

<b>Date:</b>	Wednesday, February 18, 2026	<b>Type:</b>	Virtual - Zoom
<b>Start Time:</b>	12:30 p.m.	<b>End Time:</b>	1:30 p.m.
<b>Leaders</b>	Xavier Day (Co-chair), Martina De La Cruz (Co-chair), Mitchell Namias (CT DPH Resource Liaison), Sue Major (CT DPH Resource Liaison)		
<b>Participants:</b>		<b>Next Meeting:</b>	March 18, 2026

### WELCOME AND INTRODUCTIONS

Martina De La Cruz, serving in her first meeting as co-chair, welcomed participants, reviewed meeting etiquette (raise hands, one speaker at a time, respectful engagement), encouraged participation, and facilitated introductions.

### REVIEW AND APPROVAL OF PRIOR MEETING NOTES (JANUARY 21, 2026)

The group was provided a brief recap of the January meeting summary and reminded that NAP meeting summaries are posted to the CHPC website one week after meetings. The committee was invited to submit edits directly to Ken. With no corrections raised, the January notes were treated as final.

### PRIORITY DISCUSSION 1: BREAKOUT THEMES ONE-PAGER (PWH NEEDS ASSESSMENT) – SWOT REVIEW AND REFINEMENT

#### A. Re-stating the Breakout Themes (Pre-SWOT)

Ken shared a preliminary “first pass” one-pager that synthesized themes from CHPC breakout rooms focused on the People with HIV Needs Assessment discussion. The synthesis highlighted:

#### ***What surprised participants most (breakout themes):***

- Dental needs were more prominent than expected
- Sexual health responses appeared inconsistent / possibly underreported
- Medical case management findings did not match some provider expectations
- Youth/younger people were underrepresented in the survey
- Aging-related needs stood out

#### ***Biggest gaps discussed:***

- Housing instability and affordability
- Food insecurity (and difficulty meeting needs)
- Insurance access, coverage, and re-enrollment issues
- Transportation barriers
- Service navigation gaps

#### ***Who is disproportionately impacted (as discussed):***

- Black and Hispanic/Latinx communities (especially women)
- Immigrant communities
- Youth/younger clients (not well captured)

- Older adults / aging populations

### **Opportunities raised:**

- Education/messaging improvements
- Youth engagement strategies
- Stronger navigation pathways
- Partnerships for transportation and food supports

### **B. Committee Feedback: Format and “Data Context”**

Members expressed strong support for producing the one-pager in **both** formats:

1. **SWOT-style synthesis**, and
2. A version organized by the **Four Pillars** (Diagnose, Treat, Prevent, Respond) to strengthen alignment with plan goals, objectives, and activities.

A key “data interpretation” point was added: a member shared that food insecurity may have been elevated in responses due to timing/context factors (e.g., a period when SNAP benefits were reduced and related resource strain was felt). This was raised as an important interpretation note that could help avoid over- or mis-attribution and should be remembered when moving from findings to recommendations.

Josey added a hypothesis related to medical case management: one possible reason respondents did not select it as a high unmet need is that some participants may already be receiving case management services, thereby reducing the likelihood that they report it as a gap.

Members also discussed emergency department utilization and suggested that limited access to urgent care options in certain localities (example raised: Hartford) may contribute to reliance on emergency department - another contextual point useful for interpreting needs and prioritizing strategies.

### **C. SWOT Content: What NAP Considered “In Scope”**

Sue grounded the discussion in NAP’s planning purpose: the one-pager is not just descriptive; it must identify priority findings requiring a plan response and convert them into 2–4 concrete activities that the committee can advance or recommend—distinguishing barriers, opportunities, and system gaps.

The SWOT framework under review echoed the breakout themes and was consistent with the attached SWOT document. The SWOT emphasized strengths such as frontline capacity and an active Ryan White–anchored ecosystem; weaknesses including navigation gaps, representation gaps (youth/under-30, and people not in Ryan White), and access friction; opportunities including standardizing pathways and youth engagement strategies; and threats including rising cost pressures, entrenched disparities, transportation bottlenecks, and emergency department reliance.

### **D. Decision: Refine, Post, and Convert to Pillars**

With no immediate edits requested during the meeting, NAP agreed to:

- Post the SWOT one-pager with the meeting summary (standard posting timeline), and
- Invite members to submit edits to Ken before the next meeting, and
- Begin reshuffling the same themes into a Four Pillars version for discussion at the next meeting.

### **PRIORITY DISCUSSION 2: LATE TESTERS + UNDOCUMENTED CLIENT PATHWAYS – SCOPE, STRATEGY, AND AVOIDING OVERREACH**

Martina re-introduced the committee’s previously discussed concept from January: revisiting a navigation/system-map style tool related to late testers and undocumented client pathways, emphasizing a phased approach (“start small and build in phases”).

#### **A. Key Question Raised: “Are we biting off more than we can chew?”**

A committee member asked whether NAP is taking on too much at once, balancing:

- The late testers/undocumented pathway concept,
- Breakout one-pagers and SWOT products, and
- The regional forum presenter series approach.

#### **B. Committee Response: Phase the work + align with plan activities already underway**

Ken reinforced that the work does not need to be completed all at once and can be scoped across time. Mitchell added that “late testers” is already being incorporated behind the scenes into draft goals/activities for the next Integrated Plan, including strategies such as:

- Academic detailing for providers/settings where routine testing opportunities are being missed; and
- Education strategies supporting routine testing and earlier diagnosis.

A discussion followed about how to identify “best practices” in a way that is practical. Members noted that “late tester” outcomes are influenced by multiple missed opportunities across a person’s care trajectory, and that it may be less about a single organization “doing it well” and more about identifying sites that perform strong routine testing consistently (and where testing can be improved).

#### **C. Hartford Example: Gap-focused planning approach**

Members shared that Hartford partners are examining surveillance and community context through tools like neighborhood-level indices (e.g., deprivation), looking at where providers are—and are not—and using that to identify geographic gaps and potential strategies for increasing routine testing.

#### **D. Theme: Status-neutral / syndemic testing is still uneven**

Members named a recurring challenge: despite broad agreement on syndemic and status-neutral concepts, implementation remains inconsistent across sites. One member observed that “everyone says they do it,” yet in practice, full status-neutral screening (including routine testing and prevention linkage) is not consistently operationalized. The group framed this as a workforce/training reality compounded by turnover and constant re-training needs.

### **PRIORITY DISCUSSION 3: WORKFORCE SURVEY FINDINGS – REACTIONS, GAPS, AND TRAINING**

With limited time remaining, the committee shifted to reflections on the **HIV Workforce Survey results** presented earlier the same day (at the full CHPC meeting). The group noted that the findings were largely consistent with expectations, but several points were highlighted:

### **What stood out**

- Continued evidence that a syndemic approach is growing but not yet where the system wants it to be.
- Variation in training needs by role type (clinical, non-clinical, prescribers, admin).
- Turnover as a consistent barrier—creating a need for repeated, ongoing training cycles.
- A specific gap was referenced: clinical staff reportedly offer routine testing only about “a third of the time,” while prescribers and non-clinical staff show stronger performance in certain screening and assessment practices.

### **Workforce stability and turnover: deeper nuance**

Erika emphasized turnover not only at frontline levels but also at the managerial level, which impacts training capacity and consistency (a theme also seen in housing programs and related service systems). Members discussed how onboarding investment is costly, and that retention may hinge on mission alignment, mentorship, and supportive supervision.

### **Expanding training dissemination: new channels**

Members proposed broadening how training opportunities are shared beyond the usual networks by leveraging:

- State medical and nursing associations,
- PA and NP programs,
- Medical students and professional pipelines, and
- Timing strategies (e.g., “December premium” for CE credit needs) to maximize uptake—especially if trainings are free and include continuing education credits.

## **DECISIONS / AGREEMENTS**

### **Decisions made during the meeting**

1. Breakout Themes One-Pager format: NAP will maintain the SWOT version and also develop a Four Pillars-aligned version to better map themes to plan objectives and activities.
2. Posting + review cycle: The SWOT one-pager will be posted with the meeting summary; members will review and send edits to Ken prior to next meeting.
3. March in-person work session: NAP will review the pillar-organized version of the needs assessment breakout themes and begin a parallel one-pager synthesis for the HIV Workforce Survey breakout discussions.

## **ATTENDANCE**

Attendance records are kept on file with the CHPC support staff.

## **ADJOURN**

The committee meeting ended at 1:30 p.m.