

Connecticut Integrated HIV Prevention and Care Plan 2022 to 2026

Annual Review and Plan Update

November 2025

Summary

See pages 2 to 5 for a more technical, detailed report

What is the Plan? Connecticut has a plan (2022-2026) to help stop the spread of HIV and help people who have it. Every year, a group called the **Connecticut HIV Planning Consortium (CHPC)** checks how well the plan is working.

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.

The group decided to change the end date for that one objective (2.2) to the end of 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. 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.

Looking Ahead. The CHPC is already thinking about the next plan (for 2027 to 2031). They want to make sure they focus on four main areas: **Treat, Diagnose, Respond, and Prevent**. They also want to make sure they keep working on goals that weren't met this time.

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Technical, Detailed Report

Purpose. The federal government approved the Connecticut Integrated HIV Prevention and Care Plan 2022 – 2026 with the provision that the planning group(s) (1) monitor the Plan and document accomplishments and progress (actual vs. planned) and (2) update the Plan annually to reflect any mid-course adjustments.

Monitoring and Review Process. The Plan contains a set of statewide indicators that correspond to the Plan goals, objectives, and key activities. Each year, the CHPC (1) reviews progress on statewide indicators, and (2) compiles accomplishments related to implementation of key activities identified in the Plan.

The CHPC reviewed progress on statewide indicators at its regular meetings in July and September, and accomplishments at its November meeting.

- **Exhibit 1** (page 3) shows the status on statewide indicators (baseline vs. goal) as of data available in 2025.
- **Exhibit 2** (pages 4-5) shows the updated goals and objectives as well as examples of accomplishments. To date:
 - 6 Plan objectives have been achieved.
 - 6 Plan objectives remain in process through December 31, 2026.
 - 1 Plan objective currently in process was not achieved in the anticipated time frame by December 31, 2024.

Vote to Update the Plan. Upon review of the Plan progress, the CHPC Executive Committee introduced a motion to change the end date of the objective that was in process and was not achieved in the anticipated time frame. **The CHPC discussed the matter and voted unanimously to approve the change.** Specifically,

Objective 2.2. By 12/31/2026, develop a clinical provider inventory that lists capacity and capability to support referrals generated from routine HIV testing campaigns and update this inventory on an annual basis.

Looking Ahead to the 2027 – 2031 Plan. The CHPC identified other considerations during the Plan review that will inform the development of the 2027 – 2031 Plan.

- Organize around the four pillars (i.e., Treat, Diagnose, Respond, Prevent) any ongoing 2022 – 2026 Plan activities that will continue as part of the 2027 – 2031 Plan
- When setting measurable objectives and benchmarks for performance measures:
 - Continue to address areas not yet achieved in 2022 to 2026 Plan performance measures.
 - Factor in uncertainty and disruptions that may occur in service delivery and access by priority groups due to changes in funding (e.g., eligibility for services).
- Revisit feasibility of including objectives related to stigma measures and social determinants of health based on lessons learned during 2022 - 2026.

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Exhibit 1. Statewide Indicators and Status as of 2025

2022-2026 Plan Indicator	2019 Baseline	Original 2026 Goal	NHAS Goal	Status as of 2025 ¹
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	226
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	<u>Black/AA:</u> 33% decrease Male, 25% increase Female <u>Hispanic/Latinx:</u> 50% increase Male, 157% increase Hispanic <u>MSM:</u> 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%	<u>Black/AA:</u> 67% Male, 73% Female <u>Hispanic/Latinx:</u> 67% Male, 72% Female; <u>Youth 13 to 24:</u> 72.7% <u>MSM:</u> 74%; <u>IDU:</u> 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

¹ 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.

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Exhibit 2. Updated Plan Goals & Activities & Examples of Accomplishments

Goal 1. Reduce New HIV Infections by 2026 (2019 baseline of 220).

Obj 1.1 By December 31, 2026, increase awareness of PWH who know their HIV status to 93%.

Obj 1.2 By December 31, 2026, decrease new HIV diagnoses among MSM, Black men and women, and Latino men and women by 25%.

Obj 1.3 By December 31, 2026, expand treatment as prevention by developing and conducting a minimum of two (2) awareness campaigns for priority subpopulations (Men who have sex with Men-MSM, Injection Drug Users, Transgender, Latina/o young men) using new or existing (e.g., PrEP, U=U) resources.

Examples of Goal 1 Accomplishments

- Connecticut passed legislation that mandates the offer of routine HIV testing and HCV screening
- Connecticut and partners implemented an expansive Tell Everyone to Screen and Test (TEST CT) campaign
- CT DPH and partners expanded PrEP navigation services and access to PrEP
- CT DPH Syringe Service Programs and Harm Reduction Services use Data to Action methods to reach at-risk populations

Goal 2. Achieve an increased viral load suppression rate among PWH who are in care by 2026 (vs. 90% in 2019) and an increased viral load suppression rate among people with diagnosed HIV (vs. 74% in 2019).

Obj 2.1 By December 31, 2026, the percentage of newly diagnosed PWH who attend a routine HIV care visit within 1 month of diagnosis increases from 87% in 2019 to 90% in 2026.

Obj 2.2 By December 31, 2024, develop a clinical provider inventory that lists capacity and capabilities to support referrals generated from routine HIV testing campaigns and update this inventory on an annual basis.

Obj 2.3 By December 31, 2026, DPH-funded providers will document referral mechanisms and scale effective approaches to facilitate the referral process to increase access by 10% for PWH to supportive services.

Obj 2.4 By December 31, 2026, conduct a minimum of two (2) studies to better understand issues or system breakdowns or bottlenecks to help increase housing and shelter access for non- or low-income individuals and housing stability for PWH, including employment or employability options.

Examples of Goal 2 Accomplishments

- RW Part As, Bs, Cs, and Ds report viral suppression rates for clients well above 90%
- CT DPH RW Part B updated its Continuous Quality Management (CQM) Plan
- CT DPH RW Part B convenes quarterly CQM meetings with funded partners
- CT DPH RW Part B introduced updated QM Alert functionality to its data system
- CHPC hosts an annual Quality Summit that focuses on improving health outcomes and field building
- CT DPH Disease Intervention Specialists engaged persons who were not in care (Data to Care)
- Connecticut health providers expanded knowledge of and access to long-acting injectable treatment options
- The Syndemic Partners Group and CHPC are developing models to strengthen regional and local referrals

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Goal 3. Reduce HIV-related disparities and health inequities.

- Obj 3.1** By December 31, 2025, define and incorporate at least one (1) stigma and discrimination indicator(s) to add to the CHPC indicator list.
- Obj 3.2** By December 31, 2025, expand CHPC membership by 10% to include partners representing statewide and/or regional SDOH initiatives and efforts.
- Obj 3.3** By December 31, 2026, coordinate a minimum of five (5) trainings with DPH funded providers to Implement a syndemic approach within organizations that focus on sexually transmitted infections, viral hepatitis, and substance use disorders (and behavioral health).

Examples of Goal 3 Accomplishments

- CHPC, in partnership with AETC, coordinated a series of training and professional development offerings related to social determinants of health and syndemic approaches
- CHPC hosted conversations on housing and developed a resource inventory
- CT DPH established a Syndemic Partners Group and coordinates activities with CHPC
- CT DPH and CHPC developed and disseminated a Routine HIV Testing Toolkit to 18,000+ healthcare providers
- CT DPH and CHPC developed a “syndemic screener” tool
- CT DPH and the CT Sexual Health Coalition developed and disseminated a Sexual Health is Health Toolkit
- The 2025 Connecticut Persons with HIV (PWH) Needs Assessment Survey contains a subset of questions from national research studies that assess stigma and discrimination
- Connecticut passed legislation to allow mobile pharmacy services to support an InMOTION mobile pharmacy and clinic pilot project

Goal 4. Achieve integrated, coordinated efforts that address the HIV epidemic across community partners and interested parties.

- Obj 4.1** By December 31, 2026, conduct at least 15 Connecticut HIV Planning Consortium meetings as a statewide HIV prevention and care planning entity.
- Obj 4.2** By December 31, 2026, meet at least 10 times with community partners to document the integration of HIV services with other areas of syndemic focus for inclusion in the Plan.
- Obj 4.3** By December 31, 2026, implement activities in the Integrated Plan and include outbreaks or public health emergencies relevant to HIV in the Integrated Plan.

Examples of Goal 4 Accomplishments

- CHPC meets regularly and convenes 4 working committees
- RWAs convene Planning Councils and support working committees to support planning and implementation
- CT DPH convenes the HIV Funders Group to coordinate statewide data projects
- 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 introduced Data to Action capacity building and technical assistance to help local partners identified syndemic-related Area Deprivation Index (ADI)
- CT DPH established a Connecticut Sexual Health Coalition and coordinates activities with CHPC
- CT DPH established a Viral Hepatitis Elimination Technical Advisory Committee which authored Connecticut’s first HCV Elimination Plan and coordinates activities with CHPC