIV services organizations HIV/STD prevention providers Ryan White Part C recipients and health care providers	At the end of each recertification period, identify RWB clients who did not recertify Within two weeks of the end of recertification period, outreach to those clients and identify the reason why they did not recertify with assistance from case managers as needed Assist PLWH with recertification, as needed Document why they failed to recertify within the recertification period Develop process improvements to raise on-time recertification rates and prevent gaps in care	RWB clients who failed to recertify during recertification period	Percentage of RWB clients who did not recertify during recertification period Percentage of clients who did not recertify who were contacted Percentage of clients who were able to recertify after being contacted Reasons given by clients regarding why they did not recertify (qualitative measure) Percentage of PLWH in care Percentage of PLWH retained in care Percentage of PLWH who are virally suppressed

Strategy	Timeframe	Responsible Parties and Key Partners	Activity	Target Population	Data Indicators
Increase the availability and accessibility of HIV support service information for new and existing PLWH in Maine	By the end of 2019 then ongoing through 2021	**Responsible Parties:** Maine CDC HIV, STD, Viral Hepatitis Program **Key partners:** HIV case managers HIV services organizations HIV/STD prevention partners Ryan White Part C recipients and health care providers Maine AETC MaineCare	Create an information packet for PLWH that provides a comprehensive list of support services available and helpful tips to optimize their health and achieve viral suppression Identify ways to improve/ increase knowledge of RWB/ADAP and other available support services for PLWH in Maine Distribute information through all identified channels and provide to new RWB/ADAP clients and newly diagnosed PLWH Keep the information up to date, relevant and accessible for all PLWH	New and existing PLWH who are not virally suppressed All professionals working with PLWH	Percentage of PLWH who report knowledge of services available and how to access them on annual survey Percentage of providers who report knowledge of services available for PLWH on annual survey Number of PLWH directly given information packets annually by RWB/ADAP, LTC, and other HIV professionals Percentage of PLWH in care Percentage of PLWH retained in care Percentage of PLWH who are virally suppressed

Strategy	Timeframe	Responsible Parties and Key Partners	Activity	Target Population	Data Indicators
Increase the timeliness and accessibility of RWB/ADAP services for new and existing clients	By the end of 2021	**Responsible Parties:** Maine CDC HIV, STD, Viral Hepatitis Program **Key Partners:** HIV case managers HIV services organizations HIV/STD prevention partners Ryan White Part C recipients and health care providers	Identify barriers to accessibility of RWB/ADAP program Create strategies to mitigate barriers and address needs Implement program changes that lead to easier, more timely processes including, but not limited to, the ability of online processing of applications, recertifications and financial assistance requests Continue to address needs and gaps in service and work toward program improvement	PLWH who are current or future RWB/ADAP clients HIV case managers and service providers who assist clients with RWB/ADAP certifications and applications	The change in processing time for RWB/ADAP processes after implementation The number of RWB/ADAP clients who utilize online services compared to those who utilize paper-based processes Annual survey data from RWB/ADAP clients regarding their utilization and satisfaction with online services Percentage of clients who recertify on time Percentage of PLWH in care Percentage of PLWH retained in care Percentage of PLWH who are virally suppressed

NHAS Goal: Increase access to care and improve health outcomes

2017 – 2021 Objective 4: By 2021, functionally end homelessness among people who identify as HIV-positive in Maine from a baseline of five self-reported cases of homelessness among PLWH in 2015

Benefits: Stable housing leads to increased access to treatment, continuity of care, better health outcomes and reduced risk of ongoing HIV transmission. Improving the availability of housing information available increases the potential for PLWH to utilize the information, find more stable housing, and begin to improve their health outcomes and decrease their transmission risk

Resources Committed: Federal funds from HRSA/HAB and HOPWA, drug rebates

Potential Challenges or Barriers: Collaboration and buy-in from housing service organizations, obtaining information required for comprehensive resource list, timely maintenance and review of list and Adequate staff time and funding for new activities outside of the current responsibilities

Strategy	Timeframe	Responsible Parties and Key Partners	Activity	Target Population	Data Indicators
Create a resource that lists all existing collaborative efforts and services available statewide that are targeted to assist PLWH with housing, and identify any gaps or barriers in the availability of services	By the end of 2017 then ongoing through 2021	**Responsible Parties:** Maine AETC Maine CDC HIV, STD, Viral Hepatitis Program HOPWA/Frannie Peabody Center **Key Partners:** Maine housing authorities other housing assistance programs	Compile a comprehensive list of all housing services available for PLWH including organization and eligibility requirement Communicate with housing organizations to ensure that the resource is complete and timely Identify gaps / barriers that exist within the services offered for use in	Individuals who identify as PLWH in homeless shelters or short-term living facilities upon intake PLWH who identify challenges obtaining or maintaining housing and seek help or PLWH who struggle with housing but have not yet sought help	The increase in the number of PLWH who are given or access the housing information annually from baseline Number of PLWH who receive housing assistance annually Percentage of PLWH who report housing instability annually Percentage of PLWH in care

Strategy	Timeframe	Responsible Parties and Key Partners	Activity	Target Population	Data Indicators
			future planning Determine the most effective channels to distribute this information to PLWH and organizations that serve them Distribute the information through identified channels		Percentage of PLWH retained in care Percentage of PLWH who are virally suppressed
Increase collaboration and communication among all organizations that provide any type of housing assistance in Maine with the goal of overcoming existing gaps and barriers that PLWH face when seeking housing	By the end of 2018 then ongoing through 2021	**Responsible Parties:** HOPWA/Frannie Peabody Center **Key Partners:** Maine CDC HIV, STD, Viral Hepatitis Program Maine AETC Maine housing authorities and other housing assistance programs	Organize and facilitate meetings of organizations that provide housing services or supplementation for PLWH and HIV services organization Discuss housing gaps / barriers identified Find realistic solutions to fill gaps and mitigate barriers to housing for PLWH, including increased collaboration and communication among all relevant stakeholders	Individuals who identify as PLWH in homeless shelters or short-term living facilities upon intake PLWH who identify challenges obtaining or maintaining housing and seek help or PLWH who struggle with housing but have not yet sought for help	Number of meetings held Number of PLWH who receive housing assistance annually Percentage of PLWH who report housing instability annually Percentage of PLWH in care Percentage of PLWH retained in care Percentage of PLWH who are virally suppressed

Strategy	Timeframe	Responsible Parties and Key Partners	Activity	Target Population	Data Indicators
			Discuss next steps for implementation		
Create and implement an ongoing strategy to move individuals in homeless shelters who identify as PLWH upon intake into more stable and permanent housing	By the end of 2021	**Responsible Parties:** Maine housing authorities and housing assistance programs HIV case managers Ryan White Part C recipients and health care providers HOPWA/Frannie Peabody Center **Key Partners:** Maine CDC HIV, STD, Viral Hepatitis Program Maine AETC	Create a process for connecting all PLWH with housing who are in need Develop a statewide flow chart of the organizations to contact based upon housing need and location Implement flow chart throughout among organizations that provide housing services, supplementation or work with PLWH Meet monthly to discuss areas for improvement and decrease the amount of time any PLWH is without housing	Individuals who identify as PLWH in homeless shelters or short-term living facilities upon intake PLWH who identify challenges obtaining or maintaining housing and seek help Or PLWH who struggle with housing but have not yet sought out help	Annual change in the number of people in homeless shelters who identify as PLWH upon intake from baseline Number of PLWH who receive housing assistance annually Percentage of PLWH who report housing instability annually Percentage of PLWH in care Percentage of PLWH retained in care Percentage of PLWH who are virally suppressed

NHAS Goal: Reduce HIV-related disparities and health inequities

2017 – 2021 Objective 1: By 2021, reduce disparities by reducing the rate of Blacks and Hispanics living with HIV per 100,000 population by 15 percent from 1,296 to 1,102 and from 516 to 439, respectively

Benefits: Increasing knowledge of testing and positive health behaviors among the highest risk populations for HIV are high impact/low cost activities that are already occurring in the state. Targeting PS to higher risk populations could lead to lower transmission rates between serodiscordant partners, thus reducing the number of newly diagnosed PLWH annually and reducing related health care costs

Resources Committed: Federal funds from CDC and HRSA/HAB, State general funds

Potential Challenges or Barriers: Adequate staff time and funding for new activities outside of the current responsibilities, accessing targeted populations, effecting behavior changes and health care provider participation

Strategy	Timeframe	Responsible Parties and Key Partners	Activity	Target Population	Data Indicators
Intensify education and outreach efforts among the highest risk populations for HIV in Maine	Annually through 2021	**Responsible Parties:** Maine CDC HIV, STD, Viral Hepatitis Program **Key Partners:** Regional outreach workers Maine Migrant Health Program Maine HIV Advisory Committee Maine Department of Education and other state partners	Cultural competency trainings for those working with the high risk populations Translate outreach and education materials, for all high risk populations, ensuring cultural relevance Offer trainings in the spoken language of each target population Outreach, education and dissemination of	Gay and bisexual males, Blacks and Hispanics	Number of outreach efforts Number of materials provided to target population Number of people trained annually Percentage of individuals tested who identify as a gay/bisexual male, Black and/or Hispanic

Strategy	Timeframe	Responsible Parties and Key Partners	Activity	Target Population	Data Indicators
		Community health workers CDC / HRSA TA Maine AETC	prevention, care and linkage materials Disseminate CDC-approved materials for the highest risk populations Targeted education on the importance of testing by regional outreach workers and community health workers		
Intensify education and outreach efforts among health care and community providers	Annually through 2021	**Responsible Parties:** Maine CDC HIV, STD, Viral Hepatitis Program **Key Partners:** Regional outreach workers Maine Migrant Health Program Maine HIV Advisory Committee Maine Department of Education and other state partners Community health	Cultural competency trainings for those working with the high risk populations Outreach, education and dissemination of prevention, care and linkage materials Disseminate CDC-approved materials for the highest risk populations Targeted education on the importance of testing by regional outreach workers and community health	Providers, community health and outreach workers and all Maine CDC Prevention Program staff	Number of outreach efforts Number of materials provided to target population Number of people trained annually

Strategy	Timeframe	Responsible Parties and Key Partners	Activity	Target Population	Data Indicators
		workers CDC / HRSA TA Maine AETC	workers		
Target screening and testing among the highest risk populations for HIV in Maine	Annually through 2021	**Responsible Parties:** Maine CDC HIV, STD, Viral Hepatitis Program **Key Partners:** HIV/STD prevention partners Regional outreach workers HIV services organizations Ryan White Part C recipients and health care providers	Maintain community-based testing with target numbers for each prioritized population Translate outreach and education materials, for all high risk populations, ensuring cultural relevance Outreach efforts to providers who provide health care services to the high risk populations	Gay and bisexual males, Blacks and Hispanics	Percentage of individuals tested who identify as a gay/bisexual male, Black and/or Hispanic
Target PS education and promotion among the highest risk populations for HIV in Maine	Annually through 2021	**Responsible Parties:** Maine CDC HIV, STD, Viral Hepatitis Program **Key Partners:** HIV/STD prevention	Contract for three regional outreach workers to conduct educational activities related to PS Regional outreach workers will assist in the implementation of regional and local	PLWH Gay and bisexual males, Blacks and Hispanics	Outreach logs Number of activities initiated and completed Percentage of individuals tested who identify as a gay/bisexual male,

Strategy	Timeframe	Responsible Parties and Key Partners	Activity	Target Population	Data Indicators
		partners HIV case managers HIV services organizations Ryan White Part C recipients and health care providers	screening/testing events Promote linkage to care and PS		Black and/or Hispanic Percentage of gay/bisexual male, Black and/or Hispanic PLWH who are linked to care Percentage of gay/bisexual male, Black and Hispanic PLWH who are retained in care
Target PS education and promotion among health care and community providers	Annually through 2021	**Responsible Parties:** Maine CDC HIV, STD, Viral Hepatitis Program **Key Partners:** HIV/STD prevention partners HIV case managers HIV services organizations Ryan White Part C recipients and health care providers	Contract for three regional outreach workers to conduct educational activities related to PS Regional outreach workers will assist in the implementation of regional and local screening/testing events Promote linkage to care and PS	HIV/STD prevention partners Health care providers who serve PLWH	Outreach logs Number of activities initiated and completed

NHAS Goal: Reduce HIV-related disparities and health inequities

2017 – 2021 Objective 2: By 2021, reduce disparities among gay and bisexual men, Blacks and Hispanics retained in care by increasing the percentage of each population in care at least 61 percent from the respective baselines of 50 percent, 46 percent and 46 percent

Benefits: Engagement in care improves health outcomes and reduces health care costs. Individuals retained in care and more likely to be virally suppressed, leading to improved health outcomes, lower health care costs and a decreased likelihood of transmitting HIV to others. Individuals who have consistent access to their medications have an increased likelihood of following the required regimen, which leads to viral suppression

Resources Committed: Federal funds from CDC and HRSA/HAB, State general funds, drug rebates, MaineCare

Potential Challenges or Barriers: Contacting PLWH who are out of care, willingness of PLWH to be re-engaged in care, accessing PLWH who are not connected to case management or health care, Adequate staff time and funding for new activities outside of the current responsibilities, willingness and collaboration among health care providers and labs and competing priorities among health care providers

Strategy	Timeframe	Responsible Parties and Key Partners	Activity	Target Population	Data Indicators
Increase efforts to identify individuals in the highest risk populations of PLWH in Maine who are currently out of care and implement effective practices to re-engage them in care	By the end of 2017 then ongoing through 2021	**Responsible Parties:** Maine CDC HIV, STD, Viral Hepatitis Program **Key Partners:** HIV case managers HIV services organizations Ryan White Part C recipients and health care providers MaineCare	Identify those who are out of care using eHARS and CAREWare data Outreach to those out of care and assist with re-engagement in medical care	Gay and bisexual male, Black and/or Hispanic PLWH who are not in care	Percentage of gay/bisexual male, Black and Hispanic PLWH who are in care Percentage of gay/bisexual male, Black and Hispanic PLWH who are virally suppressed

Strategy	Timeframe	Responsible Parties and Key Partners	Activity	Target Population	Data Indicators
		Peer support networks and community members			
Increase the availability and accessibility of information regarding HIV support services, including those that promote care utilization, for new and existing PLWH in Maine among the highest risk populations of PLWH in Maine	By the end of 2019 then ongoing through 2021	**Responsible Parties:** Maine CDC HIV, STD, Viral Hepatitis Program **Key partners:** HIV case managers HIV services organizations HIV prevention partners Ryan White Part C recipients and health care providers Maine AETC	Create an information packet for PLWH that provides a comprehensive list support services available and helpful tips to optimize their health and achieve viral suppression Identify ways to improve/ increase knowledge of RWB/ADAP and other available support services for PLWH in Maine Distribute information through all identified channels and provide to new RWB/ADAP clients and newly diagnosed PLWH Keep the information up to date, relevant and accessible for all PLWH	Gay and bisexual male, Black and/or Hispanic PLWH who are not in care All professionals working with PLWH	Percentage of PLWH who report knowledge of services available and how to access them on annual survey Percentage of providers who report knowledge of services available for PLWH on annual survey Number of PLWH directly given information packets annually by RWB/ADAP, LTC, and other HIV professionals Percentage of gay/bisexual male, Black and Hispanic PLWH who are in care Percentage of gay/bisexual male, Black and Hispanic

Strategy	Timeframe	Responsible Parties and Key Partners	Activity	Target Population	Data Indicators
					PLWH who are virally suppressed
Intensify outreach efforts regarding care utilization and other preventive methods among the highest risk populations of PLWH in Maine	Annually through 2021	**Responsible Parties:** Maine CDC HIV, STD, Viral Hepatitis Program **Key Partners:** HIV/STD prevention partners Maine AETC Maine Migrant Health Program	Contract for three regional outreach workers to conduct educational activities related to PS Regional outreach workers will assist in the implementation of regional and local screening/testing events Promote linkage to care and PS	Gay and bisexual male, Black and/or Hispanic PLWH who are not in care HIV/STD prevention partners Health care providers who serve PLWH	Number of outreach efforts Number of materials provided to target population Number of people trained annually Percentage of individuals tested who identify as a gay/bisexual male, Black and/or Hispanic

NHAS Goal: Reduce HIV-related disparities and health inequities

2017 – 2021 Objective 3: By 2021, increase the viral suppression rate among HIV-positive individuals who inject drugs from 53 percent to at least 70 percent

Benefits: Engagement in care improves health outcomes and reduces health care costs. Individuals retained in care and more likely to be virally suppressed, leading to improved health outcomes, lower health care costs and a decreased likelihood of transmitting HIV to others. Individuals who have consistent access to their medications have an increased likelihood of following the required regimen, which leads to viral suppression

Resources Committed: Federal funds from CDC and HRSA/HAB, State general funds, drug rebates, MaineCare

Potential Challenges or Barriers: Adequate staff time and funding for new activities outside of the current responsibilities, accessing targeted populations, interest and ability among targeted population to achieve viral suppression, keeping resources and information current, effecting behavior changes and health care provider participation

Strategy	Timeframe	Responsible Parties and Key Partners	Activity	Target Population	Data Indicators
Intensify efforts to identify PLWH who reported injection drug use as the mode of transmission and are not virally suppressed and implement effective practices to help them reach and maintain viral suppression	By the end of 2018 then ongoing through 2021	**Responsible Parties:** Maine CDC HIV, STD, Viral Hepatitis Program **Key Partners:** HIV case managers HIV services organizations HIV/STD prevention partners Ryan White Part C recipients and health	Identify those who are out of care using eHARS and CAREWare data Outreach to those out of care and assist with re-engagement in medical care Consider any unique or helpful demographic characteristics to help target / reach PWID	PLWH who report injection drug use who are not virally suppressed	Percentage of PWID who report knowledge of services available and how to access them on annual survey Percentage of PWID with HIV who are in care Percentage of PWID with HIV who are retained in care Percentage of PWID

Strategy	Timeframe	Responsible Parties and Key Partners	Activity	Target Population	Data Indicators
		care providers	Provide education to both PLWH and providers regarding harm reduction measures		with HIV who are virally suppressed
Increase the availability and accessibility of HIV support services and medical adherence information for PLWH who inject drugs in Maine	By the end of 2019 then ongoing through 2021	**Responsible Parties:** Maine CDC HIV, STD, Viral Hepatitis Program **Key partners:** Regional outreach workers HIV case managers HIV services organizations HIV/STD prevention providers Ryan White Part C recipients and health care providers Maine AETC	Create an information packet for PLWH that provides a comprehensive list support services available and helpful tips to optimize their health and achieve viral suppression Identify ways to improve/ increase knowledge of RWB/ADAP and other available support services for PLWH in Maine Distribute information through all identified channels and provide to new RWB/ADAP clients and newly diagnosed PLWH Keep the information up to date, relevant and accessible for all	PLWH who have identified their HIV transmission source to be injection drug use All professionals working with PLWH	Percentage of PLWH who report knowledge of services available and how to access them on annual survey Percentage of providers who report knowledge of services available for PLWH on annual survey Number of PLWH directly given information packets annually by RWB/ADAP, LTC, and other HIV professionals Percentage of PWID with HIV in care Percentage of PWID with HIV retained in care

Strategy	Timeframe	Responsible Parties and Key Partners	Activity	Target Population	Data Indicators
			PLWH		Percentage of PWID with HIV who are virally suppressed
Target outreach and education among communities where injection drug use and HIV are concentrated	Annually through 2021	**Responsible parties:** Maine CDC HIV, STD, Viral Hepatitis Program **Key partners:** Regional outreach workers Needle exchange programs Substance abuse treatment centers Maine Harm Reduction Alliance Peer support network and organizations, such as Voices Heard	On the ground outreach efforts within PWID communities to educate PWID with HIV about the benefits of achieving viral suppression and how it can be accomplished Point of service education efforts at needle exchange programs and substance abuse treatment centers that promote viral suppression and improved health outcomes among PLWH who inject drugs	PLWH who inject drugs and their partners Treatment providers	Percent of PWID who were engaged in an outreach/education activity among all outreach activities Number of outreach / educational efforts targeted to treatment providers Percentage of PWID with HIV in care Percentage of PWID with HIV retained in care Percentage of PWID with HIV who are virally suppressed

B. Collaborations, Partnerships and Stakeholder Involvement

Maine's Integrated HIV Planning Body includes representatives from Maine's Ryan White Part C Programs, the AIDS Education and Training Center, community-based organizations that provide HIV prevention and case management services, the Housing Opportunities for People with AIDS (HOPWA) grantee and other Maine housing organizations, Maine Migrant Health Program, needle exchanges, Maine's MaineCare Program (MaineCare), Maine's State Epidemiologist, the Minority Outreach Specialist who works with new Mainers and a diverse group of people living with HIV representing all regions of the state. Representatives from all parts of Maine CDC's HIV, STD and Viral Hepatitis Program also participated.

Members of the Integrated Planning Body as well as representatives from Maine's Departments of Education, Corrections and Mental Health and Substance Abuse Services and rural health and primary care centers throughout Maine provided funding information for the Statewide Coordinated Statement of Need (SCSN). Partners contributed data they had previously collected such as MaineCare's provider survey and client satisfaction survey. Others assisted with the SCSN by hosting focus groups, providing aggregate data and/or administering surveys developed by Maine CDC. Many content experts provided information on specific topic areas, such as the current health behaviors and trends among high risk populations in Maine. All of the stakeholders and partners involved in this process, as well as those who were not able to attend meetings, were asked to give their perspective and feedback on the draft SCSN. Recommendations, clarifications and updated data points were included as a result of their suggestions. The collaboration during the development and finalization of the SCSN created the foundation for the Integrated Plan.

Stakeholders and partners provided valuable suggestions to make this plan as integrated, relevant and forward thinking as possible. They contributed at every stage of Plan development by discussing SCSN findings in the context of the National HIV/AIDS Strategy and providing insight and subject matter expertise on the many components within each strategy. Some partners included initiatives that they are currently working on or services that they offer within the Integrated Plan. Others were included as key partners within the Integrated Plan due to their ongoing collaboration and participation in identified strategies. Maine CDC also reached out to some organizations individually to obtain additional information, such as the state's HOPWA grantee, to create the most influential and relevant strategies possible. Moving forward, these partners will be key players in many of the Integrated Plan strategies in order to successfully improve outcomes along Maine's HIV Care Continuum.

Despite the diverse representation among stakeholders and partners throughout the development of the Integrated Plan, there were some additional organizations – particularly among health care providers – that were unable to participate in the planning discussions that could have provided additional perspective and experience and whose cooperation will be vital to improving health outcomes along the Care Continuum. These additional collaborators have been identified for further outreach in the ongoing planning process.

Please see Appendix A for planning body letter of concurrence

C. People Living with HIV (PLWH) and Community Engagement

Representation

Maine's high risk and HIV-positive community members were among the first to participate in the planning process. The SCSN includes qualitative data collected from MSM, PWID and PLWH at various stages of the Care Continuum. These individuals completed surveys and participated in focus groups that were targeted toward people at high risk of acquiring HIV and those currently living with HIV. Individuals who participated in this process generally aligned with the demographic and geographic distribution of prevalent cases of HIV in Maine.

New Mainers and people with chronic housing instability issues are two populations with significant needs and unique challenges who were not able to participate directly on the Integrated Planning Body. HIV service providers, who specialize in work with these groups, were called upon to serve as a proxy to ensure that the experiences and challenges that they face were included in the planning process.

Contributions of PLWH

PLWH contributed to this plan by voicing their concerns and unmet needs during the needs assessment phase, reviewing and critiquing the draft SCSN, participating in the development of the strategies and proposing activities to be included in the final plan. The inclusion of community members within the Integrated Planning Body throughout the entire planning process added a much needed perspective and voice of experience from the population that the Integrated Plan is intended to serve.

Engagement

Before launching the integrated planning process, Maine CDC reached out to community members who had expressed interest in participating in the plan, recruited at two conferences for PLWH and continued recruitment at focus groups and through surveys administered during the needs assessment phase.

A broad spectrum of PLWH, people at high risk for HIV and related community members described their service needs and challenges through targeted needs assessment surveys, key informant interviews and focus groups. All of the information gathered was included in the SCSN and helped to identify needs that were later turned into strategies in the Integrated Plan. Members of the Integrated Planning Body provided additional context, voicing thoughts on barriers and proposing solutions to close identified gaps in care.

Community members were invited to and had representation at every Integrated Planning Body meeting throughout the process. Maine CDC also reached out to community members between meetings to ensure that those who wanted their voices heard were given additional opportunities to provide feedback or ask questions.

Integrated Planning Body members will continue to be engaged in future meetings where progress will be reported and the plan will be further refined to address emerging issues or respond to changes in needs or resources.

Section III: Monitoring and Improvement

Regular Updates

Following the submission of the Integrated HIV Prevention and Care Plan, the Planning Body will continue to meet once a month. An initial goal of the Planning Body is to increase membership among PLWH, high risk community members and health care providers who were unable to participate in the planning process and development of this plan. Moving forward, frequent communication and scheduling regular meetings far in advance will be two primary strategies to keep Planning Body members engaged and meeting attendance high. Meetings will be facilitated in person with a call-in option and webinar to minimize barriers to participation. Standing agenda items will include progress reports on the implementation of the Integrated Plan. Meetings will provide a forum for discussing emerging needs and issues, challenges to strategy implementation, goal attainment and partner participation. The plan will be updated as needed based on these discussions. Communication will also occur outside of meetings with specific stakeholders when additional information is needed.

Monitoring and Evaluation

Responsible parties and key partners have been identified for each strategy in the plan. The responsible parties will oversee implementation, progress and reporting with assistance from key partners. This information will be reported at monthly Planning Body meetings. Data indicators identified in the plan shall be monitored and reported on at Planning Body meetings at least annually or as data are available. A timeline and monitoring plan will be created and published as an update to the plan annually.

Success of the Integrated Plan will be judged by several factors: implementation of strategies as described, timely completion of activities and deliverables and outcomes measured by data indicators. This information shall be included in an annual written report presented at a Planning Body meeting and sent to all Planning Body members.

Utilizing Surveillance and Program Data

Current surveillance and program data were used to create the SMART objectives in the Integrated Plan. Surveillance data shall be used to populate Maine's Continuum of Care at least annually. Where possible and relevant, other program and surveillance data may be monitored more frequently to measure progress toward fulfilling the strategies in the plan. The baseline Continuum of Care data presented in the SCSN will serve as the cornerstone for evaluating the effectiveness of the plan's strategies and activities. Strategies, activities and the overall objectives themselves may be updated as outcomes along the Continuum improve. The Planning Body will be tasked with rethinking strategies and activities if Continuum data do not show improvements.

Appendix A: Letter of Concurrence between the Planning Body and State Health Department

August 10, 2016

Kerry Hill, MSW; Public Health Analyst
Health Resources and Services Administration
5600 Fishers Lane
Mail Stop 09SWH03
Rockville, MD 20857

Kischa Hampton, HIV Prevention Project Officer
U.S. Centers for Disease Control and Prevention
CORP Bldg 8 Rm 3029
MS E-58
Atlanta, Georgia 30329

Dear Mr. Hill and Ms. Hampton:

The Maine Integrated HIV Planning Body ***concurs*** with the following submission by the Maine Center for Disease Control and Prevention in response to the guidance set forth for health departments and HIV planning groups funded by the U.S. CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan.

The Maine Integrated HIV Planning Body has reviewed the Integrated HIV Prevention and Care Plan submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas that bear the greatest burden of HIV disease. The planning body ***concurs*** that the Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the Funding Opportunity Announcement PS12-1201 and the Ryan White HIV/AIDS Program legislation and program guidance.

Maine's Integrated HIV Prevention and Care Plan was developed through a collaborative process between the Integrated HIV Planning Body and Maine CDC. The Planning Body contributed its experience and perspective at every stage of development by participating needs assessments and providing feedback on findings included in the Statewide Coordinated Statement of Need (SCSN), participating in bi-weekly meetings throughout the planning process, discussing SCSN findings and their relationship to the goals in the National HIV/AIDS Strategy and assisting with the development of the final Integrated HIV Prevention and Care Plan. The Planning Body reviewed each section of the Integrated HIV Prevention and Care Plan as it was drafted and participated in a final review of the complete document before submission.

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

Signature: Date:

Planning Body Chair(s):