

Main Meeting Summary

April 15, 2026

Date:	April 15, 2026	Type:	In-Person, Hartford
Start Time:	9:15 a.m.	End Time:	1:10 p.m.
Participants:	82	CHPC Members:	26
Co-Chairs:	Dante Gennaro, Jr., Blaise Gilchrist, Africka Hinds		
Next Meeting:	May 20, 2026 (in-person)		

WELCOME AND MOMENT OF SILENCE

CHPC Co-Chairs started the meeting by welcoming participants and asking individuals to honor the work with a collective moment of silence. The group reviewed the CHPC vision, mission, values, structure, and process. Participants quickly introduced themselves.

CHPC GENERAL BUSINESS

Dante shared announcements related to CHPC operations.

CHPC Membership. The CHPC welcomed Brian Datcher as a CHPC Member. Four additional membership openings exist. Please apply at www.cthivplanning.org.

Approval of Prior Meeting Summary. The CHPC Members approved the meeting summary from the prior month using a virtual vote that occurred during the week prior to the CHPC meeting.

CHPC May Meeting. The meeting will be held in-person and focus on reviewing the 2027-2031 Plan.

CHPC Member Engagement. The CHPC conducted a CHPC Member engagement and experience survey. Results are shown in the table.

2026 CHPC Member Engagement Survey Results Summary

Key Strengths	Areas for Improvement
<ul style="list-style-type: none"> Members value having a voice in discussions and decision-making Strong appreciation for collaboration, networking, and cross-agency communication Meetings support learning and awareness of HIV prevention and care initiatives A strong sense of community, respect, and inclusion 	<ul style="list-style-type: none"> Comfort levels in speaking and participating for some members Desire for clearer explanations and reduced use of acronyms Interest in hybrid meeting options and varied meeting locations Requests for increased inclusion of diverse voices in planning and implementation

The CHPC Members will discuss results and next steps during a members only “lunch and learn” discussion later today.

PARTNER COORDINATION AND UPDATES

The Co-Chairs opened the floor for any partners collaborating on the development of the Statewide Integrated HIV Prevention and Care Plan 2027 – 2031 to share any updates from planning groups or individual organizations.

- Jordan explained that the Ryan White A TGA (Hartford) has shifted its Planning Council support staff to Hartford Community that Cares. This will approach will result in a shift in meeting spaces and opportunities to connect with youth as well as the North End community in Hartford.
- Danielle shared that the Ryan White Part D funding applications will be released sometime in early May and most likely will be due within two weeks of release. This expedited timeline relates to the fact that funding for some of the awards ends on June 30. Funding will be available for existing Ryan White Part D to “re-compete” and an additional 20 supplemental awards will be available.

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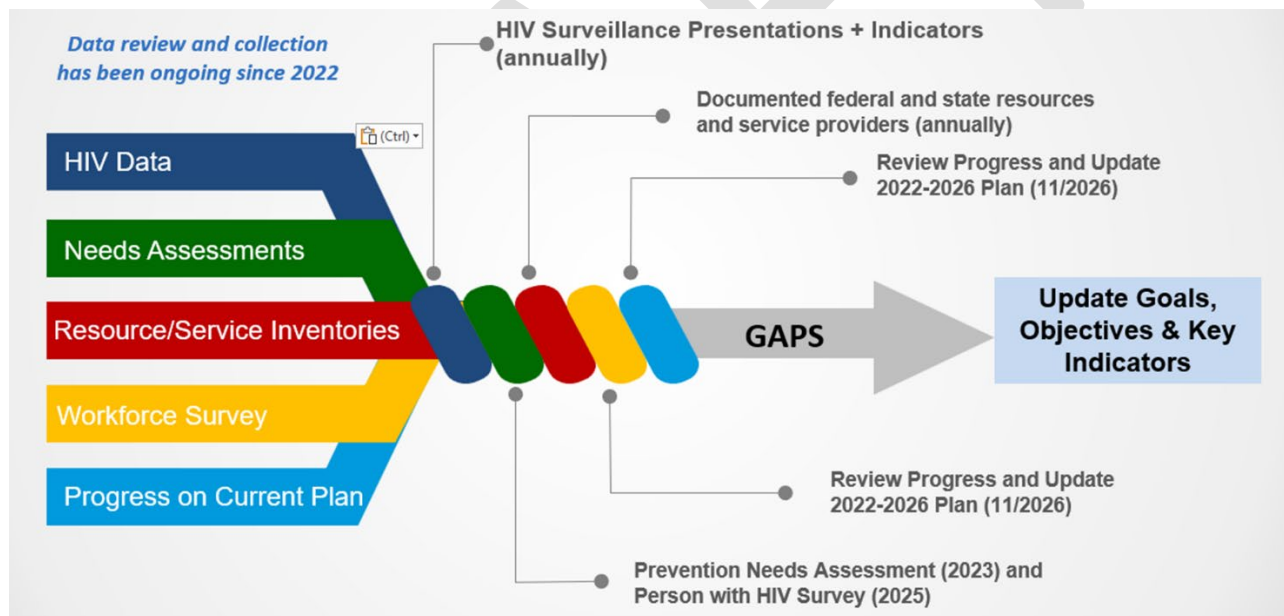
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- Andre shared information about the employability services model coordinated through the Ryan White A TGA (Hartford) Planning Council. The approach may serve as a blueprint for other parts of the state as it engages and coordinates access to employability services, entrepreneurship services, life skills supports and other relevant services that allow persons with HIV to develop pathways to self-sufficiency. Employability efforts like this become more important with new Federal workforce participation requirements.
- Peta-Gaye shared that the City of Hartford would be hosting a Federal HRSA site visit from April 28 to May 1. The process will include sessions with the Planning Council to learn about the shift in mission and vision as well as the impact of shifting the Planning Council support staff location to the North End of Hartford.
- Dante shared that the AETC representatives will be attending a North East Alliance Conference in Portland, Maine on May 14 and 15. He shared that an HIV Symposium will be held on June 23 at the Yale West Campus in Orange, Connecticut. More information will be shared via e-mail.

2027-2031 PLAN DEVELOPMENT: INPUT ON PLAN GOALS AND PILLARS

Blaise explained that the meeting focus will now shift to activities related to developing the 2027-2031 Plan. The activities mirror the very successful March meeting with a large group presentation followed by small group discussions that expand the participation and engagement the CHPC community.

Mitchell Namias reviewed the themes of the small group discussions from the March CHPC meeting. The March CHPC meeting summary contained this information and was included in the participant meeting packets. He tied the various components of planning work together – including the gap analysis completed in March (see image).



He stated that the Plan development activities today will focus on a review of the Plan pillars – including the goals, objectives, key activities and explained that the HIV Funders Group has been doing advance work to develop draft versions to make it easier for the broader community to provide input and insights. Specifically, the HIV Funders Group:

- Used the current Plan as a starting point
- Reviewed the updated data sets and inputs from planning partners (ongoing)
- Developed a draft (12/2025)
- Asked the federal government to review the draft (1/2026)
- Continued to revise the content (1/2026 to 3/2026)
- Shared a “public comment” version of the draft (4/6/2026) [*See handout]

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- Will meet on April 22, 2026 to review the CHPC discussion, public comments to date, and input from other planning partners

Mitchell reviewed all of the Plan pillar goals and objectives. He noted that the goal statements for pillars were framed in short, easy-to-understand language and did not include any references to numbers. This format followed the examples in the federal guidance document. He reviewed with the group the overarching goals and the goals required to align with the National HIV and AIDS Strategy.

- The group was alerted to the fact that the “number of newly diagnosed persons with HIV decreases 90%” will be adjusted. The current number does not represent a 90% reduction from baseline. The number based on 2017 baseline should be 28. The number based on a 2023 baseline should be 25.

The group shared some initial comments about the goals and objectives.

- The DIAGNOSE pillar objectives call for a 10% increase in testing in clinical and non-clinical sites. This objective might not be set high enough to reach the goal number for reducing new HIV diagnoses by 2030.
- The Public Comment version of the Plan is still too “involved” and may prevent individuals and partners from reviewing it and providing comments.
 - Mitchell appreciated the feedback. He shared that the Public Comment version (included in the meeting packets) contained tables plus one page of explanation for each Pillar. The back half included key data points and visualizations that had been covered at CHPC meetings and shared with HIV partners.
 - Mitchell noted that several engagement sessions – including CHPC meetings and Ryan White Part A Planning Council meetings will occur. The Plan does require a significant amount of technical information. Also, during the past Plan development process, HIV partners requested this type of information be shared more readily. Plus, HIV partners have been very intentional about sharing information with their planning groups and colleagues and creating opportunities to discuss the content or answer any questions.
 - Several input sessions have occurred with statewide groups such as the Prevention Power Hour, the Crimson Table Talks, and the CHPC Needs Assessment Project Committee to get input useful to identify the needs and gaps.
 - Dante noted that once the lengthier technical version of the Plan was approved by the Federal government, the CHPC could make a shorter and more accessible version of the Plan.
 - Danielle shared best practices from her experience on the Community Advisory Board of the Center for Interdisciplinary Research on AIDS and indicated that starting simple with 1 or 2 pages and allowing the participants to ask questions works better than sharing with them all of the information which can be overwhelming – even though well-intentioned. She appreciated the effort to share information and the intention to keep consumers at the forefront (vs. an afterthought).

Mitchell then explained that the full group would review the RESPOND pillar for several reasons: (a) cuts across all the other pillars, (b) involves technical data systems and processes often supported or led by CT DPH subject matter experts (e.g., epidemiologists), (c) involves compliance with federal and state requirements, and (d) the process means that everyone has a chance to provide input (today or later) on the Respond pillar with the benefit of hearing from the subject matter experts.

He explained that he would focus on one objective at a time and review the key activities and performance measures. A series of guided questions would be used to allow participants to provide feedback about whether:

- The key activities addressed relevant needs and gaps in Connecticut
- Implementation of the key activities would result in achieving the objective
- The performance measures would allow the HIV partners to assess progress (or lack of progress)
- Any other suggestions or observations

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He noted that the process used to review this pillar would be the same process used in the small group discussion sessions and follow a process that the HIV Funders Group used to develop the draft and to solicit input from all of the different participants.

Review of the RESPOND Pillar. Mitchell shared that the CT DPH staff were highly involved in reviewing the draft RESPOND pillar content. He welcomed Jenn Vargas and Mukhtar Mohamed, CT DPH epidemiologists, and subject matter experts in surveillance to participate in the presentation of information.

Jenn reviewed more technical information about the requirements for a statewide HIV Response Outbreak Plan. The Center for Disease Control and Prevention requires every state health department to have a statewide HIV Response Outbreak Plan to quickly identify and stop rapid transmission. These plans must be updated once a year and act as a “fire drill” for public health to ensure staff know exactly how to deploy testing and treatment if a sudden spike in cases occurs. The HIV Response Outbreak Plan includes (a) leadership and roles, (b) surge capacity to expand resources and support for local teams, (c) data security, (d) community partnerships, and (e) a triggers list for what counts as an outbreak. The process usually involves detection (e.g., time-space tracking, molecular tracking), investigation (Disease Intervention Specialists, Partner Services), and response (e.g., expanded testing and treatment in the community).

- Jenn noted that the RESPOND objectives mirrored the steps of the Outbreak Response Plan.
- Jenn and Mukhtar explained that the CT DPH staff participate in national technical advisory sessions and communities of practice to learn from other states how they approach the work – especially the states that have had outbreaks.
- The CT DPH convenes monthly meetings of its surveillance team, prevention team, HIV care team, and Disease Intervention Specialists to stay current on emerging issues.
- The states response to COVID 19 and the opioid overdose epidemic (i.e., Overdose Data to Action strategies) are examples of Outbreak Response Plans in action.

Participants asked clarifying questions and Jenn, Mukhtar and Mitchell shared responses along with assistance from Ramon Rodrigues-Sanchez (CT DPH Epidemiologist) and Lisa Corpora (Disease Intervention Specialist).

- A Response Outbreak Plan exists for HCV and is underway for Sexually Transmitted Diseases. Individual disease condition plans are required. However, CT DPH uses a uniform and integrated approach for infectious disease.
- Maine is currently experiencing a significant HIV outbreak and did not have an up-to-date Outbreak Response Plan due to resource constraints. The adverse outcomes show the value of the Outbreak Response Plans.
- After action reports and debriefing processes are used to learn from any outbreak events. These processes involve all of the partners.
- The CT DPH core group meets monthly and maintains open dialogue to stay current on all disease conditions.
- The proposed RESPOND pillar includes key activities to create communication channels with providers and the community, especially related to “emerging” issues that, if addressed, can prevent an outbreak.
- The use of the Area Deprivation Index (ADI), which combines data on social determinants of health (e.g., poverty, housing) and public health helps to identify geographic areas (i.e., census tracts) with high risk of disease transmission. Ideally, engaging partners in these areas will reduce the likelihood of outbreaks or may represent emerging hotspots.
- Pilot presentations and community engagement using ADI data has resulted in more focused work and services in specific geographic areas. Hartford, through a “call to action” mobilized partners, educated them on the data, organized a foot-tour of the North End, and began to review what actions could be taken to provide a better response. The process included interviewing and talking to residents and community partners.

- The ADI process supports conversations to change how resources are deployed into communities (e.g., hours of service, use of mobile units, location of mobile units) as well as the need for additional community mapping and interviews.
- Lisa explained the Disease Intervention Specialist (DIS) role and process and how Partner Services works. She stated that partners can “opt out” of the service which explained why the RESPOND 4 objective is set at 85% (vs. 100%). She noted that DIS workers do reach out to 100% of clients referred to them. She also explained the process to: (a) “classify” a case which takes into consideration risk factors that might lead a case to be identified as an immediate priority (i.e., pregnant and under 24 years of age with an infectious disease that has adverse consequences to mom and baby), and (b) “investigate” a case using public records, access to hospital records, and CT DPH required reporting forms from providers. DIS workers call providers to learn more about the cases – including the course of treatment which can also inform how a case is classified as a priority.

Participants appreciated the detailed explanations and the connection of the technical work to the community partners.

Throughout the review and discussion of individual RESPOND pillar objectives, key activities, and performance measures, Mitchell asked the group to use their (red/green) paddles as a way of showing informal consensus with the draft content.

- *Participants agreed via consensus with the approach to each of the objectives, key activities, and performance measures in the RESPOND pillar.*

Mitchell thanked everyone for their input and general consensus for the RESPOND pillar. He noted that much effort had been put into developing the draft Pillar and stated that the other Pillars were developed in a similar way.

Participants were randomly assigned into three small groups and, after a brief self-care break, re-assembled to hold Plan “pillar” discussions.

Review of DIAGNOSE, TREAT, PREVENT Pillars. Three small group discussions were co-led by a CHPC Co-Chair and a CT DPH Resource Liaison with a CHPC project support staff documenting comments and suggestions. Each group covered at least one pillar and often two. Each group started on a different pillar to ensure each pillar received (immediate) input from two thirds of the total group. A separate summary document contains the detailed comments from each group. The table summarized the headline themes across the three pillars.

General Themes from Small Group Review of Plan Pillars

Area	Key Themes
General	<ul style="list-style-type: none"> • Objectives do address Connecticut’s gaps and needs • Key activities do align with the objectives, and if implemented will result in progress toward achieving the objective • Connecticut’s performance measures and indicators, and its connection to a strong team of subject matter experts in data, translate to capabilities and capacity to measure and monitor progress
Objectives	<ul style="list-style-type: none"> • Consensus in small groups that the objectives make sense for Connecticut’s Plan and needs/gaps • In the DIAGNOSE pillar need to be clarified • Might need to be more “aggressively” framed to reach the goal numbers
Activities	<ul style="list-style-type: none"> • Consensus in small groups that activities identified would lead to achieving the objectives • Some of the activities read more like milestones (e.g., increase a measure). Where possible, add detail to the activity language by describing what will be done
Performance Measures	<ul style="list-style-type: none"> • Performance measures (especially in the TREAT pillar) need to be revised based on changes to activities and the fact that data (access) does not exist for some of the performance measures

The Co-Chairs thanked everyone for their input and indicated that the results will be shared at the next CHPC meeting and also used by the HIV Funders Group as part of a process to ensure that the draft Plan goals, objectives, and key activities address the gap areas to the greatest extent possible.

CHRYSALIS CENTER

CHPC co-chairs stated that it holds CHPC meetings at the Chrysalis Center in part because of mission alignment. Co-Chairs wanted to increase awareness by the CHPC community of the Chrysalis Center’s work. Summer Sivetz, Director of Development and Communications at the Chrysalis Center (host facility) shared information about the organization. The Chrysalis Center is a Hartford-based nonprofit dedicated to transforming lives and improving communities. They serve individuals and families across Connecticut who are navigating poverty, homelessness, mental health challenges, substance abuse, HIV/AIDS, or transitioning back into society after incarceration. Core services include supportive housing, case management, employment services (La Cocina - culinary arts), and food hub (Freshplace) and hydroponic garden (Urban Roots).

CHPC COMMITTEE OVERVIEW

CHPC Committee meetings will start 10 to 15 minutes after the adjournment of the main CHPC meeting. Areas of focus for each committee meeting were reviewed (see table).

Ending the Syndemic (ETS)	Public Awareness & Community Engagement (PACE)	Needs Assessment Projects (NAP)	Quality & Performance Measures (QPM)
<ul style="list-style-type: none"> Review meeting notes Syndemic Partners Group updates Update on syndemic summit Patient journey activity 	<ul style="list-style-type: none"> Review meeting notes Review of 2026 work plan Social media campaign concept June Newsletter Youth subcommittee update 	<ul style="list-style-type: none"> Review meeting notes Workforce Needs Assessment Survey 1 Pager Update on presenters Prevention Needs Assessment Survey review of instrument 	<ul style="list-style-type: none"> Review meeting notes 2027-2031 Plan performance measures; select key performance measures to highlight in Plan Future QPM meeting topics

ANNOUNCEMENTS

CHPC Co-Chairs asked participants to share any announcements or important updates relevant to their programs, services, or communities.

- Dante reminded the group to check their e-mails for upcoming AETC events.
- Arleen reminded the group that April is STI Awareness Month. Get yourself tested!
- Venesha thanked everyone involved in organizing the successful 2026 Hepatitis C Symposium.

MEETING FEEDBACK

56 participants completed a CHPC main meeting feedback poll to share their meeting experience and suggestions for improvement. 96% 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 1:05 p.m.

ATTENDANCE

Attendance records are on file with the CHPC support staff.