

## Main Meeting Summary

March 18, 2026

<b>Date:</b>	March 18, 2026	<b>Type:</b>	Virtual
<b>Start Time:</b>	9:15 a.m.	<b>End Time:</b>	1:05 p.m.
<b>Participants:</b>	71	<b>CHPC Members:</b>	24
<b>Co-Chairs:</b>	Blaise Gilchrist, Africka Hinds		
<b>Next Meeting:</b>	April 15, 2026 (in-person)		

### WELCOME AND MOMENT OF SILENCE

CHPC Co-Chairs Blaise Gilchrist and Africka Hinds 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 were encouraged to use their two-colored paddles (green = thumbs up; red = thumbs down) to increase engagement and also to make certain everyone understands the information. Blaise quickly reviewed the

### 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.** Five CHPC Membership openings exist. Please apply at [www.cthivplanning.org](http://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 April and May will be organized as in-person events.

**Syndemic Summit.** The CHPC's annual quality summit will be organized to expand the awareness and use of syndemic approaches with a tentative emphasis on connecting local and regional partners. The Ending the Syndemic Committee will take a leading role in the event planning.

**CHPC Member Engagement.** A process is underway to assess CHPC Member engagement and experience. The CHPC Members will discuss results and next steps during a "lunch and learn" discussion at the April CHPC meeting.

### 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. No partners shared any updates.

### 2027-2031 PLAN DEVELOPMENT: SMALL GROUP DISCUSSIONS

**Background.** The group was reminded that the 2027-2031 Plan Guidance requirements call for a "situational analysis" or a snapshot of the current HIV situation in your community designed to understand what is happening, who is affected, and what resources are available. This short overview across the HIV prevention and care continuum includes (a) strengths, (b) challenges, (c) identified needs, and (d) structural and systemic issues impacting people and communities disproportionately impacted by HIV.

The CHPC has been coordinating information sharing and discussions related to support this situational analysis. Examples include: (a) Epidemiological profile, (b) HIV surveillance data and statewide indicators, (c) Prevention needs assessment, (d) Persons with HIV needs assessment, (e) HIV workforce survey, and (f) Updates from HIV prevention and care partners such as AIDS Education and Training Center services, Ryan White Part B service utilization and allocations, Ryan White A priorities and special projects, and the Hepatitis C Elimination Plan.

**Focus of Activity.** The Plan Development activity for today will involve a discussion about gaps, or the difference between what our community needs to stay healthy and the services that are available. The HIV Funders Group and Executive

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Committee have identified important areas of focus where gaps appear to exist and would like input from the CHPC. The areas of focus include:

- **Sexual health and prevention services** (e.g., PrEP, PEP, condoms, sexual health education)
- **Harm reduction services** (e.g., syringe service programs, overdose prevention, naloxone)
- **HIV awareness, outreach and testing** (e.g., campaigns, case finding, screening and testing)
- **Rapid linkage to care** (medical services, medication, and support services)
- **Retention in care and viral suppression** (engaging out-of-care, impact of support services)
- **Engaging partners beyond traditional HIV prevention and care community** (e.g., urgent care, non-Ryan White funded providers)

Group Process and Discussion Questions. The large group would be randomly assigned into one of three small groups that would be facilitated by a CHPC leader, supported by one or more subject matter experts and a recorder who would document the discussion. Each group would start on a different topic to ensure that feedback was collected across all areas of focus. The groups would use four questions to guide discussion on 3 to 4 of the gap areas (shown above). The questions were: (1) What is working? (2) What is not working? (3) What else could be done? and (4) What is needed to close the gaps in this area?

**Small Group Discussion Results.**<sup>1</sup> The small group discussions reveal a consensus that success is driven by low-barrier, community-centered care, while progress is stalled by fragmented systems and educational gaps.

- **Non-Traditional Engagement:** Across all topics, there is a push to expand community-embedded service delivery models to bring services to where people already are, (barbershops, churches, laundromats, clubs, and sex-party venues) and to engage non-Ryan White providers
- **Education and Detailing:** A recurring need exists for "academic detailing" to educate both traditional providers (ER staff, pediatricians) and non-traditional ones (pharmacists)
- **Impact of Systemic Barriers:** Issues like insurance limitations, lack of data system integration, funding limitations for harm reduction programs, and transportation in rural areas consistently hinder progress
- **Holistic/Syndemic Approach:** Success is linked to "One-Stop Shops" and addressing social determinants of health, such as housing, food, and mental health

What is Working? Success is rooted in meeting people where they are. Integrated "One-Stop Shop" models, the Disease Intervention Specialist / Medical Case Management framework, and co-located services (medical care paired with housing/food) are highly effective. Innovative outreach—like vending machines, mobile vans, and Grindr campaigns—successfully reaches high-risk and younger populations.

- **Integrated & Co-located Services** ("One-Stop Shops"): Successful programs often utilize a syndemic approach, where medical care, testing, and support services (like housing and food) are provided in one location or through a highly coordinated "whole-person" model
- **Effective Case Management:** Both Medical Case Management (MCM) and Disease Intervention Specialists (DIS) are credited with high viral suppression rates and successful navigation of the healthcare system
- **Meeting People Where They Are:** Outreach that goes beyond traditional clinics—such as vending machines for Narcan and condoms, community health vans, and testing at food banks, shelters, and clubs—has proven effective at reaching high-risk populations
- **Leveraging Technology & Social Media:** Digital outreach, specifically Grindr campaigns ("Know Your Status") and telehealth platforms like Q Care Plus, are successfully engaging younger and tech-savvy demographics

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<sup>1</sup> These results were NOT shared at the meeting. However, the overall summary of results have been inserted into the meeting summary as evidence of the nature and type of discussions that occurred. A separate summary report has been produced and contains the summary information as well as feedback by each area of focus and for each question.

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- **Strong Financial & Legislative Support:** Programs like CADAP (CT AIDS Drug Assistance Program) are essential for maintaining care, while the Routine Testing Law and Expedited Partner Therapy (EPT) provide the legal framework necessary for expanded services
- **Community Involvement:** Incorporating affected persons in the process and ensuring that outreach workers are representative of the communities they serve helps build the trust necessary for retention in care

What is Not Working or Barriers? Significant hurdles include financial constraints (high co-pays, limited PrEP funding) and systemic silos, where non-integrated data systems prevent seamless care. A critical knowledge gap exists among providers; pediatricians often don't prescribe PrEP, and pharmacists frequently misunderstand programs like CADAP. Furthermore, traditional clinic hours and a lack of demographic representation in staff create mistrust and accessibility issues.

- **Financial & Insurance Barriers** such as high costs (co-pays and labs) and restrictive private insurance policies often discourage testing and PrEP access, or limited specific funding, such as only \$25K being available for PrEP/PEP, creates service gaps
- **Provider & Knowledge Gaps** including a persistent lack of provider education; for example, pediatricians are not prescribing PrEP to youth, and some pharmacists are unfamiliar with the CADAP program, or provider wariness exists regarding complex treatments (like syphilis) or ordering necessary follow-up viral load tests
- **Systemic & Data Fragmentations** including data systems that do not communicate with each other, making it difficult to track patients or coordinate care across different agencies, and privacy issues and "red tape" regarding disclosing "out of care" status hinder re-engagement efforts
- **Access & Logistical Challenges** such as use of traditional hours (9-to-5) that do not work for many clients, particularly men with 12-hour shifts, or dispersed service locations and a lack of transportation in rural areas create physical barriers to care. Geographic coverage limits appear to exist for certain types of services (e.g., harm reduction) beyond urban centers (e.g., New Haven, Hartford).
- **Social & Demographic Disconnects** such as organizations that lack demographic representation of the communities they serve, contributing to a mistrust of medical providers, and stigma remains a major hurdle for testing, and many people (especially youth) have a low perception of harm regarding HIV/STIs
- **External & Environmental Factors** ranging from weather (winter) and housing instability significantly affect client behavior and their ability to access services to fear related to immigration status prevents some individuals from seeking any medical services

What are Suggested Solutions to Close the Gaps? Participants advocate for "Academic Detailing" to educate traditional and non-traditional providers (e.g., barbers, pharmacists). They recommend a "Rapid-Rapid" model for immediate medication initiation and the expansion of vending machines and mobile pharmacies. Finally, solutions should focus on legislative advocacy to increase funding and mandate better reporting from urgent care centers to ensure no one "falls through the cracks".

- **Expanding Outreach into Community Spaces** by increasing the presence of health information and services within the community by partnering with local businesses and faith-based organizations to meet people where they are or using modern communication tools and social media storytelling to engage younger populations and raise awareness in public spaces.
- **Comprehensive Provider and Staff Training** such as implementing academic detailing programs to provide one-on-one, evidence-based education for healthcare providers, pharmacists, and clinic staff regarding routine testing and preventative care, or training community advocates and peer leaders to support the distribution of harm reduction materials and health information.
- **Improving Accessibility through Low-Barrier Care Models** such as deploying mobile units and specialized vending machines to provide services to rural areas or individuals experiencing housing instability, adjusting clinic hours to include evenings and weekends to better serve working individuals and those with traditional schedules, or adopting rapid-linkage models that allow for immediate initiation of care following a reactive test result.

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- **Policy Advocacy and Data Integration** solutions such as engaging with policymakers and public health leadership to advocate for increased funding and the modernization of health reporting laws and improving data systems to allow for better communication between agencies, ensuring patients do not fall out of the care continuum.
- **Culturally Responsive and Representative Care** involves prioritizing the recruitment of staff and board members who reflect the demographics of the communities they serve to build trust and reduce social stigma and establishing centralized consultation lines to assist providers with referrals and simplify the process for patients seeking specialized care.
- **Focusing on Social Determinants of Health** including supporting "one-stop-shop" service models that integrate medical care with essential support services like housing assistance, nutritional support, and mental health resources.

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.

### 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"> <li>• Review meeting notes</li> <li>• Syndemic Partners Group updates</li> <li>• Discussion about connection of current and future HIV Plan activities to STD prevention and care strategies</li> </ul>	<ul style="list-style-type: none"> <li>• Review meeting notes</li> <li>• Review of 2026 work plan</li> <li>• Newsletter distribution update</li> <li>• Youth subcommittee</li> </ul>	<ul style="list-style-type: none"> <li>• Review meeting notes</li> <li>• Discuss key themes from PWH Needs Assessment results and HIV Workforce Survey results</li> <li>• Recruit next NAP forum presenter</li> </ul>	<ul style="list-style-type: none"> <li>• Review meeting notes</li> <li>• 2027-2031 Plan performance measures</li> </ul>

### ANNOUNCEMENTS

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

- Xavier Day invited participants to attend a celebration at The Place (74 Garfield Avenue, New London, CT) on March 31 for National Transgender Day of Visibility from 5:30 p.m. to 8:30 p.m. The event is sponsored by outCT Inc. The them of the celebration will be “Trans Ancestors: Visibility throughout history.

### 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.