Connecticut HIV Planning Consortium

Main Meeting Summary

February 18, 2026

Date:	February 18, 2026	**Type:**	Virtual
Start Time:	9:00 a.m.	**End Time:**	12:06 p.m.
Participants:	103	**CHPC Members:**	29
Co-Chairs:	Dante Gennaro, Blaise Gilchrist, Africka Hinds		
Next Meeting:	March 18, 2026 (in-person)		

WELCOME AND MOMENT OF SILENCE

CHPC Co-Chair Blaise Gilchrist started the meeting by welcoming participants and introducing CHPC Co-Chairs Dante Gennaro, Jr. and Africka Hinds. He asked individuals to put their names, affiliations, and e-mail information into the chat and encouraged participants 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. Blaise quickly reviewed the CHPC vision, mission, values, structure, and process.

CHPC GENERAL BUSINESS

Africka Hinds 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. She shared several announcements related to CHPC operations.

CHPC Membership**:** The CHPC welcomed four new members: William Morales, Ruth Murray, Ruth Pennacchia, and DeLita Rose-Daniels. Five additional openings remain at this time. 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 Timeline. Participants were shown the annual timeline and meeting milestones and topics for 2026. Meetings in March, April, and May will be organized as in-person events.

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. CHPC Committee meeting time was shortened during virtual meetings. However, the Executive Committee agreed that each committee could extend its meeting time if agreed upon by the group. Areas of focus for each committee meeting (which will start at 12:30 p.m.) were shared.

Ending the Syndemic (ETS)	Public Awareness & Community Engagement (PACE)	Needs Assessment Projects (NAP)	Quality & Performance Measures (QPM)
• Review of January meeting notes • Syndemic Partners Group updates • Concept for syndemic summit • Key syndemic activities for the 2027 - 2031 Plan	• Review of January meeting notes • Newsletter review • Approach to support statewide awareness campaigns	• Review of January meeting notes • Update on work in process • Discussion of 2025 HIV Workforce Survey results and recommended actions	• Review of January meeting notes • QPM and 2027-2031 Plan performance measures and indicators + SMART objectives

PARTNER COORDINATION AND UPDATES

Africka 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. Various partners shared that the communication process continues to work well and appreciated the effort involved by all groups to stay connected (e.g.,

dedicated time on agendas), to share information (e.g., monthly activity updates), and to ask for additional information on any topic or process as needed.

DATA SHARING: 2025 PERSONS WITH HIV NEEDS ASSESSMENT (PWA NA) SURVEY RESULTS – Part 2

Mitchell Namias, Pharm.D., who is a CT DPH Pharmacy Consultant and administrator for RWB (Ryan White Part B) funding briefly reviewed the survey methodology, limitations, and demographics of responses. Mitchell explained that the presentation would cover part 2 and focus on sharing results related to questions on discrimination and stigma.

General

- As presented last month, 1019 respondents completed the survey (42% Hispanic, 37% Black/African American, 17% White; 54% Men and 44% Women).
- The questions used were from a nationally vetted survey and designed by CDC and used by several states.
- Some of the questions are not person-friendly language. Resources were provided to case managers to help clients in crisis.
- The intent behind these questions is to better understand stigma and how it impacts PWH (people with HIV).

Internal Stigma and Summary

- Overall, there was no significant difference between gender responses.
- The majority of respondents answered similarly, regardless of race and ethnicity.
- White respondents utilized "don't know" less than Black or Hispanic respondents.
- White respondents reported lower rates of concern regarding disclosing their HIV status. Hispanic respondents were on the other end of the spectrum.

Discrimination Experiences During the Past 12 Months

- Overall, there was no significant difference between gender responses.
- The majority of respondents answered similarly, regardless of race and ethnicity.
- White respondents reported "never" for all responses at a lower rate than Black or Hispanic respondents, but still fairly close to the overall response.
- Most clients report little or no discrimination with their medical professionals.

Reasons for Discrimination

- There was a high rate of "don't know" responses for every question.
- Women identified higher rates of discrimination based on HIV status.
- Black respondents identified the highest rate of racial discrimination.
- Overall, there did not seem to be a significant difference between race, ethnicity, or gender for most responses.

How Connecticut Compares to Other Jurisdictions

- Comparing CT's results to other jurisdictions proved challenging.
- Few jurisdictions published results in a way that can be compared.
- Many published their results using weighted averages. This means their study findings can be generalized. This also requires IRB (institutional review board) approval. Connecticut's results were not meant to be used in that way.
- Jurisdictions that had available, comparable information include: New York City and Oregon. Comparable information is still limited.

Next Steps and Recommendations

- CT DPH recommends using the results collected from the CT PWH NA to establish a baseline indicator for stigma. DPH can measure results again in the next Needs Assessment to determine if improvement occurred such as using the question, "Most people with HIV are rejected when others find out." An alternative example could be questions focused around healthcare services.
- There are policy changes that the Funders Group can consider such as quality improvement projects to improve stigma and discrimination, grievance policies and procedures, and data reports.
- Overall, Connecticut is doing better than New York City with stigma and discrimination.

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

- People of color do not get the same treatment opportunities. For example, prescribers are less likely to write a prescription for pain medication.
- Discrimination of people of color is a given with a long historical course.
- Many people move to Connecticut to access care. This suggests progress or improvement compared to other states.
- The findings represent only Ryan White clients. It may be the case that these clients receive better treatment than individuals in healthcare services that do not specialize in HIV services.
- Black men indicated a higher response than all others when it comes to racial discrimination. Research studies show that Black men get treated differently; efforts exist to better engage Black, heterosexual men with HIV. Black heterosexual males do not want to be compared with LGBTQ populations because their exposure was not through gay sex or drug use. It was noted that as youth (born with HIV) transition from pediatricians to adult providers, these types of assumptions affect their engagement in care.
- Engaging young people in healthcare conversations remains challenging even though it appears to be improving over time. This may or may not be true of other groups.
- Examples were shared about individuals with HIV that have not disclosed their status to family or peer groups.
- It is very challenging, if not impossible, to change the attitudes and behaviors of providers outside the Ryan White care system.
- Would it be possible to analyze the discrimination and stigma questions by age group as well as by newly diagnosed?
- Providers should participate in cultural competency training and support health literacy efforts which will improve communication.
- Individuals (patients or providers) may already have bias and that affects how they perceive the world and navigate their daily activities.
- The CHPC (via QPM committee) should explore developing an indicator. However, it might make sense to first identify activities and how specific activities will produce change (outcomes). This step will be important because discrimination and stigma is widespread and connected to broader social issues. Examples were given of looking at organizational policies, procedures, and leadership culture.
- Clients need to be empowered and taught to advocate for themselves. This includes asking questions and not making assumptions which may lead to stigma or discrimination.
- Stigma is difficult to separate out into its own issue because it is tied to complex, structural racism. More should and can be done to address trauma caused by these issues.
- Language matters. In some Native American cultures, HIV does not have a specific name because naming it would be like creating a monster. Many folks agreed that cultural awareness remains important.
- Providers need to show empathy which changes the conversation space.

- The results reflected the experience of many providers.
- Suggestions were made to do more marketing and awareness campaigns and make use of existing resources, trainings, and toolkits.
- The Greater Hartford Planning Council Positive Empowerment Committee is hosting a membership engagement session where they will have a session about Cultural Humility.
- Doctors should be encouraged to do a better job explaining results and options.
- Individuals being affected or harmed the most should be involved in developing content or training materials. No funding exists for this activity.

Mitchell thanked everyone for sharing their feedback and comments.

SELF CARE BREAK

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

DATA SHARING: HIV WORKFORCE SURVEY RESULTS

Dante shared findings from the 2025 Connecticut HIV Workforce Needs Assessment Survey. The presentation included some interactive polls to increase engagement.[1]

Methodology

Mode: Web-based, self-administered (SurveyMonkey)

Sample: Convenience sample across CT HIV-related settings

Fielding: October 14 – November 21, 2025

Design: Modular survey with skip logic developed by the HIV Funders Group and the CHPC Needs Assessment Project (NAP) Committee with three pilot tests

Core questions for all: Role & responsibilities (direct service; prevention/treatment focus; syndemic approach)

Questions by Role for: (1) Prescriber/Dispenser, (2) Clinical, (3) Non-clinical, and (4) Admin/Program Manager

Respondents (n = 257 responded; 221 completed)

- Half of the respondents represent prescribers/dispensers or clinicians.
- The responses contain a strong showing by workers between the ages of 25 and 44.
- Individuals identifying as female accounted for 8 out of 10 survey responses.
- The racial/ethnic background of survey respondents tends to reflect more diversity than the general population and less diversity than PWH.

Dante noted that this sample represented a snapshot of the HIV service delivery system which is part of a much larger healthcare workforce. For example, over 17,000 physicians are licensed in Connecticut with over 7,500 practicing, of which over 225 are infectious disease doctors. Over 90,000 nurses are licensed in Connecticut with over 45,000 practicing. Estimates show that the number of licensed pharmacists in Connecticut is between 3,500 and 6,000 (supporting over 650 pharmacies). Ending the HIV epidemic will require engaging this larger healthcare workforce. The first step involves understanding the HIV workforce better.

Results (see presentation on CHPC website for details)

Prescribers / Dispensers

- Strengths. Routine testing is high within the HIV community: HIV 84%; HCV 73%; Broad biomedical scope: STI/STD Treatment 76%, PrEP 68%, ART 58%, PEP 55%, HCV meds 53%; Substance Use Disorders: 83%+ conduct SUD risk assessments; 53% prescribe MAT/MOUDs
- Opportunities. Syndemic Integration: Room to improve syndemic approaches; Harm-reduction linkage: 45% report high capacity to connect to harm reduction services; Patient rights: 32% educate on grievance

[1] Results of the interactive polls are not included in these notes.

procedures; Patient stigma reported by 45%; Confidence about Youth PrEP: 39% comfortable prescribing PrEP to <18

Clinical

- Strengths. Routine testing (36% HIV, 36% HCV); Syndemic screening (Mental health screening 88%, Alcohol & substance use screening 82%); Sexual health histories (53% routinely conduct comprehensive histories)
- Opportunities. 90% required to do case management/linkage; Capacity ratings = Strong: linkage to medical care (82%), Moderate: linkage to PrEP (56%) and PEP (55%), Weaker: linkage to housing (35%) and food/nutrition (46%). Top "what would help" themes: (a) Streamline referral/linkage workflows, (b) More education/training, (c) Better regional partnerships and data sharing, and (d) Supportive technology (EHRs, tracking tools)

Non-Clinical

- Top Challenge. 62.7% improve patient access to services through transportation, insurance, and translation services. Populations most served: People who use drugs (87.8%), People experiencing homelessness (81.6%), Recently incarcerated (59.2%), and youth, LGBTQIA+ communities, immigrants
- Opportunities. Top need: Streamlined referral & linkage-to-care systems (>50%); Reduce silos: Regional/local partnerships and data sharing (42%); More support: Education & training resources (41.8%); and Harm reduction: Core role, but confidence in SUD screening and mental health linkage is mixed

Administrative

- Opportunities. Language access training gap (42.6% trained on using translators/translation services, 31.4% assist with interpretation/translation operationally) and Stigma and complaint response (31.4% clients report experiences of stigma – administrative staff often manage complaints, investigations, corrective actions)

Top Needs by Role

- Prescriber: starting medication treatment regimens with active substance users, working with CT DPH Partner Services and Disease Intervention Specialists, and starting treatment for HCV with active substance users
- Clinical: taking a comprehensive drug risk assessment, taking a comprehensive sexual health history, recognizing and addressing burnout
- Non-Clinical: using translators/translation services to improve communication, taking a comprehensive mental health history, and recognizing and addressing burnout
- Administrative: working with CT DPH Partner Services and Disease Intervention Specialist, infectious disease reporting to CT DPH, and harm reduction strategies and resources available

Cross Cutting Themes

- Evidence exists that the syndemic approach is rippling across each of the different response groups
- All response groups report that patient's share they experience stigma (30%+)
- Disconnects ranging from internal workflows to knowledge and external connection to community resources affect service delivery and health outcomes
- Education and training needs differ by response groups and roles/responsibilities

Next Steps

- Consider assembling a statewide syndemic workforce advisory group with partners responsible for or funded to deliver higher volume training (e.g., AETC, CHC, CHC/ACT, ACT, CT DPH, DMHAS)
- Could be connected to the HIV Funders Group or CHPC Committee
- Identify competency-based, re-usable and scalable solutions such as online learning that are sustainable
- Expand work-based learning options to enhance classroom or virtual delivery methods

- Review how various groups / forums can be used to delivery training – especially for core topics. Examples include: Prevention Power Hour, Crimson Table Talks, VHETAC, Sexual Health Coalition, and more; RWA, RWB, and Prevention networks; and statewide summits or symposia
- Conduct additional surveys with a sharper focus (e.g., providers outside the HIV community, specific subgroups or job titles that are critical to a Plan strategy)

A brief group discussion occurred. Key themes included:

- It is important to understand the responsibilities of the respondents. For example, pediatricians are responsible for prescribing PrEP to youth whereas physicians serving adult populations are not allowed to prescribe for youth. The results need to be understood in the context of the respondents.
- It's time to ask large systems or providers (e.g., CHC/ACT, CHC, Hartford Healthcare) to help increase routine HIV testing across their systems and settings (vs. working with individual prescribers).
- The healthcare workforce appears to be stating that more patients report stigma and discrimination to them as compared to the findings just presented in the PWH Needs Assessment Survey results.
- The results reinforce the importance of training by specific roles (vs. offering general trainings).
- Dr. Seja Jackson in Hartford is a champion in providing PrEP and PEP care.
- Providers may not be comfortable taking sexual health histories. These are uncomfortable conversations and providers may make assumptions (e.g., adults over 55 or married individuals may not be asked questions about sexual health). More opportunities must occur to help providers practice these skills.
- More online, self-paced trainings would be helpful. ACT facilitates trainings and supports an online learning management system.
- It was helpful to see how different groups have different training needs.
- Prescribers may not be connected to CT DPH or know the specific reporting protocols. It is important to understand who else is in the workflow (e.g., other supervisors).

Meeting participants entered breakout rooms (via random assignment) to continue discussion on the HIV Workforce Survey results.

BREAKOUT GROUPS TO DISUCSS HIV WORKFORCE 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 HIV Workforce results? (b) Is the syndemic approach working? (c) What are the bigger concerns about workforce? (d) What are the top priorities for the future? and (e) Any other discussion topics that emerge. An analysis of themes recorded across the groups is shown below.[3]

1. What surprised people about the HIV Workforce Survey results?

Rules for Doctors: Many were surprised that some doctors have restrictions on their licenses that prevent them from prescribing certain preventative medicines (like PrEP) to younger patients.

Need for Help with Referrals: It was unexpected that even experienced medical staff asked for more training on how to work with state health departments to track and prevent the spread of diseases.

Comfort Levels: There was surprise that many clinical staff members do not feel comfortable talking to patients about their sexual history or do not do it regularly.

Housing & Stigma: Participants were struck by how much stable housing affects health and how a provider's choice of words can accidentally make a patient feel judged or "stigmatized".

[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] Participants from each group shared key themes. The content in the minutes reflects themes identified during an analysis conducted in the days after the meeting.

2. Is the syndemic approach working?

Making Progress: Most groups feel Connecticut is moving toward a "whole-health" approach—looking at HIV, liver health (HCV), and addiction together rather than as separate problems.

The "Hand-off" Problem: While doctors are getting better at testing for multiple things, they still struggle with the next step: successfully connecting patients to the right treatment or specialty care.

Uneven Results: This approach works well in specialized clinics but isn't as common yet in general doctor's offices.

3. What are the biggest concerns for the workforce?

Burnout and Turnover: High stress is causing many workers to leave their jobs. When staff change frequently, patients can "fall through the cracks" and lose their connection to care.

Training Gaps: There is a major concern that new workers don't know the history of HIV care, and many staff members lack the "plain language" skills needed to explain complicated medical information to patients.

Assumptions and Bias: Some providers wrongly assume that older adults or married people don't need HIV testing, which leads to late diagnoses when the person is already very sick.

Funding Fears: There is worry that the government does not fully understand how important these services are, leading to fears that budget cuts could take away patient support.

4. What are the top priorities for the future?

Better Training for Doctors: Since doctors "set the tone" for a patient's visit, they need more training on how to talk comfortably about sensitive topics like youth health and harm reduction.

Fixing Computer Systems: Experts suggest changing medical software so that it prompts doctors to ask important health questions that they might otherwise forget.

Better Teamwork: Different types of workers (like doctors, office staff, and case managers) need clear "how-to" guides so they know exactly who is responsible for helping a patient at every step of their journey.

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.

- The RWA Planning Council TGA (Hartford) is celebrating its 30th anniversary this year. More information will be shared in the future.
- The AETC, High Watch Recovery Center, and the CT DPH Viral Hepatitis Elimination Technical Advisory Committee (VHTAC) will be hosting a second statewide HCV symposium on April 10, 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

33 participants completed a CHPC main meeting feedback poll to share their meeting experience and suggestions for improvement. 95% 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 12:06 p.m.

ATTENDANCE

Attendance records are on file with the CHPC support staff.