Connecticut Integrated HIV Prevention and Care Plan 2027–2031

June 2026

DIAGNOSE

Increase HIV testing and identify all people with HIV as early as possible.

TREAT

Engage and retain people with HIV in care and achieve viral suppression.

PREVENT

Reduce new HIV transmissions through evidence-based prevention strategies.

RESPOND

Respond quickly to outbreaks and address health access.

Stronger Together. Healthier Connecticut.

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Frequently Used Acronyms

Acronym	Definition
ADAP	AIDS Drug Assistance Program
AETC	AIDS Education and Training Center
ADI	Area Deprivation Index
ART	Antiretroviral Therapy (ART)
+CADAP	Connecticut AIDS Drug Assistance Program
CDC	Centers for Disease Control and Prevention
CHC	Community Health Center
CHPC	Connecticut HIV Planning Consortium
CIPA	Connecticut Insurance Program Assistance
CMS	Centers for Medicare and Medicaid Services
CQI	Continuous Quality Improvement
CT	Connecticut
CT DMHAS	Connecticut Department of Mental Health and Addiction Services
CT DOC	Connecticut Department of Corrections
CT DPH	Connecticut Department of Public Health
CT DSS	Connecticut Department of Social Services
CT HFG	Connecticut HIV Funders Group
CT SHC	Connecticut Sexual Health Coalition
CT SPG	Connecticut Syndemic Partners Group
E2CT	Electronic Evaluation Connecticut
EFA	Emergency Financial Assistance
EHE	Ending the HIV Epidemic
EIS	Early Intervention Services
EMA	Eligible Metropolitan Area
ETS	Ending the Syndemic
FQHC	Federally Qualified Health Center
HCV	Hepatitis C Virus
HHS	United States Department of Health and Human Services
HIV	Human Immunodeficiency Virus
HOPWA	Housing Opportunity for Persons with AIDS
HRSA	Health Resources and Services Administration
IDU	Injection Drug Use
LHD	Local Health Departments / Districts
LTC	Linkage to Care
MPOX	Formerly known as the Monkeypox virus (MPXV)
MSM	Men Who Have Sex With Men
NAP	Needs Assessment Projects
NAS	Needs Assessment Survey
NHAS	National HIV and AIDS Strategy
OD2A	Overdose Data to Action
PACE	Public Awareness & Community Engagement
PC	Planning Council (Ryan White A)
PEP	Post-Exposure Prophylaxis
PrEP	Pre-Exposure Prophylaxis
PWH	Person With HIV
PWUD	Person Who Uses Drugs
PWLE	Persons with Lived Experience
QI	Quality Improvement
QPM	Quality & Performance Measures
RW	Ryan White
RWA	Ryan White Part A
RWB	Ryan White Part B
RWC	Ryan White Part C
RWD	Ryan White Part D
RWF	Ryan White Part F
SCSN	Statewide Coordinated Statement of Need
SDOH	Social Drivers of Health
SPG	Syndemic Partners Group
SPNS	Special Projects of National Significance
SPWUD	Services for Persons Who Use Drugs
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
SUD	Substance Use Disorder
TA	Technical Assistance
TB	Tuberculosis
TGA	Transitional Grant Area
VHETAC	Viral Hepatitis Elimination Technical Advisory Committee
VL	Viral Load
WICY	Women, Infant, Children & Youth

Section I. Introduction of Integrated Plan and Statewide Coordinated Statement of Need

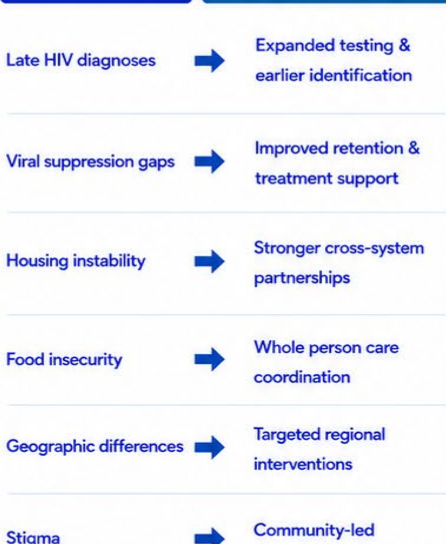
A UNIFIED VISION FOR 2027–2031

Connecticut's roadmap for Ending the HIV Epidemic through an integrated, whole person, and syndemic approach.

HIV	STDs	Substance Use Disorder	Hepatitis C	Social Drivers of Health
Integrated prevention and treatment	Coordinated sexual health response	Prevention services for PWUD and linkage to care	Expanded testing and treatment	Addressing housing, food, transportation, stigma, and more

THE FOUNDATION: STATEWIDE COORDINATED STATEMENT OF NEED (SCSN)

The SCSN is the analytical engine behind every goal in this Plan. It transforms data into action by identifying key needs and gaps.



KEY FINDINGS		HOW THE PLAN RESPONDS
Late HIV diagnoses	➡	Expanded testing & earlier identification
Viral suppression gaps	➡	Improved retention & treatment support
Housing instability	➡	Stronger cross-system partnerships
Food insecurity	➡	Whole person care coordination
Geographic differences	➡	Targeted regional interventions
Stigma	➡	Community-led service design

HOW THE INTEGRATED APPROACH WORKS

DATA → ACTION

SCSN findings directly drive priorities across the four Plan pillars.

DIAGNOSE	TREAT	PREVENT	RESPOND
Target late diagnoses	Close viral suppression gaps	Increase PrEP access	Health access
Expand HIV/HCV/STD testing	Improve linkage and retention in care	Reduce transmission risk	Strengthen outbreak response

COMMUNITY-DRIVEN PLANNING

People with HIV, providers, and community partners shaped every stage of development.

- People with lived experience
- Ryan White consumers and providers
- Community-based organizations
- Clinical providers
- Prevention specialists
- Public health leaders & regional partners

CONNECTICUT'S JURISDICTIONAL APPROACH

CONTINUOUS EVOLUTION

Building on success from the 2022–2026 Plan and using a syndemic approach.

UNIFIED STATEWIDE STRUCTURE

Coordinated by the Connecticut HIV Planning Consortium.

CLEAR, CONNECTED PLAN DESIGN

Easy to understand and organized to meet all federal requirements.

COMPLIANCE & TOTAL ALIGNMENT

- ✓ CDC Requirements Met
- ✓ HRSA Requirements Met
- ✓ Letters of Concurrence Included

1. Introduction

Describe the Integrated Plan

Connecticut's 2027–2031 Integrated HIV Prevention and Care Plan is more than a strategic plan; it is a living document that evolves to meet the needs of people in the state of Connecticut. This Plan represents a bold "refresh" of our previous roadmap, taking the lessons learned from 2022–2026 and sharpening them into a highly-focused, person-centered movement. By aligning our state's deep-rooted expertise with the national Ending the HIV Epidemic (EHE) pillars, Connecticut is moving from managing the epidemic to ending it.

Since 2017, Connecticut has pioneered a unified approach to HIV care. This 2027–2031 update continues that storyline by merging the latest data from our Statewide Coordinated Statement of Need (SCSN) with real-world feedback from the people and communities disproportionately impacted by HIV. The process continues to evolve. Connecticut has taken the existing infrastructure and modernized it to address the "syndemic" nature of health—recognizing that we cannot defeat HIV without simultaneously tackling the interconnected challenges of STDs, HCV, and SUD.

The 2027-2031 Plan uses the four national pillars to end the HIV epidemic to organize objectives and activities tailored specifically for the unique landscape of Connecticut:

> **Diagnose.** Routine HIV/HCV testing laws pave the way for Connecticut to find undiagnosed individuals. By expanding routine, opt-out testing in emergency rooms and rapid testing in community settings, we aim to also eliminate the late tester gap that has persisted for too long.
>
> **Treat.** For those living with HIV, the Plan intends to close the viral suppression gap between patients served by the RWHAP funded service system and non-RWHAP service providers. Also, the Plan continues to shift the focus to removing the structural and system level barriers—like housing instability, transportation, and stigma—that prevent individuals from staying in care.
>
> **Prevent.** Connecticut's HIV partners continue to prioritize prevention and protection. By prioritizing long-acting injectable PrEP and expanding Doxy PEP, condom distribution, and services for persons who use drugs, access to prevention becomes more accessible to priority populations and communities.
>
> **Respond.** Connecticut continues to accelerate its reaction time to detect and respond to outbreaks by using innovative molecular surveillance and working closely with community partners to identify emerging clusters. This work applies a syndemic lens to end the HIV epidemic more effectively.

This Plan proves that Connecticut no longer operates in fragments. By synchronizing federal CDC and Ryan White funding into a single, cohesive engine that supports status neutral and whole person approaches to prevention and care services. Whether a person tests positive or negative, they are immediately connected to a pathway of support. This 2027–2031 Plan represents a pledge to move forward together, ensuring that in Connecticut, everyone has access to care and prevention services who need them.

Statewide Coordinated Statement of Need. Connecticut's HIV epidemic reflects higher rates of HIV in certain populations and geographic areas and persistent needs across the prevention and care continua. Key statewide needs include supporting earlier diagnosis, increasing consistent engagement in care and sustained viral suppression, strengthening provider education, and expanding access to prevention services such as routine testing and PrEP. Ongoing barriers—including variations in service availability, challenges navigating the service system, and workforce capacity constraints—limit timely and consistent access to prevention and care. Additional improvements are needed in coordination across programs, alignment of resources with areas of greatest need, and refinement of data systems to support effective monitoring and decision-making. Addressing these statewide needs will require

specific, data-informed strategies that enhance access, continuity, and overall service delivery across the HIV prevention and care systems.

a. Approach

The Plan development process represents a "refresh" and continuation of the existing 2022-2026 Plan.

b. Documents Submitted to Meet Requirements

The Plan meets all HRSA and CDC mandates, and individual sections correspond directly to the guidance. The next page contains a checklist and cross-references the sections by page number with Plan guidance.

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Insert checklist about here

after Plan approved

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Section II. Community Engagement and Planning Process

Connecticut built this plan through a **data-driven, community-first** process that meets all federal legislative and programmatic requirements (CDC and Ryan White Parts A & B). Led by the **Connecticut HIV Planning Consortium (CHPC)**, our process follows four core principles to ensure a unified, compliant, and effective response.

PRINCIPLES OF CONNECTICUT'S PLAN DEVELOPMENT PROCESS

DELIBERATE

Persons with HIV and lived experience and HIV resource partners lead the way in the Plan development process. The planning bodies mirror Connecticut's demographics, centering on people with HIV and those disproportionately impacted. This includes a broad representation from community leaders, healthcare providers, and housing and mental health specialists, among others.

DATA

Evidence drives our action. The Plan development process included updating a comprehensive Statewide Coordinated Statement of Need (SCSN), mapping current HIV trends, auditing available resources, and identifying gaps in the prevention and care continuum through surveillance data to ensure support goes where it is most needed.

DIALOGUE

This plan is rooted in 15 months of "the voice of the people." Through deep community engagement and public comment, we ensured that lived experience—not just statistics—informed every priority and strategy, including a role in cluster detection activities and outbreak response strategies.

DIRECTION

The result of the community engagement and planning process is Connecticut's 2027–2031 Plan (Section V). The CHPC will serve as the primary navigator for this roadmap and will continue to engage and coordinate Plan partners as well as provide ongoing oversight and updates to keep Connecticut on the path to ending the HIV epidemic (Section VI).

OUR 15-MONTH JOURNEY: FROM COMMUNITY INPUT TO ACTION

ENGAGE
Listen to the community through focus groups, listening sessions, surveys, and ongoing outreach.

ANALYZE
Use data to understand needs, trends, resources, and gaps.

INFORM
Center lived experience and public comment to shape priorities and strategies.

PLAN
Develop strategies that are evidence-based, community-informed, and federally compliant.

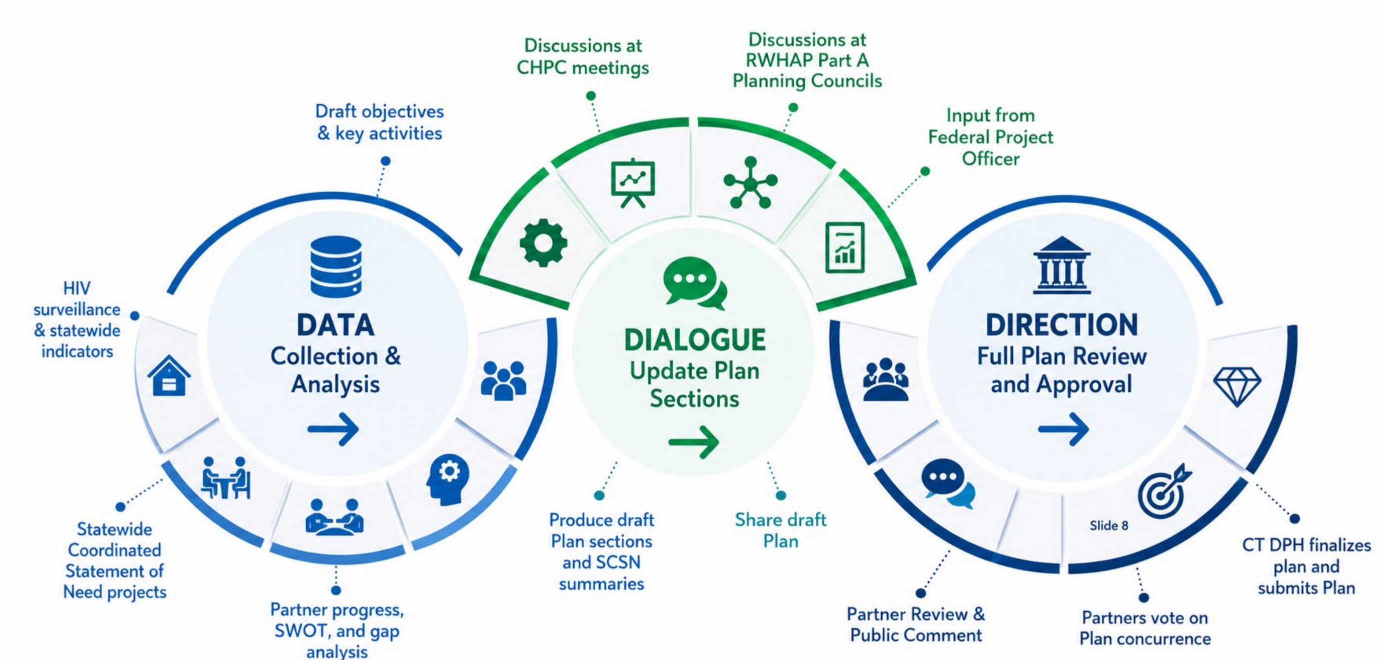
ACT
Implement, monitor, and update—together—on the path to an HIV-free Connecticut.

1. Jurisdiction Planning Process

Planning Steps

Figure II-1 shows the process used to develop Connecticut's 2027-2031 Plan over a 15-month planning period that began in April 2025. The formal plan development process was organized into three distinct phases: data, dialogue, and direction.

Figure II-1. Connecticut's Plan Development Process: April 2025 to June 2026



Groups Involved

The Connecticut Department of Public Health (CT DPH) relies on the Connecticut HIV Planning Consortium (CHPC) for overall coordination of the Plan development and monitoring process – including assistance in completing Statewide Coordinated Statement of Need (SCSN) projects and goal setting.

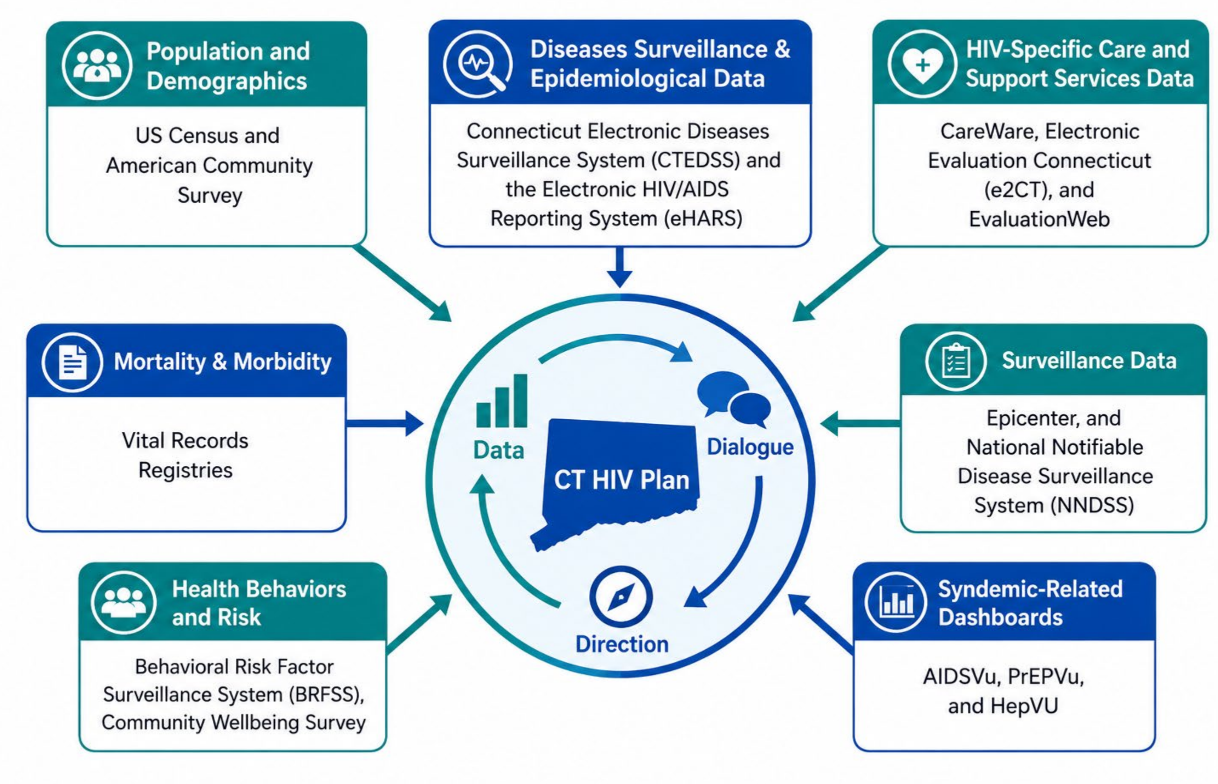
The CHPC serves as the primary advisory and coordinating body for the state's unified approach to ending the HIV epidemic. The CHPC brings together key stakeholders including persons with HIV, practitioners, representatives of other HIV planning groups and partners, and subject matter experts to develop and monitor a single, comprehensive plan for the entire state. By integrating the voices of people living with and most affected by HIV, the CHPC ensures that Connecticut's HIV-related resources are used effectively to ensure that every resident has access to high-quality prevention, testing, and treatment services regardless of where they live.

The 2027-2031 Plan development process represents a collaboration with other partners. Sections II.2, II.3, and II.4 describe other partners and entities involved in the Planning process.

Usage of Data Sources

The data-driven Plan development process relied on a wide variety of data sources related to population demographics, social factors, and health conditions including HIV, HCV, STD, and SUD. These data sources create a full picture of the epidemic in Connecticut and ensure that resources like testing and medical care are placed exactly where people need them most. A participatory planning process adds in the voices of persons with HIV and residents of communities facing higher incidence and prevalence of disease conditions as well as HIV prevention and care providers and partners. These data systems supported critical tasks such as annual monitoring the Plan. Figure II-2 describes data sources.

Figure II-2. Data Sources Use in the Development of Connecticut's HIV Plan



The Plan development partners collected data to complete Statewide Coordinated Statement of Need (SCSN) planning requirements such as (a) Statewide Prevention Needs Assessment Survey, (b) Statewide Persons with HIV Needs Assessment Survey, (c) Statewide Financial Resource Inventory, (d) Statewide HIV Services Resource Inventory, (e) Statewide HIV Workforce Needs Assessment Survey, and (f) program-specific reports for submission to the federal government or for use in program planning, management, continuous improvement.

Figure II-3 shows the connection of the data sources to the Plan development process. Section III describes the results and key findings related to these data sources.

Figure II-3. Data Sources and Connection to Plan Development Process

DATA
What We Learn

Multiple data sources give us a clear picture of the HIV landscape in Connecticut.

SCSN PROJECTS
1. Prevention Survey (n=2000+)
2. Persons with HIV Survey (n=1000+)
3. HIV Workforce Survey (n=200+)
4. HIV Services Resource Inventory
5. Epidemiological Profile
6. Annual Review of Current Plan and Progress on Statewide Indicators

DIALOGUE
How We Engage

We engage partners and communities in meaningful conversations to ensure diverse voices shape the plan.

CHPC MEETINGS (n=10)
1. Review Progress on Current Plan
2. Review Data Sets
3. Identify Gaps
4. Situational Analysis
5. Refine Goals, Objectives, and Key Activities
6. Approve Plan

PARTNER MEETINGS
1. RWHAP A Planning Council EMA
2. RWHAP A Planning Council TGA
3. HIV Funders Group
4. Syndemic Partners Group
5. RWHAP B CQM meetings

COMMUNITY ENGAGEMENT
1. Prevention Power Hour
2. Crimson Table Talks
3. Focus Groups and Community Conversation
4. Public Comment on Draft Plan

COMMUNICATION
1. CHPC listserv (600+)
2. CHPC website
3. Leadership Updates

DIRECTION
Where We're Headed

What we learn and hear guides our decisions to create an effective, community-informed HIV Plan.

CT HIV PLAN 2027–2031
A plan that reflects our data, our communities, and our shared commitment to ending the HIV epidemic in Connecticut.

Representation from People and Communities Disproportionately Impacted by HIV

Representatives from people and communities disproportionately impacted by HIV were included in several, meaningful ways.

- The CHPC membership (Figure II-4) and the RWHAP Part A Planning Councils require at least 33% of members to be persons with HIV and encourage individuals with lived experience (e.g., homelessness, justice-involved, sexually transmitted diseases, history with mental health or substance use). PWH and persons with lived experience hold leadership positions in these groups.

Figure II-4. Connecticut HIV Planning Consortium Membership (May, 2026)

We bring together a diverse group of partners and community members to ensure a comprehensive, patient-centered, and data-driven plan that reflects the needs of all communities.

RACIAL AND ETHNIC IDENTITY
- 56% African American / Black
- 25% Hispanic/Latino
- 28% White

AGE DISTRIBUTION
- 8% 18 to 34 years
- 36% 35 to 54 years
- 56% 55+ years

The central body that coordinates, collaborates, and guides the development of the Connecticut HIV Plan
2027–2031

LIVED EXPERIENCE
- 42% persons with HIV
- 64% reporting 2 or more lived experiences such as homelessness, mental health, substance use, STDs

HIV PARTNERS
- 40% affiliated with HIV prevention and care service providers
- 90% serving on other statewide, regional, or local planning or action teams

- The planning groups engage stakeholders from communities disproportionately impacted by HIV. The RWHAP Part A Planning Council's represent geographic areas that contain over 90% of persons with HIV. Section II.2 contains more information about entities involved in the process.

- The Statewide Coordinated Statement of Need (SCSN) projects were designed to amplify the voices of residents and persons with HIV through the statewide HIV Prevention Survey and Persons with HIV Needs Assessment Survey, respectively. Section III contains information about these projects.

- The Plan development process included an intentional design to engage the RWHAP Part A Planning Councils through (a) representation of individuals on multiple planning groups – CHPC, Planning Councils, and HIV Funders Groups, to ensure continuity and communication between and among groups, (b) structured time on the agendas of each planning group to discuss the Plan development process and partner updates, (c) use of planning group committees and membership to pilot SCSN data collection instruments, (d) additional community conversation and engagement sessions as needed – including engagement meetings held for funded care and prevention contractors of statewide networks such as CT DPH's Crimson Table Talks and Prevention Power Hour, and (e) a public comment period (April 2026) to gather feedback and suggestions on draft Plan goals, objectives, key activities, and performance measures.

By prioritizing leadership roles, inclusion of persons with HIV in planning groups, and statewide surveys, Connecticut's Plan development process has ensured that those most impacted by HIV have been included as primary architects of the state's strategy. This Plan is built by and for the community.

a. Entities Involved in the Process

Table II-2 illustrates the diversity of entities involved in the Plan development process. This list is not exhaustive. Section II.b describes the RWHAP Planning Councils, and Section II.C describes the role of other planning bodies and entities.

Table II-2. Examples of Entities Involved in the Plan Development Process or with Representatives on Planning Groups. This list is not exhaustive. An "*" Denotes REQUIRED partners

Type	Examples of Entities Involved
Public Health, Epidemiologists, Subject Matter Experts, Disease Intervention Specialists	Connecticut Department of Public Health*, Local Health Departments and Districts (e.g., New Haven*, Hartford*, Bridgeport, Waterbury, Stamford)
Community-based Organizations / Social Service Providers	APEX, Advancing CT Together, A Place to Nourish Your Health (APNH), Alliance for Living, CTHRA, Mid Fairfield AIDS Project, Family Centers, Greater Bridgeport Area Prevention Program (GBAPP), The Health Collective, Hispanic Health Council, Mercy Housing and Shelter, Hands on Hartford, Windham Regional Community Council, Chyrsalis Center, Human Resources Agency of New Britain
People with HIV / People with Lived Experience	Planning groups include requirements for 33% of members as persons with HIV and persons with lived experience; SCSN projects include a focus on involvement of PWH in the design of data collection instruments; results represent the voices of PWH and persons with lived experience (See Section II.e)
Healthcare and Medical Providers, HIV Clinical Care Providers	Anchor Health Initiative, Yale New Haven Hospital, Hartford Hospital Community Cares Center, Connecticut Children's Medical Center, The Health Collective, UConn Health, Planned Parenthood, Yale University Health Care Van

Table II-2. Examples of Entities Involved in the Plan Development Process or with Representatives on Planning Groups. This list is not exhaustive. An "*" Denotes REQUIRED partners

Type	Examples of Entities Involved
Community Health Care Centers	Community Health Centers, Inc., Community Health Services, Inc., Cornell Scott Hill Health Center, Fair Haven Community Healthcare, Generations Family Health Center, Optimus Healthcare, Southwest Community Health Center, Staywell Health Center, Community Health Center Association of Connecticut
Substance Use Treatment Providers	Connecticut Department of Mental Health and Addiction Services, Liberations Programs, Root Center for Advanced Recovery, Connecticut Counseling Centers, CTHRA
Jurisdictions with CDC Funded Programs	Connecticut Department of Public Health*, City of New Haven* (APNH), City of New Haven and City of Hartford receive Overdose Data to Action Local funding
Justice-involved Individuals	Approximately 10% of planning group members have been justice-involved, with a higher amount with lived experience related to justice-involved populations
Corrections or Law Enforcement	A member of the Department of Corrections attends CHPC meetings and works closely with CT DPH; a representative of a statewide transition and linkage to care program (for justice involved individuals)

b. Role of the RWHAP Part A Planning Council / Planning Body

The Ryan White Part A Planning Councils are essential partners in Connecticut's integrated approach, ensuring local priorities align with statewide goals. Both Connecticut jurisdictions formally committed to this unified plan, bridging the gap between city-level needs and state-level strategy. Figure II-5 illustrates the ways in which the CT DPH and CHPC support the integrated Plan development process.

Figure II-5. Coordination of RWHAP Part A Planning Councils and the CHPC

Strong partnerships and meaningful engagement drive our success.

COORDINATED PARTNERS

Working together to improve health, advance access, and end new HIV infections in Connecticut

COORDINATING PARTNERS

Build and engage a strong, network.

- Recruit new voices to regional and statewide groups
- Drive participation in communities of practice, networking forums and special events
- Integrate partners into SCSN and QI workflows

PEOPLE WITH HIV (PWH)

Center the voices and leadership of people with lived experience.

- PWH hold 33%+ of seats in regional and statewide planning groups
- PWH members serve in key decision-making roles
- SCSN and quality improvement projects include PWH

PEOPLE & COMMUNITIES DISPROPORTIONATELY IMPACTED BY HIV

Ensure our strategies reflect the needs of those most affected.

- Use data-driven surveillance to respond to emerging outbreaks
- Support engagement in planning groups
- Convene focus groups
- Design SCSN projects to maximize consumer voices

PROVIDERS & ADMINISTRATORS FROM DIFFERENT FUNDING STREAMS

Align resources and improve outcomes.

- HIV Funders Group assembles funding partners across prevention and care funding streams
- Annual update of HIV prevention and care services and funding inventory
- Reviews of service utilization, outcomes and needs/gaps

NEW PARTNERS

Expand our reach and strengthen collaboration.

- Recruit new voices to regional and statewide groups
- Drive participation in communities of practice, networking forums and special events
- Integrate partners into SCSN and QI workflows

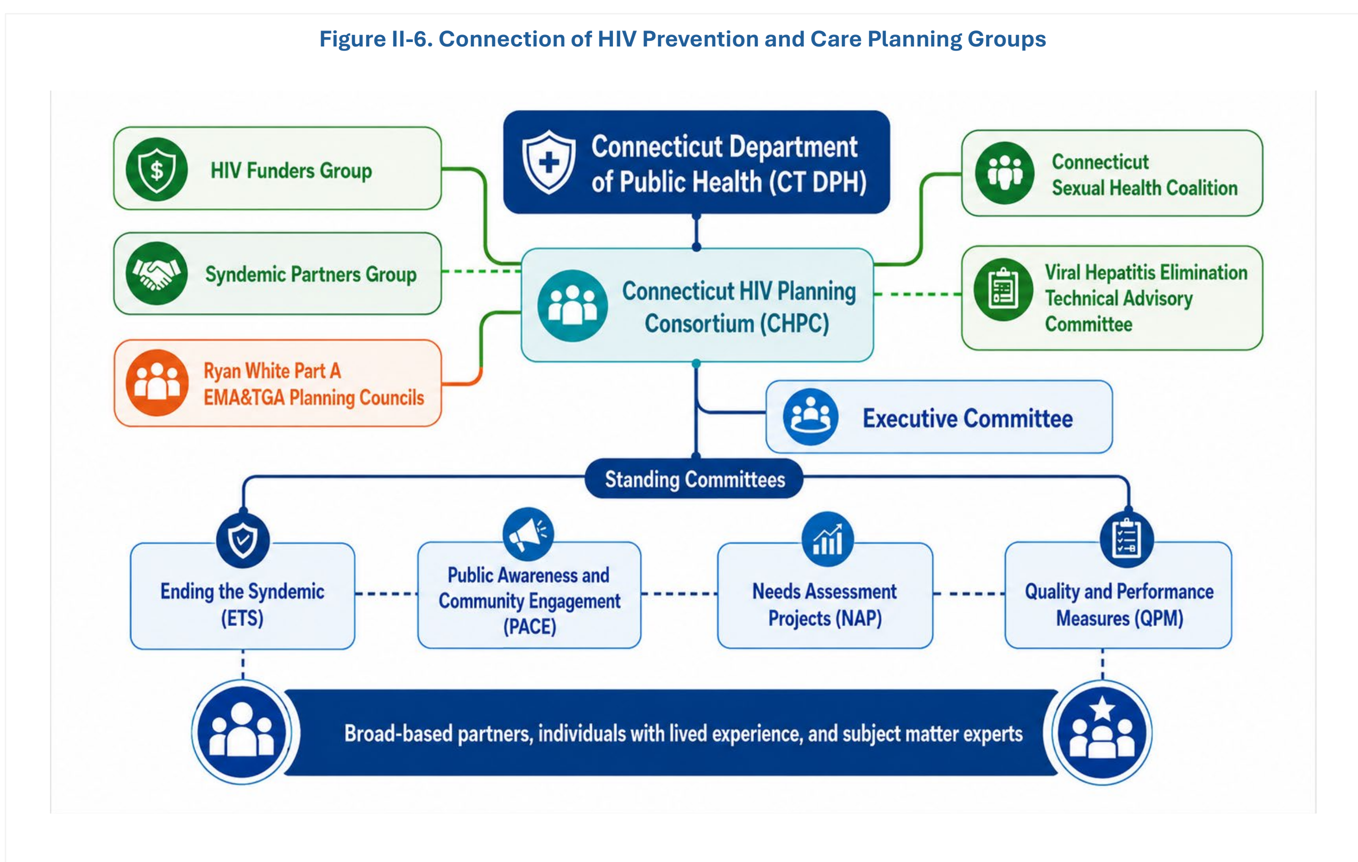
The partnership is built on active, regular collaboration rather than occasional updates and includes (a) ***dual leadership and membership*** with Council leaders serve on statewide planning groups to ensure local voices drive state decisions, (b) ***synchronized data*** with HIV surveillance and epidemiological updates and SCSN project results to feed directly into local funding and priority-setting cycles, and (c) ***shared intelligence*** with Councils sharing specialized needs assessments and project results to create a more complete picture of the epidemic.

To maintain momentum, the CHPC provides monthly briefings to the Planning Councils, who reserve dedicated time in every meeting for plan monitoring and development. This ensures that federal resources are allocated effectively and that directives for care are consistently met. The result is a seamless connection between local service delivery and the state's 2027–2031 vision (see Section VII for Letters of Concurrence).

c. Role of Planning Bodies and Other Entities

To ensure a unified response, CT DPH supports a network of specialized bodies that align federal requirements with local expertise. These groups transform complex mandates into a single, coordinated roadmap. Figure II-6 shows how the various groups interface.

Figure II-6. Connection of HIV Prevention and Care Planning Groups



The ***CHPC*** is the state's lead advisory body for both HIV prevention (CDC) and care (RWHAP Part B) and the membership includes representation from other RWHAP Parts as well as persons with HIV. The CHPC does not control any funding, and focuses on planning, monitoring, coordination of partners, and community engagement. The CHPC organizes its work around standing committees including Executive, Ending the Syndemic, Needs Assessment Projects, Public Awareness and Community Engagement, and Quality and Performance Measures. Visit www.CTHIVPlanning.org for additional information about the CHPC.

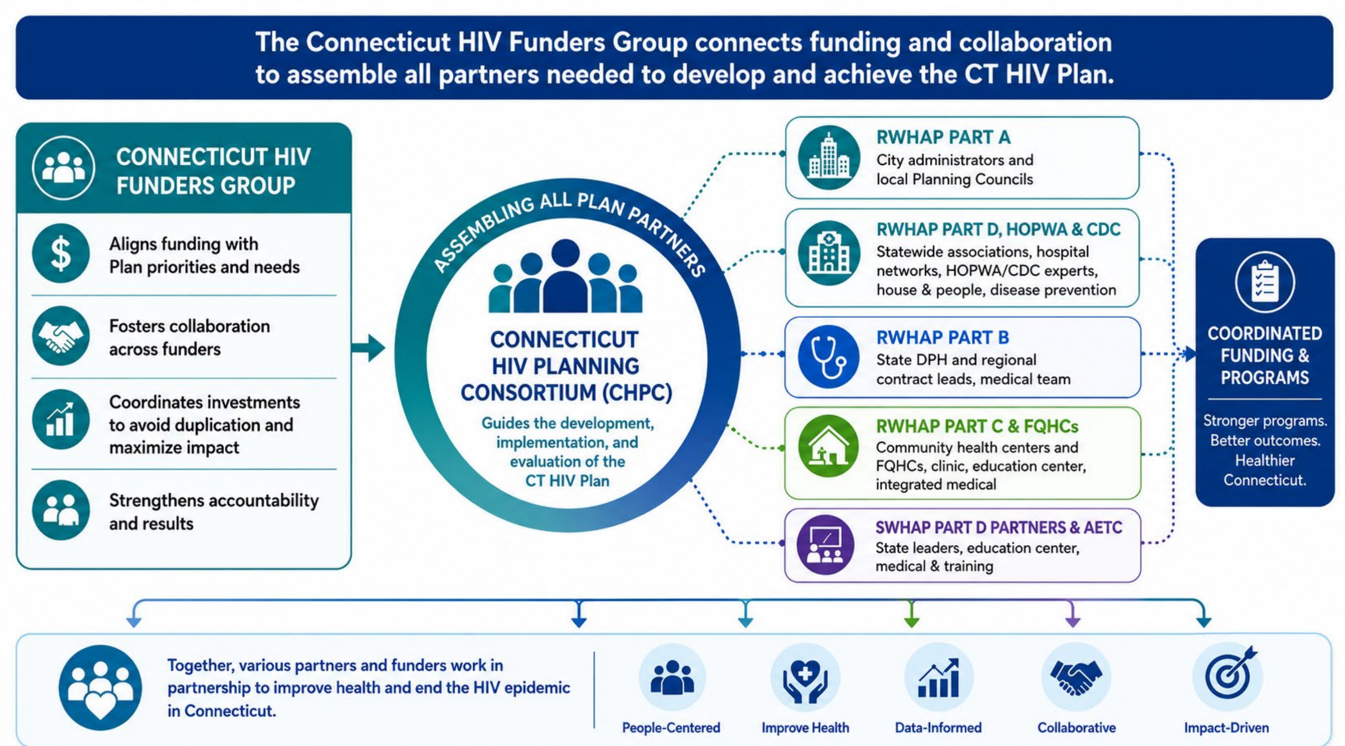
The ***Connecticut HIV Funders Group*** assembles administrators of all federal and state HIV funding (RWHAP Parts A–F, HOPWA, SPNS, and CDC). This group is the core mechanism for collaborating across RWHAP Parts and CDC prevention partners to meet all SCSN data requirements. The group played a significant role in drafting 2027-2031 Plan objectives, key activities, and performance measures. (See Section II.d for more information.)

The ***Syndemic Partners Group*** bridges the gap between HIV, HCV, STDs, and SUD. The group facilitates initiatives that expand use of integrated service models. This group includes CT DPH agency leads that support the Connecticut Sexual Health Coalition, the Viral Hepatitis Elimination Technical Advisory Committee, and Statewide Opioid Response partners as well as representatives from the Connecticut Department of Mental Health and Addiction Services and the DPH Injury Prevention Program. The Syndemic Partners Group members participate as leaders, members, and subject matter experts on the CHPC Ending the Syndemic Committee.

d. Collaboration with RWHAP Parts – SCSN Requirement

The Connecticut HIV Funders Group serves as the strategic engine for the Statewide Coordinated Statement of Need (SCSN). By centralizing data collection and plan monitoring, they transform technical requirements into a powerful, participatory process. This group assembles over ***40 subject matter experts*** representing the full spectrum of HIV prevention and care recipients of federal or state funding (Figure II-7). Through crossover leadership—where members serve simultaneously as CHPC or RWHAP Part A Planning Council chairs and RWHAP Part B, C, D, and F program directors—the group fosters seamless communication and a unified vision.

Figure II-7. Connecticut HIV Funders Group Partners



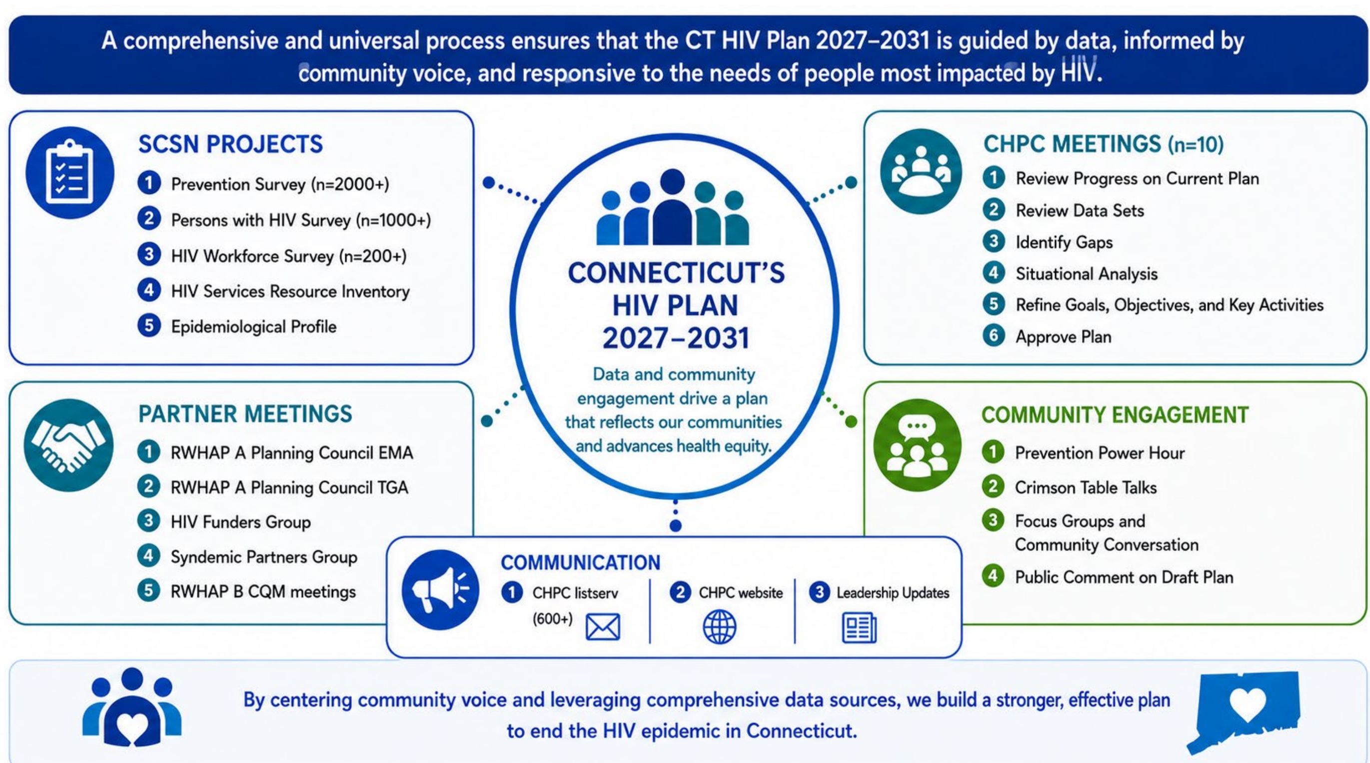
The centralization of the SCSN process transforms a technical requirement into a deep participatory process. The Funders Group drove the data collaboration engine by: (a) ***designing tools and crafting and field-testing*** survey instruments with expert input, (b) ***aligning and connecting statewide and local partners*** and local planning groups to ensure a unified methodology, and (c) ***coordinating collection efforts*** to avoid duplication and maximize reach.

The collaboration results in a more accurate, inclusive data set that serves as the foundation for Connecticut's statewide strategy.

e. Engagement of People with HIV – SCSN Requirement

The Plan development process included multiple forms of community engagement, including ongoing and intentional involvement of persons with HIV and lived experience as members of planning groups or through various community engagement and data collection processes. Figure II-8 provides examples of how the Plan development process created engagement opportunities for persons with HIV and stakeholders.

Figure II-8. Community Engagement of People with HIV

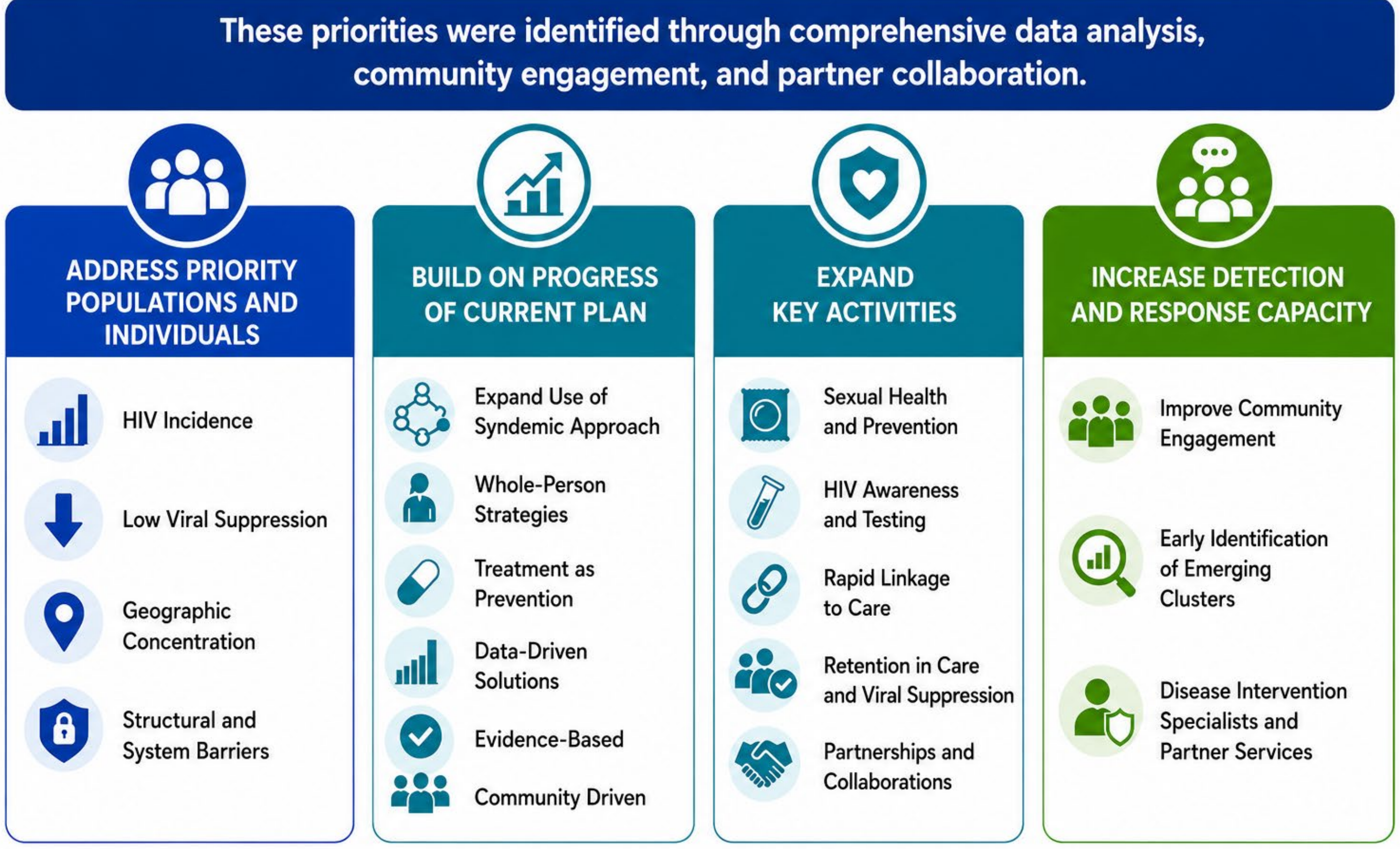


Section VI describes involvement of planning groups and persons with HIV in implementation, monitoring, evaluation and continuous improvement processes.

f. Priorities

Figure II-9 summarizes the key priorities arising out of the planning and community engagement process. Section IV includes a situational analysis and SWOT analysis by Plan pillar.

Figure II-9. Key HIV Prevention and Care Priorities Identified through Planning and Community Engagement



g. Updates to Other Strategic Plans to Meet Requirements

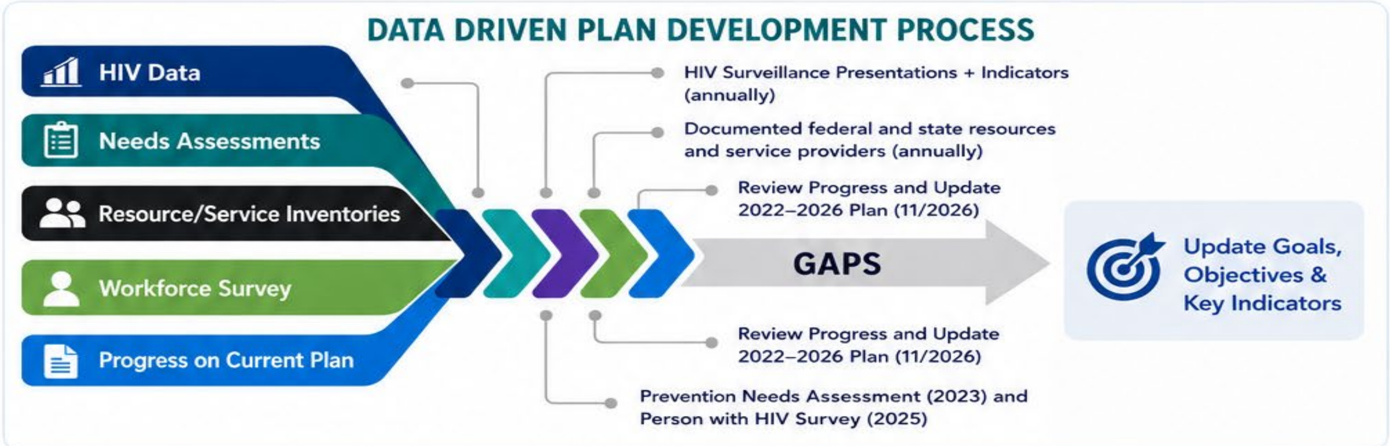
Connecticut does not qualify to receive Ending the HIV Epidemic funding. Nor does it use portions of another local strategic plan to satisfy the Plan development requirement.

** * * * * * End of Section II * * * * **

Section III. Contributing Data Sets and Assessments

DATA-DRIVEN. COMMUNITY-FOCUSED. RESULTS-ORIENTED.

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. These insights guide a unified, strategic response.



CONNECTICUT HIV PREVALENCE AND INCIDENCE AT A GLANCE

	PREVALENCE (2023)	INCIDENCE (2019–2023)
TOTAL	10,814 Total number of people with HIV (PWH)	1,094 Total new HIV diagnoses
SEX: 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

1. Data Sharing and Use

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. Table III-1 shows examples of the different types of data sets and assessments used to guide the Plan development.

Table III-1. 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	

Section II, Figure II-2 summarizes the data sources used in the Plan development process. Figure III-1 shows how data sources have been used to drive Plan development. The CHPC uses its monthly regular meetings to present and discuss data sets ranging from progress on statewide indicators and Plan performance measures as well as SCSN projects.

Figure III-1. Data Driven Plan Development Process

CT DPH maintains data sharing agreements to perform surveillance-related activities within the state and across jurisdictions.

2. Epidemiological Snapshot

General Demographics. As of 2025, Connecticut's population hovers around 3.69 million residents, ranking as the fourth most densely populated state in the United States. The state's demographic profile is roughly 51% female and 49% male, with a median age of 41.2 years. The population remains majority non-Hispanic White (60-64%). However, it is becoming increasingly distinctive, with Hispanic or Latino residents comprising 19%, Black or African American residents 10-12.7%, and Asian residents approximately 5%.

Economically, Connecticut is characterized by extreme contrasts. The state reports median household incomes of approximately $95,781 (in 2024 dollars) yet ranks among the highest in the nation for income disproportionality.

Social drivers of health (SDOH) present significant challenges, as 10.2% of the population lives in poverty and financial insecurity affects nearly 40% of adults as of late 2024. Recent reports suggest a sharp rise in food insecurity, reaching 14.3% by 2025—the highest rate in New England. The state has broad insurance coverage. However, approximately 5% of residents remain uninsured, and housing instability remains a critical driver of health access. Geographic density is highest in urban centers where these SDOH factors are often most concentrated.

According to the 2025 Data, New Haven Connecticut Community Wellbeing Survey, believed to be the largest and most comprehensive neighborhood-level wellbeing survey in the United States, 83 percent of adults saying they are satisfied with the place they live. However, the data reveal areas of concern that communities are working hard to address, including cuts to food assistance, health care, and housing that affect over a million people in the state. The results also show rising anxiety, worries about immigration enforcement, differences in access to economic and health opportunity, and financial stress, especially for renters and families with children. Figure III-2 shows key findings related to the largest changes from the 2018 and the 2025 survey.

Figure III-2. Key Changes in Connecticut's Community Wellbeing Survey: 2018 vs. 2025

INCREASES & IMPROVEMENTS

1 CANNABIS USE DOUBLED
12% 2018 → 24% 2025
+350,000 MORE ADULTS
Adult use in last 30 days

2 JOB OPPORTUNITY OPTIMISM
+250,000 MORE ADULTS RATE LOCAL JOBS AS "EXCELLENT" OR "GOOD".
Underemployment improved.

3 SAFE BICYCLE PLACES
+150,000 ADDITIONAL RESIDENTS REPORT SAFE PLACES TO RIDE BICYCLES.
New protected bike paths.

4 CIGARETTE SMOKING DECREASED
~100,000 FEWER ADULTS SMOKE CIGARETTES.
Note: Vaping popularity increases (especially among younger adults).

CARE & SUPPORT DIFFERENCES

9 ACCESS TO MEDICAL CARE
HIGHER-INCOME: IMPROVED
MODERATE- & LOWER-INCOME: CONTINUED TO WORSEN
+100,000 MORE ADULTS UNABLE TO GET NEEDED MEDICAL TREATMENT IN THE LAST YEAR.
Peak pandemic spike, then divergent trends.

10 SOCIAL SUPPORT DECLINED
HIGHER INCOMES: STABLE.
BELOW-MEDIAN INCOMES: DECLINED.
100,000 FEWER ADULTS SAY THEY USUALLY RECEIVE NEEDED SOCIAL OR EMOTIONAL SUPPORT.

CHALLENGES & NEEDS

5 MENTAL HEALTH CHALLENGES
+200,000 MORE ADULTS REPORT ANXIETY OR DEPRESSION.

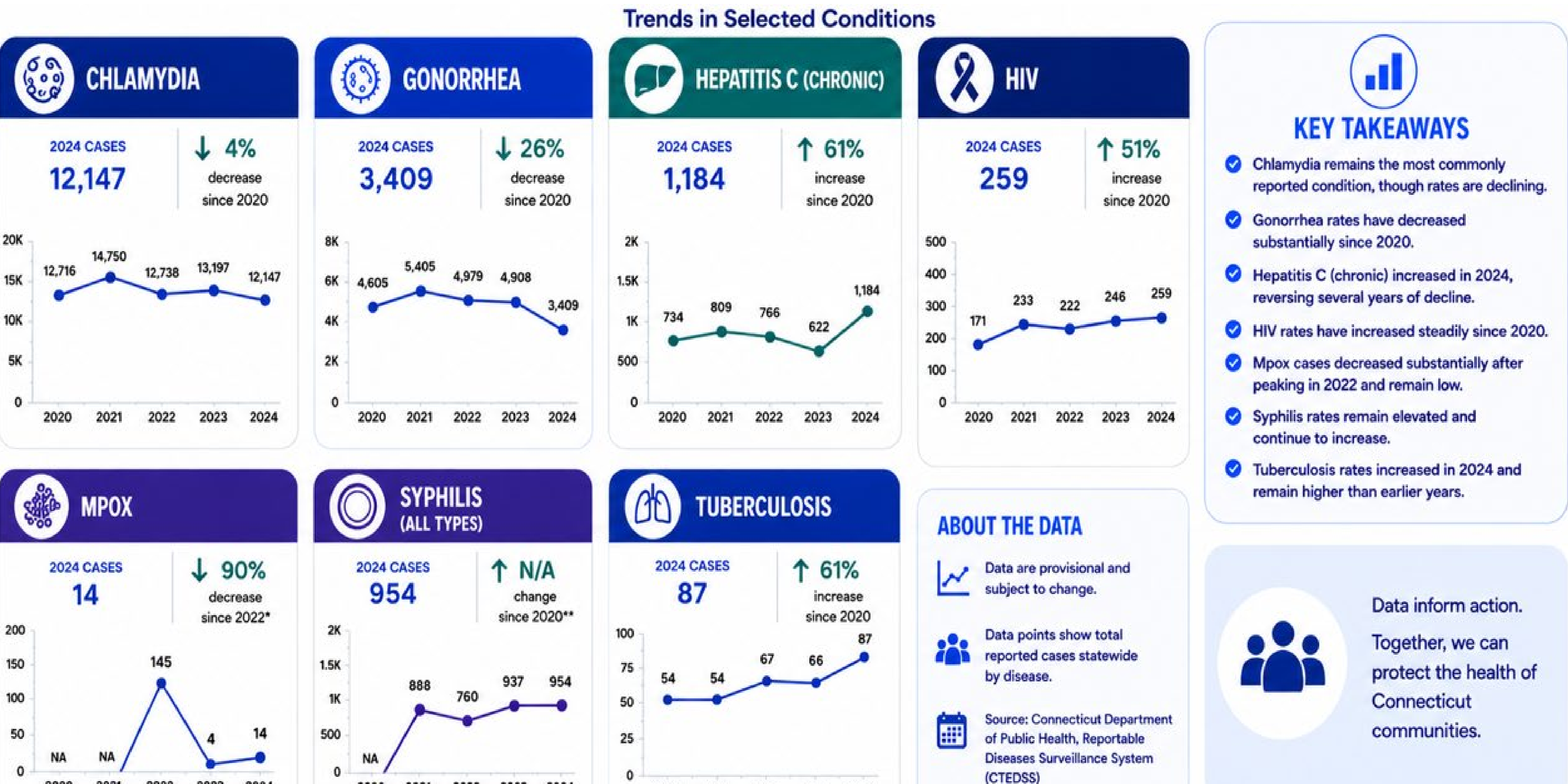
6 CHRONIC DISEASE DIAGNOSES
+150,000 MORE ADULTS REPORT DIABETES OR HYPERTENSION.
Aging population, improved screening.

7 HOUSING & TRANSPORTATION BARRIERS
HOUSING AFFORDABILITY
+150,000 MORE ADULTS RAN OUT OF MONEY FOR HOUSING.
2025: 11% OF ADULTS (320K PEOPLE) DOUBLE THE RATE 10 YEARS AGO.
TRANSPORTATION ACCESS
+150,000 MORE ADULTS STAYED HOME LACKING RELIABLE TRANSPORT.
7% MISSED DOCTOR'S APPOINTMENTS DUE TO TRANSPORTATION.

FOOD INSECURITY IS RISING
PRE-PANDEMIC
2021 LOW (Expanded Child Tax Credit)
2025
+100,000 MORE ADULTS SINCE PRE-PANDEMIC.
ADULTS LIVING WITH CHILDREN
With Children (26%) VS. Without Children (11%)
Strike increase compared to 2021 low.
UP TO HALF OF ADULTS WITH CHILDREN IN LARGEST CITY CENTERS RAN OUT OF MONEY FOR FOOD THIS PAST YEAR.
DataHaven 2025
Connecticut Community Wellbeing Survey

Reportable Infectious Diseases. Figure III-3 shows overall reportable infectious disease trends by disease condition for 2020 to 2024. The data shows a complex shifting landscape in Connecticut public health, characterized by a decline in traditional high-volume STDs, a steady rise in HIV and Tuberculosis, and a significant surge in late-stage Syphilis. Chlamydia and gonorrhea saw a peak in 2021 followed by a steady decline. Gonorrhea cases dropped approximately 26% from 2020 to 2024. HIV cases have risen steadily every year since 2022, reaching a five-year high of 259 in 2024. Tuberculosis shows a concerning 61% increase from 2020/2021 levels, signaling potential gaps in screening or changes in at-risk populations. The rapid emergence and then reduction in Mpox cases suggests a robust outbreak detection and response capacity in the state.

Figure III-3. Summary of Reportable Diseases in Connecticut, 2020 to 2024



The syphilis data suggests a shift from early detection to late-stage diagnosis. The drop in "Early non-primary" syphilis cases (from 280 to 135) alongside the spike in "Late/Unknown" cases (from 269 to 524) likely indicates that many infections are being missed in their early stages and only caught much later. The sharp increase in Chronic Hepatitis C in 2024 (1,184 cases) compared to the disappearance of Acute cases indicates a backlog in screening and a result of the 2023 HCV testing law. The steady rise in HIV (up ~51% from 2020) often correlates with the presence of other STDs like syphilis. Ulcerative STDs (like syphilis) significantly increase the risk of HIV transmission and acquisition. The simultaneous high levels of both suggest a syndemic—where multiple outbreaks interact and worsen one another.

HIV Incidence and Prevalence. Figure III-4 compares HIV incidence (2019-2023) and HIV prevalence in Connecticut. 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.

Figure III-4. Comparison of HIV Incidence and Prevalence in Connecticut

HIV PREVALENCE (2023) People living with HIV (PWH)	DESCRIPTION	HIV INCIDENCE (2019–2023) New HIV diagnoses
10,814	TOTAL NUMBER	1,094
67%	MALE SEX AT BIRTH	77%
33% Black/African American 36% Hispanic/Latino 28% White	RACE / ETHNICITY	36% Black/African American 35% Hispanic/Latino 25% White
<24: 2% 25–34: 10% 35–44: 14% 45–54: 20% 55+: 54%	AGE	<24: 17% 25–34: 37% 35–44: 20% 45–54: 13% 55+: 12%
35% MSM 28% Heterosexual Contact 22% PWUD	TRANSMISSION CATEGORY	56% MSM 28% Heterosexual Contact 6% PWUD
91% Viral Suppression (PWH in Care)	VIRAL SUPPRESSION (PWH IN CARE)	74% Viral Suppression (PWH in Care)

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.

Most people living with HIV are **age 55 or above.** However, most new HIV diagnoses are occurring in **younger individuals.**

HIV prevalence and incidence concentrates in the **10 largest urban areas.**

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.**

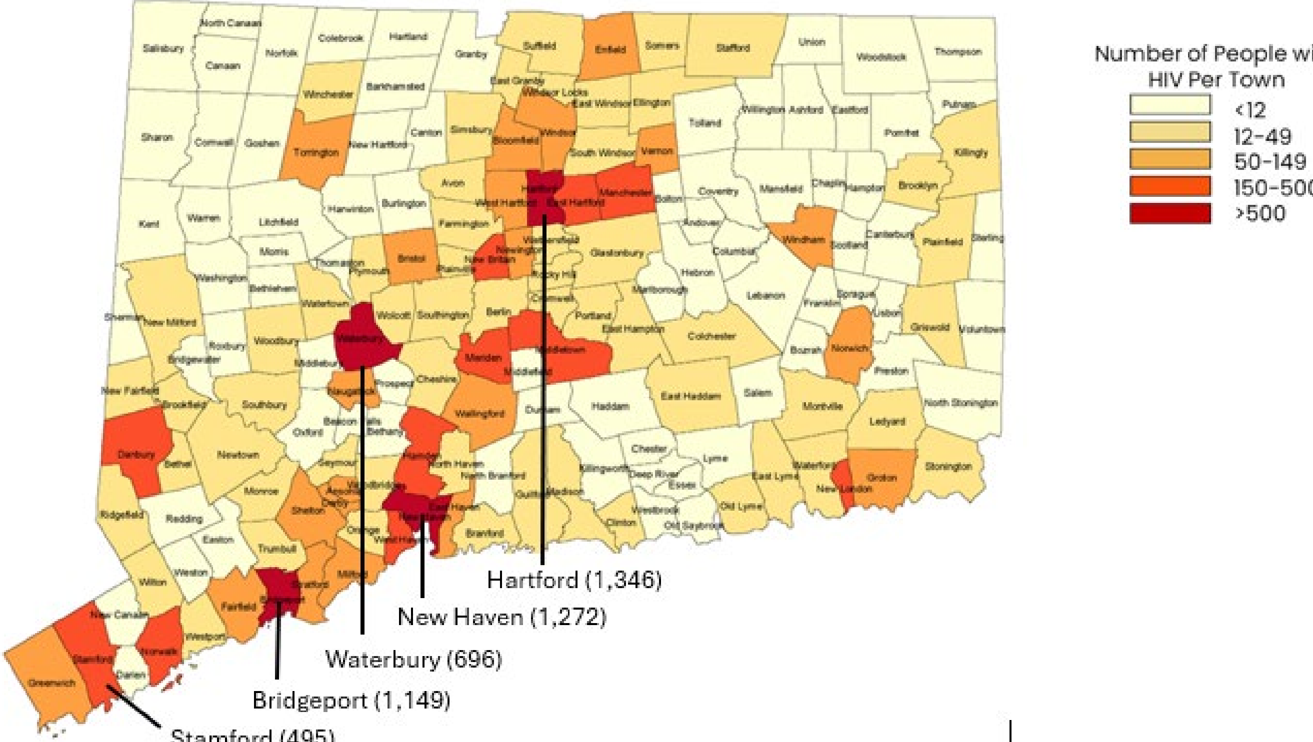
HIV disproportionately affects **Black/African American** and **Hispanic/Latino** populations.

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.

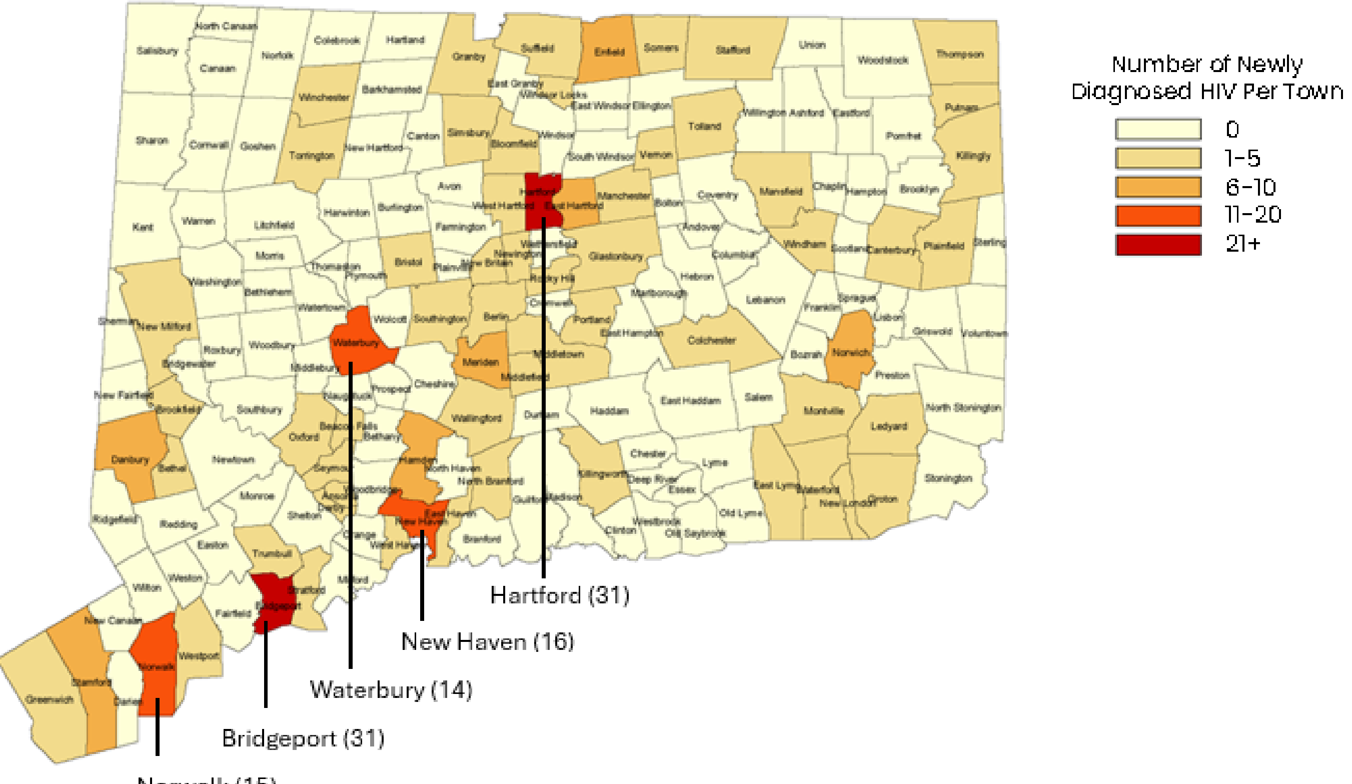
Incidence is the number of people who develop a condition during a specific time. It measures the risk of getting a disease.

Maps III-1 and III-2 shows the geographic distribution of HIV prevalence (2023) and incidence (2019-2023) in Connecticut.

Map III-1. HIV Prevalence or Total Cases in Connecticut (2023)



Map III-2. HIV Incidence or New Cases in Connecticut (2019-2023)



PREVALENCE: Patterns and Trends in People with HIV. Figure III-5 summarizes HIV prevalence in Connecticut, 2023. 10,814 PWH reside in Connecticut (2023).

Figure III-5. Summary of HIV Prevalence in Connecticut, 2023

10,814
People living with diagnosed HIV in CT

92.2%
Virally suppressed in 2023*

15%
Decline in HIV-related death rate since the peak (1993)

Disproportionate impact among **Black/African American (38%) and Hispanic/Latino (27%)**

WHO IS AFFECTED? (N=10,814)

N = 10,814

Group	Number (%)
Hispanic/Latino	3,903 (36%)
Black/African American	3,547 (28%)
White	3,070 (33%)
Other	294 (3%)

BY AGE GROUP (N=10,814)

Age	Number (%)
≤24	166 (2%)
25–34	1,116 (10%)
35–44	1,537 (14%)
45–54	2,120 (20%)
55+	5,875 (54%)

N = 10,814

BY EXPOSURE CATEGORY (N=10,814)

N = 10,814

Category	Number (%)
MSM	3,769 (35%)
Heterosexual Contact	3,070 (28%)
PWUD	2,350 (22%)
Other	1,365 (13%)
MSM + PWUD	260 (2%)

VIRAL SUPPRESSION OVER TIME*

Year	2019	2020	2021	2022	2023*
Viral suppression	92.1%	92.2%	92.8%	92.7%	92.2%

HIV-RELATED DEATHS HAVE DECLINED

Number of Deaths; Total Deaths among Persons with Diagnosed HIV; HIV Underlying Cause of Death; % Deaths HIV

Annotated % Deaths HIV: 80%, 62%, 46%, 30%, 15% (1985–2023)

HIV-related death rate declined 15% from the peak (1993) to 2023.

RACE/ETHNICITY TRENDS OVER TIME

Number of Casss

Group	2019	2020	2021	2022	2023
Black/African American	75	84	79	87	78
Hispanic/Latino	60	63	66	76	77
White	55	62	53	67	48
Other	7	3	4	7	6

DISPROPORTIONATE IMPACT

Black/African American	Hispanic/Latino	White	Other
38%	27%	32%	3%

HIV continues to disproportionately affect Black/African American and Hispanic/Latino communities in Connecticut.

*Data through 2023

Combined, persons who identify as Hispanic/Latino and Black/African American account for 70% of PWH in Connecticut yet account for less than 40% of the Connecticut's total population. More than half (54%) are aged 55 or older, reflecting the success of treatment and the aging of the population with HIV. MSM account for HIV transmission (35%) of total cases followed by heterosexual contact (28%). Awareness of HIV status has remained relatively steady, ranging from about 92% to nearly 93%. Today, with highly active antiretroviral therapy (HAART) as the standard of care, about 15% of dealths among PWH are attributable to HIV as compared to 80% in the mid 1980s. HIV iself remains the single leading cause of death among PWH followed by cancer, cardiovascular disease, and accidental overdose.

Figures III-6 and III-7 show the HIV Continuum of Care and viral suppression for PWH diagnosed through 2022 and residing in Connecticut at the end of 2023. 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. Of the PWH, nearly 78% received care in 2023. However, only 51.5% were retained in care, in part explained by PWH not seeing their HIV care provider more than once per year because their health status remains stable. Once people are engaged, over 70% achieved viral suppression.

Figure III-6. Persons with HIV infection diagnosed through 2022 and residing in Connecticut (12/2023)

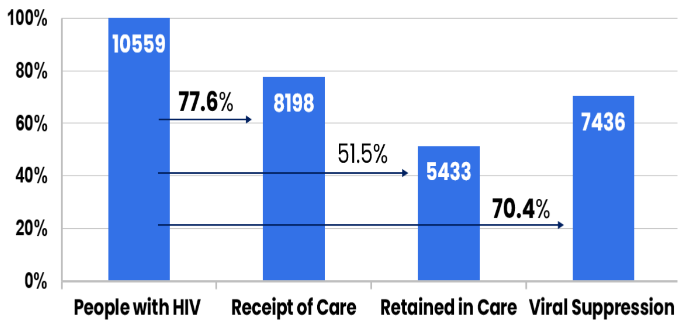


Figure III-7. Percent of people living with HIV in care who are virally suppressed

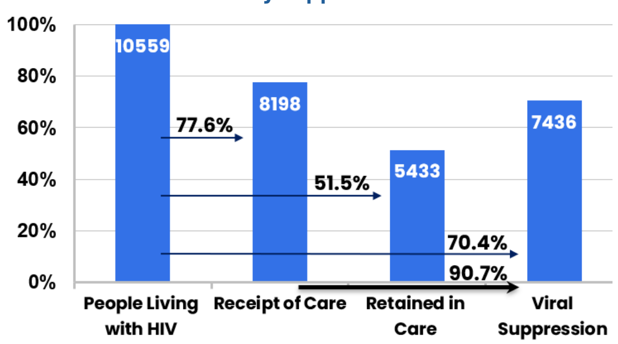
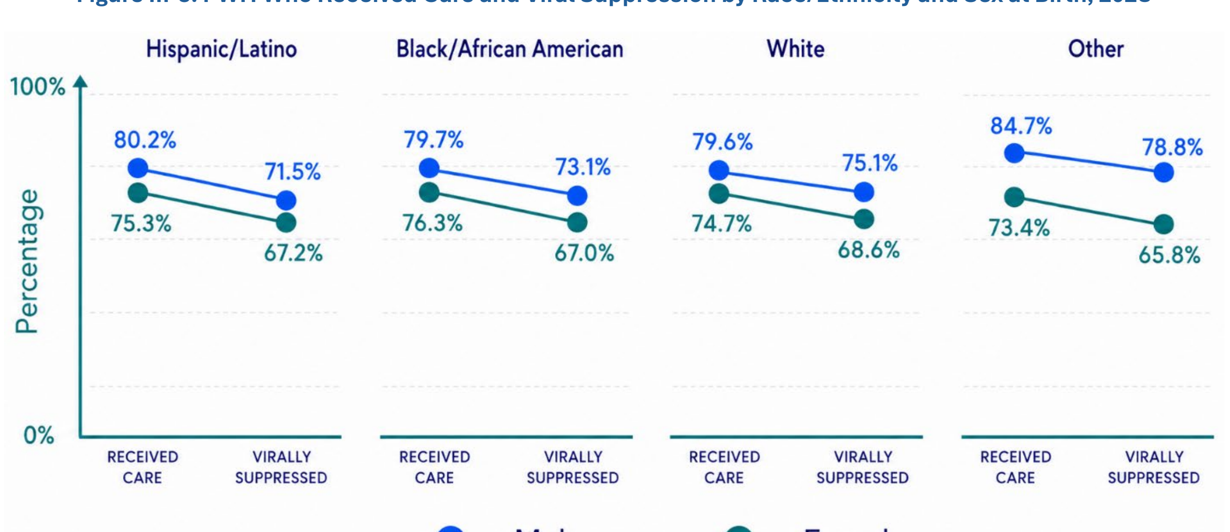


Figure III-8 shows the percentage of PWH who received care and viral suppression by race/ethnicity and sex at birth. For PWH who identify as Hispanic/Latino about 80% of men and 75% of women received care. However, viral suppression rates drop to 71% for men and 67% for women. For PWH who identify as Black/African American, about 80% of men and 76% of women received care yet 73% of men and 67% of women achieved suppression. For

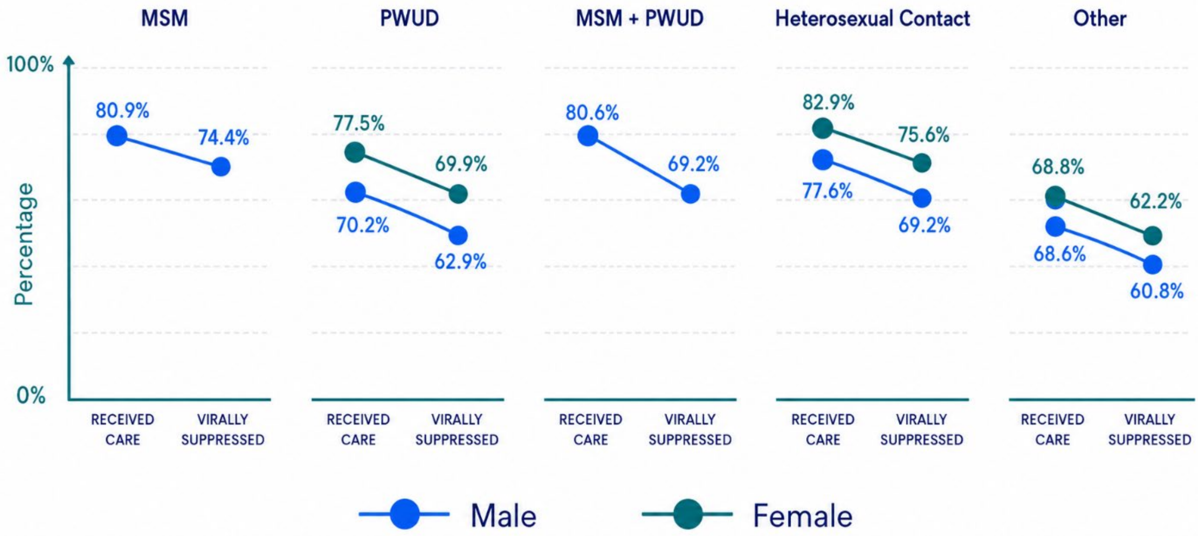
Figure III-8. PWH Who Received Care and Viral Suppression by Race/Ethnicity and Sex at Birth, 2023



PWH identifying as White, around 80% of men and 75% of women received care, and 75% of men and 69% of women achieved viral suppression.

Figure III-9 shows the percentage of PWH who received care and viral suppression rates by transmission category and sex at birth. The largest gaps between care and viral suppression are in people with a history of injection drug use, particularly those who also identify MSM, as well as males with a risk of heterosexual contact.

Figure III-9. PWH Who Received Care and Viral Suppression by Transmission Category and Sex at Birth, 2023



Finally, Connecticut has achieved progress in viral suppression among youth ages 13 to 24 has increased from a baseline of 65 % (2019) to 73% in 2023.

INCIDENCE: Patterns and Trends in New Diagnoses, 2019 - 2023. Figures III-10 and III-11 describe the number and race/ethnicity for the 1,094 PWH with new diagnoses that occurred during 2019-2023. An upward trend exists for the number of newly diagnosed PWH overall with an upward trend among persons who identify as Hispanic / Latino.

Figure III-10. Number of Newly Diagnosed PWH by Year, 2019-2023

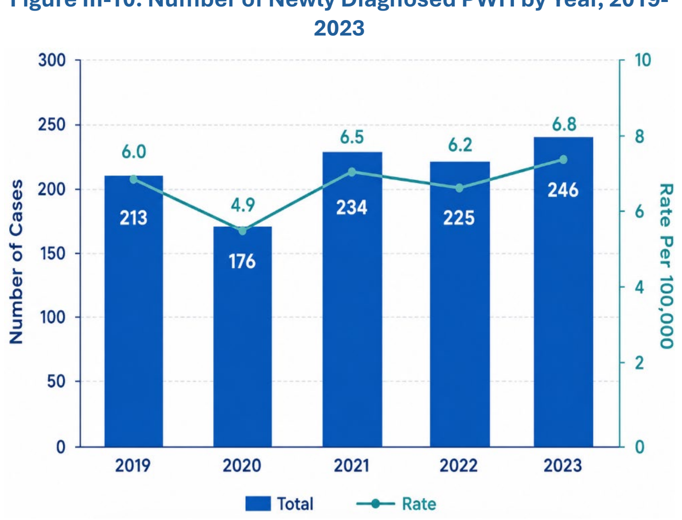


Figure III-11. Race/Ethnicity of New Diagnosed PHW by Year, 2019-2023

Number of Cases

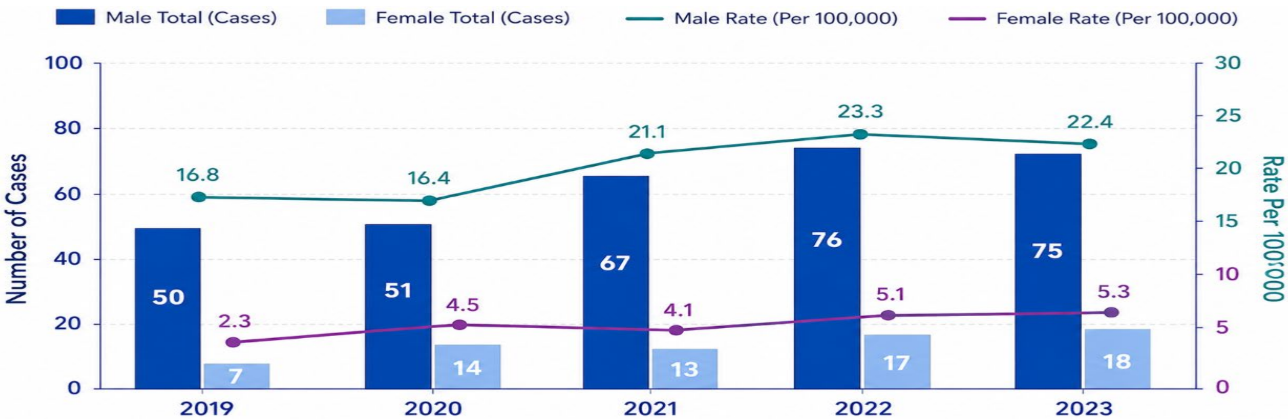
	2019	2020	2021	2022	2023
Black/African American	97	57	84	79	79
Hispanic/Latino	57	65	80	93	93
White	51	48	64	48	64
Other*	8	6	6	≤5	10

Black/African American	36%	Hispanic/Latino	35%
White	25%	Other*	3%

Figures III-12 and III-13 show the PWH with new diagnoses by sex at birth and race/ethnicity. The figures shows a decline in newly diagnosed Black/African American males and increases in Black/African American females as well as Hispanic/Latino males and females.

Figure III-12. Black/African American PWH Newly Diagnosed by Sex at Birth: 2019-2023

Figure III-13. Hispanic/Latino PWH Newly Diagnosed by Sex at Birth: 2019-2023



Figures III-14 and III-15 the age at diagnosis and transmission category for the 1,094 PWH with new diagnoses that occurred during 2019-2023. The largest share of newly diagnosed PWH involves persons ages 25-34 years (37%) followed by the 35-44 year age group (20%), and then 24 years and under (17%). Men who have sex with men (MSM) make up more than half of the newly diagnosed PWH. A notable increase has occurred in heterosexual transmission.

Figure III-14. Age of Diagnoses for Newly Diagnosed PWH by Year, 2019-2023

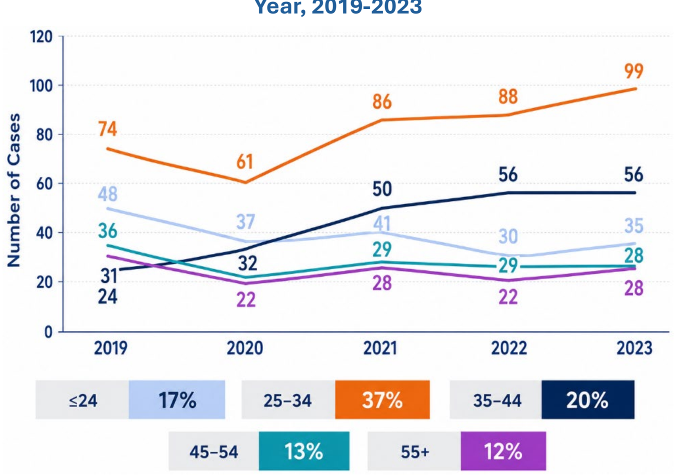
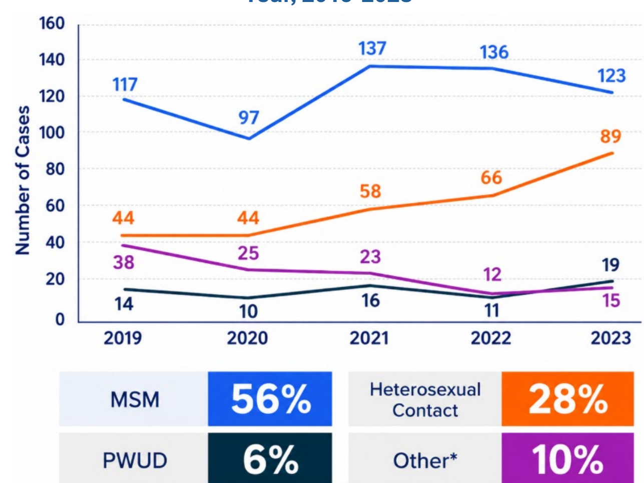


Figure III-15. Transmission Category Newly Diagnosed PWH by Year, 2019-2023

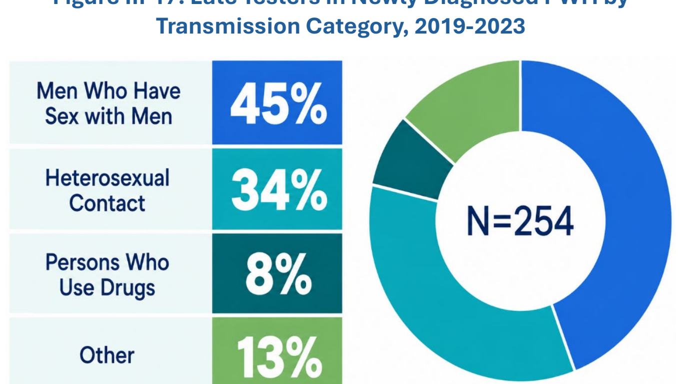


Figures III-16 and III-17 show patterns related to “late testers” or individuals who present with or are diagnosed with Stage 3 (AIDS) within 3 months of HIV diagnoses. The percentage of late testers increased along with the total number of newly diagnosed PWH. MSM (45%) and heterosexual contact (34%) accounted for the highest transmission categories. An analysis of 10 highest zip codes that contained late testers showed geographic concentrations in Bridgeport (3 zip codes with 6 to 7 late testers), Hartford (4 zip codes with 6 to 9 late testers), New Haven (2 zip codes with 8 late testers), and Stamford (1 zip code with 10 late testers).

Figure III-16. Late Testers in Newly Diagnosed PWH, 2019-2023

Year	Newly Diagnosed	Late Testers	% Late Testers
2019	213	58	27%
2020	176	43	24%
2021	234	46	20%
2022	225	38	17%
2023	246	69	28%

Figure III-17. Late Testers in Newly Diagnosed PWH by Transmission Category, 2019-2023

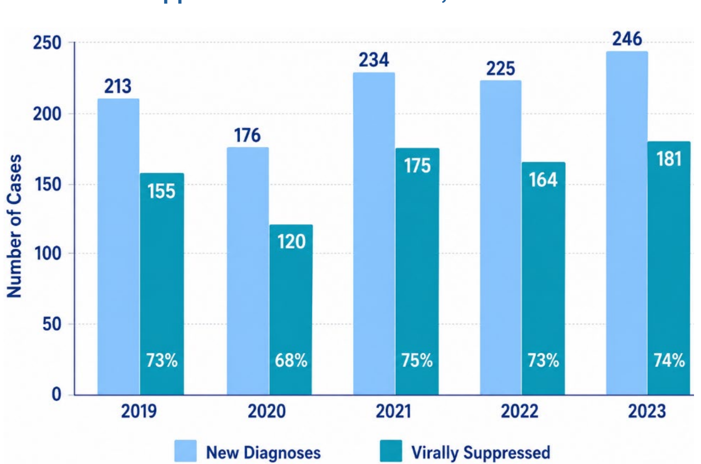


Figures III-18 and III-19 show the extent to which newly diagnosed PWH attended a routine HIV care visit within 1 month of diagnoses and viral suppression rates within 6 months of diagnosis. Nearly all patients are eventually linked to care within 12 months, ranging from 94% to 97%, the percentage linked within one month has remained lower and relatively flat, between 81% and 85%. Over this five-year period, viral suppression rates have hovered in the low to mid-70s, ranging from 68% in 2020 to 75% in 2021. Not shown in the figures, the lowest viral suppression rates were among those 45-54 year age group, white, IDU female, and IDU plus MSM.

Figure III-18. Percentage of Newly Diagnosed PWH Who Attended a Routine HIV Care Visit within 1 Month of Diagnoses, 2019-2023

Year	New Diagnoses	Linked ≤1 month	Linked ≤12 months
2019	213	180 (85%)	207 (97%)
2020	176	142 (81%)	165 (94%)
2021	234	199 (85%)	227 (97%)
2022	225	189 (84%)	217 (96%)
2023	246	204 (83%)	236 (96%)

Figure III-19. Percent of PWH Newly Diagnosed Who are Virally Suppressed within 6 Months, 2019-2023



HIV 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 an 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 means 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.

Figures III-6 and III-7 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, respectively. Of the total persons living with HIV, nearly 78% received care in 2023.[1] 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%.

Progress on the 2022-2026 Plan. The Connecticut HIV Planning Consortium reviews and monitors progress on the Plan each year. In addition to identifying accomplishments, the CHPC reviews a list of statewide indicators to understand how the key activities are or are not contributing to achieving the bigger goals identified in the National HIV and AIDS Strategy. Table III-2 shows current versus baseline measures for Connecticut's indicators from the review conducted in November 2025.

Table III-2. Connecticut Statewide Indicators and Status as of 2025

2022-2026 Plan Indicator	2019 Baseline	Original 2026 Goal	NHAS Goal	Status as of 2025[2]
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

[1]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.
[2] 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.

Table III-2. Connecticut Statewide Indicators and Status as of 2025

2022-2026 Plan Indicator	2019 Baseline	Original 2026 Goal	NHAS Goal	Status as of 2025 [2]
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
Gaps 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/Latino: 50% increase Male,157% increase Hispanic MSM: 5% increase
Gaps in Viral Load Suppression: Viral load suppression rates among: youth and young adults, PWUD, 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/Latino: 67% Male, 72% Female; Youth 13 to 24: 72.7% MSM: 74%; IDU: 66%
Services for Persons Who Use Drugs (SPWUD): Number of clients served Number of prevention supplies 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

3. HIV Prevention, Care and Treatment Resource Inventory

Providers. The HIV Funders Group assembles agencies that administer or receive federal funding for HIV care and prevention services in the jurisdiction as well as other syndemic services (i.e., STD, HCV, SUD). The HIV Funders as well as the Syndemic Partners Group foster coordination and service integration of HIV prevention and care services. Accomplishments in the 2022-2026 Plan included: (a) Passage of routine HIV and HCV testing legislation, (b) Development and piloting of a syndemic screening tool, and (c) Integrated HIV and HCV testing.

Funding Sources. Table III-5 describes HRSA (all RWHAP parts) and CDC funding sources as well as additional Federal funding sources such as HRSA's HUD's HOPWA Program and Substance Abuse and Mental Health Services Administration programs relevant to HIV prevention and care services.

Provided Services. Table III-3 describes services and activities by organizations relevant to the identified Federal funding sources described in Table III-4.

Table III-3. HIV Prevention, Care and Treatment Federal and State Funding Resource Inventory

Funder	Funding Source	Recipient		Jurisdiction		Program Name and Nature of Services	HIV Care Continuum					EHE Strategies			
		Primary	Sub(s)	County	Planning Region (EMA, TGA, Statewide)		HIV Diagnosis	Linkage to Care	Engagement or Retention in Care	Prescription of ART	Viral Suppression	Diagnose	Treat	Prevent	Respond
HUD	HOPWA	AIDS CT	Yes	Hartford	Statewide	State AIDS Housing			●		●		●	●	
RWHAP	RWHAP C	APEX	No	Fairfield	EMA	Ryan White Part C Outpatient EIS Program (H76)	●	●	●	●	●	●	●	●	●
RWHAP	RWHAP C	APEX	No	litchfield	EMA	Ryan White Part C Outpatient EIS Program (H76)	●	●	●	●	●	●	●	●	●
RWHAP	RWHAP C	CHC, Inc.	No	Middlesex	Statewide	Ryan White Part C Outpatient EIS Program (H76)	●	●	●	●	●	●	●	●	●
RWHAP	RWHAP D	CHCACT	Yes	New Haven	EMA	Ryan White Title IV WICY & Affected Family Members AIDS Healthcare (H12)	●	●	●	●	●	●	●	●	●
RWHAP	RWHAP C	CHS, Inc.	No	Hartford	Statewide	Ryan White Part C Outpatient EIS Program (H76)	●	●	●	●	●	●	●	●	●
RWHAP	HOPWA	City of Bridgeport	Yes	Fairfield	EMA	US HUD HOPWA			●		●		●	●	
RWHAP	RWHAP A	City of Hartford	Yes	Hartford	TGA	Ryan White Part A HIV Emergency Relief Grant Program (H89)	●	●	●	●	●	●	●	●	●
RWHAP	HOPWA	City of Hartford	Yes	Hartford	TGA	US HUD HOPWA			●		●		●	●	
RWHAP	HOPWA	City of New Haven	Yes	New Haven	EMA	US HUD HOPWA			●		●		●	●	
RWHAP	REWHAP A	City of New Haven	Yes	New Haven	EMA	Ryan White Part A HIV Emergency Relief Grant Program (H89)	●	●	●	●	●	●	●	●	●
RWHAP	RWHAP C	Cornell Scott Hill Health	No	New Haven	EMA	Ryan White Part C Outpatient EIS Program (H76)	●	●	●	●	●	●	●	●	●
RWHAP	RWHAP D	Connecticut Children's	Yes	Hartford	TGA	Ryan White Title IV WICY & Affected Family Members AIDS Healthcare (H12)	●	●	●	●	●	●	●	●	●
CT	State Budget	CT DOC	No	Statewide	Statewide	Medical Care and Treatment Expense	●	●	●	●	●	●	●	●	●
RWHAP	RWHAP HOPWA	CT DOH	Yes	Hartford	TGA	US HUD HOPWA			●		●		●	●	
CT	State Budget	CT DMHAS	Yes	Statewide	Statewide	Inpatient treatment expenses for clients with HIV diagnoses (state facilities)	●	●	●	●	●	●	●	●	●
CDC	Prevention	CT DPH	No	Hartford	Statewide	Infectious Disease and Opioids Epidemic	●	●				●	●	●	
RWHAP	CT DPH RWHAP B	CT DPH	Yes	Hartford	Statewide	Ryan White Part B HIV Care Grant Program (X07)	●	●	●	●	●	●	●	●	●
RWHAP	CT DPH RWHAP B	CT DPH	Yes	Hartford	Statewide	Ryan White Part B Supplemental (X08)	●	●	●	●	●	●	●	●	●
RWHAP	CT DPH RWHAP B	CT DPH	Yes	Hartford	Statewide	ADAP Shortfall Relief (X09)				●			●		
RWHAP	CT DPH RWHAP B	CT DPH	Yes	Hartford	Statewide	CADAP Rebate Expenditures				●			●		
CDC	Prevention	CT DPH	Yes	Harford	Statewide	Domestic HIV/AIDS Prevention and Research	●	●	●			●		●	●
CT	State Budget	CT DPH	Yes	Statewide	Statewide	HIV Prevention & Programs	●	●	●			●		●	●
CDC	Prevention	CT DPH	Yes	Hartford	Statewide	Sexually Transmitted Infections	●	●	●			●		●	●
CDC	Prevention	CT DPH	Yes	Hartford	Statewide	Tuberculosis	●	●	●			●		●	●
CDC	Prevention	CT DPH	Yes	Hartford	Statewide	Viral Hepatitis	●	●	●			●		●	●
HHS/CT	Medicaid/Medicare	CT DSS	N/A	Statewide	Statewide	Medicaid / Medicare estimates*	●	●	●	●	●	●	●	●	●
Insurance	Varies	Medical Providers	N/A	Statewide	Statewide	Private Insurance**	●	●	●	●	●	●	●	●	●
RWHAP	RWHAP C	Fair Haven CHC	No	New Haven	EMA	Ryan White Part C Outpatient EIS Program (H76)	●	●	●	●	●	●	●	●	●
RWHHAP	RWHAP C	Generations FHC	No	Windham	Statewide	Ryan White Part C Outpatient EIS Program (H76)	●	●	●	●	●	●	●	●	●
RWHAP	RWHAP F	Hartford Hospital	No	Hartford	TGA	Dental Reimbursement Program (T22)	●	●	●			●		●	●
RWHAP	RWHAP C	Optimus Healthcare	No	Fairfield	EMA	Ryan White Part C Outpatient EIS Program (H76)	●	●	●	●	●	●	●	●	●
RWHAP	RWHAP C	Optimus Healthcare	No	Fairfield	EMA	Ryan White Title III HIV Capacity Development and Planning Grants (P06)	●	●	●	●	●	●	●	●	●
RWHAP	RWHAP C	Southwest CHC	No	Fairfield	EMA	Ryan White Part C Outpatient EIS Program (H76)	●	●	●	●	●	●	●	●	●
RWHAP	RWHAP C	Staywell Health Care	No	New Haven	EMA	Ryan White Part C Outpatient EIS Program (H76)	●	●	●	●	●	●	●	●	●
NIMH	NIMH ARC	Yale University	No	New Haven	National	NIMH AIDS Research Centers Program (P30MH062294)	●	●	●		●	●	●	●	●
RWHAP	REHAP SPNS	Yale University	No	New Haven	EMA	SPNS - Demonstration/Implementation Sites (H97)	●	●	●		●	●	●	●	●
RWHAP	RWHAP F	Yale University	No	New Haven	Statewide	AETC Regional Partner (U10HA49824)	●	●	●		●	●	●	●	●

Table III-4. Detailed Service Inventory of HIV Prevention, Care, and Treatment Services Supported with Federal Funding

Type of Service *(Service definitiions reflect langauge used by Federal funders)*	ACT	AFL	Anchor Health	APEX	APNH	CCMC	CHC, Inc.	CHCACT	CHS	City of Bridgeport	City of Hartford Clinic	Charter Oak CHC	City of New Haven	CRT	CSHHC	CT DMHAS	CT DOC	CT DPH Prevention	CT DPH RW	CT DPH SSP	CTHRA	CTHRA SWAN	Fair Haven CHC	Family Centers	GBAPP	Generations	HHC	HHCCC	HRA	LCS	Libertions	MFAP	Optimus Healthcare	Planned Parenthood	Recovery Network	SWCHC	Staywell CHC	The Health Collective	THOCC	UCONN ID	City of Waterbury	WRCC	Yale Healthcare Van	Yale University	YNHH
CORE MEDICAL SERVICES																																													
Outpatient/Ambulatory Health Services				●	●	●	●		●			●	●		●	●			●				●	●	●			●	●				●			●	●		●	●		●	●	●	●
AIDS Drug Assistance Program				●															●																	●	●							●	
AIDS Pharmaceutical Assistance				●															●																	●	●							●	
Early Intervention Services				●	●	●	●		●					●	●	●			●	●			●	●	●			●	●							●	●						●	●	
Health Insurance Premium & Cost Sharing				●								●	●						●					●												●	●							●	
Home and Community-Based Health Services																																													
Home Health Care																																													
Hospice Services																																													
Medical Case Management	●			●	●	●	●	●	●			●	●	●	●				●				●	●	●	●	●	●	●			●	●			●	●		●	●		●	●	●	
Medical Nutrition Therapy																																													
Mental Health Services				●	●	●	●					●	●	●	●	●							●	●	●			●	●				●			●	●			●		●	●	●	
Oral Health Services				●									●											●								●				●	●	●					●		
Substance Abuse Outpatient Care				●		●							●		●	●								●							●					●	●						●		●
SUPPORT SERVICES																																													
Non-Medical Case management	●																																												
Housing Services	●			●	●	●	●			●			●											●	●							●				●	●							●	
Medical Transportation	●	●		●	●	●	●						●						●					●	●							●	●			●	●					●		●	
Emergency Financial Assistance	●	●		●	●		●						●						●					●	●							●	●			●	●					●		●	
Food Bank / Home Delivered Meals	●	●		●	●		●						●						●					●	●							●	●			●	●	●				●		●	
Psychosocial Support Services	●			●																																									
Linguistic Services				●																																									
Health Education/Risk Reducation				●																																									
Outreach Services				●													●	●																											
Legal Services				●																																									
Child Care Services																																													
Respite Care																																													
Referral for Health Care and Support Services																																													
Rehabilitation Services																																													
Residential Substance Abuse Services													●																						●										
Other Professional Services																																													
Permanency Planning																																													
PREVENTION SERVICES																																													
HIV/HCV Testing in Clinical Settings			●	●		●	●		●									●										●					●	●			●			●					●
HIV/HCV Testing in Non-Clinical Settings	●	●		●	●						●						●	●		●	●	●		●	●					●		●						●			●		●		
PrEP and PEP Coordination	●	●	●	●	●	●	●		●		●						●	●		●	●	●		●	●			●		●		●	●	●			●	●		●	●		●		●
Condom Distribution	●	●	●	●	●	●	●		●		●							●		●	●	●		●	●			●		●	●	●	●	●			●	●		●			●		●
Services for Persons Who Used Drugs		●		●														●		●	●	●		●							●	●					●				●		●		
Partner Services																	●	●																											
CAPACITY BUILDING / Research																																													
Education and Training								●	●		●		●			●		●	●																									●	
HIV Prevention and Treatment Research																																												●	

In general, the federal funding supports services for people and communities disproportionately impacted by HIV who are eligible for RWHAP and CDC prevention services consistent with the epidemiologic profile and care continuum data. RWHAP Part A Planning Councils review data annually and make priority setting and allocation decisions in response to changes in conditions that affect the service delivery area.

To the extent possible with the available funding, services maximize the quality of health and support for individuals and communities with certain risk factors of acquiring or with HIV. However, the data sets ranging from the Community Wellbeing Index (see Figure III-2) to the persons with HIV needs assessment survey findings reinforce the message that support services that address basic human needs are increasingly important. Funding levels within the HIV prevention and care system support a subset of basic human needs.

Multiple allowable services in the service inventory have been identified as needs or gaps but are not supported by the HIV prevention, care, and treatment funding sources because or resource constraints. These services are difference makers as evidenced by the difference in viral suppression rates between persons with HIV affiliated with RWHAP funded service providers and those who receive care outside of the RWHAP funded service system.

a. Assessment of Strengths and Gaps across the HIV Prevention and Care Continuum

Geographic Landscape. HIV affects nearly every of the 169 towns in Connecticut. However, the incidence and prevalence tend to be concentrated in urban areas. 91% of persons with HIV live in the state's two RWHAP Part A service regions. Refer also to Map III-1 and III-2.

Occurrence of HIV Clusters / Outbreaks. Connecticut has not experienced any recent HIV outbreaks. Several opioid overdose outbreaks have occurred in major urban areas (e.g., New Haven, Hartford).

Underuse of New HIV Prevention Tools. Connecticut has continued to pioneer innovative prevention tools ranging from data (e.g., Area Deprivation Index to mobilize local action) to PrEP and long-acting injectables. Uptake for PrEP remains a challenge and a priority. Equally important is a focus on proven evidence-based approaches such as increasing condom use.

b. Approaches and Partnerships

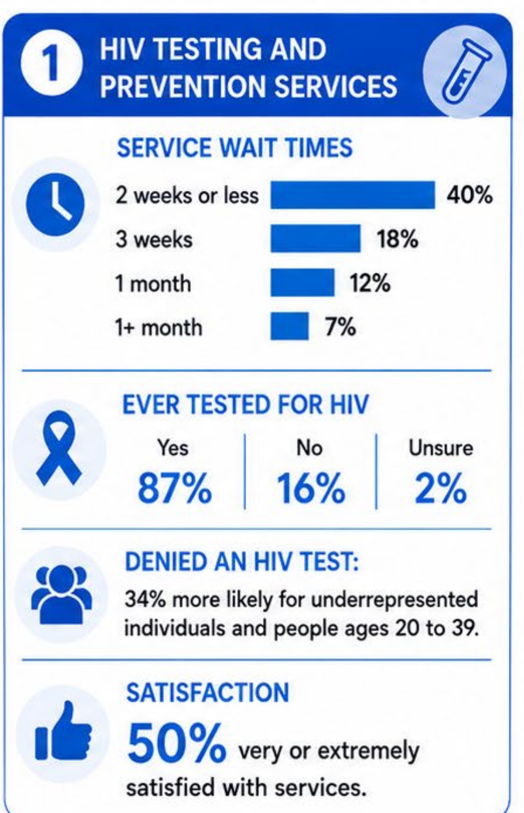
The HIV Funders Group coordinated the completion of the HIV prevention, care, and treatment inventory. The group invites all entities that administer federal or state HIV-related funding to attend meetings. Participation has been expanded to invite new partners such as representatives who attended the Syndemic Partner Group (HCV, STD, and SUD) such as the Connecticut Department of Mental Health and Addiction Services with a recent invitation to the Department of Corrections representative who attends the CHPC Ending the Syndemic Committee. The CHPC Members are currently discussing recommendations related to inviting a CHPC Member who is a non-provider to attend the HIV Funders Group.

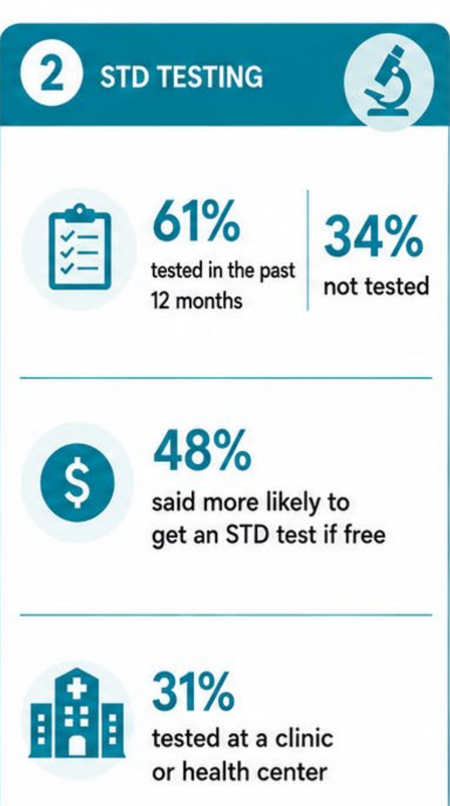
4. Needs Assessment

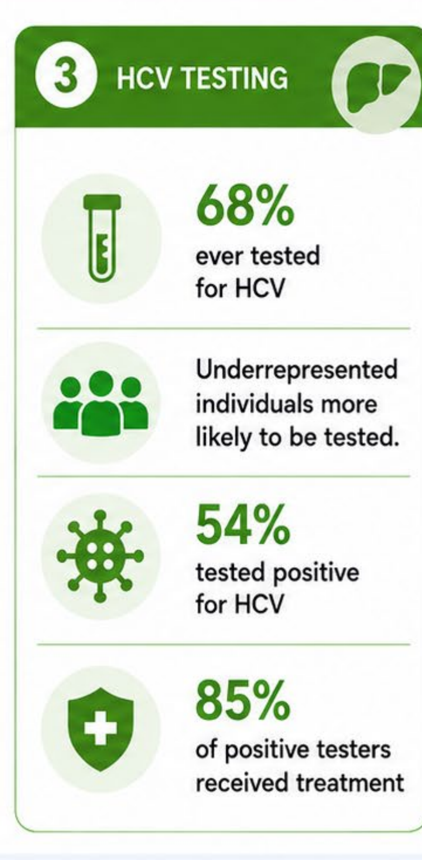
Connecticut used findings from three statewide needs assessment surveys to complete this section: (a) HIV prevention (Figure III-20), (b) persons with HIV (Figure III-21), and (c) HIV workforce (Figure III-22) as well as the evaluation of services for persons who use drugs, 2025 (Figure IIII-23). Section 4c describes the methodology for each survey.

Figure III-20. Notable Findings from the 2022 Connecticut HIV Prevention Survey

The survey gathered input from 2,000+ Connecticut residents to understand their experiences, needs, and priorities for HIV prevention and related services.







These findings help guide a more comprehensive, responsive, and effective HIV prevention system for all Connecticut communities.

Figure III-21. Notable Findings from the 2025 Connecticut HIV Persons with HIV Needs Assessment Survey

Over 1,000 persons with HIV who were affiliated with Ryan White funded services completed the survey.

KEY FINDINGS BY THEME

ORAL HEALTH

23% need more services or could not access services

33% have not been to a dentist in the last 12 months

FOOD ASSISTANCE

37.8% need help paying for food

SERVICES FOR PEOPLE WHO USE DRUGS

35% did not feel informed about services for individuals who used drugs

Almost all respondents reported not needing these services.

HEALTHCARE UTILIZATION

Few clients use telehealth services.

25% of respondents used the Emergency Room for routine care

64% were Medicaid clients

28% were Medicare clients

HOUSING STABILITY

6% of clients were experiencing homelessness

37% of clients who were experiencing homelessness did not know how to access emergency shelters

These findings will help strengthen HIV services and supports to better meet the needs of people with HIV across Connecticut.

Figure III-22. Notable Findings from the Connecticut HIV Workforce Survey, 2025

Web-based, self-administered survey
Oct 14 – Nov 21, 2025

257 started
221 completed

Convenience sample across CT HIV-related settings

Modular survey with skip logic
4 role pathways:
Prescriber/Dispenser, Clinical, Non-clinical, Admin/Program Manager

METHODOLOGY

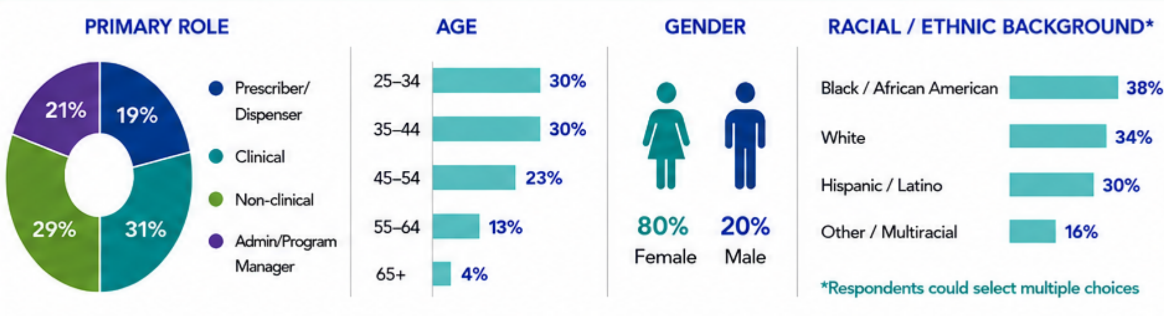
Designed to capture workforce roles, service delivery context, and training/technical assistance needs.

All respondents answered core items on role & responsibilities (direct service; prevention/treatment focus; syndemic approach) then routed to role-specific questions.

Results reflect "impressions" and "insights" due to small sample size and convenience sampling. Proceed with caution.

See full report for details and limitations.

WHO TOOK THE SURVEY? (DEMOGRAPHICS)



30% of respondents identify as Hispanic.

Sample reflects intentional efforts by HIV service organizations to hire employees that reflect the HIV epidemic. Demographic patterns similar to the 2021 HIV workforce survey.

KEY FINDINGS BY WORKFORCE CLUSTER: STRENGTHS & COVERAGE

PRESCRIBER / DISPENSER
n = 40

- **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

CLINICAL
n = 69

- **Strong engagement in HIV care:** **80%**+ conduct adherence support and care coordination
- **Prevention services commonly** provided: PrEP education **72%**, risk reduction counseling **72%**
- **Behavioral health integrated:** Mental health screening **78%**; substance use counseling **72%**

NON-CLINICAL
n = 64

- **Frontline connection to communities:** Outreach/education **88%**; Linkage to care **76%**
- **Prevention & risk support:** Condom distribution **74%**; **Prevention services for people who use drugs 71%**
- **HIV testing & navigation:** HIV testing **69%**; Navigation / referrals **72%**

ADMIN / PROGRAM MANAGER
n = 48

- Program management is the core: Program planning **85%**; Staff supervision **75%**
- **Quality & data focus:** Data reporting **73%**; Quality improvement **65%**
- **Resource stewardship:** Grant management **63%**; Budget oversight **60%**

CROSS-CUTTING THEMES

Training & TA Needs:
Ongoing needs in HIV updates, SUD, behavioral health, stigma reduction, and culturally responsive care.

Workforce Challenges:
Staffing shortages, burnout, and competing priorities impact capacity across all roles.

Opportunity:
Leverage existing strengths and partnerships to expand integrated, syndemic-informed care across the HIV continuum.

Figure III-23. Notable Findings from Services for Persons who Use Drugs Funded by CT DPH, 2024

1. TOTAL INDIVIDUALS SERVED

10,797 individuals

83,495 visits

4,050 (37.5%) were new clients

65% were male

Age range of 20 to 87 with median age of **45** years

36% reported heroin use at enrollment

2. GEOGRAPHIC DISTRIBUTION BY COUNTY

County	%
Hartford	32%
New Haven	27%
Fairfield	22%
New London	5%
Litchfield	4%
Windham	2.5%
Tolland	<1%

3. SERVICES PROVIDED

Service	Number
HIV tests	5,397
HCV tests	5,370
Ancillary prevention supplies for PWUD	68,241
Condoms	94,247
Treatment referrals	355

4. PREVENTION SUPPLIES FOR PWUD

Distributed **2,323,162**

Collected **1,939,743**

5. TESTING STRIPS

Fentanyl strips distributed **20,394**

Xylazine strips distributed **9,053**

6. OVERDOSE PREVENTION AND REVERSAL

Overdose prevention kits distributed **10,001** (20,002 doses)

Kits used to reverse an overdose **1,946**

7. STATEWIDE IMPACT

Preventing HIV spread by diagnosing **19** new cases

Saving lives by preventing overdose

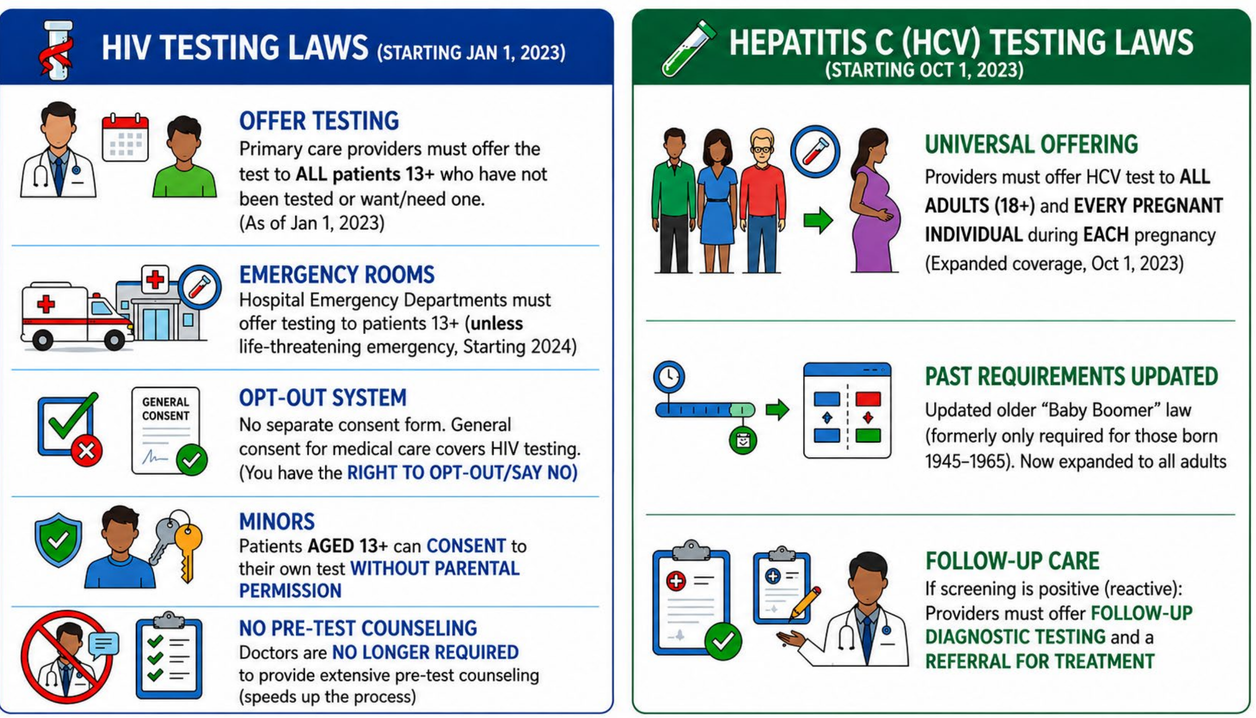
Stopping HCV

Saving millions in healthcare costs

HIV Testing Services

Figure III-24 summarizes Connecticut's routine HIV and HCV testing legislation that was passed in 2023. This sets the context for HIV and HCV testing.

Figure III-24. Routine HIV and HCV Testing Legislation in Connecticut



1.Services Needed for HIV Testing Access

Figure III-25 shows key findings from the 2022 statewide HIV Prevention survey completed by 2,038 respondents that help inform responses to this section.

HIV Testing. Prevention programs strive to keep the wait time for services less than 2 weeks. Forty percent (40%) of respondents reported waiting 2 weeks or less to receive services, 18% waited 3 weeks, 12% waited 1 month, and 7% waited more than one month. Over half of respondents (53%) were very or extremely satisfied with the prevention services they received. Only 2% were not satisfied. Respondents were asked about HIV testing they had received. The overwhelming majority had ever been tested for HIV (81%), with only 16% never being tested and 2% not sure if they had ever been tested. Among those who had been tested, at their most recent HIV test, 73% tested negative, 26% tested positive, and 1% didn't know their results. Thirty-four percent (34%) of respondents reported ever being denied an HIV test.

Evaluation "One-Stop Shop" Services for People Who Inject Drugs

A comprehensive analysis of the New Haven prevention services program for persons who use drugs since its inception and through the COVID-19 pandemic, findings suggest the services:

- Attract a high volume of clients
- Provide on-demand services
- Reaches a wide range of clients
- Serves as a model program

Source: Ibrahim N, Jones S, Rich K, Alvarez L, Price C, Kil N, et al. (2025). PLoS One 20(11): e0337528.

84% of prescribers and dispensers completing the HIV workforce survey indicated that they regularly offered HIV testing to their patients. Clinicians were less likely to offer routine HIV testing (36%).

Figure III-25. Notable Findings from the 2022 Connecticut HIV Prevention Survey

HIV TESTING & PREVENTION SERVICES
Service Wait Times
40%
18%
12%
7%
≤2 weeks
3 weeks
1 month
>1 month
Satisfaction:
Over 50% very/extremely satisfied
Only 2% not satisfied
Ever Tested for HIV
15%
2%
81%
Yes
No
Unsure
Denied an HIV Test (24%):
More likely among:
• Individuals aged 20–29
• Individuals with experiencing more risk factors

STD TESTING
Tested in Past 12 Months
61% Tested
34% Not Tested
Tested at Clinic/Health Center (31%)
More likely to test if free (48% of all respondents)

HCV TESTING
New CT Viral Hepatitis Testing Law (Oct 1, 2023)
Ever Tested for HCV
68%
Total
Tested Positive (54%):
38% positive in past 12 mos
Received Treatment:
85% of positive tests

SUD & MENTAL HEALTH SCREENING
Drug Use (Last 12 Mos)
45% No use
Injecting Drugs:
Half Ever
34% in Past 12 mos
74% shared prevention supplies or equipment
Wanted to Stop or Asked to Stop Using Drugs (48% of all respondents)

STD Testing. Over half of respondents reported being tested for STDs in the past 12 months (61%), while 34% reported not being tested. About a third of respondents (31%) reported being tested at a clinic or health center. All respondents were asked what would make it more likely for them to get an STD test. Almost half of respondents (48%) said they would be more likely to be tested if it were free.

53% of clinicians responding to the HIV workforce routinely conducted sexual health histories.

HCV Testing. A new Viral Hepatitis Testing Law (HB6733) became effective in Connecticut on October 1, 2023, that requires hepatitis C (HCV) testing among certain populations. Sixty-eight percent (68%) of respondents reported ever being tested for HCV. Individuals who identified as not male or not female were more likely to have ever been tested. Among respondents who had been tested for HCV, 54% had tested positive, with 38% testing positive within the past 12 months. Among respondents who tested positive for HCV, 85% received treatment.

73% of prescribers and dispensers completing the HIV workforce survey indicated that they regularly offered HCV testing to their patients compared to 36% of clinicians.

SUD and Mental Health Screening. Forty-five percent (45%) of respondents reported not using any drugs in the last 12 months. Half of respondents reported ever injecting drugs, with 34% injecting drugs within the past 12 months. Seventy-four percent (74%) of respondents who had ever injected drugs reported also sharing prevention supplies. Among all respondents, 48% reported that they have wanted to stop using drugs, or someone close to them asked them to stop using drugs. When asked about the number of days over the past month they had felt stressed, depressed, hopeless, isolated, anxious, or had other emotional problems, only 11% reported feeling like this for all 30 days. Thirty-five percent of respondents reported feeling suicidal within the past 12 months.

83% of prescribers and dispensers completing the HIV workforce survey indicated that they regularly conducted SUD risk assessments with their patients. Clinicians reported high rates of screening for mental health (88%) and alcohol and substance use screening (82%).

2. Services for Staying HIV Negative (e.g., PrEP, services for persons who use drugs)

PrEP. When asked about pre-exposure prophylaxis (PrEP), 81% of respondents had heard of it and 24% were currently taking it. Individuals who identified as not male or not female and White respondents were more likely to have heard of PrEP. Among respondents who were aware of PrEP but did not take it, the number one reason for not taking it was they didn't think they needed it. Among Prevention Needs Assessment Report respondents who were aware of PrEP but couldn't get it, the top two barriers to accessing PrEP were "I can't use my insurance because of privacy concerns," and "I'm afraid to talk to my doctor about it." The number one reason respondents stopped taking PrEP was "Too many labs and/or doctor's visits."

PEP. Seventy-six percent (76%) of respondents had heard of post-exposure prophylaxis (PEP), with 28% having used PEP. A clinic or health center was the most frequently utilized facility where PEP was accessed (42%). The number one barrier to accessing PEP was not feeling comfortable asking for it.

Condoms. When asked about condom use, 27% of respondents stated they always used one, and 12% never used one. The top three reasons these respondents didn't use a condom were because they were having sex with their regular partner (42%), they were having sex with someone they know (26%), and they already had sex with that person without a condom (20%).

Services for Persons who Use Drugs. CT DPH supports a statewide network of services for persons who use drugs. These community-based services provide access to prevention supplies and facilitate safe disposal of used prevention supplies and provide and link to other important services. In 2024, these programs served 10,797 individuals and distributed over 2.4 million prevention supplies (Figure III-23).

Finally, prescribers and dispensers completing the HIV workforce survey reported various degrees of biomedical services with 76% offering STD treatment followed by PrEP (68%), PEP (55%), and HCV medication (53%). See Figure III-22.

3. Rapid Linkage to HIV Care after Positive Diagnosis

Rapid linkage to HIV care in Connecticut—ideally defined as starting antiretroviral therapy (ART) within 48 to 72 hours of a positive diagnosis—is the current clinical standard. While state laws now mandate routine screening to find new cases, bridging the gap between a positive test and the first medical appointment faces several structural and psychological hurdles. Bridging the gap requires immediate case management to address housing and financial needs the same day a diagnosis is delivered.

Even when a diagnosis occurs in a clinical setting, several factors can delay the immediate start of treatment such as:

- *Inadequate Guidance*. Some patients report receiving positive results without clear instructions on where to go next or how to apply for financial assistance.
- *Documentation Requirements*. Rapid enrollment often requires proof of residence, income, or a government ID, which can be difficult for those experiencing homelessness or housing instability.
- Provider Capacity. High patient volume at major clinics in cities like Bridgeport, New Haven, and Hartford can lead to wait times for initial appointments that exceed the "rapid" 72-hour goal.
- *Priority to Address Basic Needs*. Some patients face extreme challenges related to social determinants of health (e.g., access to food, stable housing) and prioritize basic needs over healthcare. (See next section that also discusses persons with HIV survey results related to support services.)

Patients report facing psychological and social hurdles. A new diagnosis may cause emotional stress leading some individuals to self-isolate and avoid care for months or even years. Perceived or actual partiality from healthcare workers regarding sexual orientation or substance use can discourage patients from returning for follow-up care.

HIV Care and Treatment

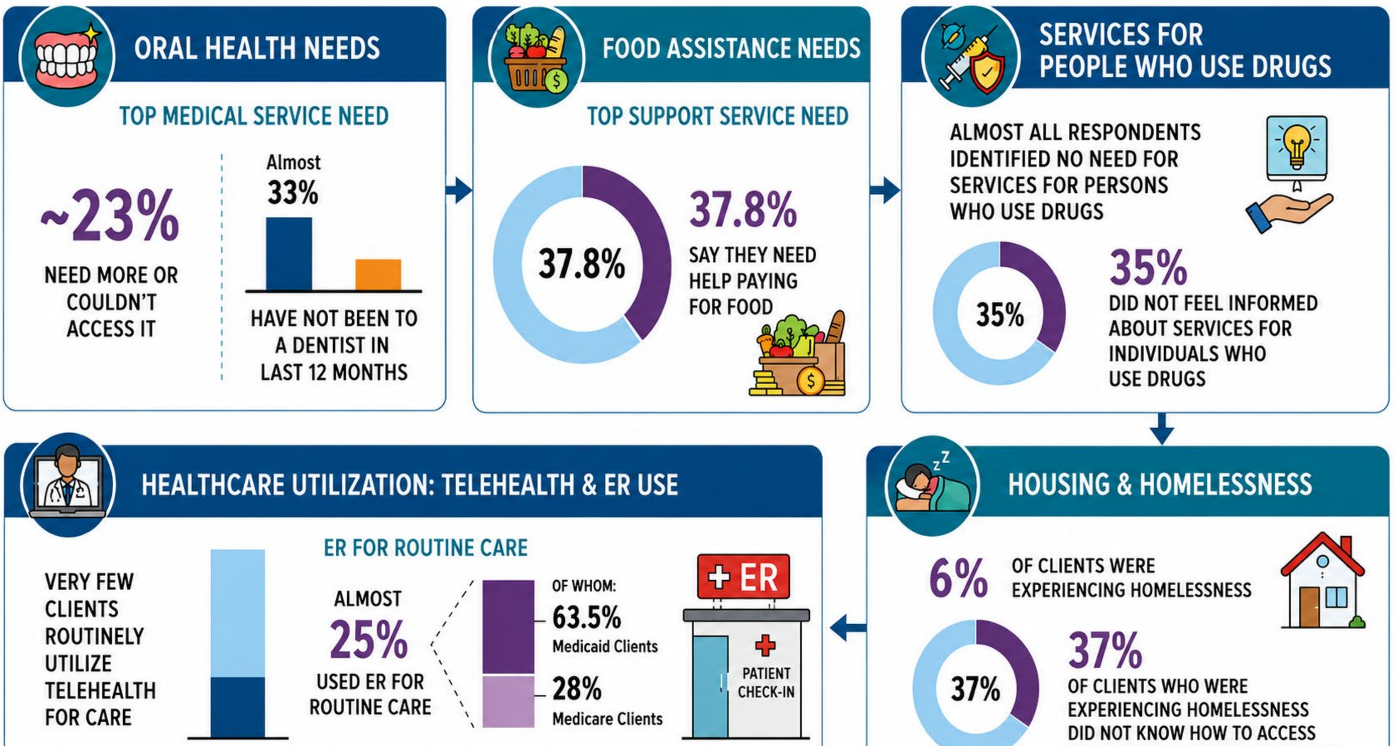
4. Services for Maintaining HIV Care and Reaching and Sustaining Viral Suppression

The Plan indicators suggest that room exists for improvement with respect to achieving viral suppression rates of 95% for all persons with HIV. Presently, the rate for persons with HIV receiving services from RWHAP funded programs is 91% whereas the statewide average for all persons with HIV hovers around 74%. Viral suppression rates vary by priority population as well.

The statewide persons with HIV needs assessment survey results provide useful insights about access to services for maintaining HIV care and reaching and sustaining viral suppression.

Services. Figure III-26 summarizes key findings about services from the statewide persons with HIV needs assessment survey.

Figure III-26. Notable Findings about Services from Persons with HIV Needs Assessment Survey



Oral Health was the top medical service identified as a need, with ~23% of respondents saying they need more or could not access it. Almost 33% have not been to a dentist in the last 12 months. Food was the top support service identified as a need, with 37.8% saying they need help paying for food. Almost all respondents identified no need for services for people who use drugs, but 35% of respondents did not feel informed about services for individuals who use drugs. Very few clients routinely utilize telehealth for their care. Almost 25% of clients used the Emergency Room for routine care, of whom 63.5% were Medicaid clients and 28% were Medicare clients. 6% of clients were experiencing homelessness, with 37% of those did not know how to access shelters or emergency housing.

Findings from the statewide HIV workforce survey, particularly the non-clinical respondents, indicate their top need was streamlined referral & linkage to care systems and a top challenge of improving patient access to services through transportation, insurance, and translation services. Many of the non-clinical respondents reported their patients experiencing homelessness, substance use, and involvement with the justice system. For these populations, social drivers of health affect treatment access and adherence to medication regimens. Administrators and program supervisors completing the workforce survey identified a gap related to translation services.

Client Education. Overall, of the 18 knowledge areas, a gap existed in 12 topics when asking clients if they felt well informed on the following: long acting injectables, ART, PrEP, PEP, HCV testing/treatment, resources for intimate partner violence (IPV), resources for reproductive health, sex positivity, recognizing abusive relationships, services for persons who use drugs, partner Services, community planning groups, and funding threats. A noticeable difference existed in knowledge broken out by gender. Women felt less informed on LAI ART, PrEP, PEP, SSPs, Partner Services, and funding whereas men felt less informed on resources for IPV, sex positivity, recognizing abusive relationships, resources for reproductive services, and planning groups.

Stigma and Partiality. The statewide persons with HIV needs assessment survey contained questions on stigma, partiality, and discrimination. Connecticut used questions form the Medical Monitoring Program (MMP), a study sponsored by CDC, but adjusted the responses to a “never, rarely, most of the time” response set (vs. Strongly agree, agree, disagree). These questions were part of an effort of the 2022-2026 Plan to gather baseline data that could inform a statewide indicator related to stigma, partiality, and discrimination.

With respect to internal stigma, overall, no significant difference existed 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. White respondents reported lower rates of concern regarding disclosing HIV status. Hispanic respondents were on the other end of the spectrum.

With respect to discrimination, a high rate of “Don’t Know” responses occurred for every question. Women identified higher rates of discrimination based on HIV status. Black respondents identified the highest rate of adverse experiences based on race. Overall, a significant difference did not exist between race, ethnicity, or gender for most responses. Most clients report little or no discrimination with their medical professionals.

The statewide HIV workforce survey included a subset of questions related to stigma and discrimination. Unlike the persons with HIV survey respondents, roughly one third of HIV workforce respondents reported that patients have shared that they experience stigma or discrimination.

Barriers to Access

1. HIV Testing Barriers

Approximately 93% of Connecticut residents with HIV are aware of their status as of 2025, several persistent barriers prevent the remaining 7% from accessing testing. These obstacles range from deep-seated social stigmas to logistical and financial challenges.

- *Fear and Stigma*: Many avoid testing due to the shame and social rejection associated with HIV. In Connecticut, young people specifically cite fear that peers or family might find out as a primary reason to skip testing.
- *Confidentiality Concerns*: Despite state laws protecting privacy, many—especially minors—are unaware of their right to confidential testing and fear their parents or guardians will be notified.
- *Perceived Risk*: A major barrier is the underestimation of personal risk, particularly among heterosexual women and those who do not identify as being in a "high-risk" group.
- *Logistical Constraints*: Typical clinical hours (8 AM to 4 PM) often clash with work schedules. Additionally, some men report feeling uncomfortable entering gender-specific clinics like Planned Parenthood for testing.

- *Financial & Insurance Issues*: Costs, lack of insurance, or the fear of a parent seeing the test on a joint insurance statement remain significant hurdles.

2. Challenges with State Laws and Regulations

Connecticut legislation provides a broad net of support needed to end the HIV epidemic beyond the routine HIV and HCV testing (Figure III-27). For example,

- *Public Act 23-19* allows a licensed retail pharmacy to operate a mobile unit for specific public health purpose such as vaccination clinics, opioid antagonist training, and providing healthcare to inadequately served communities.
- *Expanded Access (PA 23-52)* allows pharmacists and practitioners to partner with local health organizations, EMS, and even schools to distribute opioid antagonists (like Narcan) through secured boxes or vending machines.
- *Over-the-Counter (OTC) Availability* outlines regulations approved in 2024 permit the sale of non-prescription drugs, including Narcan and emergency contraception like Plan B, in vending machines across the state to improve 24/7 access. Legislation allows these machines to distribute fentanyl and xylazine test strips, which help individuals check for lethal additives in drug samples before use.
- *EMS Distribution (PA 23-97)* requires Emergency Medical Services personnel to provide overdose reversal kits (and educational materials) directly to patients who show symptoms of opioid use disorder or their families.
- Recent law established a *pilot program for three overdose prevention centers* in different municipalities. These centers provide a wide range of services, including fentanyl testing, counseling, and basic needs like meals or laundry.

Connecticut laws now mandate routine offers for testing, social stigma and lack of awareness about privacy rights continue to be the most significant hurdles for residents. Challenges with state laws and regulations vary and include:

- Redaction of small numbers to prevent deductive identification. The data suppression by CT DPH can limit the extent to which local health departments and districts can access data.
- Disease specific restrictions to sensitive data that prevent data sharing by CT DPH with local health departments and districts. These can be addressed only through formal written data sharing agreements with the individual patients.
- The HCV testing legislation does not currently include any language related referral to treatment options. A cure exists for HCV and connecting individuals who test positive to treatment makes sense.

3. HIV Prevention, Care, and Treatment Service Access Issues

All HIV prevention survey respondents were asked about ways prevention services could be improved. More education with the most frequently selected improvement opportunity for HIV, STD, and HCV prevention services. For substance use disorder, the number one improvement opportunity was increased access to substance use treatment.

a. Priorities

Figure III-27 describes key priorities arising from the needs assessment process.

Figure III-27. Key HIV Prevention and Care Priorities Identified through Planning and Community Engagement

b. Action Taken

The CHPC pilots data collection instruments with the relevant groups and uses feedback to adjust language and streamline the data collection process. Feedback from the pilots helped the group to shorten the survey and to improve language availability. The prevention and persons with HIV needs assessment surveys also included an incentive for completing the survey. No incentive was offered for respondents of the workforce survey. Other suggestions to help improve data collection related to offering real-time support from case managers to persons with HIV who requested assistance. Finally, the limitations of the methodology (Section c below) for data collection processes were taken into consideration during the discussion of the results. In some instances, additional conversations or focus groups were held for populations that may have been underrepresented in the statewide survey process.

c. Approach

Table III-7 describes the methodology used by the HIV Funders Group to support the core needs assessment processes relevant to SCSN project requirements.

Table III-7. Summary of Methodologies for SCSN Needs Assessment Projects

Description	Needs Assessment		
	Persons with HIV	HIV Prevention	HIV Workforce
Area	Statewide	Statewide	Statewide
Respondent	RWHAP patients	Prevention services and general public	Workers affiliated with RWHAP and prevention services

Table III-7. Summary of Methodologies for SCSN Needs Assessment Projects

Description	Needs Assessment		
	Persons with HIV	HIV Prevention	HIV Workforce
Survey Instrument	Revised 2022 needs assessment survey with stigma and partiality questions	Customize and modeled after similar projects in Nevada, Ohio, and San Diego, CA	Revised 2019 needs assessment survey with custom questions for 4 types of roles
Sampling Methodology	Random sample	Cross-sectional design	Convenience sample
Survey Administration	Online	Online and in-person (public intercept)	Online
Limitations	All surveys were affected by factors that influenced the interpretation of the findings such as sampling partiality, self-reported data, survey administration, mental health variables, and generalizability, among others		
Data Collection	September 19, 2025 to November 21, 2025	October 31, 2022 to December 31, 2022	October 14, 2025 to November 21, 2025
Survey Assistance	Case Managers	Not applicable	Not applicable
Language Option	English, Spanish	English, Spanish	English
Incentive	$25 gift card	$10 gift card	Not applicable
Response Size	1,018	2,038	221
Race/Ethnicity	**37%** Black **42%** Hispanic **17%** White	**25%** Black **20%** Hispanic **43%** White	**23%** Black **30%** Hispanic **46%** White
Sex	**55%** men **45%** women	**35%** men **36%** women	**17%** men **79%** women
Age	**5%** 20-29 years **14%** 30-39 years **15%** 40-49 years **23%** 50-59 years **40%** 60+ years	**3%** 10-19 years **38%** 20-29 years **37%** 30-39 years **12%** 40-49 years **7%** 50-59 years **3%** 60+ years	**1%** 18 to 24 years **28%** 25 to 34 years **25%** 25 to 44 years **15%** 45 to 54 years **8%** 65+ years
Other	Not applicable	Not applicable	**36%** clinical **23%** administrative **23%** non-clinical **18%** prescriber/dispenser

Summary reports or presentation of the surveys will be made available upon request to CT DPH.

** * * * * End of Section III * * * * **

Section IV. Situational Analysis

Connecticut's efforts to end the HIV epidemic are driven by a syndemic approach, which acknowledges that HIV, STDs, HCV, and SUD are biologically and socially intertwined.

Despite robust clinical infrastructure, systemic "social drivers of health" such as housing instability, economic shifts, and healthcare fragmentation, continue to sustain the epidemic in disproportionately impacted communities.

THESE BARRIERS DON'T JUST AFFECT HEALTH—THEY ANCHOR THE EPIDEMIC.

SOCIAL DRIVERS OF HEALTH

- Housing Instability
- Economic Shifts
- Healthcare Fragmentation

DISPROPORTIONATE IMPACT

Use surveillance data to identify populations and communities most impacted.

PLACE MATTERS

These barriers affect individual health and anchor the epidemic in specific zip codes and demographics.

Not evenly distributed. Not equally felt. But together, we can change that.

When the system fails to address the "syndemic" nature of HIV—ignoring the overlap with mental health, substance use, and poverty—it ensures that clinical advancements remain out of reach for the very people who need them most.

CONNECTICUT'S PLAN BUILDS STRONGER PILLARS THROUGH CROSS-CUTTING ACTIONS

1 EXPANDING WHOLE PERSON CARE

Addressing physical, mental, and social needs together to improve health access.

2 PROMOTING THE SYNDEMIC APPROACH

Integrating services and policies to tackle HIV, STDs, HCV, SUD, and co-occurring conditions together.

3 EMBRACING SYNDEMIC EDUCATION

Building knowledge and akills across communities and systems to drive smarter, more compassionate care.

4 BUILDING SYSTEMS & BEHAVIORS TO END STIGMA

Creating inclusive systems and communities where everyone is respected, supported, and empowered.

1. Situational Analysis

Overview

Table IV-1 shows a statewide overview of strengths, challenges, and need across the EHE pillars.

Analysis of Structural and Systemic Issues Impacting People and Communities Disproportionately Impacted by HIV

Evidence-based strategies and advanced clinical tools exist in Connecticut. However, the structural environment limits universal access and results in adverse health effects for people and communities disproportionately affected by HIV. The following paragraphs describe the more prominent structural and system barriers for each ending the HIV epidemic Pillar. Section III contains quantitative evidence related to gaps and barriers.

Figure IV-1. Systemic Barriers Impacting Connecticut's Ending the HIV Plan

Table IV-1. Overview Across the HIV Prevention and Care Continuum: Strengths, Challenges & Identified Needs

Pillar	Strengths	Challenges	Identified Needs
Diagnose	• High awareness of HIV status • Routine HIV/HCV testing legislation • Broad testing entry points • Emerging use of syndemic screening and testing • Statewide public awareness campaigns	○ Stigma and privacy ○ High rate of late HIV diagnoses ○ Differences in access to services by people and communities ○ Provider compliance with routine HIV/HCV testing laws ○ Expansion of routine HIV/HCV testing in non-clinical sites ○ Expansion of rapid and integrated testing models – including for STDs ○ Out-of-state and insurance testing results not shared – sometimes even with the individuals	▪ Awareness of HIV/HCV testing laws ▪ Routine HIV/HCV testing in clinical and non-clinical settings – including self-testing ▪ Better engagement of people and communities disproportionately affected by HIV ▪ Provider education and training
Treat	• High viral suppression rates in PWH served by RWHAP funded services • Robust CADAP formulary and financial support • RWHAP Part A, B, C, D and F resources for medical and support services • Mobile healthcare and pharmacy services • Quality management initiatives and supportive data systems	○ Lower viral suppression rates in PWH served by non-RWHAP funded providers ○ High social vulnerabilities and economic distress ○ Not in care or lost to care due to lack of insurance, SUD, or mental health ○ Aging HIV population faces other chronic conditions ○ Access to support services that lead to stability for treatment regimens ○ Access to medical case management for PWH served by non-RWHAP funded providers	▪ Low-barrier clinical models – one-stop clinics ▪ Rapid start ART and knowledge of long-acting medications ▪ Viral suppression rates of PWH served by non-RWHAP funded providers ▪ Referral resources and process for access to HIV specialists ▪ Addressing basic needs (SDOH) ▪ Better engagement of people and communities disproportionately affected by HIV
Prevent	• Statewide Prevention services for people who use drugs with comprehensive service offerings • Condom distribution • Emerging PrEP-DAP program • Statewide public awareness campaigns	○ Uneven sexual health education in schools ○ New statewide condom distribution plan and local access to condoms in areas of high need ○ Values and beliefs about PrEP ○ Access to DoxyPep ○ Concerns about used prevention materials	▪ Increase awareness, access, and uptake of PrEP, PEP, and DoxyPEP ▪ Provider education and training ▪ Better engagement of people and communities disproportionately affected by HIV
Respond	• Statewide HIV Outbreak and Response Plan • Molecular surveillance • Monthly surveillance reviews by integrated CT DPH teams • Use of syndemic approach and social vulnerability data to identify hot spots • Data to Care initiative to identify and re-engage out-of-care • Response TA by CT DPH surveillance team to providers	○ Community trust (e.g., privacy) ○ Time lags in reporting ○ Sustainable funding for DIS ○ Increasing provider knowledge and compliance for reporting ○ Multiple data systems ○ Transient populations	▪ Additional capacity for rapid molecular testing ▪ Access by local health departments to data ▪ Develop resources for referral pathways for ancillary services, like services for justice-involved individuals ▪ Enhancing community pathways for input and engagement on Outbreak and Response Plans ▪ Protocols to expedite community input on emerging outbreaks ▪ Data sharing agreements ▪ Protocols to analyze negative HIV/HCV labs

a. Diagnose

Despite high overall awareness of HIV status, the diagnostic system(s) do not yet reach the most vulnerable populations.

- *Late Diagnoses*. Far too many newly diagnosed persons with HIV are advancing to AIDS, signaling a failure in routine screening and testing.
- *Uneven Routine Testing and Syndemic Misses*. HIV testing is not yet universally "opt-out" across all primary providers and emergency departments, where many individuals seek primary care. The rapid expansion of urgent care settings creates new challenges because patients typically visit urgent cares in response to specific symptoms versus a primary care visit.

Missed Opportunity

CT DPH epidemiologists and DIS responding to newly diagnosed persons with HIV regularly see missed opportunities. Providers have screened and even treated for STDs; however, HIV went undetected for months or even years. The emergence of urgent care settings and an "issue-based" approach to care translates to missed opportunities for routine testing.

While a cure for HCV exists, testing to identify cases continues to be challenging.

- *Testing Access*. In urban areas as well as rural pockets, a lack of syndemic testing sites, providers who may not look like the patients, and fear of stigma continues to limit early engagement. Timely and accurate compliance to communicate reportable disease conditions with CT DPH remains a challenge.
- *Innovation*. Standing up, scaling, and integrating innovative approaches to testing such as mobile healthcare and pharmacy services, home-testing, and telehealth is complex work.

b. Treat

Although Connecticut boasts a robust infrastructure through CADAP and Medicaid coverage, systemic friction points prevent these tools from achieving universal viral suppression. The "Treat" pillar is currently undermined by several structural failures:

- *Survival Gap*. Clinical care is only as effective as a patient's living environment. For those facing housing instability, unemployment, or mental health issues, medical adherence becomes secondary to survival. The hidden costs of care—such as pharmacy travel, co-pays for lab work, and lack of food to take with medication—create a high-barrier system that effectively excludes the state's most vulnerable residents.
- *Clinical Access & Referral Trap*. A stark difference exists in outcomes between Ryan White programs and general healthcare providers. Many primary care clinicians and pharmacists lack the "HIV comfort" or technical knowledge required for modern treatment, let alone same day treatment. This leads to a "Referral Trap," where patients are burdened with navigating new systems and locations just to receive basic care, increasing the likelihood they will fall out of the continuum.

System Breakdowns and Disconnects

A prescription suggests an individual is "in care". In reality, successful treatment requires stable housing, food security, and affordable transportation. The system breakdowns often involve physical and financial logistics of daily life.

- ***Medication access*** may be affected by availability of medication or a pharmacy benefit tied to a specific pharmacy.
- ***Lab and other co-pay costs*** can result in a patient missing an important appointment or renewing a prescription.
- ***Lack of access to safe, private place*** to store food and medication may affect adherence to medication regimens.

- *The Comorbidities of Aging*. With the majority of Connecticut residents living with HIV aged 55 and older, the care system is encountering new challenges. HIV care is rarely integrated with geriatric medicine, leaving the state under-equipped to manage the complex intersection of HIV with age-related conditions like diabetes and cardiovascular disease.
- *Vanishing Expertise and Rapid Start Roadblocks*. The frontline of treatment is shrinking. A wave of pharmacy

closures and staff turnover has depleted the pool of experts who understand complex ART billing. Furthermore, many providers lack the on-site medication supplies necessary for Rapid Start treatment, shifting the burden onto the newly diagnosed patient.

- *Administrative Burden*. The Treat pillar is complicated by a patchwork of Medicaid, private insurance, and Ryan White regulations. Providers are forced into "redundant data entry" across multiple systems, stealing time from patient care. This administrative bloat makes it harder to track surveillance data or re-engage patients who have disconnected from care.

Connecticut does not have a medication problem; it has a logistics and infrastructure problem. To end the epidemic, the state must transition from a model that simply "offers" medicine to one that removes the economic and administrative friction of staying on it. As HIV has become less of a specialty, more primary care providers are needed who are willing and able to provide HIV treatment as a part of overall health and wellness care.

c. Prevent

Connecticut's **Prevent** pillar is anchored by high-quality clinical options like PrEP and DoxyPEP, but its impact is limited by systemic friction that affects populations and communities disproportionately affected by HIV. To end the epidemic, the state must move beyond simply "offering" tools and accelerate the dismantling of the structural hurdles that prevent their consistent use.

- *Persistence Trap*. Prevention is not a one-time prescription but rather a supported journey. A shift toward long-acting injectable PrEP and peer-led navigation can help patients manage the logistics of long-term protection.
- Access. Clinical tools are effective with access. Prevention access is concentrated in major cities, leaving rural and suburban residents—especially those without reliable transportation—in "prevention deserts." Decades of medical mistrust and the persistence of PrEP stigma in healthcare settings prevent many high-risk individuals from even starting the conversation with their providers.
- *Hidden Costs*. Even when the medication itself is "free" or covered by insurance, the ancillary costs of staying protected can be prohibitive. Mandatory labs for kidney function and STDs can trigger unexpected, high out-of-pocket costs that cause low-income users to drop out of care. Tools like condoms remain high-barrier items, often locked behind plexiglass in pharmacies or priced as luxuries making them out of reach due to cost or embarrassment. creating a "pay-to-prevent" model that excludes youth and the underemployed.
- *Syndemic Disconnect*. Connecticut's prevention efforts have historically been siloed. A person seeking PrEP might be sent to one clinic, while their need for mental health support, housing, or substance use treatment is handled elsewhere—if at all. The state is moving toward a Whole Person Approach, where a negative HIV test is not the end of a visit, but the beginning of a comprehensive plan that integrates HIV prevention with STD care, Narcan distribution, and housing support.

Cost of Prevention? Public Health vs. Private Retail

Even the most effective prevention tool like a condom fails without public access. For low-income individuals who may be sexually active, the highly effective primary prevention tool of a condom may represent a luxury item.

A small box of condoms at a retail pharmacy may costs $15 to $20. Individuals who seek to access condoms from retail spaces may also need the courage to face social judgment at the checkout counter.

Prevention costs and access impacts people and communities disproportionately affected by HIV.

To succeed, Connecticut must transition from a clinical model to a structural model, focused on supporting the whole person.

d. Respond

Connecticut maintains a sophisticated defense system anchored by the Connecticut HIV Cluster and Outbreak Detection Response Plan (CDR). The CT DPH utilizes molecular surveillance and monthly syndemic reviews—integrating HIV, Hepatitis C, and social vulnerability data—to identify hotspots. Programs like Data to Care further strengthen this by identifying and re-engaging individuals who have fallen out of the healthcare system.

Structural challenges include:

- *The Trust Gap*. Concerns regarding privacy and the potential use of molecular data and private information create a barrier between public health teams and the communities they serve.
- *Data Fragmentation*. The response is hampered by reporting lags and a lack of integration with out-of-state activities and private insurance data. Teams must navigate multiple, disconnected databases to track highly transient populations.
- *Resource Constraints*. A lack of sustainable funding for DIS and inconsistent provider compliance in reporting hinder the state's ability to act in real-time.
- *Community-Led Response*. The state must establish protocols that expedite community input and create formal pathways for engagement on outbreak plans, ensuring the response is "done with" rather than "done to" the community.
- *Integrated Monitoring*. New data-sharing agreements and protocols to analyze negative HIV/HCV labs are needed to better understand the "true" landscape of risk and prevent new clusters before they emerge.

Disease Intervention Specialists (DIS): An Obstacle Course

DIS work illustrates multiple barriers and obstacles relevant to ending the HIV epidemic.

- ***Gatekeeper Barriers***. DIS rely on the clinical provider to share information legally required for public health follow-up. Providers vary in their capacity, availability, and even understanding of this process.
- ***Referral Loops***. Providers vary in their knowledge of HIV protocols and may refer DIS workers to other specialists where the patient was referred.
- ***Electronic Health Records***. Access to and completeness of social history section of the electronic health records varies and may reflect decisions made by providers based on perceived “low risk”.

Connecticut has the analytical capacity and tools to detect clusters. It lacks the structural "connective tissue" to respond at the speed of the epidemic. Success requires bridging the gap between state-level data and local, community-trusted action.

a. People and Communities Disproportionately Impacted by HIV

Connecticut’s Plan to end the epidemic is affected by systemic and structural barriers and challenges across the HIV prevention and care continuum. In urban centers, these hurdles create a compounding effect that stalls progress toward ending the epidemic. Systemic and structural barriers in Connecticut transform manageable health conditions into a cycle that can change preventable, manageable, and even curable health conditions into individual and community crises (Figure IV-2).

These barriers affect individual health and anchor the epidemic in specific zip codes and demographics. When the system fails to address the "syndemic" nature of HIV—ignoring the overlap with mental health, substance use, and poverty—it ensures that clinical advancements remain out of reach for the very people who need them most.

Figure IV-2. The Cycle of Exclusion: How Stigma and Erosion of Trust are Fueled by Other Factors

Rooted in Social Determinants of Health

Systemic barriers that disproportionately affect certain communities directly impact their ability to receive healthcare.

Breaking the Cycle Takes All of Us

By addressing stigma, building trust, and removing structural barriers, we create a cycle of inclusion, access, and better health for all.

1 Social and Economic Gaps

Poverty, housing instability, food insecurity, and limited resources create survival priorities over health.

2 Stigma and Perception

Judgment, bias, and negative perception in communities and systems drive fear and silence.

3 Erosion of Trust in Systems

Growing gaps in ability to receive services and care lead to mistrust of healthcare, government, and community systems.

4 Barriers to Care

Late testing, complex systems, cost, transportation, and limited culturally responsive services delay or prevent care.

5 Worse Health Outcomes

Higher rates of new HIV diagnoses, advanced disease, and lower viral suppression increase gaps in health access access.

Stigma and Erosion of Trust

Feeling judged, unsafe, or unwelcome leads to disengagement from care.

Solutions That Break the Cycle

- Invest in communities and address social determinants of health
- Promote health access, cultural humility, and anti-stigma efforts
- Build and sustain trust through transparency and community partnerships
- Expand accessible, culturally responsive services
- Monitor, evaluate, and improve for lasting impact

To make the ending the HIV epidemic pillars more effective, Connecticut's Plan (Section V) includes cross-cutting activities such as:

- *Expanding Whole Person Care*. Providers are trained to treat every patient with the same high level of care, regardless of their HIV status. A "positive" result leads to the Treat pillar, while a "negative" result leads to the Prevent pillar.
- *Promoting the Syndemic Approach*. Integrating and coordinating overlapping health issues creates a total health model and encourages health care delivery systems and providers to expand patient access to comprehensive, one-stop-shop care that addresses the root social and biological factors driving all four epidemics (HIV, HCV, STD, SUD).
- *Embracing Syndemic Education*. Opportunities exist to expand integrated HIV, HCV, and STD testing. Both patients and providers cite a lack of knowledge on syndemic testing and prevention methods and appear eager to implement whole-person approaches. Addressing these education gaps will lead to healthier populations.
- *Building Systems and Behaviors to End Stigma*. Connecticut continues to address stigma reduction which often prevents people from engaging with any of the four pillars. This work draws upon a strong partner network for provider education, training, and capacity building as well as efforts to increase patient self-management and peer-support models.

** * * * * * End of Section IV * * * * **

Section V. 2027-2031 Goals and Objectives

Connecticut's Plan represents a continuation of the 2022–2026 Plan. It addresses both HIV prevention and care needs, and ensures a comprehensive, coordinated approach for all HIV prevention and care funding.

THREE OVERARCHING GOALS

GOAL 1

End the HIV epidemic

Reduce new HIV infections by increasing testing, preventing transmission, and ensuring all people with HIV achieve viral suppression.

GOAL 2

Address the intersecting epidemics of STDs, HCV, and SUDs by using a syndemic approach

Integrate services and address the overlapping biological and social factors that drive HIV and related health outcomes.

GOAL 3

Enhance and expand health access

Remove barriers, strengthen systems, and promote universal access to high-quality prevention, care, and support services.

OUR 2031 INDICATORS OF SUCCESS

95% of persons with HIV are aware of their status

An increase from **92.2%** in 2023

25 persons with HIV are newly diagnosed in 2030

A **90%** decrease from the 2023 baseline of **246**

95% of newly diagnosed persons with HIV attend a healthcare visit within 1 month of diagnosis

An increase from the 2023 baseline of **83%**

95% of persons with HIV are virally suppressed

An increase from the 2023 baseline of **74%**

OUR FOUR PLAN PILLARS AND GOALS

GOAL: Increase HIV testing and identify all people with HIV as early as possible.

GOAL: Engage and retain people with HIV in care and achieve viral suppression.

GOAL: Reduce new HIV transmissions through evidence-based prevention strategies.

GOAL: Respond quickly to outbreaks and address health access.

1. Goals and Objectives Description

Overarching Objectives

Connecticut's Plan represents a continuation of the 2022-2026 Plan. It addresses both HIV prevention and care needs, and ensures a comprehensive, coordinated approach for all HIV prevention and care funding. The 2027-2031 Plan includes three overarching goals:

- End the HIV epidemic
- Address the intersecting epidemics of STDs, HCV, and SUDs by using a syndemic approach
- Enhance and expand health access

Integrating HIV, STDs, Hepatitis C (HCV), and substance use disorder (SUD) into a unified syndemic approach is the most effective way for Connecticut to end the HIV epidemic. This strategy acknowledges that these conditions do not exist in isolation but rather interact to worsen health outcomes (Figure V-1).

Figure V-1. The Power of the Syndemic Approach

A SYNDEMIC REALITY

HIV, STDs, HCV, and SUD often occur together and are driven by the same social, economic, and structural factors.

HIV
STD
People not conditions
HCV
SUD

A syndemic approach addresses multiple health challenges together—improving health outcomes and saving lives.

SHARED RISK FACTORS

Unprotected sex and multiple partners
Sharing prevention supplies
Overlapping sexual and drug-using networks
Prior incarceration and criminalization
Unstable housing and homelessness
Limited access to prevention and care

IMPACT OF SOCIAL DRIVERS OF HEALTH

Poverty and income instability
Stigma
Trauma and adverse childhood experiences
Low education and health literacy
Lack of transportation
Housing insecurity
Food insecurity

SOLUTIONS: A SYNDEMIC RESPONSE

WHOLE-PERSON CARE
Treat the whole person, not just the disease.
Medical Care
Mental Health Services
Substance Use Treatment
Peer Support and Navigation
Social Services and Basic Needs
Culturally Responsive and Trauma-Informed Care

INTEGRATED SERVICE DELIVERY
Coordinated, client-centered services in one place or through strong partnerships.
HIV Prevention and Care
STD Testing and Treatment
HCV Screening and Treatment
SUD Treatment and Recovery

INCREASED ACCESS
- Low-barrier services
- Flexible and convenient options
- Community-based and mobile services

STIGMA
- Respect and dignity for all
- Welcoming environments
- Policies and practices that promote health outcomes

BETTER OUTCOMES FOR ALL

IMPROVED HEALTH
STRONGER COMMUNITIES
REDUCED GAPS IN HEALTH OUTCOMES
MORE EFFICIENT SYSTEM
PROGRESS TOWARD ENDING THE EPIDEMICS

A syndemic approach offers multiple advantages and benefits such as:

- *Efficiency and impact* through coordinated and combined funding and staffing for multiple conditions, promoting comprehensive whole person care in one visit, and reaching people through multiple access points to prevent missed opportunities and identify and treat multiple conditions.
- *Clinical proficiency* by addressing shared transmission risks, providing integrated screening, and addressing health concerns in a holistic manner as well as improving health outcomes.
- *Health Access* by breaking down silos and simplifying a fragmented healthcare system for patients, reducing stigma and normalizing HIV care within multiple settings (e.g., primary care, emergency care, SUD treatment facilities, STD clinics) and creating a "no wrong door" approach where services can be rendered at various access points in urban and rural communities.

Using a syndemic framework considers people, places, science and action. The approach moves Connecticut from "treating diseases" to "treating people." By centering people, addressing the root causes and co-occurring conditions together, and leveraging resources, the state can close the gaps that allow the HIV epidemic to persist.

Ending the HIV Epidemic Plan Pillars

Figure V-2 shows the Plan pillars and objectives. Connecticut's Ending the HIV Epidemic Plan aims to eliminate new transmissions by 2031 through four pillars: increasing HIV/HCV testing, accelerating rapid care linkage to achieve 95% viral suppression, expanding PrEP and prevention access, and implementing focused, rapid outbreak response. Key objectives include strengthening clinical testing by 10%, raising viral suppression rates to 95%, and enhancing prevention outreach for high-risk populations.

The subsequent pages provide a description of Connecticut's 2027-2031 Plan including pillar goals, pillar objectives, and key activities for the five (5) years of implementation. Section VI contains additional information about implementation, performance measurement, evaluation, monitoring, and reporting. The plan moves away from "siloed" care toward a model where every medical encounter addresses multiple risks at once:

- *Dual Screening* (DIAGNOSE): Objectives D1 and D2 integrate HIV and HCV testing, recognizing that these infections often co-occur.
- *Risk Reduction* (PREVENT): Objective P2 focuses on people who use drugs (PWUD), acknowledging that SUD is a primary driver for HIV and HCV transmission. It also focuses on people at risk through sexual transmission by prioritizing PrEP uptake and condom distribution.
- *Whole-Person Care* (TREAT): Objectives focus on providing a "whole-person" approach where treatment for one condition—like SUD—is seen as a critical step to achieving viral suppression for HIV.
- *Outbreak and Cluster Detection* (RESPOND): Objectives focus on using surveillance data to monitor epidemics and respond accordingly.

Stigma and discrimination often prevent people from seeking care. The plan counters these barriers through several targeted strategies:

- *Community-Led Solutions*: The Ending the Syndemic (ETS) Committee and programs like Positive Prevention CT use community engagement to ensure services are culturally competent and welcoming.
- *Strategic Resource Allocation*: Objective R3 uses the Area Deprivation Index in concert with incidence and prevalence data to proactively fund the five most historically underserved communities experiencing higher burden of disease, directly challenging the structural barriers.
- *Education and Awareness*: Marketing campaigns (like U=U) and provider trainings aim to re-educate the public and medical professionals, reducing the judgment associated with HIV, drug use, and sexual health.

Figure V-2. Connecticut's Ending the HIV Epidemic Plan Pillars and Objectives

Progress on all objectives will be reviewed annually, particularly objectives that focus on publicly funded services. Changes in the broader healthcare system will be necessary to end the HIV epidemic and will require additional time and partnerships.

DIAGNOSE

GOAL

Increase HIV testing and identify all people with HIV as early as possible.

OBJECTIVES

- **D1** Increase HIV/HCV testing by 10% (9,632) in publicly funded clinical settings by 12/2031.
- **D2** Increase HIV/HCV testing by 10% or 282 tests in DPH funded non-clinical settings by 12/2031.
- **D3** Develop an approach to assess, analyze, and share statewide HIV testing volume by 12/2028.

TREAT

GOAL

Engage and retain people with HIV in care and achieve Viral suppression.

OBJECTIVES

- **T1** Increase the percentage of newly diagnosed PWH who attend a routine care visit within 1 month of diagnosis from 83% (2023) to 95% by 12/2031.
- **T2** Increase the percentage of newly diagnosed PWH prescribed ART within 12 months from 92% (2023) to 95% by 12/2031.
- **T3** Increase the percentage of PWH achieving viral suppression from 74% (2023) to 95% by 12/2031.

PREVENT

GOAL

Reduce new HIV transmissions through evidence-based prevention strategies.

OBJECTIVES

- **P1** Increase the PrEP-to-NEED Ratio from 23.1 (2023) to 36 by 12/2031.
- **P2** Increase the number of individuals accessing publicly funded prevention services for people who use drugs from 9,500 (2023) to 11,000 by 12/2031.
- **P3** Increase condom distribution in publicly funded programs by 10% from 876,500 (2023) to 964,150 by 12/2031.

RESPOND

GOAL

Respond quickly to outbreaks and address health access.

OBJECTIVES

- **R1** Update syndemic outbreak and response plans annually.
- **R2** Identify syndemic and single disease condition transmission clusters and outbreaks.
- **R3** Provide resources and tools to 5 communities with high Area Deprivation Index scores.
- **R4** Disease Intervention Specialists or Partners Services contact 85% of newly diagnosed HIV positive individuals.

DIAGNOSE Increase HIV Testing and Identify All People with HIV as Early as Possible

Objective D1. Increase HIV/HCV testing by 10% or 9,632 tests (baseline 96,326 in 2024) in publicly funded clinical settings by 12/2031

Early diagnosis 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. 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. Offering routine testing to patients when they have the opportunity will reduce stigma and new diagnoses.

Routine Testing is the Law in Connecticut

Connecticut has officially entered a new era in public health, making routine HIV and Hepatitis C (HCV) testing a standard part of everyday healthcare. By normalizing these screenings, the state is removing the guesswork and stigma from essential health checks, ensuring that no one is left behind. Starting in 2023, Connecticut primary care providers and emergency departments are required to offer:

- HIV Testing offered to all patients aged 13 to 64 in primary care settings and emergency rooms
- HCV testing offered to all adults aged 18 and older, as well as pregnant individuals during each pregnancy

Objective D1. Increase HIV/HCV testing by 10% or 9,632 tests in DPH funded clinical settings by 12/2031

Key Activities	• Create at least one Statewide integrated HIV/HCV screening and testing awareness campaign for providers to increase routine testing among non-DPH funded provider sites in high impact areas • Conduct personalized academic detailing sessions with healthcare providers in urgent care, emergency departments, and primary care settings to increase routine HIV/HCV testing • Increase the use of the syndemic screening tool to expand STD and SUD screening in publicly funded clinical settings • Develop process to analyze late tester data and identify locations that have a high percentage of late testers to provide education on implementing routine HIV/HCV testing • Annually organize at least 3 testing events in partnership with healthcare facilities • Expand routine testing in clinical sites by using pharmacy mobile units, extended clinic hours, or new testing locations • Expand the number of Emergency Departments and FQHCs in high-prevalence communities performing routine opt-out HIV screening • Distribute digital syndemic resources and materials to clinical providers statewide • Annually evaluate the status of all activities and progress on objective
Performance Measures	○ # 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 ○ # of individuals who are late testers in clinical settings ○ # and % of persons with HIV who are aware of their status ○ % of late testers
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

DIAGNOSE Increase HIV Testing and Identify All People with HIV as Early as Possible

Objective D2. Increase HIV/HCV testing by 10% or 282 tests (baseline 2,824 in 2024) in DPH funded non-clinical settings by 12/2031

Early diagnosis 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. To truly end the syndemic, healthcare must move beyond the four walls of a clinic and into the heart of the community. Outreach in non-traditional settings is the cornerstone of this movement, meeting people in the parks, transit hubs, and neighborhoods where they live and congregate.

Strategies like "street" outreach—where frontline workers carry testing kits and prevention materials directly to people experiencing homelessness—and face-to-face engagement bridge the gap for those who may feel alienated by traditional medical institutions. By utilizing these unconventional entry points, Connecticut transforms every interaction into a life-saving opportunity, dismantling barriers of stigma, transportation, and distrust to ensure that health access is a reality for everyone.

Non-Clinical Testing Models in Connecticut

- **Waterbury Mobile Unit.** The City of Waterbury uses a mobile unit to provide rapid testing, medication adherence support, and case management.
- **Yale Community Health Care Van (CHCV).** Operating in New Haven since 1993, the mobile clinic provides barrier-free prevention services for people who use drugs, primary care, and HIV testing directly in the community.
- **Free In-Home Test Kits**. The CT DPH partners with local agencies to distribute free HIV self-test kits that residents can use in private, with results available in 20 minutes.
- **Event-based Outreach**. Numerous public health fairs and testing days meet people where they are at in their communities.

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

Objective D2. Increase HIV/HCV testing by 10% or 282 tests in DPH funded non-clinical settings by 12/2031

Key Activities	• Increase HIV/HCV testing in outreach non-traditional settings (e.g., social establishments, faith-based groups, low-income housing) located in communities impacted by HIV/HCV identified via local epidemiological data • Identify, recruit, onboard, and deploy mobile testing units to provide HIV/HCV testing in high impact settings such as faith-based groups, shelters, food pantries, local businesses and substance use treatment centers • Increase HIV at-home or self-testing options for STDs by expanding participating providers offering test kits • Annually review local data to inform outreach to increase HIV/HCV testing in non-clinical settings
Performance Measures	○ # of and geographic location of non-clinical partners offering routine testing options ○ # of individuals who receive HCV and HIV tests in non-clinical settings ○ # individuals using at home HIV testing or STD self-testing options ○ # and % of persons with HIV who are aware of their status
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

DIAGNOSE Increase HIV Testing and Identify All People with HIV as Early as Possible

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

Early diagnosis 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 clinical and 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).

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.

Recent Advancement in Public Health Surveillance

The shift toward analyzing HIV-negative lab data, rather than focusing solely on positive results, marks a revolutionary advancement in public health surveillance. By capturing the full volume of testing—not just the outcomes—health partners can finally see the big picture: where people are being tested and, more importantly, where they are being missed.

This comprehensive data serves as a diagnostic tool for the healthcare system itself, allowing Plan Partners to identify specific geographic testing gaps. Instead of reacting to new diagnoses, Connecticut can now proactively measure the success of testing efforts across primary care, emergency departments, and non-traditional settings.

Objective D3. Develop a methodology to assess, analyze, and share HIV/HCV testing volume data by 12/2028

Key Activities	• Develop approach to analyze HIV negative lab tests • Pilot methodology for use of data from HIV negative lab tests (e.g., understand routine testing) • Use new data to revise Plan indicators • Use data to inform objectives D1 and D2 and revise them to include all sites providing syndemic testing
Performance Measures	○ Methodology for HIV negative lab tests ○ Update to statewide Plan indicators ○ # and % of persons with HIV who are aware of their status ○ % of late testers
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

TREAT Engage and Retain People with HIV in Care and Achieve Viral Suppression

Objective T1. Increase the percentage of newly diagnosed PWH who attend a routine care visit within 1 month of diagnosis from 83% (2023) to 95% by 12/2031

In the race to end the HIV epidemic, time is the most effective intervention we have. Rapid Start treatment protocols—starting antiretroviral therapy (ART) on the very same day as a diagnosis or at the first medical visit—represent a profound shift from "wait and see" to "treat and thrive." By eliminating the weeks of anxiety and administrative hurdles that traditionally followed a diagnosis, Rapid Start capitalizes on a patient's immediate motivation to take charge of their health. This approach does more than just lower the viral load quickly; it builds immediate trust, reduces the psychological burden of a new diagnosis, and moves patients toward a status where the virus is undetectable and untransmittable (U=U) faster than ever before.

Expanding Same-Day Start Programs

Connecticut has recently launched innovative pilot programs designed to make "Same-Day Start" the standard of care across the state. These pilots are streamlining the bridge between testing sites and clinics, ensuring that a positive test result is met with an immediate prescription and a dedicated support team. By reimagining the transition from diagnosis to treatment as a seamless, 24-hour process, Connecticut's pilot programs are proving that when the barriers to entry are removed, it results in improvements to individual health outcomes and strengthens the health and safety of the entire community.

Linkage to care within 30 days of a new diagnosis 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 notifying 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.

Objective T1. Increase the percentage of newly diagnosed PWH who attend a routine care visit within 1 month of diagnosis from 83% (2023) to 95% by 12/2031

Key Activities	• Provide academic detailing to help providers develop at least 3 rapid linkage to care programs • Offer education and training to at least 5 providers to establish referral mechanisms to support rapid linkage to care. • Develop and promote a standard practice to assign a medical case manager within 72 hours of new diagnosis. • Facilitate access to CADAP and CIPA Program • Connect newly diagnosed patients with Disease Intervention Specialists and Partner Services • Implement quality improvement projects that address linkage to care • Make referral resources available to providers (e.g., RW medical case managers, peer support specialists), including referrals to address social determinants of health affecting treatment access
Performance Measures	○ # academic detailing sessions completed ○ # education and training participants ○ # newly diagnosed clients matched with medical case manager ○ # of (eligible) newly diagnosed enrolled in CADAP and CIPA ○ # referrals to DIS and Partner Services ○ # and type of support services matched with newly diagnosed RWHAP patients ○ # of newly diagnosed clients attending an appointment in 30 days
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

TREAT Engage and Retain People with HIV in Care and Achieve Viral Suppression

Objective T2. Increase the percentage of newly diagnosed PWH prescribed ART within 12 months from 92% (2023) to 95% by 12/2031

HIV begins impacting the immune system immediately. Starting ART as soon as possible protects the immune system from damage and prevents long-term health complications. Early and effective treatment can lead to viral suppression which helps people with HIV live longer and healthier. Research also shows patients who start medication quickly are more likely to stay in care. Viral load suppression is also an effective method of prevention. Achieving an undetectable viral load means the virus cannot be sexually transmitted. 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 providers 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.

First in the Nation to Legalize Mobile Retail Pharmacies

Connecticut is leading a national transformation in health access as the first state to legalize mobile retail pharmacies. By passing Public Act 23-19 in 2023, the state dismantled the traditional "brick-and-mortar" requirement for dispensing medication, clearing a path for pharmacies to travel directly to those most in need.

The InMOTION (Integrated Mobile Opioid Treatment and Infectious disease cOordinated care in your Neighborhood) project is the centerpiece of this historic legislation. Operated by Yale Medicine and Yale New Haven Health, this 38-foot mobile unit is a "clinic-pharmacy on wheels" that combines clinical expertise with real-time prescription fulfillment. It offers "one-stop" care where patients can meet with a clinician, have lab work drawn, and receive their medications—including HIV antiretrovirals (ART), Hepatitis C treatments, and PrEP—all in a single visit. In its first year of operation, it engaged hundreds of patients many of whom were unhoused (37%) or uninsured (32%).

Objective T2. Increase the percentage of newly diagnosed PWH prescribed ART within 12 months from 92% (2023) to 95% by 12/2031

Key Activities	• Establish a CADAP Rapid ART program. • Use academic detailing to educate providers about ART to expand access to HIV medications • Educate patients about ART medications options, including long-acting injectable treatment • Expand access to ART through mobile pharmacy, healthcare, and telehealth options to areas affected by HIV, including non-traditional settings such as faith-based organizations, shelters, and food pantries • Implement at least 5 new rapid ART programs in provider offices • Annually review and adjust RWHAP services to help engage individuals in care and address costs • Implement at least 5 quality improvement projects through RWHAP providers that address medication adherence
Performance Measures	○ # academic detailing sessions completed (providers, pharmacies) ○ # education and training participants ○ # new areas mobile pharmacy, healthcare, or telehealth provide services ○ # new rapid ART programs implemented ○ # of quality improvement projects focused on medication adherence ○ Documentation of changes made to RWHAP services ○ % of newly diagnosed PWH prescribed with ART within 12 months ○ % of newly diagnosed patients with viral load suppression
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

TREAT Engage and Retain People with HIV in Care and Achieve Viral Suppression

Objective T3. Increase the percentage of PWH achieving viral suppression from 70.4% (2023) to 95% by 12/2031

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. Promoting long-acting injectable ART provides a more flexible option that can drastically improve adherence and suppression for those who find daily dosing difficult. By using CADAP 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 new health challenges arise and stop going to the doctor. Creating a safety net to help providers reach patients who have fallen out of care strengthens the support network. Finally, quality improvement projects and data sharing agreements will help providers identify and address specific needs and gaps.

Viral Suppression and Stability

Viral suppression is built on a foundation of stability. Addressing Social Determinants of Health (SDOH)—such as secure housing, food security, and reliable transportation is not just a compassionate choice; it is a clinical necessity. By providing robust support services, Connecticut ensures that patients can focus on their health rather than their survival, creating the stability required for long-term medication adherence. The Plan leverages the robust CADAP and intends to expand the Medical Case Management model that has helped RWHAP patients achieve a viral suppression rate of 90.7%.

Objective T3. Increase the percentage of PWH achieving viral suppression from 70.4% (2023) to 95% by 12/2031

Key Activities	• Annually review the CADAP formulary, update as needed, and promote long-acting medications to improve viral suppression • Expand the use of CIPA Program to increase program utilization by 100 clients from baseline of 324 • Conduct annual MCM trainings on CADAP and CIPA • Improve mechanism for providers to identify out-of-care patients and rapidly re-engage in care • Conduct outreach and education in non-traditional, community settings such as faith groups, barbershops, and low-income housing • Develop and implement quality improvement activities to identify clients at risk of falling out of care • Incorporate U=U and treatment as prevention messages in planned awareness campaigns • Annually implement at least 1 quality improvement project focusing on medication adherence and support for populations impacted by lower viral suppression rates • Create at least 1 data sharing agreement with state agencies, other than the Department of Public Health, to enhance HIV care delivery and viral suppression.
Performance Measures	○ Annual CADAP formulary review and # updates made ○ # clients accessing CIPA ○ # MCM trainings ○ # of outreach and education activities in non-RW settings ○ # completed quality improvement projects focusing on viral suppression ○ # completed quality improvement projects focusing on retention in care ○ Creation of a data sharing agreement ○ # clients re-engaged in care ○ Viral suppression rates based on epidemiological data
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, other Connecticut State Agencies

PREVENT Reduce new HIV Transmissions through evidence-based prevention strategies

Objective P1. Increase the PrEP-to-Need Ratio from 23.1 (2023) to 36 by 12/2031

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 medication 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.

PrEP navigators play a critical role in HIV prevention medication access. These specialists act as a link to care, assisting individuals with navigating the healthcare system, including enrollment processes, financial assistance options, and scheduling required lab work. By combining program funding for various prevention options with personalized navigation services, the initiative aims to support individuals in maintaining consistent care.

Breaking Down Barriers to Access PrEP

Connecticut is addressing the financial barriers to HIV prevention through its innovative PrEP Drug Assistance Program (PrEP-DAP) pilot initiative.

Collecting data will help determine the true need for PrEP access. Starting with financial support for oral medications, this program aims to better understand the barriers people face. This data will help inform future PrEP initiatives and better allocate funds to support further access to PrEP.

These activities demonstrate how combining financial resources with dedicated support can create a more accessible pathway to prevention services and are a vital piece for Ending the HIV Epidemic by focusing on communities that have historically faced systemic hurdles to care. By streamlining the enrollment process and integrating it with existing sexual health services, Connecticut is offering a prescription and providing a simplified, dignified pathway to prevention.

Objective P1. Increase the PrEP-to-Need Ratio from 23.1 (2023) to 36 by 12/2031

Key Activities	• Provide at least three academic detailing sessions for provider education around PrEP, PEP, and DoxyPEP topics and services • Expand PrEP and PEP drug assistance program to include all necessary pharmacy, medical and laboratory services required for access to PrEP/PEP • Support a minimum of three different pilot projects or quality improvement projects to increase PrEP and PEP uptake • Deliver technical assistance to agencies on how to accurately report PrEP data • Coordinate a statewide public awareness campaign and annual social media messaging to the public on how to access PrEP and PEP
Performance Measures	○ # individuals trained as academic detailers ○ # providers completing academic detailing sessions ○ # individuals accessing PrEP or PEP drug assistance program ○ # pilot projects completed ○ # individuals who have received at least one PrEP prescription ○ # of individuals campaign reaches and total # of times campaign messages viewed by individuals
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

PREVENT Reduce new HIV Transmissions through evidence-based prevention strategies

Objective P2. Increase the number of individuals accessing publicly funded prevention services for people who use drugs from 9,500 (2023) to 11,000 by 12/2031

Prevention services for people who use drugs are highly effective community-based prevention programs that have been shown to reduce new HIV and HCV cases by approximately 50%. Prevention services act as a safe disposal point for used materials. By taking contaminated materials off the street, they prevent unintentional disease transmission.

When someone has easy, no-cost access to materials for prevention services, they are far less likely to share or reuse. Sharing materials is a direct route for HIV transmission because it can transfer HIV or HCV to another person through blood. Prevention sites are often a place where people who use drugs feel safe and respected. This trust allows the programs to offer more than just materials, including HIV and HCV testing, access to prevention services and resources, and referrals to other healthcare or treatment services.

The Power of Prevention

Connecticut's prevention sites for people who use drugs are much more than just a place to get prevention materials. They serve as the front door to recovery and health and act as vital hubs for:

- Rapid HIV and HCV Testing: Getting results in minutes while in a safe, non-judgmental space
- Overdose Prevention: Distributing Narcan and educational materials that save lives every day
- Seamless Referrals: Creating a direct bridge to medical care, mental health support, and substance use treatment

Connecticut has been supporting prevention services for people who use drugs since the late 1900's.

Objective P2. Increase the number of individuals accessing prevention services for people who use drugs from 9,500 (2023) to 11,000 by 12/2031

Key Activities	• Expand annual distribution of prevention materials for people who use drugs by identifying new distribution sites based on local data, secondary distribution, and other pilot projects. • Support quality improvement projects to remove contaminated drug using materials from public spaces • Coordinate and hold bi-annual partner meetings for prevention services for people who use drugs to deliver capacity building and training to funded service providers • Develop and execute a plan to connect HIV prevention partners with SUD partners to enhance syndemic testing and accidental overdose prevention • Coordinate public awareness campaigns and social media messaging to promote services for people who use drugs
Performance Measures	○ # prevention materials for people who use drugs distributed ○ # of prevention services for people who use drugs partner meetings ○ # individuals accessing prevention services for people who use drugs ○ # of contaminated drug using materials removed from public spaces ○ Secondary distribution of prevention supplies ○ Return rate for prevention supplies ○ # campaigns submitted and approved by the DPH materials review panel
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

PREVENT Reduce new HIV Transmissions through evidence-based prevention strategies

Objective P3. Increase condom distribution in publicly funded programs by 10% from 876,500 (2023) to 964,150 by 12/2031

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 primary mode of prevention because they protect against all STDs.

Effective condom distribution moves beyond simply handing out materials; it creates a supportive environment where protection is available, accessible, and acceptable. The CT DPH distributes condoms through a network of strategic partners including local health departments, community-based organizations, and mobile prevention units. However, opportunities exist to more widely distribute condoms in new community settings.

A Cornerstone of Public Health

The impact of condoms is undeniable: when used consistently and correctly, they are over 90% effective in preventing HIV transmission, providing a low-cost, barrier-based shield that complements modern treatments like PrEP.

Objective P3. Increase condom distribution in DPH funded programs by 10% from 876,500 (2023) to 964,150 by 12/2031

Key Activities	• Study condom availability in communities with high concentrations of STDs – including distinctive communities and settings (e.g., college campuses, fraternities and sororities, public housing, local education, community-based organizations, faith-based organizations) • Create a statewide campaign to increase condom use • Develop and implement a statewide condom distribution and monitoring plan • Expand condom distribution options in communities with high incidence and prevalence of HIV and STDs
Performance Measures	○ # condoms distributed by publicly funded prevention contractors ○ # of community partners (e.g., schools, youth programs) that expanded condom distribution options ○ # of individuals campaign reaches and total # of times campaign messages viewed by individuals ○ Creation and implementation of statewide condom distribution and monitoring plan
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 Quickly to Outbreaks and Address Health Access

Objective R1. Update syndemic outbreak and response plans annually

An HIV Outbreak and Response Plan is a vital public health roadmap that allows state agencies to transition from routine monitoring to rapid, life-saving action when an unusual spike in new cases is detected. Its primary value lies in its ability to mobilize resources instantly—such as testing units, medical staff, and peer outreach—directly to the neighborhoods or social networks where the virus is spreading fastest.

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, HCV, and SUD—that often cluster together in the same populations and geographic areas. The plan allows different state agencies and community partners to align their funding, data systems, and staff. This reduces "siloed" work and makes the healthcare system more efficient.

The Power of Integration: Connecting the Syndemic

Connecticut recognizes that HIV does not exist in a vacuum. Because HIV, STDs, HCV, and opioid use often overlap—a phenomenon known as a syndemic—the state's response plans are intentionally interconnected.

By breaking down the silos between these different health crises, Connecticut's outbreak plan does not just stop a single cluster—it builds a more resilient healthcare system that catches and treats every interconnected health threat.

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 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—is paramount.

Objective R1. Update syndemic outbreak and response plans annually

Key Activities	• Annually engage stakeholders to review current outbreak response and communication plans • Disseminate information on Plans
Performance Measures	○ # of response plans developed ○ # community engagement sessions ○ # and type of partners engaged ○ # updates or modifications to outbreak response and communication plans ○ Review and reflection of after- action reports (conducted after outbreaks)
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

RESPOND Quickly to Outbreaks and Address Health Access

Objective R2. Identify syndemic and single disease condition transmission clusters and outbreaks

Connecticut is transforming HIV data into a proactive shield through its sophisticated surveillance and molecular epidemiology framework. By moving beyond simple case counting, the state uses innovative laboratory analysis to identify molecular clusters—groups of related infections that indicate rapid, ongoing transmission. This "early warning system" allows public health officials to detect pre-clusters before they escalate into full-blown outbreaks, providing a critical window for intervention

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 CT DPH to spot sudden increases in infections (outbreaks) or overlapping health issues (syndemics) as they happen.

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, especially front-line workers, often see changes on the ground weeks before they show up in lab data.

True Value of Surveillance Technology: Bi-Directional Feedback Loops

The true value of this technology lies in its bi-directional conversations between the CT DPH and community-based providers. The proposed activities in the Plan will:

- Increase sharing of real-time insights
- Expand provider and community partner engagement
- Identify service gaps
- Shift resources in response to the data and local needs

Objective R2. Identify syndemic and single disease condition transmission clusters and outbreaks

Key Activities	• 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, training, or academic detailing to providers on reporting requirements • Review of after- action reports (as needed)
Performance Measures	○ Lab volume for genotopic data by year ○ Cross communication system protocols ○ Data sharing agreements ○ Annual list of outlier labs (i.e., providers not communicating complete or timely data) ○ Process and protocols for communication of pre-cluster or emerging outbreaks ○ # participants completing provider education or academic detailing
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

RESPOND Quickly to Outbreaks and Address Health Access

Objective R3. Provide resources and tools to 5 communities with high Area Deprivation Index scores

Connecticut is empowering local leaders to move from awareness to action by utilizing sophisticated data tools like the Area Deprivation Index (ADI).[3] By mapping socioeconomic stressors—such as housing instability, poverty, and education levels—at the neighborhood and census tract level, the state helps communities visualize exactly where the social determinants of health create the highest vulnerability for HIV, STDs, HCV, and SUD. This data-driven mobilization transforms complex statistics into a localized roadmap, allowing community-based organizations to build the capacity needed to advocate for their specific residents.

Educational sessions teach service providers how to use tools like ADI maps with surveillance data to understand where services are most needed in their community. During an outbreak, speed is everything. Mobile units are essential because they provide services where people are. 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 drivers of health are often the biggest hurdle to staying in care and achieving viral suppression. By focusing on the 5 most impacted communities, providers can proactively distribute tools—like testing kits and educational materials—where they will have the greatest impact on improving health outcomes.

Data to Action: The Connecticut Model

In 2026, the City of Hartford Health Department issued a "Call to Action" for local partners to assemble and use ADI and surveillance data to identify the most vulnerable geographic areas in the community.

Next, the local partners organized a "walking tour" of the area to see and to feel the conditions as well as to talk with residents and hear their perspectives. The partners moved forward with immediate action steps such as adjusting outreach strategies, educating residents about services and resources, and working with providers to improve service access for residents living in those areas.

Objective R3. Provide resources and tools to 5 communities with high ADI scores

Key Activities	• Facilitate education sessions on use of area deprivation index and surveillance data • Provide community partners with the tools necessary to respond to outbreaks • Offer education and training on syndemic approaches
Performance Measures	○ # ADI education and capacity building sessions ○ # of participants attending education sessions (e.g., whole person care, syndemic approach) ○ # of community mobilizations in response to pre-cluster or response outbreaks
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

[3] 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).

RESPOND Quickly to Outbreaks and Address Health Access

Objective R4. Disease Intervention Specialists or Partners Services contact 85% of newly diagnosed HIV positive individuals

Partner Services is a critical program that CT DPH administers to reduce STD and HIV transmission. The Disease Intervention Specialists (DIS) will interrupt transmission cycles by identifying and facilitating testing and treatment for individuals who have been directly exposed to HIV and STDs.

Regular meetings ensure that the DIS and HIV Program and Surveillance staff are in constant communication regarding new diagnoses. Early contact facilitates "Rapid Start" treatment for the diagnosed individual and prevention options like PrEP for their negative partners. 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 sensitive conversations, helping patients navigate the difficult process of notifying partners while providing immediate referrals for testing, treatment, and support services.

Data to Care Initiative

Connecticut's Data to Care (D2C) initiative is a strategy that ensures all people with HIV are given the opportunity to be engaged with the healthcare system.

A critical component of the D2C initiative is its focus on Partner Services. DIS offer Partner Services to all newly diagnosed individuals as well as those who have fallen out of care. By utilizing secure laboratory and surveillance data, the state can identify individuals who have not had a medical visit or viral load test in several months.

Through the D2C model, Connecticut is proving that data is crucial to linking people to critical HIV prevention and care services, thereby reducing the spread of HIV transmission.

Objective R4. Disease Intervention Specialists or Partners Services contact 85% of newly diagnosed HIV positive individuals

Key Activities	• Monthly meetings with DIS, HIV prevention, and surveillance teams • Create case events according to classifications • Develop and implement a strategy to utilize peer support specialists to rapidly identify new HIV diagnoses and provide education to their local community • Conduct investigations of new cases and contact as needed • Review and share information about DIS and partners services
Performance Measures	○ # clients referred for DIS or Partner Services ○ # cases investigated ○ Create a peer support specialist strategy ○ # and % of individuals contacted ○ Annual program review (i.e., performance data, discussion on challenges and improvements) ○ # and type of quality improvement or system change projects
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

a. Updates to Other Strategic Plans Used to Meet Requirements

Connecticut is not using portions of another local strategic plan to satisfy the federal planning requirements.

** * * * * * End of Section V * * * * **

Section VI. 2027-2031 Integrated Planning Implementation, Monitoring, and Jurisdictional Follow-Up

Connecticut will use its current, proven approach and infrastructur to support the key phases of integrated planning.

INTEGRATED PLANNING CYCLE

A continuous process for impact and accountability

1. IMPLEMENTATION
Carry out evidence-based strategies and activities aligned with Plan goals.

2. MONITORING
Track progress using established indicators and data systems.

3. EVALUATION
Assess outcomes and identify what works.

4. IMPROVEMENT
Use data and feedback to refine strategies and strengthen impact.

5. REPORTING & DISSEMINATION
Share results transparently with partners, stakeholders, and communities.

This continuous cycle ensures data-driven decisions, stronger collaboration, and measurable progress toward ending the HIV epidemic in Connecticut.

STRONG PARTNERSHIPS. SHARED ACCOUNTABILITY. GREATER IMPACT.

CHPC

HIV FUNDERS GROUP

RWHAP Part A Planning Councils

The CHPC, HIV Funders Group, and the two RWHAP Part A Planning Councils work together to synchronize resources and ensure accountability.

This partnership guarantees that implementation remains consistent across all regions and funding streams, maximizing the impact of every dollar invested.

PROGRESS IS MEASURED THROUGH A ROBUST SET OF STATEWIDE INDICATORS

ALIGNED
Built to meet the National HIV/AIDS Strategy and Ending the HIV epidemic (EHE) benchmarks.

FOCUSED
Directly linked to specific Plan objectives.

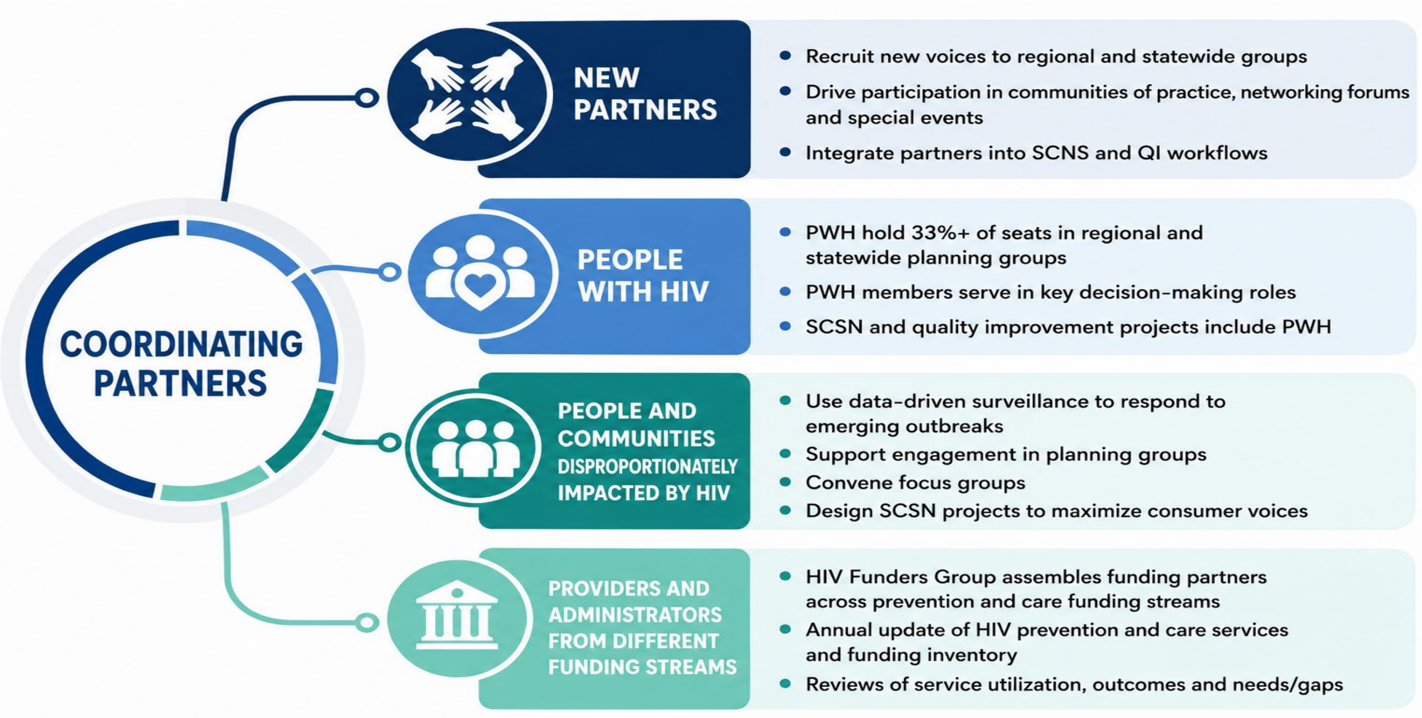
VALIDATED
Supported by reliable, real-time data systems and formal sharing agreements.

1. Describe the Infrastructure, Procedures, Systems, and/or Tools Used to Support the 5 Key Phases of Integrated Planning

a. Implementation: Coordinating Partners

Figure VI-1 describes a variety of ways that Connecticut involves persons with HIV in the Plan development and implementation process, to engage new partners, and to respond to and support people and communities disproportionately impacted by HIV. Subsequent paragraphs provide additional information.

Figure VI-1. Connecticut's Approach to Coordinating Partners Involved in the 2027-2031 Plan



New Partners

The statewide planning process employs an intentional strategy to recruit, engage, and retain a comprehensive partner network. Recruitment focuses on reaching beyond traditional silos to invite non-traditional stakeholders and communities disproportionately impacted by HIV through focused outreach and community forums. Engagement is fostered by integrating these partners directly into the decision-making infrastructure—such as the CHPC and specialized committees —where their lived expertise and data insights actively shape plan implementation. Finally, retention is sustained through transparent performance management, regular feedback loops, and leadership opportunities that demonstrate the direct impact of partner contributions on statewide health outcomes.

People with HIV

The Connecticut HIV Planning Consortium (CHPC) and Ryan White Part A Planning Councils prioritize the meaningful involvement of people with HIV by removing participation barriers and fostering a culture of leadership. To ensure a representative and sustained presence, these bodies utilize participant stipends and transportation assistance, directly addressing the financial and logistical hurdles that often hinder community engagement. Recruitment and retention are further strengthened through peer-to-peer mentoring and empowerment groups, which build the confidence and technical skills necessary for members to move into influential leadership roles. Beyond committee membership, lived expertise is centered in critical Statewide Coordinated Statement of Need (SCSN) projects through

focus groups and community surveys, ensuring that the state's data-driven strategies are grounded in the actual needs and voices of those most impacted by the epidemic.

People and Communities Disproportionately Impacted by HIV

Connecticut's statewide planning process focuses resources where the need is greatest, specifically within the Ryan White Part A Planning Councils whose geographic service areas encompass 91% of all people living with HIV in the state. By prioritizing these areas, the Plan directly engages residents who face disproportionate HIV rates and adverse health outcomes driven by systemic social determinants of health. Leveraging sophisticated surveillance and social vulnerability data, the Plan organizes targeted interventions and services tailored to these specific communities. This data-driven framework ensures that high-impact strategies—including rapid outbreak detection and response plans—are proactively deployed to disrupt transmission and eliminate health gaps in the state's most impacted neighborhoods.

Providers and Administrators from Different Funding Streams

The Connecticut HIV Funders Group serves as a strategic alliance of state, and local agencies that manage HIV-related state and federal resources. Its primary purpose is to ensure financial investments are synchronized with the Statewide Integrated Plan to eliminate service gaps and maximize public health impact. The group acts as the financial engine of the Plan, moving beyond individual agency mandates to create a unified funding landscape. The HIV Funders Group (a) ensures that agencies and regional RWHAP Part A grants coordinate funding across the same statewide priorities, (b) breaks down barriers between prevention, care, and housing funds to create a "status-neutral" service system, and (c) identifies and resolves overlaps to prevent the duplication of funded services across the state.

The Funders Group translates the Plan's goals into operational reality through: (1) resource mapping to understand how funding such as CDC, HRSA, and state dollars are distributed across Connecticut's geographic areas and uses (i.e., services), (2) using Plan performance data to shift resources toward high-performing programs or emerging community needs, (3) coordinating SCSN projects to better understand services needs and gaps that inform Plan priorities, and (4) streamlining administrative requirements and reporting standards for community partners to reduce their burden and improve data quality.

How Plan will Influence, Leverage, and Coordinate Funding Streams

The Plan serves as the "compass" to ensure that different funding streams at the federal, state, and local levels move in the same direction to maximize impact. The Plan uses the most current data on HIV epidemiology and services to (a) prioritize high-need areas – including hot-spots and populations, (b) influence how state agencies and HIV funding administrators organize their delivery systems and fund services, (c) coordinate capacity building and education and training strategies, (d) promote integration of services for whole-person care and the use of a syndemic approach, and (e) support innovation and the use of evidence-based practices – which is the basis for Plan objectives. See Figure VI-2.

The unified roadmap breaks down funding silos for HIV care (RWHAP Parts A – F). It synchronizes prevention funding to create a seamless "whole-person" pathway as a foundation for the syndemic approach. It offers a clear vision that supports partners to attract additional resources from public, private, and philanthropic sources. The HIV Funders Group will update the statewide HIV resources and services inventory annually and use that forum to promote system integration and coordination across implementation partners.

Figure VI-2. Blending and Braiding Federal Funding to Support Connecticut's Plan

b. Monitoring

Coordinate Different Collaborators

The CHPC orchestrates a multi-layered coordination framework to ensure statewide implementation activities remain on track and impactful (Section II). By convening a coalition of state agencies, clinical providers, and community stakeholders, including persons with HIV, the CHPC facilitates a continuous feedback loop where real-time data from implementation partners is cross-referenced against the Plan's strategic milestones. This collaborative structure streamlines monitoring by standardizing reporting across different funding streams and geographic regions, allowing for the rapid identification of service gaps or emerging barriers. Through standing committees and joint review sessions, these partners transform raw performance data into actionable insights, ensuring that every collaborator is aligned and accountable to the collective goal of ending the epidemic in Connecticut.

Use Different Funding Streams to Implement Plan Goals

The decision-making process for funding allocation works differently depending on the roles and responsibilities of the planning group. For example, the CHPC does not make any funding-related decisions whereas Ryan White Part A Planning Councils determine regional priorities and budget allocations. Connecticut relies on the HIV Funders Group to facilitate information sharing about uses of funds. Section III contains a description of funding sources used to provide services.

The plan development and monitoring process ensures maximum impact by continuously aligning different funding streams with the Plan's strategic priorities. Through regular review sessions, the CHPC, HIV Funders Group, and regional planning bodies analyze real-time service utilization and expenditure data alongside current unmet needs and identified service gaps. This rigorous financial oversight allows stakeholders to determine if resources are

effectively reaching disproportionately impacted communities or if shifts in funding are required. By evaluating fiscal data through the lens of the epidemic's evolving landscape, the state can proactively adjust resource allocation, ensuring that investments are agile, targeted, and sufficient to close gaps in care and prevention.

Collaborate/Coordinate Monitoring of Multiple Different Plans to Avoid Duplication of Effort

Connecticut's HIV partners achieve a unified, non-duplicative response by anchoring all activities in a shared statewide vision (Section V) that integrates prevention and care into a single strategic roadmap. This coordination is operationalized through SMART objectives and high-impact performance measures (Section VI.c), which are systematically tracked across various programs using valid and reliable data sources (Section II). The HIV Funders Group meets regularly to foster coordination and integration of services as well as monitoring systems and processes used by different HIV partners and funding sources.

Maximizing RWHAP Part B Impact

The CT DPH manages RWHAP Part B funds to sustain a comprehensive network of medical and support services. By partnering with Part A Planning Councils, the state synchronizes these investments to eliminate duplication and bridge gaps in care. Expenditure and utilization data are regularly shared with the CHPC, sparking critical dialogue on how to realign resources when community needs shift or provider capacities change.

Coordinate Activities and Timelines

The Plan objectives (Section V) use a smart format that includes timelines and identifies key implementation partners and milestones. The HIV Funders Group provides input to inform the timing of data collection, analysis, and sharing to optimize the use of data deliverables for planning and monitoring process that vary by funding source.

c. Evaluation

Performance Measures and Methodology

The CHPC Quality and Performance Measures Committee serves as the primary mechanism for identifying Plan indicators and performance measures, and coordinating efforts to collect, analyze, and share information on these measures – including any updates to the Plan (see Section VI.d). CT DPH performance measurement and monitoring activities align with Federal evaluation requirements such as the CDC's Evaluation Performance Measurement Plan (EPMP).

Table VI-1 describes the core Plan indicators for overarching goals and objectives as well as baseline information for goals and objectives. Outcome indicators will be monitored overall and stratified for priority populations. Information about other Plan performance measures (i.e., definitions, data sources) will be made available upon request. The majority of these indicators represent a continuation of existing indicators with clear connections to reliable and valid data sources. The CHPC Quality and Performance Measures Committee will address any indicators that require baseline measures. As warranted, data on indictors will be analyzed to better understand patterns related to people or communities disproportionately affected by HIV.

Table VI-1. Core HIV Plan Indicators (*denotes national requirement)

2022-2026 Plan Core HIV Indicator	Pillar	Objective	Baseline	Goal
*New Diagnoses: Number of people newly diagnosed with HIV	Diagnose	N/A	246	25*
*Knowledge of HIV Status: Percent of PLWH aware of their status	Diagnose	N/A	92.2%	95%*
HIV/HCV Testing in Clinical Settings: Lab testing volume (HIV- and HIV+) reported to CT DPH by publicly funded clinical sites with analysis by geographic area and provider type	Diagnose	D1	96,326	10% increase
HIV/HCV Testing in Non-Clinical Settings: Lab testing volume (HIV- and HIV+) reported to CT DPH by publicly funded non-clinical sites such as prevention services programs with analysis by geographic area and provider type	Diagnose	D2	2,824	10% increase
HIV/HCV Lab Testing Methodology: CT DPH protocols to analyze and share data on HIV/HCV testing volume that facilitates understanding of routine HIV/HCV testing in clinical and non-clinical settings across the state	Diagnose	D3	TBD	Exist by 2028
*Linkage to Care: Percent of newly diagnosed who attended a routine HIV care visit within 1 month of diagnosis	Treat	T1	83%	95%*
Newly Diagnosed Persons with HIV Prescribed ART: Number of newly diagnosed individuals with evidence of ART prescriptions within 12 months of diagnosis	Treat	T2	92%	95%
*Viral Load Suppression: Percent of people with diagnosed HIV who are virally suppressed Percent of PLWH in care who are virally suppressed	Treat	T3	70.4% 90.7%	95%*
PrEP-to-Need Ratio: The number of people taking PrEP divided by the number of people newly diagnosed with HIV	Prevent	P1	23.1	36
Prevention Services for People Who Use Drugs: Number of clients served	Prevent	P2	9,500	11,000
Condom Distribution: Number of condoms distributed through publicly funded programs	Prevent	P3	876,500	964,150
Outbreak and Response Plan Update: CT DPH HIV Outbreak and Response Plan updated annually	Respond	R1	2026 update	Annual update
Outbreak and Cluster Detection Capacity: CT DPH surveillance team conducts monthly (or more frequently as needed) data analysis and uses advanced techniques for pre-cluster detection	Respond	R2	TBD	Ongoing
Community Outbreak Response: Localized communities with high Area Deprivation Index scores that develop and implement a coordinated response action plan	Respond	R3	TBD	5
Partner Services: The percentage of clients referred to Partner Services that are interviewed by DIS / Partner Services and name partners	Respond	R4	13%	18%

Frequency of Analysis of Performance Measures

The CHPC maintains a rigorous data-review calendar to ensure the Plan remains effective and responsive to emerging trends relevant to HIV (Figure VI-3).

Figure VI-3. Analysis of Performance Measures by Level and Frequency

1 LEVEL 1
GENERAL PRESENTATIONS
(ONGOING)

The CHPC coordinates general presentations on topics related to the Plan.

- SCSN project results
- Service utilization
- Social drivers of health
- Voice of the consumer

BIG PICTURE
Broad topics to inform priorities and direction.

2 LEVEL 2
PERFORMANCE MEASURES
(ONGOING)

The Quality and Performance Measures Committee conducts "drill down" discussions on specific Plan performance measures or quality improvement projects.

- PrEP uptake
- Data to Care
- Viral suppression
- Syndemic quality improvement projects

FOCUSED ANALYSIS
Deep dive into key measures and quality improvement priorities.

3 LEVEL 3
PLAN INDICATORS
(ANNUALLY)

CT DPH epidemiologists present annually to the CHPC on the status of Plan indicators.

TRACKING PROGRESS
Annual review of Plan indicators to measure progress and impact.

CT DPH epidemiologists update all Plan indicators annually. This high-level analysis directly informs year-over-year revisions to the Plan's goals, objectives, and key activities. The Quality and Performance Measures Committee conducts "deep dives" during regular meetings and focuses on service utilization data, quality improvement projects, and program evaluations. The CHPC Executive Committee coordinates the featured presentations to maximize impact. For example, an in-depth, drill down analysis and discussion about topics related to CHPC indicators such as PrEP uptake or HIV suppression may follow a more general presentation that occurs at the main CHPC meeting.

Frequency of Presenting Data to the Planning Group

In collaboration with CT DPH epidemiologists, the full CHPC evaluates all Plan indicators annually. Coordination occurs in real-time through a standing Partner Update segment at CHPC meetings. The HIV Funders Group shares regular findings to synchronize spending with performance. RWHAP Part A Planning Councils provide continuous feedback on service expenditures and local gaps as do representatives from other RWHAP parts and CDC prevention partners.

d. Improvement

Continue to Use Data

The review process includes the CT DPH surveillance team presenting information on Plan indicators (actual vs. planned) and identification of accomplishments and milestones by Plan indicator.

Community Input to Make Revisions and Improvements

The CHPC committees identify key activities and timelines that may be affected by implementation challenges or unanticipated changes such as funding levels. The CHPC Executive Committee reviews the information and develops relevant initial recommendation to change the Plan. The CHPC discusses the recommendations and formally votes to update the Plan. Updates to the Plan widely with partners and the general public (e.g., CHPC website).

Revision Decisions and Frequency

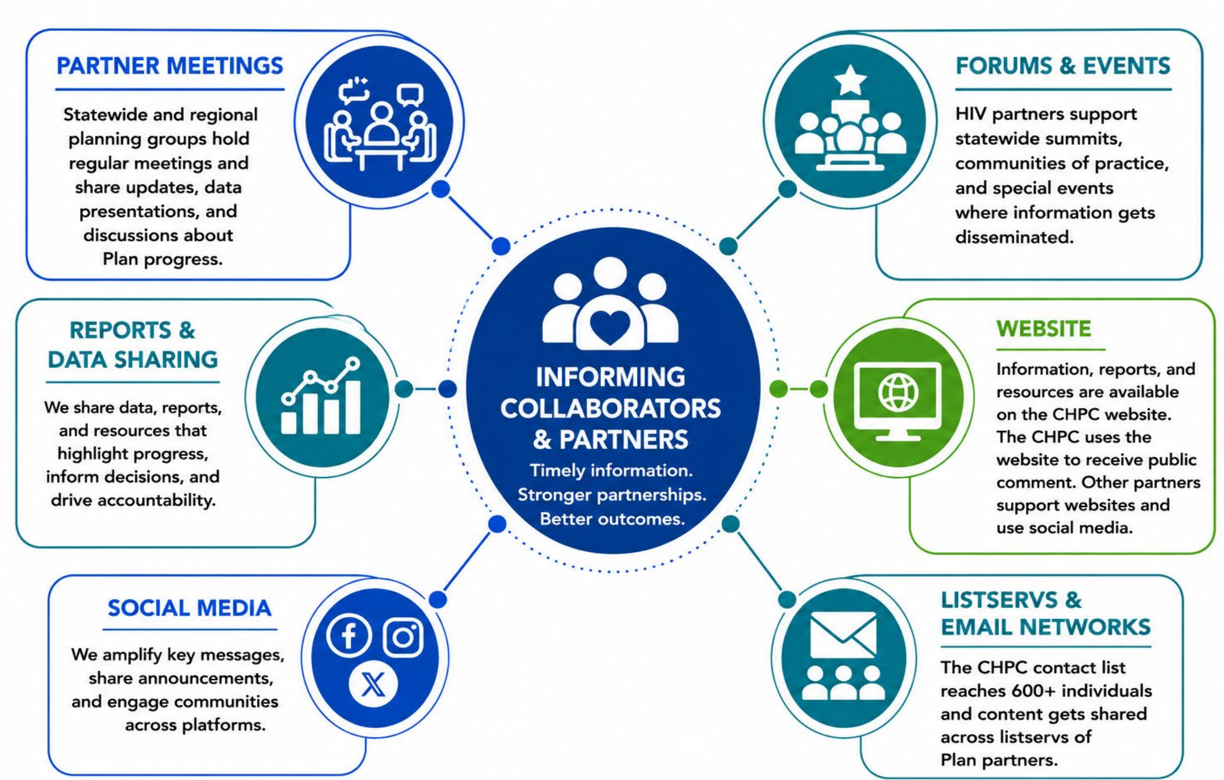
The CHPC reviews progress on the Plan each year. The CHPC ensures the Integrated Plan remains responsive through a structured annual review and voting process. The DPH Surveillance Team presents actual vs. planned progress on all key indicators. Committees document milestones achieved and identify implementation barriers. Groups adjust timelines and activities based on funding shifts or emerging challenges. The Executive Committee drafts initial revisions based on data and committee feedback. The full CHPC reviews and discusses proposed changes. A formal vote is held to officially update the Statewide Plan.

e. Reporting and Dissemination

Process for Informing Collaborators and People with HIV About Progress Made on the Plan

Figure VI-4 shows the core methods of dissemination used by the CHPC and other Plan implementation partners to inform collaborators and people with HIV about progress made on the Plan. CT DPH provides project support to the CHPC and the HIV Funders Group. RWHAP Part A Planning Councils receive project support. Each of these groups maintain communication channels that reach the general public as well as specific subgroups such as planning group members or partners. Approved updates are published on the CHPC website and shared with partners to disseminate. This ensures broader awareness and alignment of the Plan across partners and stakeholders.

Figure VI-4. Core Processes for Informing Collaborators and People with HIV About Progress Made on the Plan



f. Updates to Other Strategic Plans to Meet Requirements

Connecticut will not use portions of another local strategic plan to satisfy this requirement.

** * * * * * End of Section VI * * * * **

Section VII. Letters of Concurrence

A COLLABORATION OF INTENT

This plan was forged through the active leadership and representation from required partners:

CDC PREVENTION PROGRAM (STATEWIDE)

with funds administered by the CT DPH

RWHAP PART A PLANNING COUNCIL

for the New Haven / Fairfield Counties Eligible Metropolitan Area (EMA) with funds administered by the City of New Haven

RWHAP PART A PLANNING COUNCIL

for the Greater Hartford Transitional Grant Area (TGA) with funds administered by the City of Hartford

RWHAP PART B PROGRAM (STATEWIDE)

with funds administered by the CT DPH

THE CONNECTICUT HIV PLANNING CONSORTIUM (CHPC)

which serves as the statewide integrated planning body

A MOMENT WITHIN A MOVEMENT

The intentionality of partners extends well beyond organizing meetings to collaboration, integration, and system change. This Plan reflects the movement from "cooperation" to synchronized action through:

CROSSOVER LEADERSHIP

by maintaining "dual-membership" between statewide and regional planning bodies to ensure no community is left behind.

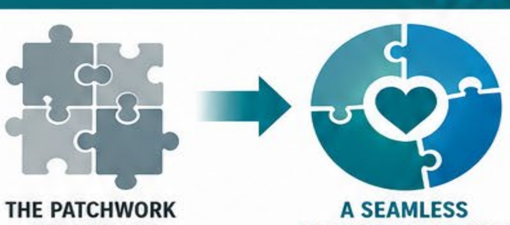
UNIFIED DATA

through synchronization of Statewide Coordinated Statement of Need (SCSN) projects and outbreak and response plans so that every data point serves both local neighborhoods and state-level strategy.

BROAD ENGAGEMENT AND PARTICIPATION

by fostering a planning environment where people living with HIV are not just consulted but serve as primary architects of implementation and monitoring.

THE COMMITMENT



By aligning resources, data, and voices, Connecticut has moved past the "patchwork" of the past to create a seamless continuum of care.

THE LETTERS THAT FOLLOW AFFIRM THAT THIS PLAN IS A SHARED PROMISE TO EVERY RESIDENT OF THE STATE: CONNECTICUT IS ENDING THIS EPIDEMIC TOGETHER.

1. CDC Prevention Program Planning Body Representative

- -
Insert letter about here
- -

2a. RWHAP Part A Planning Council/Planning Body

Insert letter about here

2b. RWHAP Part A Planning Council/Planning Body

- -
Insert letter about here
- -

3. RWHAP Part B Planning Body Chair or Representative

Insert letter about here
----

4. Integrated Planning Body

Insert letter about here

5. EHE Planning Body

Not applicable.

** * * * * * End of Section VII * * * * **