Connecticut HIV Planning Consortium

Main Meeting Summary

January 21, 2026

Date:	January 21, 2026	**Type:**	Virtual
Start Time:	9:00 a.m.	**End Time:**	11:59 a.m.
Participants:	98	**CHPC Members:**	24
Co-Chairs:	Dante Gennaro, Blaise Gilchrist, Africka Hinds		
Next Meeting:	February 18, 2026 (Virtual)		

WELCOME AND MOMENT OF SILENCE

CHPC Co-Chair Africka Hinds started the meeting by welcoming participants and introducing CHPC Co-Chairs Dante Gennaro, Jr. and Blaise Gilchrist. She asked individuals to put their names, affiliations, and e-mail information into the chat and reviewed best practices to create a friendly and productive virtual meeting environment. The group observed a moment of silence in honor of all individuals past and present affected by HIV or involved in ending the HIV epidemic. Africka shared an overview of the CHPC by covering information such as vision, mission, values, structure, and process.

CHPC GENERAL BUSINESS

Dante Gennaro, Jr. explained that the general business segment for upcoming meetings will be kept brief to expand the amount of time for data presentations and discussions related to the 2027 to 2031 Plan development. He shared several announcements related to CHPC operations.

CHPC Membership**:** The names of CHPC Members were shown and committee leaders were denoted. Eight (8) membership openings exist with preferences for persons with HIV (PWH), persons under age 29, individuals who live or work in Tolland, Litchfield, Windham, or New London counties, or persons representing new resource partners to the CHPC. The Executive Committee will review applications on January 29, 2026. Interested individuals should submit their applications using the online form available at www.CTHIVplanning.org.

Approval of Prior Meeting Summary. The CHPC Members will approve the meeting summaries virtually outside of the CHPC main meetings.

CHPC Timeline. Dante reviewed the CHPC timeline (shown below) and explained in more depth the areas of focus for each quarter and the approach to using in-person meetings.

Executive Committee. Dante shared the topics that were currently under consideration by the CHPC Executive Committee. Topics that involve changes to the by-laws will be submitted to CHPC Members for a formal vote. Most of these topics originated directly from CHPC meetings via meeting polls, suggestions, or comments on CHPC meeting feedback forms. The topics include: (a) Discussion on increasing stipend for eligible CHPC Members from $80 per month to $100 per month, (b) By-laws change related to the attendance policy to define "allowable" absences, (c) Selection of in-person meeting locations

for 2026, (d) Input on the topic for a 2026 statewide summit, (e) Strengthen coordination between and among CHPC committees, and (f) Coordination of tasks to develop the 2027-2031 Plan.

- Danielle Warren Dias asked what it meant to be an "eligible" CHPC member relative to accessing a stipend. Dante explained this stipend support was intended to help CHPC members who were not attending CHPC meetings as part of their regular job duties (e.g., a HIV prevention or care service provider or required partner). These individuals could be persons with HIV or not.

Integrated Plan Data Projects**.** An update was provided on several data initiatives coordinated by the Connecticut Funders Group. These projects will inform the 2027–2031 Integrated Plan. Overall, all SCSN (Statewide Coordinated Statement of Need) projects remain on schedule.

CHPC Committees – 2026 Areas of Focus. Dante explained that the CHPC standing committees would continue to meet each month. Today and February (for virtual meetings), the committee meetings would start at 12:30 p.m. after a 30-minute self-care / lunch break. The Executive Committee had encouraged committee co-chairs to (a) reduce the meeting time of committees so that time could be used in full-group Plan development activities, and (b) reserve part of their agenda time during the first four months of the year to address Plan development topics (vs. 2022 – 2026 Plan implementation activities). The figure shows the 2026 areas of focus by CHPC committee.

Ending the Syndemic (ETS)	Public Awareness & Community Engagement (PACE)	Needs Assessment Projects (NAP)	Quality & Performance Measures (QPM)
• Updates from the Syndemic Partners Group • Discussions and input on key strategies to be included in the 2027 to 2031 Plan • Continuation of current projects	• CHPC Newsletter • Social media resource folder • Youth subcommittee planning • Community engagement	• Review of needs assessment survey results and input on SWOT and gap analyses • Continuation of regional forums	• Approach to 2027 to 2031 Plan indicators and measures • Annual review of CHPC indicators • Annual summit planning • QI featured spotlight data presentations

PARTNER COORDINATION AND UPDATES

Blaise Gilchrist explained that the required partners collaborating to lead the development of the Statewide Integrated HIV Prevention and Care Plan 2027 – 2031 have agreed to reserve time on the agendas of their planning groups to share any updates from the partners. The required partners involve the Ryan White Part A (RWA) Planning Councils, Ryan White B (RWB) and prevention – represented by CT DPH, and the CHPC representing all key stakeholders. Key themes from updates included:

- Dante Gennaro, Jr. read a news release to update the group on Federal funding from the House Appropriations Committee. The proposed approach looks very different from the past and restores most of the funding to prior levels. Small cuts or reductions include areas such as the Minority AIDS Initiative ($4 million), while other areas such as Hepatitis C Virus programs received a $4 million increase. Proposed prevention funding levels also appeared to be flat-funded at previous levels.
    - Mitchell Namias agreed that this represents a good sign and cautioned folks that this proposal had not yet been voted on by the House or Senate. Those votes would occur during the last week of January.
- Roberta Stewart, a CHPC Member and also Co-Chair of the RWA Planning Council in New Haven and Fairfield Counties, stated that the RWA Planning Council remains current on matters related to the Plan Development Process. Several Planning Council Members participate on the CHPC and the HIV Funders Group, and the

CHPC has been diligent in sharing information with staff and leaders at Planning Council meetings and through e-mail communications. Roberta shared that the Federal project officer was pleased to hear about this level of collaboration and asked to learn more about the approach. Roberta shared that the Planning Council will be making some adjustments and improvements to its needs assessment survey process and updating its service standards. She acknowledged City of New Haven Health Department staff for their assistance.

- Peta Gaye Tomlinson, a CHPC member and Administrator from the City of Hartford Department of Health and Human Services who oversees RWA, RWB, and HIV Prevention Division funding in the Hartford Transitional Grand Area expressed similar feedback. The groups are well connected with members participating in multiple groups and Mitchell Namias (CHPC Member, RWB lead, HIV Funders Group lead) plays an important role as do the CHPC project support staff. Peta Gaye shared that the RWA Planning Council was updating bylaws, rebranding the Planning Council, and preparing to hold its first ever regional partner meeting. She expressed interest in learning more from Roberta about the changes and improvements shared by the New Haven and Fairfield Counties RWA Planning Council. She also stated RWA is preparing for our HRSA site visit in late April. Additionally, RWA turns 30 at the City of Hartford this year.
- Danielle Warren Dias shared that the Ryan White Part D (RWD) funding opportunity has been forecasted to be released in March 2026 with a submission deadline of May 2026. The funding opportunity was initially scheduled for release in October 2025. It appears that the existing RWD awardees (Connecticut Children's, Community Health Centers Association of Connecticut) will be eligible to apply for the same amount of funding.

DATA SHARING: 2025 PERSONS WITH HIV NEEDS ASSESSMENT (PWA NA) SURVEY RESULTS

Africka Hinds reviewed the Federal planning requirements for the 2027 – 2031 Plan – including the four Plan pillars (prevent, diagnose, treat, respond), the plan development process and timeline, and how the data collection fit into the sections of the Plan and also informed the development of Plan objectives and key activities. She introduced CHPC Member Mitchell Namias, Pharm.D., who is a CT DPH Pharmacy Consultant and administrator for RWB funding. Mitchell helped lead the coordination of the statewide 2025 PWH NA Survey. Mitchell recognized the work of Ramón Rodriguez-Santana, MPH, MBA, an Epidemiologist 4 at CT DPH. Ramón played a critical role in analyzing the data.

The presentation (a) reviewed the needs assessment process, (b) shared disclaimers and limitations, (c) reviewed results, (d) identified key findings, and (e) shared next steps and recommendations. The presentation included several interactive polls to keep participants engaged and understand how their working assumptions and perspectives compared to actual results. For example, the initial interactive poll question asked, "Why did we do a needs assessment?" with response options ranging from "just for fun!" and "the government wants to know my business" to "it's a requirement of RW funding and integrated planning."

Review of Needs Assessment Process. Mitchell explained that Ryan White grantees are required to conduct needs assessment and the needs assessment is necessary for the Integrated Plan. The CHPC NAP Committee and HIV Funders Group developed a survey, and it was piloted at 3 sites prior to its launch. The survey included 19 questions and addressed topics related to service needs, stigma, discrimination, and demographics. Seven (7) partners statewide supported data collection.[1] 1,919 medical case managed Ryan White clients were randomly selected to participate with a response rate goal of 50%. Respondents who completed a survey would be offered a $25 gift card. Data collection began September 19, 2025 and ended November 21, 2025.

Data Disclaimers and Limitations. Mitchell shared data disclaimers and limitations relative to the methodology: (a) Findings are based on self-reported responses from a voluntary needs assessment survey and may be subject to recall, response, and non-response bias, (b) Although a random sampling method was used, respondents may not be fully representative of the entire Ryan White population due to access barriers or survey fatigue, (c) The use of incentives to encourage survey participation may have introduced response bias, as some respondents may have prioritized survey completion over response accuracy or thoughtful engagement with survey questions, (d) Some surveys were completed with assistance from case managers, which helped reduce literacy and access barriers but may have influenced how questions were interpreted

[1] Part A Hartford/Tolland/Middlesex, Part A New Haven, Part B Statewide, Part C Stay Well, Part C Southwest, Part D Connecticut Children's, Part D Community Health Center Association of Connecticut

or answered, (e) Missing responses and the use of "select all that apply" questions may affect percentage totals and limit interpretation of prevalence or prioritization of needs, and (f) Survey results reflect a point in time and should be interpreted alongside other data sources.

Results and Findings. Mitchell explained that the presentation would cover the first part of the survey results and focus on responses related to service needs and access. The remainder of the results (e.g., discrimination, stigma) would be shared at the February meeting. He shared reviewed detailed slides showing survey results. The full slide presentation is available on the www.CTHIVplanning.org website.

Demographics

- Compared to the Ryan White Services Report from 2024, (a) Youth and younger adults were underrepresented. 6% of respondents are under the age of 30. The RSR indicates 13.4% under the age of 34, (b) Overall, race/ethnicity close to RSR [White (17% vs 15.9%); Black (36.7% vs 40.3%);Hispanic (41.2% vs. 41.8%)], (c) Men were underrepresented (54.4% vs 61.4%) and women were overrepresented (43.8% vs 38.6%).
- 65% of respondents identify as heterosexual; 25% MSM as compared to state HIV data, 37.3% MSM and MSM+IDU.

Services

- Oral Health was the top medical service identified as a need, with approximately 23% of respondents saying they need more or couldn't access it. Almost 33% have not been to a dentist in the last 12 months.
- Food was the top support service identified as a need, with 37.8% saying they need help paying for food.
- Almost all respondents identified no need for Harm Reduction, but 35% of respondents did not feel informed about SSPs (Syringe Services Programs).
- Very few clients routinely utilize telehealth for their care.
- Almost 25% of clients used the Emergency Room for routine care. Of them, 63.5% were Medicaid clients and 28% were Medicare clients.
- 6% of clients were experiencing homelessness. Of them, 36.5% do not know how to access shelters or emergency housing.

Client Education

- Overall, of the 18 knowledge areas, there was a gap in 12 topics when asking clients if they felt well informed on the following: LAI ART, PrEP, PEP, HCV Testing/Treatment, Resources for IPV, Resources for Reproductive Health, Sex Positivity, Recognizing Abusive Relationships, SSPs, Partner Services, Community Planning Groups, and Funding threats.
- A noticeable difference existed in knowledge broken out by gender: Women felt less informed on LAI ART, PrEP, PEP, SSPs, Partner Services, and Funding. Men felt less informed on Resources for IPV, Sex Positivity, Recognizing Abusive Relationships, Resources for Reproductive Services, and Planning Groups.

Sexual Health

- 41.75% of respondents identified that they have sex. Vaginal insertive sex was the most common reported type of sex, followed by oral insertive and receptive. With only 25% of respondents identifying as MSM, it makes sense that vaginal sex would be a top option.
- Only 27% of clients indicated more than 1 sex partner.
- Almost 39% indicated never using condoms.
    - For clients with only 1 sex partner: 42.7% indicated using condoms 0-20% of the time. 32.9% indicated using condoms 100% of the time.
    - For clients with more than 1 sex partner: 29.5% indicated using condoms 0-20% of the time. 29.5% indicated using condoms 100% of the time.

Zip Code Analysis

- Waterbury did not appear in residence zip codes until #13 but was #3 in where care is provided. Clients were more evenly distributed among the Waterbury zip codes, representing 10% of total respondents.
- Hartford and New Haven only had 1 zip code each in the top 10, but were #2 and #4 for care locations, respectively. Hartford had 12% of respondents. New Haven had 6.5% of survey respondents

Next Steps and Recommendations

- CHPC identifies priorities and creates strategies to address (e.g., Dental, Health Insurance, Food, Utilities, and Rent were areas of highest need).
- Consider additional client focus groups or listening sessions for underrepresented areas (e.g., Youth, New Haven).
- These findings contribute to the SCSN, a required component of the Integrated Plan. The Plan must be submitted in June.

General Discussion (Large Group). Mitchell addressed general questions and observations from the large group.

- Roselyn Wimbish observed that the timing of the data collection may have affected responses related to access to food.
- Dr. Virata reiterated that these findings represent only RW clients and the findings may not translate to PWH receiving care from non-RW funded services. This might be a future study for the CHPC.
- Kasima Geter expressed appreciation for the zip code breakdown of results and confirmed that many PWH who do not reside in Waterbury receive their care from providers located in Waterbury. Also, some PWH hesitate to participate in surveys for various reasons (e.g., feel voice is not heard, no additional resources so what does it matter?).
- Several individuals shared that Medical Case Management (MCM) may not have shown up as a big need (in comparison to past surveys) because the survey respondents were connected to MCMs.
- Danille Warren Dias appreciated the presentation and storytelling because it was easy to understand. She suggested doing a future "focused survey" on the younger demographic (18 to 34) vs. conducting focus groups. Another focused survey might address Medicaid and Medicare recipients – given the high number of PWH who are age 55 and above or on disability.
- Peta-Gaye Tomlinson stated that access to housing typically is a high need and a deeper dive may need to occur on specific issues (e.g., paying late rent, help finding housing/emergency shelters) related to these services and limitations.
- Roberta Stewart shared how managed Medicare has changed the service landscape and affected access to services – particularly behavioral health services. This is something that requires further discussion (perhaps by the HIV Funders Group).
- DeLita Rose-Daniels shared that the data presentation challenged people to stretch their thinking beyond the traditional way in which services are offered or accessed. She expressed concerns about housing solutions with most of PWH aged 55 and above.
- Permanency planning (i.e., advanced life directives, wills) is not a service currently funded by RW. Danielle Warren Dias explained that it was long ago when PWH were more likely to die and especially if they had children. It is important again because of the number of PWH above age 55 and also because Medicaid/Medicare is complicated.
- Dr. Virata stated that nutritional counseling is not currently funded as a RW service and may contribute to knowledge about food access or actual connections to food resources.
- Several individuals noted a reduction in community resources related to food.

- Roselyn Wimbish suggested offering the survey in paper format to expand access to those who may not have technology or be comfortable with technology. Mitchell shared that Medical Case Managers could support the survey process.
- Danielle Warren Dias suggested taking the data presentation on a "road show." Mitchell stated that he would arrange for this to happen as requested. Kasima Geter agreed that this was a great idea as data presentations from other partners outside of the local area tend to be heard.

Mitchell thanked everyone for the opportunity to collaborate with so many partners on the PWH NA project and for the high level of engagement and participation during the presentation.

SELF CARE BREAK

The group took a 10-minute self-care break.

DATA SHARING: BREAKOUT GROUPS TO DISUCSS 2025 PWH NA SURVEY RESULTS

Meeting participants were informed that the group would enter breakout rooms to continue discussion on the PWH NA Survey Results. Facilitators/recorders[2] used a set of guided questions to structure and document the small group discussion. Small group discussions were intended to increase participation and interaction. The guided questions included: (a) what surprised you about the PWH NA Survey results? (b) What are the biggest needs or gaps in services? (c) What are the priority populations for service needs and gaps? (d) What opportunities exist to address the service needs and gaps? and (e) Any other discussion topics that emerge.

The groups stayed in the breakout rooms for almost 45 minutes and then participated in a share out. Several groups shared themes from the discussion. The information below reflects a compilation of themes across all 7 groups.[3]

Q1. What Results Were Surprising?

- Dental needs were more prominent than expected (and may be under-recognized). Dental surfaced repeatedly as a "standout" finding, including questions about why people report not needing dental care (e.g., dentures, fear, education gaps).
- Sexual health responses felt inconsistent / likely underreported. Multiple groups flagged the "sexually active" and condom-use findings as surprising or potentially influenced by discomfort, social desirability, or question framing.
- Medical Case Management (MCM) findings didn't match provider expectations. Several groups noted a mismatch between provider views (MCM is critical) and consumer selections (lower than expected), and/or raised awareness gaps (people may have it but not recognize it).
- Youth/younger people were underrepresented (and aging needs stood out). Groups flagged concern about missing youth input, alongside observations that the respondent population skewed older (50+, including 65+).

Q2. What Are the Biggest Needs or Gaps in Services?

- Housing instability and affordability remain central (often connected to utilities/food). Housing came up as a dominant "gap," with attention to emergency shelter barriers, affordability, and tradeoffs between rent/utilities/food given capped assistance.
- Food insecurity is increasing and harder to meet. Multiple groups pointed to rising demand, stigma in using pantries, reduced availability, and Ryan White caps/limits.
- Insurance access / coverage and re-enrollment issues. Groups highlighted coverage gaps, re-enrollment challenges, and the complexity of navigating Access Health / coverage – especially for undocumented / immigrant clients.

[2] Facilitators and recorders were individuals representing the CHPC Executive Committee, CT DPH Resource Liaisons affiliated with CHPC Committees, or CHPC project support staff.
[3] The CHPC project support staff distilled and compiled themes from the notes taken from the 7 breakout sessions.

- Transportation barriers (medical transport + aging-related mobility). Transportation was repeatedly cited as a major barrier, including access to state medical transportation and limitations for older adults.
- Service navigation and "visibility" gaps (knowing what exists and how to access it). Several groups emphasized health literacy / service visibility and navigation friction (including 211 variability).

Q3. Who is Disproportionately Impacted?

- Black and Hispanic/Latinx communities, especially women. This was the most consistent disparity theme across the summaries.
- Immigrant communities (fear, eligibility uncertainty, access hesitancy). Immigrant impact surfaced directly, including fear / hesitancy to enroll and navigate supports.
- Youth / younger clients are not being captured well (survey "blind spots"). Multiple groups flagged underrepresentation and the need for youth-specific engagement and methods.
- Older adults / aging population (mobility, Medicare navigation, permanency planning). Aging-related needs were raised as both a population reality and a service-design issue (transportation, permanency planning, Medicare/insurance help).

Q4. What Opportunities Exist to Address Needs or Gaps in Services?

- Education and messaging improvements (sexual health, PrEP/PEP, oral health, services). Education was a recurring "opportunity lever," including dental education, prevention education, and clearer service information.
- Youth engagement strategies (mini-surveys, focus groups, school partnerships). Groups suggested youth-specific recruitment and engagement models, including school-based outreach and structured youth groups.
- Strengthen navigation pathways (standardize language, reduce 211 friction, "broker" models). Several summaries pointed toward standardization, faster pathways, and process supports to move people through systems more efficiently.
- Expand partnerships (food banks, dental schools, transportation solutions). Concrete partnership ideas included food-bank coordination, dental school linkages, health fairs, and rideshare-type transportation partnerships.

Q5. Other or Cross Cutting Themes

- Dental is both a "surprise" finding and a service gap—with a strong education / navigation component (dentures ≠ no dental care).
- Survey design / interpretation issues matter (sexual activity / condom items, underrepresentation of youth, desire for deeper dives).
- Basic needs are intertwined (housing–food–utilities–transportation), and caps / administrative barriers can keep needs unmet.
- "Navigation + visibility" is a recurring root cause—people may not know what exists, how to access it, or encounter inconsistent pathways.

The CHPC Co-Chairs thanked everyone for contributing to the discussions and for sharing their voices.

ANNOUNCEMENTS

Blaise asked participants to share any announcements or important updates relevant to their programs, services, or communities.

- William Morales shared that RWB funding in Hartford was available for PWH who may need eyeglasses or medical co-payments and he could help guide PWH through the process.
- Dante Gennaro shared links to several upcoming trainings offered by the AETC.

- Venesha Heron shared a registration link to a Viral Hepatitis Elimination Technical Advisory Committee (VHETAC) meeting that will take place at noon on January 22, 2026.
- CHPC Co-Chairs reminded the group that CHPC committee meetings start at 12:30 p.m. and will require using a different virtual access link. The links were shared in the chat. Participants could also access the links at www.CTHIVplaning.org

MEETING FEEDBACK

48 participants completed a CHPC main meeting feedback poll to share their meeting experience and suggestions for improvement. 99% of respondents (members and public participants) graded the CHPC event as an "A" or a "B" and expressed positive feedback for the presentation and discussion space.

ADOURN

The CHPC Co-Chairs adjourned the meeting at 11:59 a.m.

ATTENDANCE

Attendance records are on file with the CHPC support staff.