Keeping Connecticut Healthy

DPH

Connecticut Department of Public Health

State of Connecticut Integrated HIV Prevention and Care Plan 2022 – 2026

A Syndemic Approach to Ending the HIV Epidemic

Greater Hartford Ryan White Part A Planning Council

CHPC
CONNECTICUT HIV PLANNING CONSORTIUM

NEW HAVEN / FAIRFIELD COUNTIES
RYAN WHITE PLANNING COUNCIL

December 9, 2022

Table Of Contents[1]

TABLE OF CONTENTS 2

ACKNOWLEDGEMENTS 3

COMMON ACRONYMS 4

COMMON TERMS 5

1. EXECUTIVE SUMMARY 6

2. COMMUNITY ENGAGEMENT & DESCRIPTION OF JURISDICTIONAL PLANNING PROCESS 12

3. CONTRIBUTING DATA SETS AND ASSESSMENTS 20

    a. Epidemiologic Snapshot 21

    b. HIV Prevention, Care and Treatment Resource Inventory 49

    c. Needs Assessment 52

4. SITUATIONAL ANALYSIS OVERVIEW INCLUDING PRIORITY POPULATIONS 61

5. CY 2022-2026 GOALS AND OBJECTIVES 67

6. IMPLEMENTATION, MONITORING, AND EVALUATION 82

7. LETTERS OF CONCURRENCE 86

8. APPENDIXES 94

Appendixes

Appendix 1: HIV/AIDS – Resource Summary for Connecticut Residents Available to the Public through the United Way of Connecticut 211 (Last modified May 2022) 94

Appendix 2. Reference Materials Connecticut HIV Epidemiological Profile, 2021 96

Appendix 3: Connecticut HIV Planning Consortium Material 100

[1] The table of contents follows the required format contained in the CY2022-2026 CDC DHAP and HRSA HAB Integrated Prevention and Care Plan Guidance Checklist.

Living Document

This Plan represents a "living document" and a starting point that HIV-related partners and parties will use to expand continued coordination and collaboration to advance shared goals, objectives, strategies, and indicators. For example, Statewide HIV Prevention Survey is currently underway, and the results will affect the plan implementation.

Acknowledgements

Narrative Sections of this Plan were written by the following entities:

- The CHPC Contractor, Cross Sector Consulting LLP Staff
- DPH HIV Prevention Program Staff
- DPH Ryan White Part B Program Staff

Sections pertaining to Needs Assessment and Data Sets were provided by the following:

- DPH Surveillance Staff
- RWPA Partners

Contributions were provided by the following entities:

- Ryan White Part A Eligible Metropolitan Area – New Haven and Fairfield Counties
- Ryan White Part A Transitional Grant Area – Hartford
- Ryan White Part B Statewide – Connecticut Department of Public Health
- HIV Prevention Statewide – Connecticut Department of Public Health
- Connecticut Department of Public Health Ending the Syndemic Partners Group
- Connecticut HIV Planning Consortium and its Committees
- Connecticut HIV Funders Group
- Community Partners
- People with Lived Experiences

The Connecticut Department of Public Health has been PHAB accredited since 2017 and will be going under reaccreditation in 2023.

Common Acronyms

AETC	AIDS Education and Training Center
AIDS	Acquired Immunodeficiency syndrome
ART	Anti-Retroviral Therapy
CDC	Centers for Disease Control and Prevention
CHPC	Connecticut HIV Planning Consortium
CIRA	Center for Interdisciplinary Research on AIDS (Yale University)
CTDPH	Connecticut Department of Public Health
D2C	Data to Care
EHE	Ending the HIV Epidemic
EIIHA	Early Identification of Individuals with HIV/AIDS
EMA	Eligible Metropolitan Area
ETS	Ending the Syndemic
FQHC	Federally Qualified Health Center
G2Z	Getting to Zero
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HOPWA	Housing Opportunities for Persons With AIDS
IDU	Injection Drug Use
MAC	Membership and Awareness Committee
MSM	Men Who Have Sex with Men
NAP	Needs Assessment Projects Committee
NHAS	National HIV and AIDS Strategy
OTL	Outreach, Testing, and Linkage
PEP	Post-Exposure Prophylaxis
PLWH	Person(s)/People Living With HIV
PWID	Person(s)/People Who Injects Drugs
PWLE	Person(s)/People with Lived Experience
PWUD	People Who Use Drugs
PPCT	Positive Prevention Connecticut Committee
PrEP	Pre-Exposure Prophylaxis
QPM	Quality and Performance Measures Committee
RTS	Routine Testing Services
RWHAP	Ryan White HIV/AIDS Program
SCSN	Statewide Coordinated Statement of Ned
STI	Sexually Transmitted Infection
STD	Sexually Transmitted Disease
SUD	Substance Use Disorder
TGA	Transitional Grant Area
VH	Viral Hepatitis
WICY	Women Infant Children and Youth

Common Terms

Biomedical Prevention	The use of HIV medications either Pre-exposure Prophylaxis (PrEP) or Post-Exposure Prophylaxis (PEP) to prevent acquisition of HIV.
Comprehensive Sexuality Education	A rights-based approach to sexuality education that seeks to equip people with the knowledge, attitude, and skills needed to determine and enjoy healthy sexuality.
Disparity	Measurable differences between individuals, groups, races, religions, states, and/or nations that usually result in poorer outcomes.
Equity	Providing the same to all while recognizing not everyone starts from the same place and may need adjustments to achieve equity.
Harm Reduction	Engaging directly with People Who Use Drugs (PWUD) and meeting them without judgement where they are.
HIV Continuum of Care	A public health model that outlines the steps that people with HIV go through from diagnosis to viral suppression.
Jurisdictional Partners	Entities within the same state that have entered into an agreement to collaborate in a planning process to develop a jurisdictional plan.
Person-First Language	Language that puts a person before a particular health condition or experience.
Person With Lived Experience	People who are regarded as subject matter experts based on their firsthand experiences.
Priority Population	Populations who are vulnerable and in need of services and therefore are prioritized to receive them.
Racism	A form of prejudice that assumes that members of racial categories have distinctive characteristics that result in being treated inferior.
Stigma	The disapproval of, or discrimination against, a person based on perceivable social characteristics that serve to distinguish them from other members of a society. Social stigmas are commonly related to culture, gender, race, and health.
Status Neutral Care	An approach where all people are treated the same regardless of HIV status and receive treatment and services based on their HIV test result.
Syndemic	A set of two of more linked health conditions affecting the same people and communities that lead to greater burden of disease.

SECTION I. EXECUTIVE SUMMARY

1. Executive Summary of Integrated Plan and Statewide Coordinated Statement of Need (SCSN)

The Connecticut HIV Planning Consortium (CHPC) is Connecticut's only statewide planning body for HIV prevention and care. The diverse CHPC membership roster of approximately 30 people includes persons with lived experience as well as representatives from throughout the state who hold a connection to and passion for ending the HIV epidemic, including representatives from other Ryan White HIV AIDS Program (RWHAP) partners. The CHPC meets at least eight (8) times throughout each year and supports five working committees that expand opportunity for community engagement. CHPC meeting attendance during 2022 ranged between 50 and 93 participants. The CTDPH provides financial support for CHPC staff as well as access to data and subject matter experts who assist and serve as liaisons to the CHPC and its committees.

This Integrated Plan (Plan) represents a statewide effort in Connecticut led by the CHPC and serves as the state's plan to end the HIV epidemic. The CHPC and its partners collaborated on all planning processes and documents including the Statewide Needs Assessment, Resource Inventory, and Gap Analysis/Statewide Coordinated Statement of Need (SCSN). Plan goals and objectives include strategies and activities to meet statewide goals and are reflective of the National HIV/AIDS Strategy.

The Plan represents a logical extension of the 2017 – 2021 Integrated Plan in response to changing conditions in HIV epidemiology, service configurations, resources, systems, and policies. The ongoing activity of the CHPC and its committees and the incredible implementation work by HIV prevention and care partners effectively make Connecticut's Plan a "living" document. All future iterations of Connecticut's Integrated Plan will align with the State's Health Improvement Plan, *Healthy Connecticut 2025*.

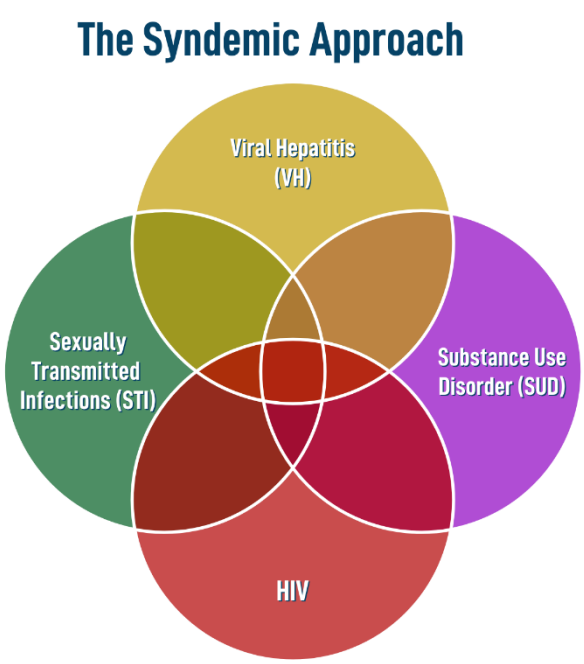
In 2018, the CTDPH Commissioner assembled a statewide Getting to Zero (G2Z) Commission in response to the alarming trends in the HIV epidemic, with emphasis on the growing number of new cases of HIV in men having sex with men (MSM) of color, Black heterosexual women, and the Transgender community. The G2Z Commission issued specific statewide and city-wide recommendations to get to zero new HIV infections, zero HIV-related deaths, and zero HIV-related stigma and discrimination in Connecticut. These recommendations provided a foundation for future HIV Prevention and Care planning.

In response to the G2Z recommendations, the CTDPH adjusted its epidemiological profile to align with the work, the CHPC established a Getting to Zero Committee to coordinate the work across the state, HIV prevention and care implementation partners enhanced and expanded services in areas such as PrEP. Next, the Ryan White Part A EMA secured one (of 10) grant awards that deepened the work through the input of more than 115 community residents and 25 providers across six urban areas to answer the question, *"What needs to happen in the next two to five years that will result in the end of the HIV epidemic in Connecticut?"* Themes and priorities emerging from this work inform the strategies included in the 2022 to 2026 Plan.

In 2021, the CTDPH began to explore adopting a syndemic approach to achieve its goals and to ultimately end the HIV epidemic. The CTDPH introduced the concept at the CHPC meetings and CHPC leadership found subject matter experts to present on viral hepatitis (VH), sexually transmitted infections (STIs), substance use disorders (SUD) and mental health to demonstrate their connection with the HIV epidemic. Partners such as the Greater Hartford Ryan White TGA were conducting groundbreaking demonstration projects to address HIV and Hepatitis C coinfections. Syndemic conversations led to change. The CHPC's Getting to Zero Committee morphed into an Ending the Syndemic Committee. The CTDPH established an Ending the Syndemic Partners Group (ETS Partners Group) to focus on policy and system-level implementation issues and ensure integration and coordination of the Plan. The CTDPH designated a full-time Ending the Syndemic Coordinator. The CHPC Quality and Performance Measures (QPM) Committee developed new statewide indicators to reflect the syndemic areas of focus in the plan.

a. Approach

The approach to create and submit the 2022-2026 Integrated Plan involved a higher level of community and partner engagement than previous plans. This community driven plan was developed through a syndemic lens while considering the impact that health equity and social determinants of health has on our communities.



The G2Z, In It to End It, and Syndemic activities produce several tipping point moments critical to ending the HIV epidemic. In 2021, community organizers with the support of legislators changed Connecticut's law to require Routine HIV Testing be offered in Primary Care Settings beginning in 2023 and Emergency Room Departments in 2024. During this same time, jurisdictional partners (RWHAP A-D and F, Prevention, HOPWA) involved in the CHPC planning process called for action to address disparities in viral load suppression of PLWH who were affiliated with RWHAP providers as compared to their counterparts who received services from non-RWHAP providers. RWHAP Part A EMA and Part B identified ways to coordinate funding and service delivery within geographic regions using hub-based approaches. CTDPH HIV Prevention will shift to this model in 2023 to strengthen the HIV prevention and care continuum.

Throughout 2021 and 2022, the CHPC leaders expanded the conversation space inviting Planning Council leaders from the Ryan White Part A EMA and TGA to share their insights, perspectives, and needs assessments. The CHPC meetings shifted into small breakout discussions to expand opportunity for input on Plan goals, objectives, strategies, and priorities. Ultimately, the CHPC Members voted to approve the Plan at its meeting on November 16, 2022.

Ending the HIV epidemic in Connecticut will require a higher emphasis on using data-to-care to improve health outcomes, engaging non-RWHAP providers, building capacity to implement routine HIV testing, status neutral care models, rapid start medications, and linkage to care coordination and supportive services. It will require rethinking how to effectively engage non-RWHAP providers and to activate and to increase knowledge equity of residents, particularly those who face social and economic injustices. This represents a significant challenge, particularly with few additional resources and challenges created by the COVID-19 pandemic, upward trends in STIs, opioid overdoses, mental health issues, other economic factors, and emerging outbreaks such as MPOX.

Plan Goals, Objectives, Strategies, and Indicators. The 2022 to 2026 Plan still organizes the work around four goal areas and key strategies in the National HIV and AIDS Strategy (NHAS). It anchors the work to a set of existing and new statewide data indicators that reflect achievable outcomes for Connecticut. These indicators hold relevance to the work of the jurisdictional partners and include an equity lens to identify disparities by subpopulations and geographic areas, among others. The subsequent pages summarize the goals and objectives as well as the statewide indicators.

The CHPC acknowledges that Connecticut's Plan differs slightly from the specific numeric indicators identified in the NHAS. For example, Goal 1 differs quantitatively from the NHAS goal of reducing new HIV infections by 75% by 2025. CHPC and CTDPH leaders consulted with the Integrated HIV/AIDS Planning Technical Assistance Center (IHAP TAC) for guidance and clarification on this matter and received feedback that Connecticut could "customize your goals while addressing the nations…." The CHPC recognizes the value of setting aspirational goals. However, the QPM Committee, with an extensive input process, set a realistic and achievable Goal 1 for 2026 that reflects the best available data and scope, the complexity of the issues in Connecticut, and the need to engage non-Ryan White funded providers and partners to make progress in areas such as implementing routine HIV testing, increasing PrEP uptake, scaling up a status neutral care approach, and increasing viral suppression rates – without any additional funding. Connecticut's Goal 1 will keep Connecticut on a trajectory to achieve the 2030 goal of reducing new HIV infections by 90% (compared to the 2019 baseline).

The following contains the CT HIV Prevention and Care Integrated Plan Goals and the CHPC Integrated Plan Indicators.

Connecticut HIV Prevention and Care Integrated Plan Goals	
Goal 1: Reduce New HIV Infections to 174 by 2026 (2019 baseline of 220).	
Objective 1.1:	Increase awareness of PLWH of their HIV status to 93% by 2026 from a baseline of 91% (2019).
Objective 1.2:	Achieve a 25% decrease in new HIV diagnoses among MSM, Black men and women, and Latino men and women.
Objective 1.3:	Expand treatment as prevention.
Goal 2: Achieve a 95% viral load suppression rate among PLWH who are in care by 2026 (vs. 90% in 2019) and an 87% viral load suppression rate among people with diagnosed HIV (vs. 74% in 2019).	
Objective 2.1:	90% of newly diagnosed PLWH attend a routine HIV care visit within 1 month of diagnosis (vs. 87% in 2019)
Objective 2.2:	Increase access by PLWH to high-quality HIV healthcare (core medical) and medication
Objective 2.3:	Increase access by PLWH to supportive services
Objective 2.4:	Expand housing for PLWH
Goal 3: Reduce HIV-related disparities and health inequities.	
Objective 3.1:	Develop a constellation of sustainable strategies to reduce HIV stigma and discrimination.
Objective 3.2:	Address social determinants of health (SDOH) through policy and partnerships.
Objective 3.3:	Implement a syndemic approach with areas of focus on sexually transmitted infections, viral hepatitis, and substance use disorders (and behavioral health).
Goal 4: Achieve integrated, coordinated efforts that address the HIV epidemic across all partners and interested parties.	
Objective 4.1:	Maintain the vitality and relevance of the Connecticut HIV Planning Consortium as a statewide HIV prevention and care planning entity.
Objective 4.2:	Strengthen collaborative workspace and capacity to improve coordination and integration of HIV services with other areas of syndemic focus.
Objective 4.3:	Increase capacity of public health system to implement Plan and respond to outbreaks or public health emergencies relevant to HIV.

2022-2026 CHPC Integrated Plan Indicators

Indicators	2019 Baseline	2026 Goal
PrEP-to-Need Ratio: The number of people taking PrEP divided by the number of people newly diagnosed with HIV	**12.0**	**36.0**
New Diagnoses: Number of people newly diagnosed with HIV	**220**	**174**
Knowledge of HIV Status: Percent of PLWH aware of their status	**91%**	**93%**
Late Testers: Percent of people presenting with or diagnosed with AIDS within 3 months of their initial HIV diagnosis	**29%**	**20%**
Linkage to Care: Percent of newly diagnosed who attended a routine HIV care visit within 1 month of diagnosis	**87%**	**90%**
Partner Services: The number of newly diagnosed clients interviewed by DIS / Partner Services	**143**	**8% increase**
Viral Load Suppression: Percent of people with diagnosed HIV who are virally suppressed Percent of PLWH in care who are virally suppressed	**74%** **90%**	**87%** **95%**
Disparities in New Diagnoses: Annual number of new HIV diagnoses among: MSM, Black men and women, and Latino men and women	**15% decrease**	**25% decrease**
Disparities in Viral Load Suppression: Viral load suppression rates among: youth and young adults, injection drug users, MSM, Black men and women, and Latino men and women.	**65% to 78% depending on population**	**85%+ for all populations**
Syringe Services Program (SSP): Number of SSP clients served Number of syringes distributed	**4,428** **1.2 million**	**9,000** **2.4 million**
Sexually Transmitted Infections (STIs): Number of syphilis cases	**210**	**204 (Projected 380 cases by 2026)***
Hepatitis C: Number of newly diagnosed chronic Hep C infections	**1,309**	**1,178**
Substance Use: Number of overdose deaths Total number of overdoses (ED Visits for suspected overdoses)	**1,528 (2021)** **12,000 (approx..)**	**1,750** **13,950 (Projected 2122 cases by 2026)***

**Projections based on historical trends in Connecticut* *Source: Quality and Performance Measures Committee, CHPC 2022*

Implementation, Monitoring, and Evaluation. The CTDPH will continue in its role as the fiduciary to support the coordination of statewide planning through the CHPC and its committees. The CHPC as a planning entity does not control or influence any funding decisions by implementation partners. In fact, partners such as the Ryan White Part A EMA and TGA maintain Planning Councils within their local jurisdictions that conduct annual priority setting and allocation decision-making processes for their respective funds. Other partners such as RWHAP Part Cs and Ds submit their funding applications and implementation plans directly to the federal government.

The CHPC and its committees will serve as an ongoing forum to expand the collaborative workspace to partner, coordinate services, and create maximum health outcomes for Connecticut's residents more effectively. The CTDPH will provide funding for the support of staff to CHPC and its committees. The CHPC will adjust its committee structure and/or refine its processes to better support implementation by partners of this Plan as well as to facilitate information flow across partners. This includes a commitment by the CHPC to move data presentations about individual CHPC indicators from the committee level to the full CHPC. The CTDPH will convene other groups to advance the system-level work of this Plan. For example, the CTDPH will convene an Ending the Syndemic Partners Group and an HIV Funders Group to address matters such as policy change, practice (e.g., standards of care), coordinated services, system-level integration, and statewide communication campaigns. RWHAP partners, the CTDPH (Prevention and Care), and other partners such as the Department of Mental Health and Addiction Services (CTDMHAS) will drive implementation and maintain accountability for strategies and activities relevant to this Plan. The CTDPH and the CHPC Quality and Performance Measures (QPM) Committee will play a leading role in facilitating data collection, reporting, monitoring and evaluation activities for this Plan as described in the next sections.

The Plan will be reviewed and updated at least annually or as needed. Multiple levels of monitoring will occur by CTDPH, the CHPC, and respective implementation partners. The CTDPH will continue in its role to collect (statewide) surveillance data and to provide subject matter experts such as epidemiologists to analyze and present annual updates to the CHPC indicators, refresh any statewide performance dashboards, and conduct any special program evaluations relevant to funding administered by their agency. Individual implementation partners will comply with data collection, quality assurance, continuous quality improvement, and reporting requirements relevant to their funding sources.

The jurisdictional partners of this Plan as well as other RWHAP partners collaborate in areas relevant to quality assurance and continuous quality improvement. All funded HIV prevention and care providers develop workplans and timelines for implementing HIV services. Ryan White service providers develop quality management plans and evaluate all services. CTDPH monitors HIV prevention services through the Evaluation Performance Measurement Plan (EPMP). The CHPC Quality and Performance Measures Committee supports cross-part collaboration and hosts a statewide annual quality management summit. The 2021 Summit theme of "Ending the HIV Epidemic – Equity, Stigma, and Engagement" featured national subject matter experts and a carousel approach that allowed participants to learn across a variety of topics including PrEP, STIs, re-engaging in care, stigma/equity, and program effectiveness.

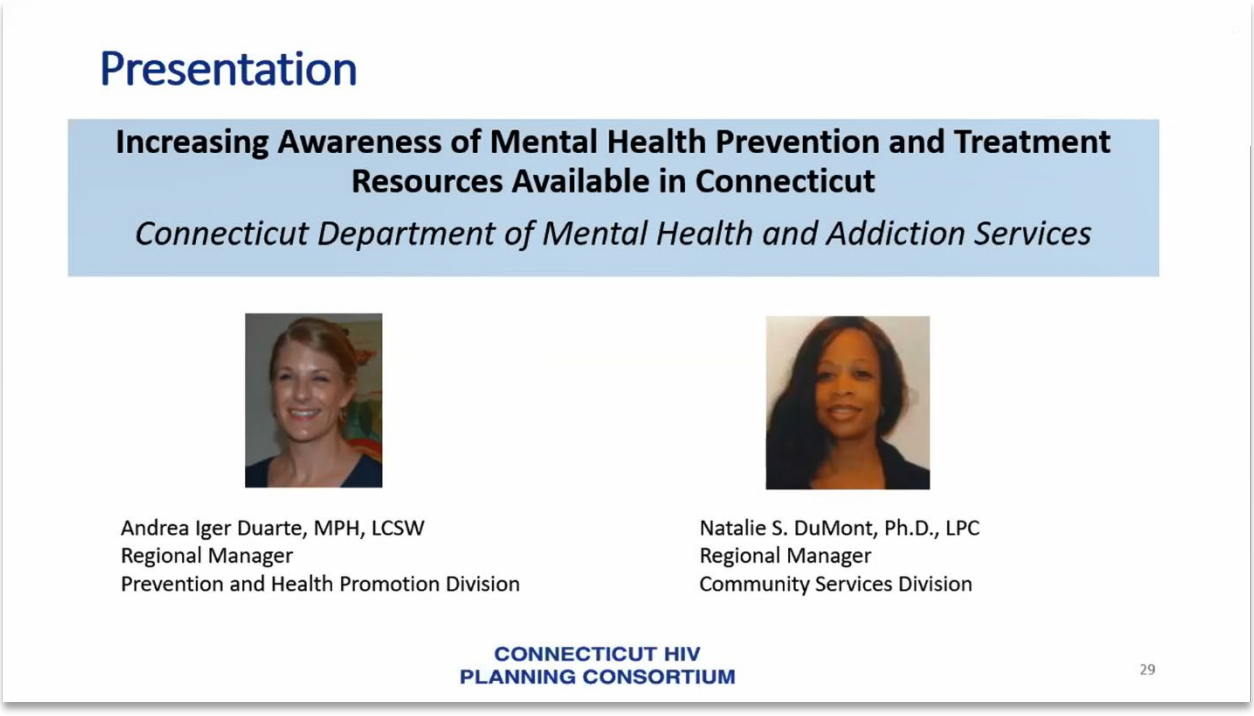
The CHPC, led by the Executive Committee and with the support of the Quality and Performance Measures (QPM) Committee, will conduct an annual review of the Plan, publish an update, and suggest any recommendations to the CHPC for mid-course adjustments. The QPM committee will guide and support the development of standardized work processes for each committee. The CHPC will engage subject matter experts affiliated with the Center for Interdisciplinary Research on AIDS (CIRA) at Yale School of Public Health to provide technical assistance in developing evaluation measures, metrics, and methodologies.

b. Documents Submitted to Meet Requirements

The Plan draws heavily on data provided in the Connecticut HIV Epidemiological Profile and/or special analyses conducted by CTDPH epidemiologists. Other inputs into the Plan include needs assessments, priority setting allocations, funding applications, and program reports from HIV Prevention and RWHAP partners to their respective funding sources. The Appendices contains a list of documents and reports used during the Plan development process such as the Statewide HIV Epidemiological Profile as well as excerpts from these documents that provide more in-depth information relevant to Plan requirements.

The Plan includes letters of concurrence from jurisdictional partners. The CHPC voted to approve the Plan on November 16, 2022. While the majority of the CHPC members voted in concurrence of the Integrated Plan, only two CHPC members voted "non-concurrence" on the basis that the Plan did not align exactly to the NHAS numeric goals irrespective of the CHPC's extensive, data-driven process to develop realistic and measurable objectives. The RWHAP Part A TGA voted non-concurrence with the Plan for the same reason. The RWHAP Part A EMA voted concurrence with reservations, with their reasons indicated in their letter found in Section 7. The CHPC leaders expressed appreciation for the high level of engagement from representatives of the Ryan White Part A EMA and TGA in the Plan development process, acknowledged that this was the starting point, and reiterated the process for making mid-course adjustments to the Plan. CHPC leaders will address through process improvement other reservations or recommendations such as sharing a full, near final plan sooner in the process.

The picture below is a screenshot from a virtual CHPC meeting that took place in March 2022, demonstrating the collaboration between the CTDPH with the Connecticut Department of Mental Health and Addiction Services to present on Mental Health Prevention and Treatment Resources available in Connecticut.



SECTION II. COMMUNITY ENGAGEMENT & JURISDICTIONAL PLANNING PROCESS

1. Jurisdiction Planning Process

Over an 18-month period (2021 to 2022), 28 diverse representatives, including PLWH, from across the state served as CHPC members. The CHPC met 18 times on the third Wednesday of the month ("CHPC Wednesday"). On average, 67 participants (range of 45 to 100) including CHPC members, met as a full group for updates, knowledge builds, and a featured presentation or small group discussions on topics relevant to the plan. Participants then attended one of five standing committee meetings.

During this time, the committee work focused intentionally on 2022 to 2026 plan development tasks and led to development of draft goals, objectives, strategies, and activities reviewed by the full CHPC during July, August, and September 2022. The CHPC conducted additional outreach sessions with the community.

The CHPC used the National HIV AIDS Strategy and the federal HIV planning guidelines as a primary reference point to develop this Plan. This created alignment and continuity with Connecticut's 2017 to 2021 Plan and a natural interface across four jurisdictional partners.

CHPC members and public participants rated their satisfaction and experience at CHPC meetings at 98% and 97%, respectively.

Throughout 2022, the CHPC leaders expanded the conversation space inviting Planning Council leaders from the Ryan White Part A EMA and TGA to share their insights, perspectives, and needs assessments. The CHPC meetings shifted into small breakout discussions to expand opportunity for input on Plan goals, objectives, strategies, and priorities. All attending members of the CHPC and guests from the community were asked to review, provide feedback, and make recommendations on the Integrated Plan during breakout sessions and Sub-Committee meetings. Ultimately, the CHPC Members voted to approve the Plan at its meeting on November 16, 2022.

a. Entities Involved in Process

This Plan represents a statewide effort in Connecticut in partnership with multiple jurisdictions and partners: the Connecticut HIV Planning Consortium (CHPC), one (1) Ryan White Health Administration Program (RWHAP) Part A- funded Eligible Metropolitan Area (EMA), one (1) RWHAP Part A-funded Transitional Grant Area (TGA), and the Connecticut Department of Public Health (CTDPH) which administers RWHAP Part B (that serves people living with HIV that can't get services elsewhere- balance of the state) and the Centers for Disease Prevention and Control (CDC) HIV Prevention Program.

The plan's creation included representatives and partnerships from other entities such as the RWHAP Part Cs and Ds, the AIDS Education and Training Center (AETC), Yale's Center for Interdisciplinary Research on AIDS (CIRA), the members of the CHPC, and members of the public who attended our monthly CHPC meetings. CTDPH partners on Implementation Science projects with Institute for Community Research (ICR) to move public health practices into the community.

b. Role of the RWHAP Part A Planning Councils

The RW Part A TGA and EMA represent jurisdictional partners in this process. The CHPC and RW Part A Planning Councils (TGA and EMA) include cross-over membership. The CHPC leaders used an intentional process to increase engagement of RW Part A Planning Councils in the Plan development process. This included inviting representatives from Planning Councils to share information and best practices at the CHPC committee meetings, invitations for RW Part A Planning Council members to attend CHPC meetings and sending CHPC representatives to their Planning Council meetings to discuss the plan.

The Plan recognizes that the RW Part A Planning Councils review priorities and funding allocations annually in response to funding allocations and changes in community needs.

The CHPC and jurisdictional partners continue to improve the collaborative workspace as it relates to data collection, needs assessments, analysis of resources and services, professional development, and implementation of special initiatives.

c. Role of Planning Bodies and Other Entities

The CTDPH serves as the fiduciary of the CHPC. The CTDPH administers funding from the CDC and RWHAP Part B. The CTDPH uses the CHPC as the vehicle to support statewide planning, coordination, and integration of HIV prevention and care services.

The CADAP Clinical Advisory Board convenes annually to review medications covered by CADAP. The Advisory Board makes recommendations to add or remove medications on the CADAP formulary to help clients maintain viral suppression and help treat other HIV related diseases. The Advisory Board is composed of several physicians, APRNs, physician assistants, pharmacists, CBO staff, and DPH staff.

The CTDPH convenes an Ending the Syndemic Partners Group (ETS Partners Group) and supports a full-time Ending the Syndemic Coordinator. The ETS Partners Group includes representatives from the RWHAP Part A jurisdictions, RWHAP Part B, Part C, the State Department of Mental Health and Addiction Services (DMHAS), and the CTDPH from areas that include HIV prevention, viral hepatitis, and sexually transmitted diseases.

The ETS Partners Group focuses on policy and system-level implementation issues and ensures integration and coordination of the Plan with the work of two new statewide planning groups in syndemic areas of focus: Viral Hepatitis Technical Advisory Group and the emerging Connecticut STI Consortium. Representatives of the ETS Partners Group serve on the CHPC Ending the Syndemic Committee.

All Jurisdictional Partners:

- Hold public meetings and welcome diverse public participation.
- Conduct specific needs assessment surveys and focus groups that allow PLWH to express their needs. This includes a first-ever statewide HIV prevention survey.
- Engage PLWH and persons with lived experience through special initiatives such as the statewide Getting to Zero Commission (2018) and the In It to End It Plan (2021).
- Use other methods such as newsletters (see text box) and social media to engage PLWH and persons with lived experience in the process.

d. Collaboration with RWHAP Parts

The CHPC membership includes representatives from RWHAP Parts A – D providers as well as the RWHAP Part F AIDS Education and Training Program (AETC). Presently, the CHPC membership roster does not include a representative from a RWHAP Part F dental grant as an active member of the CHPC but will continue efforts to engage with them as needed.

The CTDPH convenes quarterly an HIV Funders Group with representatives from RWHAP parts, prevention providers, and other interested partners. This group assembles to share partner updates, to facilitate changes in policy and systems (e.g., data collection), to promote quality management and innovation, and to attract additional funding to Connecticut.

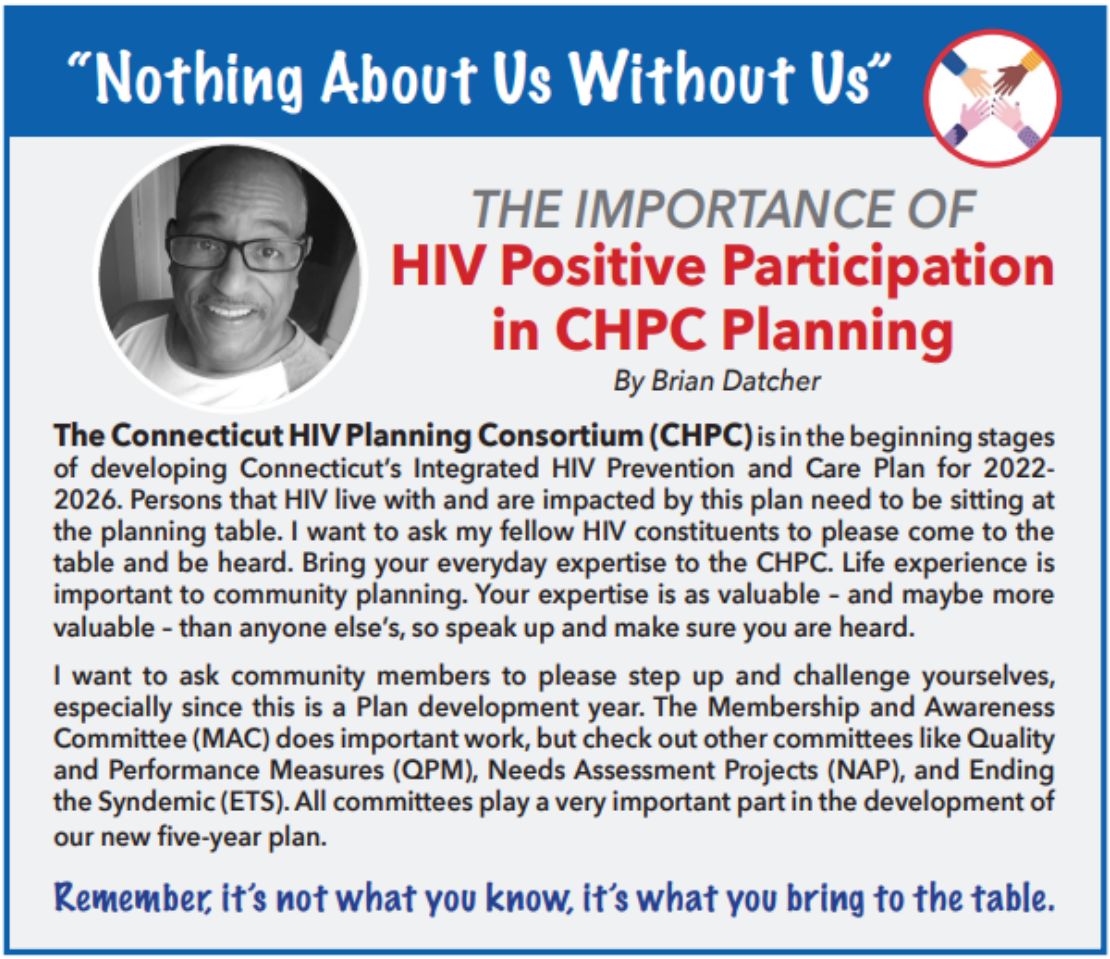
The CTDPH and the CHPC continue to strengthen their working relationship with the subject matter experts from the Center for Interdisciplinary Research on AIDS at the Yale School of Public Health. CIRA was established in 1997 and is currently New England's only National Institute of Mental Health (NIMH) funded AIDS research center, and one of five nationally. CIRA brings together scientists from 25 different disciplines and three institutions to support innovative, interdisciplinary research that focuses on the implementation of HIV prevention and treatment and the elimination of HIV disparities.

e. Engagement of Persons with Lived Experiences

The CHPC planning process involves PLWH and other persons with lived experience relevant to HIV prevention and care. The CHPC planning process involves a diverse array of individuals with lived experiences in: living with HIV/AIDS, people living with SUD, individuals who identify as Transgender, and HIV negative individuals actively engaged in PrEP. The CHPC is in full support of the slogan, "Nothing about us, without us" and continually seek opportunities to have persons with lived experience participate at our meetings, in our newsletters, and in the development of our campaigns. Every year the CHPC hosts a "Voice of the People" panel where members and guests from the public who identify as persons with lived experience.

The CHPC's goal is to have at least 50% of its members reflect and represent the HIV epidemic. We have representation of individuals with lived experiences through leadership roles and moving forward, the other epidemics in our syndemic approach. The RW Part A Planning Councils (EMA, TGA) maintain similar goals to expand the participation of persons with lived experience and offer stipends.

The Importance of HIV Positive Participation in CHPC Planning Process.



Source: CHPC News and Notes, March 2022

In It To End It: Community Engagement

The figure below offers a graphic illustration from "*In It to End It* Community Engagement Sessions" led by our Ryan White Part A EMA Partner. These illustrations represent a priority population and reinforce that the nature of HIV Prevention and Care work requires a continuum of solutions that extend far beyond the traditional HIV prevention and care partners and services. Each community engagement session assembled priority populations and asked them, "What needs to happen in the next two to five years that will result in the end of the HIV epidemic in Connecticut?"

Discussion Highlights

- Ryan White Programs provide access to medical care and relief from the financial burden of medical care costs. "We're here today because of Ryan White."
- The amount of paperwork and documentation needed to enroll in Ryan White and other programs is overwhelming. Continually having to provide you need and qualify for services is demeaning.
- PWH want to be more involved in educating the community about HIV. To help reduce stigma and discrimination, several PWH stated that they would be willing to share their HIV status publicly to demonstrate they are living healthy and well with HIV.
- Participants shared that they wanted to help other PWH, but agencies wouldn't hire them because they didn't have relevant experience and skills.
- Participants shared they felt some agency staff are not qualified for their positions. There is a need for additional training for staff at community-based organizations.
- Long-term survivors shared that in the initial years of their diagnosis, they stopped working to manage their HIV. Now, they felt well enough to work, but their professional skills were no longer relevant.

To view more illustrations in this creative and thought-provoking initiative, click below: www.ourhivplan.org/community-input.

Getting To Zero CT: Community Engagement

Eighteen listening sessions were conducted in Hartford, Waterbury, New Haven, Bridgeport and Stamford to gather data with a focus on three population: young MSM of color, Black women and transgender women. Close to 200 individuals participated in the listening sessions. The listening session questions related to experiences and barriers with accessing HIV prevention and care, specifically HIV testing, PrEP, treatment and stigma, and how to address barriers in their communities. The following lead questions were posed:

HIV Knowledge	What do you know/have you heard about HIV in your community?
HIV Testing	What barriers are there to HIV testing in your community?
HIV Care	What have you heard about HIV care?
HIV Stigma	Describe HIV stigma within your community.

Most listening session participants were knowledgeable about HIV and prevention, although some misconceptions exist related to PLWH who were undetectable, and PrEP. There was a consistent theme that more education and marketing are needed for PrEP. The listening sessions indicated there are barriers to testing, including fear of positive HIV status, stigma from the community, rejection from family, friends and partners, and concern about actions to be taken after learning of a positive status. Additional barriers include a desire for discretion, stigma from medical professionals, lack of insurance, and financial challenges. Perceptions regarding care for PLWH were varied with a sense that care had improved over time; however, there appeared to be a lack of standardization of care depending on where PLWH sought it. Most individuals with HIV were aware of what they should be doing; however, some were resistant to disclosing their HIV status, or accessing care and medication.

One barrier to care and prevention, which seemed counterintuitive, was the lack of education and sensitivity from some medical professionals. Medical school training and continuing medical education (CME) were common suggestions. Stigma seemed to be the common denominator which affects whether people get tested, if they take PrEP, how they care for themselves, and whether they disclose their status to partners or their sexual or drug risk behavior to their provider. PrEP is perceived by many to be marketed primarily to gay men, adding to some false ideas that HIV is a gay men's disease. Also, women voiced concerns that the messaging about PrEP missed the opportunity to reach others who could also benefit. Uninformed parents and grandparents who are unaware of current protocols for prevention and care of HIV, which have changed greatly from 30+ years ago, has contributed to stigma. An additional level of stigma exists for the transgender population, as well as a lack of gender-affirming testing spaces, which leads to barriers in testing, prevention, and care. Mental health and substance abuse issues were additional barriers for testing, prevention, and care.

To view the entire Getting To Zero Initiative report, click below:
https://gettingtozeroct.org/wp-content/uploads/2019/01/Getting-To-Zero-CT-Report.pdf

Connecticut's Ending the Syndemic Initiative:

Connecticut's Ending the Syndemic initiative began in 2021 to create integrated strategies to end the HIV epidemic by addressing Human Immuno-deficiency Virus (HIV), Sexually Transmitted Infections (STIs), Substance Use Disorder (SUD), and Viral Hepatitis (VH). A syndemic is two or more overlapping epidemics connected by behaviors and conditions that impact the same populations and their communities and can lead to a higher burden of disease. In Connecticut the same people in the same areas of the state are impacted by one or more of these co-occurring epidemics. Having HIV and Hepatitis or HIV and an STI can impact effectiveness of treatments and lead to poorer health outcomes. Therefore, it is important to screen individuals for all conditions in the syndemic and link them to appropriate services.

The initiative evolved from previous campaigns to end the HIV epidemic, namely the Getting to Zero (GTZ) Campaign. The Ending the Syndemic campaign is *Connected Til The End* and was launched in 2022 to create awareness across the state that to completely irradicate Human Immuno-deficiency virus (HIV), Sexually transmitted infections (STIs), substance use disorder (SUD), and Viral Hepatitis (VH), we must address all of the epidemics simultaneously instead of individually. The goal of the initiative is for all people living with HIV, HCV, STIs, and SUD to have access to the prevention and care services they need.

The CTDPH designated a full-time staff position as the Syndemic Coordinator and established an Ending the Syndemic Partner Group (ETS Partners Group). The ETS Partners Group focuses on issues such as supporting development and deployment of integrated screening and testing processes, coordinating funding across syndemic partners, and improving referral mechanisms between and among syndemic partners and their community-based resource networks.

The ETS Partners Group interfaces with the CHPC Ending the Syndemic Committee (ETS Committee). The ETS Committee focuses more on coordinating operational-level activities such as developing provider resources and information to support implementation of routine HIV testing in response to 2022 legislation that mandates beginning in 2023 Primary Care Providers must offer HIV testing to all patients 13 and older. Then in 2024 Emergency Room Providers must offer testing to all patients 13 and older unless presenting with a life-threatening emergency.

Data shows how the epidemics that make up Connecticut's syndemic are interconnected.

Approximately 5% of PLWH are co-infected with Hepatitis C. At least 60% and as many as 80% of PLWH coinfected with HCV inject drugs. Disparities exist among those co-infected such as 78% among people of color, 75% in persons who inject drugs, and 67% among 30–49-year-olds. Having HIV and Hep C more than triples the odds for liver disease, liver failure, and liver-related death.

Approximately 4% of PLWH co-infected with an STI, with 90%+ of STDs diagnosed after HIV diagnosis. Of those co-infected, 74% are among MSM, and 69% among people of color. Trends in sexually transmitted infections in Connecticut for 2014-2018 continue to rise. CTDPH epidemiologists confirm that women and youth experience a disproportionate rate of STDs and remain at very high risk of acquiring HIV. Epidemiologists and the Women, Infant, Children and Youth HIV Services Consortium of Connecticut (WICY-HSCC) partners report an increase in congenital syphilis as well.

Over the last few years, unintentional drug overdose deaths continue to increase, and higher demand and utilization exists for harm reduction services; such as Narcan distribution, Syringe Services Programs, and adequate linkage to care.

f. Priorities

Connecticut's State and Local HIV planning bodies set prevention and care priorities through their own priority setting processes, all of which involve engagement of key stakeholders and affected populations. Several shared priorities continue to emerge about what must happen for Connecticut to end the HIV epidemic. The following are our high-level, shared priorities:

- Address social and economic injustices that cause disparities and inequities (i.e., social determinants of health).
- Embrace a syndemic approach that includes engagement of priority populations.
- Build knowledge equity to reduce stigma and increase access to resources.
- Strengthen sexual health education.
- Improvements in data to action processes.
- Expand PrEP and PEP uptake as well as use of harm reduction programs.
- Normalize routine HIV testing and screening across all areas of the syndemic.
- Build capacity for providers to implement a status neutral care approach to care with a rapid start medication protocol for ART or PrEP based on HIV status.
- Reduce disparities in viral load suppression between patients served by RWHAP- and non-RWHAP funded providers.

Connecticut's State and Local HIV planning bodies set specific prevention and care priorities through their own priority setting processes, all of which involve engagement of key stakeholders and affected populations.

The Ryan White Part A EMA's 2022 Service Priorities
Substance Use/Outpatient Services
Emergency Financial Assistance
Food Bank/Home Delivery Meals
Health Insurance Premium and Cost Sharing Assistance (HIPSSA)
Housing
Medical Case Management
Medical Transportation
Mental Health Services
Oral Health Services
Substance Abuse/Inpatient Services

The Ryan White Part A TGA's 2022 Service Priorities
Emergency Financial Assistance
Housing
Medical Case Management (including Treatment Adherence)
Outpatient/Ambulatory Medical Care
Mental Health
Early Intervention Services
Substance Use Disorder Outpatient Services
Medical Transportation
Psycho-social Support Services
Food Bank/Home Deliveries

The Ryan White Part B's Service Priorities
Medical Case Management (including Treatment Adherence)
Oral Health Care
Outpatient/Ambulatory Medical Care
Non-medical Case Management/Transitional Case Management (TLC)
Emergency Financial Assistance (housing, medical and utilities)
Food Bank/Home Deliveries (food vouchers only)
AIDS Drug Assistance Program (ADAP)
Medical Transportation

DPH Statewide HIV Prevention Service Priorities
Implementing Status Neutral Model of Care
Expanding HIV/HCV Testing in Clinical and Non-Clinical/Outreach Settings
Establishing a PrEP/PEP Center for Excellence
Capacity Building Assistance (CBA) / Workforce Development
Free Rapid HIV/HCV Testing and Conventional HIV/HCV Testing
HIV Self-Testing (HIVST) Program
Positive Prevention CT- Statewide Public Health Campaigns
Drug User Health Services- (e.g., Syringe Services Program, Naloxone Distribution, Fentanyl Testing, collaboration with Veteran Affairs)
Harm Reduction Services- Drug Treatment Advocacy
Provider Detailing
Patient Education
Community Distribution Center- Sexual Health Education and Condom Distribution
Harm Reduction Distribution Center

g. Updates to Other Strategic Plans Used to Meet Requirements

The CHPC draws upon plans by RWHAP partners and prevention partners as building blocks and inputs to develop the statewide Plan and to make mid-course adjustments to the statewide Plan. The RWHAP and prevention partners follow specific planning requirements from their funding source and use the statewide Plan as a reference point and input for their processes. These plans are driven by community engagement and localized or regional needs assessments. As changes occur in data sets, funding allocations, priorities, policies, or other conditions, the various partners adjust their plans accordingly and recognize that changes at the local level may affect the statewide Plan and vice-versa.

For this Plan, the CHPC Needs Assessment Projects (NAP) Committee coordinated a review of the most relevant need assessment projects by the RWHAP Part A EMA and TGA as well as the 2022 statewide PLWH Needs Assessment with data collection and analysis coordinated by RWHAP Part B. Several groups exist to facilitate coordination and collaboration of data collection within and across the HIV funding partners. Three groups in particular champion this work: The CHPC, the Connecticut HIV Funders Group, and the DPH Ending the Syndemic Partners Group. The CHPC NAP will identify priority assessment and/or special analyses that inform gaps most relevant to this statewide Plan and develop an annual work plan and milestones that advance the five-year Plan. An example of the impact of this process: the current Plan includes an explicit objective that address the lack of housing options for PLWH. This has been a need and a gap identify by PLWH needs assessments for the past five years.

SECTION III. CONTRIBUTING DATA SETS AND ASSESSMENTS

1. Data Sharing and Use

Connecticut holds a robust history of responding to the HIV epidemic. CTDPH began confidential name-based reporting for AIDS in 1982. Over time, reporting requirements expanded to meet CDC case definitions and improve understanding of the HIV epidemic using surveillance data analysis. Milestones for improvements in reporting include perinatal exposure (2001), HIV in adults and adolescents (2002), HIV serum (2005), all viral load (2006), genotype (2009), and all CD4 and HIV-2 (2014). In 2022, Connecticut lawmakers enacted legislation requiring that beginning in 2023 Primary Care Providers must offer HIV testing to all patients 13 and older. Then in 2024 Emergency Room Providers must offer testing to all patients 13 and older unless presenting with a life-threatening emergency.

The CTDPH serves as the lead organization for the CHPC. The CTDPH:

- Posts the surveillance and programmatic data sets for its TB, HIV, STD, and viral Hepatis Programs on publicly available websites with an option to request custom analyses.
- Provides access to epidemiologists who conduct customized analysis (e.g., priority population, geographic region), assist in developing methodologies to collect, analyze, and interpret data sets and assure meaningful use and application.
- Designates subject matter experts to serve as liaisons to CHPC committees to support a data to action approach.
- Provides support and coordination for statewide data collection efforts such as the PLWH needs assessment survey (2022) and the statewide HIV Prevention survey (2022).
- Facilitates connection, coordination, and collaboration among and between partners on matters related to data integration and/or research and demonstration projects.
- CADAP and HIV Surveillance developed a data-sharing agreement in 2022 to facilitate the exchange of CD4/viral load information to improve data quality and reduce data reporting burden on consumers.

RWHAP Partners use different data systems based on their funding and in the context of their affiliation with larger healthcare systems. RWHAP Part As use CAREWare, a free, electronic health and social support services information system for RWHAP recipients and providers. HIV Prevention Program uses EvaluationWeb and E2CT Prevention. RWPB Program uses E2CT software to collect their HIV Care data and partner with Magellan RX to manage their enrollment for CADAP services.

Providers affiliated with larger healthcare systems use software solutions such as Epic that power administrative, clinical, and patient portals. All healthcare providers adhere to strict data confidentiality, data privacy, and data sharing requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as well as other applicable Connecticut legislative requirements.

Each of the jurisdictional partners use a variety of surveillance, service utilization, funding, and customer satisfaction data to monitor their progress, to support continuous quality improvement, and to support jurisdictional planning processes as required by their individual funding sources. The CHPC uses these various data sources as inputs for the statewide Plan development process.

The CHPC Quality and Performance Measures Committee serves as the primary vehicle for meaningful use of data sets to monitor progress of the plan. The CHPC Needs Assessment Projects Committee coordinates statewide surveys.

The HIV Funders Group represents a vehicle to engage RWHAP and HIV prevention partners in data collection (e.g., financial resources, HIV workforce surveys). The CTDPH led Ending the Syndemic Partners Group continues to emerge as a catalyst for system and policy change.

2. Epidemiological Snapshot

Context:

Approximately 3.57 million people live in Connecticut, of which 51.2% are female and 48.8% are male. Of the total population, 66.82% are Non-Hispanic White, 16.86% are Hispanic/Latinx, 10.98% are Black/African American, 5.07% are Asian/Pacific Islander, and 0.27% are American Indian. The US Census Bureau reports an estimated 7.0% of the Connecticut population is under age 65 and without insurance, while 10.0% of the population lives under the Federal Poverty Level (FPL). Connecticut is a Medicaid expansion state with 949,551 people (26.6% of the total population) enrolled in Medicaid (April 2021), a 2.5% increase from April 2020.

The CTDPH publishes a comprehensive Epidemiological Profile of HIV that includes surveillance data, special analyses by priority populations such as transgender, analyses for RW Part A jurisdictions, and other special analyses. This section provides highlights to communicate the themes and data points most relevant to the Plan development process.

Social Determinants of Health. Social determinants of health (SDOH) refer to conditions in the environments where people are born, live, learn, work, play, worship, and age that affect quality of life and its outcomes. The Connecticut HIV Epidemiological Profile includes a section on SDOH. Summary themes are shown in the paragraphs. The prevalence rate of PLWH across Connecticut equals 299 per 100,00 and ranges across the eight (8) counties from 93 in Tolland County to 395 in New Haven County.

Poverty, Income, and Education. Between 2015 and 2019, the average household size in Connecticut was 2.5 persons. Of all Connecticut households, 66.1% are owner-occupied. An estimated 90.6% of Connecticut residents aged 25 years and older had attained a high school degree or higher, and 39.3% had a bachelor's degree or higher. The estimated median household income in Connecticut was $78,444. Approximately 20% of the population had income <200% federal poverty level.

Incarceration and Crime. In 2019, Connecticut's crime rate (16.1 per 1000) was lower than the national average (24.9 per 1000).

Property crimes accounted for 88% of the crime rate and violent crimes accounted for 11% of the crime rate. Connecticut's incarceration rate was 245 per 100,000 adult population. In December 2019, the Connecticut Department of Corrections custody population was 12,274 persons incarcerated.

Health Indicators. The 2019 United Health Foundation's America's Health Rankings Report, Connecticut ranked 4th out of 50 in overall health. This annual health report scores states based on 35 measures across 5 categories of health including behavioral, community and environment, policy, clinical care and health outcomes. Connecticut's strengths were low prevalence of smoking, high rate of primary care physicians, and low cardiovascular death rate. Notable challenges included high prevalence of excessive alcohol consumption, high rate of deaths attributed to drug injury, and high- income inequality.

Public Aid. Between 2015 and 2019, an estimated 7% of Connecticut residents were without health insurance. In 2019, Medicaid covered 20% and Medicare covered 11% of all persons living in Connecticut. Medicaid expenditures in Connecticut totaled $8 billion in the 2019 fiscal year. In 2019, 1 in 3 children were insured through Medicaid.

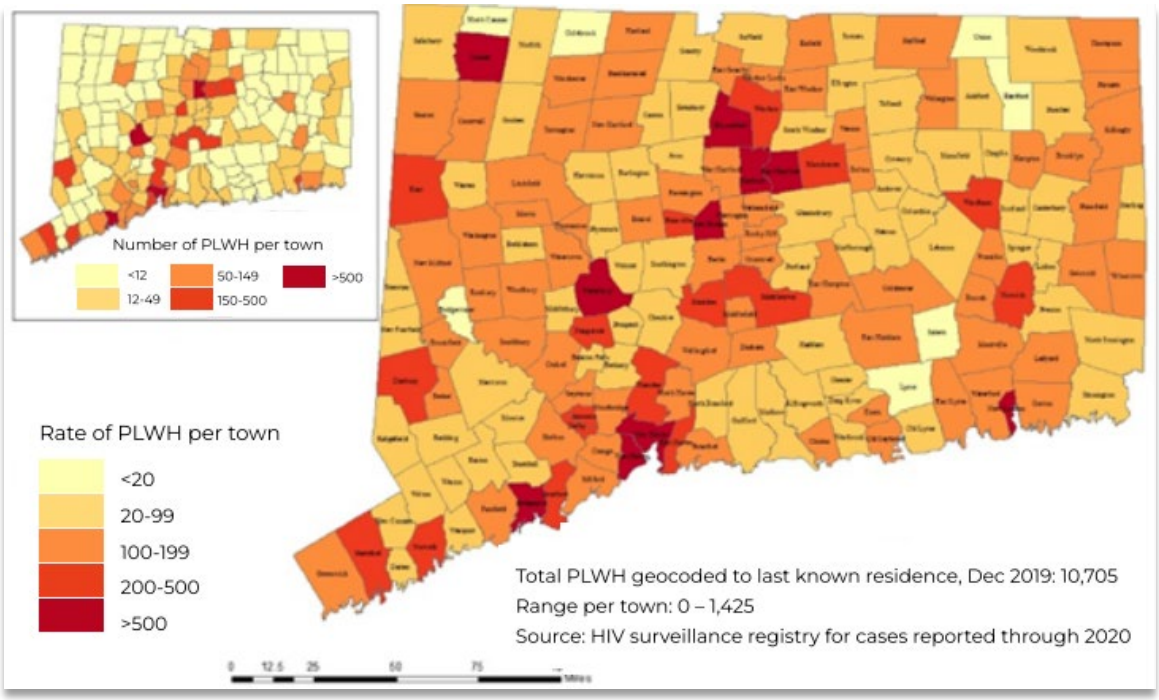
Housing Stability. Housing costs remain astronomical, affordable housing options remain limited (need 80,000+ units), inflation continues to increase the cost of basic expenses like food and heat, and homelessness counts have risen (13%) for the first time in nearly a decade.38% of Connecticut households struggle to make ends meet. 27% are Asset Limited Income Constrained Employed (ALICE) and not 11% of households were living below the Federal FPL.

HIV Prevalence

According to Connecticut's Epidemiologic Profile of HIV (2021): [2]

- Since 1981, over 22,000 people have been reported with HIV.
- In 2021, there were 10,665 people living with HIV residing in Connecticut.
- Racial disparities continue to be evident in Connecticut. Black/African Americans are seven (7) times more likely to be living with HIV than White persons, and Hispanic/Latinx are five (5) times more likely to be living with HIV than Whites. Black and Hispanic females living with HIV/AIDS account for 77.4% of all identified HIV/AIDS cases among women.
- In 2020, the highest proportion of PLWH were ≥50 years old (65%, 495 per 100,000 persons); 82% of PLWH are aged 40 or older. Regarding risk factors for HIV transmission, MSM, which surpassed inject drug use in 2017, continues to rise as a prominent transmission category for people living with HIV in Connecticut. In 2020, 32% of the PLWH had a risk of MSM, 25% injection drug use and 28% heterosexual contact.
- As of December 2019, 10,705 people were living with HIV (300 per 100,000 population).
- Prevalence tends to gather in or around Connecticut's major urban centers such as Bridgeport, Danbury, Hartford, New London, New Haven, Norwalk, Stamford, and Waterbury.

Map 1. Connecticut's Plan covers the entire state. The majority (95%) of all persons with HIV live with the Ryan White Part A Eligible Metropolitan Area (EMA) or the Ryan White Part A Transitional Grant Area (TGA).



[2] DPH epidemiologists recommend that 2020 data be interpreted with caution. New HIV cases may be under-reported. People with HIV who are identified as "not-in-care, "may have had a tele-health visit that would not reflect in HIV surveillance data.

Below shows a summary table on PLWH and AIDS by gender, race/ethnicity, age, and risk factor as well as select data visualizations on HIV prevalence.

People Living with HIV & AIDS by Gender, Race/Ethnicity, Age & Risk, CT, 2020

	AIDS		HIV		Total	
	N	% Of Total	N	% Of Total	N	% Of Total
Total	**6,309**	**100**	**4,369**	**100**	**10,678**	**100**
Gender						
Male	4,129	65.4	2,892	66.2	7,021	65.8
Female	2,140	33.9	1,429	32.7	3,569	33.4
Transwomen	34	0.5	41	0.9	75	0.7
Transmen	6	0.1	4	0.1	10	0.1
Additional Gender Identity	0	0	3	0.1	3	0
Race/Ethnicity						
Black/African American	2,129	33.7	1,482	33.9	3,611	33.8
Latinx	2,195	34.8	1,422	32.5	3,617	33.9
White	1,833	29.1	1,344	30.8	3,177	29.8
Other Races	152	2.4	121	2.8	273	2.6
Age as of December 2020						
<20	5	0.1	33	0.8	38	0.4
20-29	120	1.9	489	11.2	609	5.7
30-39	436	6.9	882	20.2	1,318	12.3
40-49	955	15.1	854	19.5	1,809	16.9
50-59	2,309	36.6	1,171	26.8	3,480	32.6
60+	2,484	39.4	940	21.5	3,424	32.1
Risk						
PWID	1,978	31.4	655	15	2,633	24.7
MSM	1,659	26.3	1805	41.3	3,464	32.4
MSM/PWID	159	2.5	87	2	246	2.3
Heterosexual Contact	1,818	28.8	1,118	25.6	2,936	27.5
Perinatal	114	1.8	82	1.9	196	1.8
Other/Unknown	581	9.2	622	14.2	1203	11.3

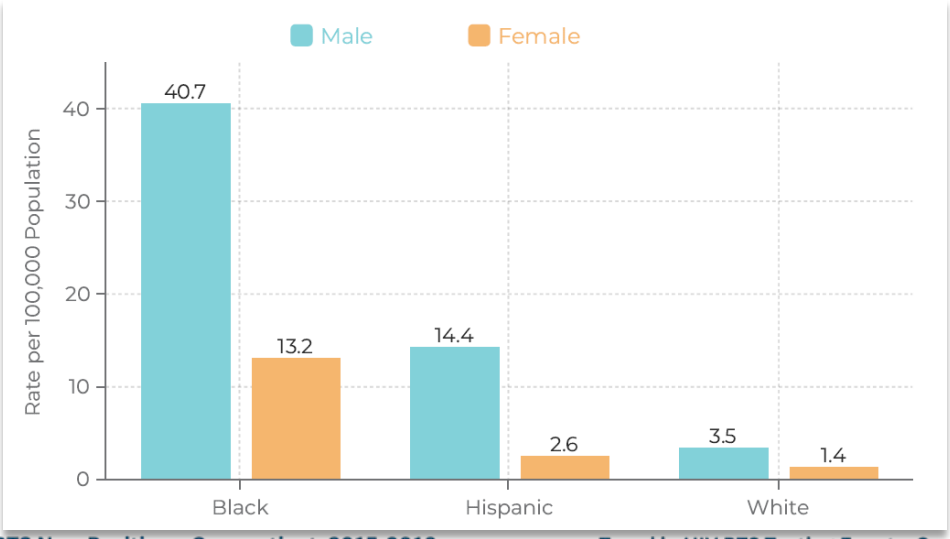
Source: Connecticut Department of Public Health, HIV Surveillance Program, HIV Surveillance Registry (eHARS) preliminary data as of July 2021.

HIV Incidence and Newly Diagnosed*

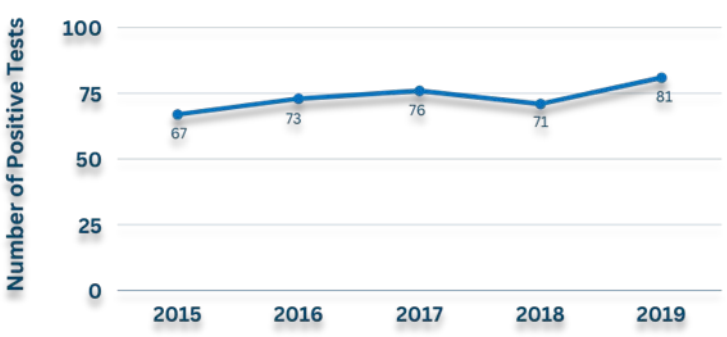
Over the past 10 years, there has been a steady decline in new HIV diagnoses. New diagnoses are sometimes interpreted as new infections however, an HIV diagnosis does not indicate when a person was infected with HIV. Medical providers test people for HIV both routinely and when patients have symptoms indicative of acute HIV or AIDS, which are classified as Stage 0 (early HIV) and Stage 3 (AIDS), respectively. These data are representative of HIV prevalence, the number of cases observed within a population in a specified timeframe.

- In 2019, 220 people were newly diagnosed with HIV in Connecticut.
- In the past 5 years, (2015 - 2019), an average of 261 persons were newly diagnosed.
- In the past 10 years (2010 - 2019), the rate of new HIV diagnoses ranged from a high of 11.0 per 100,000 population in 2010 to a low of 6 per 100,000 population in 2019.
- In the past 10 years (2010 - 2019), there has been a 44% decrease in the number of new HIV diagnoses identified.

Rate of New HIV Diagnoses by Race/Ethnicity and Sex at Birth, Connecticut, 2019



Trend in HIV RTS New Positives, Connecticut, 2015-2019



Trend in HIV RTS Testing Events, Connecticut, 2015-2019

The graphs above demonstrate an upward trend in newly diagnosed individuals who were tested for HIV at Routine HIV Testing Sites in relevance to the number of HIV testing events at Routine Testing Sites that took place the same year.

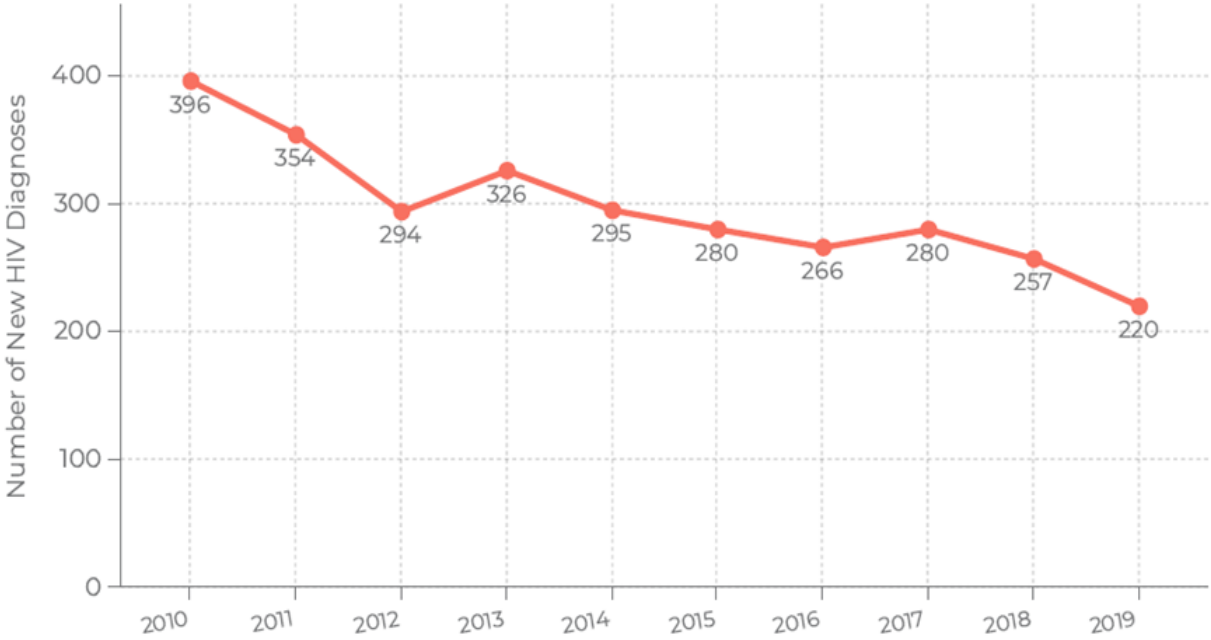
Source: Connecticut Department of Public Health, HIV Surveillance Program, Connecticut Epidemiologic Profile of HIV (2021)

According to the Connecticut HIV Epidemiological Profile (2021):

- In the last 5 years, 1,303 HIV infections were newly diagnosed and reported to DPH. Twenty-three percent of newly diagnosed cases met the criteria for AIDS at diagnosis.
- In the last 10 years, a 71% decrease occurred in injection drug use (IDU) as the mode of transmission for HIV.
- 19% of people diagnosed with HIV in private medical settings are not in care compared with 95% of PLWH who are tested and diagnosed in non-private medical settings (i.e., RWHAP partners).
- Data from the HIV and STD surveillance systems continue to indicate ongoing coinfection in MSM. Of 352 syphilis cases diagnosed the past 5 years, 71% were among MSM and 21% were co-infected with HIV.
- 80% of people diagnosed with HIV were engaged in care in 2019.
- 87% of adolescents and adults diagnosed with HIV were linked to care within 1 month of their diagnosis.

The following graph shows the downward trend of New HIV Diagnoses in Connecticut over the last nine years pulled from the Connecticut Epidemiologic Profile of HIV (2021).

Number of New HIV Diagnoses, Connecticut, 2010-2019



Over the past 10 years, there has been a steady decline in new HIV diagnoses. New diagnoses are sometimes interpreted as new infections however, an HIV diagnosis does not indicate when a person was infected with HIV. Medical providers test people for HIV both routinely and when patients have symptoms indicative of acute HIV or AIDS, which are classified as Stage 0 (early HIV) and Stage 3 (AIDS), respectively. These data are representative of HIV prevalence, the number of cases observed within a population in a specified timeframe.

While the steady decline in new diagnoses is encouraging, disparities continue to exist among new HIV diagnoses occurring within specific sub-populations.

Select Subpopulations

This section provides themes about various subpopulations from the Connecticut HIV Epidemiological Profile. Priority subpopulations vary by jurisdictional area and by the type of service – prevention or care.

PLWH by Risk Category. Of all people living with HIV in Connecticut, 31% of had a risk category attributed to men having sex with men, 28% reported heterosexual sex with a high-risk partner, and 26% reported injection drug use. Gender-specific risk characterization indicates nearly half of HIV-positive males had risk attributed to sex with men and 25% to injection drug use while female risk was predominately attributed to heterosexual sex with a high-risk partner (54%).While transmission risk attributable to injection drug use represents over a quarter of prevalent HIV cases, new HIV diagnoses occurring among people who inject drugs has steadily declined as the result of well-established, robust harm reduction programs in Connecticut. In 2019, 9% of new diagnoses were attributed to injection drug use.

PLWH Who Do Not Know Their Status. Between 2015 and 2019, statistical estimates showed the number of people living with HIV who were aware of their diagnosis improved annually. By 2019, Connecticut had met the National HIV/AIDS Strategy (NHAS) 2020 goal of 90%. However, among younger ages (13- 24 years of age), the proportion estimated to be aware of their HIV status fell between 42 and 54%.

PLWH Who are Out of Care. The CTDPH provided an update on its Data to Care (D2C) initiative which uses HIV surveillance and other data to identify persons living with HIV who need HIV medical care or other services and facilitating linkage to these services. Key findings from the 2021-22 cycle included: a) 519 clients were identified to be out-of-care; b) 253 clients (49%) were located (and subsequently linked to care); c) The demographic characteristics of out-of-care clients were in line with all PLWH in Connecticut (e.g., for sex at birth, age, race/ethnicity, risk factor). No differences existed between the two groups; d) No major differences existed in the demographic characteristics of clients who were located vs. clients who were not located; e) Most of the clients were in Connecticut's cities; f) contacted clients, had an increase had an increase in viral suppression from 14% (on their first lab) to 78% (on their most recent lab) and g) Virtually all (99%) receive medical care.

Perinatal HIV Exposure. Connecticut was the first state to enact mandatory opt-out prenatal HIV testing in 1999 and today, all pregnant women are tested for HIV during prenatal care. If an expectant mother elects to opt-out, their infant is tested upon delivery. Initially, HIV testing occurred within 30 days of the first prenatal visit and between 26- and 28- week gestation. The regulation succeeded in reducing perinatal transmission. In response to a perinatal infection in 2014 and improved testing technology, the regulation was changed in 2017. The second prenatal HIV test now occurs between 32- and 36-week gestation and, for mothers who present for labor and delivery prior to the second HIV test, the second test is performed during the hospital admission for delivery. As a result, only two infants have been born with perinatally-acquired HIV infections between 2008 to 2019.

Transgender PLWH.[3] In 2019, there were 83 HIV-positive persons living in Connecticut who identified as transgender: 71 transwomen, 9 transmen, and 3 persons with additional gender identity. 76% of transgender persons living with HIV were persons of color. During 2015-2019, 56% of the diagnoses among transgender people were among persons aged 20-29 years. Of the transgender persons living with HIV in Connecticut, 57% were over age 39. In 2019, 70% of transgender persons living with HIV reported a sexual transmission risk, 22% reported a sexual transmission risk and injection drug use, and 7% did not report risk.

[3] While these data are likely underreported, the Connecticut surveillance data includes people who identified as transgender at any time by self-report, medical provider, chart review, or ongoing data collection.

HIV Clusters. 90% of PLWH live in the Ryan White Part A EMA and TGA. HIV incidence clusters around Connecticut's urban centers. Other analysis of subpopulations shows similar patterns. For example, over the past 5 years (2015 to 2019), most HIV diagnoses among transgender people occurred in Hartford (33%) and Fairfield (39%) counties and most of the PLWH who are out of care live in or around urban areas.

Each of the core partners identifies other subpopulations at risk. For example, high-risk groups in the RW Part A EMA include:

People Experiencing Homelessness. According to the CT Point in Time Count, as of January 2020 there were 2,904 persons experiencing homelessness in CT, with 1,309 in the New Haven-Fairfield EMA and 27 self-reporting to be living with HIV. In 2019, according to CAREWare data from the FY2019 Ryan White HIV/AIDS Program Data Report (RDR), there were 201 PLWH (9.7%) that were active in RWHAP funded programs that reported being unstably or temporarily housed.

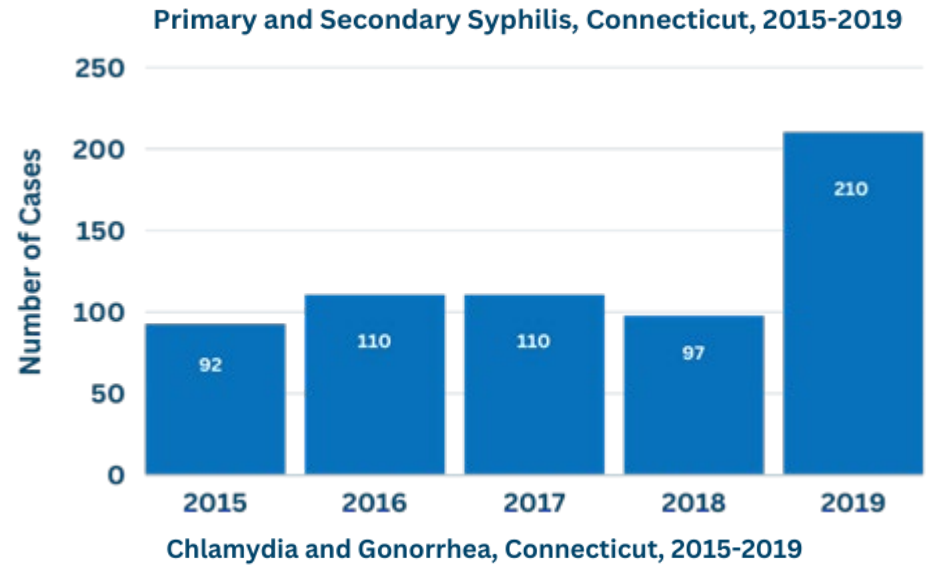
Staff of an HIV Prevention funded site seen distributing new injection drug equipment to reduce the spread of pathogens transmitted through blood.

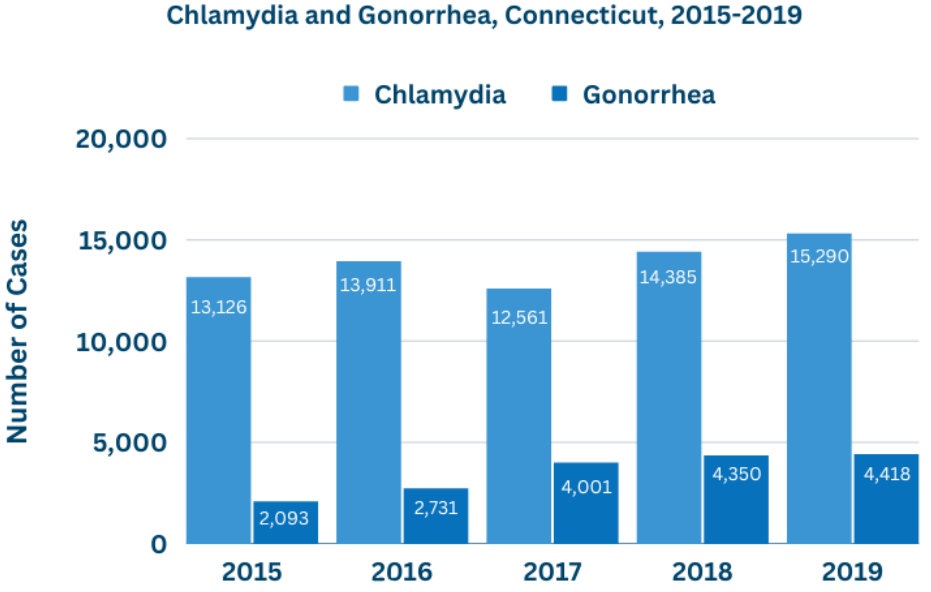
PWUD. PWID account for 31% of people living with AIDS and 16% of PLWH in the New Haven-Fairfield Counties EMA. IDU continues to be a transmission factor in the total PLWH population (9% new AIDS cases, 3% new HIV cases, and 25% of PLWH total prevalence). 285 PLWH in the EMA that received Substance Use Outpatient Care services in the EMA, and 66 PLWH that received Substance Use Services (Residential) in 2019 (CAREWare custom report FY2019).

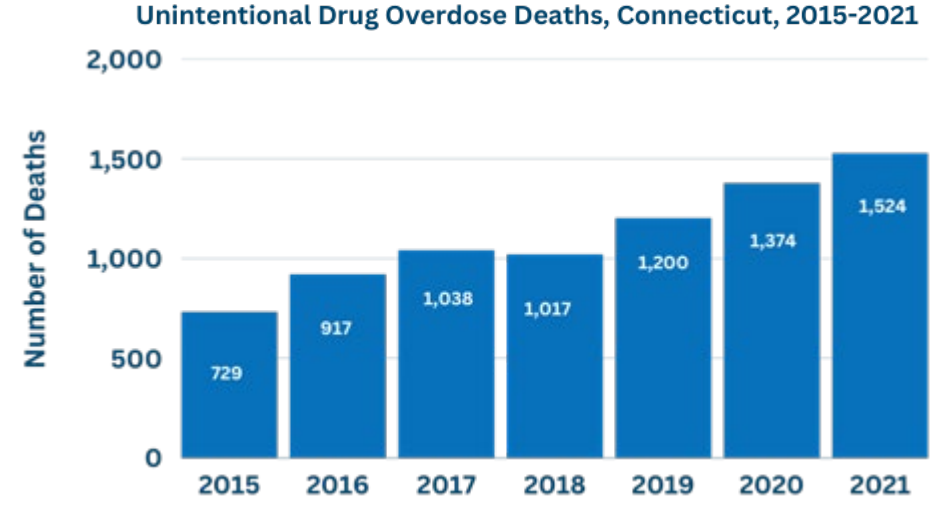
Individuals with Mental Health Needs. HIV can also directly infect the brain, causing impairment to memory and thinking. Receiving an HIV diagnosis can inherently produce strong emotional reactions. In addition, some anti-HIV drugs can have mental health side effects, specifically some psychiatric disorders may be exacerbated by Efavirenz, Rilpivirine, and infrequently by integrase strand transfer inhibitors (INSTIs). Among the most common disorders are HIV- associated minor cognitive motor disorder, HIV-1-associated dementia complex, delirium, and psychosis. In FY2019, the RWHAP program provided mental health services to 279 PLWH in the EMA, who received a total of 3,788 units of services (either individual therapy or group therapy sessions; CAREWare custom report FY2019).

Individuals with Justice System Involvement. 1,233 persons in the EMA were confined (636 and 597 respectively). The U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, HIV in Prisons, 2010-2015, released August 2017 (NCJ250641), (most recent data available) reported that 230 inmates, or 1.5% of the total inmate population in Connecticut reported to be HIV positive or have confirmed AIDS. Using this percentage of reported HIV/AIDS to estimate the number of inmates with HIV/AIDS as of July 2020 in both New Haven and Fairfield Correctional Centers would yield 18 incarcerated PLWH.

Collaboration is Key. To help demonstrate the need for collaboration between the various programs addressing the syndemic epidemics, the graphs below were created using data from the Connecticut Epidemiological HIV Profile 2021 related to Sexually Transmitted Infections and Substance Use Disorder.







Unmet Need

The below table shows the calculations for statewide unmet need (all populations) using surveillance data and the HRSA unmet need framework. Of 219 individuals diagnosed with HIV in 2019, 26.9% were late diagnoses. Unmet need is estimated at 10.2% of the number of people living with HIV (9,560) based on most recent known address without any CD4 or VL test. Not virally suppressed was estimated at 16.2% of people living with HIV who are in care and whose most recent viral load test results was greater than or equal to 200 copies/ml in the most recent calendar year.

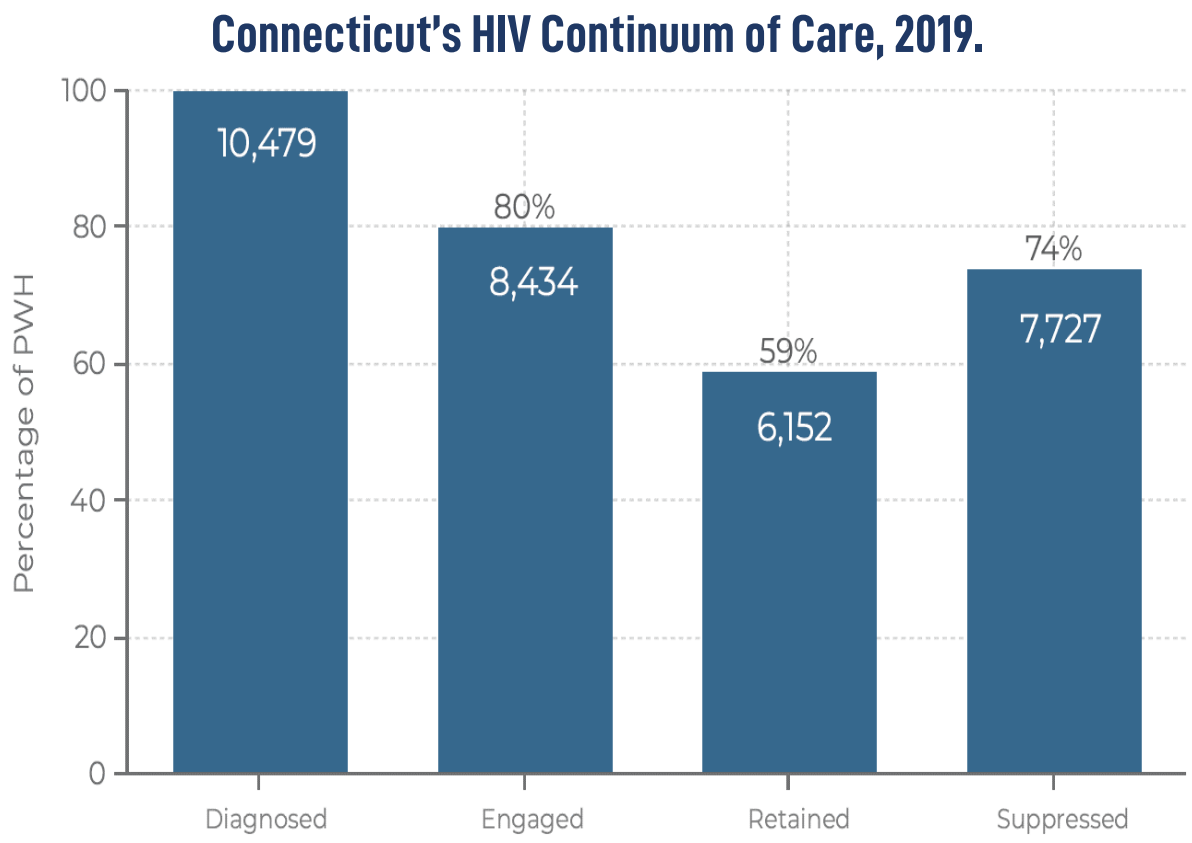
Unmet Need Framework HIV Surveillance Data: Connecticut (Source: CTDPH, 2022)

Years of Data				
1	**New Diagnoses:** Most recent calendar year for which data are available	2019		
2	**Care Patterns:** Most recent calendar year for which data are available	2019		
3	**Population size:** Most recent 5 calendar year period for are available	2015 - 2019		
	Definition/Description	Number	Percent	Data Source
Late Diagnosed				
4	**Late diagnoses:** Number of people with late diagnosed years in jurisdiction based on residence at the time of diagnosis. Late-diagnosed HIV is based on the first CD4 test result (200 cells/mL or a CD4 percentage of total lymphocytes of <14) or documentation of an AIDS-defining condition ≤ 3 months after a diagnosis of HIV infection.	59	26.9%	HIV Surveillance Data
5	**New diagnoses:** Number of people in the jurisdiction with HIV diagnosed in the most recent calendar year based on residence at time of diagnosis.	219		
Population Size				
6	**Populations size:** Number of people living with diagnosed HIV infection in the jurisdiction based on most recent known address who had an HIV diagnosis or other HIV-related lab data (e.g., CD4, VL genotype, or HIV test even if already diagnosed) reported to the HIV surveillance program during the most recent five calendar year period	9,560		HIV Surveillance Data
Care Patterns				
7	**Met need (In care):** Number of people living with diagnosed HIV infection in the jurisdiction based on most recent known address with a CD4 test or VL in the most recent calendar year	8,581	89.8%	HIV Surveillance Data; if linked databases are used please specify[1]
8	**Unmet need:** Number of people living with diagnosed HIV infection in the jurisdiction based on most recent known address without any CD4 or VL test in the most recent calendar year	979	10.2%	
In Care, Viral Suppression				
9	**Virally suppressed:** Number of people living with diagnosed HIV infection in the jurisdiction who are in care and whose most recent viral load test result was <200 copies/mL in the most recent calendar year	7,194	83.8%	HIV Surveillance Data; if linked databases are used please specify
10	**Not virally suppressed:** Number of people living with diagnosed HIV infection in the jurisdiction who are in care and whose most recent viral load test result was ≥200 copies/mL in the most recent calendar year	1,387	16.2%	

[1]Linked database jurisdictions may also use data from RWHAP or other databases as long as data are from a clinical source. Linked databases may only be used for care pattern.

Connecticut's HIV Continuum of Care

Connecticut uses the HIV Care Continuum as a public health tool to monitor the care outcomes of people living with HIV in the state. This model captures individuals from the moment of diagnoses to viral suppression.



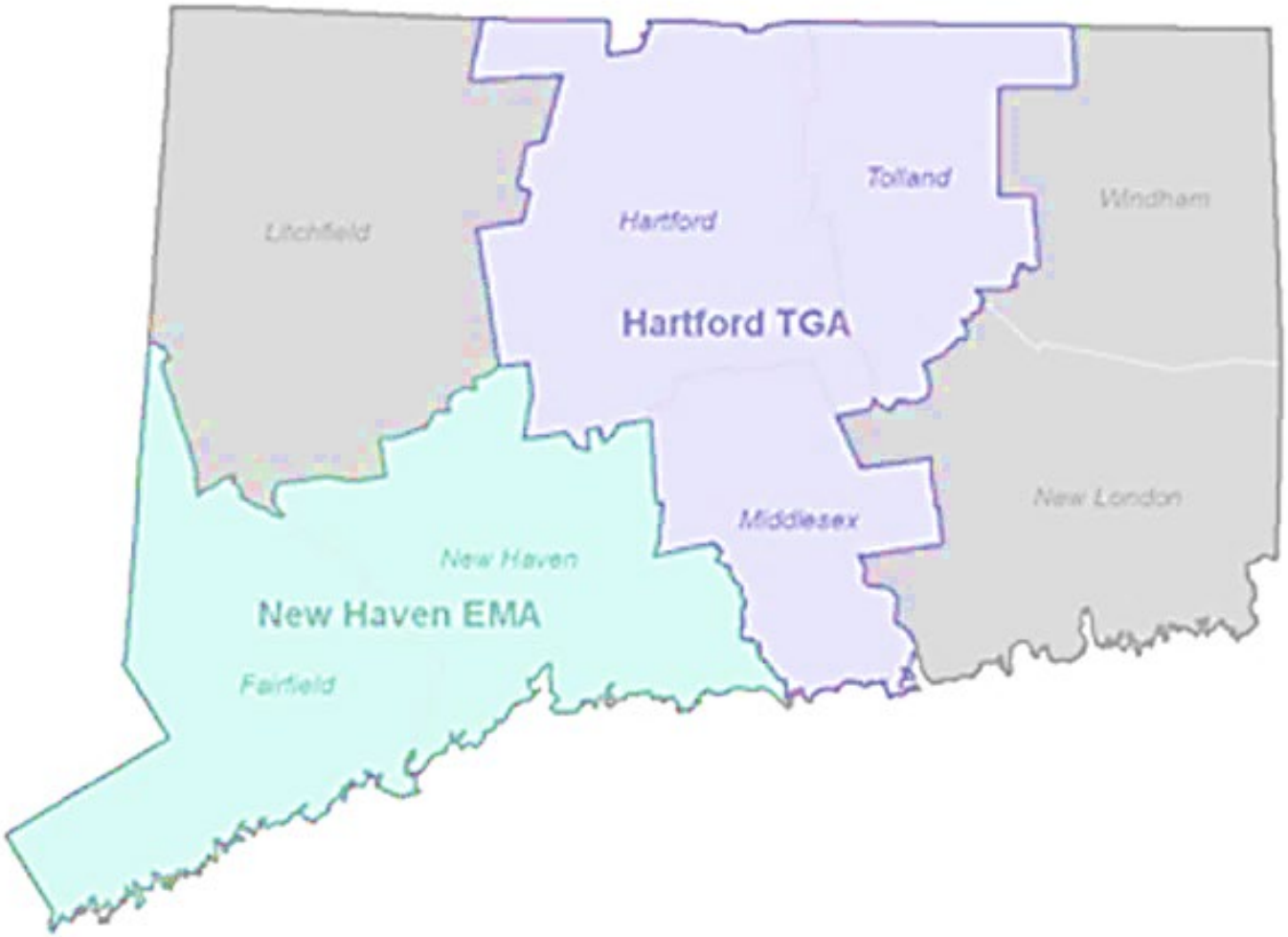
Source: Connecticut HIV Epidemiological Profile.

The figure above shows the HIV Continuum of Care for Connecticut based on people with HIV who received care in 2019, were ≥13 years old at diagnosis, resided in Connecticut (most recent residence), diagnosed with HIV before 2019 and living with HIV as of December 31, 2019. Laboratory results reported to DPH are used as proxy for a care visit, which is defined as receipt of a CD4, viral load, or genotype test result during the evaluation period.

Ryan White Part A EMA & TGA Jurisdictions

Connecticut has two Ryan White Part A Programs (Hartford Transitional Grant Area (TGA) and New Haven Eligible Metropolitan Area (EMA)) and a statewide Part B Program. Of the 22,019 HIV infections reported during 1981-2019, 7,680 were residents of the New Haven EMA, representing 91% of cases ever diagnosed in Connecticut.

There is much programmatic cross-over in the state and analysis included for the epidemiologic overviews of the Hartford TGA and Hew Haven EMA include people with HIV residing within the counties of the service areas, regardless of care provider.



PLWH affiliated with the RWHAP Part A care system are achieving higher viral suppression rates and are retained in medical care at higher rates than the general PLWH population in the EMA. The differences in continuum of care analysis within the RW Part A EMA and TGA reflect the work done in the community by sub-recipients to reduce barriers to care for PLWH entering the RWHAP system The Ryan White Part A EMA and TGA continue to enhance their EIIHA plans to further reduce barriers and increase viral suppression among PLWH.

Ryan White Part A Program (Greater Hartford Transitional Grant Area):

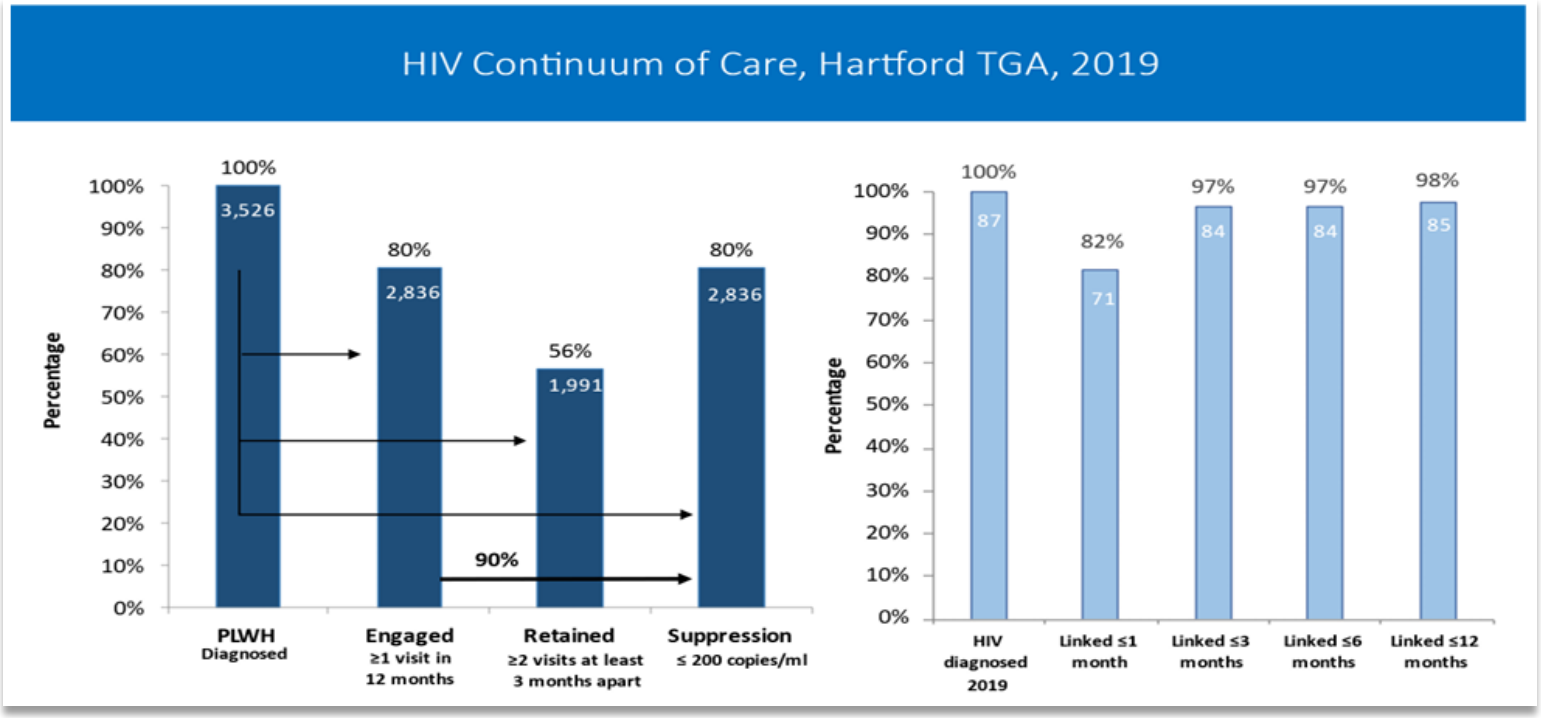
People served by the Greater Hartford TGA in 2019:

In 2019:

- 3,617 people living with HIV in the Hartford TGA
- 70% people of color | 28% white
- 62% 50 years of age or older
- 31% MSM | 28% of IDU

People diagnosed with HIV as residents of the TGA between 2015 and 2019 were younger (58% under 40) and had risk factors of MSM (50%) and heterosexual contact (29%), but were disproportionately people of color (70%).

Source: HIV surveillance registry for cases reported through December 2020 based on last known address as of December 2019



Based on persons receiving HIV care in 2019 resided in the Hartford TGA. Source: HIV Surveillance Data through Dec. 2020. To view the entire Hartford TGA HIV/HCV Quality Management Plan click this link[1].

[1] https://gbb009.p3cdn1.secureserver.net/wp-content/uploads/2021/11/Hartford-TGA-QMP-2018-2021-Revised-Oct2021.pdf

Ryan White Part A Program (New Haven / Fairfield Counties Eligible Metropolitan Area):

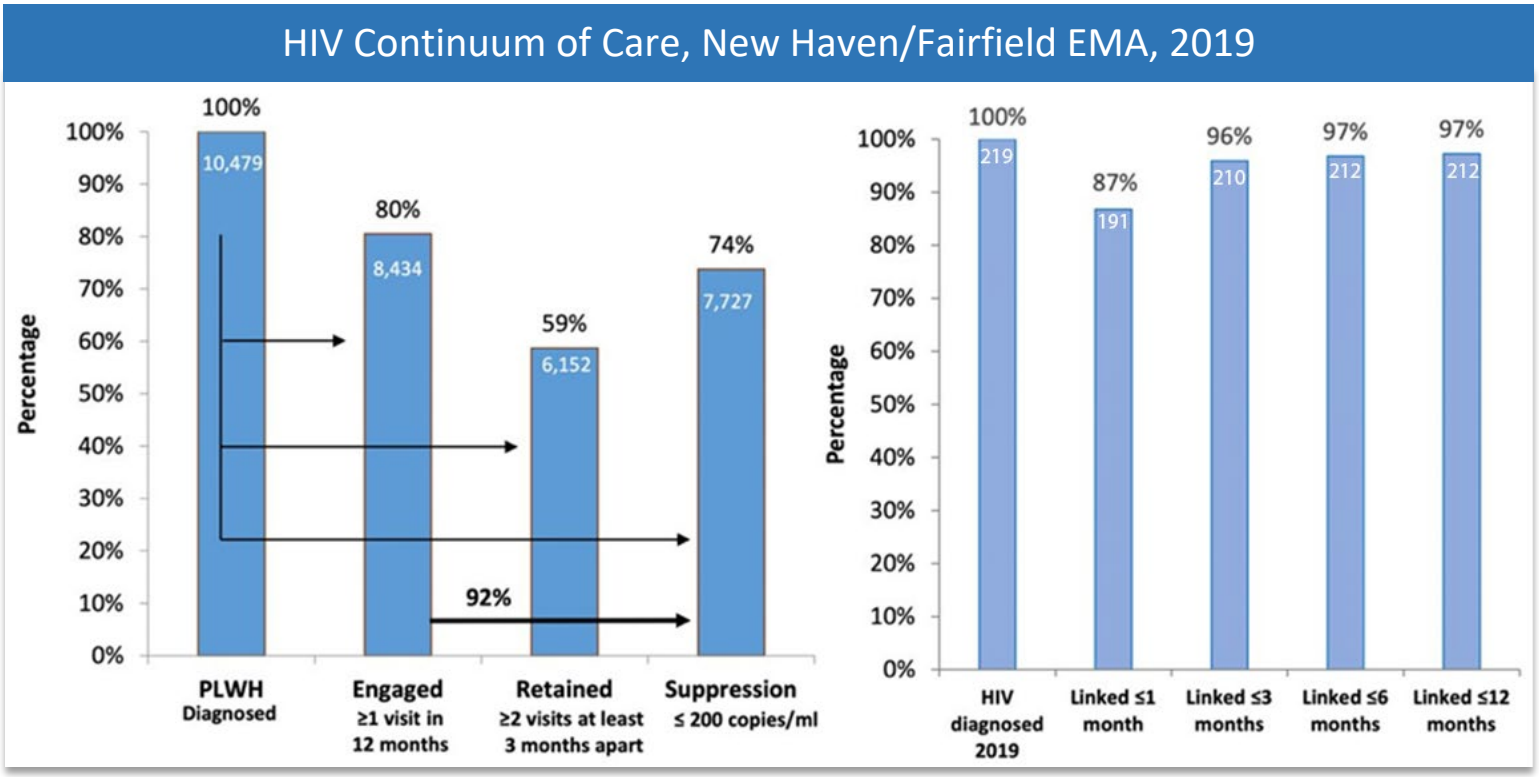
People served by the New Haven / Fairfield Counties EMA in 2019:

In 2019:

- 6,082 people living with HIV in the New Haven EMA
- 71% people of color | 27% white
- 64% 50 years of age or older
- 31% MSM | 29% Heterosexual contact

People diagnosed with HIV as residents of the EMA between 2015 and 2019 were younger (59% under 40) and had risk factors of MSM (53%) and heterosexual contact (27%) and were disproportionately people of color (74%).

Source: HIV surveillance registry for cases reported through December 2020 based on last known address as of December 2019



Based on persons receiving HIV care in 2019 resided in the Hartford TGA. Source: HIV Surveillance Data through Dec. 2020. To view the entire Hartford TGA HIV/HCV Quality Management Plan click this link[1].

[1] https://www.ourhivplan.org/_files/ugd/580e14_e7932b179fbf4aeba2bdbad377f7993c.pdf

Data to Care (D2C)

D2C is a public health strategy that uses HIV surveillance and other data to support the HIV Care Continuum, by identifying PLWH who need HIV medical care or other services and facilitating linkage to these services. In 2021, CTDPH designated a D2C Coordinator to lead the states' efforts in improving D2C outcomes. D2C is informed by data from the HIV Surveillance Program, Ryan White Part B (Health Care and Support Services Program), and STD Prevention and Control Program. There are two pathways for locating and linking PLWH to medical care: HIV Surveillance Program laboratory reports and HIV Confidential Case Report Forms; and STD Prevention and Control Program Disease Intervention Specialists (DIS) are notified by a publicly funded agency or a private health care provider about a newly diagnosed case.

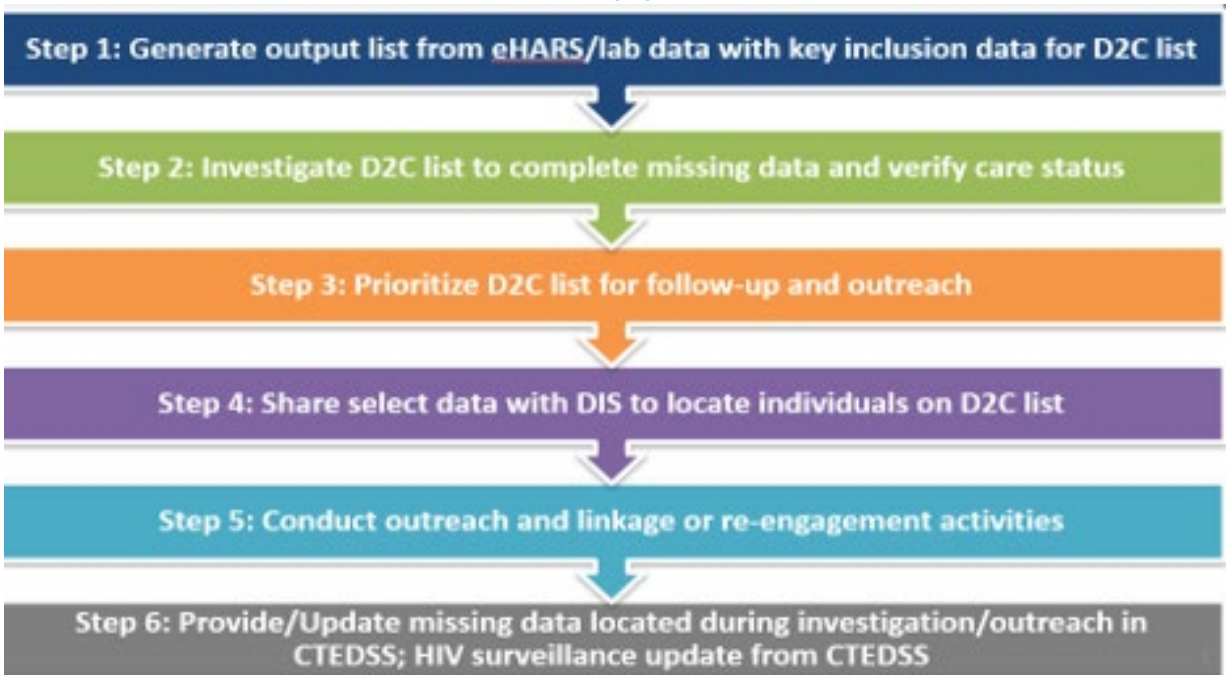
Connecticut's model has six steps (see visualization below). Connecticut plans to conduct a D2C cycle every six months. Connecticut identified PLWH who might not have received HIV medical care during a 15-month time interval based on laboratory test results and other evidence of receipt of HIV care.

The initial D2C list was generated on November 18, 2021 and covered the 15-month period for 8/17/2020 through 11/18/2021. Key findings included:

- 519 clients were identified to be out-of-care.
- 253 clients (49%) were located (and subsequently linked to care). Located means clients referred to DIS, located by DIS, and who had either labs sent to eHARS or received medication (antiretroviral) and services through Ryan White Part B Program.
- The demographic characteristics of out-of-care clients were in line with all PLWH in Connecticut (e.g., for sex at birth, age, race/ethnicity, risk factor).
- Most of the D2C clients were located in Connecticut's urban centers.
- For located clients, the percent virally suppressed rose from 14% (on their first lab) to 78% (on their most recent lab). Virtually all (99%) receive medical care.

CTDPH will implement D2C cycles every six (6) months to support Plan implementation. CTDPH is in the process of hiring DIS Supervisors for the New Haven and Hartford regions.

Connecticut's Data to Care (D2C) Model to Identify PLWH Who Are Not in Care and Link or Re-Engage Them in Care



Resource Inventory Narrative

HIV Prevention Services. Connecticut receives funding from the Centers for Disease Control and Prevention (CDC) to provide prevention services throughout the state. CDC funded Connecticut-based prevention services include evidence-based HIV prevention interventions focusing on the following populations: PLWH, Men Who Have Sex with Men (MSM), Black Indigenous People of Color (BIPOC), Youth, Inmates and those recently released to the community, and People Who Inject Drugs (PWID). These communities are offered the following services: Outreach Testing and Linkage (OTL), Routine HIV Testing, and Drug User Health Programs including Syringe Service Programs (SSP).

HIV Care Services. Connecticut receives funding from the Health Resources and Services Administration (HRSA) to provide core medical/support services throughout the state. Connecticut provides core medical and supportive services to people living with HIV or AIDS (PLWH) and their families through various "HIV/AIDS service and community-based organizations." These services can change on a yearly basis, heavily depend on available funding, and may differ per region. The following is a list of services that fall under the HIV Care Services: medical case management, primary medical care, oral health, mental health, substance abuse-outpatient, medical nutrition therapy, HIV-related medications, health insurance premium and cost sharing assistance, home health care, home-and-community based services, hospice care, medical transportation, housing-related services, food bank/meals, psychosocial support, linguistic services and related emergency financial assistance. Eligible PLWH can access these core medical and support services throughout Connecticut at no cost to them.

The CTDPH makes available a comprehensive HIV/AIDS Prevention and Care Guide on the United Way of Connecticut's 2-1-1 website as well as on its other HIV specific websites (e.g., Positive Prevention Connecticut, Ending the Syndemic). The resource provides up-to-date HIV care and prevention information, as well as information about other social and support services beyond the scope of HIV. For a listing of Statewide HIV/AIDS Services see HIV Care, Prevention and Support Services by County.

Healthcare Systems. 65 local public health departments and districts serve 96.5% of the State's population. In addition to the 65 local public health departments, Connecticut is home to two sovereign nations — Mashantucket Pequot Tribal Nation and the Mohegan Tribe — that provide public health services to their communities through the federal Indian Health Services and a self-organized local health department, respectively. State residents can access a wide network of hospitals, hospital outpatient centers, urgent care centers, and community and school-based health centers.

The American Hospital Directory lists 51 hospitals in Connecticut (2020). Most of these hospitals are affiliated with one of four (4) healthcare systems that operate in Connecticut. Connecticut residents can access HIV prevention and care services – including drug user help, through the state's network of hospitals and community-based health care providers.

CTDPH and its RWHAP partners provide funding to these healthcare providers and community-based organizations to support services and health collaborations specifically to serve PLWH and to prevent new HIV diagnoses. The CTDPH and RWHAP partners continue to improve coordination of services and funding within regions to improve access and to improve healthcare outcomes.

Routine HIV Testing Services with PrEP Navigation. CTDPH funds nine (9) contractors to provide integrated HIV testing services in health care settings that serve populations with a high prevalence of HIV. Routine Testing is an HIV testing intervention geared towards increasing HIV screening of patients, including pregnant women, in health-care settings. Routine testing fosters earlier detection of HIV infection;

identifies and counsels' persons with unrecognized HIV infection and links them to clinical and prevention services; and further reduces perinatal transmission of HIV in Connecticut. PrEP Navigation is a process of service delivery to help a person obtain timely, essential, and appropriate PrEP-related medical and social services to optimize his or her health and prevent HIV transmission and acquisition. Several of these providers participate in CTDPH's Home Test Kit Initiative.

Outreach, Testing, Linkage (OTL) with PrEP Navigation. CTDPH funds eight (8) contractors to provide focused outreach that includes HIV testing and linkage to other services, such as PrEP navigation. Outreach, Testing and Linkage (OTL) is an HIV testing intervention conducted in nonclinical settings. The main objective of this intervention is to increase HIV testing among high-risk populations who might not access medical services regularly. The OTL intervention priority populations are men who have sex with men (MSM), injection drug users (IDU), and other persons at high risk for HIV infection in Connecticut. Examples of nonclinical settings where HIV testing may be offered include, but are not limited to, community-based organizations (CBOs), mobile testing units, churches, bathhouses, parks, shelters, syringe services programs, health-related storefronts, homes, and other social service organizations. These services include condom distribution to PLWH and individuals at high risk of contracting HIV. Several of these providers participate in CTDPH's HIV Self-Testing (HIVST) Program.

OTL Staff from Greater Bridgeport Area Prevention Program conducting outreach on their mobile testing unit.

Drug User Health Programs. Drug User Health includes three components: Syringe Services Program, Overdose Prevention, and Harm Reduction Education. Drug User Health services are a scope of services that underlines a harm reduction philosophy that emphasizes "meeting drug users where they are" by providing services that reduce blood-borne infections (e.g., HIV/HCV), and support harm reduction activities that addresses drug users' structural and social barriers to care and treatment. CTDPH funds nine (9) contractors to implement Drug User Health Programs statewide.

CT Overdose Prevention Education and Naloxone (OPEN) Access CT provides education and training on how to prevent opiate-related overdoses through Naloxone provision and administration. These services are provided through existing HIV Prevention Programs.

Partner Services (PS) A range of services offered to persons with HIV or other sexually transmitted diseases (STD) and their sexual or needle-sharing partners. PS can improve the health of an individual by identifying persons, confidentially notifying their partners of their possible exposure, and providing persons and their partners a range of medical, prevention, and psychosocial services. CTDPH Disease Intervention Specialists (DIS) provide assistance with delivering positive test results, notifying and testing partners and making linkages to other services.

HIV Care Services. Connecticut DPH maintains a Ryan White Care Finder to help residents find prevention and care providers who offer DPH funded prevention and/or Ryan White funded services. Of the 64 RWHAP funded services providers, 11 are Ryan White Part C funded providers and two (statewide) Ryan White Part D providers. The website includes a key word search engine (e.g., town, type of service) as well as an interactive map. The site makes available vital information for each provider (e.g., address, hours of operation, contact, type of service).

The Connecticut AIDS Drug Assistance Program (CADAP) is a pharmaceutical assistance program that pays for medications approved by the U.S. Food and Drug Administration (FDA) on its formulary to treat HIV and HIV disease related conditions. Magellan Rx Management, in partnership with the Connecticut Department of Public Health, administers the program. CADAP provides assistance with health insurance payment through its Connecticut Insurance Premium Assistance (CIPA). The program requires verification of HIV/AIDS by a medical provider, proof of Connecticut residency, health insurance status, and income less than 400% of the FPL.

Transitional Linkage into the Community (Project TLC) assists PLWH ready for release from, or recently released from, Connecticut's correctional system with linkages and referrals to community services, including CADAP, core medical and support services, medical transportation, and referrals for individuals 30-60 days following release.

CADAP has developed a medication adherence program that involves the patient and the prescriber to identify drug interactions, medication optimization, and medication adherence issues. Magellan pharmacists will provide education to patients about how to take their medications (i.e., take with food or on an empty stomach) as well as counsel on drug interactions that could be affecting medication efficacy. The pharmacist will also assess if pill burden is an issue for the patient. The pharmacist will then contact the prescriber of the medication and work to optimize the medication therapy, helping improve patient adherence.

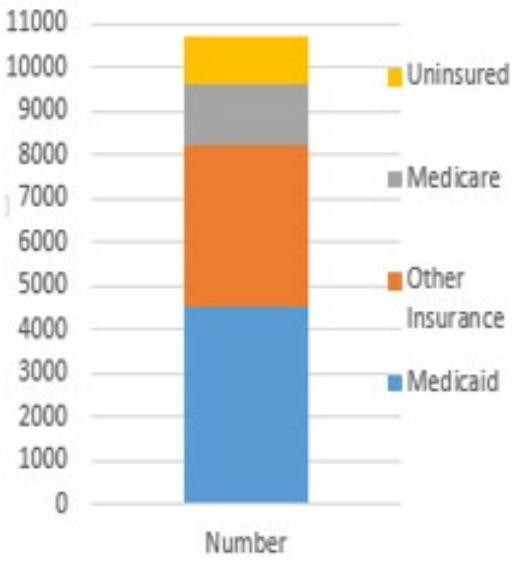
The Statewide Medical Case Management (MCM) programs assist PLWH with income levels of 400% FPL or less to enter and remain in medical care through bio-psychosocial assessments, individualized care plans, advocacy, and referrals for core and support services including health insurance.

Medical Nutrition Therapy Programs provides client nutritional health assessments, individualized nutritional plans, and nutritional counseling for PLWH. Licensed registered dieticians/nutritionists manage the programs. Clients can access nutritional supplements and nutritional food to maintain healthy weight, reduce side effects from certain medications, and improve their health outcomes.

The figure shows the type of insurance coverage for PLWH living in Connecticut and reinforces the role of Medicaid and Medicare coverage for PLWH. A significant number of PLWH remain uninsured or uninsurable.

Type of Insurance Coverage for PLWH in Connecticut

Source: CTDPH Unmet Need Calculations



Funding Sources

The table below shows an analysis of HIV Funding in Connecticut by Source for Fiscal Year 2021. This includes leveraged resources from HRSAs Community Health Center Program, HUD's HOPWA program, and Substance Abuse and Mental Health Services Administration Programs. The DPH convenes quarterly a Connecticut HIV Funders Group comprised of representative from RHWHAP partners, CDC funded service providers, and other partners (e.g., Cities that administer HUD HOPWA funding). The HIV Funders Group facilitates data and information sharing and assists with system-level coordination issues (e.g., policy, funding, workforce training).

Analysis of HIV Funding in Connecticut by Source: FY 2021 unless denoted by *

Source	Amount	%Total	Notes (FY 2021 unless otherwise noted)
RW A	$8,296,423	7.92%	Includes formula, supplemental & MAI
RW B	$15,867,532	15.15%	Includes base, ADAP & emergency relief
RW C	$3,957,912	3.78%	Includes EIS & 3 capacity building grants ($450,000)
RW D	$1,086,349	1.04%	Includes any supplemental awards
RW F Dental	$15,881	0.02%	Dental reimbursement program
RW F SPNS	0	0.00%	No new awards; continuation awards from prior years
AETC	$238,000	0.23%	Yale sub recipient from regional center
HOPWA	$3,597,414	3.43%	Awards to 4 cities
Medicaid/Medicare*	$60,000,000	57.27%	Estimate only; Kaiser Family Foundation; Medicaid covers 42% of adult population (v. 13% overall); Medicaid on HIV accounts for 30% of all spending on HIV care
SAMHSA	$600,000	0.57%	PWUD
CDC Prevention*	$4,474,204	4.27%	FY 2022; includes only HIV, STIs, Hep, TB
State HIV Prevention*	$5,447,805	5.20%	FY 2022; HIV Prevention, Needle Exchange/SSP
Directly funded CDC PS21-2102 APNH & APEX	$882,625	.84%	Comprehensive HIV Prevention Programs for HIV Prevention Programs
Total	$104,764,145	100%	Sources: FY 2021 data from HRSA website(s) and the CDC website

Coordination of Substance Abuse Prevention and Care Services

Jurisdictional partners of this Plan allocate funding to support core medical services including access to substance abuse treatment services. The RWHAP partners expect their investments in core medical services to meet standards of care for provider screening for substance-related use and misuse as well as the identification of other risk factors.

The CTDPH supports a wide array of harm reduction strategies and services including a statewide network of Syringe Services Programs (SSPs). SSPs represent community-based access to sterile needles and syringes, facilitate safe disposal of used syringes, and provide and link drug users to other important services and programs such as Referral to substance abuse disorder treatment programs; Screening, care, and treatment for viral hepatitis and HIV; Education about overdose prevention and safer injection practices; Vaccinations, including those for hepatitis A and hepatitis B; Screening for sexually transmitted diseases; Abscess and wound care; Naloxone distribution and education; Referral to social, mental health, and other medical or drug user health services.

Plan implementation partners interface with the Connecticut Department of Mental Health and Addiction Services (CTDMHAS) at multiple levels. For example:

- A CTDMHAS representative serves as a CHPC member and subject matter expert and participates on the CTDPH Ending the Syndemic Partners Group with an eye to strengthening the connection between Infectious Disease Services offered by CTDHMAS providers in the context of substance abuse treatment. Risk reduction plans get developed for high-risk patients. Plans include HIV counseling and testing as well as services for Hepatitis C and tuberculosis; all HIV seropositive clients develop a treatment plan determining their HIV needs and priorities. Prevention/case management services and education are offered to clients as well as their families and significant others.
- The CTDPH coordinates an Opioids and Drug Overdose Prevention initiative to address the misuse of prescription medication and opioid-based drugs. For example, 'Change the Script' is a statewide public awareness campaign to help communities address the prescription drug and opioid misuse crisis. In collaboration with the CTDMHAS, Department of Consumer Protection (DCP), and Department of Children and Families (DCF), and CTDPH's Office of Injury and Violence Prevention launched an educational campaign for state residents that helps to increase awareness of the dangers of opioid and prescription drug misuse while focusing on decreasing the stigma of addiction and promoting life-saving measures such as naloxone and treatment. The campaign materials available for use include social media messages, PSAs (radio and TV), billboards, posters, and brochures.
- State agency partners promote access to other important resources such as the Naloxone + Opioid Response App (NORA), a free interactive educational tool that will expand the understanding of what naloxone is and reinforce initial training given when a person fills their prescription for it. Updates will be ongoing with input from users of the app, with the intent that local coalitions and support staff at hospitals will share the app with family, friends, and persons at risk of overdose.
- Multiple partners of this Plan play a role in community-based initiatives supported by the CTDMHAS Prevention and Health Promotion Division. This Division promotes the overall health and wellness of individuals and communities by preventing or delaying substance use through strategies such as information dissemination, education, alternative activities, strengthening communities, promoting positive values, and problem identification & referral to services. The Division supports a statewide prevention infrastructure (Resource Links) and connection to 156 Local Prevention Councils. CTDMAS community-based programs and initiatives include Cannabis Awareness and Education Program, Connecticut Strategic Prevention Framework Coalitions, Connecticut Healthy Campus Initiative, Strategic Prevention Framework for Prescription Drugs, and State Opioid Response grant prevention programs. All these resources are identified in a Prevention and Health Promotion Division Compendium (2020) report.

- The CTDMHAS Office of Recovery Community Affairs serves as a liaison for people who may identify with having mental health and/or addiction challenges, their families, friends, and allies, as well an information and resource guide to all providers. The Office informs residents of Initiatives, Services and Resources that are offered by DMHAS and DMHAS-funded agencies throughout the state. The Office embraces a 'No Wrong Door' motto for recovery and encourages people to find the pathway(s) that work best for them, including support for recovery communities (e.g., recovery coaches) and peer support models (e.g., Peer Recovery Certification).

It is anticipated that this Plan's syndemic approach, including SUD as an area of focus, will strengthen the collaboration and coordination of substance abuse prevention and care services at the system, provider, and community level as well as across all strategies (e.g., integrated screening, awareness campaigns).

Maximize Quality of Health and Support Services for People At-Risk for or living with HIV

Connecticut provides core medical and supportive services to people living with HIV or AIDS (PLWHA) and their families through various "HIV/AIDS service and community-based organizations." These services include medical case management, primary medical care, oral health, mental health, substance abuse-outpatient, medical nutrition therapy, HIV-related medications, health insurance premium and cost sharing assistance, home health care, home-and-community based services, hospice care, medical transportation, housing-related services, food bank/meals, psychosocial support, linguistic services, and related emergency financial assistance. Eligible PLWHA can access these core medical and support services throughout Connecticut at no cost to them.

- Access Health CT is the state health insurance exchange administered by the State of Connecticut to meet the requirements of the federal Affordable Care Act. The exchange provides individuals, families, and small businesses with a range of qualified, approved health plans from brand name carriers.

- The Connecticut AIDS Drug Assistance Program (CADAP) can help pay for Food and Drug Administration (FDA) approved HIV-related drug treatments. No asset limit exists, and the income limit is 400% of the Federal Poverty Level. Physician verification of HIV/AIDS and proof of Connecticut residency is required.

- CTDPH administers a Connecticut Insurance Premium Assistance (CIPA) program that helps individuals with the cost of their premium for approved health insurance plans. To be eligible, an individual must be a resident of Connecticut, at or below 400% FPL, HIV positive, have a CD4 and viral load count data submitted, not be enrolled in the Connecticut Department of Social Services Medicaid with prescription drug coverage, and have an approved Health or Prescription Insurance plan. Information can be accessed through https://ctdph.magellanrx.com/member/.

- The Children, Youth and Family AIDS Network of Connecticut (CYFAN) of the Community Health Centers Association of Connecticut (CHCACT) offers HIV/AIDS primary care services, coordination of the Perinatal HIV Transmission Project, medical case management services (intensive child and youth centered), mental health services and support groups for infected and affected children, youth, and their families. Community health centers participating in CYFAN also administer comprehensive, culturally competent HIV/AIDS outreach services to provide appropriate linkages to care for youth between the ages of 13-24.

- "Project TLC" is a statewide program designed to assist HIV-positive individuals ready for, or recently released from Connecticut's correctional system with linkages and referrals to community-based and core medical services, including the Connecticut AIDS Drug Assistance Program (CADAP). Project TLC offers transitional case management, medical transportation and referrals to individuals for 30-60 days following release.

- The CTDPH funds statewide Medication Adherence Programs (MAP) to assist PLWH adhere to their medication regimens. Many people living with HIV are living longer and healthier lives due to the advent of modern antiretroviral drugs (ART). The ability for PLWH to take these drugs and maintain the medication regimen is essential for maximizing the potential benefits of the medications. However, because these medications are difficult to take because of side effects, other co-morbidities (e.g., depression, substance use, hepatitis) and psychosocial factors (e.g., homelessness, issues with access to health care), adherence to the treatment regimen is often difficult. Poor adherence to a prescribed HIV medication regimen may also lead to the development of drug resistance, which can affect future treatment options.

The following are examples of quality improvement activities and plans carried out by Integrated Planning partners:

- The Ryan White Part A TGA, in collaboration with several statewide and local partners, implemented pilot projects (e.g., Hepatitis C and HIV Co-infection, Data Integration Grant Project in housing and presented findings at national conferences.

- The Ryan White Part B (CTDPH) continues to improve its approach by increasing meaningful use of its technology platform. For example, the system can identify and flag individuals who have not picked up their HIV medication which in turn sets in motion a communication and outreach protocol.

- The CHPC's Quality and Performance Measures (QPM) Committee serves as a forum to stimulate cross-part collaborations in quality improvement. The CHPC and QPM host an annual Quality Management Summit and individual partners present regularly at national conferences).

The Connecticut State Health Improvement Plan as well as this Plan places an emphasis on addressing social determinants of health. Affordable housing represents a significant challenge in Connecticut in general and among the HIV community. Connecticut receives approximately $3 million in Housing Opportunities for Persons with AIDS (HOPWA) program funding (fiscal year 2015). HOPWA provides housing assistance and related support services for low-income persons with HIV/AIDS and their families. CTHousingSearch.org represents a free resource for finding and listing housing anywhere in Connecticut.

The remainder of this page was intentionally left blank.

Priority Populations

Each of the jurisdictional partners as well as other RWHAP partners identify priority populations specific to their funding and in response to their geographic service areas. This Plan recognizes that it serves as an umbrella for all priority populations and subpopulations or participating partners. Section 4 provides specific details by partner. The Plan incorporates strategies to address the general population (e.g., campaigns for routine HIV testing and syndemic screening) as well as strategies specific to address disparities in incidence and health outcomes most relevant to the Plan indicators described in Section 5.

A. Strengths and Gaps

Strengths. Connecticut's HIV Prevention and Care system offers many strengths. The Resource Inventory section illustrates the depth and breadth of prevention services statewide with more services in areas with the highest incidence and prevalence of HIV. The service delivery system seeks to make changes to integrate prevention and care services, to innovate by using unique strategies, engage non-RWHAP providers who serve PLWH and those who are at risk of acquiring HIV, and to address social determinants of health.

Examples of notable strengths through collaboration, modernization, and innovation by Connecticut's HIV Prevention and Care services include:

- HIV care services organized by regional service delivery networks. The hubs increase access, strengthen collaboration and integration of local service providers, and create administrative efficiencies. The Ryan White Part A EMA established this model. The CTDPH replicated this approach with statewide Ryan White Part B funding, and in upcoming years will use this approach with statewide HIV Prevention services.
- The Surveillance program has a Cluster Detection and Response Plan and an Outbreak Response Coordinator in place with defined roles and responsibilities that will lend to structured and coordinated responses in the future. The plan can be found at this link: https://my.visme.co/view/4dy0d9dz-18r27v18ee8w26qz
- HIV care service delivery providers have expanded their capacity to offer prevention and behavioral health services through innovative business models and partnerships with healthcare system partners and payers. Blending and braiding HIV Prevention and SUD Tx funding creates organizational stability and sustainability and aligns with the vision implement a syndemic approach. The Connecticut Harm Reduction Alliance (CTHRA) reaches 3,500 people statewide to reduce harm and stigma to people who use drugs, those experiencing homelessness, and those engaging in sex work. Harm reduction services expand and enhance partnerships and create opportunities to expand prevention partnerships and keep Connecticut on the leading edge of harm reduction work.
- The Ryan White Part B Program is administered by the Healthcare and Support Services Unit at the CTDPH. The Part B Program currently funds Medical Case Management, Outpatient/Ambulatory Health Services, Oral Health Services, Emergency Financial Assistance, Medical Transportation, Food Bank/Home Delivered Meals, and Non-Medical Case Management for Project TLC (Transitional Linkage to the Community). In 2020, the Part B Program secured X09 ADAP Emergency Relief Funds in the amount of $5 million per year for ADAP specific funding. The Part B program continues to apply for this funding on an annual basis. In addition, the Part B Program also applied for the X08 Grant, Part B Supplemental. The Part B program used justification from the 2022 Statewide Needs Assessment to justify additional funding for the Part B services. The Part B Program was successful in their first application for the X08 grant and received $1.9 million. The Part B program plans to continue to apply for this annual funding. With this additional funding brought into the State, the DPH was able to increase Ryan White Part B service contracts by $3 million per year and provides more funding than was previously available under the Part B program. The DPH will continue to work with community partners to identify client needs and additional funding opportunities to help enhance the continuum of care in Connecticut.

- The Data Integration Grant (DIG) HIV Care and Housing coordination through data integration to improve health outcomes along the HIV Care Continuum. The Hartford DIG project objectives included: 1) Enact new policies and processes to support data exchange and analysis; 2) Create a bi-directional interface between the CAREWare and CaseWorthy systems; 3) Develop and implement a cross training curriculum to foster improved service delivery, data exchange and analysis; 4) Analyze comprehensive data to assess changes in health outcomes; 5) Document and disseminate challenges, lessons learned, best practices, and innovative models; and 6) Improve health outcomes for persons living with HIV/AIDS and those prone to homelessness. The project featured cross training and coordination of providers include creation of a Joint Peer LEAD HOPWA Housing and Ryan White Case Management coordination / training approach recognized by HRSA as a best practice model. Over 150 individuals were trained on the integrated system across 15 provider sites. 60+ joint clients were identified and benefitted from data sharing agreements. The system identified out of care clients who were housed and not virally suppressed. Of the total 160 clients on the HOPWA waitlist: 93 received a RW service, 45 completed at least one medical visit, 38 had at least one CD4 or Viral Load test, and 40 (of 48) were virally suppressed.
- The RW Part A TGA and its partners introduced a jurisdictional approach to improve HCV provider and patient education, expansion of screening and linkage to care and systems transformation. The program intended to address modifiable barriers to accessing HCV services. This included: a) system barriers such as underdeveloped surveillance system, lack of HCV providers, and lack of coordinated HCV services; b) provider level barriers such as physician prejudice, referral bias, limited HCV testing and intake capacity, and lack of patient navigation; and c) patient level barriers such as medical mistrust, substance use, psychiatric conditions, and adherence issues. This highly participatory process included interviews with PLWH and PWLE (15 to 17), non-medical providers (8 to 10), and medical providers. Consumers reported: a) a need for increased HCV-specific services, including social support and events; b) a need for more education out in the communities affected by HCV; c) stigma reduction particularly in communities affected the most by HIV and VH; and d) better communication about HCV, screening, and a cure. Providers reported a need for: a) increased peer support services necessary to create an inclusive environment; b) funding for services; and c) increased HCV education for providers and consumers.
- Connecticut Children's secured RW Part D Supplemental funding to establish the Youth Stable Housing Collaboration (YSHC). The YSHC exists to improve health and housing outcomes for youth living with HIV ages 18-24 throughout Connecticut. Activities center around three objectives: 1) Expanded Housing Support Specialist services link youth to housing appropriate for youth with HIV and provide steady support throughout their passage through emergency (up to 30 days) and/or stabilization (up to 90 days) housing, following up thereafter to ensure that the goal of stable housing is achieved; 2) Enhanced access to emergency housing by providing vital urgent housing placement; and 3) Expansion of YSHC to include jurisdiction across the state to ensure that the Housing Support Specialist and others can readily identify appropriate housing for women, children and youth (WICY) with living or affected by HIV, that need accommodations are widely available and accessible. The model engages youth in a developmentally appropriate, culturally relevant, and whole health approach that addresses social determinants of health while providing access to HIV specialty services provided by compassionate and caring professionals and paraprofessionals who can connect youth to healthcare providers in the adult system, connect them to other resources (e.g., mental health, education, employment), and support their process to address trauma and stigma and build a strong network of resources. Since establishing the YSHC initiative, viral load suppression among youth participants ages 13 to 24 increased from 42% (2018) to 85% (2021). 95% of youth served in this program secured permanent housing.
- The 2022 Routine HIV Testing legislation spurred the development of a statewide campaign centered on the core message of "T.E.S.T. CT". The acronym of T.E.S.T. refers to "Tell Everyone to Screen and Test" and intends to routinize and normalize screening and testing across all areas of syndemic focus.

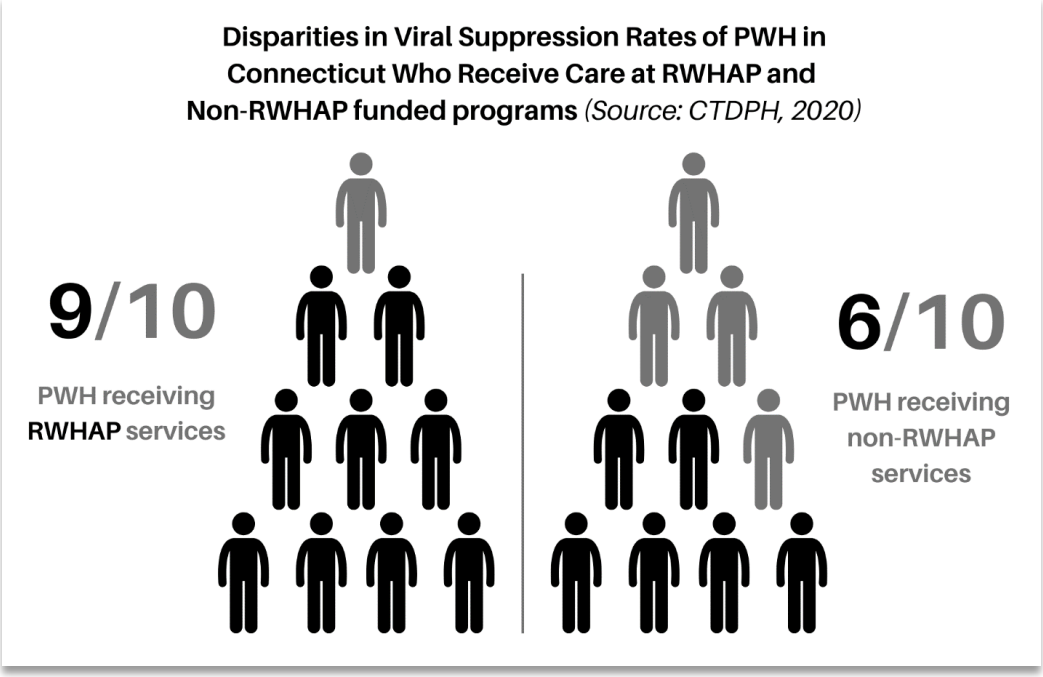
The awareness campaigns will drive residents and providers to a common landing page which then allows them to choose their pathway to resources that best fit their needs.

- During 2022, CTDPH leveraged its HIV-related community and provider networks to offer a series of informational sessions on the topic of Monkey Pox. The sessions included updates on surveillance data, information about vaccines and treatments (access, availability, and treatment resources), and access to persons with lived experience who could share their personal and provider journey.
- CTDPH and AETC collaborated on a health equity summit focused on ending the syndemic. This was one of many events organized to provide opportunities for building knowledge of health equity and social determinants of health.
- The Community Health Center Association of Connecticut (CHCACT) works with nine health centers in CT to help them provide health and support services to people living with and/or impacted by HIV or AIDS. These services include training for patients to better self-manage the disease, as well as care coordination, referrals, and assistance with transportation. CHCACT works closely with the AETC to enhance and expand training opportunities for the HIV workforce. A recent example includes the development of training modules related to intimate partner violence.
- CT DPH collaborates with statewide Federally Qualified Health Center (FQHC) through contracts with providers for HIV Prevention and Care. In addition, the CT DPH supports the HRSA funded Project ECHO in the jurisdiction with free access to HIV and hepatitis C testing kits. The goal of Project ECHO is ensuring access to HIV and viral hepatitis screening, linkage to care and treatment services.
- The HIV prevention and care providers and partners assemble to support initiatives to better engage community residents at the statewide (CHPC), regional (Ryan White Part A EMA and TGA), and local levels. As part of its engagement strategy to inform the development of an Ending the HIV Epidemic Plan, the New Haven/Fairfield Ryan White Part A Program invited Black faith leaders and seminary students to discuss the impact of HIV on their communities and the role of Black clergy in ending the local HIV epidemic. Black faith leaders were very vocal: “We’re doing this work already. We want to do more. We want to partner with your program and the community to end this epidemic.” Hearing this, the Ryan White Program facilitated a series of six engagement and planning sessions with Black faith leaders, facilitated by the Black AIDS Institute. The outcome of this work was a six-month plan to develop a faith-led, community-driven Ending the Epidemic strategy. The activities of this plan include reducing HIV-related stigma among faith leadership and the community, welcoming PLWH to worship, and educating congregations on HIV. The foundation of the strategy is to build an infrastructure to provide education and peer support to faith leaders that are new to HIV work, so that they can convey factual, compassionate HIV messaging to their congregations and communities. The Ryan White Part A Program included the monitoring and evaluation of faith-based strategies as part of its quality improvement initiatives to increase engagement and retention in care among Black PWLH.
- The Connecticut AIDS Drug Assistance Program (CADAP) is a Ryan White Part B Service Category provided by the Healthcare and Support Services Unit at the CTDPH. CADAP provides prescription medication assistance to low-income eligible individuals with HIV. CTDPH continues to modernize CADAP. The application for CADAP can be completed entirely online and clients can log in to their own personal portal to view their application status, eligibility renewal timeline, and submit required documents. In 2020, CADAP made an enhancement that allows Ryan White Part B Medical Case Managers access to a case manager portal. This portal will allow Medical Case Managers the ability to review their clients’ application status, eligibility renewal timeline, and submit required documents on behalf of the client. This tool was especially helpful during the COVID-19 pandemic. The CTDPH continues to expand access to Medical Case Managers that are funded by Ryan White Part B and will hopefully be able to expand this access to non-Part B funded case managers.
- The Center for Interdisciplinary Research on AIDS (CIRA) was established in 1997 and is currently New England's only National Institute of Mental Health (NIMH) funded AIDS research center. The Center

presently more than 200 affiliates comprised of HIV scientists representing multiple disciplines, research trainees, community, and institutional partners, and provides support to 68 active grants, including 25 international research and training programs. CIRA supports and advances HIV-related implementation science to close the gap between evidence-based HIV prevention and treatment approaches and clinical and community practice. CIRA engages consumers and providers in its work and advisory groups. This Plan strengthens the partnership with CIRA to better leverage its expansive network of subject matter experts and potential to transform service delivery systems through dissemination, training, consultations, and research.

Gaps. In the state of Connecticut, the highest incidence of HIV is in the following cities: Hartford, New Haven, Bridgeport, Waterbury, and Stamford. CTDPH continues to allocate resources to the areas with the highest burden of HIV. Connecticut partners conducted multiple needs assessments that identified strengths and gaps in providing HIV Prevention, Care, and Treatment services. The results of these assessments in conjunction with the state's epidemiological data confirm a number of disparities among PLWH.

Viral Suppression Rates Among PLWH Who Receive Ryan White Services and Those Who Do Not.

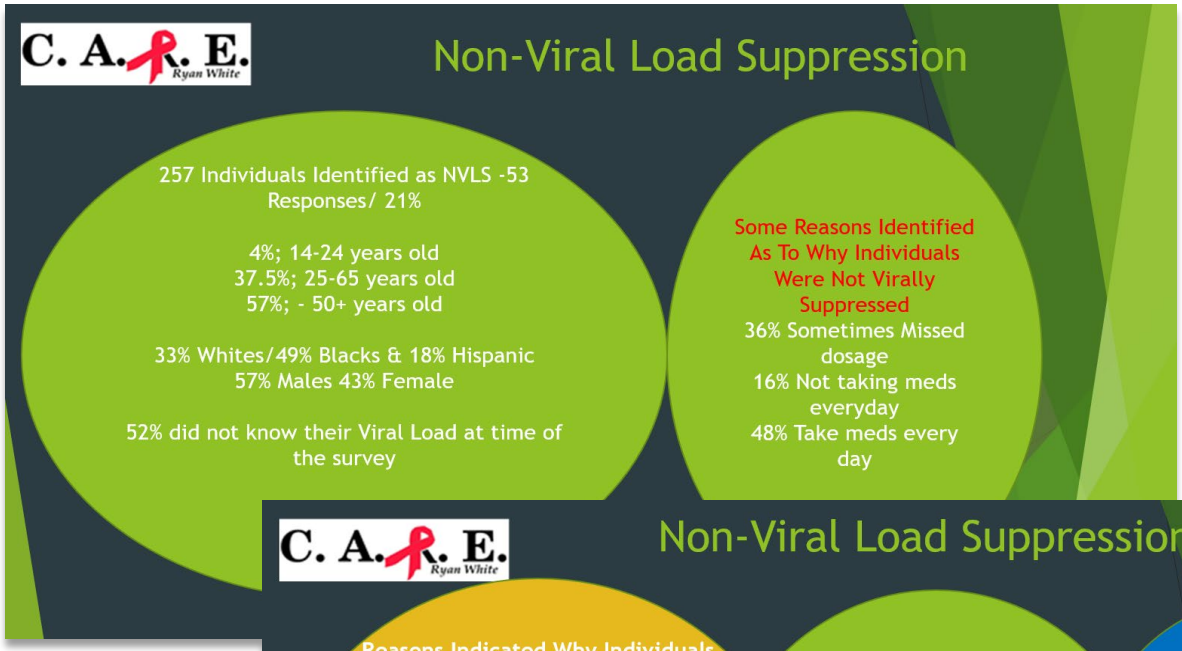


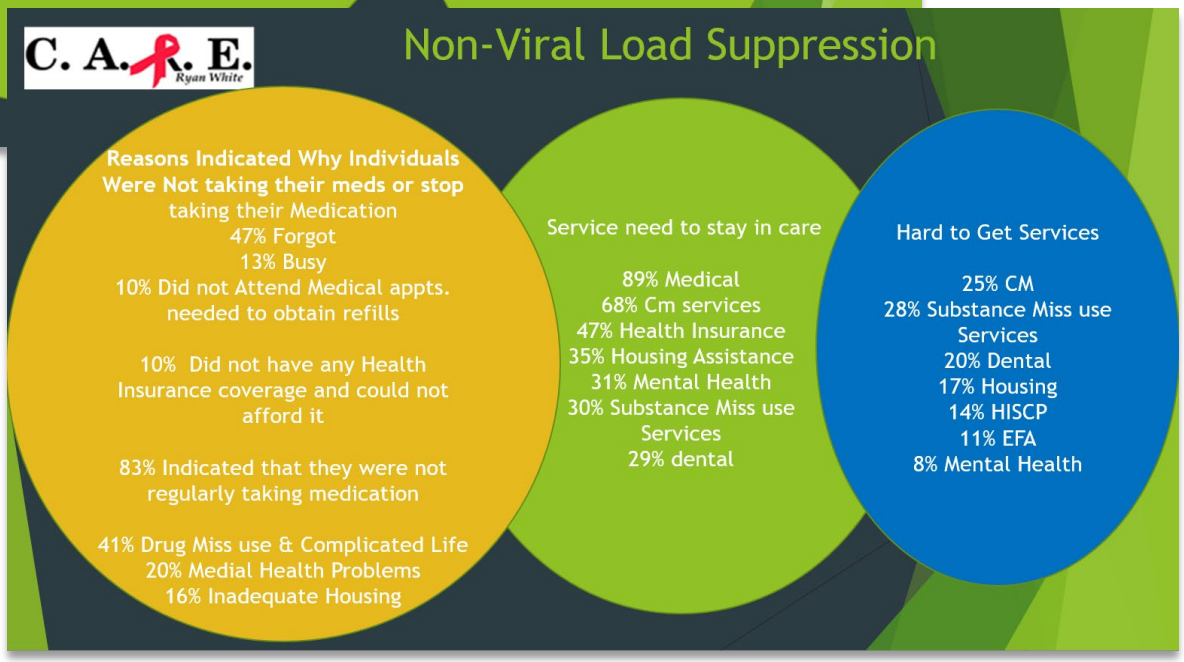
Connecticut recognizes the importance of engaging Non-Ryan White providers to improve the health outcomes of all people living with HIV and not just those receiving Ryan White services.

During the implementation of this Integrated Plan, the CTDPH will collaborate with all partners to adjust our mechanisms for linking people to services and improving health outcomes.

In 2021, the Ryan White Part A Hartford TGA conducted 4 Need Assessment Surveys. The surveys conducted were an *Out of Care Survey*, a *Non-Viral Load Suppression Survey*, a *COVID Survey*, and an *Unmet Needs Framework Model* survey. A complete list of resources including Standard of Care documents, their Quality Management Plan, Reference Materials, Meeting minutes, and more can be found on their website: https://ryanwhitehartford.info/resources/.

The graphics below are snapshots from the Greater Harford RWPA TGA's *Non-Viral Load Suppression Survey*, highlighting a summary of who participated in the survey, some reasons identified as to why individuals were not virally suppressed, reasons indicated why individuals were not taking their medication, services participants felt were needed to stay in care and services participants felt were hard to obtain.





All the Greater Hartford Ryan White Part A TGA survey findings were presented to their members and directly influence their resource allocation process to ensure their funding is appropriately aligned with their clients' needs.

Survey findings were also presented at the CHPC's Needs Assessment Projects (NAP) Committee to provide insight on the gaps and strengths within their jurisdiction. Goal two of our Integrated Plan demonstrates how the CHPC and other jurisdictional partners plan to continue active collaboration and unite our strengths to carryout our key strategies in the TGA and throughout the state.

Barriers. The following multi-level barriers were identified from a variety of stakeholders through periodic monitoring and evaluations.

Health Department Barriers:

CTDPH is committed to working with stakeholders on developing and implementing goals, objectives, and activities despite the following challenges:

- CTDPH was not designated an EHE state or given any specific funding for EHE activities
- Limited Health Department staffing capacity in the following programs, HIV Surveillance, STD Prevention and Control specifically, Partner Services (DIS), and Ryan White Part B Health Care and Support Services
- Restrictions on the use of federal funds to support Harm Reduction Activities specifically, Syringe Service Supplies, and Naloxone Distribution

Provider Barriers:

CTDPH is committed to expanding relationships with providers and serving as a resource to them in the provision of HIV services. Developing provider toolkits and academic detailing are examples of future activities to support providers.

- While Connecticut does have a PrEP provider network, not all healthcare providers are aware of biomedical prevention options or participate in the provision of them.
- While Connecticut has an LGBTQ Provider Network, not all healthcare providers provide services that are welcoming or culturally sensitive to LGBTQIA+ populations
- Not all healthcare providers conduct comprehensive sexual risk assessments
- Not all providers are implementing Status Neutral Care models

Client Barriers:

Various Needs Assessment surveys have been conducted by planning partners that identify the following client barriers to accessing services:

Various reasons for not taking medications and maintaining viral suppression (i.e., forgetting, missing medical appointments, inadequate housing, no health insurance coverage, complicated life circumstances, and mental health problems).

The remainder of this page was intentionally left blank.

The table below shows gaps organized by Plan goals as identified by CHPC and jurisdictional partners.

Gap Analysis Summary Table

Goal 1. Prevent new HIV infections	• Effective infrastructure to deliver comprehensive K-12 sexual health education programming (in-schools or community-based). • Limited surveillance capacity in areas of STIs and hepatitis. • Optimal use and deployment of disease intervention specialists (DIS). • No routine HIV testing and standard use of status neutral care approach. • PLWH in private medical settings experience lower viral suppression (Treatment as prevention). • PrEP uptake not reaching scale or priority populations. • No prevention needs assessment. • No real-time, updated provider data base to understand access to syndemic services.
Goal 2. Improve HIV related health outcomes of people with HIV	• PLWH in private medical settings experience lower rates of viral suppression. • PLWH falling out of care or not adhering to medication regimens. • Status neutral care approach not yet the standard. • Rapid start treatment (7 days or less) not yet the standard. • Uneven, siloed (via funding), informal, or inefficient referral mechanisms and processes to facilitate access to care across all areas of syndemic focus. • Professional development in core HIV competencies and diversity, equity, and inclusion (Goal 3). • Limited or suboptimal use of resources that address SDOH (e.g., access to housing food). • Other factors such as mental health affecting engagement and health outcomes.
Goal 3. Reduce HIV-related disparities and health inequities	• CHPC does not have measures, metrics, or methodology to assess stigma reduction. • CHPC does not have measures, metrics, or methodology to address all areas of focus for the syndemic approach. • HIV/AIDS workforce does not reflect the priority populations which affects engagement and efficacy. • Limited coordination, reach, and uptake of professional development activities in areas of diversity, equity, and inclusion and cultural relevance. • General awareness and knowledge of HIV and health inequities and disparities remains low • Partnerships and strategies to engage communities remain uneven or less than optimal.
Goal 4. Achieve integrated, coordinated efforts that address the HIV epidemic among all partners and stakeholders.	• CHPC does not have optimal mechanism to document annual progress (beyond statewide indicators). • Different data systems used by core partners which increases the complexity of data integration and causes duplication in data entry and reporting. • Outdated language or lack of alignment across syndemic areas in state statutes (e.g., age for routine HIV testing and hepatitis). • Coordination of needs assessment activities and timing across the HIV-funded partners. • Coordination and standardization of policies, funding approaches, and practices (e.g., brief screens, referrals) by partners most relevant to areas of syndemic focus. • Limited involvement and integration of non-HIV partners, including education, housing, and local health departments/districts. • Resources and personnel gaps to address workforce openings and advance modernization efforts at statewide and local public agencies.

b. Approaches and Partnerships

The HIV prevention, care, and treatment resource inventory represents data contributed by CHPC partners, particularly the RWHAP administrators, through their involvement in the CHPC or other groups such as the Connecticut HIV Funders Group or the DPH Ending the Syndemic Partners Group. The CHPC project support staff collected and analyzed data from secondary sources as well to supplement the information made available by the partners.

3. HIV Prevention, Care, and Treatment Resource Inventory

HIV Prevention, Care, and Treatment Resource Inventory as of December 2022

Funding Source	Amount	%Total	Services & Activities	Priority Populations
RW A (Includes EMA & TGA)	$8,296,423	7.92%	Substance Abuse/Outpatient Services Emergency Financial Assistance Food Bank/Home Delivery Meals Health Insurance Premium and Cost Sharing Assistance (HIPSSA) Housing Medical Case Management Medical Transportation Mental Health Services Oral Health Services Substance Abuse/Inpatient Services	Black/AA PLWH unaware or out of care Hispanic PLWH unaware or out of care Black/AA PLWH MSM unaware/out of care Trans persons of color Young MSM of color Black women
RW B	$15,867,532	15.15%	Medical Case Management (only) Oral Health Care Outpatient/Ambulatory Health Services Non-medical Case Management/Transitional Case Management (TLC) Emergency Financial Assistance (housing, medical and utilities) Food Bank/Home Deliveries (food vouchers only) Medical Transportation	People Living with HIV (PLWH) MSM of color Black and AA Heterosexuals Hispanic/Latinx Heterosexuals
RW C	$3,957,912	3.78%	Outpatient/Ambulatory Services Behavioral Health Outpatient Care Early Intervention Services Substance Abuse Outpatient Care Prevention Outreach Medical Case Management Mental Health Services Treatment Adherence Early Intervention Services Prevention Outreach	Varies by specific community Approaches tend to address populations that demonstrate disparities
RW D	$1,086,349	1.04%	Outpatient/Ambulatory Health Services Treatment Adherence Services Early Intervention Services Outreach, Testing and Linkage to Care Medical Nutrition Therapy Non-Medical Case Management Mental Health Services	Black/AA & Hispanic/Latina Women Young MSMs of color Women, Infants, Children, & Youth

			Health Education/Risk Reduction Medical Case Management Medical Transportation Services	
RW F Dental (Hartford Hospital)	$15,881	0.02%	Dental Reimbursement Program	PLWH who meet eligibility
RW F SPNS* HRSA-22-028 (Yale University)	$300,000	0.29%	Emerging Strategies to Improve Health Outcomes for People Aging with HIV	People Aging with HIV
RW F AIDS Education and Training Centers (AETC)	$238,000	0.23%	Adherence to HIV and Nutrition Pre-Exposure Prophylaxis (PrEP) Cultural Competency Post-Exposure Prophylaxis (PEP) Opportunistic Infections Reproductive Health HIV Home Test Training Antiretroviral Treatment Clinical HIV Manifestations	Persons living with HIV (quality, peer supports) Clinical providers Physicians, physician assistants & nurses Medical and nursing students
HOPWA	$3,597,414	3.43%	Housing Assistance	PLWH experiencing Homelessness Black/AA Gender varies by city 51 and older
SAMHSA	*	0.57%	Mental Health, Substance Use Treatment, Opioid Prevention, and HIV Prevention Services	People Who Use Drugs
Medicare Medicaid	$60,000,000	57.27%	HIV Screening HIV Diagnosis HIV Treatment	65+ Older People with certain disabilities Low-income people, families, and children Pregnant women People with disabilities
CDC Prevention PS18-1802	$4,474,204	4.27%	Component A- Outreach Testing & Linkage (OTL) Routine Testing Services (RTS) Partner Services Pre & Post-Exposure Prophylaxis (PrEP & PEP) Navigation Effective Behavioral Interventions (EBI) HIV Surveillance Activities Drug User Health Services Component B- Demonstration Project	Gay, bisexual, and other MSM Black/AA and Hispanic men & women People who use drugs Youth 13-24 Transgender women
State HIV Prevention	$5,447,805	5.2%	Contractual/Syringe Service Programs (SSP)- Supplies	People Who Use Drugs (PWUD)

PS21-2102 Recipients-APNH and APEX	$882,625	.84%	High Impact Prevention Programs	Persons living with or greatest risk for HIV
Total	$104,764,145	100%		

The remainder of this page was intentionally left blank.

4. Needs Assessment

The jurisdictional partners routinely conduct needs assessments within their jurisdictions and statewide to inform priority setting and allocations processes that support HIV prevention and care services.

New Haven / Fairfield Counties Ryan White Part A EMA:

The New Haven/Fairfield Counties Ryan White Part A EMA conducted a variety of surveys as displayed in the table below:

DATASET PRESENTATION

Service Category	2022 PRIORITY SETTING DATA SETS					
	Data Set #1: 2020 In Care Needs Assessment	Data Set #2: 2021 Non-Virally Suppressed Needs Assessment	Data Set #3: 2020 Newly Diagnosed Needs Assessment	Data Set #4: 2019 Aged Needs Assessment	Data Set #5: 2019 Priority Populations	Data Set #6: 2021 MCM Survey
Outpatient/Ambulatory Health Services	2	1	2	3	2	13
Medical Case Management	1	2	6	13	1	13
Oral Health Care	7	9	5	6	3	3
Food Bank/Home Delivered Meal	8	7	1	4	4	2
Mental Health Services	9	5	9	5	6	13
Emergency Financial Assistance	4	6	3	9	7	4
Medical Transportation	5	3	7	2	5	6
Housing Services	3	4	8	1	8	1
Substance Abuse Services-Outpatient	11	11	10	7	9	13
Health Insurance Premium/Cost Sharing Assistance	6	8	4	13	10	5
Substance Abuse Services-Inpatient	10	10	11	8	11	13
Denotes Core Service	Most Important Services to maintain/achieve Viral Suppression	Most Important Services to maintain/achieve Viral Suppression	As a person living with HIV/AIDS, what are the 5 most important services you receive	Most Important Services to maintain/achiev Viral Suppressio	Most Important Services to maintain/ achieve Viral Suppression	What service needs are you hearing from your clients that Ryan White does provide but not enough of?
Denotes Support Service	Surveys completed=507	Surveys completed=59	Surveys completed=24	Surveys completed=66	Surveys completed=85	Surveys completed = 35

The following page highlights examples of their *In Care Needs Assessment*, but to learn more about the Ryan White Part A New Haven/Fairfield EMA and all of the amazing work they're doing, click the following link: https://ourhivplan.org

The following are snippets from the New Haven/Fairfield Counties Ryan White Part A Planning Council's *2019 Populations of Focus in Care Needs Assessment* specifically selected to demonstrate the council's devotion to maintain focus on the populations most impacted by HIV in their jurisdiction and how their dedication helps encourage the rest of the jurisdictional partners to do the same.

NEW HAVEN / FAIRFIELD COUNTIES
RYAN WHITE PLANNING COUNCIL

2019 POPULATIONS OF FOCUS IN CARE NEEDS ASSESSMEMT

This Needs Assessment was a collaboration between the Strategic Planning & Assessment Committee of the Ryan White Planning Council of New Haven & Fairfield Counties and the Ryan White Office, City of New Haven. The following populations of focus were approved by the Strategic Planning & Assessment committee to be used for this needs assessment because they align with our Ryan White Part A grant application and narrative for the 'Getting to Zero' campaign.

1. Young MSM of Color (age 29 and under, African American & Hispanic)
2. African American Women
3. Transgender Women

Population of Focus	ACTUAL
1. Young MSM of Color-African American age	
2. Young MSM – Latino age 29 and b	
3. African American Women	
4. Transgender Women	
ACTUAL SURVEYS COMPLETED	

MOST IMPORTANT SERVICES TO MAINTAIN/ACHIEVE VIRAL SUPPRESSION

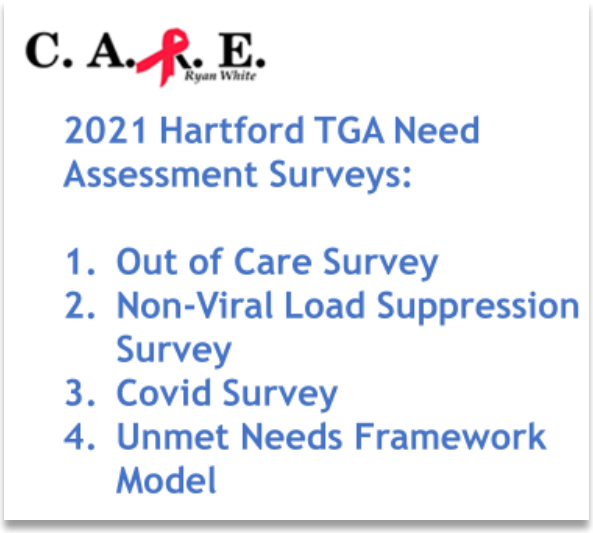
SERVICE	YOUNG MSM HISPANIC	YOUNG MSM AA	AA WOMEN	TRANSGENDER WOMEN
OAHS	93%	80%	100%	100%
HIPCSA	36%	22%	2%	22%
ORAL HEALTH	86%	60%	48%	57%
MENTAL HEALTH	43%	30%	28%	67%
SA OUTPATIENT	14%	10%	17%	63%
MCM	100%	90%	98%	100%
HOUSING	29%	30%	39%	33%
EFA	29%	44%	24%	68%
TRANSPORTATION	36%	30%	35%	89%
SA RESIDENTIAL	7%	10%	4%	22%
FOOD BANK/HDM	50%	20%	65%	68%
EIS	23%	30%	0%	11%

Greater Hartford Ryan White Part A TGA:

Identical to the New Haven / Fairfield Counties RWPA EMA, the Greater Hartford RWPA TGA conduct numerous needs assessments to guarentee adequate delivery of services and ensure their needs are being heard. The results of these needs assessments are presented at a Priorities and Reallocation Session for discussion.

Throughout 2021, the Greater Hartford RWPA TGA conducted 4 Need Assessment Surveys. They were an Out of Care Survey, a Non-Viral Load Suppression Survey, a COVID survey, and an Unmet Needs Framework Model survey. Below are additional examples of their Needs Assessment.

Located in Appendix 2 is a link for the Greater Hartford Ryan White Part A TGA website.



C. A. R. E.

HIV Cases

- TGA Wide - 3617 PLWHA (34% of statewide cases)
- RW Part A - TGA served 1248 PLWHA (35% of all cases in 2021)

Demographic as of 2019

TGA wide	Ryan White Part A
28% White	27% White
39% Hispanic	44% Hispanic
31% Black	29% Black/AA
RISK	
31% MSM	25% MSM
28% PWID	22% PWID
26% Heterosexual	47% Heterosexual

- More than 62% PLWHA are over 50yo

Newly Diagnose	
51.7% MSM	Viral Load Suppression Rate as of 1/31/2022 was 87% for the overall Ryan White Part A program
8.6% PWID	
27.6% Heterosexual	

Ryan White Part B (CTDPH):

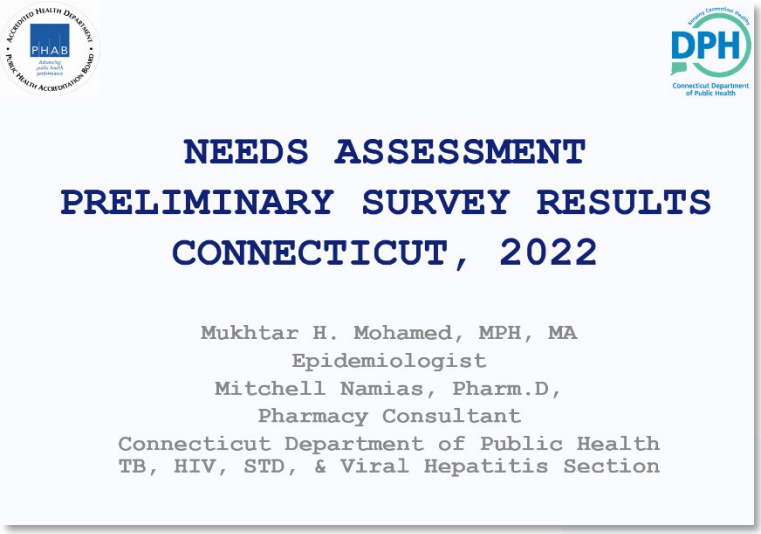
Approach for Statewide Needs Assessment Survey (2022)

The CHPC, RWHAP partners, and Ending the Syndemic Partners Group used guided discussion processes to identify strengths, weaknesses, opportunities, and threats (SWOT) as well as to identify gap areas and confirm priority populations.

Ryan White Part B coordinated a statewide PLWH needs assessment survey in 2022. Inclusion criteria included active medical case management clients by Ryan White Part B, no deceased or discharged in e2CT as of December 2021. The survey was developed with input from the CHPC and the HIV Funders Group. Data collection occurred during the time of February 18, 2022, to May 2, 2022. Of 813 clients selected to participate in the survey, 457 (56%) completed the survey.

CTDPH subject matter experts analyzed the data set and shared the information with the CHPC and its NAP Committee over the series of three meetings in which representatives from Ryan White Part A EMA, TGA, and Part B shared their priority needs assessment findings. These findings represented data sets relevant to their jurisdictional planning and priority setting activities. The CHPC NAP Committee Chair presented the main themes of the needs assessment findings to the CHPC and the CHPC participants assembled into small groups and used a guided discussion process (see Actions Taken).

The CTDPH will be collecting data on a statewide HIV Prevention Needs Assessment with data collection occurring in 2022 and 2023. The CHPC and other partners provided input into the survey design through an interactive poll process at the July 2022 CHPC meeting.



NEEDS ASSESSMENT
PRELIMINARY SURVEY RESULTS
CONNECTICUT, 2022

Mukhtar H. Mohamed, MPH, MA
Epidemiologist
Mitchell Namias, Pharm.D,
Pharmacy Consultant
Connecticut Department of Public Health
TB, HIV, STD, & Viral Hepatitis Section

Summary

- The survey data reveals communities of color have more barriers when accessing services
- There is an aging population
- Childcare for medical appointments, substance use reduction/treatment, and reproductive health services were identified as the least accessible services
- Opportunities exist for health enhancement and promotion

Numerous other reports hold relevance to the implementation of this Plan such as:

- The *Getting to Zero Commission Report (2018)* led by the CTDPH. The Connecticut Getting to Zero (G2Z) initiative was created to respond to the alarming trends in the HIV epidemic, with emphasis on the growing number of new cases of HIV in MSM (men having sex with men) of color, women of color, and Transgender individuals in urban centers where the epidemic is most concentrated: Hartford, Waterbury, Bridgeport, New Haven, and Stamford. The GTZ report resulted in six recommendations to end the HIV epidemic, many of which have already been implemented. Additionally, the Commission published a listening session report documenting feedback from the communities mostly impacted by HIV listed above. To view the report, click the link below: https://gettingtozeroct.org/
- The *In It to End Plan (2021)* led by RW Part A EMA. In 2019, the RW Part A EMA secured one of just 10 HRSA awards to develop a comprehensive, community-driven plan to end the local HIV epidemic. The effort included a review of Ending the HIV Epidemic Plans from 25 other jurisdictions, interviews with over 25 HIV community leaders and input from PLWH and residents through community conversations. The process led to identification of needs and recommended strategies reflected in this Plan.
- The *Connecticut Statewide PLWH Needs Assessment Survey (2022)* led by the CTDPH Ryan White Part B collected survey responses from 457 PLWH to identify priority needs and learn more about healthcare interactions such as healthcare screening and testing across various conditions (e.g., STIs, Hep, diabetes, HPV) during the last 12 months. The CHPC Needs Assessment Project team compared findings from this needs assessment with similar PLWH needs assessment efforts conducted by jurisdictional partners. The CHPC leaders structured a CHPC meeting and small group discussions to gain insights about priority needs.
- The *Connecticut LGBTQ+ Statewide Needs Assessment* (2021) conducted to increase the understanding of the number of people that identify a part of the LBGTQ+ community in Connecticut and learn more about their needs including safety, housing, health, mental health, legal services, social support, and community engagement. 3,048 adults across Connecticut completed a survey. About half (55%) of the respondents identified as Cisgender, 40% Transgender, and 5% Gender Diverse (not Transgender). About one-third of respondents identified as Lesbian (29%), Gay (32%), or Bisexual (35%). An additional 5% identified as Straight. The recommendations tie in with the prevention and equity strategies of this Plan.
- The *Community Wellbeing Survey (2021)* measures the quality of life in every Connecticut town across different categories including healthcare coverage, attitudes toward vaccines and masks, social trust, fear of gun violence and financial, food and housing insecurity.
- The *Healthy Connecticut 2025: State Health Improvement Plan* (2021) draws upon a comprehensive statewide need assessment and outlines a strategy to improve health and racial equity in Connecticut – key themes contained in this Plan. The HIV Prevention Program plays an integral role in the creation of the State Health Improvement Plan. (e.g., CTDPH is currently in the process of submitting its 2023 reaccreditation application to the Public Health Accreditation Board (PHAB) to which much of the work of the HIV integrated plan is highlighted.)

Both the RW Part A EMA and TGA identify high percentage of foreign-born individuals in the EMA and challenges associated with language and cultural barriers, issues with disclosure and gender relations, and for certain subpopulations, highly transient lifestyles affecting treatment adherence.

a. Priorities

Several key priorities arose out of the planning and community engagement process. These priorities represent gaps and themes identified in data-driven plans developed by Connecticut's prevention and care partners such as the RWHAP Part A TGA and EMA – including the In It to End It Plan, as well as the RW Part B and CDC prevention programs administered by the CTDPH. These priorities represent common ground across other RWHAP partners (e.g., Part Cs, Part Ds) as well.

Prevent New Infections:

- Increasing knowledge equity for residents to understand issues and access services and for providers to deliver services. [Source: In It to End It Plan]
- Improving public awareness campaigns designed to reach priority populations – including young adults and heterosexual, female, and male populations of color and marginalized subpopulations such as transgender or men who have sex with men (MSMs) with an emphasis on promoting routine HIV testing. [Sources: CHPC meetings, Positive Prevention CT, Getting to Zero Report. In It to End It Plan]
- Increasing PrEP uptake. [Source: CHPC, RWHAP Parts, DPH, In It to End It]
- Increase community level engagement and community partner engagement, especially in areas relevant to address social determinants of health. [Sources: CHPC, RWHAP partners, CTDPH, HIV Funders]
- Building capacity of providers and community to conduct routine HIV testing in support of new legislation and to treat and or refer individuals to appropriate and accessible prevention and care services. [Sources: CHPC ETS Committee, ETS Partners Group]
- Strengthening the (community-based) uptake of sexual health education especially within younger and high-risk populations. [Source: CHPC, DPH, RWHAP partners, In It to End it Plan]

Improve HIV-Related Health Outcomes:

- Building capacity to integrate syndemic areas of focus (viral hepatitis, STIs, SUD) into the Plan [Sources: CHPC Ending the Syndemic. (ETS) Committee, DPH Ending the Syndemic Partners Group (ETS Partners Group)]
- Addressing the disparities in viral load suppression that exist between patients of RWHAP funded partners and patients of non-RWHAP funded partners. [Source: CHPC, RWHAP Part As and B]
- Increasing access to ambulatory services, medical case management, housing, and oral health. [Source: RWHAP partner needs assessments, CHPC]
- Enhancing and standardizing professional development training with an emphasis on foundational skills and competencies, status neutral care approach to care, and diversity, equity, and inclusion – all of which will contribute to stigma reduction. [Source: RWHAP Part As and B, CHPC, DPH Prevention]
- Improving access and standards statewide for rapid start medication for prevention and treatment. [Source: In It to End It Plan, RWHAP Part As and B, CHPC]
- Increasing the efficacy and impact of disease intervention specialists (DIS) and Data-to-Care systems to support engagement of people into care – newly diagnosed and those who may have fallen out of care. [Source: RWHAP Part As, B, CHPC]

Reduce HIV-Related Disparities and Health Inequities:

- Introducing a syndemic approach that focuses on areas most relevant to HIV epidemic: STIs, viral hepatitis, and substance use disorders.
- Developing a CHPC indicator relevant to stigma and discrimination. [Source: CHPC, RWHAP partners]
- Increasing the diversity of the HIV prevention and care workforce. [Sources: CHPC, RWHAP partners, HIV Funders]
- Strengthening workforce training to support core competencies for HIV as well as other syndemic areas of focus. [Sources: CHPC, RWHAP partners, HIV Funders, AETC]
- Promoting evidence-based practices and quality improvement efforts that address disparities in priority subpopulations. [Source: CHPC RWHAP partners]
- Engaging different partners that in addressing social determinants of health or intentionally joining their efforts to increase the visibility and relevance of HIV to the work. [Source: RWHAP Partners, CHPC, DPH Prevention]

Achieve Integrated, Coordinated Efforts:

- Aligning administrative and procurement processes to improve integration of prevention and care services, increase access to services, and reduce administrative requirements. [Source: RWHAP Parts, DPH, CHPC]
- Increasing coordination and impact of overdose prevention and harm reduction efforts at the state and local levels. [CHPC, HIV Funders, DPH, RWHAP Parts]
- Improving the process to monitor implementation progress on the plan. [Source: CHPC, HIV Funders Group, DPH]
- Improving the coordination of needs assessment processes across jurisdictions and addressing gaps such as a statewide prevention needs assessment and drill-down assessments on priority topics such as housing or oral health. [Source: RWHAP parts, CHPC, DPH]
- Increasing data capacity and meaningful use across syndemic areas of focus, including developing of statewide and/or community-level care cascades for viral hepatitis. [Source: RWHAP partners, DPH, CHPC, HIV Funders]
- Supporting and scaling up innovation in areas such as telehealth, injectable medications, affordable housing, and efforts to address social determinants of health. [Source: CHPC, RWHAP partners, DPH, HIV Funders]

b. Actions Taken

The 2022 to 2026 Plan builds on accomplishments achieved during the 2017 to 2021 Plan and lessons learned. Some notable examples include:

- CADAP Clinical Advisory Board meets annually to evaluate medications covered and adds or removes medications as needed, including new long acting injection ART in April 2021.
- The Data to Care (D2C) initiative to identify PLWH who are not in care will run regular cycles every six months.
- The CHPC and other RWHAP partners continue to implement the recommendations from the 2018 Getting to Zero Commission Report to better engage and serve the community.
    - The *In It to End It* activities led by the Ryan White Part A EMA focused on community engagement.
    - The 2022 to 2026 Plan includes a syndemic focus.

  - The CTDPH convenes an Ending the *Syndemic Partners Group*, the CHPC established an *Ending the Syndemic Committee*.
  - The Connecticut HIV Epidemiological Profile contains information on syndemic areas of focus.
  - The CTDPH continues to build operating capacity and capabilities in these areas.

- Connecticut lawmakers passed legislation (2022) to mandate the offer of routine HIV testing by certain healthcare providers, including emergency departments.
- Connecticut continues to expand access to and uptake of PrEP and PEP.
- Connecticut partners collaborate to expand access to harm reduction and drug user health services.
- In 2021, CTDPH successfully secured funding for Integrated Viral Hepatitis Surveillance and Prevention Services. Funding will support surveillance and expand prevention for viral hepatitis, especially for testing, treatment, and cure for persons coinfected with HIV/HCV in Connecticut.
- In 2021, Connecticut lawmakers with support of DPH Prevention and community partners passed a law to allow for the use of Syringe Service Program vending machines in Connecticut.
- In 2022, Connecticut lawmakers with support of DPH Prevention and community partners revised the CT drug paraphernalia law to remove the ban on drug testing equipment, such as fentanyl test strips, to allow for increased access to fentanyl testing strips through harm reduction programs in CT.
- Numerous examples exist of innovation and demonstration projects in priority areas of the 2017 to 2021 Plan.
  - Data Integration Grant Project that focuses on integrating data systems between housing and HIV providers.
  - The RW Part A TGA and its partners introduces a jurisdictional approach to improve HCV provider and patient education, expansion of screening and linkage to care and systems transformation. The program intended to address modifiable barriers to accessing HCV services.
- CTDPH modernized its data systems supporting CADAP to increase accessibility, efficiency, and meaningful use of data by patients, providers, prescribers, and administrators.
- The CHPC and its partners coordinated a series of professional development trainings and workshops to strengthen knowledge and competencies in response to the statewide HIV workforce survey.
- In 2022, CTDPH was recognized by the CDC for coordinating several Capacity Building Assistance (CBA) technical assistance and training workshops during 2019-2022 in topic areas such as harm reduction (SSPs), reducing stigma (HIV & mental health), advancing health equity (Annual Health Equity Summit), PrEP, and Ending the Syndemic Summit in collaboration with local partners, the New England AIDS Education and Training Center (NEAETC) and Yale New Haven Hospital.
- CTDPH developed two policy proposals for the 2023 legislative session: (1) Routine HCV Screening for all adults 18 years and older and all pregnant women to align with CDC recommendation and CT RTS law. (2) Expand access to PrEP by establishing a PrEP/PEP Drug Assistance Program (PrEP/PEPDAP) for anyone in need who is uninsured, underinsured, or uninsurable, serving as a payor of last resort.
- The CHPC has included actions in the Plan to address monitoring, accountability, and coordination mechanisms between core partners.

c. Approach

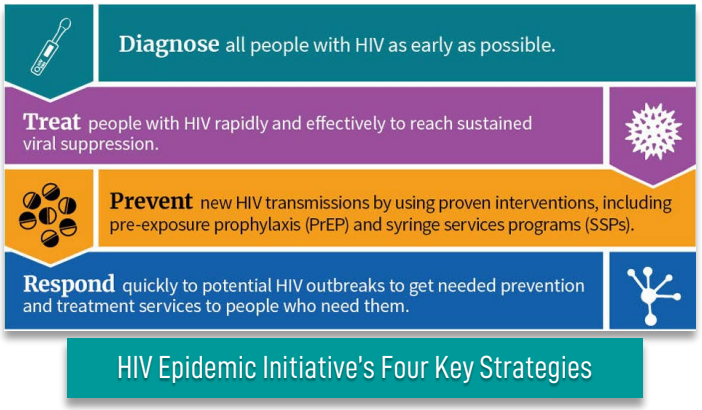
The Plan development process used needs assessments, priorities, and allocations developed (annually) by core partners as inputs to the Plan. These core partners rely upon data sets provided by the CTDPH as well as customized needs assessments relevant to their jurisdictions. The CHPC supplemented the needs assessments conducted by the jurisdictions as needed. For example, the CHPC and Ryan White Part B coordinated a statewide PLWH needs assessment survey (2022). The jurisdictional partners shared needs assessment findings at the CHCP Needs Assessment Projects Committee which in turn presented summary information to the full CHPC for review and discussion of needs, gaps, and priorities. These discussions occurred over a three-month period using small group discussions to maximize participation and engagement.

The remainder of this page was intentionally left blank.

SECTION IV. SITUATIONAL ANALYSIS

In 2019, the Ending the HIV Epidemic Initiative was released in the United States. It includes the following four key strategies for ending the HIV epidemic:

- Diagnose all people with HIV as early as possible.
- Treat people with HIV rapidly and effectively to reach sustained viral suppression.
- Prevent new HIV transmissions by using proven interventions, including pre-exposure prophylaxis (PrEP) and syringe services programs (SSPs).
- Respond quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them.



HIV Epidemic Initiative's Four Key Strategies

The Goals and Objectives in Connecticut's Integrated Plan demonstrate the alignment with the HIV Epidemic Initiative's Four Key Strategies which address the updated National HIV/AIDS Strategies (NHAS). The National HIV/AIDS Strategies are the following:

- Prevent New HIV Infections
- Improve HIV-Related Health Outcomes of People with HIV
- Reduce HIV-Related Disparities and Health Inequities; and
- Achieve Integrated, Coordinated Efforts That Address the HIV Epidemic Among All Partners.

National HIV/AIDS Strategies (NHAS)

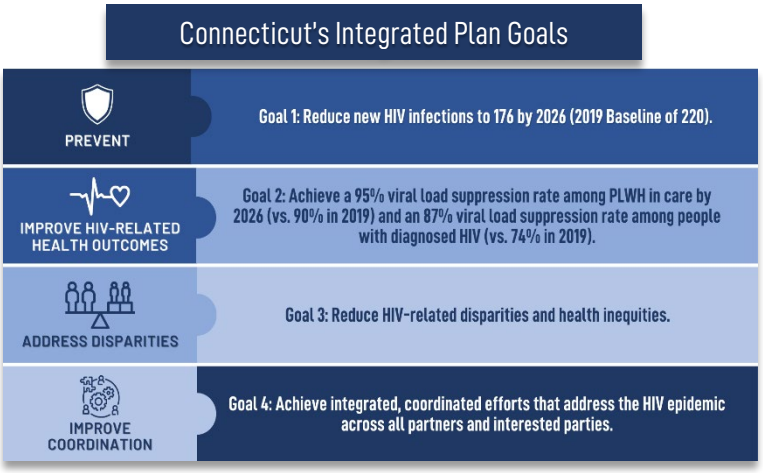
The CHPC acknowledges that Connecticut's Plan differs slightly from the Ending the HIV Epidemic Initiative Strategies and the specific numeric indicators identified in the NHAS. The CHPC based our Integrated Plan Goals and Objectives on the updated NHAS while keeping in mind the Ending the Epidemic Initiative's four key strategies.

For instance, with Goal 1- by reducing the number of new HIV infections through increased HIV testing, it will in-turn Prevent New HIV Infections.

Similarly, with Goal 3- by reducing HIV-related disparities and health inequities, it would improve our focus population's ability to gain access to PrEP and Syringe Services Programs, leading to the prevention of new HIV transmissions.

Lastly, is goal 4- by achieving integrated, coordinated efforts that address the HIV epidemic across all partners and interested parties, it would allow for quick response to potential HIV outbreaks to get needed prevention and treatment service to people who need them.

More information on Connecticut's Goals and Objectives, can be found in more detail in Section Five of this plan.



1. Situational Analysis

The table below summarizes an analysis of strengths, weaknesses, opportunities, and threats that were developed as an activity by the CHPC most relevant to the statewide jurisdiction. These themes may differ within smaller jurisdictions or individual communities, however, these themes reflect the findings of the SWOT analysis conducted by the Ending the Syndemic Partners Group (page 53).

SWOT Summary Table for 2022-2026 Integrated HIV Plan Development (General)	
Strengths	• Robust CHPC with history of assembling diverse partners and stakeholders and connection to transformative initiatives such as statewide Getting to Zero Commission. • Statewide epidemiological profile and various needs assessment activities. • Decision to apply syndemic approach (HIV, STIs, hepatis, and SUD). • Increasing connection of HIV/AIDS service organizations within smaller geographic regions. • Strong HIV/AIDS ecosystem and supporting organizations (AETC, DPH, RW Part A, Yale CIRA). • Strong Syringe Services Programs and innovative harm reduction programs. • Ongoing capacity building and modernization efforts in statewide HIV/AIDS, STI, hepatitis, and opioid surveillance (CT DPH) and regional reporting systems (Ryan White TGA, EMA). • Increasing awareness of status neutral care approach with evidence of early adopters. • Highly effective ADAP program that embraces modernization and innovation. • History of and ongoing support for advancing LGBTQI+ inclusion.
Weaknesses	• Disparities and health inequities exist, particularly in young, Black, and Brown populations. • Stigma, distrust, misperceptions, and lack of knowledge and awareness of HIV prevention and treatment. • High cost of living that affect access to housing, food, transportation, childcare, and healthcare. • Limited and uneven sexual health education in K-12. • Longstanding needs such as oral health remain un-addressed. • Increasing trend in opioid overdoses and in sexually transmitted infections. • Breakdowns in delivery systems and accessibility to services due to SDOH and amplified by COVID-19 pandemic. • Uneven access to and uptake of professional development training for fundamental competencies in HIV and areas of syndemic focus. • Uneven capacity and supports to scale evidence-based strategies (e.g., Rapid Start treatment, PrEP).
Opportunities	• Cure to end HIV on the horizon. • Development of new medications, methods of administration (e.g., vaccinations), and more effective community-based and population-based implementation strategies. • Routine HIV testing to start in 2023 and will change begin shift to normalize testing. • Emphasis – nationwide and statewide, on syndemic approach (STIs, hepatitis, SUD). • Public funders of HIV services structuring contracts to build regional networks and more effective “hub” models. • Digital health and home health innovations increase options to access services. • Increased investment in and capacity to support public-facing communications and media campaigns. • Adjustments to CHPC structure and organization of work to achieve objectives.
Threats	• Community-based organizations not able to increase capabilities and capacities (e.g., technology investments, attract competitive workforce). • New forms of infectious or contagious diseases affect public health landscape (e.g., barriers to routine care visits) and emphasis of local health departments. • Increased incidence of mental health-related concerns amplified by COVID-19. • Increasing patterns of incidence for behaviors that correlate with new HIV infections such as STIs, hepatitis, and substance use disorders. • Lower perception of risk and harm (e.g., medical cures exist). • Inflation and higher prices amplify inequities and adverse impacts of social determinants of health, including participation of persons with lived experience in planning processes. • Structural racism, stigma, and systemic SDOH barriers that contribute to health disparities.

Situational Analysis – Ending the Syndemic Partners Perspective

Connecticut's Ending The Syndemic Partners Group conducted a SWOT process as part of its ongoing planning efforts. The table below shows the themes emerging from that process.

SWOT Summary Table for 2022-2026 Integrated HIV Plan Development (Ending the Syndemic Partners Group)	
Strengths	• Existing Testing Infrastructure. Free testing. Testing at SSPs (HIV, HCV). Accessible point of care testing. Some integrated testing (SUD, STIs, HCV). RWHAP Part B test for syphilis and link to other testing. Linkage to services. Some Rapid Start ART/PrEP/PEP. Status neutral approach. Central database for STI/HCV. • Existing Provider Networks. HIV testing providers. PrEP navigators. Partner Services. At Home Testing initiative. Some mobile services. SUD providers partner with HIV testers. Increased provider connection with surveillance. Statewide partnerships and program collaborations. • Multiple Testing Modalities and Tools. Multiple options (conventional, rapid). HIV/HCV same rapid modalities. Data to Care components. Telehealth. Some funding. Supportive legislation. Messaging and campaigns similar.
Weaknesses	• Widespread, Multi-level Health Communication and Education. Adequate messaging. Adequate education. Inclusivity discussions. Ongoing and institutional education and communications. • Surveillance and Data Capacity and Funding. Not enough providers or network. Not enough outside partnerships. Low/no funding and surveillance capacity for STD and HCV. Low state funding to promote STD services. No state or local plans for sustainable STD funding. Cooperation / collaboration with private providers, hospitals, and local health departments. Data system limitations (Hep C). Provider reporting for STD and HIV. • Service Gaps and Provider Gaps. Gaps in services (rural). Consistent and comprehensive testing. PrEP uptake for priority populations. PrEP testing. Testing in hot spots. Addressing LGBTQ and no specific LGBTQ health centers/resources. Sustainability plans. Workforce reflects populations served. Mobile services. • Stigma, Health Disparities, and Inequities. Focus on SDOH and building bridges. Diversity and CLAS among workforces. Welcome / safe space environments. Addressing stigma and disparities. Support services for women of color.
Opportunities	• Expand and Integrate Services. Routine and comprehensive testing across programs. Increase and expand integrated screening. Develop integrated and quick screening tools and protocols for use across programs. Provider detailing. Education to community providers and consumers. Showcase best practice models. Normalize sexual health assessments. Increase home testing services. Provide culturally relevant services. Implement status neutral model. Mobile Medication Assisted Treatment vans. • Expand Partnerships and Collaborations. Expand current collaborations and pilots. New statewide coalitions (STDs, VH). Pursue new funding opportunities with new partners or new programs. Identify billing and revenue advantages for providers and payers. Work with faith community to promote sexual wellness. Support routine HIV testing implementation and strengthen referral systems. Cross training for workforce. Move from collaboration to service integration. Communication with local health departments. • Expand Information and Data Collection and Meaningful Use. Internal integration and data capacity at CTDPH. Drive traffic to existing website(s) and resources. Coordinate and integrate awareness campaigns, especially for similar priority populations or in geographic areas.
Threats	• Lack of Resources and Capacity. Limited money to move the work or to track the progress. Demand for some services and supplies are higher than available resources. Data limitations. Lack of adherence to CLAS standards. Diversity of staff. Cultural relevance of services.

SWOT Summary Table for 2022-2026 Integrated HIV Plan Development (Ending the Syndemic Partners Group)	
	Disconnects in data collection and use of available data. Lack of standardized workforce training. Competitive pay scales, turnover, and available workforce. • Systems, Structures, and Policy Barriers. Social Determinants of Health. Health disparities and inequities widespread. Resistance to change among providers. Turf mentality. Mentality of "not my job" to embrace syndemic approach. Existing policies and statutes do not support efforts such as Fentanyl test strips. Siloed funding streams at federal level create disconnects and/or duplicative efforts such as harm reduction activities funded by SAMHSA, HRSA, and CDC. Retirements and loss of institutional knowledge and networks.

Actions Taken

The Ryan White Part A and B jurisdictions use needs assessment information to conduct their priority and allocation setting processes. Other RWHAP partners (RW Cs and Ds) use this information as well as other statewide information to develop their applications for funding.

The needs assessment summary information was shared at a CHPC meeting by the NAP Committee Chair. CHPC leaders facilitated small group discussions to get additional community-level feedback that ultimately informed the development of the statewide priorities. During small group discussions, leaders asked: 1) what surprised you the most about the needs assessment information? 2) what are the top three needs for PWLH? and 3) What other information or needs assessments should the CHPC and its partners consider doing in the upcoming years? The table below describes the themes from the small group discussions. The July 2022 CHPC meeting summary contains additional documentation.

Discussion Question	Themes from Small Group Discussions
What surprised you the most about the needs assessment information?	• Type of Need: Similar results and themes from different surveys and regions; Dental and housing continue to be top needs. • Patient / Respondent Knowledge: Surprised that so many survey respondents did not understand "viral suppression" or did not know their viral load; Clients are comfortable saying, "I am undetectable." • Access To Services: How can people not have access to services – including medical case management and ambulatory care with so many resources available? Stigma affects access to services. • Action or Inaction on Information: We need to act on the information, especially in gap areas that continue to appear year after year; Need better follow-through and accountability; Housing and Dental are always top two needs. • Needs Assessment Process May Need to Change: Change the survey questions. We keep getting the same answers.
What are the top three needs for PWLH?	• Housing and Housing Related • Ambulatory Services • Oral Health • Medication And Treatment Adherence and New Medications • Medical Case Management to Coordinate Across All Needs • Mental Health Services • Addiction Services • Management Of Other Chronic Conditions • Food Bank • Emergency Financial Assistance

Discussion Question	Themes from Small Group Discussions
	• Co-Occurring Needs • Medical Insurance
What other information or needs assessments should the CHPC and its partners consider doing in the upcoming years?	• Improve Needs Assessment Tools: Most of these tools are home-grown surveys v. national or other proven tools; Do more pilot testing; Needs assessments related to syndemic approach or areas of focus; Impact of COVID/telehealth on future needs assessments; Offer surveys in multiple languages – Spanish, French-Creole (*this includes the upcoming prevention survey); Ask questions beyond Ryan White needs – which might place a focus on linkage to those services; and Ask where clients are receiving their services • Apply a More Specific Focus / Change The Approach: Focus more deeply on issue areas such as PrEP uptake, MPOX, Reproductive health, Dental / oral health, HCV, Substance use services, and Supportive services (Part B survey); Focus on subpopulations (by survey or focus groups) such as Prevention / PrEP users (including those not using PrEP like Black women and Latinas), Incarcerated, Youth, Out of care, Undocumented or uninsurable, Demographic subgroups that match the (incidence) data, and identify the disparities in current data sets (e.g., why are some folks still without insurance?); Ask case managers / front line worker in a simple way, what services do their client's most frequently need and the case managers cannot make these linkages; and Need to understand "why" you cannot get these services despite these resources throughout the state. This would lead to more actionable items. • Work Together and/or With Other Partners: Seems like every group do their own thing. Now we are trying to make sense of it, planned and coordinated (Part As, Bs, prevention) it more and use the same tools or methodology; Understand that a needs assessment is an opportunity to engage people; Partner with CT Coalition to End Homelessness to understand the housing issues or the CT Oral Health Initiative for oral health; Partner with other entities outside RW; and Cross Part collaboration on Surveys • Other Suggestions: Folks not seeing themselves in the advertisements or public service announcements deters them from taking the messages seriously; The message is that I am not being seen in these messages; Share the results and share the follow-up of what actions were taken; Partner with pharmaceuticals to increase awareness of new medications; Advocacy efforts; Opportunities received during the public health emergencies – what worked well with providers or clients (that might go away after public health emergency; and Describe how these findings compare to prior needs assessments.

The CHPC used these themes as well as the data sets and priority setting decisions by jurisdictional partners to inform the development of the Plan objectives, strategies, and activities. CHPC Committee-level work plans will reflect priority activities relevant to the jurisdictional partners. Jurisdictional partners will use needs assessment information relevant to their jurisdictions and continue to improve the process to coordinate and collaborate on data collection projects.

a. Priority Populations

The table below shows the priority populations as identified by the various RWHAP partners and CTDPH prevention through needs assessment related discussions and in the context of the requirements by specific funding sources. Connecticut's plan contains objectives and activities that apply to these various subpopulations as well as the public in general. For example, the CHPC and its partners will support public awareness campaigns that create a new norm in the public for routine HIV testing in response to newly enacted legislation.

Partner	Priority Populations Identified in Jurisdictional or Local Plans	
DPH Prevention	• Gay, bisexual, and other MSM • Black/AA and Hispanic men & women • People who use drugs	• Youth 13-24 • Transgender women
RWHP Part A HTFD TFA	• Black/AA PLWH unaware or out of care • Hispanic PLWH unaware or out of care	• Black/AA PLWH MSM unaware/out of care
RWHAP Part A NH/FF EMA	• Trans persons of color • Young MSM of color	• Black women
RWAHP Part B Statewide	• MSM of color • Black and AA Heterosexuals	• Hispanic/Latinx Heterosexuals
RWHAP Part Cs (9 in State)	• Varies by specific community	• Approaches tend to address populations that demonstrate disparities
RWHAP Part D Statewide (2)	• Black/AA & Hispanic/Latina Women • Young MSMs of color	• Women, Infants, Children, & Youth
AETC	• Persons living with HIV (quality, peer supports) • Clinical providers	• Physicians, physician assistants & nurses • Medical and nursing students
G2Z Commission (2019)	• Transgender women • Black and AA women	• Young MSMs of color
CIRA	• Researchers • Clinicians	• Providers (implementation science)
HOPWA (4 Cities)	• Black/AA • Gender varies by city	• 51 and older

SECTION V. 2022-2026 GOALS AND OBJECTIVES

1. Goals and Objectives Description

The table below summarizes the statewide Plan indicators around which the CHPC developed its 2022 – 2026 goals and objectives. The CHPC, with approval from federal project officers, used 2019 data for its baseline measures due to the impact of the COVID-19 pandemic. Notes:

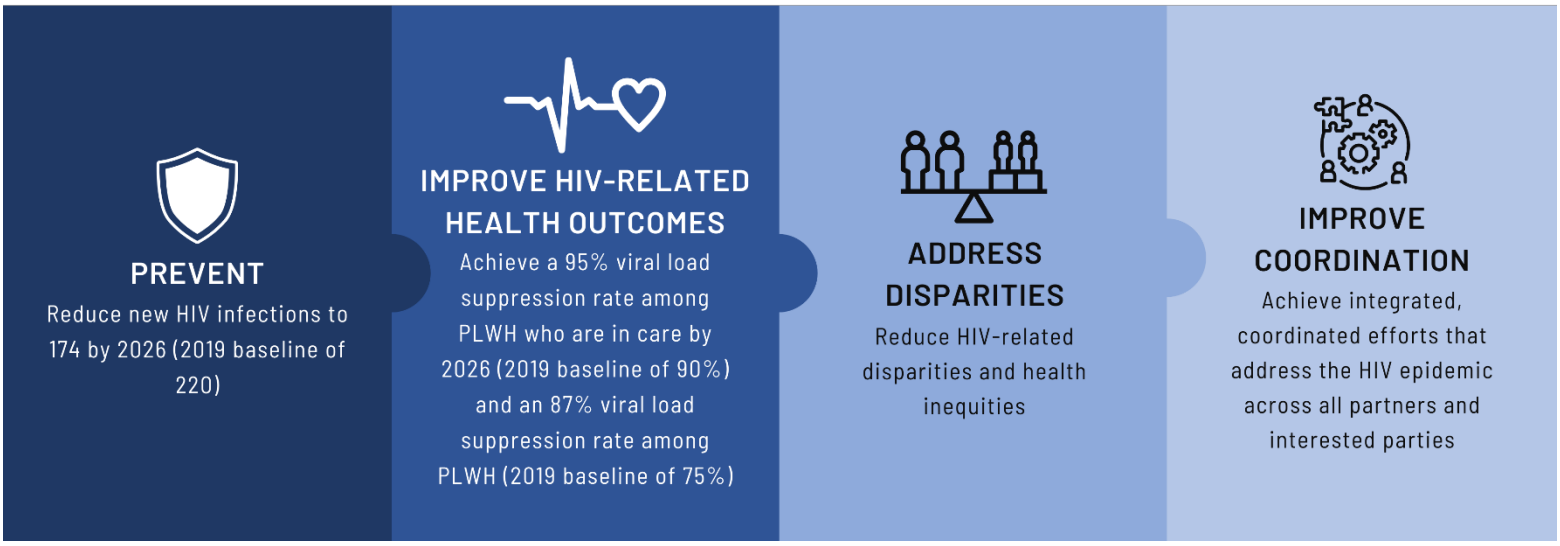
- These statewide Plan indicators continue to undergo development. The CHPC will continue to adjust the Plan indicators to reflect the syndemic areas of focus as well as other priorities such as measuring stigma and discrimination.
- The CHPC reviews these indicators with an "equity lens" and analyzes the information to understand differences and disparities related to factors such as income, race/ethnicity, age, income level, and geography. The table shows only summary indicators. The CHPC reviews indicators by subpopulations.
- Some of these indicators suggest minimal improvements and, in some instances, worsening over time. These 2026 goals represent a realistic approach in response to factors such as upward data trends in opioids and STIs, the identification of more PLWH because of routine HIV testing legislation, and the need to engage non-Ryan White funded partners in the work with no additional resources.

2022-2026 Plan Indicator	2019 Baseline	2026 Goal
PrEP-to-Need Ratio: The number of people taking PrEP divided by the number of people newly diagnosed with HIV	**12.0**	**36.0**
New Diagnoses: Number of people newly diagnosed with HIV	**220**	**174**
Knowledge of HIV Status: Percent of PLWH aware of their status	**91%**	**93%**
Late Testers: Percent of people presenting with or diagnosed with AIDS within 3 months of their initial HIV diagnosis	**29%**	**20%**
Linkage to Care: Percent of newly diagnosed who attended a routine HIV care visit within 1 month of diagnosis	**87%**	**90%**
Partner Services: The number of newly diagnosed clients interviewed by DIS / Partner Services	**143**	**8% increase**
Viral Load Suppression: Percent of people with diagnosed HIV who are virally suppressed Percent of PLWH in care who are virally suppressed	**74%** **90%**	**87%** **95%**
Disparities in New Diagnoses: Annual number of new HIV diagnoses among: MSM, Black men and women, and Latino men and women	**15% decrease**	**25% decrease**
Disparities in Viral Load Suppression: Viral load suppression rates among: youth and young adults, injection drug users, MSM, Black men and women, and Latino men and women.	**65% to 78% depending on population**	**85%+ for all populations**
Syringe Services Program (SSP): Number of SSP clients served Number of syringes distributed	**4,428** **1.2 million**	**9,000** **2.4 million**
Sexually Transmitted Infections (STIs): Number of syphilis cases	**210**	**204** **(Projected 380 cases)**
Hepatitis C: Number of newly diagnosed chronic Hep C infections	**1,309**	**1,178**
Substance Use: Number of overdose deaths Total number of overdoses (ED Visits for suspected overdoses)	**1,528 (2021)** **12,000 (approx.)**	**1,750** **13,950**

Source: Quality and Performance Measures Committee, CHPC 2022

Goals and Objectives

The Plan structure parallels the approach set forth by the National HIV and AIDS Strategies (NHAS). This framework represents a logical extension of Connecticut's Integrated HIV Plan 2017 – 2021. The figure below summarizes Connecticut's goals.



The Plan structure parallels the approach set forth by the National HIV and AIDS Strategies (NHAS). This framework represents a logical extension of Connecticut's Integrated HIV Plan 2017 – 2021. The figure below summarizes Connecticut's goals.

The CHPC acknowledges that Goal 1 aligns differs quantitatively from the NHAS goal of reducing new HIV infections by 75% by 2025. CHPC and CTDPH leaders consulted with the Integrated HIV/AIDS Planning Technical Assistance Center (IHAP TAC) for guidance and clarification on this matter and received feedback that Connecticut could "customize your goals while addressing the nations…." The CHPC recognizes the value of setting aspirational goals. However, the QPM Committee, with an extensive input process, set a realistic and achievable Goal 1 for 2026 that reflects the best available data and scope, the complexity of the issues in Connecticut, and the need to engage non-Ryan White funded providers and partners to make progress in areas such as implementing routine HIV testing, increasing PrEP uptake, scaling up a status neutral care approach, and increasing viral suppression rates – without any additional funding.[4] Connecticut's Goal 1 will keep Connecticut on a trajectory to achieve the 2030 goal of reducing new HIV infections by 90% (compared to the 2019 baseline).

The following pages provide a summary of the goals, objectives, strategy bundles, and example activities.[5] The CHPC and its Committees will develop annual work plans that reference specific objectives, strategies, and activities referenced in this plan. The work plans will identify milestones. At the end of each year, CHPC Committees will review progress (planned v. actual) and the CHPC will review progress on the CHPC indicators. The CHPC indicators represent a core accountability process for this Plan and its partners. Section 6 describes this process.

[4] QPM meeting summaries provide a detailed accounting of the data, working assumptions, and decision-making process that led to a clear majority recommending setting the Goal 1 indicator for Connecticut.

[5] Activities will change over time based on factors such as response to local needs, priorities, resources, and partnerships.

PREVENT

Goal 1: Reduce new HIV infections to 176 by 2026 (2019 Baseline of 220).

Objective 1.1. Increase awareness of PLWH of their HIV status to 93% by 2026 from a baseline of 91% (2019).

Short term priorities for this objective relate to the implementation of 2022 legislation that mandates Primary Care Providers offer routine HIV testing as well as the expansion of prevention and harm reduction strategies. Implementation drivers include CTDPH prevention investments and the RWHAP program early intervention activities that drive implementation of the Ryan White Part A In It to End It Plan. The integration of syndemic strategies gets driven by the Ending the Syndemic Partners Group (ETS Partners Group) and other emerging coalitions in areas such as STIs and VH.

Strategies	Key Activities (Partners)
1.1.1 Implement routine HIV testing and syndemic screening campaigns and other health promotion campaigns	• Launch Tell Everyone to Screen and Test (TEST CT) campaign that incorporates and features perspectives of persons with lived experience (PPCT) • Update CTDPH website landing pages to contain relevant information about syndemic resources (PPCT, CTDPH) • Implement at least two statewide HIV prevention campaigns or topics relevant to prevention such as syndemic areas of focus or social determinants of health (PPCT, CTDPH RWHAP partners)
1.1.2 Build capacity of healthcare providers to implement routine HIV testing and screening	• Launch TEST CT campaign to engage healthcare providers (PPCT, ETS, CTDPH, RWHAP) • Deliver a series of events, training, and resource materials to help providers build knowledge and capacity to implement routine testing and screening (ETS, RWHAP partners, AETC and training partners) • Facilitate the use of an Academic Detailing program to help providers adjust routine testing and screening workflows (CTDPH) • Participate on the legislatively mandated task force to develop and implement routine HIV testing in Emergency Departments (CTDPH, ETS) • Advocate for and attract additional funding to expand proven models such as integrated HIV/HCV testing and peer support models (CTDPH, RWHAP partners, CHPC, AETC) • See also status-neutral care model (RWHAP partners, AETC and training partners) • See objective 2.1 to strengthen referral mechanisms (ETS, RWHAP partners, CTDPH, ETS Partners Group)
1.1.3 Enhance community awareness and engagement efforts that increase knowledge equity about issues and available resources	• Implement a series of knowledge equity discussions or trainings consistent with the In It to End It Plan (RWHAP partners, CTDPH, CHPC, AETC) • Attract additional resources to scale successful community engagement projects such as engaging leaders of black faith communities (RWHAP partners, CTDPH) • Use CHPC list serv, website, and network to facilitate information sharing on resources, services, and opportunities available from Plan partners (CTDPH, CHPC, PPCT)
1.1.4 Strengthen integrated approach to promote prevention, health promotion, and harm reduction related efforts	• Conduct first ever statewide HIV prevention survey (CTDPH, CHPC) • CHPC members and RWHAP partners serve as participants on the coalition to develop Connecticut's STD Elimination Plan (CTDPH, CHPC, RWHAP partners)

and initiatives to engage the community	• CHPC members and RWHAP partners serve as participants on the advisory group that develops Connecticut's Viral Hepatitis Elimination Plan (CTDPH, CHPC, RWHAP partners) • Use CHPC list serv, website, and network to facilitate information sharing on opportunities to participate in community events across the syndemic areas of focus (CTDPH, CHPC, PPCT)

Objective 1.2. Achieve a 25% decrease in new HIV diagnoses among MSM, Black men and women, and Latino men and women.

Short term priorities for this objective create an "equity-lens" emphasis for prevention strategies most relevant to priority subpopulations to achieve Goal 1. The two strategies that will require more intensive work from all partners and involve scaling up the status neutral care approach and strengthening of community- and school-based sexual health education programs.

Strategies	Key Activities (Partners)
1.2.1 Implement education and message campaigns to increase awareness about HIV-related health inequities and disparities	• Develop and conduct awareness campaigns for priority subpopulations such as African American, Blacks, Latinos, and Transgender (PPCT, CTDPH, RWHAP partners) • Use CHPC list serv, website, and network to facilitate information sharing on opportunities to participate in community events (CTDPH, CHPC, PPCT) • HIV partners support other campaigns and initiatives that address social determinants of health and reach priority subpopulations (PPCT, CTDPH, RWHAP partners)
1.2.2 Recognize the status neutral care model as the standard for HIV-related services	• Define standards for status neutral service delivery model across syndemic areas of focus (CTDPH, Ending the Syndemic Partners Group, RWHAP partners) • Change contract language and monitoring practices to align with the use of the status neutral care model as the standard of care (CTDPH, RWHAP partners) • See routine HIV testing activities 1.1.2 to expand the number of providers implementing a status neutral service delivery model (CTDPH, ETS Partners Group, RWHAP partners, AETC)
1.2.3 Expand access to PrEP and PEP	• Develop and conduct PrEP and PEP awareness campaigns for priority subpopulations such as youth, African American / Black, Latino, Transgender, MSMs, and LGBTQ (PPCT, CTDPH, RWHAP partners) • Annual DPH website updates with new PrEP and PEP resources (PPCT, CTDPH, RWHAP partners) • Expand use of PrEP and PEP Patient Navigation model (CTDPH, RWHAP partners) • Propose changes in legislation that will increase access to PrEP and PEP (CTDPH) • Explore feasibility of adding PrEP and PEP to CADAP formulary (CTDPH) • Recognize clinical providers as PrEP and PEP Centers of Excellence (CTDPH, RWHAP partners) • Implement same day PrEP and PEP as standard of care (DPH, RWHAP partners) • See also activities under objective 2.1 effective referral mechanism
1.2.4 Increase access to syringe service programs (SSPs)	• Expand access to SSP by priority populations and regional needs (CTDPH, RWHAP partners) • Evaluate SSP to enhance and improve service delivery to priority populations (CTDPH, QPM) • See also activities under objective 2.1 effective referral mechanism

(Continued on Next Page)

1.2.5 Expand and enhance harm reduction and recovery services to reach priority populations	• CHPC and partners participate in Opioid Overdose Prevention Task Force (DPH, Ending the Syndemic Partners Group) • HIV partners fund the use of peer support groups to increase resilience and/or recovery (DPH, RWHAP partners) • CHPC identifies and explores the introduction of pilot projects (e.g., medication storage for unstably housed, vending machines to dispense and collect syringes) that address the needs of priority populations (CTDPH, RWHAP partners, Ending the Syndemic Partners Group)
1.2.6 Advocate for the delivery of school- and community-based comprehensive sexual health education programs	• CHPC and partners serve as members to develop the STD Elimination Plan (CTDPH, CHPC, RWHAP partners) • Conduct first ever statewide HIV prevention survey and use process to engage community partners (DPH, CHPC) • CHPC recognizes schools with exceptional comprehensive sexual health education programming (DPH, CHPC, AETC, RWHAP partners) • CHPC identifies and explores innovation with community partners around community-based sexual health education solutions across various settings (e.g., CTDPH, RWHAP partners, CIRA)

Objective 1.3. Expand Treatment as Prevention (TasP).

Short term priorities for this objective draw heavily upon existing activities and campaigns designed to recognize the value and benefits toward ending the HIV epidemic when PLWH achieve viral suppression and when people who are HIV negative, stay that way through the use of PrEP. Messages will eventually connect to other syndemic areas of focus such as treating STIs and curing Hep C.

Strategies	Key Activities (partners)
1.3.1 Implement and support awareness campaigns related to treatment as prevention	• Develop and conduct awareness campaigns for priority subpopulations using new or existing (e.g., U=U) resources (PPCT, CTDPH, RWHAP partners) • Websites updated to provide residents with resource materials (PPCT, CTDPH, RWHAP partners) • HIV partners support other campaigns and initiatives that address social determinants of health and reach priority subpopulations (See activity 1.1.4)
1.3.2 Communicate to PLWH and their partners the benefits of viral suppression to reduce HIV transmission	• See Goal 2 strategies designed to increase achieve viral suppression

The remainder of this page was intentionally left blank.

Goal 2: Achieve a 95% viral load suppression rate among PLWH in care by 2026 (vs. 90% in 2019) and an 87% viral load suppression rate among people with diagnosed HIV (vs. 74% in 2019).

Objective 2.1. 90% of newly diagnosed PLWH attend a routine HIV care visit within 1 month of diagnosis (vs. 87% in 2019).

Short term implementation priorities for this objective will pave the way to accomplish more complex system-related changes such as effective implementation of the CTDPH-led Data to Care initiative that increases meaningful use of data to the work of Disease Intervention Specialists and the enhancement of more robust referral mechanisms especially as it relates to non-Ryan White funded providers.

Strategies	Key Activities (Partners)
2.1.1 Improve implementation of Data to Care (D2C) and coordination with local partners	• Update and implement Early Identification of Individuals with HIV/AIDS (EIIHA) plans for priority populations in regional and/or local jurisdictions (RWHAP partners, CTDPH) • CTDPH builds capacity (technology, personnel) to implement D2C systems, deploys Disease Intervention Specialists in an optimal way, and shares performance dashboards (CTDPH) • Develop a standardized, scalable, and sustainable professional development approach for program-facing staff to support D2C implementation (CTDPH, RWHAP partners, AETC) • Coordinate integration of D2C data systems relevant to other efforts and initiatives such as Outbreak Response Plan, syndemic areas of focus, and effective referral mechanisms (CTDPH, RWHAP partners, local health departments) • Develop annual legislative and policy proposals to facilitate data sharing that improved D2C, identification of out-of-care, and referrals from routine HIV testing activities (CTDPH, RWHAP partners) • See also activities under 2.1.2 improve referral processes • Attract additional resource to support pilot projects or innovations including new technologies (e.g., CTDPH, RWHAP partners, CIRA)
2.1.2. Develop and implement a plan to improve referral processes that result in linkage to care (core medical and supportive services)	• Develop a provider inventory that lists capacity and capabilities to support referrals generated from routine HIV testing campaigns and update this inventory annually (CTDPH, ETS, RWHAP partners, HOPWA, DOH, DMHAS) • See also activities under strategy 1.1.2 to build capacity of healthcare providers to implement routine HIV testing and screening (CTDPH, ETS, RWHAP partners) • Document referral mechanisms, scale effective approaches, and support innovation to facilitate referral process (CTDPH, ETS, ETS Partners Groups, RWHAP partners) • Develop and implement recommendations for use of new technologies and/or protocols to improve the referral process including recommendations by the ED Routine HIV Testing Task Force (e.g., CTDPH, RWHAP partners, ETS Partners Groups, ETS, healthcare systems)
2.1.3. Develop and pilot strategies to reduce internal and external stigma that affects decision-making to access care	• See activities under objective 1.2.2 to promote expansion of the status-neutral care model as the standard for HIV-related services (CTDPH, ETS Partners Groups, RWHAP partners, AETC) • See activities under objective 3.1.1 to develop methodology to assess stigma, develop indicators, and identify evidence-based strategies to pilot and/or scale (NAP, QPM, CTDPH, RWHAP partners)

Objective 2.2. Increase access by PLWH to high quality HIV healthcare (core medical) and medication.

Short term implementation priorities for this objective build on the strengths of the RWHAP partners and intend to expand the collaborative workspace for continuous quality improvement, innovation, and scaling up strategies and practices beyond RWHAP funded providers. The Ending the Syndemic Partner Group (ETS Partners Groups) will over time identify areas for service integration.

Strategies	Key Activities (Partners)
2.2.1 RWHAP partners set priorities and allocations for core medical services in response to needs and priority populations within their jurisdictions and implement these plans	• Develop and update plans within RW jurisdictions to support and coordinate core medical services (outpatient ambulatory care services, medical case management, medication adherence, medication assisted treatment, and oral health) (RWHAP partners, CTDPH) • Support and scale improvements to the referral process that result in linkage to care. See activities under strategy 2.1.2. (RWHAP partners, CTDPH) • Conduct pilot projects to support innovative practices in core medical services such as community-based medication lockers, medication adherence, or use of injectables as indicated (RWHAP partners, CIRA, CTDPH) • Conduct statewide and regional needs assessment of PLWH and use findings to inform approach; focus on priority areas of need such as housing and oral health or Plan priorities such as capacity by providers to implement status neutral care model (CHPC, CTDPH, RWHAP partners) • Implement quality assurance plans and programs within and across respective RW jurisdictions to address disparities (RWHAP partners) • Facilitate access to professional development in HIV core competencies and other topic-specific areas to support delivery of core medical services (RWHAP partners, CTDPH, AETC) • See activities under objective 1.2.2 to promote expansion of the status neutral care model as the standard for HIV-related services (CTDPH, ETS Partners Groups, RWHAP partners, AETC) • Improve access to services for substance use disorders (SUD) and other behavioral health issues. See also Goal 4. • Coordinate an annual statewide quality management summit on a topic relevant to the HIV plan which could include a focus on core medical services (QPM, RWHAP partners, CTDPH)
2.2.2. RWHAP partners establish rapid start standards and protocols for PLWH to access safe, effective, and affordable medication	• Funders incorporate language to make rapid-start (same day or within 7 days) medication the norm and hold contractors/providers accountable (RWHAP partners, CTDPH) • Coordinate rapid start medication protocols and process with Data to Care process to quickly engage PLWH who did not meet the rapid start time horizon and may be at risk for falling out of care. See activities under strategy 2.1.1. (RWHAP partners) • Update CADAP formulary (e.g., add new medications, remove unsafe medications) using input from RWHAP partners and CADAP advisory group (CTDPH, RWHAP partners) • Support and scale improvements to the referral process that result in linkage to care. See activities under strategy 2.1.2. • Facilitate access to professional development in HIV core competencies and other topic-specific areas to support delivery of core medical services (RWHAP partners, CTDPH, AETC)

	• Coordinate an annual statewide quality management summit on a topic relevant to the HIV plan which could include a focus on core medical services (QPM, RWHAP partners, DPH)
2.2.3 Increase access to affordable health insurance and co-pays	• HIV funders review options to expand access to financial supports including eligibility criteria or more flexible use of funds (CTDPH, RWHAP partners) • Train service providers to link clients to the Connecticut Insurance Premium Assistance (CIPA) program, Access Health CT, and 4-CT for direct cash assistance (CHPC, CTDPH, RWHAP partners) • Identify, document, and expand effective workforce development projects that lead to employment of PLWH and access to health benefits (CTDPH, CHPC, RWHAP partners)
2.2.4 Reduce stigma that prevents linkage to care	• Refer to Goal 3

Objective 2.3. Increase access by PLWH to supportive services.

Short term implementation priorities address non-medical services and include activities underway by RWHAP partners in response to local needs, priority setting, and allocations processes. These activities begin to bridge the gap created by the role of social determinants of health. This area specifically calls for action related to housing stability for PLWH because housing has been identified consistently in PLWH needs assessments as a gap.

Strategies	Key Activities (Partners)
2.3.1. RWHAP partners set priorities and allocations for core medical services in response to needs and priority populations within their jurisdictions and implement these plans.	• Develop and update plans within RW jurisdictions to coordinate delivery of support services (RWHAP partners) • Implement quality assurance plans and programs within respective RW jurisdictions (RWHAP partners) • Support and scale improvements to the referral process that result in linkage to care. See activities under strategy 2.1.2. (RWHAP partners) • Conduct pilot projects to support and expand innovative practices in support services such as innovative approaches to supportive services including peer support models or telehealth (DPH, RWHAP partners, ETS Partners Groups, CIRA) • Coordinate an annual statewide quality management summit on a topic relevant to the HIV plan which could include a focus on support services (QPM, RWHAP partners, DPH)
2.3.2 Reduce stigma and discrimination	• See Goal 3

The remainder of this page was intentionally left blank.

Objective 2.4. Expand housing options for PLWH.

Short term implementation priorities specifically call for action related to housing stability for PLWH because housing issues have been identified consistently as a gap in PLWH needs assessments.

Strategies	Key Activities (Partners)
2.4.1. Establish a clear and effective structure to focus on housing for PLWH	• Establish a housing-specific mechanism to strengthen collaboration and coordination with housing funders and expand role of HIV partners in existing efforts to address housing insecurities (CTDPH, CHPC, HIV Funders, HOPWA, DMHAS, DOH) • Conduct additional studies to better understand issues or system breakdowns or bottlenecks most relevant to help increase housing and shelter access for no- or low-income individuals and housing stability for PLWH, this can include employment or employability options (CHPC, RWHAP partners, CTDPH, HIV Funders, HOPWA, DMHAS, DOH)
2.4.2. Scale effective solutions and promote best practices	• Develop a process to share and to scale best practices that promote access to stable housing through workshops, trainings, and quality improvement projects (CTDPH, CHPC, HIV Funders, HOPWA, DMHAS, DOH) • Support scaling up an expansion of pilot or demonstration projects such as the Youth Stable Housing Collaboration and attract additional housing resources for PLWH (CHPC, RWHAP partners, CTDPH, HIV Funders, HOPWA, DMHAS, DOH) • Scale and sustain practices and system changes to increase access and reduce barriers developed through the Data Integration Grant Project or other efforts to end homelessness and housing instability (CHPC, RWHAP partners, CTDPH, HIV Funders, HOPWA, DMHAS, DOH) • Offer trainings and resources to HIV providers and PLWH that expand awareness of and connection to home ownership programs and resources for PLWH (CHPC, RWHAP partners, CTDPH, HIV Funders, HOPWA, DMHAS, DOH)

The remainder of this page was intentionally left blank.

Goal 3: Reduce HIV-related disparities and health inequities.

Objective 3.1. Develop a constellation of sustainable strategies to reduce HIV stigma and discrimination.

Short term implementation priorities respond to a clear message by PLWH and other prevention priority populations that stigma and discrimination continue to persist at unacceptable levels and affect their access to services as well as their health outcomes. This area represents a significant lift for Plan partners because no clear methodology exists to measure stigma and discrimination, and changes in this area must occur at the system, provider, community, and individual levels.

Strategies	Key Activities (Partners)
3.1.1 Develop and implement methods to measure and assess stigma and discrimination – internal and external	• Pilot instrument and methodology to collect information on stigma and discrimination at the provider and individual level (NAP, CTDPH, RWHAP partners, CIRA) • Develop recommendations for a sustainable approach to collect data on stigma and discrimination (NAP, CTDPH, RWHAP partners, CIRA) • Develop stigma and discrimination indicators and as indicated, add this to the CHPC indicator list (QPM, CIRA, CHPC)
3.1.2 Establish routine HIV testing and syndemic screening as the norm	• See strategy 1.1.1 to promote awareness of routine HIV testing • See strategy 1.1.2 to build provider capacity for routine HIV testing and syndemic screening • See strategy 1.2.2 to scale the status neutral care model
3.1.3 Encourage healthcare providers to comply with best practices and standards that promote patient empowerment, equity, and access	• Include in contract language the adoption and use by providers of National Standards for Culturally and Linguistically Appropriate Services (CLAS) in health and health care or comparable standards for cultural relevance and inclusion (AETC, CTDPH, RWHAP partners) • Conduct campaigns that increase awareness of the patients' bill of rights and expand resources for self-advocacy and peer-based advocacy (CTDPH, RWHAP partners, AETC) • Organize forums or special events (e.g., Quality Management Summit, CHPC presentations) to share best practices and evidence-based awareness, health promotion, prevention, harm reduction, and care strategies for priority populations (CTDPH, RWHAP partners, ETS Partners Groups, CIRA, AETC) • Use CHPC list serv, website, and network to facilitate information sharing on opportunities to participate in community events (CTDPH, CHPC, PPCT)
3.1.4 Increase the diversity and capacity of the HIV prevention and care workforce	• Conduct a statewide HIV prevention and care workforce assessment and use the results to enhance and expand training offerings (NAP, CTDPH, RWHAP partners) • Offer HIV 101 core competency training to facilitate onboarding and knowledge equity and other specialized training topics based on priorities (CTDPH, RWHAP partners, AETC) • Share best practices in contracting, policy, and program that relate to recruiting, hiring, training, and retaining diverse and competent workers (CTDPH, RWHAP partners) • Offer regular opportunities for professional networking, mentoring, and self-care for the HIV prevention and care workforce (CTDPH, CHPC, RWHAP partners, AETC) • Use CHPC list serv, website, and network to facilitate information sharing on opportunities to participate in community events (CTDPH, CHPC, PPCT)

Objective 3.2. Address social determinants of health (SDOH) through policy and partnerships.

Short term implementation priorities focus on changing awareness, building knowledge equity necessary to support SDOH-related conversations, strengthening workforce training, and referral processes into available resources at community-based providers.

Strategies	Key Activities (Partners)
3.2.1 Strengthen participation and representation on statewide, regional, and local SDOH partnerships	• Expand CHPC membership to include partners representing statewide and/or regional SDOH initiatives and efforts and emphasis community engagement and involvement by persons with lived experience (CHPC) • HIV funders require participation of staff, contractors, and patients in statewide/regional, and local SDOH initiatives and efforts and identify a specific plan each year to do so or to implement priority work such as objective 2.4 housing (CTDPH, RWHAP partners) • See Objective 2.4 (housing)
3.2.2 Promote and/or coordinate trainings and events that address topics such as equity, cultural relevance, diversity, and inclusion	• Coordinate presentations and knowledge builds from SDOH subject matter experts at CHPC meetings (CHPC) • Coordinate presentations and events for healthcare professionals and students on SDOH, cultural relevance, diversity, equity, and inclusion (AETC) • Maintain mechanism to share information about events, trainings, and resources offered by other national and/or state partners (CHPC, RWHAP partners) • See strategy 1.1.3 on strategy for community awareness and engagement (RWHAP partners, DPH, CHPC)
3.2.3 Ensure data collection systems include fields that facilitate analyses relevant to understanding inequities and disparities	• Analyze CHPC indicators by subpopulations and review annually to understand existing or emerging inequities (DPH, QPM) • Use data to identify priority subpopulations most relevant to RW jurisdictions and core services (RWHAP partners) • Agree on standardized use of demographic questions in surveys and/or other qualitative data collection protocols (NAP, DPH, RWHAP partners, CIRA) • Promote and encourage use of culturally relevant data collection instruments and/or methodologies such as translation options (NAP, DPH, RWHAP partners) • See also 2.1.2 effective referral processes
3.2.4 Support continuous quality improvement and innovation to effectively engage priority populations in health promotion, prevention, and care services	• Coordinate an annual statewide quality management summit on a topic relevant to the HIV plan which could include a focus on SDOH and/or inequities (QPM, RWHAP partners, DPH) • Strengthen and scale programs that facilitate transitions for priority populations such as community re-entry for justice-involved populations or those transitioning from treatment facilities (DPH, RWHAP partners, DMHAS, DOC, HOPWA) • Attract and allocate resources to pilot and/or scale effective peer-driven programs (RWHAP Partners, HIV Funders Group, ETS Partners Groups)

Objective 3.3. Implement a Syndemic Approach with areas of focus on Sexually Transmitted Infections, Viral Hepatitis, and Substance Use Disorder (and Behavioral Health).

Short term implementation priorities for this objective recognize the scale and impact generated by adopting a syndemic approach and integrating this approach into all strategies.

Strategies	Key Activities (Partners)
3.3.1 Integrate the syndemic approach into the Integrated HIV Prevention and Care Plan	• Work with partners to develop information on CT's Syndemic for inclusion in the Plan. See strategy 4.2.2 that describes the Ending the Syndemic Partners Group and the approach to facilitate integration.
3.3.2 Scale the status neutral care approach	• Work across programs to support a "no wrong door" approach so that everyone leaves with a service. See strategy 1.2.2.
3.3.3 Develop and implement a plan to improve referral processes that result in linkage to care	• Work with prevention and care providers to strengthen referral and linkage mechanisms and provide a support to providers newly implementing routine testing. See strategy 2.1.2.

The remainder of this page was intentionally left blank.

Goal 4: Achieve integrated, coordinated efforts that address the HIV epidemic across all partners and interested parties.

Objective 4.1. Maintain the vitality and relevance of the Connecticut HIV Planning Consortium as a statewide HIV prevention and care planning entity.

Short term implementation priorities respond to lessons learned from prior Plan implementation, address areas for improvement – including Plan monitoring, and facilitate structural changes relevant to achieving Plan goals.

Strategies	Key Activities (Partners)
4.1.1 Strengthen and enhance the engagement of partners and diverse individuals with lived experience in the planning processes and activities	• Adjust CHPC membership application and recruitment process to ensure the CHPC membership reflects PLWH and individuals with lived experience across syndemic areas of focus (CHPC, MAC) • Conduct quarterly coordinated community outreach to priority populations and persons with lived experience to increase community engagement and participation of PLWH and persons with lived experience in Plan implementation (MAC, RWHAP partners) • Assess CHPC participant meeting satisfaction and experience and adjust process to ensure that scores meet or exceed standards (CHPC) • Publish "News and Notes" newsletter at least 3 times per year and include special features related to Plan implementation and/or other special features such as recognition of exceptional efforts by HIV providers and partners (MAC) • Facilitate as needed (daily, weekly) information sharing via list serv, website, and social media (CHPC, DPH, RWHAP partners) • Offer annual leadership development opportunities and mentoring program for CHPC members (CHPC Executive Committee, MAC) • Adjust financial incentives as needed for CHPC members who are not employed or who must forego work to access and/or attend CHPC meetings (CHPC, MAC, CTDPH)
4.1.2 Facilitate structures and processes that support statewide, coordinated planning activities	• Review at least every two years the CHPC organizational and committee structure to align with Plan activities and changing conditions affecting the work (CHPC, Executive) • Maintain quarterly, structured communication between CHPC and RWHAP Part A Planning Councils (CHPC co-chairs, RWHAP Part A EMA, TGA) • Develop a specific plan to conduct annual needs assessment projects in areas that represent gaps or needs in relation to other ongoing needs assessment projects (NAP) • Coordinate annual statewide quality management summit on a topic relevant to the HIV plan such as best practice sharing and/or recognition of exceptional efforts by HIV providers and partners (QPM, RWHAP partners, CTDPH)
4.1.3 Implement a monitoring and accountability process to show progress on implementation of the plan and to identify areas for mid-course adjustments	• Develop annual committee work plans that connect to Plan objectives, strategies, and activities and contain accountability milestones (CHPC committees) • Develop and implement CHPC monitoring plan and complete annual review process for accountability (QPM, CHPC, CIRA) • CHPC Co-Chairs maintain quarterly, structured communication with RWHAP partners, particularly RW Part A Planning Council Co-Chairs (CHPC, RWHAP partners) • Review progress annually including changes to data dashboards and DPH performance measures (QPM, CHPC)

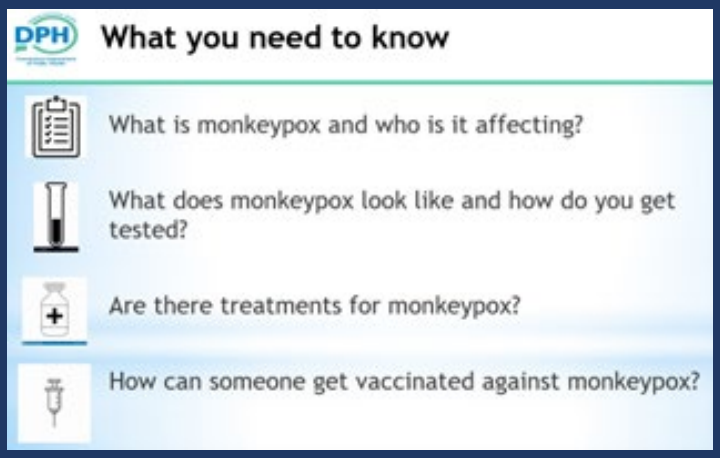
Objective 4.2. Strengthen collaborative workspace and capacity to improve coordination and integration of HIV services with other areas of syndemic focus.

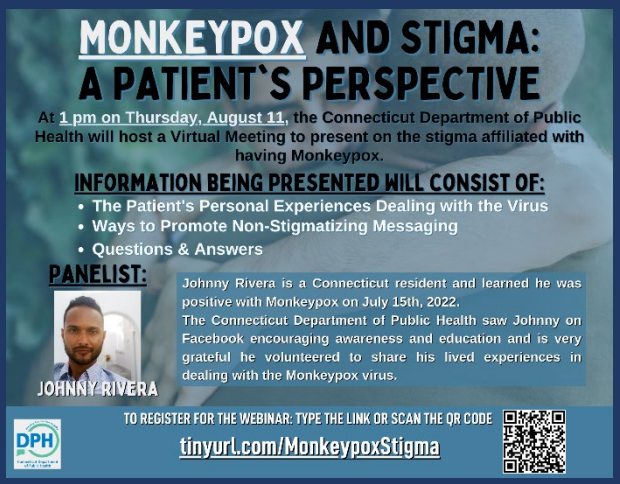
Short term implementation priorities reflect the critical role of CTDPH as the lead organization for statewide coordination.

Strategies	Key Activities (Partners)
4.2.1 CTDPH Convenes Ending the Syndemic Partners Group	• Conduct SWOT analysis across Ending the Syndemic partners (ETS Partners Groups) • Develop recommendations and next steps for collaboration, coordination, and integration such as assessment tools, referral mechanisms, adjustments to contracts or funding (ETS Partners Groups) • Participate on each other's planning groups as indicated in various ways such as members, subject matter experts, or presenters (ETS Partners Groups)
4.2.2. CTDPH convenes Connecticut HIV Funders Group	• Convene quarterly meetings (CTDPH, RWHAP partners) • Develop annual workplan that advances specific objectives in this Plan and develops milestones for accountability (CTDPH, RWHAP partners) • Facilitate data sharing and data collection (DPH, RWHAP partners) • Identify priorities to improve and/or change policies (CTDPH, RWHAP partners) • Identify priorities for quality improvement (CTDPH, RWHAP partners)
4.2.3 CTDPH liaisons participate on other groups relevant to the HIV plan	• CHPC / DPH co-chairs or representatives participate on RWHAP Part A councils or other advisory groups, and vice-versa (CTDPH, CHPC, RWHAP partners) • CHPC and RWHAP Part A Councils encourage their members to participate on other HIV-related planning groups (CHPC, RWHAP partners) • Syndemic partners participate on each other's planning and/or advisory groups as indicated including statewide STI Coalition and the Viral Hepatitis Elimination Technical Advisory Committee (ETS Partners Groups, CTDPH, RWHAP partners) • CHPC, CTDPH, and RWHAP program partners participate on SDOH initiatives as well as other statewide plans related to syndemic areas of focus (CHPC, CTDPH, RWHAP partners, ETS Partners Group)

CTDPH AND MPOX

During 2022, CTDPH leveraged its HIV-related community and provider networks to offer a series of informational sessions on the topic of Monkey Pox. The sessions included updates on surveillance data, information about vaccines and treatments (access, availability, and treatment resources), and access to persons with lived experience who could share their personal and provider journey.





Objective 4.3. Increase capacity of public health system to implement Plan and respond to outbreaks or public health emergencies relevant to HIV

Short term implementation priorities reflect the critical role of CTDPH as the core organization for statewide coordination and the important role of coordinating systems and processes, particularly as it relates to policy, funding, communications, and data collection.

Strategies	Key Activities (Partners)
4.3.1 Develop annual legislative agenda	• Align viral hepatitis language with 2022 routine HIV testing language (CTDPH) • Canvass CHPC committees and RWHAP partners annually to develop a list of policy barriers (CHPC, RWHAP partners, CTDPH) • Educate decision-makers on benefits and limitations of changing policy (CTDPH, Community Partners and Advocates) • Arrange support and testimony as warranted for policy work (CTDPH, Community Partners and Advocates)
4.3.2. Strengthen communication support for collaboration, information sharing, and statewide campaigns	• Update information and data on CHPC website monthly or more frequently as warranted (CHPC) • Update information and data on CTDPH website monthly or more frequently as warranted (CTDPH) • Attract funding to support statewide education and awareness campaigns relevant to the HIV plan (CTDPH, RWHAP partners) • Promote messaging through communication platforms of other (state) partners (CTDPH, HIV Funders, RWHAP partners, ETS Partners Group) • Coordinate and/or promote events and seminars such as the Monkey Pox series in 2022 or the health equity summit (CTDPH, ETS Partners Group)
4.3.3 Implement improvements that optimize funding, increase operational efficiencies, and improve outcomes	• Continue to explore improvements to regional funding models that expand collaboration and coordination with RWHAP partners, promote integration of HIV prevention and care services, and innovation in syndemic service delivery (CTDPH, RWHAP partners) • Promote standards of care such as rapid start medication and status neutral care model (CTDPH, RWHAP partners) • Identify a mechanism to facilitate and coordinate professional development and training delivery (CTDPH, RWHAP partners, AETC, CHPC)
4.3.4 HIV partners strengthen data collection and reporting capabilities and capacity	• Finalize and regularly update CTDPH Outbreak Detection and Response Plan (CTDPH) • Enhance statewide epidemiological profile to address priority areas such as syndemic areas of focus and publish every three years (CTDPH) • Align Data to Care initiative resources to local needs and priorities and emerging innovations such as improvements to the referral process (CTDPH, RWHAP partners) • Share and produce infographics and other surveillance products especially as it relates to syndemic areas of focus (CTDPH, RWHAP partners, CHPC, ETS Partners Group)

a. Updates to Other Strategic Plans used to Meet Requirements

The CHPC exists to coordinate efforts among and between syndemic partners and interested parties, including access to and meaningful use of information to update and to align local and/or statewide plans, to reduce duplication of effort, to increase efficiencies in data collection and sharing, and to improve the experience of people with lived experience or PLWH who may participate in plan development activities. The CHPC processes as well as the RWHAP Part A Planning Council processes for the EMA and the TGA, are open to the public and involve diverse participation from relevant syndemic partners and parties. Other RWHAP program partners (e.g., Part Cs, Part D) rely on this information to develop their funding applications.

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

1. 2022-2026 Integrated Planning Implementation Approach

a. Implementation

The CTDPH will continue in its role as the core organization to support the coordination of statewide planning through the CHPC and its committees. The CHPC as a planning entity does not control or influence any funding decisions by implementation partners. In fact, partners such as the Ryan White Part A EMA and TGA maintain Planning Councils within their local jurisdictions that conduct annual priority setting and allocation decision-making processes for their respective funds. Other partners such as RWHAP Part Cs and Ds submit their funding applications and implementation plans directly to the federal government.

The Plan identifies common ground for statewide goals, objectives, and strategies relevant to implementing a syndemic approach to end the HIV epidemic. The CHPC and its committees will serve as an ongoing forum to expand the collaborative workspace to partner, coordinate funding, and create maximum health outcomes for Connecticut's residents more effectively.

1. The CTDPH will provide funding for the support of staff to CHPC and its committees.
    - CTDPH will provide in-kind support for CTDPH resource liaisons or subject matter experts relevant to the work of each committee.
    - The CHPC will adjust its committee structure and/or refine its processes to better support implementation by partners of this Plan as well as to facilitate information flow across partners. This includes a commitment by the CHPC to move data presentations about individual CHPC indicators from the committee level to the full CHPC level.
2. The CTDPH will convene other groups to advance the system-level work of this Plan. For example, the CTDPH will convene an Ending the Syndemic Partners Group and as indicated a HIV Funders Group to address matters such as policy change, practice (e.g., standards of care), coordinated funding, system-level integration, and statewide communication campaigns.
3. RWHAP partners, the CTDPH (prevention), and other partners such as the Department of Mental Health and Addiction Services (CTDMHAS) will drive implementation and maintain accountability for strategies and activities relevant to this Plan in the context of the funding administered by each respective partner.
4. The CTDPH and the CHPC Quality and Performance Measures Committee will play a leading role in facilitating data collection, reporting, monitoring and evaluation activities for this Plan as described in the next sections.

b. Monitoring

The Plan represents a "living document" that will be reviewed and updated at least annually or as needed. Multiple levels of monitoring will occur by CTDPH, the CHPC, and respective implementation partners.

1. The CTDPH will continue in its role to collect (statewide) surveillance data and to provide subject matter experts such as epidemiologists to analyze and present annual updates to the CHPC indicators, refresh any statewide performance dashboards, and conduct any special program evaluations relevant to funding administered by their agency.
2. Individual implementation partners will comply with data collection, quality assurance, continuous quality improvement, and reporting requirements relevant to their funding sources.
    - These entities will share information through the CHPC committee process and/or other partnership groups such as the Ending the Syndemic Partners Group or the HIV Funders.

- This includes special studies and/or program evaluations on flagship strategies relevant to the Plan described in the evaluation plan section.

3. The CHPC, led by the Executive Committee and with the support of the Quality and Performance Measures (QPM) Committee, will conduct an annual review of the Plan, publish an update, and suggest any recommendations to the CHPC for mid-course adjustments. The QPM committee will guide and support the development of standardized work processes for each committee. This includes:

    - Development of an annual work plan with milestones that connect directly to Plan objectives. This will occur each year by the end of January.
    - Each CHPC Committee will conduct an annual reflection session wherein the participants will review progress (actual v. planned) on the committee's work plan. This will occur during the last committee meeting of each year. The Committee will identify accomplishments, barriers, and challenges in completing tasks, and identify other potential activities for the committee (or another committee).
    - The Executive Committee will include in its annual reflection identification of any structural or process change recommendations that the CHPC should consider.

c. Evaluation

The table shows how the CHPC will evaluate implementation progress on the plan. Subject matter experts affiliated with the Center for Interdisciplinary Research on AIDS (CIRA) at Yale School of Public Health will provide technical assistance in developing evaluation measures, metrics, and methodologies.

Approach to Evaluating the Plan

Type	Questions	Methodology
Process	To what extent has CHPC and CTDPH changed its structure and/or partnerships to support ongoing planning, implementation, and monitoring of the Plan?	• Documentation of changes in CHPC by-laws, policies and procedures, committee structure • Evidence of new partners or partnerships, includes new representatives as CHPC members • Evidence of changes in policy, funding, or staffing configurations
	To what extent has CHPC and CTDPH changed its processes to support ongoing planning, implementation, and monitoring of the Plan?	• CHPC satisfaction and experience surveys and monthly meeting dashboards • Evidence of committee compliance in developing and following work plans – including deliverables • Meeting minutes
Outcome	To what extent have flagship strategies from the Plan produced outcomes and impact based on special evaluation studies?	• Deliverables from special projects by partners or CHPC committees such as needs assessments, quality improvement projects, events, trainings, or pilot projects • Customized evaluation for flagship strategies or pilot projects most relevant to the Plan (includes development and testing of new CHPC indicators in areas such as measurement of stigma and discrimination)
	To what extent has Connecticut achieved its 2026 goals across the statewide indicators?	• CTDPH and CHPC QPM will update the CHPC indicators annual and present the information to the CHPC with any recommendations (e.g., adjust the 2026 goal, place emphasis on a particular issue or priority population)

SAMPLE: CHPC Quality and Performance Measures Plan Update Table

The CHPC Quality and Performance Measures (QPM) Committee is in the process of developing monitoring and evaluation tools specific to the 2022 – 2026 Plan. Monitoring and evaluation activities were identified as areas for improvement during the Plan development process.

Goal 1. Reduce New Infections				
Objective 1.1 Decrease the number of new infections by 25%, from 291 in 2014 to 218 in 2021.				
Focus Area	**Priority Activities**	**Responsible Party(ies)**	**Performance Measures (as of XXX Date)**	**Overall Progress & Next Steps**
A. Strengthen statewide communication platform to deliver prevention and health promotion messaging	**Marketing & Communications** ○ Position www.positivepreventionct.org as a primary gateway for information to the HIV community ○ Use social media channels and marketing campaigns to reach priority populations & into geographic hotspots **Outreach, Engagement & Training** ○ Train and deploy PLWH and peers on social media and outreach to engage priority populations in focus groups, community listening sessions; message development; and social marketing campaigns ○ Provide tools and coordinate digital event calendars for prevention and risk reduction events ○ Increase involvement of prevention stakeholders with the CHPC committees and statewide plan	PPCT – lead for communications DPH and all Ryan White Parts Other partners noted in Plan	• Ending the Syndemic website launched • XXX website views • XXX trained • X social marketing campaigns in geographic hot spots • XX peers trained • XX listening sessions • XX venues engaged (e.g., schools, churches) • Peer voices: excellent training, but need more follow-up coaching and/or groups to improve effectiveness	**Substantial Progress** • Engage MAC members to support PPCT development and outreach • Engage NASTAD to identify additional trainings and tools
B. Increase access to PrEP and n-PEP	**Marketing & Communications** ○ Use marketing and social media campaigns to increase awareness of PrEP, benefits of PrEP and how to access PrEP ○ Publish a digital resource inventory of PrEP providers & resources **Outreach, Engagement & Training** ○ Train HIV program staff, other peers and staff – including PLWH about PrEP, potential PrEP candidates, and PrEP services and supports **Service Delivery Improvements** ○ Review and refine clinical delivery systems to offer and deliver PrEP; start with priority populations (e.g., MSM, transgender) ○ Identify opportunities to apply non-clinical support services for individuals on PrEP to improve risk reduction, facilitate medication adherence and retain in care	DPH and all Ryan White Parts Other partners noted in Plan	• Digital resource inventory published • X social media campaigns • XX peers and staff trained to conduct outreach; # trained to administer & support PrEP • XX programs offering PrEP • Implementation of PrEP Navigation program as of XXX • Development of PrEP Navigation database to measure quality of navigation services • YMSM of color: PrEP messages not effective for us	**Some Progress** • Implement demonstration projects to increase PrEP uptake among YMSM of color • DPH develop on-demand webinars for program staff, agencies infuse PrEP into orientation for new staff

d. Improvement

The CHPC QPM Committee reviews and discusses regularly progress related to specific indicators and stimulates discussion that informs the CHPC's focus on continuous quality improvement activities, including coordination of an annual statewide Quality Management Summit. The text box shows the flyer for the 2021 Quality Management Summit. Individual RWHAP partners support their own quality improvement programs in compliance with their respective funding sources.

2021 CHPC Statewide Quality Management Summit

e. Reporting and Dissemination

The CHPC posts meeting and plan-related information on its website (cthivplanning.org). The CHPC dedicates one meeting each year to reviewing progress on the CHPC indicators and one meeting each year to review any significant changes in the epidemiological profile and/or specific subsets of surveillance data. CTDPH makes data sets and reports available on its website.

f. Updates to Other Strategic Plans Used to Meet Requirements

The CHPC exists to coordinate efforts among and between syndemic partners and interested parties, including access to and meaningful use of information to update and to align local and/or statewide plans, to reduce duplication of effort, to increase efficiencies in data collection and sharing, and to improve the experience of people with lived experience or PLWH who may participate in plan development activities. The CHPC processes as well as the RWHAP Part A Planning Council processes for the EMA and the TGA, are open to the public and involve diverse participation from relevant syndemic partners and parties. Other RWHAP program partners (e.g., Part Cs, Part D) rely on this information to develop their funding applications

SECTION VII. LETTERS OF CONCURRENCE

Context. This Plan represents a statewide effort in Connecticut led by the Connecticut HIV Planning Consortium (CHPC) and in partnership with multiple jurisdictions: one (1) Ryan White Health Administration Program (RWHAP) Part A- funded Eligible Metropolitan Area (EMA), one (1) RWHAP Part A-funded Transitional Grant Area (TGA), and the Connecticut Department of Public Health (CTDPH) which administers RWHAP Part B and the Centers for Disease Prevention and Control (CDC) HIV prevention funding.

The CHPC serves as Connecticut's primary vehicle for statewide HIV prevention and care planning. The diverse CHPC membership roster of approximately 30 people includes individuals with lived experience as well as representatives from throughout the state who hold a connection to and passion for ending the HIV epidemic, including representatives from other HIV prevention and Ryan White HIV AIDS Program (RWHAP) partners.

The CTDPH administers CDC Prevention Program funding (statewide) the Ryan White Part B funding (statewide). The CTDPH serves as the core organization for the CHPC, Connecticut's primary lead for statewide HIV prevention and care planning. The CHPC by-laws requires the inclusion of CTDPH personnel. Specifically, CTDPH designates one (of three) CHPC Co-Chairs. The CHPC requires representatives from CTDPH prevention and Ryan White Part B to serve as CHPC members. The CTDPH supports CHPC planning activities through access to data and to subject matter experts. The CTDPH representatives participate as members on the Ryan White Part A Planning Councils (EMA and TGA) who are jurisdictional partners in this Plan. Other CHPC Members participate on the Ryan White Part A Planning Councils as well (and vice-versa).

Concurrence Process for CHPC, CDC Prevention, and Ryan White Part B. The Letter of Concurrence from the CHPC serves as the official correspondence from the CDC Prevention Program Representative(s) and from the Ryan White Part B Representative(s). The CHPC leaders reviewed the CHPC concurrence voting process with all CHPC members via a short video and also in presentation format prior to a virtual vote at the November 16, 2022, CHPC meeting. The instructions explained the voting options and the importance of sharing specific concerns, if any, with the Plan – particularly for CHPC members who chose to vote non-concurrence. The majority of CHPC members participated in the virtual concurrence vote at a CHPC meeting. Four members were not in attendance due to extenuating circumstances. These members were contacted individually by CHPC project staff members to record their votes.

Concurrence Process for Ryan White Part A Planning Councils. Each of the Planning Councils convened the relevant group within their structure to review draft materials associated with the Plan. These groups provided feedback above and beyond input from Planning Council representatives who participated in the CHPC meetings. The respective Planning Council Groups determined their official position and forwarded a letter to the CHPC Co-Chairs for inclusion in this Plan (Subsection 2). Planning Councils were asked to share any specific concerns or reservations about the Plan and the process so the CHPC leaders could respond accordingly.

1. Integrated Planning Body (CHPC)

December 5, 2022

Laura W. Cheever, MD, SCM
Associate Administrator, HIV/AIDS Bureau
Health Resources and Services
Administration

Demetre Daskalakis, M.D.
Director, Division of HIV/AIDS Prevention
National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
Centers for Disease Control and Prevention

Dear Dr. Cheever and Dr. Daskalakis:

This letter attests to the fact that the Connecticut HIV Planning Consortium (CHPC) concurs with the submission of Connecticut's Integrated HIV Prevention and Care Plan 2022 to 2026 in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB).

The Connecticut HIV Planning Consortium (CHPC) is Connecticut's only statewide planning body for HIV prevention and care. The diverse CHPC membership roster of approximately 30 people includes persons with lived experience as well as representatives from throughout the state who hold a connection to and passion for ending the HIV epidemic, including representatives from other Ryan White HIV AIDS Program (RWHAP) partners.

This Plan represents a statewide effort in Connecticut in partnership with multiple jurisdictions and partners: the Connecticut HIV Planning Consortium (CHPC), one (1) Ryan White Health Administration Program (RWHAP) Part A- funded Eligible Metropolitan Area (EMA), one (1) RWHAP Part A-funded Transitional Grant Area (TGA), and the Connecticut Department of Public Health (CTDPH) which administers RWHAP Part B (that serves people living with HIV that can't get services elsewhere- balance of the state) and the Centers for Disease Prevention and Control (CDC) HIV Prevention Program.

The CHPC membership includes representatives from each of the core jurisdictional partners and invites public participation to its CHPC meetings. The CHPC enhanced its efforts to increase collaboration and coordination with core jurisdictional partners including presentations by jurisdictional partners at CHPC committee meetings and an intentional effort to expand community engagement in the Plan development process. This included a request to the Ryan White Planning Council's to submit separate letters of concurrence or non-concurrence.

While the majority of the CHPC members voted in concurrence of the Integrated Plan, only two (2) of 24 CHPC members voted for non-concurrence. These two members explained that the proposed goal 1 and objective 1.1 of the Plan did not conform explicitly with the numeric goals referenced in the National HIV and AIDS Strategy (NHAS). These very same concerns were expressed and documented in the letters from the Ryan White Part A Planning Councils.

The CHPC numeric goals and objectives were determined by the CHPC's Quality and Performance Measures Committee over the course of a 12-month data-driven planning process that was open to the public and used information made available by the Connecticut Department of Public Health to the core jurisdictional partners. The QPM determined and recommended through its public process that Connecticut could not reach the reference points identified in the NHAS due to multiple factors. The QPM recommended that Connecticut set objectives that were realistic and achievable (v. aspirational) and make modifications in the event it accomplished these goals and objectives before the end of the planning period.

In response to the concerns raised specifically by the Ryan White Part A Planning Councils, the CHPC leaders reached out to the IHAP TAC for clarification. The IHAP TAC responded that, "you can customize your goals while addressing the nation's, but in so doing…add something explaining why your goal is customized to your jurisdiction…. there are not strict requirements regarding metrics for goals/objectives or the process used to develop the plan." The CHPC leaders communicated this information to the Ryan White Part A Planning Councils prior to their vote and indicated that the Plan would explain that it recognizes the aspirational goals of the NHAS, sets practical and achievable goals for 2026 that position the state to achieve NHAS goals in 2030.

Two other CHPC members voted for concurrence and expressed reservations that related to the Plan development process. Specifically, these members suggested that in future years, the CHPC send out the entire final review copy of the entire Plan document as compared to sending out multiple sections of the incomplete draft document. CHPC Co-Chairs agree with this suggestion and commit to improving this process as it relates to updates to the Plan. Equally important, the CHPC will continue to address bottlenecks and/or breakdowns in communication identified during the Plan development process.

CHPC leaders, including members of the Executive Committee, have identified specific areas for process improvement to support implementation and monitoring of the Plan and expanding further community engagement, including partners that can address social determinants of health and social and economic injustices.

The CHPC will continue as Connecticut's primary vehicle for statewide HIV prevention and care planning and play a leading role in monitoring Plan implementation. The CHPC does not control any HIV prevention or care funding. CHPC committees will develop annual workplans that relate to specific goals, objectives, and strategy areas identified in the Plan. The CHPC will conduct an annual review of the Plan indicators and collaborate with implementation partners to evaluate priority strategies, including Connecticut's syndemic approach.

We recognize that this Plan represents a living document that will change in response to changes in priorities and allocation the core jurisdictional partners and new information such as the results of a first-ever statewide HIV prevention survey (results in 2023) and the rollout of new routine HIV testing campaigns in response to recently enacted legislation.

Connecticut's Plan will move the needle on statewide HIV prevention and care and other syndemic indicators, and ultimately position us to reach the NHAS goals for 2030.

Our signatures below confirm the CHPC's, HIV Prevention Program, and Ryan White Part B Program's concurrence with the Integrated HIV Prevention and Care Plan.

Nilda Fernandez
Community Co-Chair
CT HIV Planning Consortium

Barry Walters
Community Co-Chair
CT HIV Planning Consortium

Mitchell Namias
CT DPH RWPB Representative

Dante Gennaro Jr.
CT DPH Co-Chair
CT HIV Planning Consortium
CT DPH HIV Prevention Representative

2. CDC Prevention Program Planning Body Chair(s) or Representative(s)

The CTDPH leads statewide CDC HIV Prevention Program. The CTDPH serves as the core organization for the CHPC, Connecticut's primary vehicle for statewide HIV prevention and care planning.

The CHPC by-laws require that the CTDPH designates a CTDPH employee as a CHPC Co-Chair. Dante Gennaro, Jr., a CTDPH employee and representative of the CTDPH Prevention Program, serves as one (of three) CHPC Co-Chairs who guided this statewide planning effort. Numerous other CTDPH CDC Prevention Program Representatives participated in the planning process and served as subject matter experts to the CHPC and its committees as well as to the other jurisdictional partners involved in the Plan.

The CHPC letter included in this Plan (subsection 4) and signed by serves as the documentation of concurrence for this Plan by the CDC Prevention Program Representative.

The remainder of this page was intentionally left blank.

3. RWHAP Part A Planning Council / Planning Body(s) Chair(s) or Representative(s)

New Haven / Fairfield Eligible Metropolitan Area

NEW HAVEN / FAIRFIELD COUNTIES
RYAN WHITE PLANNING COUNCIL

November 29, 2022

Connecticut HIV Planning Consortium (CHPC) Co-Chairs
Barry Walters, Nilda Fernandez, Dante Gennaro, Jr.

Re: Letter of Concurrence with Reservations for the 2022-2026 Connecticut Integrated HIV Prevention and Care Plan

CHPC Co-Chairs-

The New Haven/Fairfield Counties Ryan White Planning Council (NHFF PC) would like to recognize and celebrate the work CHPC has done on the 2022-2026 State of Connecticut Integrated HIV Prevention and Care Plan (the plan) and supports the plan's objectives and strategies.

However, after review of the current version of the plan, the NHFF PC voted, on November 28th, 2022, to offer a Letter of Concurrence with Reservations for the plan. The NHFF PC has considerable reservations that the goals, including metric numerators and denominators, do not align with the *HIV National Strategic Plan: A Roadmap to End the Epidemic for the United States, 2021-2025*. Additionally, the NHFF PC has reservations that baseline data presented in the plan is not indicative of the true goals and thus, are confusing to the reader.

As the New Haven/Fairfield Eligible Metropolitan Area represents 65% of the state's new HIV cases and 61% of the state's HIV prevalence, it is the jurisdiction that seeks to be the most aggressive in striving to achieve the *HIV National Strategic Plan* goals. If we are to End the HIV Epidemic in Connecticut and the United States, we must aspire to achieve the ambitious goals outlined in the *HIV National Strategic Plan*.

Respectfully submitted,

Roberta Stewart, Co-Chair
New Haven/Fairfield Counties
Ryan White Planning Council

Christopher Cole, Co-Chair
New Haven/Fairfield Counties
Ryan White Planning Council

Hartford Transitional Grant Area

Greater Hartford Ryan White Part A Planning Council
178 Oakwood Drive, Glastonbury CT 06033
Email: ryanwhitehartford@amplifyct.org

November 9, 2022

The CHPC Co-Chairs
2558 Whitney Avenue
Hamden, CT 06518

Dear Co-Chairs

The Greater Hartford Ryan White Planning Council recognizes and appreciate the work CHPC has done on the plan.

After reviewing version 5 of the current draft of the 2022-2026 Integrated HIV Prevention and Care Plan, the Greater Hartford Ryan White Planning Council (GHRWPC) voted not to concur with the plan. The GHRWPC has concerns that the goals stated in the current draft of the plan do not align with the National HIV/AIDS Strategy for the United States 2022-2025.

As stated in the Executive Summary of the HRSA/CDC June 2021 issued Integrated HIV Prevention and Care Plan guidance, "jurisdictions should submit plans that follow the goals and priorities as described in the National HIV/AIDS Strategic Plan: A Roadmap to End the Epidemic for the United States, 2021-2025".

Should CHPC align the plan's goals with the National HIV Strategic Plan goals and include suggested changes and/or additions offered after much consideration from GHRWPC, the GHRW TGA planning council will review the updated goals and vote to provide a letter of concurrence in support of the 2022-2026 Connecticut Integrated HIV Prevention and Care Plan.

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

Danielle Warren-Diaz
Co-Chair

Maria Lorenzo
Co-Chair

4. RWHAP Part B Planning Body Chair or Representative

The CTDPH leads statewide Ryan White Part B Program. The CHPC requires CTDPH Ryan White Part B representative(s) to serve as CHPC members. The CHPC supports CHPC planning activities through access to data and to subject matter experts. For much of the Plan development process, the Ryan White Part B representative served as the chair of the CHPC Needs Assessment Committee. The CTDPH Part B representative(s) participate as members on the Ryan White Part A Planning Councils (EMA and TGA) who are jurisdictional partners in this Plan.

The CHPC letter included in this Plan (subsection 4) serves as the documentation of concurrence for this Plan by the Ryan White Part B Program Representative.

The remainder of this page was intentionally left blank.

5. EHE Planning Body

Connecticut is not eligible for and does not receive Ending the HIV Epidemic (EHE) funding. The Plan includes EHE strategies and addressing syndemic areas of focus including viral hepatitis, sexually transmitted infections, and substance use disorders.

The remainder of this page was intentionally left blank.

SECTION VIII. APPENDICES

Appendix 1: HIV/AIDS – Resource Summary for Connecticut Residents Available to the Public through the United Way of Connecticut 211 (Last modified May 2022)

The 211 database shows **196 results when using the search terms "HIV/AIDS". It offers specific description of services, eligibility, hours of services, contact information, and other functions (e.g., map and directions).*

Information/Frequently Asked Questions About HIV/AIDS:

For information and for answers to frequently asked questions about HIV and AIDS, go to the Centers for Disease Control web site: http://www.cdc.gov/hiv/default.html/ or to the Connecticut Department Public Health's FAQs.

Connecticut's HIV/AIDS Prevention And Care Guide:

http://uwc.211ct.org/wp-content/uploads/2015/01/2015-AIDS.HIV-Prevention-and-Care-Guide_Test.pdf

Federal Aids Information Sites:

- Centers for Disease Control and Prevention – National AIDS Hotline http://www.cdc.gov/hiv/ or call 1-800-CDC-INFO.

Connecticut State Agencies Offering Services for People With HIV/AIDS:

Connecticut Department of Social Services Administers cash and medical benefits programs including, cash assistance programs, Medicaid, Medical Spend Down, SNAP (Food Stamps). Apply online or at a DSS regional offices.

Department of Public Health's HIV/AIDS Services page:
https://portal.ct.gov/DPH/AIDS–Chronic-Diseases/Care/HIVAIDS-Services-in-Connecticut

HIV/AIDS Related Services and Programs in Connecticut:

(For specific information on service providers for any of the following, please search our online database, or dial 2-1-1 to speak to a 2-1-1 Specialist. 2-1-1 is open 24 hrs./7 days; calls are anonymous and confidential.

- **CBOs/ASOs:** Client Based Organizations (CBOs) / AIDS Service Organizations (ASOs) in Connecticut provide case management, assistance with basic needs services, counseling, information on alternative therapies, educational outreach, linkage to community services and social support to people with AIDS or HIV.
- **Medical Case/Care Management* HIV/AIDS:** Case management links people who have AIDS or who are HIV positive to entitlement and benefits programs, housing, treatment and health services, and other support services.
- **Drug Treatment Advocates:** Connecticut's Department of Public Health funds case managers (usually in urban areas) who do drug/alcohol addiction assessments and then find treatment beds for PWUD who want to get into drug or alcohol treatment. Case managers can also arrange for subsequent levels of care.
- **Health Related Support Groups* HIV/AIDS:** There are over 60 support groups statewide for people with AIDS/HIV and their families, friends, and caregivers.
- **HIV Prevention Counseling**: Connecticut Department of Public Health funds several different types of prevention counseling. These programs target both people who are at risk of becoming HIV+ to teach them strategies to stay healthy, and people who are HIV+ or who have AIDS to teach them how to stay healthy and prevent transmission to others.
- **HIV Testing:** In Connecticut everyone is entitled to a confidential and anonymous HIV antibody test. Testing and counseling are offered at various health agencies including city health departments and community health clinics. Private physicians can also give a patient an HIV test.
- **Housing For People With AIDS:** AIDS Connecticut (ACT) produces a directory of member AIDS residence provider agencies.

- **Medication Adherence Programs:** Nurses/counselors help people who are HIV+ how to best manage their medication regimens.
- **Mental Health Services for Children/Youth Who Have A Loved One With HIV/AIDS:** Several child guidance clinics in Connecticut offer special support and counseling for children and teens who have a family member who is HIV+ or has AIDS, or who have experienced the death of a loved one because of the disease.
- **Needle Exchange Programs:** For a list of Needle Exchange programs in Connecticut, visit the 2-1-1 database here.
- **Partner Notification Program –Care Program:** (Companion Awareness and Risk Education: AIDS) helps people with HIV/AIDS or other STDs notify present and previous sex or needle-sharing partners that they may have been exposed. Counselors will tell partners and keep the source confidential or will provide the support needed for the person who is infected to inform the partner(s) him/herself. DPH manages the CARE Program.
- **Prescription Assistance:** CADAP (Connecticut AIDS Drug Assistance Program) is a state program that helps eligible people living with HIV/AIDS pay for federally approved HIV antiretroviral drugs and drugs which prevent opportunistic infections associated with HIV/AIDS. Net countable income must be at or below 400% Federal Poverty Level; there is no asset limit.
- **Rent Subsidy Program**: Shelter Plus Care programs provide subsidized rental housing for adults who are homeless or at risk of homelessness AND who have a history of psychiatric disability, substance use, dual diagnosis, or who are homeless/at risk of homelessness AND HIV symptomatic. People apply for this program through their case managers.
- **Ryan White Funding:** Ryan White Care funding provides a system of services for people living with and affected by HIV and AIDS. Different parts of the Ryan White Act fund different types of services; some services are targeted for low-income households. Funded services include medical treatment, and for some regions of Connecticut, non-medical services such as emergency financial assistance, transportation, congregate meal programs, mental health services.
- **Specialized Treatment* HIV/AIDS:** Many health agencies in Connecticut provide HIV/AIDS treatment including hospitals, community health centers, and health clinics.

To Find Providers in Connecticut's Community Resources Database:

To find providers offering services targeted SPECIFICALLY for people who are HIV+ or who have AIDS, type in AIDS in the search box, at www.211ct.org and wait for drop down suggested terms. Select the resources and hit the search button. ***NOTE***: Non-targeted services can of course also be used by people with AIDS! The difference is that the ones with the targets are designed specifically for people with HIV or AIDS. To find non-targeted services, search the whole database.

Appendix 2: Reference Materials

Reports and Source Documents from Jurisdictional Partners:

Connecticut Statewide Health Improvement Plan (2020). Connecticut Department of Public Health.

Connecticut Statewide Health Needs Assessment Report (2019). Connecticut Department of Public Health.

Connecticut HIV Epidemiological Profile (2021). Connecticut Department of Public Health.

Connecticut LGBTQ+ Statewide Needs Assessment (2021). The Consultation Center, Yale School of Medicine.

Ending the HIV Epidemic in the U.S. (2019). Office of Infectious Disease and HIV/AIDS Policy, Health and Human Services.

Getting to Zero: A Comprehensive Report on Ending the HIV Epidemic in Connecticut (2018). The Connecticut Getting to Zero Commission, the Connecticut Department of Public Health.

HIV Prevention Application to the Centers for Disease Control and Prevention (2019). The Connecticut Department of Public Health.

In It to End It: Our Plan to End the HIV Epidemic in Connecticut (2021). Ryan White Part A Eligible Metropolitan Area New Haven and Fairfield Counties, City of New Haven.

National HIV and AIDS Strategy: 2022 to 2025. White House Office of National AIDS Policy.

Ryan White Part A Eligible Metropolitan Area New Haven and Fairfield Counties Application for Funding (2022). City of New Haven Department of Health.

Ryan White Part A Transitional Grant Area Hartford Application for Funding (2022). City of Hartford Department of Health.

Ryan White Part B (Statewide) Application for Funding (2022). Connecticut Department of Public Health.

Ryan White Part D Application for Funding (2022). Connecticut Children's.

Reference Materials Available on the Connecticut Department of Public Health Website via the HIV Surveillance, STD Control Program, Tuberculosis Program, and HIV Prevention & Care:

Frequently Asked Questions About: HIV and AIDS Health Care and Support Services

- Health Care and Support Services Contractors

Connecticut Ryan White Part B Standards of Care

- Part B Service Standards of Care
- Part B Universal Standards of Care

Connecticut Ryan White Part B Forms

- Client Care Plan
- Client Assessment

Connecticut Ryan White Care Finder

- Ryan White Care Finder

Data Maps

- Hep C Cases
- Fatal Opioid Overdoses
- Non-Fatal Opioid Overdoses
- Newly Diagnosed HIV Cases

- People Living With HIV (PLWH)
- Syringe Services Programs (SSPs) Clients

Health Care and Support Services Quality Management Plan

- Quality Management Plan
- HIV / AIDS Services in Connecticut
- HIV Care, Prevention, and Support Services in Connecticut by County

HRSA Monitoring Standards for Part B

- Universal Monitoring Standards Frequently Asked Questions
- Universal Monitoring Standards Part A & B
- Part B Fiscal Monitoring Standards
- Part B Program Monitoring Standards

Medication

- Medication Adherence Protocol document
- Medication Adherence Programs
- Medical Nutrition Therapy Programs

HIV and Employment

- Communicable Disease Guidance

HIV Prevention and Education

- Condom Ordering Policy
- Condom Ordering Information
- HIV/AIDS Epidemiological Profile
- DPH Funded HIV Interventions
- Connecticut OTL 2021 Report
- Connecticut Routine Testing 2021 Report
- Connecticut Syringe Service 2021 Report

HIV Partner Services Referrals

- Partner Services Client Referral Checklist
- Partner Services Referral Criteria
- Partner Services Department of Corrections Referral Criteria
- Client Referral Form
- Partner Referral Form

HIV Prevention Policies

- Condom Distribution Policy
- Incentive Policy
- Program Review Panel

HIV Testing

- HIV Testing
- Implementing HIV Testing in Nonclinical Settings: A Guide for Testing Providers
- HIV testing locations in Connecticut
- Informed Consent to HIV test

- HIV and HCV Reporting Guidance
- HCV Rapid Test Report Form
- HCV and HIV Free Testing Locations

Overdose Prevention Education and Naloxone Distribution - OPEN Access CT

- OPEN Access Guidelines
- OPEN Access Membership Form
- Responding to an Overdose using Naloxone
- FAQs about the Teleflex Medical Voluntary Recall of Certain Atomizers included in Some Naloxone Kits
- 2022 International Overdose Prevention Day Event Locations

Codes for L4 field to be entered in EvaluationWeb:

- How did you hear about our HIV testing service

HIV Case Reporting

- Case Reporting Instructions
- Adult HIV Case Report Form for Counselors
- Quick Reference

Pre-Exposure Prophylaxis (PrEP)

- PrEP Fact Sheet
- Connecticut PrEP Providers
- Pre-Exposure Prophylaxis Guidelines
- Post-Exposure Prophylaxis Guidelines

Sexual Assault and HIV

- Sexual Assault Crisis Services Brochure

Syringe Services Program (SSP)

- Guide to Developing & Managing Syringe Access Programs
- SSP Development & Implementation Guidelines for Health Departments
- Syringe Service Programs in Connecticut
- Syringe Service Programs Map
- Safe Needle Disposal
- Fentanyl Testing to Prevent Overdose

Tell Me What You See (TMWYS)

A supplemental resource developed in Connecticut that health educators can use to enhance existing curricula for high school-aged youth. The initiative addresses STDs, hepatitis and HIV prevention and integrates essential knowledge and skill development through an art-based approach to prevention education. Tell Me What You See

Routine HIV Testing in Health Care Settings

- Consent Law and Resources for Clinicians
- CDC Info Center

Other Sources of Information Used in the Plan:

Centers for Disease Control and Prevention Grant Funding Profiles by state at https://www.cdc.gov/fundingprofiles/index.htm

Center for Interdisciplinary Research on AIDS – Yale University at https://cira.yale.edu/

Community Health Center Association of Connecticut HIV/AIDS and Hepatitis C Programs at https://www.chcact.org/about/hiv-aids/

Connected Til the End: Connecticut's Ending the Syndemic Initiative resources available at www.endthesyndemicct.org

Connecticut HIV/AIDS Services and Contact Information available at https://portal.ct.gov/dph/AIDS--Chronic-Diseases/AIDS-Home/HIV-and-AIDS

Connecticut HIV Surveillance Data and Epidemiological Reports available at https://portal.ct.gov/dph/AIDS--Chronic-Diseases/Surveillance/HIV-Surveillance-Program

Connecticut HIV Planning Consortium Meeting and Committee meeting summaries, presentations, and resources available at www.cthivplanning.org

Connecticut HIV Cluster and Outbreak Detection and Response Plan available at https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/AIDS--Chronic-Diseases/Surveillance/statewide/Epi-Profile-2022.pdf

Connecticut Department of Mental Health and Addition Services Infectious Disease Services at https://portal.ct.gov/DMHAS/Divisions/Community-Services-Division/Infectious-Disease-Services

Connecticut Prevention and Health Promotion Division of the Connecticut Department of Mental Health and Addiction Services at https://portal.ct.gov/DMHAS/Prevention-Unit/Prevention-Unit/Prevention-and-Health-Promotion-Division

Health Resources and Services Administration Ryan White HIV/AIDS Program Funding Profiles at https://data.hrsa.gov/data/reports/datagrid?gridName=ProgramActivity

Health Resources and Services Administration Special Populations Funded Program and Find HIV/AIDS Program Medical Provider at https://findhivcare.hrsa.gov/

Health Resources & Services Administration Ryan White HIV/AIDS Program Part B: Grants to State and Territories at https://data.hrsa.gov/

Health Resources and Services Administration Ryan White HIV/AIDS Program Part C Early Intervention Services at https://data.hrsa.gov/

Health Resources and Services Administration Ryan White HIV/AIDS Program Prat D Coordinated HIV Services and Access to Research for Women, Infants, Children, and Youth (WICY) at https://data.hrsa.gov/

Health Resources and Services Administration Ryan White HIV/AIDS Part F AIDS Education and Training Center Program at https://ryanwhite.hrsa.gov/about/parts-and-initiatives/part-f-aetc

HIV/AIDS – Resource Summary for Connecticut Residents at www.uwc.211ct.org/hivaids-resource-summary-for-connecticut-residents/

Greater Hartford Ryan White Part A Planning Council meeting summaries, presentations, and resources available at https://ryanwhitehartford.info/resources/

Local HIV Data for the State of Connecticut at www.aidsvu.org

HIV/AIDS – Resource Summary for Connecticut Residents at www.uwc.211ct.org

New England AETC Education and Training Center Connecticut Regional Partner at www.aetcct.org

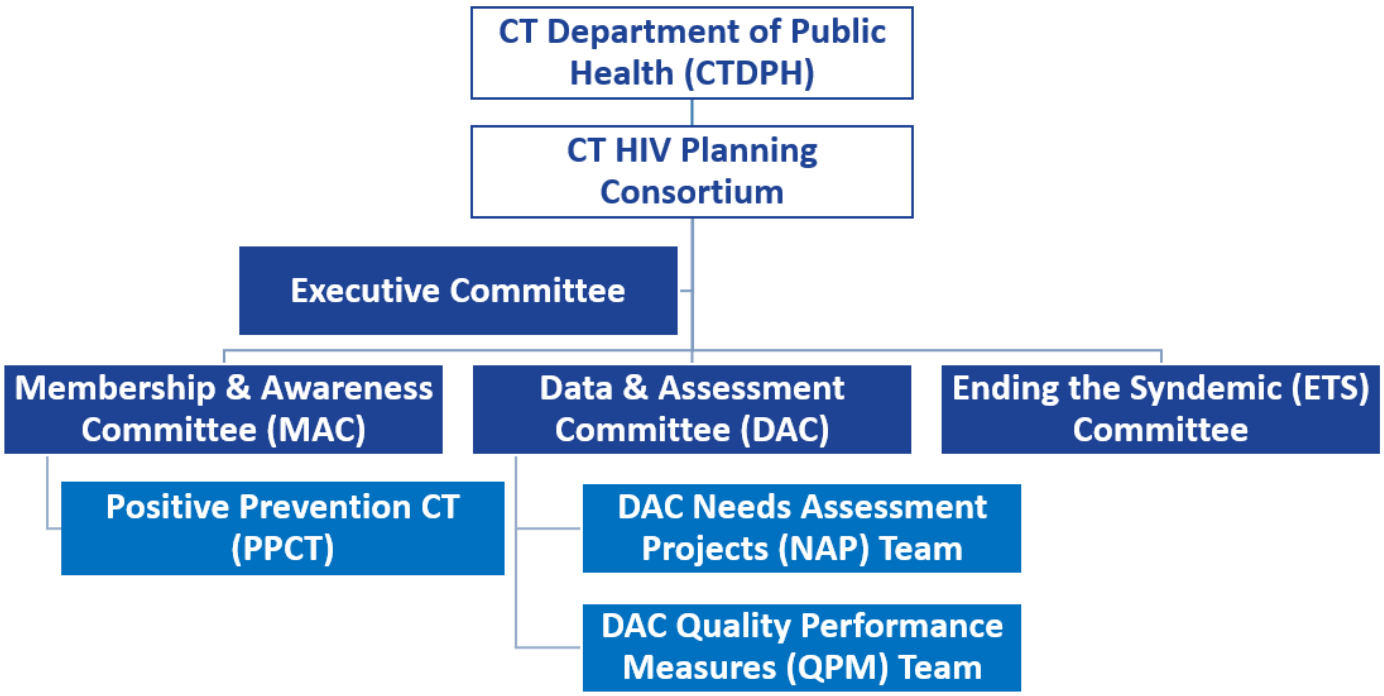
New Haven / Fairfield Ryan White Planning Council meeting summaries, presentations, and resources available at www.nhffryanwhitehivaidscare.org

Appendix 3: Connecticut HIV Planning Consortium Materials

CHPC Mission and Goals:

Mission	Goals
Establish and maintain a coordinated statewide prevention and care system that reduces the rate of new HIV infections and connects those living with and affected by HIV/AIDS to appropriate services.	1. Prevent new HIV infections 2. Improve health outcomes of persons with HIV 3. Reduce HIV-related disparities and inequities 4. Achieve a more coordinated statewide response to end the HIV epidemic

CHPC Committee Structure:



This diversity grid is used to ensure the members of the CHPC are reflective of the communities being served.

Membership Diversity Chart January 2022 Based on CDC Guidance and Data on Recently Diagnosed HIV Cases and PLWH:

Categories	Current Membership	Goal[6]	Members Needed	% Short of Goal
Total	**31**	**30[7]**	0	--
Consumer/Provider[8]				
Consumer (HIV+)	14	15	1	7
Provider	20	15	0	--
Priority Populations[9]				
Men who have sex with men	14	13	0	--
People who inject drugs	3	5	2	40
Heterosexual	14	9	0	--
Gender				
Female	12	9	0	--
Male	17	21	**4**	19
Transgender	2	2	0	--
Race/Ethnicity[10]				
Black[11]	13	11	0	--
Hispanic or Latino/a	8	9	1	11
White	11	9	0	--
Age				
<29	1	6	**5**	**83**
30-39	8	5	0	--
40-49	5	6	1	17
50-59	9	7	0	--
60+	8	6	0	--
County[12] [13]				
Fairfield	6	7	1	14
Hartford	11	9	0	--
Litchfield	1	1	0	--
Middlesex	1	1	0	--
New Haven	9	10	1	10
New London	2	2	0	--
Tolland	0	1[14]	1	**100**
Windham	1	1	0	--
Department of Correction[15]	2	3	1	33

[6] Goals are based on CTDPH HIV Surveillance data – 2015-2019 data on diagnosed HIV cases and people living with HIV in 2019
[7] The CHPC Charter has a target range of 25-35 members.
[8] The CHPC has an internal goal of having its membership be 50% consumers (PLWH) and 50% non-consumers/providers (non-HIV+ individuals)
[9] Categories are not mutually exclusive, so total may be larger than # of members.
[10] Categories are not mutually exclusive, so total may be larger than # of members.
[11] Black includes African-American, African, Caribbean-American, West Indian, Haitian, etc.
[12] Categories are not mutually exclusive, so total may be larger than # of members.
[13] Members who work in one region and live in another region are categorized according to their work region
[14] Although epi data does not indicate high incidence of HIV for Tolland County, the CHPC strives to have representation for each region of the state.
[15] The Department of Correction is represented by former inmates.

CHPC Membership Diversity: Non-Data-Driven Portion Based on CDC Guidance and Required Categories:

Funding Source	# of Members
Part A	11
Part B	11
Part C	1
Part D	2
Part F Provider (Dental, SPNS, AETC)	2
Prevention Funds	9
Required Partners	**# of Members**
New Haven/Fairfield TGA Part A Grantee	1
Hartford TGA Part A Grantee	1
State of Connecticut Part B Grantee	1
Part C Grantee	1
Part D – Connecticut Primary Care Consortium	1
Part F – Dental Reimbursement Program	0
Part F – AIDS Education & Training Centers	1
CT AIDS Drug Assistance Program (CADAP)	1
CT Department of Mental Health and Addiction Services	1
CT Department of Correction	0
Sexual Orientation	**# of Members**
Heterosexual	14
Gay Man	14
Lesbian	0
Bisexual	3
Occupation	**# of Members**
State health dept. HIV / AIDS staff	2
State health dept. hepatitis staff	0
State health dept. STD / STI staff	0
State health dept. tuberculosis staff	0
Local health dept. HIV prevention/STD treatment staff	3
State education agency	0
Local education agency	2
Non-governmental STD agency	1
Non-governmental TB agency	0
Non-governmental substance use prevention & treatment	5
Non-governmental mental health services	3
Non-governmental homeless shelters	0
Non-governmental prisons/corrections	1
Non-governmental HIV care and social services	14
Non-governmental education agency	2
Medical doctor	0
Business community	0
Labor community	1
Faith community	0
Field of Expertise	**# of Members**
Health Planning	12
Behavioral Science	7
Social Science	7
Program Evaluation	9
Epidemiology	0

CHPC Newsletter (Sample, September 2022):

CHPC
CONNECTICUT HIV PLANNING CONSORTIUM

SEPTEMBER 2022

The CHPC is an integrated, statewide prevention and care planning group comprised of diverse partners—including persons living with HIV.

IN THIS ISSUE:

- Recovery & Harm Reduction
- CHPC Update
- PPCT Providers' Corner
- Housing = Healthcare
- My Housing Journey
- Voice of the People Panel
- DPH Corner
- World AIDS Day 2022

MISSION STATEMENT:

To create a coordinated statewide prevention and care system in which the rate of new HIV infections is reduced, and those who are living with and affected by HIV/AIDS are connected to appropriate care and support services.

RECOVERY & HARM REDUCTION:

What Communities Do We Really Serve?

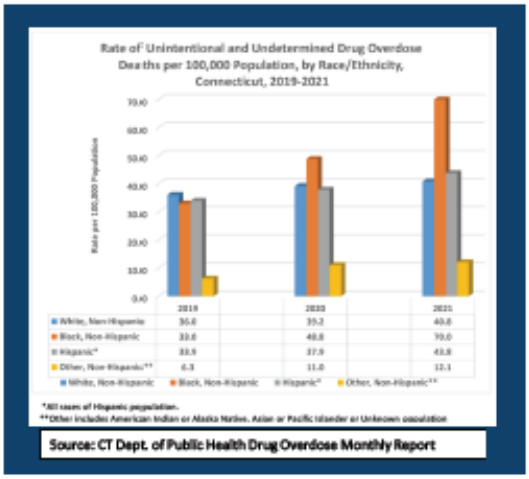
By Alixe Dittmore, Training and Content Development Coordinator, National Harm Reduction Coalition

As we close out August with International Overdose Awareness Day and enter September's National Recovery Month, I ask providers this question: "What communities do we really serve?"

During the June CHPC meeting, I spoke with two other panelists about substance use, recovery, harm reduction, and overdose prevention. Since fentanyl entered the drug supply, we have seen drastic upticks in non-fatal and fatal overdoses nationwide, with corresponding increases in federal funding. What we do with that money is critical. Safe consumption spaces are slowly becoming a reality in some parts of our nation. The continued expansion of harm reduction in public health is life-saving – but for who?

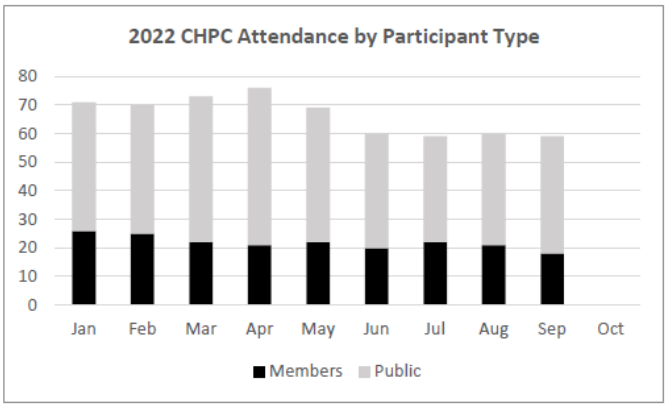
In Connecticut, we cannot talk about these subjects without addressing the stark racial disparities in who we are losing to fatal overdoses. From 2019 to 2021, the rate of drug overdose fatalities among non-Hispanic Black residents more than doubled (see chart). As more providers, agencies, and people begin to integrate harm reduction into their practices and services, I ask again: "What communities do we really serve?" If we integrate harm reduction but fail to address our own implicit biases and inequities within our own programs, we will perpetuate the harms that cause this grave disparity. Visit the CT Harm Reduction Alliance **(ghhrc.org)** and National Harm Reduction Coalition **(harmreduction.org)** websites for information and resources.

We all need funds for more than just safer drug use supplies and Naloxone. We also need more safe consumption spaces in communities that need them most. We need to bring our services directly into underserved communities, because only then will we truly begin to bridge gaps and help set pathways to recovery for all people.

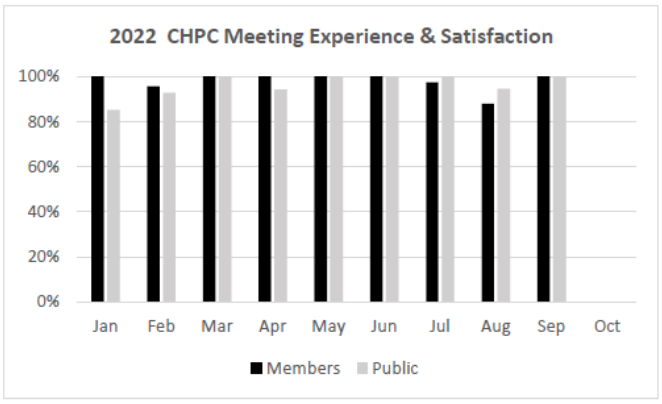


CHPC Meeting Dashboard (excerpts from September 2022):

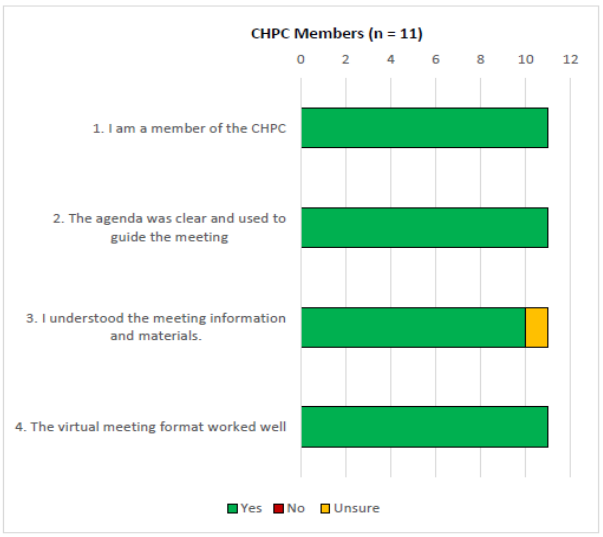
Attendance

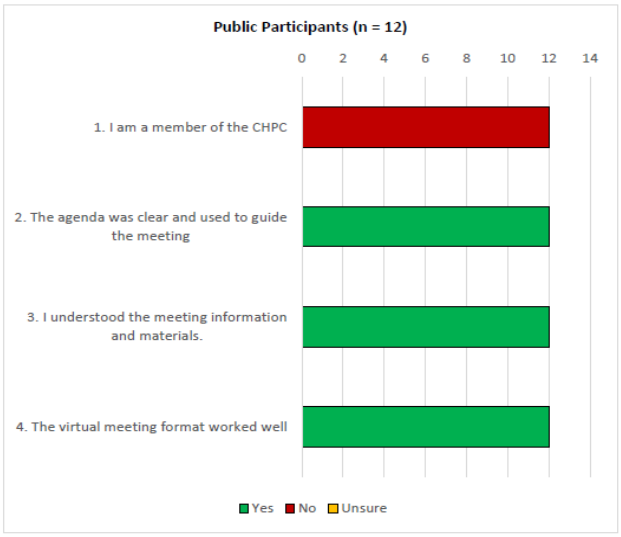


Overall Satisfaction *(23 responses in September)*



Detailed Feedback





One thing I liked best about the CHPC meeting was...		One suggestion I have to improve the CHPC meeting is...	
CHPC Members	**Public Participants**	**CHPC Members**	**Public Participants**
○ Small group discussions ○ Breakout rooms because it allowed everyone the possibility to talk, to listen to each other and provide input for the Integrated Plan. ○ Providing input into the plan ○ Breakout session ○ I LOVED MY SMALL GROUP! It was a powerful discussion ○ Group discussions ○ The break out group ○ NAP meeting	○ Break out room ○ Small group activity ○ The break- out session, how people engaged in the discussion. ○ Collaborations to improve health ○ Discussion groups ○ Good dialogue in our group. ○ The discussions and difference of opinions. ○ Interaction ○ Small group discussion space and more time ○ Small Group Activity ○ Collaboration	○ Encourage everyone to speak up and provide their input when needed (especially for the purpose of the Integrated Plan). ○ I am not sure at this time, but like I said before it was a lot of information to be process at once ○ No more virtual meetings ○ More time! ○ No improvements to suggest. I like the format. ○ No comments this month ○ NA ○ N/a	○ Possibly more frequent shorter meetings ○ Move forward after discussing a topic instead of beating it to death. ○ Notes in small groups should be done on the screen; the feedback to the large group does not always sound like what was articulated ○ Include some type of celebration or accomplishment to balance with all of the work ○ More time ○ Nothing ○ None ○ None ○ None ○ NA

Excerpts from Quality and Performance Measures (QPM) Committees about CHPC Indicators:

In looking at the trends, the goal set by QPM was to "turn the curve" for those indicators in which the data showed significant recent increases (Hep C and overdoses) or the QPM determined that a realistic, achievable goal may differ from the 2025 (national) goals identified by the NHAS. The information below represents exceprts from actual QPM meeting summaries. Full summaries are available on the CHPC website.

New Diagnoses: The number of people newly diagnosed with HIV. The number of new diagnoses decreased by 21% from 2015 through 2019.

Goal 1: Prevent New HIV Infections

Indicator	Description	2019 Baseline	CT Trend (2015-19)	NHAS 2026 Goal
PrEP	PrEP-to-Need Ratio: The number of people taking PrEP divided by the number of people newly diagnosed with HIV	12.0	Increased 3.2 times, close to 15.0 goal	Increase 3.8 times
New HIV Diagnoses	Number of people newly diagnosed with HIV	220	Decreased 21%, close to 218 goal	Decrease by 75%
Knowledge of HIV Status	Percent of PLWH aware of their status	91%	Increased 2%	95% aware

Ms. Nembhard noted nuances with this indicator – especially with routine testing legislation likely to become law and with new testing initiatives such as Ryan White New Haven-Fairfield County's faith-based effort. As more people are tested, Connecticut may "find" more people infected with HIV. While this is good news and could decrease the percent of late testers, it may also increase the number of newly diagnosed. QPM will need to look across its indicators to "tell the story" of how we're ending the epidemic. Ms. Fernandez noted that even if the governor signs the routine testing legislation, it will take several years to roll out (so may not affect testing in the short term). Mukhtar Mohamed noted that the 2020 data should be viewed with caution; there were much fewer tests than in prior years. (In the chat, Mr. Rodriguez-Santana noted we need to also look at 2021 data to confirm that the 2020 decrease in newly diagnosed was due to COVID. If in 2021, we get less new cases than in 2020, the COVID impact on HIV newly diagnosed cases theory needs to be rejected.)

- Poll. A clear majority (61%) voted to set the goal at 174 – continuing the current trend.

Sexually Transmitted Infections (STIs): Number of syphilis cases. The number of syphillis cases has increased by 128% from 2015 to 2019. The National STI Plan set a goal of reducing STI infections by 3%.

- Poll. 53% voted to set the goal at 204 syphilis cases, and 24% voted to set the goal at 210 cases.
- Discussion. Mr. Butcher suggested going with the national goal (204 cases or a 3% decrease), given that the different between the top 2 vote-getters was only 6 cases. The group agreed.
- Decision. The group set the goal at 204 cases.

Hepatitis C: Number of newly diagnosed chronic Hep C infections. The number of cases decreased 12% from 2015 to 2019. The federal Hepatitis Plan sets a goal of decreasing cases by 20%.

Ms. Nembhard asked if the DPH data system includes more detailed data on Hep C treatment. Ms. Major stated that they are not there yet but is hopeful that additional data will be added in the future. QPM can look at additional indicators once additional data is incorporated into the state data system.

- First Poll. 40% voted to set the goal at 1,178 cases, 27% voted for 1,100, and 27% voted for 1,050.
- Discussion. Ms. Nembhard stated that in her jurisdiction (Hartford region), they had funds to implement Hepatitis C initiatives and partnerships with DPH. Ms. Major noted that one challenge in setting an ambitious goal is that the state is doing more testing – integrating Hep C testing into SSPs and increasing testing at correctional facilities. So (as with HIV testing), they may find more positives. Dave asked if DPH is able to track the number of Hep C tests; Ms. Major replied that they have some testing data (negative PCR tests) but not all tests (negative antigen tests). Ms. Nembhard reminded the team that we can reassess our goals in the future based on new information and new initiatives.
- Second Poll. A clear majority (67%) voted for 1,178 cases – continuing the statewide trend.

Substance Use: Number of overdose deaths. There were 1,528 overdose deaths in 2021, and the number of overdoses has been increasing at a high rate over the past 5-10 years. Mr. Rodriguez-Santana shared additional projections if current trends continue – 2,122 overdose deaths in 2026, within a range of 2,032 and 2,211 (95% confidence interval). Dave asked if the COVID lockdowns affected number of overdose deaths (i.e., more people overdosing while home alone). Mr. Rodriguez-Santana stated that more than half of overdoses occur in the home, so the main question is whether there are witnesses. Connecticut is focusing on community distribution of Naloxone to friends, family members and neighbors to try to address this challenge.

- Poll. 45% voted for 1,750 and 29% voted for 1,528.
- Discussion. Ms. Major stated that the realistic goal is closer to 2,100 but thought we should set a goal to strive for, at 1,750. Mr. Rodriguez-Santana noted that the state only reaches a small percentage of all people at risk of overdose; we need much more Naloxone to meet the need, and a good network to make sure it reaches the people who can reverse overdoses. Ms. Nembhard suggested going with 1,750 as a goal, given lack of time for an in-depth discussion and re-vote. Mr. Butcher agreed, and noted that the Plan goes through 2026, so we have time to turn things around.
- Decision. The group agreed to set the goal at 1,750 overdose deaths.