



Montana Integrated HIV Prevention and Care Plan 2027-2031

Prepared by:

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STI/HIV/Viral Hepatitis Section & Montana HIV Planning
Group**

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Acronyms

ADAP	AIDS Drug Assistance Program	HRSA	Health Resources and Services Administration
ADR	AIDS Drug Assistance Program Data Report	IHS	Indian Health Services
AETC	AIDS Education Training Center	IRB	Institutional Review Board
AI/AN	American Indian Alaskan Native	LHJ	Local Health Jurisdiction
AIDS	Acquired Immune Deficiency Syndrome	MCA	Montana Code Annotated
ART	Antiretroviral Therapy	MIDIS	Montana Infectious Disease Information System
CBO	Community-Based Organization	MSM	Men who have sex with men
CDC	Center for Disease Control and Prevention	MPCA	Montana Primary Care Association
CDEpi	Communicable Disease Epidemiology	MPHTC	Montana Public Health Training Center
CQM	Clinical Quality Management	PBM	Pharmacy Benefit Manager
CTRS	Certified Therapeutic Recreation Specialist	PEP	Post-Exposure Prophylaxis
DIS	Disease Intervention Specialist	PrEP	Pre-Exposure Prophylaxis
DPHHS	Department of Public Health and Human Services	PWID	People who inject drugs
ECHO	Extension for Community Healthcare Outcomes	RW	Ryan White
eHARS	Electronic HIV/AIDS Reporting System	RWHAP	Ryan White HIV/AIDS Program
EIS	Early Intervention Services	RSR	Ryan White Services Report
ELR	Electronic Lab Reporting	SAMHSA	Substance Abuse and Mental Health Services Administration
FPL	Federal Poverty Level	SCSN	Statewide Coordinated Statement of Need
FQHC	Federally Qualified Health Center	SDOH	Social Determinants of Health
HCV	Hepatitis C	SGRX	ScriptGuideRX
HIV	Human Immunodeficiency Virus	SOR	State Opioid Response

HOPWA	Housing Opportunities for People with AIDS	STI	Sexually Transmitted Infection
HRH	High Risk Heterosexual		

Acknowledgements

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Section I – Executive Summary of Integrated Plan and SCSN

This Integrated Plan builds on the second iteration of Montana’s 2022-2026 Integrated Plan, and advances HIV prevention and treatment during 2027-2031. The plan fulfills a funding requirement of the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA), as well as meeting the federal requirement regarding HIV prevention and care planning activities and the Statewide Coordinated Statement of Need (SCSN), a legislative requirement for grantees of the Ryan White HIV/AIDS Program.

Throughout this strategic plan, we have centered the work and voices of those affected by human immunodeficiency virus (HIV), hepatitis C virus (HCV), and sexually transmitted infections (STIs) in Montana.

Stakeholders were given the opportunity to provide feedback and share recommendations through a series of community forums and surveys.

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

- Section II describes how community members were engaged throughout the integrated planning process.
- Section III includes data sharing agreements, a five-year epidemiological profile, the resource inventory, and the needs assessment results.
- Section IV provides a situational analysis of HIV prevention and care in Montana, including strengths, gaps, priority populations, and the four pillars: Diagnose, Treat, Prevent, and Respond.
- Section V outlines the plan’s goals and objectives, developed from findings from the needs assessment and input from the Montana HIV Planning Group (HPG) and local public health partners.
- Section VI describes how Montana will implement and monitor the plan. The Montana HIV Integrated Plan is a living document that will be reviewed annually and refined over time. Implementation and monitoring are shared responsibilities among the Montana Department of Public Health and Human Services (DPHHS), the Montana HPG, and Ryan White Program recipients.

Section II – Community Engagement and Planning Process

Jurisdictional Planning Process

Montana's statewide planning process for the 2027-2031 Integrated HIV Prevention and Care Plan was designed to prioritize engagement with partners across the state. This approach focused on hearing directly from HIV treatment and prevention partners, local and tribal public health agencies, community-based organizations, healthcare providers, and people living with HIV (PLWH) to identify priority populations, barriers to care, resource gaps, and assess community-specific needs.

The process for developing the planning structure began in early 2025. After formalizing the development process, we began engaging with public health partners and community members in late summer 2025 to discuss HIV care priorities, challenges, and emerging trends. Partners included in this process were the Montana DPHHS, the Montana HPG, local and tribal public health agencies, and community-based organizations.

Entities Involved in Process

HIV Planning Group

The Montana HPG plays a central role in both the development and implementation of the Integrated HIV Prevention and Care Plan. As a representative body of stakeholders engaged in HIV prevention, care, and support services across the state, the HPG ensures that the plan is grounded in real-world experience, community needs, and system-level insight.

The Montana HPG operates under bylaws approved by its members that guide its structure, membership, and decision-making process. Montana's HPG is composed of five communities: people living with HIV, HIV service providers, men who have sex with men, people who inject drugs, and American Indian communities. Each community consists of four representatives serving a three-year term and one MT DPHHS appointed co-chair. Community representatives are selected based on their ability to accurately reflect the perspectives of the populations they represent, either through lived experience or through their experience working directly with community members. Other considerations for membership selection include age, geography (urban, rural, frontier), and level of expertise in understanding and addressing Montana's HIV prevention and treatment needs. As a result of the membership considerations, the HPG brings together

individuals with diverse backgrounds and experiences, including people with lived experience, representatives from local and Tribal public health agencies, community-based organizations serving people at risk for or living with HIV, and Ryan White providers.

The HPG works with MT DPHHS to identify priorities, service gaps, and emerging needs among those living with HIV and those at risk across Montana. Feedback and perspectives shared through the group help inform the plan's goals, objectives, and strategies. The HPG provides insight into the experiences and needs of people living with HIV, and collaborative work with the group helps to ensure that the plan goals are structured in a way to respond to the needs of people living with HIV and those at risk. This involvement promotes transparency, accountability, and alignment across prevention and care efforts, ensuring that statewide strategies are both community-informed and actionable.

HRSA and CDC emphasize meaningful stakeholder and community involvement in plan development and ensure their feedback is used to drive decision-making. MT DPHHS's collaborative work with the Montana HPG aligns with these expectations.

Since 2009, the HPG has met in person twice annually (with the exception of 2020-2021 due to COVID-19). Meetings include presentations on the status of the HIV epidemic in Montana, along with updates on prevention efforts and the delivery of medical and support services. Through facilitated discussions, participants identify gaps, barriers, and disparities and provide recommendations that inform program strategies and planning efforts.

University of Montana – The Rural Institute for Inclusive Communities

Montana DPHHS partnered with the University of Montana's Rural Institute for Inclusive Communities (RIIC) to conduct a statewide needs assessment focused on pre-exposure prophylaxis (PrEP) awareness, access, and use. Using a mixed-methods approach, including a statewide survey and in-depth interviews, the assessment identified gaps across the PrEP care continuum.

Findings from the needs assessment directly informed the development of goals, objectives, and strategies within this plan by identifying priority populations and guiding efforts to expand PrEP awareness and access. With both quantitative data and community-informed input, the assessment strengthened the plan's alignment with local needs and supported a more targeted and equitable approach to HIV prevention.

Role of the Ryan White HIV/AIDS Program Part B Planning Council

Collaboration with the RWHAP Parts

Collaboration across Ryan White HIV/AIDS Program (RWHAP) Parts is essential to developing a comprehensive and effective plan. Montana has the Ryan White Part B at the state level, and Ryan White Part Cs at two federally qualified health centers. Each RWHAP Part contributes unique insight into service delivery, system gaps, and client needs across the continuum of care.

RWHAP partners contributed to the resource inventory, situational analysis, and the plan goals, providing data on service utilization, prevention gaps, and clinical outcomes. Engagement occurred through multiple structured opportunities, including participation in two multi-day HPG meetings focused on reviewing and refining integrated plan goals, an initial focus group that helped initiate the community engagement process and inform early plan development, and ongoing input through monthly monitoring calls.

The Ryan White Part B Clinical Quality Management (CQM) program also contributed key data-driven insights. Through quarterly CQM workgroup meetings, the RWHAP partners reviewed performance measures, identified care gaps, and discussed strategies to improve outcomes such as retention in care and viral suppression. Client feedback from the annual Ryan White Client Satisfaction Survey further ensured the plan reflects lived experiences.

Engagement of People with HIV

Engagement with people living with HIV was central to plan development and ensured that the plan is grounded in lived experience and responsive to community needs. People living with HIV were actively involved through two multi-day HPG meetings, where they reviewed draft goals and discussed priorities, barriers, and opportunities for improvement. These discussions provided valuable insight into challenges such as stigma, access to services, and system navigation.

Additional input was gathered through the annual Ryan White Client Satisfaction Survey, which provided both qualitative and quantitative data on client experiences. Feedback helped identify barriers to care, areas for improvement across service delivery, and to understand experiences with HIV providers and case managers.

Engagement was further strengthened through the RIIC needs assessment, which included interviews with individuals at risk of HIV. These interviews explored awareness

of and access to PrEP and highlighted important perspectives on prevention gaps and opportunities to improve outreach and service delivery.

Together, these efforts ensured that the voices of people most impacted by HIV directly informed the development of this plan.

Priorities

The priorities of the Montana HIV Integrated Prevention and Care Plan for 2027-2031 reflect a coordinated, statewide effort to strengthen the systems, workforce capacity, and partnerships to reduce new HIV infections and improve health outcomes for people living with HIV. A key priority is building and sustaining a knowledgeable and confident workforce across healthcare and public health settings. This includes expanding training opportunities, improving provider comfort with sexual health discussions, and reducing stigma associated with HIV and related conditions. These efforts are paired with a strong emphasis on normalizing routine testing, opt-out testing, and increasing awareness and use of prevention strategies such as PrEP. Together, these approaches aim to ensure that HIV prevention and early diagnosis are accessible, consistent, and integrated into everyday care across Montana.

The plan also prioritizes expanding equitable access to testing, prevention, and care through innovative and community-based approaches, particularly in rural and underserved areas. Strengthening data systems, surveillance, and care coordination is another key focus, supporting timely identification of needs and improved linkage to care.

Finally, the plan emphasizes strong partnerships with local and tribal health agencies, healthcare providers, and community-based organizations. It promotes a syndemic approach to address HIV and related conditions through integrated, person-centered strategies, continuous quality improvement, and data-driven decision-making.

Section III – Contributing Data Sets and Agreements

Data Sharing and Use

Montana's Department of Public Health and Human Services (DPHHS) maintains all data associated with the HIV Prevention and Surveillance Programs and ensures the policies and procedures for the Division and Bureaus comply with state statute and the Administrative Rules of Montana (ARM). Montana maintains a decentralized public health system; each tribe and county has the authority to conduct case investigations

and employ disease control measures. The Montana Code Annotated (MCA) Uniform Health Care Information Act ([MCA 50-16-530](#)) allows the release of public health information, without patient authorization, to public health authorities when such information is required by law or needed to protect the public health. Once information is in possession of the local or state health department, subsequent release of the information is governed by the Government Health Care Information Act ([MCA 50-16-603](#)).

HIV related data are housed in standardized disease reporting systems including the Montana Infectious Disease Information System (MIDIS), the electronic HIV and AIDS Reporting System (eHARS), EvaluationWeb, CareWare and the MT Public Health Laboratory Information System (LIS). Provisions for the protection of privacy and confidentiality of HIV data can be found in the [DPHHS Office of Epidemiology and Scientific Support Bureau Security and Confidentiality Policy](#).

As integrated programs, the Montana HIV/HCV Surveillance, HIV/Viral Hepatitis Prevention and Ryan White Programs are not required to operate under data sharing agreements. These programs regularly review data to conduct case ascertainment and follow-up, identify potential disease clusters or outbreaks, identify training needs for local health jurisdictions, and enhance linkage to care and health outcomes. However, all local public health jurisdictions must sign a memorandum of agreement to access the MIDIS System which collects laboratory data on all reportable conditions in Montana, including those related to HIV. Outside the scope of these public health duties to identify cases of reportable conditions and to implement control measures, any HIV related data that is shared must be de-identified and comply with the DPHHS [Office of Epidemiology and Scientific Support Guidelines for the Release of Public Health Data](#).

The HIV Treatment program has data sharing agreements with its six contractors for contiguous treatment. These agreements support ADAP and the Ryan White program through CAREWare, a free scalable software provided by HRSA. CAREWare tracks ADAP services to generate two federal reports: the Ryan White Services Report (RSR) and the AIDS Drug Assistance Program Data Report (ADR). All ADAP data, including prescriptions and insurance information, come from the Prescription Benefit Management (PBM) company ScriptGuideRx (SGRX). Each of the two Ryan White Part C clinics also uses CAREWare to manage and monitor HIV clinical and supportive care. CAREWare and pharmacy claims data provide a picture of client-level insurance coverage, treatment, and care needs.

The HIV Prevention program has contracts with its nine organizations, for which the program provides tests and supplies. Each of these sites enters data directly into Evaluation Web, in addition to the data they share monthly and annually with the program.

The contractors report information needed for the HIV Prevention program, including test numbers, condom distribution, referrals for PrEP and Post-Exposure Prophylaxis (PEP), and social media reach.

Epidemiologic Snapshot

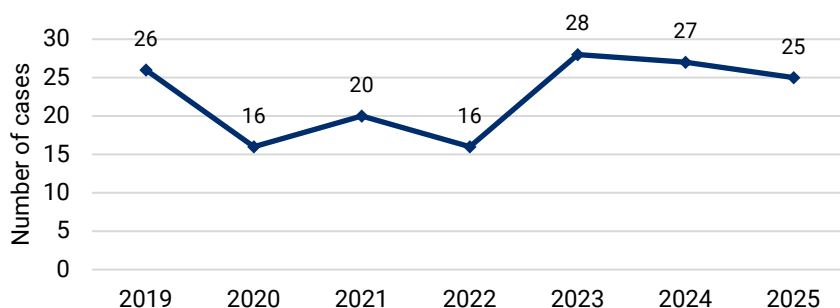
Background

HIV (human immunodeficiency virus) is spread through body fluids, such as blood, semen, and breastmilk, and targets parts of the immune system. People infected with HIV can be treated with antiretroviral therapy (ART), which can reduce viral load and prevent transmission to others. Left untreated, opportunistic infections or cancers take advantage of the weakened immune system, indicating that the person has stage 3 HIV disease or Acquired Immune Deficiency Syndrome (AIDS).

Summary

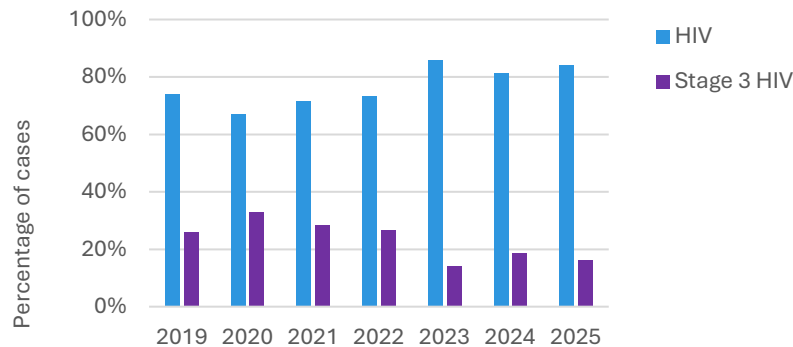
Beginning in 2020, diagnoses of HIV in the United States decreased by 17%, likely due, in part, to COVID-19-related disruptions in testing (Viguerie et al., 2023). In Montana, the number of new diagnoses also decreased in 2020 (Figure 1). In 2023, Montana saw a return to pre-pandemic levels of new HIV infections. In 2025, 25 new HIV diagnoses were reported to the Montana Department of Public Health and Human Services (DPHHS) compared to 16 cases in 2020.

Figure 1. Number of new HIV diagnoses, Montana, 2019-2025



People who have stage 3 HIV disease (AIDS) at the time of their HIV diagnosis indicate a delayed diagnosis of HIV infection, and subsequent delay in partner notification and treatment. From 2019 to 2025, there was a decrease in the number of people with Stage 3 HIV at the time of their diagnosis, from 26% to 16% of cases (Figure 2).

Figure 2. Percentage of HIV cases by disease stage at the time of diagnosis, Montana, 2019-2025



Because of the small number of events, new HIV diagnoses during 2025 are compared to the previous 5-year average (2020-2024) in Table 1. Males made up 96% of total HIV diagnoses in 2025, slightly greater than the percentage diagnosed during the 2020-2024 period. In 2025, men who reported having sex with men (MSM) made up 52% of the new diagnoses. People reporting injecting drug use (IDU) as a transmission risk were 24% of new diagnoses in 2025, compared to 7% during the previous five years. Also in 2025, 76% of new diagnoses reported MSM as at least one transmission risk. This is greater than the previous five-year average, when 66% of new diagnoses reported MSM as at least one transmission risk.

Table 1. New HIV diagnoses by transmission risk and age group, Montana, 2025 and 2020-2024

	Percentage of total 2025 cases (N=25)	Percentage of 2020-2024 cases (N=105)
Sex		
Male	96%	90%
Female	4%	10%
Transmission risk		
MSM	52%	59%
MSM/IDU	24%	7%
IDU	4%	8%
High-Risk Heterosexual Contact (HRH)	8%	6%
Risk not identified/risk not reported	12%	20%
Age group (years)		
15-24	8%	13%

Montana Quick Facts

- ✓ An average of 23 persons were newly diagnosed with HIV annually during the most recent five-year period (2021-2025). In 2025, there were 25 new HIV diagnoses.
- ✓ Men (92%) made up the majority of new HIV diagnoses between 2021 and 2025.
- ✓ In 2025, men who reported having sex with men (MSM) remained the population most affected by HIV in Montana, with 76% of new diagnoses reporting MSM as at least one transmission risk.
- ✓ During the 2021-2025 period, Montanans who were Hispanic (any race) or were American Indian (non-Hispanic) were disproportionately impacted by HIV. People who were Hispanic or American Indian each made up 13% of new HIV diagnoses while representing 5% and 6% of the state population, respectively.
- ✓ From 2019 to 2025, there was a significant decrease in the number of persons with Stage 3 HIV (AIDS) at the time of their diagnosis, from 26% to 16% of cases.

25-34	32%	43%
35-44	24%	20%
45-54	32%	16%
55+	4%	8%

MSM: Men who have sex with men, only

IDU: Injecting drug use, only

MSM/IDU: Men who have sex with men and injecting drug use

HRH: High-risk heterosexual contact with a person with known HIV, only

Most Montana HIV cases during the 2021-2025 period were among white, non-Hispanic people (Table 2). During 2021-2025, 13% of new diagnoses were among the American Indian population. The U.S. Census reports that American Indians made up 6% of the Montana population in 2023. The Hispanic population was also disproportionately impacted by HIV in Montana, making up 13% of new diagnoses in the most recent five-year period (2021-2025) while comprising 5% of the state population.

Table 2. Percentage of new HIV diagnoses by race and ethnicity, Montana, 2021-2025

Race/Ethnicity	Percentage of HIV new diagnoses, 2021-2025	Montana population, 2023
White, Non-Hispanic	68%	85%
Hispanic, any race	13%	5%
American Indian, Non-Hispanic	13%	6%
Other, Non-Hispanic	3%	4%
Black/African American, Non-Hispanic	3%	1%

Source: Single-race Population Estimates, United States, 2020-2023. July 1st resident population by state, age, sex, single-race, and Hispanic origin, on CDC WONDER Online Database.

People Living with HIV (PLWH)

As of December 31, 2025, 2,122 cumulative cases of HIV infection have been reported to the Montana DPHHS since 1985 when the Department began collecting HIV data. Of those cases, 44% were Montana residents at the time of their diagnosis. Of the total cases reported to DPHHS, more than 32% are known to have died from any cause. Table 3 describes characteristics of the 895 people living with HIV in Montana as of December 2025. People living with HIV in Montana were older than those with new diagnoses. While 24% of people with a new HIV diagnosis were older than 45 years during the 2021-2025 time period (Table 3), 62% of Montanans living with HIV in 2025 were older than 45.

Table 3. Demographic characteristics of persons living with HIV, Montana, 2025 (N=895)

Characteristics	Total	Percentage
Sex		
Male	769	86%
Female	123	14%
Total	892	100%
<i>Frequency missing = 4</i>		
Transmission risk		
MSM	495	55%
MSM & IDU	105	12%
IDU	77	9%
HRH	82	9%
Risk Not Specified	126	14%
Other	10	1%
Total	895	100%
Age group (years)		
≤12	<5	NA
13-24	17	2%
25-34	113	13%
35-44	204	23%
45-54	165	19%
55-64	230	26%
≥65	149	17%
Total	878	100%
<i>Frequency missing = 13</i>		
Race		
White, non-Hispanic	681	77%
American Indian, non-Hispanic	47	5%
Hispanic, any race	78	9%
Black, non-Hispanic	35	4%
Other	40	5%
Total	881	100%
<i>Frequency missing = 14</i>		

Priority Populations

Men Who Have Sex with Men (MSM)

Men who have sex with men were associated with 76% of new diagnoses in 2025 when MSM-only and MSM/IDU transmission categories are combined. The MSM population

has consistently represented the largest transmission category in Montana for several years, showing that MSM should remain Montana’s highest prevention priority population.

People Who Inject Drugs (PWID)

Alone, the injection drug use (IDU) population accounted for 4% of diagnoses in 2025, but MSM/IDU accounted for an additional 24%. The increase in MSM/IDU cases from 7% during 2020-2024 to 24% in 2025 suggests a growing concern and need for prioritization. Furthermore, this supports the continued emphasis on providing health services to those who use drugs.

American Indian/Alaska Native (AI/AN)

AI/AN persons accounted for 13% of new HIV diagnoses from 2021-2025 while representing only 6% of Montana’s population. This is a clear disparity and justifies the identification of the AI/AN population as a priority population.

Hispanic/Latino

Hispanic persons represented 13% of new diagnoses while making up about 5% of Montana’s population. Like the AI/AN population, this is a significant disparity supporting prioritization.

Adults Aged 25-44 Years

About 56% of new diagnoses in 2025 occurred within the 25-44 years age range. While the age group is not a standalone priority population, it should be strongly considered when targeting prevention efforts.

Persons Unaware of their HIV Status

Table 4 summarizes the estimated HIV prevalence among people (> 13 years) living with HIV in 2022 (the most recent year data is available) regardless of the time of infection or whether the person has received a diagnosis. The prevalence and the percentage of diagnosed infections among people living with HIV reflect the number of people in need of care and treatment services for HIV infection. Estimates were derived from a CD4-based depletion model using HIV surveillance data.

Table 4. Estimated HIV prevalence among persons aged ≥13 years, by year and area of residence, Montana 2022

People living with diagnosed or undiagnosed HIV infection			People living with diagnosed HIV infection		
Number	95% CI	Rate per 100,000	Number	%	95% CI

700	630-850	78.6	629	89.3%	74.1–100
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Source: HIV Surveillance Supplemental Report: Estimated HIV Incidence and Prevalence in the United States, 2018–2022.
<https://stacks.cdc.gov/view/cdc/156513>

Using this model, CDC reports that 89.3% of Montanans aged ≥ 13 years living with HIV have received a diagnosis (2022). This is slightly higher than the United States, where an estimated 87.2% of people living with HIV have received a diagnosis (2022).

HIV Continuum of Care

Rapid treatment of HIV disease and viral suppression are two key strategies to end the HIV epidemic. In Montana during the 2020-2024 period, 92.5% of new HIV cases had additional HIV labs within 30 days of initial diagnosis, indicating receipt of care. The percent of people receiving care within 30 days is similar for males and females (Table 5).

Table 5. People newly diagnosed with HIV who received at least one care visit within 30 days of diagnosis, by sex, Montana 2020-2024

	New HIV diagnoses	Number with ≥ 1 care visit within 30 days	% with ≥ 1 care visit within 30 days
Male	95	88	92.6%
Female	12	11	91.7%
Total	107	99	92.5%

People who report injecting drug use as a transmission risk were less likely to have had care within 30 days (Table 6). Because several transmission risk categories involve small numbers of cases, trends should be interpreted with caution, as modest changes in counts can result in large percentage differences.

Table 6. People newly diagnosed with HIV who received at least one care visit within 30 days of diagnosis, by transmission risk, Montana 2020-2024

	New HIV diagnoses	Number with ≥ 1 care visit within 30 days	% with ≥ 1 care visit within 30 days
MSM	63	57	90%
IDU	8	7	88%
MSM/IDU	11	11	100%
High-risk heterosexual contact	6	6	100%
Other	19	18	95%

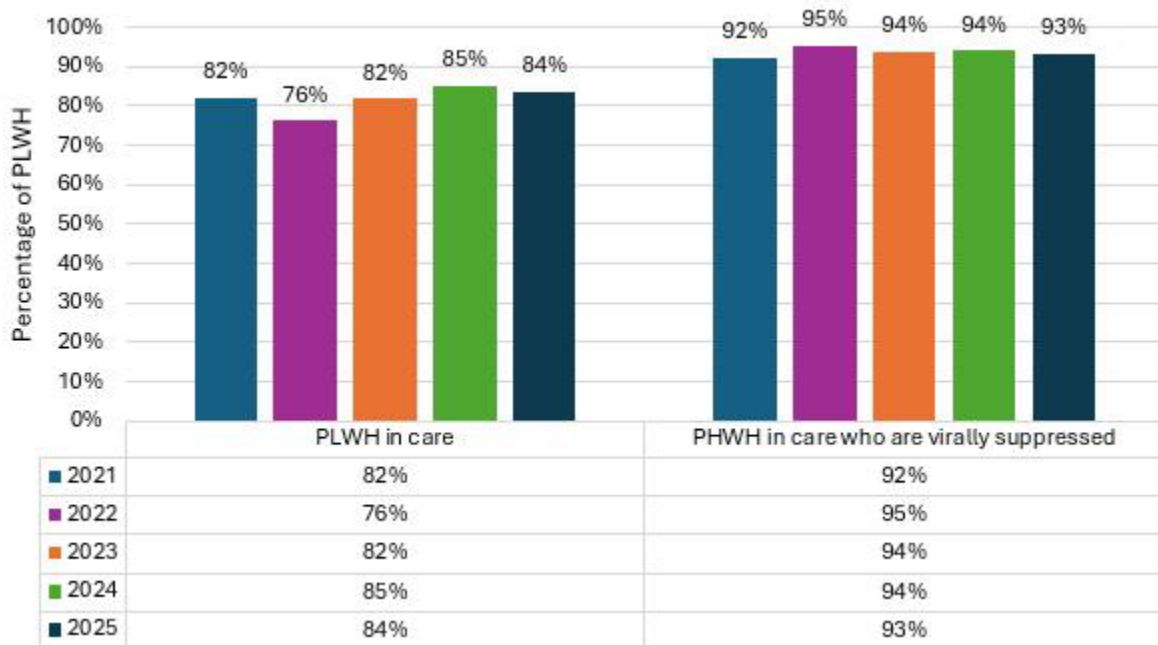
MSM: Men who have sex with men, only
 IDU: Injecting drug use, only

MSM/IDU: Men who have sex with men and injecting drug use
 HRH: High-risk heterosexual contact with a person with known HIV, only

People living with HIV (PLWH) who are virally suppressed cannot transmit HIV through sexual contact. The HIV continuum of care is a series of steps from a person's HIV diagnosis to successful treatment to achieve viral suppression. Montana's continuum of care shows that of the 895 people living with HIV/AIDS in 2025, 84% were in care, and of those, 93% were virally suppressed (viral load <200). The definition of being in care is having at least one documented HIV-related lab within the previous 12 months.

Figure 3 shows the continuum of care in Montana from 2021 to 2025. While the percent of people living with HIV (PLWH) who were in care declined between 2021 and 2022, the percentage of people in care who were virally suppressed remained stable.

Figure 3. Percentage of people living with HIV (PLWH) by care status and viral suppression, Montana, 2021- 2025



Strong outcomes have been seen among people living with HIV (PLWH) who are engaged in care. Between 2021 and 2025, the percentage of PLWH engaged in care ranged from 76% to 85%, with 84% in 2025. Among individuals engaged in care, viral suppression has been consistently high, ranging from 92% to 95% between 2021 and 2025, measuring 93% in 2025. These data show that once individuals are connected to HIV medical care, the majority achieve viral suppression. Conversely, the lower proportion of PLWH who are engaged in care compared to those who are virally suppressed continues to emphasize the need to strengthen linkage, retention, and re-engagement efforts to ensure improved

health outcomes and benefits from sustained treatment among Montanans living with HIV.

HIV Clusters

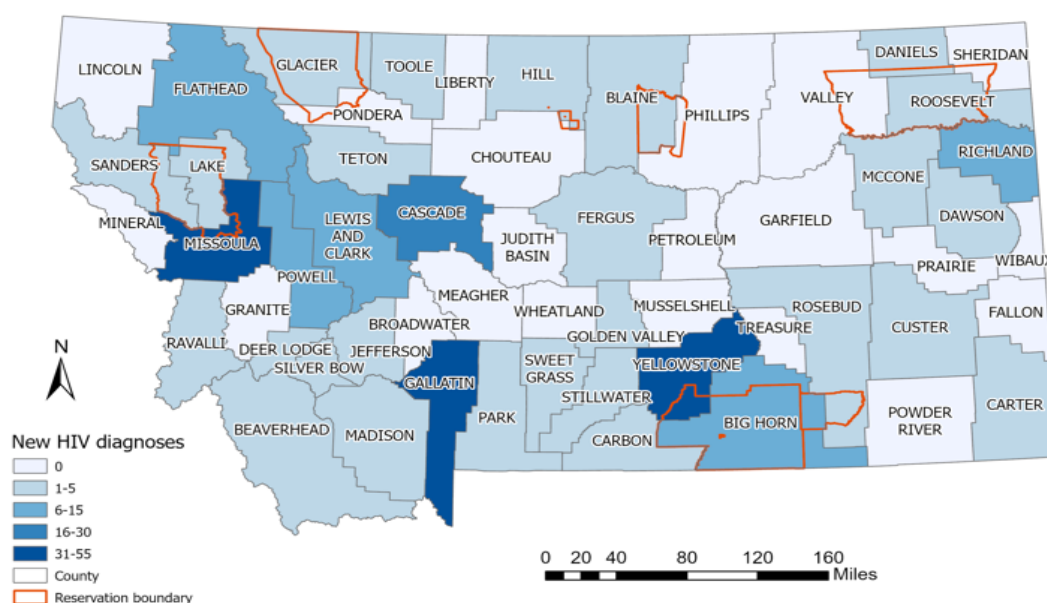
Montana identifies potential HIV clusters through consistent review of surveillance data, partners services investigations, molecular HIV sequence data, and reports from local and tribal public health agencies, healthcare providers, and clinical and public health laboratories. New HIV diagnoses are reviewed regularly by communicable disease epidemiology staff and HIV program staff to assess unusual patterns by demographics, geography, or transmission risk factor. Additionally, HIV nucleotide sequence data are reviewed and analyzed to identify potential transmission networks and clusters consistent with CDC guidance.

The most recent HIV cluster in Montana was identified in 2024. The cluster consisted of only four individuals, which makes it difficult to share demographic and transmission data due to the need to protect confidentiality. The state's low HIV incidence and small cluster sizes make it more difficult to conduct detailed epidemiological analysis, although cluster investigations are a key piece of Montana's HIV surveillance and response activities.

Geography

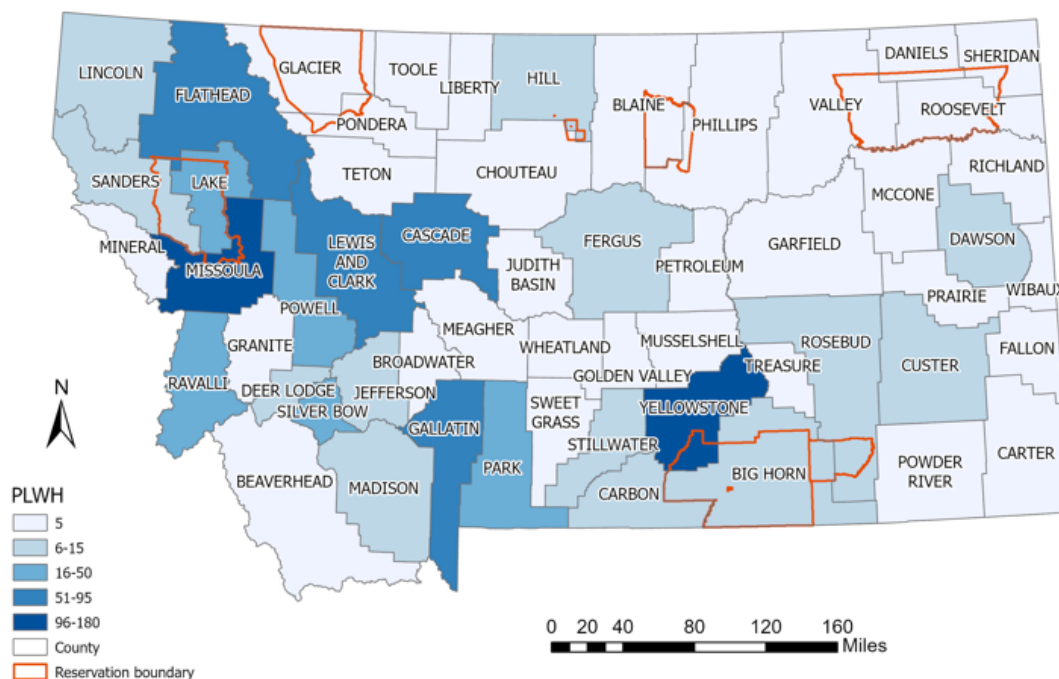
New HIV diagnoses were not evenly distributed among Montana's most populous counties (Figure 4). Yellowstone (21%), Missoula (16%), Gallatin (13%), Cascade (9%), Flathead (6%), and Lewis and Clark (6%) counties accounted for 71% of people with new HIV diagnoses between 2015 and 2025.

Figure 4. Number of new HIV diagnoses by county of residence, Montana, 2015-2025 (N=253)



The number of people living with HIV resided largely in the most populous Montana counties in 2025 (Figure 5). Nearly 50% of PLWH in Montana lived in Yellowstone (20%), Missoula (16%), and Gallatin (11%) counties. Case data from correctional facilities are included in the county of their location.

Figure 5. Number of people living with HIV (PLWH) by county of residence, Montana, 2024 (N=886)



HIV Prevention, Care and Treatment Resource Inventory

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

Funder	Funding Source	Org Receiving the Funding	Subrecipients	Services Delivered	HIV Care Continuum Steps Impacted	EHE Strategies Impacted
HRSA	Ryan White HIV/AIDS Program Part B	MT DPHHS	Partnership Health Center, Riverstone Health, Gallatin City-County Health Department, Indian Family Health Center	ADAP, Health Insurance Premium and Cost Sharing, Medical Case Management, Oral Health Care, Emergency Financial Assistance, Food Bank/Home Delivered Meals, Housing, Outreach	• HIV Diagnosis • Linkage to Care • Engagement or Retention in Care • Prescription of ART • Viral Suppression	• Diagnose • Treat • Prevent • Respond
HRSA	Ryan White HIV/AIDS Program Part B	MT DPHHS	ScriptGuideRX	ADAP, Health Insurance Premium and Cost Sharing	• Prescription of ART • Viral Suppression	• Treat
Pharmaceutical Companies	HIV Drug Rebates	MT DPHHS	ScriptGuideRX, RiverStone Health, Partnership Health Center, Butte-Silver Bow Health Department, HRDC, FDH & Associates, Open Aid Alliance, Montana Queer Alliance	ADAP, Health Insurance Premium and Cost Sharing, Medical Case Management, Oral Health Care, Emergency Financial Assistance, Food Bank/Home Delivered Meals, Housing, Outreach	• HIV Diagnosis • Linkage to Care • Engagement or Retention in Care • Prescription of ART • Viral Suppression	• Diagnose • Treat • Prevent • Respond
CDC	High-Impact HIV Prevention and Surveillance Programs for	MT DPHHS	Butte-Silver Bow City-County Health Department, FDH & Associates,	Health Education/Risk Reduction, Outreach Services, Referral for	• HIV Diagnosis • Linkage to Care	• Diagnose • Treat • Prevent • Respond



Funder	Funding Source	Org Receiving	Subrecipients	Services Delivered	HIV Care Continuum Impacted	EHE Strategies
	Health Departments		Flathead City-County Health Department, Open Aid Alliance, Riverstone Health, Montana Queer Alliance	Health Care and Support Services, Condom Distribution, HIV Transmission Cluster and Outbreak Identification and Response, Partner Services, Perinatal HIV Prevention and Surveillance, PrEP Navigation, Prevention for Persons Living with Diagnosed HIV, Social Marketing Campaigns, Support Services for People Who Use Drugs	Engagement or Retention in Care	
State of Montana	Fund 01100 General Fund	MT DPHHS	PureView Health Center, Flathead City-County Health Department, Butte-Silver Bow City-County Health Department, ScriptGuideRX	PrEP Navigation, Office Visits and Lab Costs for Uninsured and Underinsured, Medical Case Management, Outreach	- HIV Diagnosis - Linkage to Care - Engagement or Retention in Care - Viral Suppression	- Diagnose - Treat - Prevent - Respond
SAMHSA	State Opioid Response Grant	MT DPHHS	Alluvion Health, Butte-Silver Bow HD, RiverStone Health, Flathead City-	Referral for Health Care and Support Services, Support Services for	- HIV Diagnosis - Linkage to Care	- Diagnose - Treat - Prevent - Respond



Funder	Funding Source	Org Receiving the Funding	Subrecipients	Services Delivered	HIV Care Continuum Steps Impacted	EHE Strategies Impacted
			County HD, Open Aid Alliance	People Who Use Drugs		
HOPWA	Housing Opportunities for Person with AIDS	MT DPHHS	HRDC District 7 Open Aid Alliance	Housing	Engagement or Retention in Care	Treat

Assessment of Strengths and Gaps

Montana's HIV prevention and care system has a strong network of service providers, including local and tribal health departments, federally qualified health centers, community-based organizations, healthcare systems, and Ryan White providers. The variety of service settings allows individuals seeking HIV testing or treatment to access services through organizations that best meet their needs and preferences. The state's strong partnerships among prevention, care, and community organizations, as well as tribal and local health jurisdictions, also support coordination across the HIV care continuum.

Montana's population is geographically dispersed across a large rural state, creating both strengths and challenges for service delivery. While many HIV services are available in Montana's larger population areas and areas that are home to regional healthcare centers, residents in rural and frontier communities often travel significant distances to access specialized HIV services. Additionally, in many cases, individuals choose to seek services outside their local communities because of concerns related to privacy and confidentiality, stigma, or provider familiarity with HIV prevention and treatment.

The statewide resource inventory continues to highlight geographic and structural gaps in HIV prevention and care services. Limited provider availability, workforce shortages, travel distances, and transportation barriers continue to affect access to HIV testing, HIV medical care, PrEP, and support services in many regions of the state. Although strong HIV care outcomes among individuals linked to care exist, opportunities persist in strengthening equitable access to HIV prevention and care services across all regions of the state.

Approaches and Partnerships

The data compiler tool includes public and private funding sources for HIV prevention, care, treatment, and related support services throughout. Information was provided by Montana DPHHS staff and program managers, Ryan White subrecipients, and partner organizations that administer HIV programs. Collectively, these resources and partnerships play a critical role in supporting and maintaining the HIV prevention and care continuum and improving access to services for Montanans affected by HIV.

Needs Assessment

The Montana DPHHS contracted the Rural Institute for Inclusive Communities (RIIC) at the University of Montana to conduct a statewide needs assessment on HIV PrEP awareness, access, and utilization. The needs assessment was conducted between August 2024 and December 2025. In addition to the statewide HIV PrEP needs assessment, multiple assessment and planning activities guided and informed the development of this plan. These included analyses of HIV surveillance data, Ryan White client satisfaction survey, HIV care continuum monitoring, quality improvement activities with HIV partners, feedback from the Montana HPG, and input from HIV prevention and care providers in local and tribal public health. Collectively, these sources were used to identify prevention, care, treatment, and support service needs across Montana.

Purpose and Design

The needs assessment designed and conducted by RIIC was completed for a comprehensive understanding of both the prevalence of HIV pre-exposure prophylaxis (PrEP) use and the experiences of people who are eligible for, currently using, or considering HIV PrEP in Montana. The assessment was conducted using a sequential mixed-methods approach using a statewide survey followed by semi-structured interviews. Specifically, the needs assessment sought to identify patterns of HIV PrEP awareness and utilization and to examine how knowledge, attitudes, and behaviors influence HIV PrEP uptake and adherence. The RIIC team also explored how stigma and structural barriers affect engagement in HIV prevention and care services, and how geography, demographic characteristics, and social determinants of health shape access to HIV PrEP across the state. In addition, the assessment gathered participant-driven recommendations to inform future program and policy decisions aimed at improving HIV PrEP access and delivery in Montana. Findings were intended to inform HIV prevention planning and program development rather than provide population-based estimates.

Statewide Survey

The first phase of the assessment consisted of a statewide online survey. The survey was administered between December 2024 and January 2025. The development of the survey was informed by stakeholders across the state, including MT DPHHS, the Montana HIV Planning Group, community-based organizations, HIV testing programs, and organizations serving people who use drugs. The survey was designed to gather information on PrEP awareness, knowledge, utilization, barriers to access, healthcare engagement, stigma, and demographic characteristics. Survey recruitment was conducted via an online advertising campaign and outreach to community organizations and partners. A total of 94 Montana residents with recent HIV risk behaviors responded to the survey. Respondents represented metropolitan, micropolitan, and rural communities and included men who have sex with men (MSM), people who use drugs (PWUD), justice-involved individuals, and people who identified as having other risk factors.

Table 7. Descriptive Characteristics of Survey Respondents (N= 94)

Characteristic	n	%
Race		
American Indian/Alaska Native	—*	—*
Asian	—*	—*
Black	16	17.0%
Middle Eastern/North African	—*	—*
Hispanic/Latino	18	19.1%
White	55	58.5%
Age Group		
15-17	—*	—*
18-19	—*	—*
20-29	50	53.2%
30-39	22	23.4%
40-49	10	10.6%
50-59	—*	—*
60-69	—*	—*
Sex		
Female	23	24.5%
Male	71	75.5%
Sexual Orientation		
Bisexual	19	20.2%
Gay	16	17.0%
Lesbian	—*	—*
Queer	—*	—*
Straight	47	50.0%

Disability Indicators		
Cognitive difficulty (concentrating/remembering)	42	45.7%
Independent-living difficulty (for errands alone)	34	36.6%

Note: The survey employed the “alone or in combination” method, allowing respondents to check multiple races or ethnicities. Subgroups with fewer than 5 responses are masked to protect privacy.

Survey data were analyzed using descriptive and comparative statistical methods to identify trends in HIV PrEP awareness, uptake, risk perception, stigma, and healthcare access. Analyses were conducted in R software, a programming software built specifically for statistical computing and data analysis, using unweighted survey responses. Respondents were grouped into specific risk domains based on HIV risk factors (MSM, PWUD, justice-involved, or non-MSM sexual risk) and HIV PrEP status (current, former, or never users). The analysis used five composite measures from survey items to explore differences in attitudes, behaviors, and access to HIV PrEP across demographic groups. Each composite combined related survey items into a single score representing a distinct domain: (1) perceived HIV risk, (2) behavioral HIV risk, (3) HIV PrEP-related stigma, (4) discomfort discussing HIV/PrEP with providers, and (5) barriers to healthcare/HIV PrEP access. Composite measures were scaled from 0 to 1 and used to identify service gaps, assess risk discrepancies, and prioritize targeted outreach.

Semi-Structured Interviews

The second phase consisted of semi-structured interviews designed to gather a deeper understanding of participants’ experiences with HIV prevention, HIV PrEP decision-making, healthcare access, and barriers to care. Interview participants were strategically recruited to ensure representation from MSM, PWUD, individuals with non-MSM sexual risk factors, and representation of diverse geographic regions across the state. Interview recruitment occurred through local health departments, community organizations, LGBTQ+ organizations, health care clinics, in-person outreach, and social media. Interviews took place between June and October 2025, with a total of 22 interviews completed and analyzed. Interviews were transcribed and coded using qualitative analysis software, and findings were analyzed inductively through thematic analysis to identify common experiences, barriers, facilitators, and recommendations related to HIV PrEP access and utilization.

Table 8. Demographic Characteristics of Interview Participants (N= 21)

Characteristic	%
Race	
American Indian/Alaska Native	9.5%
Asian American	4.8%

Black	9.5%
White and Hispanic/Latino	4.8%
White Alone	71.4%
Age Group	
18-29	0.0%
30-39	42.9%
40-49	42.9%
50-59	14.3%
>60	0.0%
Sex	
Male	71.4%
Female	19.0%
Sexual Orientation	
Bisexual	23.8%
Gay	33.3%
Pansexual or other	14.3%
Heterosexual/straight	28.6%
Disability	
Has disability or chronic condition that impacts daily activities	72.2%

Findings

The needs assessment identified strengths and gaps across the PrEP care continuum, including awareness, risk perception, uptake, access, and adherence.

Awareness of HIV Risk Perception

Findings showed that awareness of PrEP was generally high among survey respondents. About 91% of respondents reported familiarity with PrEP and nearly 75% reported awareness of long-acting injectable PrEP. Current PrEP use was highest among MSM and lowest among women and individuals with non-MSM sexual risk factors. None of the interviewees who identified as PWUD reported current or previous PrEP use, highlighting ongoing disparities in PrEP uptake. Participants identifying as Black, Hispanic/Latino, or multiracial were also less likely to be current PrEP users than White respondents.

Barriers to PrEP Access and Use

Social and structural factors were identified as important influences on engagement in HIV prevention. Common barriers identified included HIV and PrEP-related stigma, discomfort discussing sexual behaviors and drug use with healthcare providers, worries about privacy, and limited provider knowledge of PrEP. Participants also described concerns around confidentiality and privacy when accessing HIV prevention services,

particularly in smaller communities where familiarity among residents and stigma associated with HIV, sexuality, and substance use may discourage individuals from seeking services.

Participants also reported a range of structural barriers that prevented or limited access to services, including lack of insurance coverage, no regular healthcare provider, limited transportation options, and financial difficulties. Survey findings showed that 17% of respondents lacked health insurance in the previous year, 25% reported being unhoused, and 35% expressed concern about losing housing. Almost half of the respondents experienced transportation challenges. Several reported difficulties affording health care, medications, utilities, and/or other basic needs. These findings point out the importance of addressing social determinants of health, including transportation access, housing stability, and health care affordability, when strategizing HIV prevention and care activities.

PrEP Adherence and Continued Use

Findings around PrEP adherence and continuation indicated that medication side effects, concerns about medication effectiveness, and concerns about privacy were the most common reasons for the discontinuation of PrEP use among former users. Current users most commonly cited PrEP as a source of peace of mind and integrating PrEP into existing routines supported long-term adherence. Many participants expressed interest in alternative service delivery methods, including telePrEP and mail order services, which would help reduce geographic and logistical barriers to care.

HIV Testing Needs

Needs assessment findings suggest that there are opportunities to improve HIV testing access and routine HIV prevention discussions across healthcare and health services settings. Findings showed that several participants underestimated their risk for HIV relative to their reported behaviors, indicating that individuals who would benefit from HIV testing and prevention services are not seeking them out because they do not always perceive themselves to be at risk. Participants also described not having discussions with their health care providers about HIV prevention and having inconsistent or limited awareness of available prevention services. These findings further drive continued efforts to expand and strengthen HIV testing, provider-led HIV prevention discussions, and improve awareness of prevention resources among populations at higher risk of HIV transmission.

Participant Recommendations

Participants recommended expanding PrEP education, increasing provider training and their comfort discussing sexual health and HIV prevention, and normalizing

conversations about PrEP within health care settings. There was a clear emphasis in participant recommendations on offering PrEP through community-based organizations, treatment programs, and federally qualified health centers. Increasing awareness of telePrEP options, reducing cost barriers, and providing low-barrier access were identified as opportunities to improve PrEP uptake among underserved communities.

Key Priorities Identified

Findings indicated that Montana has strong potential for expanding PrEP utilization, but critical gaps remain between awareness, perceived HIV risk, and PrEP uptake. Priority populations identified through the needs assessment include PWUD, racially and ethnically diverse populations, uninsured individuals, and residents facing housing or transportation barriers. Key opportunities identified from the needs assessment process include:

- Expanding PrEP education and risk communication efforts
- Expanding HIV testing awareness and routine testing opportunities
- Increasing provider training and implementation of routine sexual health and PrEP discussions
- Enhancing PrEP access through telehealth, community-based settings, nontraditional settings, and low-barrier service models
- Reducing stigma related to HIV, drug use, PrEP utilization, and sexuality
- Strengthening PrEP navigation services for populations with lower uptake
- Increasing awareness of emerging HIV prevention options
- Addressing transportation, housing, insurance, and other social determinants that affect HIV prevention and care engagement

Overall, the assessment points out the need for stigma-reducing, culturally responsive, and targeted approaches to improving access to PrEP across Montana, reducing social and structural barriers that limit HIV prevention engagement.

Actions Taken

The needs assessment was completed in December 2025. Following its completion, Montana DPHHS STI/HIV/Viral Hepatitis section invited the RIIC researchers who conducted the assessment to present the study methodology and findings at a biannual HPG meeting and at the 2026 Syndemic Symposium, a statewide conference hosted by the MT DPHHS STI/HIV/Viral Hepatitis section for local and tribal public health partners from across the state. These presentations provided an opportunity for stakeholders and partners to discuss current challenges related to PrEP awareness, access, and use,

strategies to improve its access and utilization, as well as potential strategies to improve uptake around Montana.

Additionally, findings from the needs assessment were incorporated into the development of this plan. Throughout the planning process, Montana DPHHS has collaborated with HPG and stakeholders to review the identified barriers, prioritize service gaps, and develop strategies and activities to address them. Activities incorporated into statewide planning efforts of this plan include:

- Expansion and strengthening of health care provider education focused on routine HIV testing, sexual health assessments, HIV prevention, PrEP, and stigma reduction.
- Continued support of community-based HIV testing, HIV self-testing, and exploration of testing approaches in nontraditional settings like pharmacies, mobile units, and public health vending machines
- Committed and ongoing collaboration with the Montana HPG, local and tribal public health, community-based organizations, and healthcare providers to improve the HIV prevention and care infrastructure in Montana
- Continued distribution of condoms and prevention resources to support HIV prevention among populations at increased risk of acquiring HIV
- Efforts to strengthen rapid linkage to care, case management capacity, care coordination, and continuity of care through Ryan White Program activities

Section IV – Situational Analysis

Montana Demographics

Montana is a large, mostly rural state with a relatively small and geographically dispersed population. In 2025, the state's population was estimated at about 1.14 million. The estimated population increased by 5.6% from 2020, faster than the national average (U.S. Census Bureau, 2025). Most of this growth was driven by people moving into the state, and as a result, demand for housing, infrastructure, and health services increased (Montana Labor Day Report [MLDR], 2024). About 87% of Montana's population is White, and around 6% are American Indian or Alaska Native (AI/AN). Smaller demographic groups include Hispanic or Latino (5%), Asian (0.8%), Black (0.6%), and Native Hawaiian and Pacific Islander (0.1%). About 5% of residents identify as more than one race (Montana State Health Assessment [MSHA], 2023).

The age distribution of Montana reveals both an aging population and demographic differences across population groups. The median age in the state is about 40 years,

while for AI/AN populations, it is significantly younger at 28.2 years (MSHA, 2023). People aged 65 and older are one of the fastest-growing age groups. As more people enter this age group, the need for health care and a strong health workforce, especially in rural areas, has grown.

Montana has 56 counties, many of which are considered rural or frontier. Montana is also home to 12 Tribal Nations, which are an important part of the state's cultural, social, and health environment. About 34% of Montana's residents live in rural areas, the highest percentage of any state (Center for American Indian and Rural Health Equity, n.d.). Out of 56 counties, 46 are considered rural, and only a few are metropolitan or micropolitan areas (MSHA, 2023). Rural residents face greater challenges, often having less access to health care, longer travel times, workforce shortages, and fewer transportation services. These challenges, combined with overlapping systemic disadvantages, make rural communities more vulnerable.

Social vulnerability is unevenly distributed across Montana, with the greatest burden in rural counties and Tribal Nations. In Montana, rural areas frequently overlap with AI/AN communities and are often characterized by older populations and lower median household incomes than urban areas. Several Montana counties are among the highest in the country for concentrated low socioeconomic status and compounding household challenges. Residents of these communities are at higher risk of poor health outcomes and have reduced ability to respond to public health challenges (MSHA, 2023). AI/AN residents also experience higher social vulnerability than other population groups, largely influenced by longstanding inequities, isolation in rural environments, and the lasting effects of historical trauma. These factors have created barriers that limit resources, economic stability, and health across the Tribal Nations.

Economic and workforce trends also shape Montana's demographic picture. While the state has grown economically and the number of available jobs has increased, many sectors, including health care, continue to experience workforce shortages (MLDR, 2024). These shortages are seen more in rural and frontier areas, where it is hard to recruit and retain workers.

Together, these demographic characteristics affect the health of communities and access to care across Montana and point to the need for equitable approaches to HIV prevention and care services.

Social Determinants of Health in Montana

Social determinants of health (SDOH) are the underlying social and economic conditions that influence people's ability to be healthy and their quality of life. They are the conditions in which people are born, live, work, and age. Stable housing, good schools and educational resources, safe neighborhoods and home conditions, access to jobs, social connectedness, and culturally responsive health care all play a role in people's well-being. In Montana, factors like economic security, access to health care, and the local environment affects whether people are able to access to HIV prevention, testing, and care.

Montana has experienced steady economic and wage growth since the COVID-19 pandemic. This growth acts as a double-edged sword, creating professional opportunities for some while intensifying economic pressures for more vulnerable communities and residents. This imbalance results from wealth concentrating in more developed, urban areas. The cost of living has increased faster than wages, which makes it difficult for many to keep up with everyday living expenses. The imbalance also further contributes to poverty rates being highly concentrated across the state, tending to be higher in more vulnerable and rural communities and among AI/AN communities, where workforce participation is often lower and economic challenges are more noticeable. Income disparities between men and women also continue to contribute to financial difficulty. In 2024, women earned about 84 cents per dollar men earned (Fry & Aragao, 2025). Additionally, the state continues to manage a labor shortage, with two job openings for every unemployed person (MLDR, 2024). For many, these financial disparities force individuals to choose between essential health care and meeting basic needs.

Housing is becoming a growing concern in Montana. The lack of affordable housing has been an increasingly difficult problem for many Montana communities. As more people move to Montana and the housing market becomes harder to navigate, many Montanans struggle to find affordable housing. The growing demand and rising home prices make it more difficult for low- and moderate-income households to find stable homes (MLDR, 2024). When households become highly cost-burdened, they experience many difficulties regarding health and well-being outcomes. Housing affordability significantly influences where people live and shapes their access to employment, health services, and other resources, all of which are essential to maintaining overall health. The difficulties of being cost-burdened extend from the individuals directly involved to the communities in which they live, resulting in community institutions having to absorb additional costs.

Food insecurity also adds to health disparities across the state. Approximately 1 in 8 Montanans experience hunger, with rural communities and low-income households

disproportionately affected (Headwaters Foundation, 2026). Food insecurity in rural communities, where there is limited access and longer travel time to supermarkets, directly increases the risk of chronic disease and mental health challenges. A mix of geographic isolation, poverty, and limited access to nutritious food often leaves individuals in a “treat or eat” dilemma, forcing them to choose between buying groceries and life-saving medications. For people living with HIV, insufficient food intake is associated with lower medication adherence and viral suppression in people living with HIV, both of which directly affect health outcomes (Kalichman et al., 2020; Weiser et al., 2015).

Behavioral health and substance use are big pieces of Montana’s SDOH. Mental health conditions and substance use disorder (SUD) are common and often not diagnosed or treated, especially in rural and underserved areas (Montana Perinatal Quality Collaborative [MPQC], 2025). Untreated psychological conditions often lead to high-risk behaviors such as substance use, which increases exposure to infectious diseases. Inadequate health assessments and screening, insufficient referral pathways, and stigma are a few existing barriers that contribute to disparities in care and reduced health outcomes that are closely tied to HIV risk and outcomes, more often among people who inject drugs and those with coinciding mental health conditions. Without integrated screening strategies that address HIV and behavioral health together, these overlapping challenges will continue to disproportionately affect vulnerable populations.

Geographic barriers significantly influence Montanans’ social determinants of health. Montana’s rural and frontier areas come with a variety of risk factors for health, including geographic isolation, fewer health care providers, decreased access to specialized health services, limited employment opportunities, lower socioeconomic status, and higher rates of health risk behaviors such as binge drinking, drinking and driving, and unhealthy diets. These geographic barriers feed broader systemic inequities, including limited educational resources, inadequate housing conditions, and economic instability. As a result of the combination of these health risk factors and systemic inequities, the overall physical and mental well-being of rural residents is easily compromised.

For Indigenous communities in Montana, the intersection of historical trauma and geographical isolation can create deeply layered and unique barriers to health. Funding constraints within the Indian Health Service (IHS) and shortages of integrated behavioral health services may require some residents of AI/AN communities on rural reservations to travel long distances to access basic medical and behavioral health care. These challenges can be further compounded by overlapping social and economic inequities such as housing instability, limited educational resources, food insecurity, and limited economic opportunities. Together, these factors accelerate all health disparities.

Addressing these gaps requires meaningful partnerships with Tribal Nations and approaches built on respect for tribal culture and sovereignty.

Repairing social determinants of health is not simple and requires gradual progress, but it is key to better HIV outcomes in Montana. Making health care and support services easier to access, building a strong workforce, and improving care coordination are all important for keeping people in care, raising viral suppression rates, and lowering HIV transmission across the state.

Overview of HIV Prevention and Care Continuum in Montana

Montana's HIV prevention and care system has several strengths across the HIV care continuum. Montana's approach succeeds by meeting people where they are through broad HIV testing reach and an integrated screening approach. Rather than approaching HIV in isolation, HIV testing is also conducted with other screenings for sexually transmitted infections and hepatitis C to support a comprehensive prevention approach and safety net (CDC, 2026). Fewer late-stage diagnoses show that early testing and detection efforts across the state are working (Montana HIV Surveillance Snapshot [MHSS], 2025).

Despite these strengths, challenges remain across the continuum. Gaps in timely linkage to care and HIV PrEP awareness, referral, and uptake keep Montana from meeting national targets (CDC, 2026). These challenges are driven by larger structural and system-wide barriers, such as workforce shortages, rural isolation, social stigma, and limited access to culturally responsive care.

These barriers disproportionately challenge populations most affected by HIV in Montana. Men who have sex with men (MSM) make up the majority of new HIV diagnoses. People who inject drugs (PWID) and those with overlapping risks, including substance use and unstable housing, face more vulnerability. AI/AN and Hispanic populations carry a larger burden compared to their share of the population (MHSS, 2025), showing inequities in access to prevention and care.

Responding to these challenges requires sustained effort and a focus on strengthening linkage to care, expanding access to HIV PrEP and prevention services, and improving coordination of essential support services, such as housing, food assistance, and transportation. Ongoing culturally responsive, community-informed approaches, especially in partnership with tribal Nations and community-based organizations, are key for reducing disparities and improving health across the continuum.

Alignment of Goals with Disproportionately Impacted Populations

The goals and objectives in this plan are designed to meet the needs of populations most affected by HIV in Montana and to address structural and systemic issues seen in HIV prevention and care across Montana. Together, these goals show a coordinated approach across HIV prevention and care. The plan aims to improve early diagnosis, strengthen access to prevention and treatment, and reduce disparities using targeted, system-level strategies.

The Diagnose pillar goals center on expanding routine and opt-out testing, reducing bias and stigma, and equipping providers and public health partners with tools to support better sexual health conversations and referral processes. These efforts address barriers identified in this situational analysis, including delayed diagnosis, inconsistent screening practices, and stigma related to HIV, sexual health, and substance use. Expanding community-based testing, integrating screening into non-traditional settings such as pharmacies and mobile units, and strengthening partner services will help improve early diagnosis and reach populations at higher risk, including MSM, PWID, and people living in rural and underserved areas.

The Prevention pillar goals focus on improving HIV PrEP awareness, screening, referrals, and access, as well as on strengthening the capacity of local and tribal public health partners to implement prevention strategies. These efforts address disconnects in HIV PrEP use and access, especially for people facing barriers like geographic isolation, stigma, and a limited number of providers. Strategies focused on risk mitigation, community-based prevention, and partnerships with organizations serving people who use drugs were identified to support efforts to decrease transmission among PWID and individuals with overlapping risks.

For the Treat pillar, the goals are to improve timely linkage to care, raise viral suppression rates, and strengthen case management and care coordination. These strategies address gaps in linking people to care and keeping them in care, as identified in this analysis, and highlight the importance of support services such as housing and assistance with navigating insurance. Efforts to advance data-to-care approaches, expand Ryan White case management capacity, and improve continuity of care across systems, notably for people transitioning from correctional settings, are meant to reduce barriers and improve health for people living with HIV.

The Respond pillar goals focus on strengthening surveillance, outbreak detection, and the ability of local and tribal public health teams to respond to HIV clusters and outbreaks. These strategies help address emerging trends in a timely manner and ensure that prevention and care services can be implemented quickly in communities experiencing

rising transmission. Building local and tribal capacity for case investigation, data use, and response planning is particularly important in Montana's rural and geographically dispersed context.

Across all pillars, there is consistent emphasis on addressing structural and systemic factors that drive inequities in HIV outcomes, including workforce shortages, geographic isolation, lack of culturally responsive care, and social stigma. Many objectives highlight working with tribes, local and tribal public health jurisdictions, and community-based organizations recognizing that effective strategies must be locally guided and approached with an understanding and sensitivity of communities' cultures. In addition, strategies that improve care coordination, streamline connections to support services, and expand access to services in non-clinical settings demonstrate a strong commitment to addressing the social determinants of health that affect HIV outcomes.

Together, these goals and objectives intend to close equity gaps for populations most affected by HIV in Montana, including MSM, PWID, AI/AN, and Hispanic populations and communities. Through aligning prevention, care, and response strategies with identified needs and system gaps, this plan's framework supports a comprehensive and equitable approach to HIV outcomes and public health across the state.

Section V – 2027-2031 Goals and Objectives

Diagnose

Goal 1: Increase healthcare provider knowledge, skills, and comfort in discussing sexual health to reduce stigma and promote routine HIV, STI, and viral hepatitis testing across Montana

Objectives/Strategies:

1. Through December 31, 2031, provide at least four virtual training sessions per year to support routine, opt-out testing, and stigma reduction among health care providers.
 - a. Develop and implement a standardized virtual training curriculum aligned with current HIV, STI, and viral hepatitis testing algorithms and screening guidelines, and stigma reduction best practices.

- b. Align virtual training topics and messaging for HIV Project ECHOs input from the HPG Outreach and Education Workgroups to ensure consistent statewide guidance on routine testing and stigma reduction.
2. By December 31, 2027, provide at least one health care provider training on conducting comprehensive sexual health assessments.
3. Through December 31, 2031, provide outreach and resources at a minimum of two medical conferences per year.
4. By December 31, 2027, develop and disseminate a testing resource, including opt-out testing, for providers and clinics.
5. By December 31, 2027, partner with Montana Primary Care Association to strengthen routine HIV and STI testing in FQHCs by identifying and implementing two system-level strategies and establishing an annual outreach effort to promote the Syndemic Symposium to primary care providers.

Responsible Parties: Montana DPHHS HIV, STI, Viral Hepatitis, Ryan White Part B Programs,

Key Partners: Montana HIV Planning Group (HPG), AIDS Education Training Center (AETC), Montana Primary Care Association (MPCA), Local and Tribal Health Departments, Federally Qualified Health Centers (FQHCs), University of Montana Public Health Training Center (MPHTC)

Performance Measures:

- # of virtual training sessions conducted annually
- # of sexual health assessment trainings conducted
- # of medical conferences at which outreach was conducted
- # of testing resources developed and disseminated
- # of system-level testing strategies identified and implemented
- # of health care providers who attend the Syndemic Symposium annually

Progress towards national HIV goals: Prevent new HIV infections by increasing provider capacity to implement routine and opt-out HIV testing, conduct sexual health assessments, and reduce stigma around HIV and sexual health conversations; Achieve integrated, coordinated efforts that address the HIV epidemic through provider workforce development, statewide training coordination, and strategic partnerships with organizations such as AETC and MPCA; Reduce HIV-related disparities and health inequities

Goal 2: Strengthen the capacity of public health partners to promote routine testing, address sexual health, and provide HIV/STI referrals

Objectives/Strategies:

1. Provide at least three educational opportunities per year to local and tribal public health jurisdictions and other public health partners through December 31, 2031.
 - a. Deliver at least three virtual training sessions per year through December 31, 2031.
 - b. Support and promote the in-person Syndemic Symposium to local and tribal public health jurisdictions and other public health partners to maintain at least 100 attendees per year.
 - c. Support and promote at least one CTRS in person training.
2. Disseminate existing HIV/STI testing resources for local and tribal public health jurisdictions and other public health partners by December 31, 2027.
 - a. Review and update existing resources to ensure they are timely and relevant.
 - b. Ensure existing resources are accessible to public health partners.
3. Develop or identify and disseminate materials to promote routine testing and sexual health to local and tribal public health jurisdictions and other public health partners by December 31, 2028.
4. Provide local and tribal public health partners with youth-friendly resources to promote understanding of sexual health assessments, encourage communication with providers, and support HIV/STI testing and referral by December 31, 2028.

Responsible Parties: Montana DPHHS HIV, STI, Viral Hepatitis, Ryan White Part B Programs

Key Partners: Tribal and Local Health Departments, Youth-Serving Organizations, University of Montana Public Health Training Center (MPHTC), Montana HIV Planning Group (HPG), STI Clinics, HIV Prevention Subrecipients

Performance Measures:

- # of educational opportunities provided annually

- # of virtual trainings completed
- Resource inventory reviewed and updated
- # of resources posted on MT DPHHS STI/HIV/Viral Hepatitis website
- # materials developed or identified and distributed
- # of youth-focused resources developed and disseminated

Progress towards national HIV goals: Prevent new HIV infections by increasing the capacity of local and tribal public health partners to promote routine HIV/STI testing, sexual health education, and referrals to prevention services. Achieve integrated, coordinated efforts that address the HIV epidemic through workforce development, partner education, resource dissemination, and strengthened collaboration

Goal 3: Increase the number of people diagnosed early before disease progression to Stage 3 HIV, from 80% to 85%

Objectives/Strategies:

1. By December 31, 2031, conduct at least 2,400 community-based point-of-care HIV tests per year.
 - a. Contract with at least 6 HIV Prevention subrecipients to provide HIV testing in the community.
 - b. Subrecipients will increase testing by 10% from a baseline of 2,419 tests (2025) to 2,660 tests by December 31, 2031.
 - c. Provide a Memorandum of Agreement with 8 or more organizations across Montana to provide HIV, hepatitis C, and syphilis POC testing annually between 2027 and 2031.
 - d. Increase the number of HIV tests that public health partners that have signed an MOA with DPHHS provide by 25% from a baseline of 112 (2025) to 140 by December 31, 2031.
 - e. Increase HIV/HCV co-infection testing at subrecipient community-based prevention programs from 77% to 85%
2. Through December 31, 2031, DPHHS will conduct internal case review of 100% of late diagnoses (Stage 3 HIV) to identify missed opportunities and inform future activities.

3. By December 31, 2031, increase access to HIV tests in community settings by expanding access to HIV testing in pharmacy settings and through mobile testing units (baseline 0 reported).
 - a. By December 31, 2028, the HIV Prevention Program will collaborate with Montana's Rural Health Transformation Program to establish reimbursement for pharmacy-based testing.
 - b. By December 31, 2028, the HIV Prevention Program will collaborate with Montana's Rural Health Transformation Program to establish mobile unit HIV testing.
4. By December 31, 2031, increase the number of Montana communities with at least one vending machine dispensing HIV self-test kits from 0 to 10.
 - a. By December 31, 2027, assess and document the current availability of public health vending machines across the state to establish a baseline
 - b. Identify, compile, and share information on public health vending machines with high-quality features (e.g., automated data collection)
5. By December 31, 2027, establish a standardized process for collecting results from distributed HIV self-tests (e.g., QR code-based reporting).

Responsible Parties: Montana DPHHS HIV Prevention & Surveillance Programs

Key Partners: HIV Prevention subrecipients, community-based organizations, local and tribal health departments, Montana Rural Health Transformation Program, community pharmacies, FQHCs, vending machine vendors, Montana DPHHS

Performance Measures:

- # of community-based HIV tests completed annually
- # of testing subrecipients funded
- # of MOAs executed
- # of organizations conducting testing
- % increase of HIV tests conducted compared to 2025 baseline
- HIV/HCV co-testing rate among subrecipient programs (77% → 85%)
- % of Stage 3 diagnoses reviewed
- % of case reviews completed annually
- # of missed testing opportunities identified
- # of pharmacy-based testing sites established

- # of tests conducted through pharmacy settings
- # of mobile testing units providing HIV testing
- # of tests conducted through mobile testing
- # of communities with HIV self-test vending machines
- # of self-test kits distributed by vending machines
- Standardized self-test reporting process developed

Progress towards national HIV goals: Prevent new HIV infections and improve HIV-related health outcomes of people with HIV by expanding access to HIV testing in community, pharmacy, and mobile settings; increasing availability of HIV self-testing; identifying missing testing opportunities through review of late diagnoses; and promoting earlier diagnosis and linkage to care

Goal 4: Strengthen statewide HIV testing, partner services, and referral infrastructure to ensure timely linkage to testing and care

Objectives/Strategies:

1. Provide partner services training to local and tribal public health jurisdictions and other public health partners by December 31, 2031.
 - a. Provide one in-person training by December 31, 2031
2. Increase the percentage of named partners of HIV cases who receive appropriate follow-up testing from 50% to 65% by December 31, 2027.
 - a. Establish baseline, develop standard protocols and data collection tool, and provide training to support consistent implementation of partner services
3. By December 31, 2031, ensure at least 85% of STI cases that are not lost to follow-up receive a referral for an HIV test.
 - a. Provide at least one virtual training per year for local and tribal public health jurisdictions aimed at improving data collection of HIV test referrals for STI cases.
 - b. Create and disseminate at least one resource for local and tribal public health jurisdictions to improve linkage to HIV testing for people diagnosed with a sexually transmitted infection.

Responsible Parties: Montana DPHHS STI and HIV Prevention & Surveillance Programs, Local and Tribal Public Health Departments, Montana DPHHS Informatics Section

Key Partners: Local and Tribal Public Health, FQHCs, Ryan White providers, healthcare providers and clinics, Montana DIS

Performance Measures:

- # of partner services trainings conducted annually
- % of named partners receiving HIV testing
- % of STI cases receiving an HIV testing referral
- # of STI cases eligible for referral
- # of HIV testing referrals documented
- # of virtual trainings conducted
- # of resources developed and disseminated

Progress towards national HIV goals: Prevent new HIV infections and improve HIV-related health outcomes of people with HIV by strengthening partner services infrastructure, increasing HIV testing among named partners and people diagnosed with an STI, promoting earlier diagnosis and linkage to prevention and care services, and improving referral systems

Prevent

Goal 1: Increase PrEP screening, access, and utilization.

Objectives/Strategies:

1. By December 31, 2031, increase the percentage of individuals tested for HIV through subrecipients and MOA holders who are screened for HIV PrEP eligibility from 86% to 90%.
2. By December 31, 2031, increase the percentage of PrEP-eligible individuals identified by subrecipients and MOU holders who are referred and/or linked to PrEP services from 57% to 75%.
3. Through December 31, 2031, provide at least one virtual training per year on prescribing HIV PrEP to health care providers.
4. By December 31, 2031, implement at least three new statewide PrEP promotion strategies.

Responsible Parties: Montana DPHHS HIV Prevention Program

Key Partners: HIV Prevention MOU holders, HIV Prevention Program subrecipients, University of Montana Public Health Training Center (MPHTC), AIDS Education Training Center, community-based organizations, FQHCs, local and tribal public health

Performance Measures:

- % of individuals receiving HIV testing who are screened for PrEP eligibility
- % of identified PrEP-eligible individuals referred to PrEP services
- % of identified PrEP-eligible individuals linked to PrEP services
- # of PrEP trainings conducted annually
- # of new PrEP promotion strategies implemented

Progress towards national HIV goals: Prevent new HIV infections by increasing PrEP screening, improving linkage and referral processes to PrEP services, expanding provider knowledge and capacity to prescribe PrEP, implementing statewide strategies to increase awareness and utilization of PrEP among those who may benefit

Goal 2: Build local and tribal public health workforce capacity to prevent HIV.

Objectives/Strategies:

1. Through December 31, 2031, provide at least two public health workforce trainings per year to strengthen knowledge and skills on HIV prevention strategies.
 - a. Offer virtual training sessions for public health professionals on the following topics:
 - i. PrEP and PEP
 - ii. Partner services
 - iii. Community engagement and complementary and alternative strategies, etc.
2. Through December 31, 2031, conduct outreach and education at least once per year at public health conferences.
3. Through December 31, 2031, host an annual in-person Syndemic Symposium to provide education, resources, and strategies related to HIV prevention and care.

Responsible Parties: Montana DPHHS HIV, STI, Viral Hepatitis Programs

Key Partners: Montana HPG, Local and tribal public health, AIDS Education Training Center (AETC), University of Montana Public Health Training Center (MPHTC)

Performance Measures:

- # of workforce trainings conducted annually
- # of PrEP/PEP trainings delivered
- # of partner services trainings delivered
- Planning and implementation of Syndemic Symposium
- # of public health conferences at which outreach and education was conducted
- # of community engagement activities

Progress towards national HIV goals: Achieve integrated, coordinated efforts that address HIV-related health and social needs and prevent new HIV infections by strengthening the knowledge, skills, and capacity of local and tribal public health to implement HIV prevention strategies, expand community engagement efforts, and support coordinated statewide HIV prevention activities

Goal 3: Promote community prevention strategies and syndemic approaches to decrease transmission of HIV in people at risk of HIV due to injection drug use.

Objectives/Strategies:

1. Strengthen contractor and community implementation of community prevention strategies by supporting the Pathways to Wellness Coalition through December 31, 2031.
 - a. Hold at least two Pathways to Wellness Coalition meetings per year for community prevention services.
2. Distribute condoms, supplies, and prevention resources to program partners biannually and provide guidance on distribution strategies through December 31, 2031.
3. Develop and disseminate at least two educational resources for people who are at higher risk of HIV by December 31, 2027.
4. Identify and disseminate at least two resources about HIV prevention strategies for providers who work with people who use drugs by December 31, 2027

Responsible Parties: Montana DPHHS HIV, STI, Viral Hepatitis Programs, Pathways to Wellness Coalition,

Key Partners: Pathways to Wellness Coalition, HIV prevention subrecipients, community-based organizations, local and Tribal public health, FQHCs, Ryan White providers

Performance Measures:

- # of coalition meetings held annually
- # of condom distribution events or shipments completed
- # of educational resources developed and disseminated
- # of provider resources disseminated

Progress towards national HIV goals: Prevent new HIV infections by strengthening community-based HIV prevention efforts, expanding access to prevention resources and supplies, increasing education for people who use drugs and the providers who serve them, and supporting coordinated syndemic approaches to reduce HIV transmission risk

Treat

Goal 1: Improve HIV health outcomes for people living with HIV in Montana

Objectives/Strategies

1. By December 31, 2027, at least 85% of people with new HIV diagnosis within the previous 12 months will have either a CD4 count or viral load test within 30 days of diagnosis.
 - a. As new cases are reported, offer technical assistance to local and tribal public health jurisdictions on linkage to timely care for new HIV diagnoses.
 - b. Collaborate with AETC to work with providers on seamless linkage to care
2. By December 31, 2027, the percentage of newly diagnosed individuals evaluated for Ryan White program eligibility within 30 days of diagnosis will be at least 85%.
3. By December 31, 2027, develop and distribute statewide guidance on rapid-start antiretroviral therapy (ART).

Responsible Parties: Montana DPHHS Ryan White Part B Program, Montana DPHHS HIV Prevention & Surveillance Program, Montana AIDS Drug Assistance Program (ADAP)

Key Partners: Ryan White medical providers, FQHCs, local and tribal public health, infectious disease providers, AIDS Education Training Center (AETC), Ryan White medical case managers

Performance Measures:

- % of newly diagnosed individuals with a CD4 or viral load test completed within 30 days
- # of newly diagnosed individuals linked to HIV care within 30 days
- % of newly diagnosed individuals evaluated for Ryan White eligibility within 30 days
- Development and dissemination of rapid-start ART guidance

Progress towards national HIV goals: Improve HIV-related health outcomes of people with HIV by improving timely linkage to HIV care, increasing access to Ryan White services, promoting rapid initiation of ART, strengthening systems that support improved health outcomes for people newly diagnosed with HIV

Goal 2: Increase engagement in HIV care for people living with HIV

Objectives/Strategies:

1. Increase viral suppression in people diagnosed with HIV statewide from 79% to 85% by December 31, 2027
2. Create and distribute a resource guide for local and tribal public health jurisdictions and other public health partners to strengthen their capacity to review HIV labs and connect people living with HIV, both newly and previously diagnosed, to care and support services by December 31, 2028.
3. Create and distribute a resource for health educators (e.g., nursing program staff) to strengthen their capacity to review HIV lab results and connect people living with HIV, both newly and previously diagnosed, to care and support services by December 31, 2028.
4. Support local and tribal public health jurisdictions in linking individuals living with HIV to treatment and support services by providing biannual reports including identified names and last known locations through established data-to-care protocols through December 31, 2031.
5. Develop and distribute a Data-to-Care toolkit, including Ryan White resources, for local and tribal public health jurisdictions by December 31, 2027.
6. Implement at least one statewide quality improvement project focused on re-engagement in HIV care for people living with HIV and not in care through the Ryan White Clinical Quality Management (CQM) workgroup by December 31, 2027.
 - a. As part of the Ryan White CQM workgroup, create and implement a tool to assess the reasons clients have left the Ryan White program.

- b. Use the findings from strategy A to guide Ryan White re-engagement strategies.

Responsible Parties: Montana DPHHS Ryan White Part B Program, Montana DPHHS HIV Prevention & Surveillance Program, Montana DPHHS Ryan White Part B Clinical Quality Management Program

Key Partners: Ryan White providers, Ryan White sub recipients, Ryan White medical case managers, infectious disease providers, FQHCs, local and tribal public health, ADIS Education Training Center (AETC)

Performance Measures:

- % of people living with HIV who are virally suppressed
- Development and distribution of HIV resource guide for local and tribal public health
- Development and distribution of HIV resource guide for health educators
- # of biannual data-to-care reports distributed
- Development and distribution of data-to-care toolkit
- Implementation of re-engagement quality improvement project
- Development of disengagement assessment tool
- # of re-engagement strategies identified

Progress towards national HIV goals: Improve HIV-related health outcomes of people with HIV by improving retention and re-engagement in HIV care, improving data-to-care efforts, increasing viral suppression, improving coordination between public health and Ryan White care systems

Goal 3: Strengthen and sustain Ryan White case management and care coordination

Objectives/Strategies:

1. Annually, offer certified insurance navigation training to Ryan White medical case managers through December 31, 2031.
2. Develop or identify, implement, and evaluate a three-tiered HIV training series (Ryan White 101, 201, 301) by December 31, 2028.
 - a. Consult with case managers to evaluate training courses and modify as needed.
 - b. Develop, distribute, and evaluate standardized Ryan White case management forms for transfer of care and service requests, including oral

care, food bank, home-delivered meals, and emergency financial assistance by December 31, 2028.

3. Host two in-person HIV care coordination and skill-building training by December 31, 2031.

Responsible Parties: Montana DPHHS Ryan White Part B Program, Ryan White Clinical Quality Management Program, ADAP Program

Key Partners: Ryan White medical case managers, Ryan White service providers, Ryan White Part B Program subrecipients, Medicare/Medicaid subject matter experts, local and tribal public health, FQHCs, AETC

Performance Measures:

- # of insurance navigation training offered annually
- # of Ryan White case managers completing insurance navigation training
- # of Ryan white case managers who participated in the identified HIV case management training series
- # of standardized forms developed and distributed
- # of in-person HIV care coordination and skill-building trainings

Progress towards national HIV goals: Improve HIV-related health outcomes of people with HIV and achieve integrated, coordinated efforts that address HIV-related health and social needs by strengthening Ryan White case management, improving care coordination, increasing access to insurance and support services, promoting a consistent and statewide approach to engaging and retaining people living with HIV in care

Goal 4: Improve continuity of care for people living with HIV across systems and settings

Objectives/Strategies:

1. Implement an integrated CAREWare system across the state to streamline Ryan White data infrastructure by December 31, 2027.
2. Establish a coordinated process with the Montana State Prison to ensure continuity of HIV care for individuals upon release by December 31, 2028.
3. Develop and distribute a toolkit to assist local and tribal public health jurisdictions in coordinating reentry, linkage to care, and available support services for people living with HIV transitioning from Department of Corrections (DOC) facilities by December 31, 2028

4. Establish and sustain a coordinated meeting with tribal jurisdictions to improve continuity of HIV care for American Indians living with HIV by December 31, 2031
5. Identify and implement one strategy to strengthen coordination with MT DPHHS Medicaid and Office of Public Assistance to streamline eligibility and reduce administrative barriers for Ryan White clients to access Medicaid by December 31, 2028.
6. Sustain the HIV Treatment Partner Group with at least two meetings annually through December 31, 2031.
7. Strengthen the alignment between HIV prevention and treatment priorities within the HIV Partners Group by collaborating with the HIV Planning Group (HPG) to incorporate coordinated prevention and treatment priority discussions in HPG meetings at least twice annually through December 31, 2031.

Responsible Parties: Montana DPHHS Ryan White Part B Program, Montana DPHHS HIV Prevention & Surveillance Program, Montana DPHHS Medicaid Division, Montana Office of Public Assistance

Key Partners: Ryan White providers, Ryan White medical case managers, Ryan White Part B subrecipient, local and tribal public health, Montana Department of Corrections (DOC), Montana Office of Public Assistance, Medicaid Division, HPG

Performance Measures:

- Implementation of integrated CAREWare system
- Continuity-of-care protocol established with Montana State Prison
- Develop and distribute re-entry tool for local and Tribal public health working with individuals living with HIV who are transitioning from DOC facilities
- # of tribal coordination meetings held annually
- Implementation of strategy to better coordinate with MT DPHHS Medicaid and OPA
- # of HIV Treatment Partners Group meetings held annually
- # of joint HIV prevention-treatment discussions incorporated into HPG meetings annually

Progress towards national HIV goals: Improve HIV-related health outcomes of people with HIV and achieve integrated, coordinated efforts that address HIV -related health and social needs by strengthening continuity of care across public health, correctional, tribal, and social service systems; improving care transitions and access to services; enhancing statewide coordination among HIV prevention and treatment partners

Respond

Goal 1: Strengthen capacity and execution of HIV detection and response activities

Objectives/Strategies:

1. Conduct annual reviews and updates of the Montana HIV and Viral Hepatitis Cluster Detection and Outbreak Response Plan through December 31, 2031.
2. Through December 31, 2031, present the Montana HIV and Viral Hepatitis Cluster Detection and Outbreak Response Plan, and any current outbreak updates, during at least one of the biannual HPG meetings.
3. Develop, implement, and evaluate a HIV outbreak response tabletop exercise on HIV outbreak response for local and tribal public health jurisdictions by December 31, 2027.

Responsible Parties: Montana DPHHS HIV Prevention & Surveillance Program, Montana DPHHS Epidemiology and Scientific Support Bureau, Montana DPHHS Viral Hepatitis Prevention Program

Key Partners: Local and Tribal public health, HPG, Rocky Mountain Tribal Epidemiology Center, Community-based organizations

Performance Measures:

- # of annual plan reviews completed
- # of plan updates incorporated
- # of HPG presentations conducted
- # of outbreak updates shared
- Development and implementation of tabletop exercise

Progress towards national HIV goals: Achieve integrated, coordinated efforts that address HIV-related health and social needs by strengthening statewide HIV outbreak response preparedness, enhancing coordination among state, local, and tribal public health partners, and improving capacity to quickly detect, investigate, and respond to HIV clusters and outbreaks

Goal 2: Increase local and tribal public health capacity to conduct HIV case investigations

Objectives/Strategies:

1. Through December 31, 2031, provide at least one annual training opportunity on conducting an HIV case investigation for local and tribal public health jurisdictions.
2. Through December 31, 2031, update MT DPHHS website annually with resources that local and tribal public health jurisdictions need to conduct HIV case investigations.
 - a. CDC guidelines
 - b. Partner services resources
 - c. Ryan White resources
 - d. Case investigation guidelines for new and previously diagnosed HIV cases
3. Through December 31, 2031, offer 1:1 technical assistance to local and tribal public health jurisdictions on HIV case investigation and partner services for new diagnoses.

Responsible Parties: Montana DPHHS HIV Prevention & Surveillance Program, Montana DPHHS Ryan White Part B Program

Key Partners: Local and tribal public health, Ryan White providers, Ryan White case managers, Montana DIS Project ECHO, AETC

Performance Measures:

- # of annual training opportunities provided
- Website and resource review and update completed annually
- % of new diagnoses receiving technical assistance support

Progress towards national HIV goals: Achieve integrated, coordinated efforts that address HIV-related health and social needs by strengthening local and tribal public health capacity to conduct HIV case investigations, implement partner services, utilize surveillance systems, and coordinate linkage-to-care activities through training, technical assistance, and resource development

Goal 3: Strengthen surveillance and laboratory monitoring to detect and respond to HIV outbreaks and clusters.

Objectives/Strategies:

1. Through December 31, 2031, at least 60% of persons diagnosed with HIV will have received drug resistance (genetic sequencing) testing within 12 months of HIV diagnosis.
2. Through December 31, 2031, conduct monthly time-space analysis and genetic sequencing analysis to identify potential clusters.

Responsible Parties: Montana DPHHS HIV Prevention & Surveillance Program,

Key Partners: Public health and clinical laboratories, local and tribal public health Disease Intervention Specialists, Ryan White providers, infectious disease providers, Montana Ryan White Part B subrecipients

Performance Measures:

- % of newly diagnosed individuals with a reported HIV nucleotide sequence within 12 months of diagnosis
- # of monthly time-space and genetic sequence analyses completed

Progress towards national HIV goals: Prevent new HIV infections and achieve integrated, coordinated efforts that address HIV-related health and social needs by strengthening molecular HIV surveillance, increasing genetic sequencing coverage, improving early identification of HIV clusters, and enhancing the state's ability to quickly implement data-driven prevention and outbreak response activities

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

Implementation

Implementation of the 2027-2031 HIV integrated plan will be led by the MT DPHHS HIV Prevention and Surveillance Programs, the Ryan White Part B Program, and the Montana AIDS Drug Assistance Program. It will require collaboration and thoughtful syndemic coordination of capacity and resources with program partners, planning bodies, and community stakeholders, including AIDS Education Training Center (AETC), University of Montana, Montana HIV Planning Group, and Montana Viral Hepatitis Advisory Council (VHAC).

Montana DPHHS HIV Prevention Program, HIV Surveillance Program, and Ryan White Part B Program will regularly review and assess progress toward achieving the goals and objectives outlined in this plan. This process will include identifying needs, gaps, and barriers that may have surfaced during implementation and are limiting progress. MT DPHHS HIV programs will also regularly convene stakeholders and planning bodies to share implementation updates, discuss successes and challenges, emerging needs and priorities, and solicit feedback to help guide future strategies and activities. Additionally, updated surveillance and epidemiological data will be presented to support monitoring trends, identify emerging needs, and plan the implementation of future activities.

DPHHS will collaborate with planning bodies and stakeholders throughout the implementation of activities to ensure strategies remain responsive and effective. Stakeholders will be asked to provide feedback on activities to ensure the strategies are appropriate for reaching the priority populations and align with the plan's goals, objectives, and community needs.

Monitoring

Ongoing monitoring of the 2027-2031 HIV Integrated Plan will be necessary to support successful implementation and to assess progress toward achieving the plan's goals and desired health outcomes. MT DPHHS will review implementation progress bi-annually using available programmatic, surveillance, and performance data, as well as stakeholder feedback.

Monitoring activities will be coordinated across state and local planning efforts to support alignment of priorities, improved health outcomes, and identify gaps in prevention, care, and support services. Montana DPHHS HIV programs will coordinate implementation activities across multiple funding streams, including CDC and Ryan White HIV/AIDS Program (RWHAP) resources, to support aligned implementation of plan priorities and efficient use of statewide resources. Coordination of implementation activities, timelines, and evaluation efforts will support consistent monitoring and ongoing assessment of progress made across the state.

Data to monitor performance will be obtained from the Montana Infectious Disease Information System (MIDIS), CAREWare, EvaluationWeb, and other electronic systems used by contracted providers. Data will be collected and analyzed by DPHHS for use in progress assessments, reporting activities, and ongoing evaluation of implementation efforts and processes.

Feedback on implementation progress, priorities, and emerging needs will be gathered through collaboration with Ryan White Part B partners, the Montana HIV Planning Group, and other stakeholders involved in HIV prevention, care, and support services.

Evaluation

Periodic evaluations will be conducted to assess the effectiveness of implementation strategies and progress toward achieving the goals, objectives, and intended health outcomes outlined in this plan. The evaluation will assess whether strategies and activities are being implemented as planned and contributing meaningfully to HIV prevention, care, and support services across Montana, as well as to the individual experience of receiving HIV care.

Evaluation will include both quantitative and qualitative measures. Quantitative measures will include an annual review of performance measures, objectives, and data indicators identified in the plan. Qualitative measures will incorporate stakeholder and community feedback gathered through formal and informal engagement activities. In addition, surveillance reports for HIV, hepatitis C, and STIs are developed annually. The reports will be used to evaluate implementation progress, monitor trends, and assess progress towards the plan's goals.

Improvement

The HIV Integrated Plan serves as a living document that may be refined throughout the implementation period. If emerging trends, updated data, identified gaps, and stakeholder input gathered through monitoring activities support the need for modifications to the plan, potential revisions and implementation adjustments will be discussed collaboratively with the MT DPHSS HIV programs and planning partners during biannual HPG meetings. Agreed-upon revisions will be finalized and formally incorporated into the plan, and updated versions of the plan will be presented to the HPG annually at the Fall HPG meeting. Revisions and implementation adjustments will support continuous quality improvement and alignment with statewide HIV prevention and care needs.

Program data, community input, and stakeholder feedback will be essential components of the improvement process. Data gathered through surveillance reports, performance measures, and stakeholder feedback during monitoring and evaluation activities will inform the assessment of progress towards the plan's goals and objectives and help identify opportunities for improvement. Findings from monitoring and evaluation

activities will also help inform future strategies, policies, and program priorities throughout the implementation period.

Reporting and Dissemination

Reporting and disseminating the Integrated HIV Prevention and Care Plan will occur digitally, with updated plan materials posted on the Montana DPHHS STI/HIV/Viral Hepatitis Section website. Electronic versions of the plan and relevant updates pertaining to plan implementation, monitoring, evaluation, and improvement will be shared with the Montana HPG, RWHAP Part B planning body members, people living with HIV, program partners, providers, and other stakeholders to ensure access to the most current information.

Progress updates and findings on plan implementation, monitoring, and evaluation efforts will continue to be presented and discussed during the biannual HPG meetings and other appropriate stakeholder engagement opportunities. These updates will inform collaborators of progress made, emerging needs and trends, and any revisions or implementation adjustments that have been formalized into the plan.

Additionally, Montana DPHHS will develop dissemination materials related to the plan to provide a brief summary, key information, and updates to stakeholders and the public in a clear and accessible manner.

Appendix A

Letter of Concurrence – HPG Co-Chairs

To Whom It May Concern:

The Montana HIV Planning Group (HPG) *concur*s with the following submission by the Montana Department of Public Health and Human Services in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV Prevention (DHP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need (SCSN) for calendar year (CY) 2027-2031.

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

The Montana HPG provided input throughout the development of the 2027-2031 HIV Integrated Prevention and Care Plan. Group members participated in discussions to identify priorities and provide feedback on the proposed goals, objectives, and strategies at the Fall 2025 and Spring 2026 biannual Montana HPG meetings. Additional input was gathered through stakeholder engagement meetings and surveys. Prior to submission, the planning body reviewed the final draft of the plan.

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

X Shannon Koenig 6/29/2026

X David Herrera 6/29/2026

Letter of Concurrence – Ryan White HIV/AIDS Program Part B

To Whom It May Concern:

The Montana Ryan White Part B Planning Council *concurs* with the following submission by the Montana Department of Public Health and Human Services in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV Prevention (DHP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need (SCSN) for calendar year (CY) 2027-2031.

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

The Montana Ryan White Part B Planning Body provided input throughout the development of the 2027-2031 HIV Integrated Prevention and Care Plan. Planning body members participated in discussions to identify priorities and provide feedback on the proposed goals, objectives, and strategies at the Fall 2025 and Spring 2026 biannual Montana HPG meetings. Additional input was gathered through stakeholder engagement meetings and surveys. Prior to submission, the planning body reviewed the final draft of the plan.

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

X Robert Elkins 6.29.2026

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