Help Shape the Future of HIV Care and Prevention in Connecticut

PUBLIC COMMENT OPPORTUNITY

To Share Feedback on the Draft of

Connecticut's 2027-2031 Integrated HIV Prevention and Care Plan

Why Your Voice Matters
Connecticut is creating a new statewide plan to improve HIV prevention and care from 2027 through 2031. To make this plan as effective as possible, we need to hear from you. Public input is a vital part of health planning—it ensures our goals meet the actual needs of our community.

About the Plan
The federal government asks states to create these plans to make sure resources are used wisely and stay connected to national goals for ending the HIV epidemic. Since mid-2025, HIV partners across Connecticut have been working together to draft this new roadmap. This plan will build on the work we are doing now and guide our efforts for the next five years.

What is in the This Draft?
In the attached document, you will find:

- **Page 2** – a Table of Contents for the full plan.
- **Pages 3–15:** Proposed goals and objectives for the new 2027–2031 Plan.
- **Page 16 and beyond:** A look at the data and facts used to help create these goals.

Submit your Comments by April 30, 2026
We invite you to review these draft goals and share your thoughts. Your feedback will be shared with the planning teams as they finalize the strategy. To access the form, use the QR code or click on this link (https://www.surveymonkey.com/r/CTHIVPLAN2026PublicComment)

QR Code to Access Public Comment Form

What to Learn More about the CHPC or Get Involved?

Visit www.cthivplanning.org to find information on upcoming public meetings where these goals will be discussed or email CHPC@xsector.com.

Thank you for helping us build a healthier Connecticut for everyone.

This public comment opportunity seeks feedback on content that will be used in Section 5 of the Plan.

As shown in the Plan Table of Contents (below), Section 5 is part of a larger technical planning document that must be submitted to the federal government.

Section 5 is the most "modifiable" section of the Plan document because it include goals, objectives, activities, and performance measures. Other sections are more relevant to telling the story of the process and data used to develop the Plan.

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2027-2031 Plan Goals and Objectives

Connecticut's Plan represents a continuation of the 2022-2026 Plan. The 2027-2031 Plan includes three overarching goals: (a) End the HIV epidemic, (b) Address at the same time related health matters of HIV, STDs, HCV, and SUDs (syndemic approach), and (c) Eliminate health disparities. Connecticut's Plan aligns with goals identified in the National HIV and AIDS Strategy and is organized according to Plan "pillars" for Ending the HIV Epidemic plans (see below).

National HIV and AIDS Strategy Goals for Connecticut

95%	Of persons with HIV are **aware of their status**, an increase from 92.2% in 2023
55	The number of **newly diagnosed person with HIV decreases** 90% from the 2017 baseline of 220
95%	Of newly diagnoses persons with HIV **attend a healthcare visit within 1 month of diagnosis**, an increase from 87% (2017) and 83% in 2023
95%	Of persons with HIV are **virally suppressed**, and increase from 90.7% (2023)

Alignment with the Four Ending the HIV Epidemic Strategies

The table shows objectives by Pillar. The pages following the table describe each pillar in more detail.

High Level Summary of the 2027-2031 Plan by Pillar

Overarching Goal	Pillar Goal	Objectives
End the HIV epidemic in Connecticut Eliminate HIV-related health disparities Expand use of syndemic strategies: HIV STD HCV SUD	**DIAGNOSE all people with HIV as soon as possible**	D1. Increase HIV/HCV testing in clinical settings by 10% by 12/2031 [baseline to be determined, see objective D3] D2. Increase HIV testing in non-clinical settings by 10% by 12/2031[baseline to be determined, see objective D3] D3. Develop an approach to assess, analyze, and share statewide HIV testing volume by 12/2028
	TREAT people with HIV rapidly and effectively to achieve viral suppression	T1. Newly diagnosed PWH who attend a routine care visit within 1 month of diagnosis increases from 87% (2017) to 95% by 12/2031 T2. Newly diagnosed PWH who receive Antiretroviral Therapy (ART) within 30 days of diagnoses increases from ##%[1] (2023) to 95% by 12/2031 T3. Achieve viral load suppression for 95% of all PWH by 12/2031 as compared to a baseline of 74% (2017)
	PREVENT new HIV transmissions	P1. Increase the PrEP-to-NEED Ratio from 12 (2017) to 36 by 12/2031 P2. Increase the number of individuals accessing Syringe Services Programs (SSP) from 9,500 (2017) to 11,000 by 12/2031 P3. Increase condom distribution statewide by 10% by 12/2031 from a baseline of 61,274 through SSPs in 2021
	RESPOND to disease outbreaks and disparities	R1. Update syndemic outbreak and response plans annually R2. Analyze surveillance data monthly to identify syndemic and single disease condition transmission clusters and outbreaks (monthly, ongoing) R3. Provide resources and tools to 5 communities with high area deprivation index (ADI) scores to detect and respond to syndemic outbreaks R4. Disease Intervention Specialists or Partner Services contact 85% of newly diagnosed HIV positive individuals to engage them in Partner Services

[1] The baseline number is undergoing additional verification and will be added. The baseline will not have an impact on the objective (95%) as this is connected to a National HIV and AIDS Strategy goal.

DIAGNOSE all people with HIV as soon as possible

This pillar and objectives will help Connecticut achieve a goal of 95% of people living with HIV who know their status as compared to a baseline of 91% in 2017 and 92% in 2023.

Objective	Key Activities	Sample Performance Measures
D1. Increase HIV/HCV testing in clinical settings by 10% by 12/2031 [baseline to be determined, see objective D3]	• Statewide (syndemic) screening and testing awareness campaigns • Academic detailing program • Process to analyze late tester data and identify facilities for provider education • Distribute digital syndemic resources and materials	○ # of individuals campaign reaches and total # of times campaign messages viewed by individuals ○ # downloads of digital materials or metrics related to the use of other digital materials ○ # of providers in clinical settings who complete an academic detailing session ○ # of individuals who receive HCV and HIV tests in clinical settings (e.g., urgent cares) ○ # of individuals who are late testers in clinical settings ○ # and % of persons with HIV who are aware of their status ○ % of late testers ○ % late testers diagnosed with an opportunistic infection, % diagnosed in ED
D2. Increase HIV testing in non-clinical settings by 10% by 12/2031[baseline to be determined, see objective D3]	• Increase HIV and HCV testing in outreach settings located in communities • Increase HIV and HCV testing in Syringe Service Programs • Expand at-home or self-testing options	○ # of and geographic location of non-clinical partners offering routine testing options ○ # of individuals who receive HCV and HIV tests in non-clinical settings ○ # of individuals who are late testers in non-clinical settings ○ # and % of persons with HIV who are aware of their status ○ % of late testers ○ % late testers diagnosed with an opportunistic infection, % diagnosed through non-clinical settings
D3. Develop an approach to assess, analyze, and share statewide HIV testing volume by 12/2028	• Develop approach to analyze HIV negative lab tests • Pilot methodology for use of HIV negative lab tests (e.g., understand routine testing) • Use new data to revised Plan indicators • Use data to inform objectives D1 and D2	○ Methodology and meaningful use protocols for HIV negative lab tests ○ Update to statewide Plan indicators ○ # and % of persons with HIV who are aware of their status ○ % of late testers ○ % late testers diagnosed with an opportunistic infection

DIAGNOSE Pillar: Brief Explanation Behind Objectives and Rationale for Key Activities

Objective D1. Increase HIV/HCV testing in clinical settings by 10% by 12/2031[2]

General Approach. Early diagnoses is the only way to improve individual health, prevent transmission, and close the awareness gap. Routine clinical testing reaches people who may think they are not at risk, or who would never seek out a specialized testing site.

Key Activities. Normalizing HIV and HCV testing means making these tests a standard part of a doctor's visit, just like a cholesterol check or blood pressure reading. When testing is "routine," it removes the stigma of having to ask for a test and ensures that nobody is overlooked based on a provider's assumptions about their risk. Emergency Departments and Urgent Care centers are "frontline" settings. For many, these are the only places they see a doctor.

Key Partners. CT DPH HIV, STD, and HCV Program, CT DPH funded partners, Local Health Departments & Districts, CT DMHAS, Planned Parenthood of Southern New England, Healthcare providers, Connecticut HIV Planning Consortium, Ryan White Parts and Planning Councils, Syndemic Partners Group, New England AETC, Community Health Centers Association of Connecticut

Objective D2. Increase HIV/HCV testing in non-clinical settings by 10% by 12/2031

General Approach. Early diagnoses is the only way to improve individual health, prevent transmission, and close the awareness gap. Routine testing in non-clinical settings reaches people who may not perceive themselves at risk, may not have access to healthcare, or who would never seek out a specialized testing site.

Key Activities. For individuals who may not have access to healthcare services in clinical settings, expanding access in non-clinical settings such as Syringe Service Programs, community health fairs, community outreach programs, supportive housing, and at-home testing may be the best or only way to engage priority populations by meeting them where they are at in the community.

Key Partners. CT DPH HIV, STD, and HCV Program, CT DPH funded partners, Local Health Departments & Districts, CT DMHAS Prevention and Health Promotion, CT Department of Housing, Connecticut HIV Planning Consortium, Syndemic Partners Group, Ryan White Parts and Planning Councils, Connecticut Housing Consortium for Public Housing Coordinated Access Networks, Community-Based Organizations

Objective D3. Develop an approach to assess, analyze, and share statewide HIV testing volume by 12/2028

General Approach. Early diagnoses is the only way to improve individual health, prevent transmission, and close the awareness gap. Connecticut legislation exists to expand and normalize routine HIV testing in healthcare settings and this Plan intends to expand routine testing in non-clinical settings. Historically, all confirmed HIV-positive results (including antibody, antigen, viral load, and genotype results) are reportable to the Connecticut Department of Public Health. Recent changes involve the reporting of negative results with negative HIV-1/2 antibody/antigen results as well as all CD4 results (regardless of the count) now reportable only via electronic file reporting.

Key Activities. Newly available HIV negative reporting creates an opportunity for Connecticut to better assess and understand the reach of routine HIV testing efforts in clinical and non-clinical settings, and to use this information to inform efforts to expand routine testing in clinical and non-clinical sites.

Key Partners. CT DPH HIV, STD, and HCV Program, CT DPH Surveillance, CT DPH funded partners, Local Health Departments & Districts, Connecticut HIV Planning Consortium, HIV Funders Group, Syndemic Partners Group

[2] Baseline is "to be determined". Refer to objective D3.

TREAT people with HIV rapidly and effectively to achieve viral suppression

This pillar and the objectives will help Connecticut achieve the goals of (1) 95% of newly diagnosed persons with HIV who attend a routine HIV care visit within one month of diagnosis as compared to a baseline of 87% in 2017 and 90% in 2023, and (2) 95% of people living with HIV who are virally suppressed as compared to a baseline of 74% (2017) and 87% (2023).

Objective	Key Activities	Sample Performance Measures
T1. Newly diagnosed PWH who attend a routine care visit within 1 month of diagnosis increases from 87% (2017) to 95% by 12/2031	• Link newly diagnosed to care within 30 days • Assign medical case manager within 72 hours • Refer all newly diagnosed to Partner Services within 30 days • Pilot approaches to improve referrals for non-Ryan White providers	○ # participants attending training sessions on medical case management standards ○ # of newly diagnosed with appointments within 7 days ○ % newly diagnosed clients interviewed by Disease Intervention Specialists or Partner Services ○ Average time from CADAP application to ART access ○ # persons with HIV using CADAP benefits coordinator (e.g., access to health insurance) ○ % persons with HIV adhering to medication ○ Viral suppression rates overall and by subgroups
T2. Newly diagnosed PWH who receive Antiretroviral Therapy (ART) within 30 days of diagnoses increases from ##[3]% (2023) to 95% by 12/2031	• Increase providers prescribing ART within 7 days for newly diagnosed • Increase # of newly diagnosed persons with HIV who receive ART within 7 days • Develop and maintain list of pharmacies trained in receiving newly diagnosed persons with HIV	○ # participants attending training sessions or academic detailing on ART standards and medications ○ # of newly diagnosed with medication access within 7 days ○ Average time from CADAP application to ART access ○ % persons with HIV adhering to medication ○ Viral suppression rates overall and by subgroups ○ Inventory of pharmacies
T3. Achieve viral load suppression for 95% of all PWH by 12/2031 as compared to a baseline of 74% (2017)	• Update CADAP formulary and promote long-acting medications • Promote use of CADAP insurance premium assistance • Improve mechanism for providers to engage out-of-care patients • Quality improvement projects focusing on viral suppression • Expand data sharing agreements with state agencies to identify persons with HIV	○ # participants attending training sessions or academic detailing on ART standards and medications ○ # of newly diagnosed with medication access within 7 days ○ Average time form CADAP application to ART access ○ % persons with HIV adhering to medication ○ Viral suppression rates overall and by subgroups

[3] The baseline number is undergoing additional verification and will be added. The baseline will not have an impact on the objective (95%) as this is connected to a National HIV and AIDS Strategy goal.

TREAT Pillar: Brief Explanation Behind Objectives and Rationale for Key Activities

Objective T1. Newly diagnosed persons with HIV who attend a routine care visit within 1 month of diagnosis increases from 87% (2017) to 95% by 12/2031

General Approach. HIV begins impacting the immune system immediately. Getting into care within 30 days ensures the virus is suppressed before it can cause significant damage. When someone is in care and their viral load is "undetectable," they cannot transmit HIV to partners (Undetectable = Untransmittable). Reaching 95% of people within a month is a critical step toward stopping new transmissions.

Key Activities. Linkage to care within 30-days of a new diagnoses represents the gold standard for care. The first month is the highest-risk period for someone to "fall through the cracks" due to shock or logistical barriers. Providing access to care coordination that addresses medical and social needs as well as notify partners who may have been exposed means that patients and partners can access services as soon as possible. This support network is especially important for patients who may receive services from healthcare providers who may not specialize in HIV or infectious disease care.

Key Partners. Ryan White Parts and Planning Councils, CT DPH HIV, STD, and HCV Program, CT DPH Surveillance, CT DPH funded partners, Local Health Departments & Districts, Connecticut HIV Planning Consortium, HIV Funders Group, Syndemic Partners Group, New England AETC

Objective T2. Newly diagnosed persons with HIV who receive Antiretroviral Therapy (ART) within 30 days of diagnoses increases from ##% (2023) to 95% by 12/2031

General Approach. HIV begins impacting the immune system immediately. Starting ART within 30 days and ideally much sooner reduces the time it takes for a person's viral load to become undetectable. This protects their immune system from damage and prevents long-term health complications. Viral load suppression is an effective method of prevention. Achieving an undetectable viral load means the virus cannot be sexually transmitted. Research shows patients who start medication quickly are more likely to stay in long-term care.

Key Activities. Many non-HIV specialists such as emergency room doctors or primary care physicians may be hesitant to prescribe ART. Academic detailers and other trainers can empower more doctors to feel confident starting treatment immediately rather than waiting for a specialist referral. A prescription is only helpful if the patient can actually get the pills. Pharmacies are often the final hurdle. Creating a list of "HIV-competent" pharmacies ensures that when a newly diagnosed person arrives, the pharmacist understands the urgency, knows how to handle complex insurance/billing, and can provide supportive counseling to improve adherence.

Key Partners. Ryan White Parts and Planning Councils, CT DPH HIV, STD, and HCV Program, CT DPH Surveillance, Local Health Departments & Districts, Connecticut HIV Planning Consortium, HIV Funders Group, NEAETC

Objective T3. Achieve viral load suppression for 95% of all persons with HIV by 12/2031 as compared to a baseline of 74% (2017)

General Approach. The 95% viral suppression goal is the "finish line" of the HIV care continuum. It shifts the focus from starting treatment to ensuring that treatment is working effectively. Viral suppression stops the virus from damaging the immune system, preventing the progression to AIDS and significantly increasing life expectancy. Reaching 95% suppression effectively halts new transmissions across the state.

Key Activities. Promoting long-acting injectables provides a more flexible option that can drastically improve adherence and suppression for those who find daily dosing difficult. By using the Connecticut AIDS Drug Assistance Program to pay for insurance premiums, the state ensures persons with HIV have continuous, affordable access to their doctors and medications without gaps in coverage. Life happens—people move, lose jobs, or face mental health crises and stop going to the doctor. Creating a safety net to help providers reach patients who have not had a lab test in a while strengthens the support network. Finally, quality improvement projects and data sharing agreements will help providers identify and address specific needs and gaps.

Key Partners. Ryan White Parts and Planning Councils, CT DPH HIV, STD, and HCV Program, CT DPH Surveillance, Local Health Departments & Districts, Connecticut HIV Planning Consortium, HIV Funders Group, Syndemic Partners Group, New England AETC

PREVENT new HIV transmissions

This pillar and its objectives will help Connecticut achieve a goal of 55 people newly diagnosed with HIV in 2031. This represents the National HIV and AIDS Strategy goal of a 90% reduction of new HIV diagnoses from the 2017 baseline.

Objectives	Key Activities	Sample Performance Measures
P1. Increase the PrEP-to-NEED Ratio from 12 (2017) to 36 by 12/2031	• Academic detailing program for provider education • PrEP and PEP drug assistance program • Pilot projects to increase PreP and PEP uptake • Provider education and training on PrEP, PEP, and DoxyPEP • Public awareness campaigns	o # individuals trained as academic detailers o # providers completing academic detailing sessions o # providers attending PrEP, PEP, or DoxyPEP education and training sessions o # individuals accessing PrEP or PEP drug assistance program o # individuals who have received at least one PrEP prescription o # of individuals campaign reaches and total # of times campaign messages viewed by individuals
P2. Increase the number of individuals accessing Syringe Services Programs (SSP) from 9,500 (2017) to 11,000 by 12/2031	• Expand annual distribution of syringes • Quality improvement projects to increase SSP return rate or address concerns about syringe litter • Bi-annual SSP partner meetings with capacity building and training • Develop plan to connect HIV prevention partners with opioid overdose prevention partners • Public awareness campaigns	○ # syringes distributed and # syringes returned ○ # individuals accessing SSPs and # individuals accessing SSPs who are screened or tested and outcomes ○ # individuals accessing SSPs who are referred to services ○ # of quality improvement projects and outcomes ○ # of opioid overdose prevention task forces or partners ○ # of individuals campaign reaches and total # of times campaign messages viewed by individuals ○ # of overdose deaths
P3. Increase condom distribution statewide by 10% by 12/2031 from a baseline of 61,274 through SSPs in 2021	• Study condom accessibility in communities with high concentrations of STIs • Develop statewide condom distribution and monitoring plan • Develop sexual health module for academic detailing program • Expand condom distribution options in communities with unmet need	o # condoms distributed by publicly funded prevention contractors o # individuals accessing STD screening and testing o # providers completing academic detailing sessions o # of community partners (e.g., schools, youth programs) that expanded condom distribution options o # of individuals campaign reaches and total # of times campaign messages viewed by individuals [see Objective P2, Activity 5] o # of sexually transmitted diseases (STDs) including chlamydia, syphilis, and gonorrhea

PREVENT Pillar: Brief Explanation Behind Objectives and Rationale for Key Activities

Objective P1. Increase the PrEP-to-NEED Ratio from 12 to 36 by 12/2031

General Approach. The PrEP-to-Need Ratio (PnR) is a public health metric used to measure how well the use of HIV pre-exposure prophylaxis (PrEP) aligns with the actual need for prevention within a specific population or geographic area. A lower PnR indicates an unmet need with uneven access to PrEP by populations as identified through ongoing surveillance and epidemiologic review.

Key Activities. Highly effective medicine to prevent HIV exists. However, uptake remains low because of high costs, lack of provider knowledge, and low public awareness. The primary goal of these activities is to make HIV prevention tools like pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) easier to get, more affordable, and better understood by both doctors and the public. Together, these steps move HIV prevention from a specialized service to a standard, accessible part of everyday healthcare.

Key Partners. CT DPH, CT DPH funded partners, Local Health Departments & Districts, Healthcare providers, New England AETC, CHPC, Ryan White Parts and Planning Councils, Syndemic Partners Group, Community-based organizations, Media partners

Objective P2. Increase the number of individuals accessing Syringe Services Programs (SSPs) from 9,500 to 11,000 by 12/2031

General Approach. Syringe Service Programs (SSPs) are highly effective community-based prevention programs that have been shown to reduce new HIV and Hepatitis C (HCV) cases by approximately 50%. SSPs act as a safe disposal point for used injection equipment. By taking contaminated needles off the street, they prevent others from accidentally or intentionally using them.

Key Activities. When someone has easy, no-cost access to new, sterile syringes, they are far less likely to share or reuse equipment. Sharing needles is a direct route for HIV transmission because it can transfer infected blood from one person to the next. SSPs are often a place where people who inject drugs feel safe and respected. This trust allows the programs to offer more than just needles, including HIV and hepatitis C testing, access to prevention services and resources, and referrals to other healthcare or treatment services.

Key Partners. CT DPH, CT DPH funded partners, Local Health Departments & Districts, CT DMHAS, Local Opioid Prevention Tasks Forces, CHPC, Ryan White Parts and Planning Councils, Community-based organizations, Media partners

Objective P3. P3. Increase condom distribution statewide by 10% by 12/2031 from a baseline of 61,274 through SSPs in 2021.

General Approach. Condom distribution and sexual health education are multi-purpose prevention tools that simultaneously prevent HIV, other STDs, and unintended pregnancies. Newer options like PrEP focus, specifically on HIV. However, condoms remain the cornerstone of broad sexual health because they "break the chain" of transmission for multiple infections at once.

Key Activities. Effective condom programming moves beyond simply handing out supplies; it creates a supportive environment where protection is available, accessible, and acceptable.

Key Partners. CT DPH HIV, STD, and HCV Program, CT DPH funded partners, Local Health Departments & Districts, CT DMHAS, Planned Parenthood of Southern New England, CHPC, Ryan White Parts and Planning Councils, Syndemic Partners Group, Community-based organizations, New England AETC

RESPOND to disease outbreaks and disparities

Other pillars (Diagnose, Treat, Prevent) focus on routine service expansion. The Respond pillar will help Connecticut identify and address spikes in transmission that could otherwise derail long-term National HIV and AIDS Strategy goals such as 95% knowledge of HIV status, 95% viral suppression, and ending the HIV epidemic.

Objectives	Key Activities	Sample Performance Measures
R1. Update syndemic outbreak and response plans annually	• Engage stakeholders to review current outbreak response and communication plans • Disseminate information on Plan	○ # community engagement sessions ○ # and type of partners engaged ○ # updates or modifications to outbreak response and communication plans ○ Review and reflection of after action reports
R2. Analyze surveillance data monthly to identify syndemic and single disease condition transmission clusters and outbreaks (monthly, ongoing)	• Use molecular epidemiology integration to identify rapid-transmission clusters • Use data to identify and engage outliers among providers reporting HIV+ labs • Develop pathways for community partners to identify pre-clusters or emerging outbreaks • Offer education and training to providers on reporting requirements	○ Lab volume for genotopic data by year ○ Cross communication system protocols ○ Data sharing agreements ○ Annual list of outlier labs ○ Process and protocols for communication of pre-cluster or emerging outbreaks ○ # participants completing provider education or academic detailing
R3. Provide resources and tools to 5 communities with high area deprivation index (ADI) scores to detect and respond to syndemic outbreaks	• Facilitate education sessions on use of area deprivation index • Identify and mobilize community partners to respond to outbreaks • Offer education and training on syndemic approaches	○ # ADI education and capacity building sessions ○ # communities developing action plans ○ # of participants attending education sessions (e.g., whole person care, syndemic approach) ○ # of community mobilizations in response to pre-cluster or response outbreaks ○ # individuals tested (outbreak response) and referred to treatment
R4. Disease Intervention Specialists or Partner Services contact 85% of newly diagnosed HIV positive individuals to engage them in Partner Services	• Monthly meetings with HIV prevention and surveillance teams • Create case events according to classifications • Conduct investigations of new cases as contact as needed • Review and share information about DIS and partners services	○ # monthly meetings ○ # cases investigated ○ # and % of individuals contacted ○ # annual reviews ○ # and type of quality improvement or system change projects

RESPOND Pillar: Brief Explanation Behind Objectives and Rationale for Key Activities

Objective R1. Review and update syndemic outbreak and response plans annually

General Approach. The purpose of a statewide syndemic and response plan for HIV, such as Connecticut's Ending the Syndemic Initiative, is to move away from treating HIV in isolation. Instead, it addresses HIV alongside the interconnected health and social issues—like STDs, Viral Hepatitis, and Substance Use Disorder (SUD)—that often cluster together in the same populations and geographic areas. The plan allows different state agencies (like the CT DPH) and community partners to align their funding, data systems, and staff. This reduces "siloed" work and makes the healthcare system more efficient.

Key Activities. Updating and reviewing the syndemic response plan is about shifting from a fixed, "top-down" strategy to a living document that evolves based on real-world feedback and emerging threats. The value of engaging partners through tools like community mapping and walking tours is that it provides "ground-truth" data that lab reports often miss. A response plan is only effective if the people responsible for executing it know exactly when and how to act. Regularly updating these plans—rather than waiting for a crisis—builds trustworthiness and preparedness.

Key Partners. CT DPH HIV, STD, and HCV Program, CT DPH Surveillance, Local Health Departments & Districts, Connecticut HIV Planning Consortium, HIV Funders Group, Syndemic Partners Group

Objective R2. Analyze surveillance data monthly to identify syndemic and single disease condition transmission clusters and outbreaks (monthly, ongoing)

General Approach. Analyzing surveillance data monthly provides a real-time early warning system that shifts public health from being reactive to proactive. Instead of waiting for annual reports, monthly analysis allows the Connecticut Department of Public Health (DPH) to spot sudden increases in infections (outbreaks) or overlapping health issues (syndemics) as they happen.

Key Activities. The surveillance system is only as good as the data it receives. Training providers ensures they understand what to report and how to do it quickly. Key activities create a blend of highly technical and community-led approaches. Predictive modeling uses multiple data to forecast where the next outbreak might occur, allowing resources to be moved before the numbers spike. Molecular surveillance analyzes the genetic "fingerprint" of the virus to identify rapid-transmission clusters. Community partners (like needle exchanges or outreach workers) often see changes on the ground weeks before they show up in lab data.

Key Partners. CT DPH HIV, STD, and HCV Program, CT DPH Surveillance, Local Health Departments & Districts, HIV prevention and care providers, Connecticut HIV Planning Consortium, HIV Funders Group, Syndemic Partners Group, New England AETC

Objective R3. Provide resources and tools to 5 communities with high area deprivation index (ADI) scores to detect and respond to syndemic outbreaks

General Approach. The Area Deprivation Index (ADI) ranks neighborhoods based on 17 indicators like income, education, and housing quality. Research shows that communities with high ADI scores often experience higher rates of infectious diseases because residents face more social and structural barriers to health (like poverty or lack of transportation). By focusing on the 5 most deprived communities, the Connecticut partners can proactively distribute tools—like testing kits and clinical education—where they will have the greatest impact on reducing health disparities.

Key Activities. Data is only useful if local leaders know how to read it. Educational sessions will teach community members how to use tools like ADI maps to "see" where their community is most at risk. This empowers them to advocate for their own needs and scope of participation. During an outbreak, speed is everything. Mobile units are essential because they physically move services—like Rapid ART or Syringe Services—to people who cannot easily get to a clinic. Mobilizing local partners ensures these units are staffed by familiar, trusted faces, which increases

community engagement. Training providers in this approach is critical for high-ADI areas, where a patient's Social Determinants of Health (SDOH) are often the biggest hurdle to staying in care and achieving viral suppression.

Key Partners. CT DPH HIV, STD, and HCV Program, CT DPH Surveillance, Local Health Departments & Districts, Ryan White Parts and Planning Councils, Connecticut HIV Planning Consortium, HIV Funders Group, Syndemic Partners Group, New England AETC

Objective R4. Disease Intervention Specialists or Partner Services contact 85% of newly diagnosed HIV positive individuals to engage them in Partner Services

General Approach. This objective intends to break the chain of transmission through rapid, professional intervention from individuals who can comply with patient confidentiality requirements. The Disease Intervention Specialists (DIS) will interrupt transmission by identifying and treating exposed partners who may be unaware of their status.

Key Activities. Regular meetings will ensure that the DIS and the data analysts (Surveillance) are in constant communication. Early contact facilitates "Rapid Start" treatment for the diagnosed individual and preventive options like PrEP for their negative partners, which is the most effective way to prevent new infections. Properly classifying and logging every case ensures that no one "falls through the cracks" and that the state has accurate data to measure its progress toward the 2031 goals. Before contacting a patient, DIS conduct investigations to understand the context of the diagnosis. This helps DIS identify potential "source" cases (people who may be unknowingly spreading the virus) and prioritize the most urgent contacts. DIS are uniquely trained to handle these sensitive conversations, helping patients navigate the difficult process of notifying partners while providing immediate referrals for testing, treatment, and support services.

Key Partners. CT DPH HIV, STD, and HCV Program, CT DPH Surveillance, Local Health Departments & Districts, Connecticut HIV Planning Consortium, Ryan White Parts and Planning Councils, HIV Funders Group, New England AETC

How the Plan Will Be Implemented and Monitored

Implementation. Connecticut will use the current partnership structure and Plan implementation approach (Section 2) with funding support for the CHPC from the CT DPH. This proven approach (a) supports communication, coordination, and collaboration of HIV-related planning groups, (b) includes opportunities for PWH and PWLE to participate in various ways (e.g., group members, focus groups), (c) encourages participation of new partners to support the syndemic approach and address social determinants of health, and (d) assembles the HIV Funders Group to address matters in areas such as policy, funding, service delivery, capacity building, and surveillance systems.

Monitoring. The CHPC, in collaboration with Plan partners, will coordinate a process to monitor progress on Plan goals and objectives. CHPC meetings will be used to share information on Plan indicators, discuss accomplishments and barriers, and to update the Plan as needed.

Baseline (2023) and Alignment with NHAS Goals

Indicator	CT Baseline (2023)	NHAS Goal
New HIV Diagnoses	246	55
Knowledge of HIV Status	92.2%	95%
Linkage to Care (% newly diagnosed who attended a routine HIV care visit within 1 month of diagnosis	83.0%	95%
Viral Load Suppression (% of PWH in care who are virally suppressed)	90.7%	95%

Source: Connecticut HIV Epidemiology Update to the CHPC, September 2025

Refer also to Appendix 1 for example performance measures and milestones for each Plan objective.

Evaluation. The CHPC and its partners will review indicators and reflect on plan progress each year. The CHPC will continue best practices for supporting collaborative planning groups such as (a) collecting data on participant experience and satisfaction at every meeting, and (b) developing annual work plans (e.g., various groups, CHPC committees) and reviewing progress (planned vs. actual). As indicated, more in-depth evaluations may be conducted for key activities in the Plan.

Improvement. The Plan includes an overarching goal of using data to action and using a collaborative public health planning model to support Plan implementation, monitoring, and course corrections to the Plan as well as to the planning structure and process(es).

Reporting and Dissemination. A variety of methods will be used to inform partners, collaborators, and the general public about progress made to the Plan. Information will be shared at CHPC meetings, posted to the CHPC website, and disseminated widely (e.g., newsletters, listservs, social media, conferences).

Letters of Concurrence from Required Partners

Planning groups reviewing the Plan and providing a letter of concurrence (agreement) will include:

- Connecticut HIV Planning Consortium (includes representation from HIV prevention and care partners including Ryan White Part A, B, C, D, F, and other key stakeholders including persons with HIV)
- Ryan White Part A Planning Council - Hartford and Tolland Counties Transitional Grant Area
- Ryan White Part A Planning Council – New Haven and Fairfield Counties Eligible Metropolitan Area
- Connecticut Department of Public Health Prevention Programs
- Connecticut Department of Public Health Ryan White Part B
- HIV Funders Group

These groups will review another version of the Plan – including and revisions to content in Section 5 that was gathered through the public comment process prior to voting to approve the Plan.

Excerpts from Other Technical Sections of the Full Plan

The HIV partners have used a data driven approach to develop the Plan. The following pages provide examples of the data used in the Plan development process and the type of information that will be included in the full technical Plan submission.

- Current data about HIV
- The HIV care continuum
- Needs assessments, service and resource inventory, and gap analyses
- Progress on the 2022-2026 Plan including statewide indicators
- Connecticut's syndemic approach

Additional information is shared and discussed regularly at the Connecticut HIV Planning Consortium. Visit www.CTHIVplanning.org for more information about the CHPC or to see the current Plan (2022-2026) or e-mail CHPC@xsector.com.

The Plan Takes Into Consideration the Current Data about HIV

The Connecticut Department of Public Health (CT DPH) publishes a statewide HIV Epidemiology Surveillance Update at least every three years. CT DPH data experts present information to the CHPC specific to progress on Plan indicators as a part of the annual process to monitor the Plan.

- HIV prevalence and incidence concentrates in the 10 largest urban areas.
- HIV disproportionately affects Black/African American and Hispanic/Latino populations.
- Most people living with HIV are age 55 or above. However, most new HIV diagnoses are occurring in younger individuals.
- Late Testers in newly diagnosed persons with HIV are more likely to be above age 55 with HIV transmission through heterosexual contact or injection drug use.

Incidence is the number of people who **develop** a condition during a specific time. It measures the **risk** of getting a disease

Prevalence is the **total number** of people who **have** the condition at a specific point in time, regardless of when it started. It measures the **total burden** of the disease on a population.

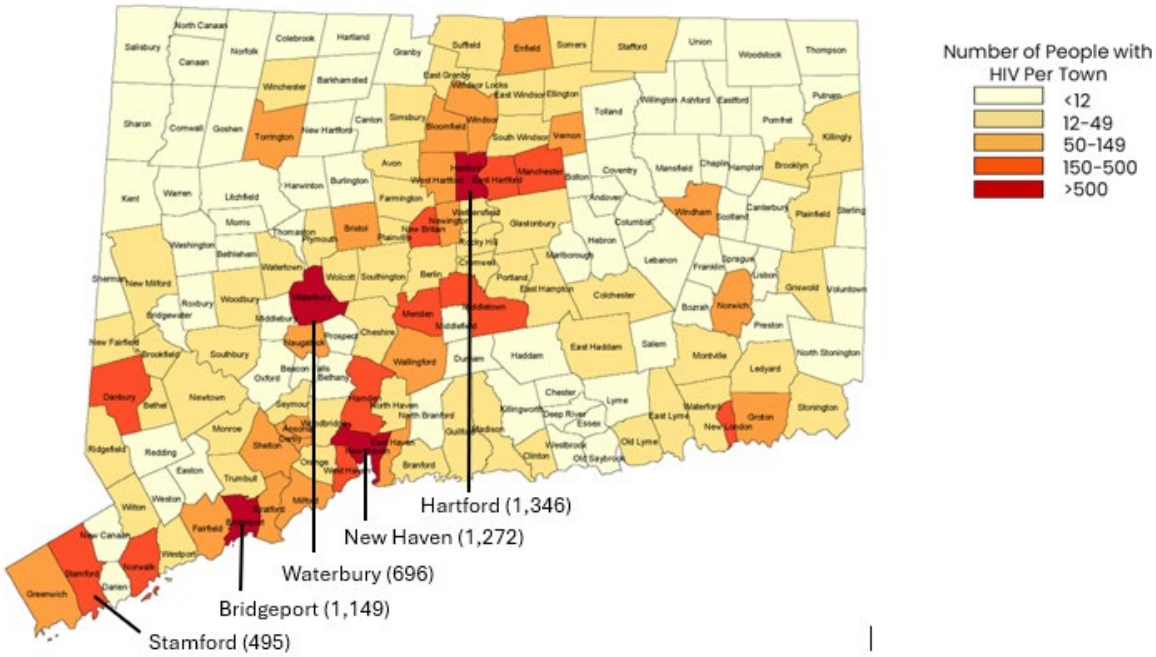
Snapshot of HIV Prevalence (2023) and Incidence (2019-2023) in Connecticut

Description	Prevalence (2023)	Incidence (2019-2023)
Total Number of PWH	10,814	1,094
Male Sex at Birth	67%	77%
Race / Ethnicity		
Black/African American	33%	36%
Hispanic/Latino	36%	35%
White	28%	25%
Age		
<24	2%	17%
25 -34	10%	37%
35-44	14%	20%
45-54	20%	13%
55+	54%	12%
Transmission Category		
MSM	35%	56%
Heterosexual Contact	28%	28%
IDU	22%	6%
Viral Suppression (PWH in Care)	91%	74%

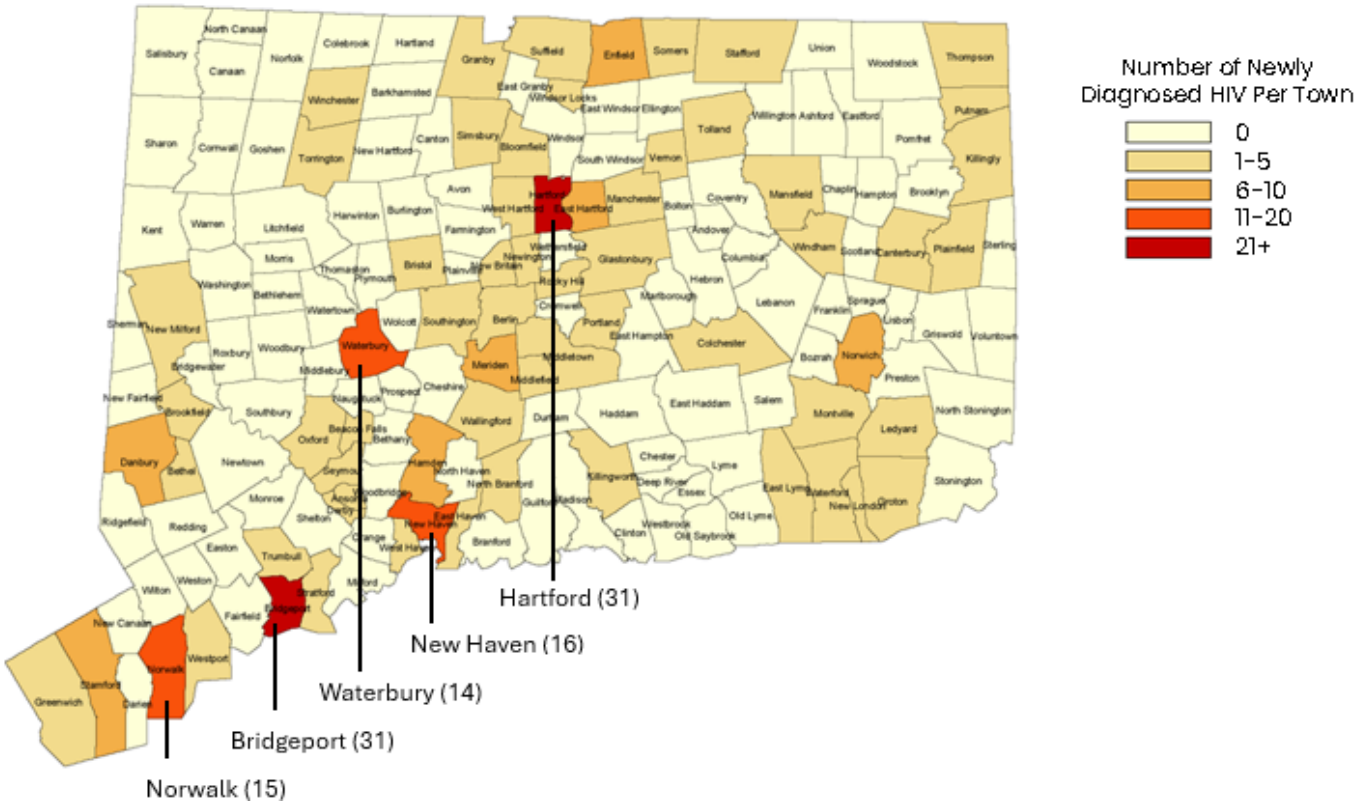
Source: Connecticut Department of Public Health, 2025

The Plan Considers HIV Prevalence and Incidence Across the State

HIV Prevalence or Total Cases in Connecticut (2023)



HIV Incidence or New Cases in Connecticut (2023)



The Plan Takes into Consideration Data on the HIV Care Continuum

The **HIV care continuum** is a public health model that maps the journey of a person living with HIV from their initial diagnosis through to successful treatment. The continuum approach helps to identify gaps and ensures that patients receive the full benefit of modern medicine. The journey includes

Diagnosis. An individual receives a positive HIV test confirmed by a healthcare provider. Knowing one's HIV status is essential for starting the care process.

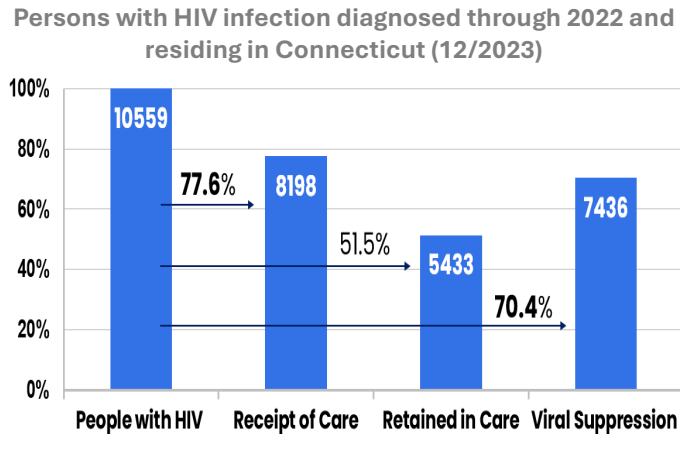
Linkage to Care. Persons diagnosed with HIV should be connected with a specialists HIV healthcare provider within 30 days – and ideally sooner, to begin medical evaluations and start treatment.

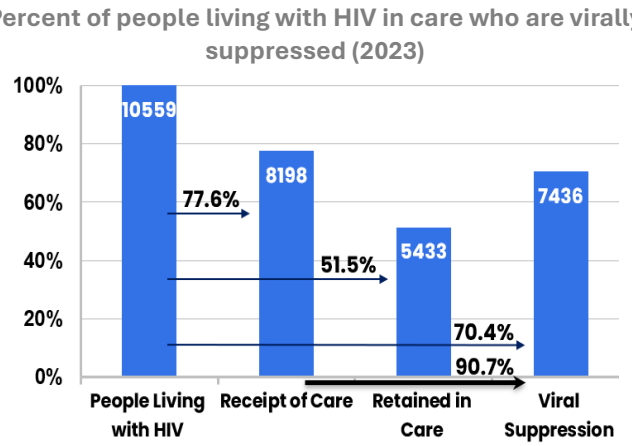
Receipt of Care. This stage means that the person with HIV has actively started medical care, usually marked by having at least one medical visit and lab tests.

Retention in Care. Retention mean staying engaged with regular medical appointments and monitoring over the long term for this lifelong condition.

Viral Suppression. The ultimate goal of treatment is for the amount of HIV in the blood to become so low that it is "undetectable" by standard lab tests.

The figures show the HIV Continuum of Care and viral suppression for **persons with HIV diagnosed through 2022 and residing in Connecticut at the end of 2023**. Of the total persons living with HIV, nearly 78% received care in 2023.[4] However, only 51.5% were retained in care, in part explained by persons with HIV not seeing their HIV care provider more than once per year because their health status remains stable. Once engaged, over 70% achieved viral suppression.





Nearly all **newly diagnosed patients** are eventually linked to care within 12 months, ranging from 94% to 97%, the percentage linked within one month has remained lower and relatively flat, between 81% and 85%.

[4]Receipt of care is measured by documentation of ≥1 CD4 or VL test during the calendar year. Retention in care is measured by documentation of ≥2 CD4 or VL test at least 3 months (≤91 days) apart in the calendar year. Viral suppression is defined as a viral load result below 200 copies.

The Plan Takes Into Consideration Prevention and Care Needs Documented Through Needs Assessments and Service and Resource Inventories

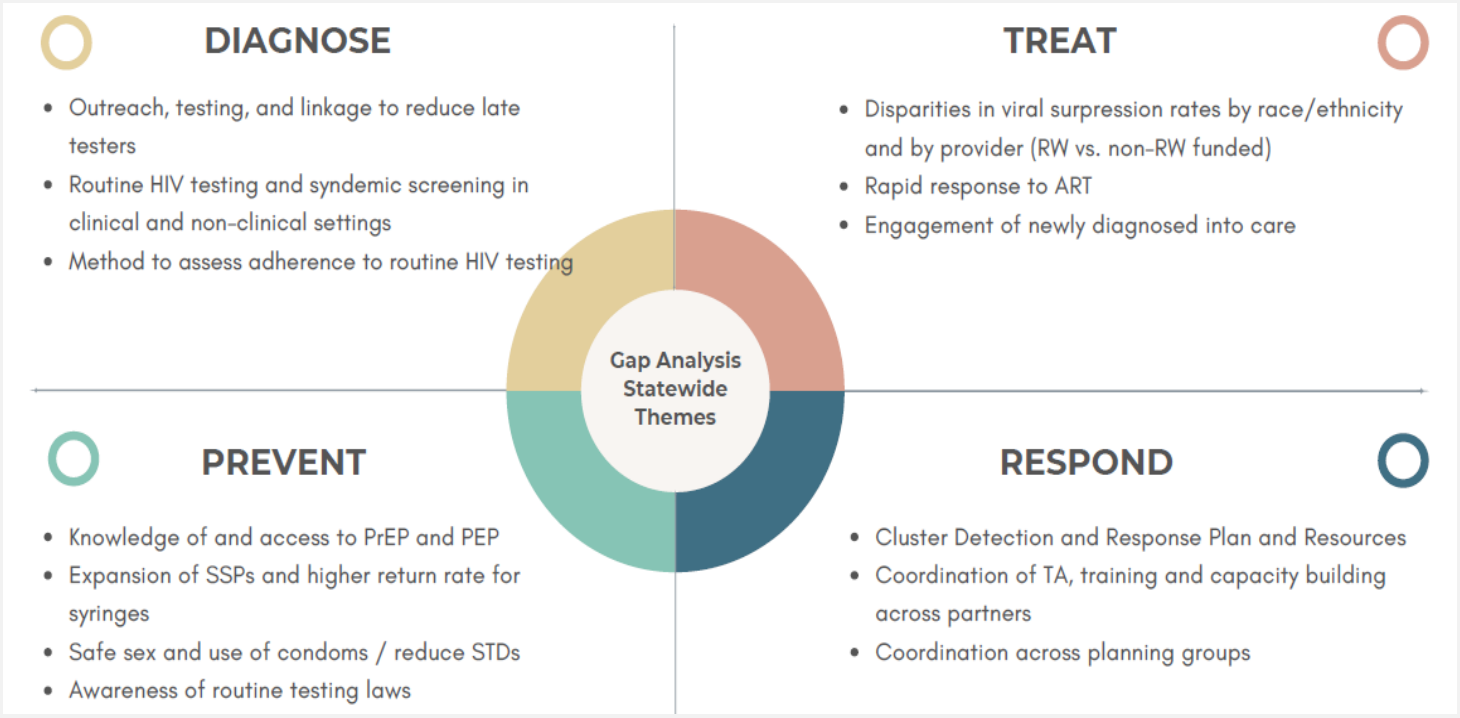
The HIV planning groups and partners reviewed many data sets to understand the needs, challenges, and gaps in the HIV prevention and care service system. The table shows examples of the different types of data sets and assessments used to guide the Plan development.

Contributing Data Sets and Assessments to Inform Development of Connecticut's Plan

HIV Surveillance Update (2025)	Statewide HIV Prevention Needs Assessment (2023)
HIV Resources Inventory (2025)	Statewide PWH Needs Assessment Survey (2025)
HIV Services Inventory (2026)	Statewide HIV Workforce Survey (2025)
SWOT Analysis (2025, 2026)	Review of 2022-2026 Plan Indicators and Progress (2025)
GAP Analysis (2025, 2026)	Review of RWB Expenditures & Service Utilization (2025)
Special Studies and Planning & Priority Setting by RWA Planning Councils in the EMA and TGA or Other Partners	

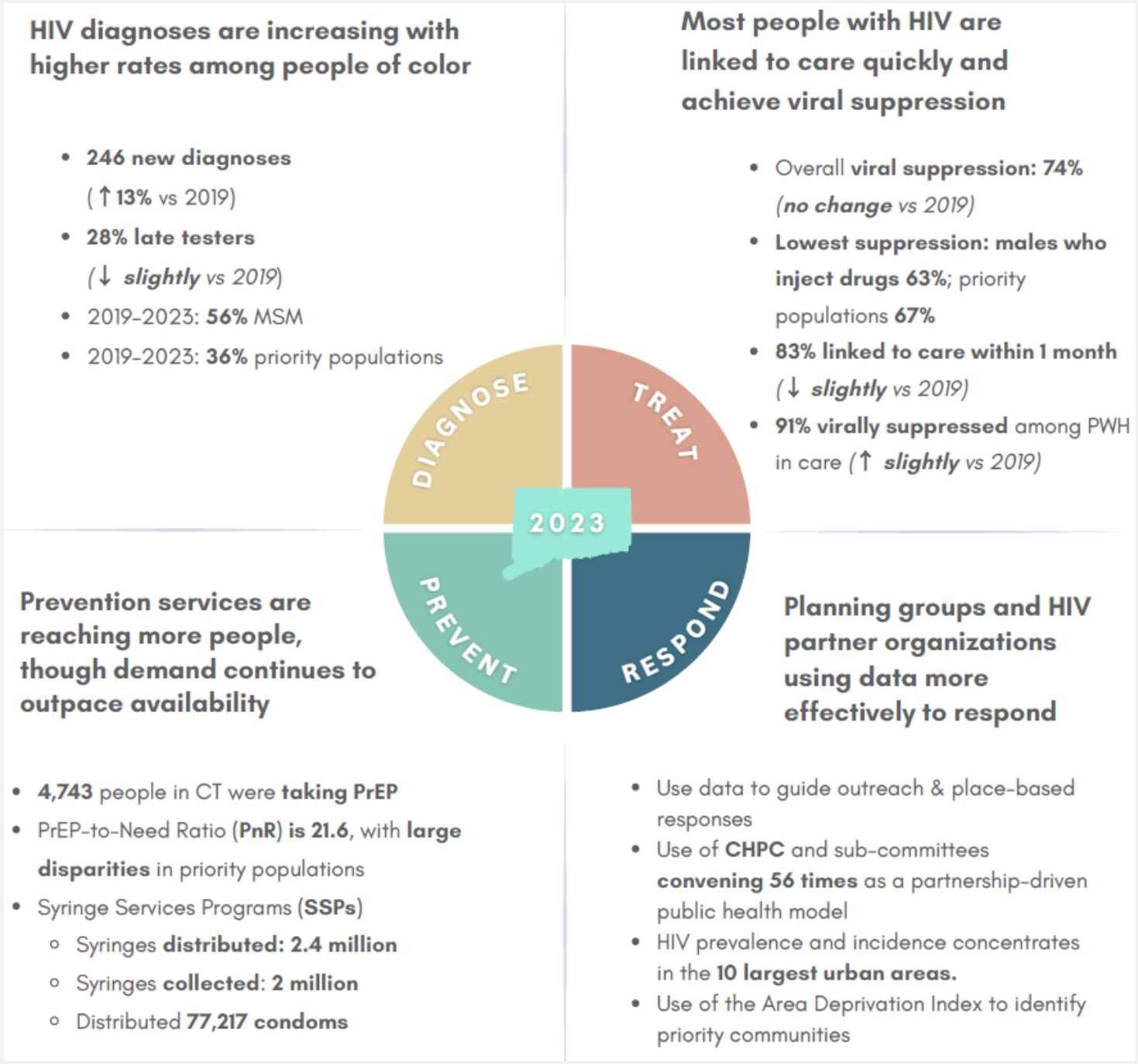
The information was collected over several years and shared with the HIV planning groups. The information helped provide reference points for discussions about prevention and care needs and gaps. The figure shows a high-level summary of statewide gaps by Plan pillars.

High-Level Summary of Statewide Gap Analysis by Plan Pillar



The Connecticut HIV Planning Consortium coordinates information sharing and review progress related to implementation of the statewide HIV Plan. The figure illustrates key data points by Plan pillar.

Summary of Key Data Points by Plan Pillar



The Plan Takes into Consideration the Progress on the 2022-2026 Plan

The Connecticut HIV Planning Consortium reviews monitors progress on the Plan each year. In addition to identifying accomplishments, the CHPC reviews a list of statewide indicators to understand how key activities are or are not contributing to achieving the bigger goals identified in the National HIV and AIDS Strategy. The table on the next page summarizes Connecticut's indicators from the review conducted in November 2025. A summary report of accomplishments can be found on the CHPC website (www.CTHIVPlanning.org).

What's Happening Now? The group checked the progress in 2025.

- 6 goals have been finished successfully.
- 6 goals are still being worked on.
- 1 goal that was supposed to be completed by the end of 2024 wasn't finished in time and the planning group agreed to extend the timeline to complete this activity by 12/2026.

How are we doing? Here are some updates on our progress in 2025.

- New cases of HIV: The goal was 174, but there were 226 new cases.
- Knowing your status: Most people with HIV (92.2%) know they have it. The goal was 95%.
- Treatment working: 74% of people with HIV are getting treatment that works well. The goal was 87%.
- Syringes given out: The program gave out 2.47 million clean syringes, meeting its goal.
- Drug overdoses: The number of overdose deaths went down in 2024 to 990 in (from 1,338 in 2023).

Accomplishments. Many good things have happened (see sidebar). For example,

- A new law means doctors should offer HIV and Hepatitis C tests more often.
- We've spread information and toolkits to over 18,000 healthcare workers to help them test more people.
- A new law allows mobile pharmacies to help people get medicine easier.

Building on Success: Examples of Accomplishments from the 2022-2026 Plan

- Connecticut passed legislation that mandates the offer of routine HIV testing and HCV screening
- HIV prevention and care partners developed a "syndemic screener" tool and began to pilot its use
- Connecticut conducted its first-ever statewide HIV prevention needs assessment
- RW Part As, Bs, Cs, and Ds report viral suppression rates for clients well above 90%
- The Syndemic Partners Group and CHPC are developing models to strengthen regional and local referrals
- CT DPH restructured HIV prevention and care funding around regional leads and networks
- CT DPH introduced forums for prevention (Prevention Power Hour) and care (Crimson Table Talks)
- CT DPH established a Viral Hepatitis Elimination Technical Advisory Committee which authored Connecticut's first HCV Elimination Plan and coordinates activities with CHPC

Connecticut Statewide Indicators and Status as of 2025

2022-2026 Plan Indicator	2019 Baseline	Original 2026 Goal	NHAS Goal	Status as of 2025[5]
PrEP-to-Need Ratio: The number of people taking PrEP divided by the number of people newly diagnosed with HIV	12.0	36.0	N/A	21.6
New Diagnoses: Number of people newly diagnosed with HIV	220	174	55	246
Knowledge of HIV Status: Percent of PLWH aware of their status	91%	93%	95%	92.2%
Late Testers: Percent of people presenting with or diagnosed with AIDS within 3 months of their initial HIV diagnosis	29%	20%	N/A	28% late testers
Linkage to Care: Percent of newly diagnosed who attended a routine HIV care visit within 1 month of diagnosis	87%	90%	95%	83%
Partner Services: The percentage of newly diagnosed clients interviewed by DIS / Partner Services	73%	8% increase	N/A	*data update in process
Viral Load Suppression: Percent of people with diagnosed HIV who are virally suppressed Percent of PLWH in care who are virally suppressed	74% 90%	87% 95%	95% N/A	74% PWH 90.7% PWH in care
Disparities in New Diagnoses: Annual number of new HIV diagnoses among: MSM, Black men and women, and Latino men and Latina women	15% decrease	25% decrease	N/A	Black/AA: 33% decrease Male, 25% increase Female Hispanic/Latinx: 50% increase Male,157% increase Hispanic MSM: 5% increase
Disparities in Viral Load Suppression: Viral load suppression rates among: youth and young adults, injection drug users, MSM, Black men and women, and Latino men and women.	65% to 78% depending on population	85%+ for all populations	95%	Black/AA: 67% Male, 73% Female Hispanic/Latinx: 67% Male, 72% Female; Youth 13 to 24: 72.7% MSM: 74%; IDU: 66%
Syringe Services Program (SSP): Number of SSP clients served Number of syringes distributed	4,428 1.2 million	9,000 2.4 million	N/A	9,529 2.47 million
Sexually Transmitted Infections (STIs): Number of syphilis cases	210	204	N/A	482
Hepatitis C: Number of newly diagnosed chronic Hep C infections	1,309	1,178	N/A	622
Substance Use: Number of overdose deaths Total number of overdoses (ED Visits for suspected overdoses)	1,528 (2021) 12,000 (approx.)	1,750 13,950	N/A	990 in 2024 (down from 1,338 in 2023); 10,500 Suspected drug OD ED visits 8/1/2024 to 7/31/2025

[5] Data provided by CT DPH uses most recent, validated data sets from 2023. Presentations occurred in July and September 2025 at the CHPC main meetings.

The Plan Addresses Related Disease Conditions of Sexually Transmitted Diseases (STDs), Hepatitis C (HCV), and Substance Use Disorder (SUD)

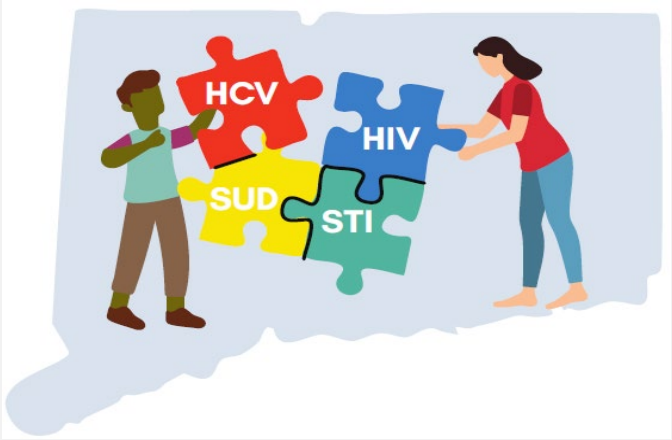
The **syndemic approach** is a way of looking at health that moves beyond treating one disease at a time. It recognizes that certain health conditions—like HIV, STDs, Hepatitis C, and substance use—don't just exist side-by-side; they interact, overlap, and make each other worse. A syndemic involves three things happening at once.

Clustering. Two or more disease conditions can affect the same group of people at the same time.

Interaction. The conditions interact with each other. For example, substance use can make it more difficult to take HIV medication, or an untreated sexually transmitted infection can make it easier for HIV to spread.

Social Context. Issues like poverty, stigma, or lack of healthcare can fuel the diseases within specific communities.

Connecticut's Syndemic Focus on 4 Related Disease Conditions



The term "syndemic" was first coined in Hartford, Connecticut in the early 1990s by researcher Merrill Singer who observed a cluster of substance misuse, violence, and HIV.

Data examples of the syndemic in Connecticut include

- Approximately 21% of people living with HIV also have HCV. Among people with HIV who inject drugs, this co-infection rate jumps significantly to above 60%. A cure exists for HCV!
- Among men who have sex with men, 21% of those diagnosed with syphilis were also co-infected with HIV.
- Recent studies in emergency departments show that over 54% of patients presenting with HIV risk reported at least three overlapping issues such as mental health struggles, substance use, and unmet basic needs like housing or food.

A syndemic approach focuses on the **whole person**. Connecticut's Plan takes into consideration ways to expand this whole person approach by

- Integrated HIV, HCV, STD, and SUD screening and testing at Syringe Service Programs as well as in clinical and non-clinical settings.
- Helping providers understand the treatment options and healthcare resources available to their patients in their communities.
- Partnering with other groups to address root causes affecting health and mental health such as housing, food, employment, and transportation.
- Using data to identify geographic areas facing higher disease burdens.