Connecticut's Integrated HIV Prevention and Care Plan

2017 - 2021

September 2016

State of Connecticut Department of Public Health, TB, HIV, STD, & Viral Hepatitis Program
410 Capitol Avenue, PO Box 340308, Hartford, CT 06134 | www.ct.gov/dph

ACKNOWLEDGEMENTS

The Connecticut HIV Planning Consortium (CHPC) appreciates the enduring support and commitment from the Connecticut Department of Public Health (DPH). Several DPH staff members provided significant, steadfast assistance to the CHPC, its committees, and its activities to push and facilitate statewide planning efforts, chief among whom include:

Laura Aponte	Heidi Jenkins
Marianne Buchelli	Andrea Lombard
Gina D'Angelo	Michael Ostapoff
Pamela Foster	Ramon Rodriguez-Santana
Deborah Gosselin	Suzanne Speers

The Department of Public Health extends great appreciation to the following parties:

- The CHPC co-chairs and CHPC committee co-chairs for the ongoing leadership and dedication that promotes effective dialogue among and between diverse stakeholders and facilitates meaningful partnerships and collaboration at the statewide, regional and local levels.
- The CHPC members whose diverse voices represent the many perspectives of truth associated with HIV.
- Cross Sector Consulting, LLP, the contractor that provides planning support to the Connecticut Department of Public Health and the Connecticut HIV Planning Consortium.

The Department of Public Health and the CHPC members extend great thanks to all of the appreciated partners and members of the public who have attended meetings, shared their perspectives and experiences, and/or assisted in the completion of statewide HIV prevention and care planning tasks, and who may also play a critical role during Plan implementation between 2017 and 2021.

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LETTER FROM DPH COMMISSIONER, DR. RAUL PINO

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

TB, HIV, STD & Viral Hepatitis Program

September 30, 2016

Dear Public Health Partner:

I am proud to present Connecticut's 2017-2021 Integrated HIV Prevention and Care Plan. This Plan represents the steadfast commitment of the Connecticut HIV Planning Consortium (CHPC) to end the HIV epidemic. I attest that this plan captures contributions from countless stakeholders, resource partners, and agency staff members. Most importantly it includes input from people living with and affected by HIV in Connecticut.

The CHPC held a business meeting on August 17, 2016, attended by roughly 70 stakeholders. Prior to the CHPC members' vote to unanimously approve this plan, we discussed challenges related to funding, outreach, and engagement, and addressed disruptions caused by healthcare system changes, among other topics. We also spoke about opportunities associated with ending the HIV epidemic and the emergence of revolutionary developments: A cure for hepatitis C; pre-exposure prophylaxis (PrEP) to prevent the chance of HIV transmission for high risk individuals; and medication regimens for Persons Living with HIV (PLWH) that help them celebrate birthdays 30 plus years after their initial diagnosis.

I challenged the CHPC to set aspirational goals, particularly with respect to reducing health disparities. I emphasized the need to rekindle the fire across all stakeholders to end this epidemic. To that end, I formally announced the commitment by the Department of Public Health to launch a statewide campaign to end the HIV epidemic in Connecticut. This plan will play a pivotal role in accomplishing that goal.

We hold the knowledge, skills and ability to dramatically reduce the number of new HIV cases through targeted outreach and prevention efforts. We operate models that connect individuals to care and help them achieve viral suppression on a statewide level. Together, we can strengthen efforts, build capacity, leverage resources, and ultimately eliminate HIV in Connecticut. This plan provides an effective road map to help us reach our goals which mirror the goals of the National HIV/AIDS Strategy as well as the goals in our State Health Improvement Plan.

Sincerely,

Raul Pino, M.D., M.P.H.
Commissioner

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EXECUTIVE SUMMARY

Since 1981, over 20,000 HIV cases have been reported in Connecticut. Despite a swift response to the epidemic, its impact remains strong. As of December 2014, 10,727 people were living with HIV in Connecticut based on diagnosis. However, its burden is disproportionate: of all known HIV cases in Connecticut, 66% are Black or Hispanic individuals (groups which, when combined, represent 23% of the state's population). HIV burden is geographically skewed, as well; though it has impacted almost the entire state, in 2014, 43% of all Connecticut PLWH lived in one of three major cities. Between 2010 and 2014, 1,658 HIV disease cases were newly diagnosed and reported; of these, 31% AIDS criteria at diagnosis, representing an alarmingly high "late tester" population.

Over the past seven years, the Connecticut Department of Public Health (DPH) relied on its partnership with the Connecticut HIV Planning Consortium (CHPC) to develop and update Connecticut's Statewide Integrated HIV Prevention and Care Plan. The CHPC represents diverse partners and stakeholders, including Persons Living with HIV (PLWH), committed to a coordinated statewide prevention and care system. The CHPC will begin 2017 with 35 members. See page 9 for more membership data; a demographic breakdown exists in the Appendix.

Connecticut applied an integrated approach long before federal requirements were in place: planning efforts have included both prevention and care perspectives since 2008 with the creation of its first Integrated Plan.

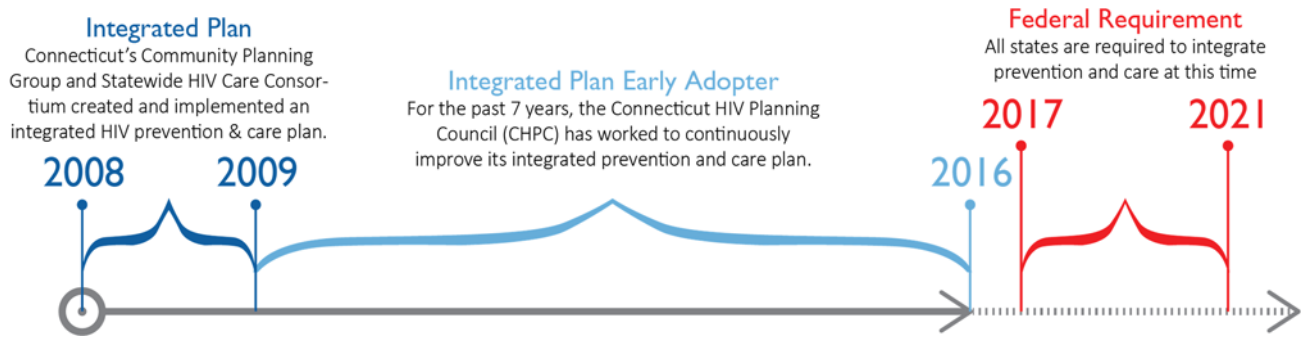


Figure 1. Timeline of Major Milestones in Connecticut's Planning Process

The CHPC's planning process complied with federal guidelines and best public health planning practices. The process included reviewing epidemiological data, existing HIV prevention and care services, policies, and PLWH needs assessments. The CHPC annually "updates" the Plan by refreshing data sets, documenting resource and policy changes, and reviewing progress; members review the update and conduct a vote of support for the Plan.

At the August 17, 2016 CHPC meeting, 24 members voted unanimously for concurrence of the Plan. The DPH and the diverse organizations receiving federal and state HIV prevention and care funding will utilize this document as a reference point for service delivery system improvement, and the CHPC will conduct annual updates.

The mission of this Plan is to create a coordinated statewide prevention and care system in which the rate of new HIV infections is reduced, and those who are living with and affected by HIV/AIDS are connected to appropriate care and support services. The Plan aligns with the National HIV/AIDS Strategy and positions the state to achieve the goals and objectives identified in Healthy People 2020 as well as requirements associated with the Affordable Care Act (ACA). Page 6 contains a summary of Connecticut's 2017 to 2021 Goals and Objectives. Page 7 contains a summary of Connecticut's Statewide Progress Indicators.

Connecticut's 2017 to 2021 Goals and Objectives

GOAL 1. Reduce New Infections	
Objective 1.1	Decrease the number of new infections by 25%, from 291 in 2014 to 218 in 2021.
Focus Area A	Strengthen statewide communication platform to deliver prevention and health promotion messaging
Focus Area B	Increase access to PrEP and n-PEP
Focus Area C	Promote "Treatment as Prevention"
Objective 1.2	Increase number of people being tested through CT funded initiatives (Routine testing, Outreach Testing & Linkage or OTL) from 13,579 in 2014 to 15,000 in 2021.
Focus Area A	Improve evidence-based HIV outreach, testing and linkage services
Focus Area B	Increase access to clean needles and syringe exchange services

GOAL 2. Increase access to care and improve health outcomes for PLWH	
Objective 2.1	Increase linkage to HIV care for newly diagnosed persons (aged 13+) from 91% in 2014 to 95% in 2021.
Focus Area A	Promote and facilitate access to healthcare *(high risk populations & PLWH)*
Focus Area B	Strengthen access to care initiatives, including re-engagement in care, for PLWH and priority populations
Objective 2.2	Increase viral load suppression among persons in HIV medical care from 86% in 2014 to 90% in 2021.
Focus Area A	Optimize and Increase Resources Available to Impact PLWH
Focus Area B	Strengthen Connecticut AIDS Drug Assistance Program
Focus Area C	Strengthen capacity to implement quality improvement initiatives *(PLWH in-care and to increase retention in care)*

GOAL 3. Reduce HIV-related disparities and health inequities	
Objective 3.1	Reduce new HIV diagnoses by 15% by 2021 in the following groups: men who have sex with men (MSM), and Black/African-American/Latino men and women.
Focus Area A	Analyze data sets by income, race/ethnicity and factors relevant to social determinants of health
Focus Area B	Introduce and scale effective Evidence Based Strategies to reach high priority populations
Focus Area C	Increase HIV workforce competencies and cultural and linguistic capacity to serve priority populations
Objective 3.2	Increase involvement in social justice initiatives and partnerships that reduce viral loads to the point of suppression (objective 2.2.) and reduce health disparities in new diagnoses (objective 3.1).
Focus Area A	Partner in a statewide campaign to end HIV
Focus Area B	Partner in core medical / healthcare service delivery initiatives that impacts health equity
Focus Area C	Partner in supportive service initiatives that impact health equity

GOAL 4. Achieve a more coordinated statewide response to the HIV epidemic	
Objective 4.1	Build capacity of Connecticut HIV Planning Consortium to develop and advance statewide planning efforts as well as to diffuse and sustain effective models.
Focus Area A	Increase organizational effectiveness of CHPC to conduct planning, coordination and stakeholder engagement
Focus Area B	Enhance communications and information sharing across CHPC stakeholders
Focus Area C	Increase HIV workforce competencies and cultural and linguistic capacity to serve priority populations
Objective 4.2	Increase capacity of HIV stakeholders and partners to implement the Statewide HIV Plan.
Focus Area A	Improve integration of Program Collaboration Services Integration model (PCSI)
Focus Area B	Establish HIV Funders Leadership Group
Focus Area C	Review and monitor progress of Plan

Connecticut Statewide Progress Indicators

Indicator 1	HIV Positivity Rate (Biological): Number of newly diagnosed (dx) in the 12-month calendar year per 100,000 people. **2021 Goal: 276 newly diagnosed** (Baseline: 350 in 2011, 295 in 2012)
Indicator 2	Seropositivity Rate (Service/Access): Number of OTL and ETI HIV positive tests in the 12-month calendar year. **2015 Goal: 0.2% ETI; 0.3% OTL** (Baseline: 0.19% ETI, 0.26% OTL (2013); 0.13% ETI, 0.26% OTL (2014))
Indicator 3	Viral Load Suppression Among Persons in HIV Medical Care: Number of persons with an HIV diagnosis with a viral load <200 copies/ml at last test in the 12-month calendar year. **2021 Goal: 90%** (Baseline: 80% 2012, 84% 2013)
Indicator 4	Linkage to HIV Care (Biological): Number of persons who attended a routine HIV medical care visit within 3 months of HIV diagnosis. **2021 Goal: 95%** (Baseline: 86.4% 2011, 87.3% 2012, 89% 2013)
Indicator 5	Retention in HIV Medical Care (Service/Access): Number of patients who had at least one HIV medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between first medical visit in the prior 6-month period and the last medical visit in the subsequent 6-month period. **2015 Goal: 65%** (Baseline: 64% 2011-2012, 67% 2012-2013)
Indicator 6	Late HIV Diagnoses (Late Testers) (Biological): Number of people who had their first HIV positive test less than 3 months before receiving AIDS diagnosis. **2015 Goal: 35%** (Baseline: 40% 2012, 34% 2013)
Indicator 7	Antiretroviral Therapy (ART) Among Persons in HIV Medical Care (Service/Access): Number of persons with HIV diagnosis who are prescribed ART in the 12-month calendar year. **2015 Goal: 95%** (Baseline: 91% 2012, 97% 2013)
Indicator 8	Partner Services (Service/Access): Number of newly diagnosed interviewed (i.e., linked) by Partner Services. **2015 Goal: 95%** (Baseline: 90% 2013)
Indicator 9	Housing Status (Service/Access): Number of persons with an HIV diagnosis who were stably housed in the 12-month calendar year. **2015 Goal: 80%** (Baseline: 76% 2012, 82% in 2013)
Indicator 10	Syringe Services Program (SSP) (Service/Access): *10a:* Number of SSP clients served: (Baseline: 2,500 [YR 2014]) *10b:* Number of syringes collected: (Baseline: 250,000 [YR 2014]) *10c:* Number of syringes distributed: (Baseline: 251,000 [YR 2014]) **Goal: To be determined**
Indicator 11	Disparities in New HIV Diagnoses: Number of newly diagnosed (dx) in the 12-month calendar year for each of the following groups: Men who have sex with men (MSM), Black/African American men and women. **Goal: Reduce disparities in the rate of diagnoses by 5%.**

THE CONNECTICUT HIV PLANNING CONSORTIUM (CHPC)

What is the CHPC?

- *Primary planning vehicle for statewide HIV prevention and care planning*
- *Convenes diverse stakeholders, including persons living with HIV (PLWH), for the specific purpose of creating a coordinated statewide prevention and care system*

Who comprises the CHPC?

- *In January 2016, CHPC membership included:*
  - ***15 PLWHA** and **18 providers***
  - ***14 Female** members and **18 male***
  - ***66% minority** membership (Black/Hispanic/Latino)*

What does the CHPC do?

- *The CHPC works toward creating a coordinated statewide prevention and care system in which the rate of new infections is reduced, and those living with and affected by HIV can access appropriate services.*
- *The CHPC's two committees are responsible for **setting goals**, **assessing data**, **recruiting new members**, **producing newsletters**, **designing survey tools**, and other planning tasks.*

THE CONNECTICUT HIV PLANNING CONSORTIUM (CHPC)

Why I Joined the CHPC

By Priscilla Pitts

A couple of years ago, I heard about this group called the Connecticut HIV Planning Consortium (CHPC) from Ronald Lee. I wanted to become a CHPC member because I have been HIV positive since 1992 and I wanted to learn more about my disease and my future.

When I started coming to CHPC meetings, there was a lot of information. Even after a year as a member, I am still learning and catching on. But everyone supports me and makes it easy to ask questions. And I enjoy the company and support everyone gives.

Now that I am in my second year as a member, I wanted to help a new member with things they don't understand. So, I volunteered to be a mentor to one of the new members. It feels good to give back. It also feels good to be part of a group that makes HIV care and prevention services better for everyone in Connecticut.

In my situation, the CHPC has made a great difference in my life and helped me change my way of life. I am taking all of my medications now, and I have learned to turn everything over in a good way. My family is sticking behind me in every way possible. I try my best to help people out in this kind of way.

Connecticut's Statewide HIV Planning Body

The Connecticut Department of Public Health (DPH) recognizes the Connecticut HIV Planning Consortium (CHPC) as its primary planning vehicle for statewide HIV prevention and care planning. The CHPC convenes diverse stakeholders, including persons living with HIV (PLWH), for the specific purpose of creating a coordinated statewide prevention and care system. A CHPC Charter informs the consortium structure.

Mission and Values. The CHPC exists to create a coordinated statewide prevention and care system in which the rate of new infections is reduced, and those living with and affected by HIV can access appropriate services. The CHPC values inclusion, representation and parity of community representatives. The CHPC reflects these values in its diverse membership; Figure 2 illustrates the diversity of the CHPC according to its January 2016 membership. The appendix contains a comprehensive diversity grid of CHPC members.

Figure 2. Diversity of CHPC Membership

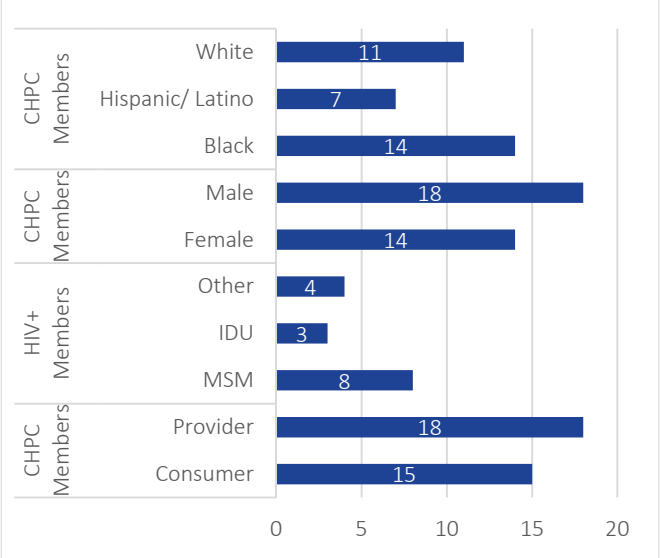
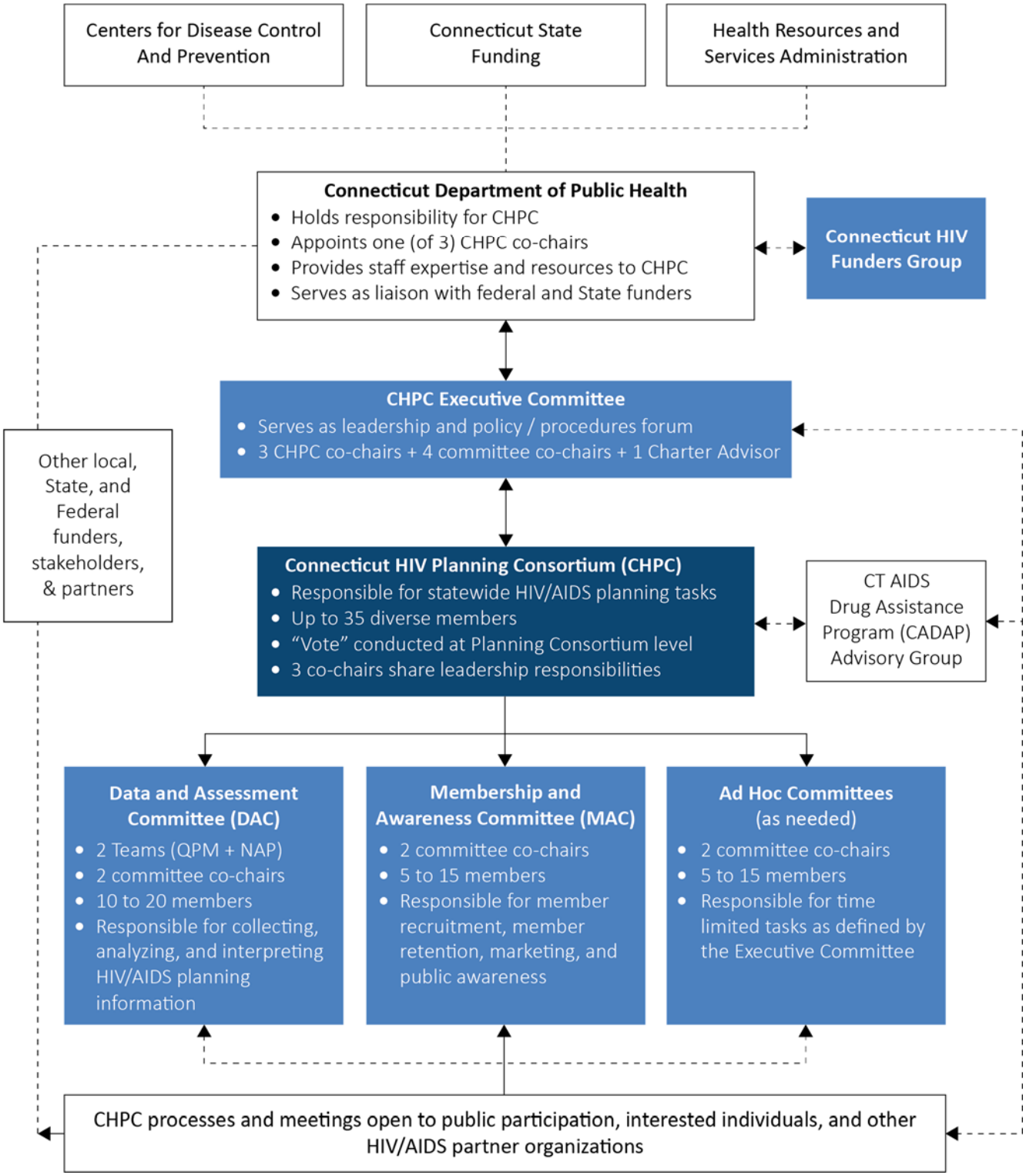


Figure 3 (page 10) shows the CHPC organizational chart. The CHPC receives planning and technical assistance from numerous Department of Public Health staff members affiliated with the TB, HIV, STD and Viral Hepatitis Section. Three units in particular deliver mission critical support for the CHPC: the HIV Prevention Unit; the Health Care and Support Services Unit, and the HIV/AIDS Surveillance Unit. See *"Relationship to the Connecticut Department of Public Health"* (page 81) for more information.

Figure 3. Organizational Structure of the CHPC



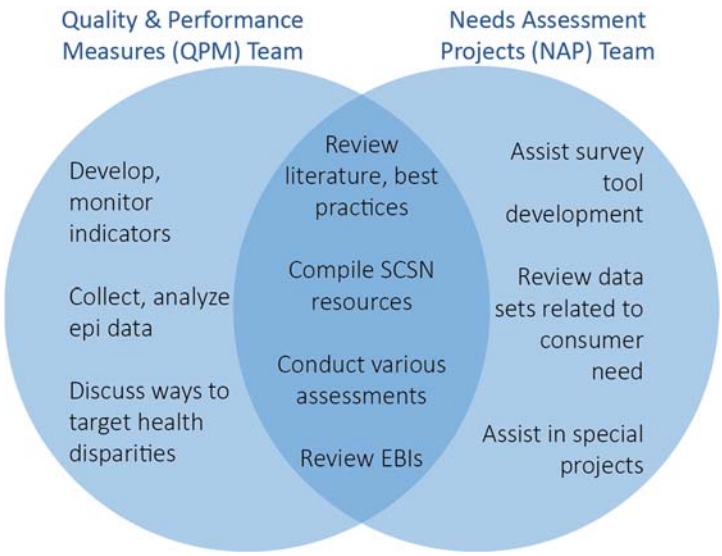
In 2014, the CHPC created two teams to serve as a united Data and Assessment Committee (DAC). The teams a) work in conjunction to review and compile existing data to implement planning work and aid in required document production, and b) perform separate sets of data-related functions (see Figure 4).

Committees. The CHPC is comprised of two committees:

Membership Awareness Committee (MAC). The MAC serves as the CHPC's group focused on member recruitment, selection, and retention. MAC is also responsible for marketing initiatives and general CHPC public awareness. In 2015, MAC implemented a mentoring program to match experienced CHPC members with new members. The program was created to help ease the transition and clarify some of the terms and references for new members. The MAC is responsible for producing three newsletters each year, from brainstorming topics to identifying authors to assembling and distributing the newsletters around the state. The MAC is a communications- and members-focused committee. The MAC will revise its roles and responsibilities to support implementation of the 2017 – 2021 Plan.

Data and Assessment Committee (DAC). In 2014, the CHPC created two teams to serve as a united Data and Assessment Committee (DAC). Figure 4 shows that the teams: a) work in conjunction to review and compile existing data to implement planning work and aid in required document production, and b) perform separate sets of data-related functions. These teams will revise their roles and responsibilities to support implementation of the 2017 – 2021 Plan.

Figure 4. CHPC Data and Assessment Committee (DAC) Teams



Decision-making. The CHPC uses a consensus model of decision-making. CHPC members vote on issues only as a full group and use a simple and transparent voting process that all members can understand. CHPC leaders and members create a welcoming, respectful and productive meeting climate by embracing practices that facilitate dialogue.

Leadership. Three co-chairs lead the CHPC. The DPH appoints one CHPC co-chair who serves as a liaison between CHPC and DPH. CHPC members elect CHPC co-chairs, who must hold at least one year of CHPC experience.

Meet the CHPC Co-Chairs (Gina, Aurelio, and André)

CHPC members serve as chairs or co-chairs of the CHPC committees. CHPC members apply for leadership positions such as co-chairs of the committees and a CHPC Charter Advisor. CHPC co-chairs, committee chairs and the Charter Advisor comprise the Executive Committee.

Meetings. The CHPC holds eight full-day meetings on the third Wednesday of the month. In 2016, these meetings occurred from January through August to support the Plan development process. These public meetings occurred in publicly accessible spaces in New Haven or Hartford. The CHPC integrates committee meeting time into the CHPC meeting agenda to create optimal member, partner and public participation. The Executive Committee meets immediately after the CHPC meeting to create operating efficiencies. During 2016, the CHPC average total attendance hovered around 70 individuals (CHPC members + public participants).

Continuous Quality Improvement. The CHPC assesses the meeting experiences of participants at every meeting. At the end of committee meetings, the committee chair asks the participants the general question, "how did we do?" At the end of the CHPC meetings, members and public participants complete a meeting feedback form containing yes/no questions and open-ended questions related to the committee meetings and the general CHPC meeting. These questions encourage feedback to help leaders improve future meeting processes.

Executive Committee members review the meeting feedback immediately after the CHPC meeting to discuss feedback and any areas for improvement. CHPC staff compile the information into a "meeting dashboard" that allows CHPC leaders to review monthly and cumulative meeting feedback results. In 2016, the CHPC identified three "focus areas" tracked at each meeting which include: 1) increasing member attendence; 2) increasing public participation; and 3) maintaining the overall satisfaction rating. Please see Table 1 for the final 2016 averages in each of the focus areas.

Table 1. CHPC Attendance and Participation in 2016

Focus Area	2016 Average
Member Attendance	82% Member Attendance
Public Participation	32 Public Participants per Meeting
Overall Satisfaction Rating	99% Overall Satisfaction Rating

CONNECTICUT'S PLAN DEVELOPMENT PROCESS

Who was involved?

- *The process involved several jurisdictions including the State (DPH), Ryan White Parts (e.g., A, B, C, D, F), and other federally funded HIV prevention programs and organizations.*
- *The CHPC, persons living with HIV, and members of the public*

What did the process look like?

- *2016 marked the beginning of the 5-year planning cycle.*
- *The process began with an updated epidemiological profile to examine the current situation to identify needs, gaps and barriers.*
- *The CHPC engaged diverse stakeholders at the consortium, community, and statewide levels to develop specific, measurable, action-oriented, reasonable, and timely (SMART) objectives.*

What are the next steps?

- *In 2017 the CHPC and its body of diverse stakeholders will begin Plan monitoring and implementation.*
- *Continuous improvement efforts involve assessing progress to update and improve the plan during implementation.*

PLAN DEVELOPMENT PROCESS

Process

Connecticut's Plan represents one Integrated HIV Prevention and Care Plan for submission on behalf of several jurisdictions such as the State, Ryan White Parts (e.g., A, B, C, D, F, Transitional Grant Areas), and prevention. The DPH will submit the same Plan to CDC and HRSA.

Figure 6 (page 15) shows the process used by the Connecticut Department of Public Health (DPH) and the Connecticut HIV Planning Consortium (CHPC) to develop the Integrated HIV Prevention and Care Plan (hereinafter referred to as the "Plan"). The process followed the Integrated HIV Prevention and Care Plan Guidance issued by the Centers for Disease control and Prevention (CDC) Division of HIV/AIDS Prevention and the U.S. Department of Health and Human Services (DHHS) HIV/AIDS Bureau (HAB).[1]

Expectation for Integrated Planning

Connecticut integrated separate statewide HIV planning groups in 2008: The Community Planning Group (prevention; CDC requirements) and the HIV Care Consortium (care; HRSA requirements). The integration process occurred over a two-year time period and included a complete revision of by-laws and organizational structure. The CHPC developed Connecticut's first integrated HIV prevention and care plan in 2011. The 2017 to 2021 Plan builds on these past integration efforts.

Stakeholder Engagement

The CHPC exists to develop the Statewide HIV Prevention and Care Plan. Figure 5 illustrates the intent of the CHPC's collaborative process, including a commitment to directly include the voices of PLWH.

Figure 5. The value of engaging and partnering with diverse stakeholders

Significant knowledge exists within individual stakeholders about HIV prevention and care issues, opportunities and resources.

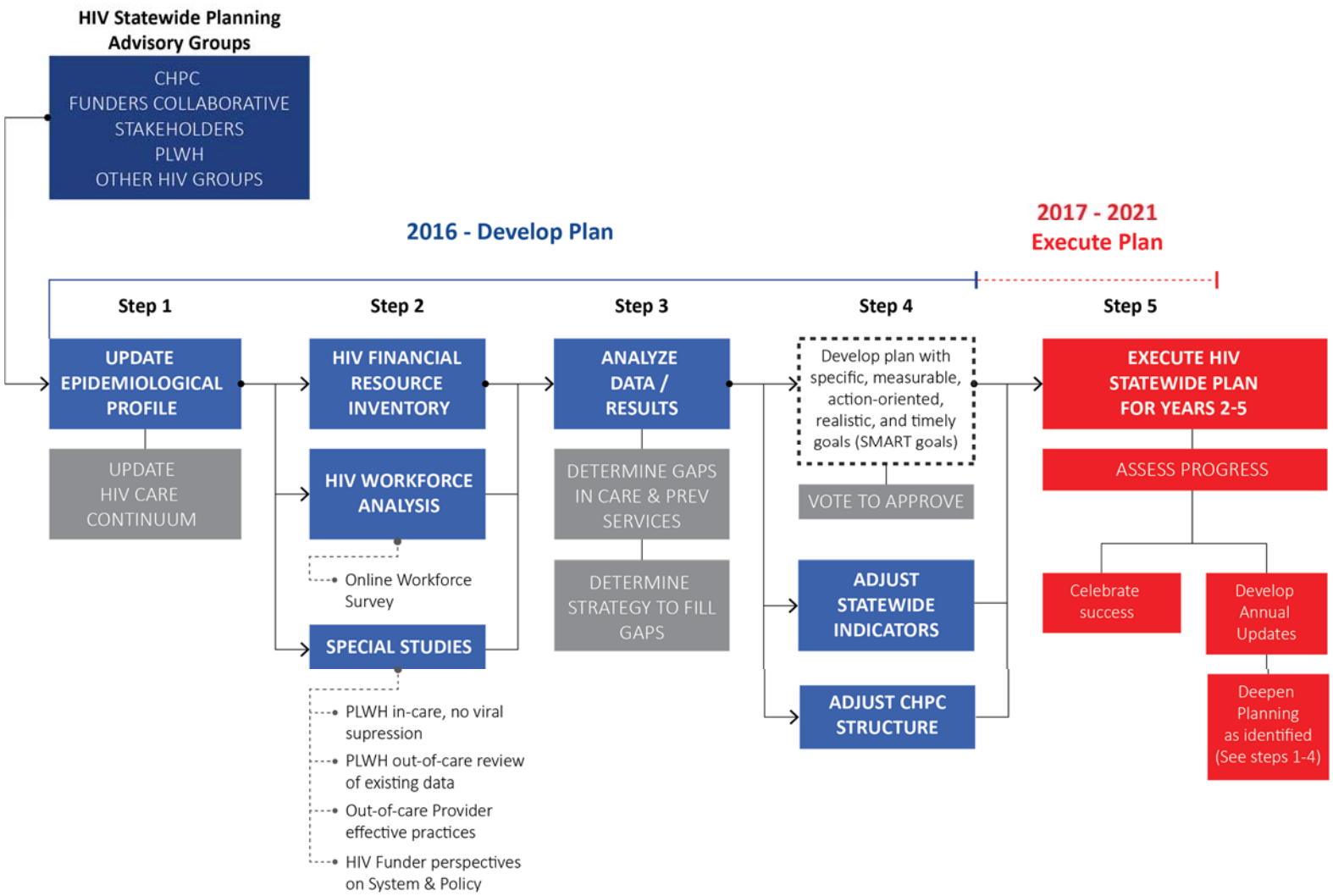
The CHPC process creates synergy and promotes productive, data-driven partnerships that create higher impact.

[1] The DPH convened the HIV Funders Collaborative in November 2015, at which point the decision was made on behalf of the aforementioned jurisdictions to submit one plan following all guidelines.

Five-Year Planning Cycle

Connecticut's previous prevention and care plans followed a three-year planning cycle required by federal funding agencies at the time. The 2017-2021 Statewide Integrated HIV Prevention and Care Plan follows a five-year planning cycle. Figure 6, below, outlines this process in Connecticut:

Figure 6. Connecticut's Statewide Data-Driven Development Process



Engaging Stakeholders

The CHPC engages diverse stakeholders at the consortium, community, and statewide levels. These partners play a critical role in the development and implementation of the Plan. For example:

- Thirty-two diverse individuals represented CHPC membership in January 2016. These members reflect the cultural and geographic diversity of Connecticut's HIV epidemic, as well as both the care and prevention arenas. The CHPC sets a membership composition goal of 50% PLWH and 50% providers. In January 2016, membership included 15 PLWH and 18 providers. Thirty-four percent of members were white, 22% Hispanic or Latino and 44% black. Thirty-one percent of members identified themselves as gay, lesbian or bisexual.

- CHPC members participate in all CHPC meeting-related activities, as well as on the Membership and Awareness Committee (MAC) or one of the two Data and Assessment Committee (DAC) teams – the Needs Assessment Projects (NAP) Team and the Quality and Performance Measures (QPM) Team. Additional opportunities to participate exist through an Ad Hoc Charter Review committee and the CHPC mentoring program.

- The CHPC promotes public participation across all CHPC activities. The CHPC convened in both New Haven, Connecticut and Hartford, Connecticut in 2016. The alternate locations helped expand the CHPC network, inviting new voices and perspectives to the table.

June CHPC Meeting

At its June 2016 meeting, the CHPC split into four groups, each charged with one of the Plan's four goals. Each group generated an extensive list of possible strategies and activities that might fit with their designated goal. The groups identified many priority implementation activities for 2017 – 2018, and many more for consideration in future years or by the statewide Task Force that will develop the campaign to end HIV.

- CHPC members participate actively in other statewide and regional HIV/AIDS prevention and care initiatives funded by the Department of Public Health or other funders.

- The CHPC promotes partner participation in all aspects of the planning process. CHPC partners offer presentations on relevant topics and information critical to complete planning tasks. CHPC members and participants network and share opportunities to get involved in other policy, research, evaluation, and training opportunities available throughout the state.

- The CHPC piloted a "visiting community" strategy, inviting PLWH and providers from an area under-represented on the CHPC to attend a CHPC meeting to recruit members, raise awareness of the CHPC, and learn about that community. The statewide campaign to end HIV will most likely include community listening sessions.

Finally, in 2015, DPH established an advisory group of HIV Funders for the express purpose of facilitating data access, coordinating data collection and expediting input into planning activities. The majority of these funders also serve as CHPC members or regularly attend CHPC meetings. Page 73 describes the HIV Funders Collaborative.

SECTION I

STATEWIDE COORDINATED STATEMENT OF NEED / NEEDS ASSESSMENT

Where are Connecticut's greatest HIV/AIDS needs?

- *Forty-three percent of all PLWH in the state reside in one of three cities: Bridgeport, Hartford, or New Haven.*
- *The highest HIV prevalence rates occur in Connecticut's urban centers.*

Who is the HIV/AIDS epidemic affecting the most in Connecticut?

- ***Gender:*** *67% male, 33% female*
- ***Race/Ethnicity****: 33% black, 32% Hispanic, and 32% white*
- ***Age:*** *39% were 30-49 years of age at diagnosis, 6.3% were 20-29 years of age, and 36.4% were 50-59 years of age*
- ***Risk Factor (prevalence cases):*** *31% cited injection drug use (IDU) as a probable source of infection; 28% were men who have sex with men (MSM), 27% cited heterosexual risk*

What else should I know about HIV/AIDS needs in Connecticut?

- *Connecticut ranks 7th nationally in the rate of persons living with AIDS across the state*
- *Connecticut's Plan focuses on emerging high priority populations in response to national and statewide data (see page 22).*

SECTION I. STATEWIDE COORDINATED STATEMENT OF NEED/NEEDS ASSESSMENT

A. Epidemiological Overview

Method

The Department of Public Health (DPH) epidemiologists update surveillance data and program reports and refresh HIV data relevant to indicators used by the CHPC or shown in the Statewide Health Improvement Plan. Additionally, every few years, DPH publishes a full epidemiological profile for the benefit of HIV planning. The appendix contains the full epidemiological profile released in July 2016.

About Connecticut

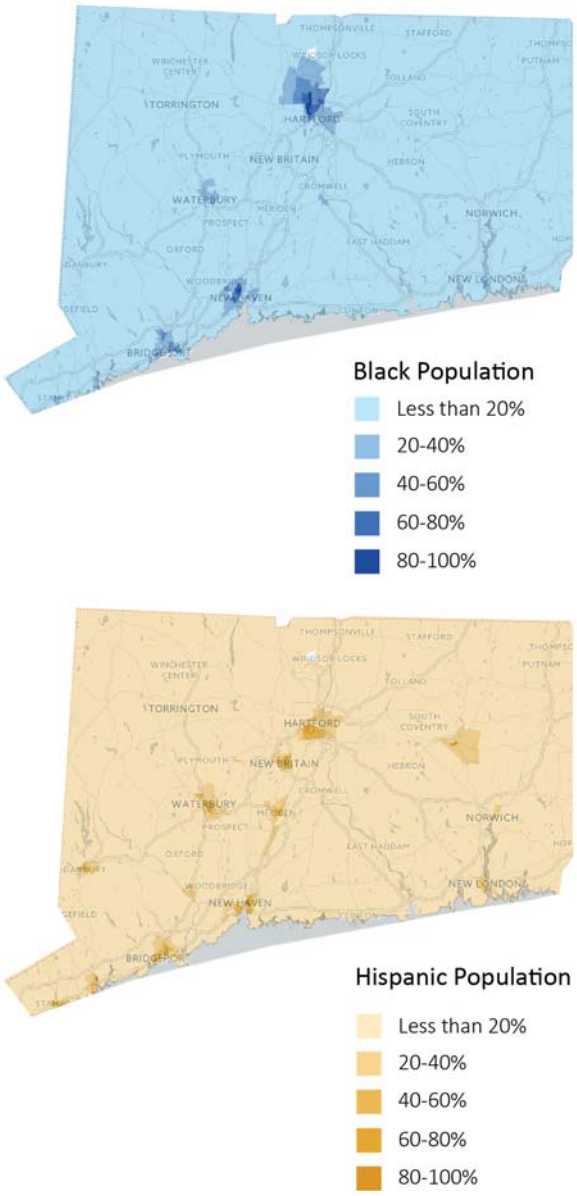
Located in the southernmost portion of the New England region of the United States, Connecticut is the third smallest state by area but one of the most densely populated in the country with nearly 3.6 million residents.

According to the 2010 Census, 78% of Connecticut residents were white, 10% black, 4% Asian, 4% other, and 3% identified as two or more races. Thirteen percent of Connecticut's population identified as Hispanic or Latino, and 22% speak a language other than English at home.

The median household income in Connecticut from April 2010 to 2014 was $69,899, and the per capita income during the same period was $38,480. Nearly 11% of Connecticut's residents are living in poverty.[2]

Almost all of Connecticut's cities and towns have been touched by the HIV epidemic, although 43% of all PLWH in the state reside in Bridgeport, Hartford, or New Haven. Please see Figure 8 on page 19 for a map of prevalent HIV infection cases by residence at diagnosis (2014). State planning leaders are dedicated to addressing and improving the lives of those infected, affected, and at high risk for contracting HIV. Connecticut is committed to preventing new HIV cases and connecting those living with HIV/AIDS to appropriate care and resources. Accomplishing these goals requires foresight, adaptability and diligence.

Figure 7. Black and Hispanic Population Concentrations in Connecticut (2010 U.S. Census)

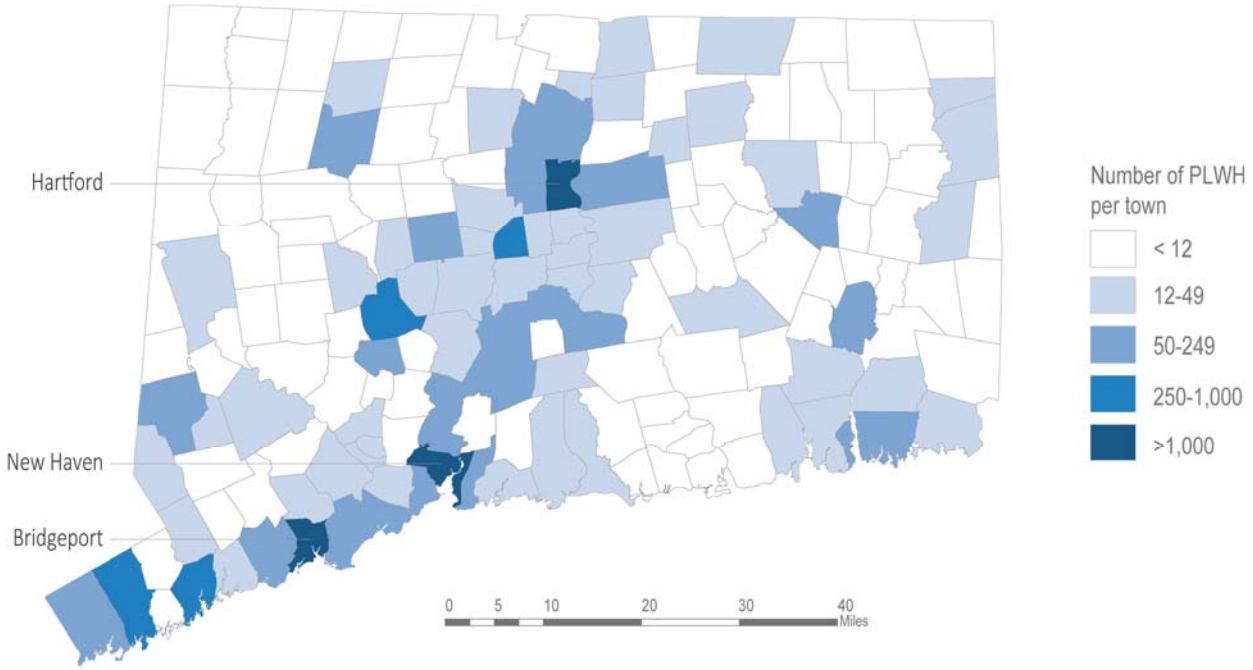


[2] 2010 United States Census, QuickFacts. U.S. Census Bureau.

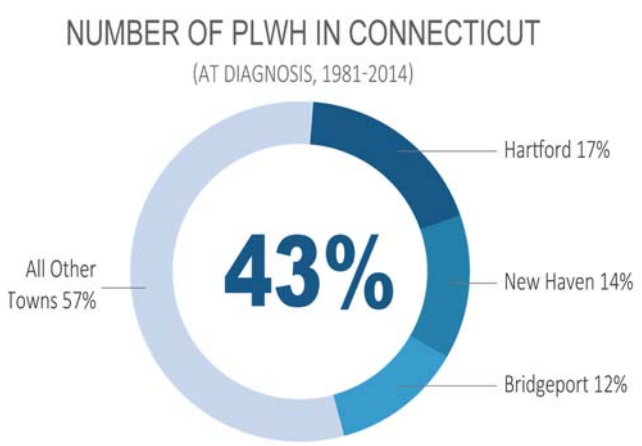
HIV Incidence and Prevalence in Connecticut[3]

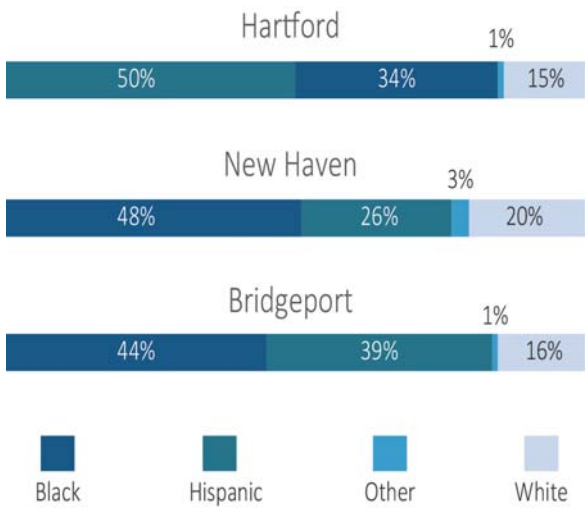
Connecticut ranks 7th nationally in the rate of people living with AIDS. In December 2014, 10,727 people were living with HIV in Connecticut (298 per 100,000). Figure 8 shows the prevalence of HIV Infection cases (N=10,727) in Connecticut as of 2015.

Figure 8. Prevalence of HIV Infection Cases (N=10,727), Connecticut 2014 (as of 2015 and 2010 Census)



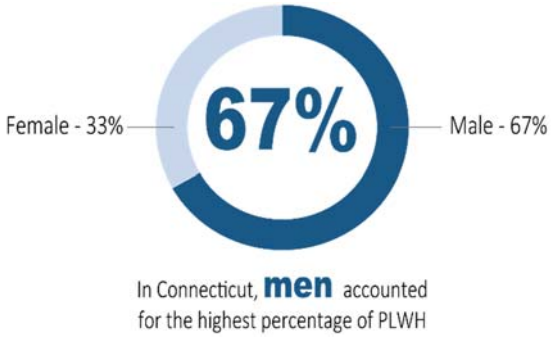
The highest prevalence rates occur in Connecticut's urban centers, which also have the highest percentages of minority residents. Of the 10,727 people living with HIV, 43% reside in Hartford, New Haven, or Bridgeport.





[3] Please refer to the appendices for additional epidemiological tables.

HIV Prevalence in Connecticut (2004 – 2014)



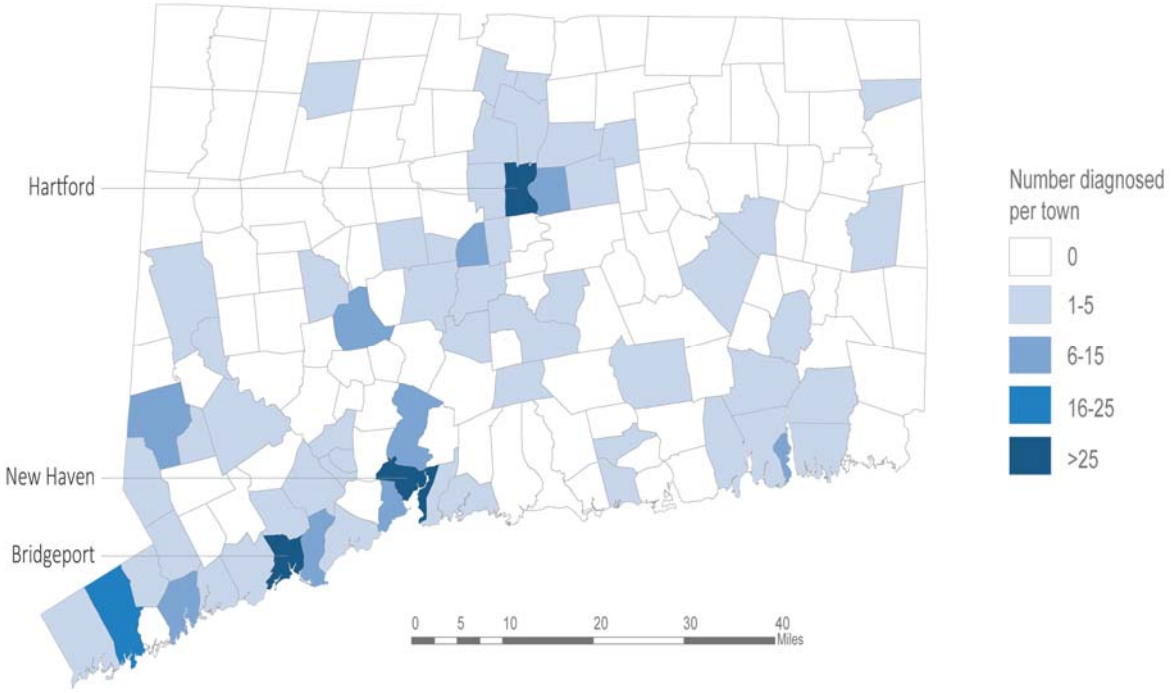
HIV Prevalence in Connecticut (2004 – 2014)

Since 1981, over 20,000 cases of HIV have been reported to Connecticut's Department of Public Health, and of these almost half have died. Among all HIV cases reported in Connecticut:

- 67% were male, 33% female
- 33% black, 32% Hispanic, and 32% white
- 39% were 30-49 years of age at diagnosis, 6.3% were 20-29 years of age, and 36.4% were 50-59 years of age
- 31% cited injection drug use (IDU) as a probable source of infection; 28% were men who have sex with men (MSM), 27% cited heterosexual risk, and 2% were infected by transmission at birth

Figure 9 shows the incidence of newly diagnosed HIV infection cases (N=291) in Connecticut for 2014.

Figure 9. Newly Diagnosed HIV Infection Cases (N=291), Connecticut, 2014 (as of 2015)



Figures 10, 11, 12, and, 13 below show the majority of newly diagnosed cases in Connecticut from 2004 - 2014 were men (75%), and nearly half were men who have sex with men (46%), and black (41%).

Figure 10. HIV Incidence in Connecticut (2010 – 2014)

In Connecticut, **men** accounted for the highest percentage of recently diagnosed HIV cases

Figure 11. HIV Incidence in Connecticut (2010 – 2014)

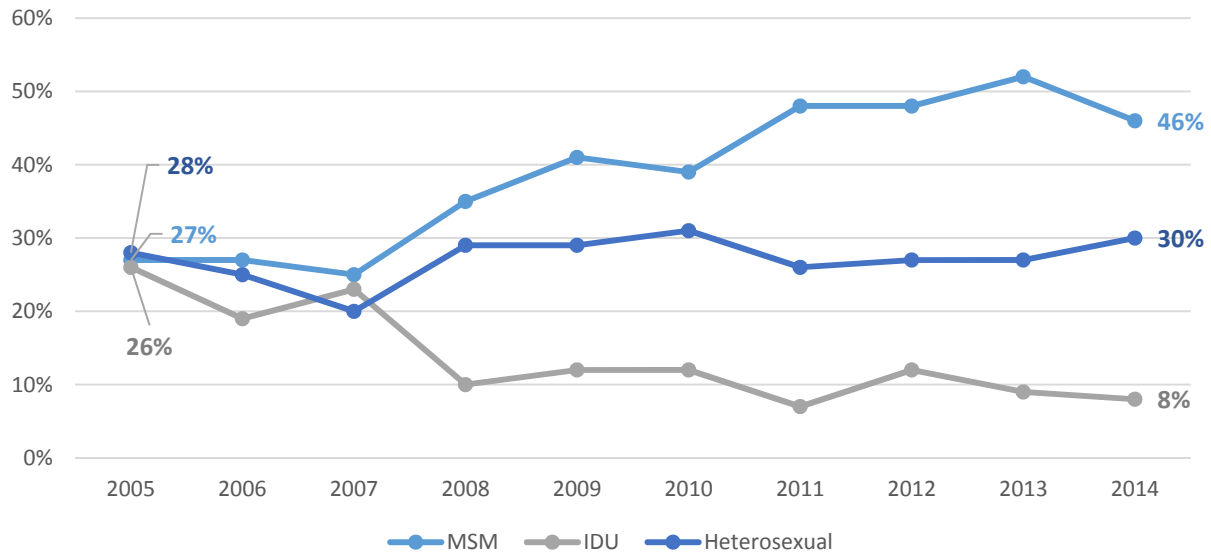
Figure 12. HIV Incidence in Connecticut (2010 – 2014)

In Connecticut, **MSM** was the most at-risk population, accounting for the highest percentage of recently diagnosed HIV cases

Figure 13. HIV Incidence in Connecticut (2010 – 2014)

Figures 10 - 13 show the five-year overall trend in the frequency of transmission methods of HIV in Connecticut for a period from 2010-2014. Consistent with emerging national patterns, gay and bisexual men are most affected by the burden of HIV over the last several years with the most common transmission method being contact between men who have sex with men (46% overall from 2010-2014). In 2014, heterosexual contact was the most common method of transmission among females (52%).

Figure 14. Connecticut HIV Infection Cases by Year of First Diagnosis and Risk (2005 to 2014)



Emerging Priority Planning Populations

HIV disproportionately affects certain groups including Black and Hispanic individuals who, although they make up only 25% of Connecticut's population, represent 65% of all HIV cases. Priority planning issues based on epidemiology include (in alphabetical order):

- African American men who have sex with men.
- Hepatitis C Virus co-infected.
- Heterosexual African American men and women.
- Heterosexual Latinas.
- Injection drug users.
- Late testers.
- Latino men who have sex with men.
- Lesbian, gay, bisexual, transgender populations.
- PLWH (retain in care).
- PLWH who are over the age of 50.
- Un- or under-insured.
- Youth up to age 24 (prevention).

Connecticut recognizes the need to address all factors, including behaviors, virus coinfection, age, and socioeconomic factors, when prioritizing populations at high risk. Please see Figures 15 - 17 for details regarding some of these priority populations.

Figure 15. HIV/HCV Co-infected Rates (2014)

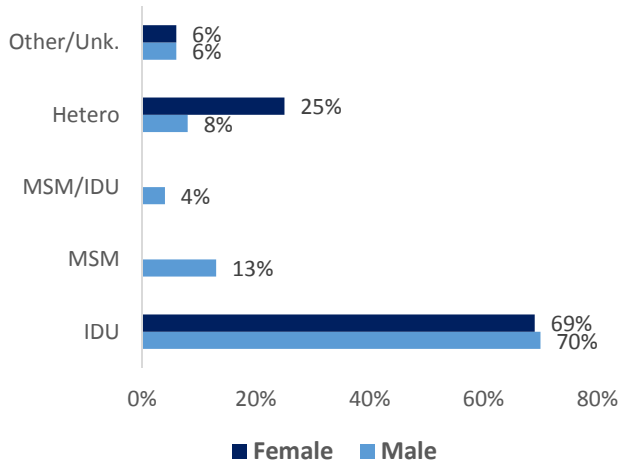


Figure 16. 2014 HIV Diagnoses by Age

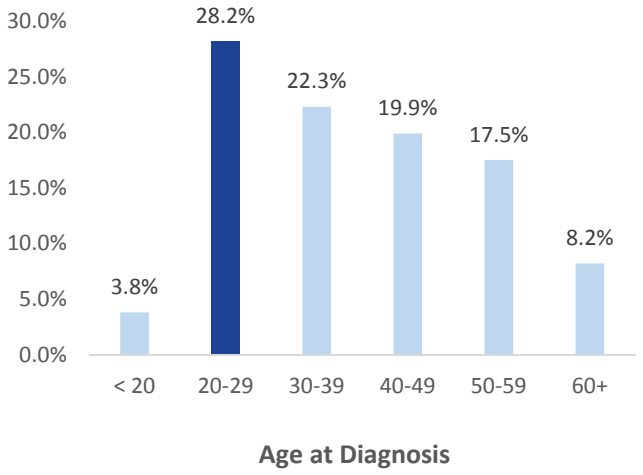


Figure 17. Percent uninsured by race/ethnicity in 5 Connecticut cities with the highest rate of PLWH (2014)

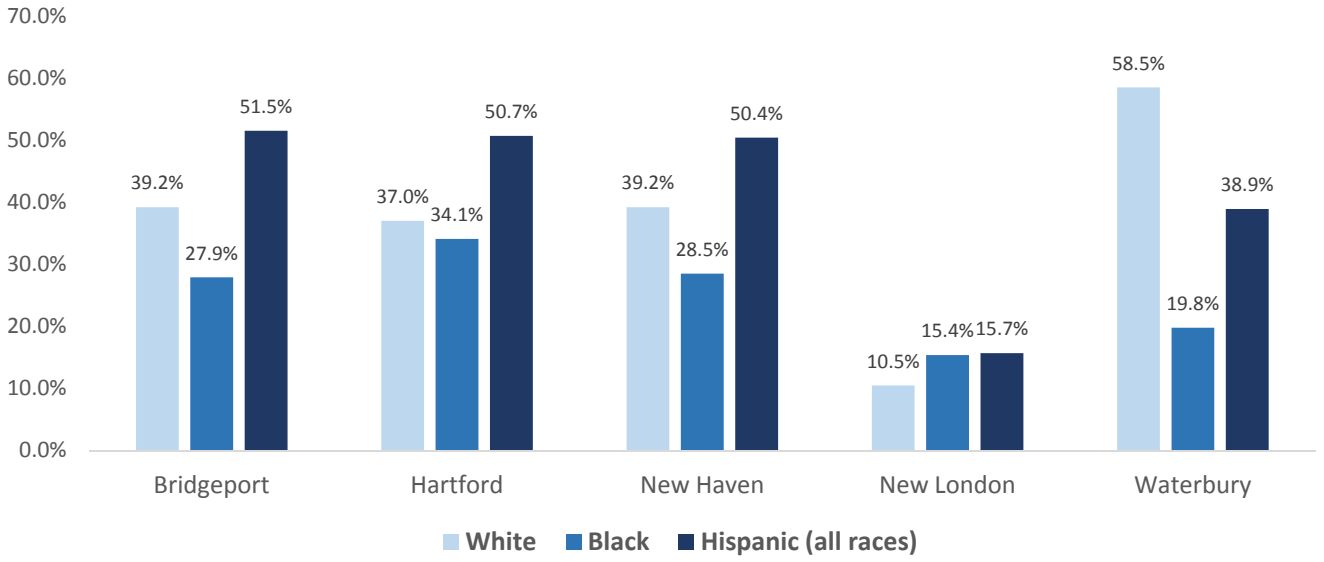


Table 2. PLWH in Connecticut by Sex, Race/Ethnicity, Risk

Highlighted values identify those in the top 15% of their respective category (sex, race/ethnicity, risk)

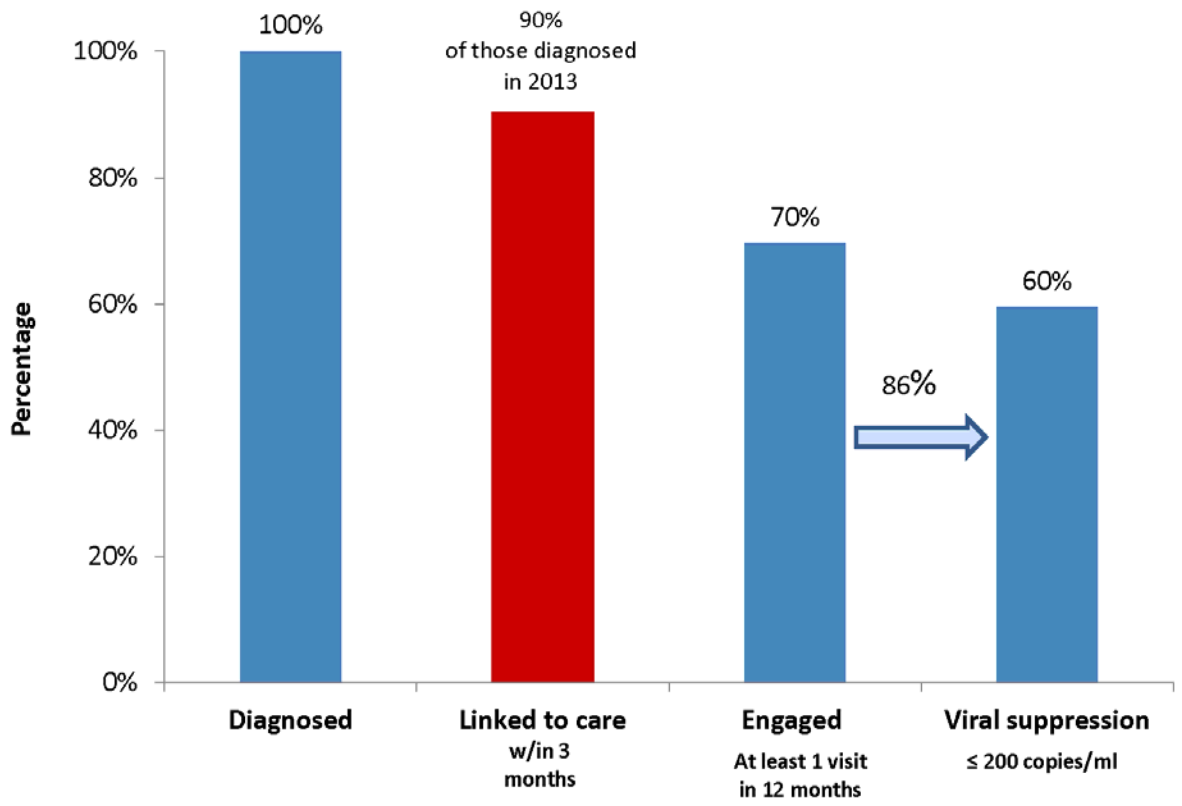
	Total	Sex		Race/Ethnicity				Risk					
		Male	Female	Black	Hispanic	White	Other	IDU	MSM	MSM/IDU	Hetero	Pedi	Oth/Unk
Residence when diagnosed with HIV	Number	% Total	% Total	% Total	% Total	% Total	% Total	% Total	% Total	% Total	% Total	% Total	% Total
Bloomfield	**88**	69.3	30.7	72.7	8	17	2.3	25	33	1.1	26.1	0	14.8
Bridgeport	**1,333**	59.7	40.3	44.9	39	15.2	0.8	31	19.1	1.6	34	1.5	12.8
Bristol	**94**	68.1	31.9	7.4	30.9	60.6	1.1	30.9	42.6	1.1	19.1	1.1	5.3
Danbury	**233**	65.7	34.3	24.5	36.9	33.9	4.7	25.3	29.6	0.9	31.8	0.9	11.6
East Hartford	**217**	62.2	37.8	41.5	31.3	25.3	1.8	27.2	23	3.2	30.9	0.9	14.7
East Haven	**90**	72.2	27.8	14.4	36.7	46.7	2.2	30	31.1	3.3	23.3	0	12.2
Fairfield	**52**	71.2	28.8	11.5	13.5	73.1	1.9	13.5	38.5	0	21.2	3.8	23.1
Greenwich	**82**	79.3	20.7	13.4	13.4	70.7	2.4	13.4	52.4	3.7	13.4	0	17.1
Groton	**56**	73.2	26.8	26.8	17.9	50	5.4	17.9	41.1	5.4	21.4	3.6	10.7
Hamden	**171**	67.3	32.7	50.9	13.5	32.7	2.9	24	29.8	1.8	33.3	1.2	9.9
Hartford	**1865**	65.7	34.3	34.9	50.1	13.8	1.2	44.1	18.1	2.6	24.6	2	8.5
Manchester	**113**	60.2	39.8	24.8	18.6	53.1	3.5	23	34.5	0	26.5	0	15.9
Meriden	**201**	61.7	38.3	15.9	46.3	37.8	0	28.4	26.9	1	30.8	0.5	12.4
Middletown	**159**	67.9	32.1	30.8	22	47.2	0	32.1	32.7	1.9	24.5	0.6	8.2
Milford	**69**	79.7	20.3	10.1	13	76.8	0	14.5	47.8	4.3	15.9	1.4	15.9
Naugatuck	**51**	78.4	21.6	21.6	27.5	51	0	29.4	39.2	0	23.5	0	7.8
New Britain	**403**	65	35	19.6	55.6	24.1	0.7	34.7	24.1	1.2	28.5	2.5	8.9
New Haven	**1452**	64	36	50.8	26	20.5	2.7	36.4	23.6	2.5	28.7	2.5	6.4
New London	**191**	58.6	41.4	33.5	33	30.4	3.1	30.9	23.6	1.6	34.6	2.6	6.8
Norwalk	**333**	64.9	35.1	36.6	25.2	34.5	3.6	24	31.2	0.9	27.3	2.7	13.8
Norwich	**150**	60	40	28.7	13.3	54	4	26.7	30.7	1.3	33.3	0.7	7.3
Stamford	**524**	69.8	30.2	45.8	27.1	25	2.1	26	27.3	0.8	29.8	2.9	13.4
Stratford	**100**	73	27	43	14	42	1	11	36	1	32	1	19
Torrington	**61**	75.4	24.6	6.6	14.8	73.8	4.9	23	41	4.9	19.7	0	11.5
Wallingford	**60**	86.7	13.3	11.7	18.3	70	0	13.3	53.3	3.3	15	3.3	11.7
Waterbury	**734**	63.1	36.9	29.3	43.5	26.3	1	40.2	23.4	1.9	24.3	2.5	7.8
West Hartford	**78**	74.4	25.6	10.3	21.8	64.1	3.8	17.9	51.3	0	17.9	1.3	11.5
West Haven	**210**	62.4	37.6	43.8	23.8	29.5	2.9	26.7	27.6	1	31.9	3.8	9
Windham	**107**	62.6	37.4	15.9	56.1	27.1	0.9	51.4	15	1.9	24.3	1.9	5.6
Windsor	**52**	69.2	30.8	38.5	26.9	34.6	0	21.2	36.5	3.8	25	0	13.5
Other towns	**1398**	79	21	10.9	12.1	75	2	18.2	47.1	1.9	18	1.4	13.4
Total	**10,727**	66.7	33.3	33.3	32.4	32.5	1.8	31.3	27.8	1.9	26.6	1.9	10.5

B. HIV Care Continuum

HIV Care Continuum

This Continuum of Care is based on persons receiving HIV care in 2014 among persons older than 13 years of age at diagnosis, resided in Connecticut (based on residence of diagnosis), diagnosed with HIV infection through 2013, and living with HIV on 12/31/2014. Persons who have at least one CD4, viral load or HIV-1 genotype test are considered as receiving HIV care. Tests that have been done in the same month are considered as one care visit. The overall HIV population is overestimated because cases are only followed up for 11 months after 12/31/2014. The CDC suggests that every case should be followed up at least 18 months to collect death certificate information.

Figure 18. Connecticut HIV Care Continuum

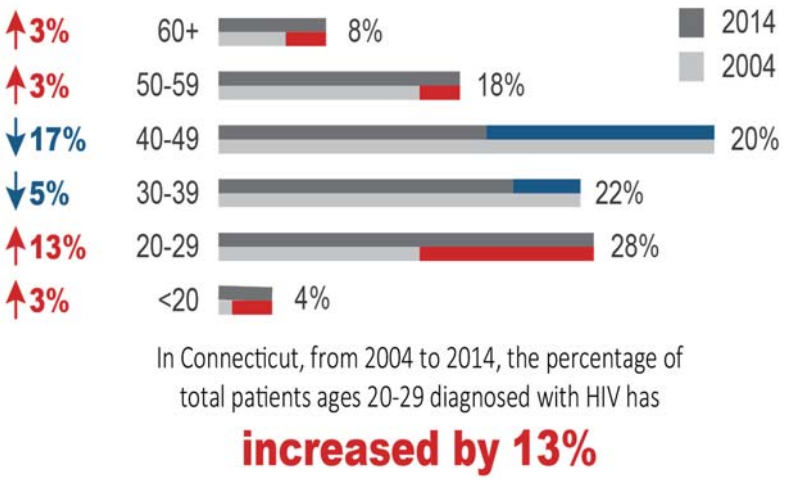


Based on persons receiving HIV care in 2014 among persons ≥13 years old at diagnosis, resided in Connecticut (based on residence of diagnosis) and diagnosed with HIV infection through 2013 and living with HIV on 12/31/2014. Persons who have at least one CD4 , viral load or HIV-1 genotype test are considered as receiving HIV care. Tests that have been done in the same month are considered as one care visit. The overall HIV population is overestimated because cases are only followed up for 11 months after 12/31/2014. CDC suggests that every case should be followed up at least 18 months to collect death certificate information.
Source: HIV surveillance registry through 2015.

Disparities in Engaging Key Populations

Figure 19 shows shifts in HIV incidence by age and areas where Connecticut must improve in testing, outreach and linkage to care. During the time period of 2004 to 2014, the greatest shift occurred in the 20-29 age group, which increased by 13%. During this same period of time the number of new cases among 40-49 year olds dropped by 17%, and 30-39 year olds by 5%. Page 22 identifies priority populations for prevention, testing, outreach and linkage.

Figure 19. Shifts in HIV Incidence in Connecticut (Age): 2004 to 2014



Figures 20 and 21 show that health disparities exist in terms of hospitalizations and HIV-related deaths, areas that relate to access to care, quality of care, and medication adherence, among others.

Figure 20. HIV-Related Hospitalizations

Per 100,000 Population (2014)

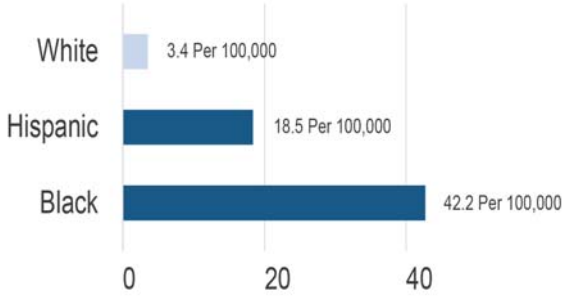
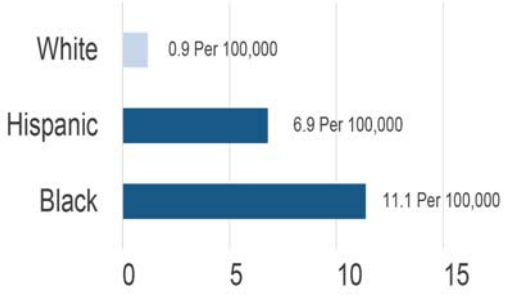


Figure 21. HIV-Related Deaths

Per 100,000 Population (2014)



Use of the HIV Care Continuum

Indicators used by the DPH and CHPC correspond with various steps of the HIV continuum of care. In many instances, these indicators create the basis for several of the measurable objectives for the Plan. The HIV stakeholders and HIV funding partners use data-driven planning to optimize and to coordinate HIV funding streams.

Connecticut Statewide Progress Indicators

Indicator 1	HIV Positivity Rate (Biological): Number of newly diagnosed (dx) in the 12-month calendar year per 100,000 people. **2021 Goal: 276 newly diagnosed** (Baseline: 350 in 2011, 295 in 2012)
Indicator 2	Seropositivity Rate (Service/Access): Number of OTL and ETI HIV positive tests in the 12-month calendar year. **2015 Goal: 0.2% ETI; 0.3% OTL** (Baseline: 0.19% ETI, 0.26% OTL (2013); 0.13% ETI, 0.26% OTL (2014))
Indicator 3	Viral Load Suppression Among Persons in HIV Medical Care: Number of persons with an HIV diagnosis with a viral load <200 copies/ml at last test in the 12-month calendar year. **2021 Goal: 90%** (Baseline: 80% 2012, 84% 2013)
Indicator 4	Linkage to HIV Care (Biological): Number of persons who attended a routine HIV medical care visit within 3 months of HIV diagnosis. **2021 Goal: 95%** (Baseline: 86.4% 2011, 87.3% 2012, 89% 2013)
Indicator 5	Retention in HIV Medical Care (Service/Access): Number of patients who had at least one HIV medical visit in each 6-month period of the 24-month measurement period with a minimum of 60 days between first medical visit in the prior 6-month period and the last medical visit in the subsequent 6-month period. **2015 Goal: 65%** (Baseline: 64% 2011-2012, 67% 2012-2013)
Indicator 6	Late HIV Diagnoses (Late Testers) (Biological): Number of people who had their first HIV positive test less than 3 months before receiving AIDS diagnosis. **2015 Goal: 35%** (Baseline: 40% 2012, 34% 2013)
Indicator 7	Antiretroviral Therapy (ART) Among Persons in HIV Medical Care (Service/Access): Number of persons with HIV diagnosis who are prescribed ART in the 12-month calendar year. **2015 Goal: 95%** (Baseline: 91% 2012, 97% 2013)
Indicator 8	Partner Services (Service/Access): Number of newly diagnosed interviewed (i.e., linked) by Partner Services. **2015 Goal: 95%** (Baseline: 90% 2013)
Indicator 9	Housing Status (Service/Access): Number of persons with an HIV diagnosis who were stably housed in the 12-month calendar year. **2015 Goal: 80%** (Baseline: 76% 2012, 82% in 2013)
Indicator 10	Syringe Services Program (SSP) (Service/Access): *10a:* Number of SSP clients served: (Baseline: 2,500 [YR 2014]) *10b:* Number of syringes collected: (Baseline: 250,000 [YR 2014]) *10c:* Number of syringes distributed: (Baseline: 251,000 [YR 2014]) **Goal: To be determined**
Indicator 11	Disparities in New HIV Diagnoses: Number of newly diagnosed (dx) in the 12-month calendar year for each of the following groups: Men who have sex with men (MSM), Black/African American men and women. **Goal: Reduce disparities in the rate of diagnoses by 5%.**

C. Financial and Human Resources Inventory

HIV Resource Inventory

DPH convened an HIV Funders Collaborative to facilitate data collection and data sharing to complete financial and human resource inventories. Table 3 (page 29) contains the financial inventory for Fiscal Year 2015 (the most complete data set) along the HIV continuum: prevention services, core medical-related services, supportive services, HIV testing, HIV education and the HIV care continuum. The table organizes information according to three geographic areas: Ryan White Part A New Haven & Fairfield Counties, the Ryan White Part A Transitional Grant Area – Hartford, and "Balance of the State" (or non-Ryan White Part A areas). The appendix contains a complete set of financial tables.

Figure 22 shows the proportion of statewide public HIV funding sources in Connecticut. Medicaid and Ryan White Part A (care) and Part B (including ADAP) account for the majority of funding.

Figure 23 shows the percentage of fiscal funding allocated by geographic area and the correspondence to the percentage of PLWH in those areas.

Figure 22. Funding by Source

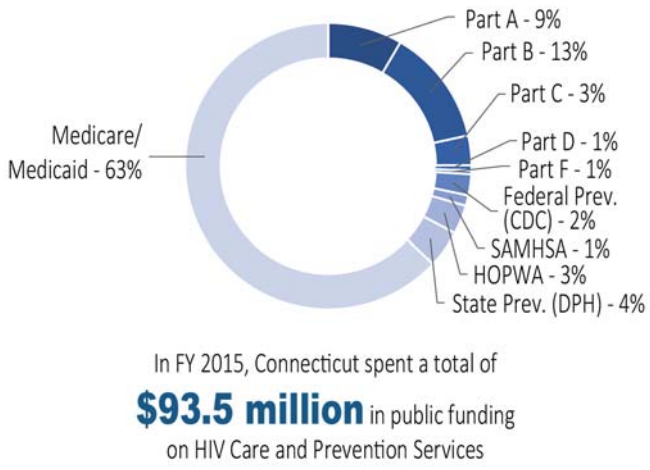


Figure 23. Funding by Geography

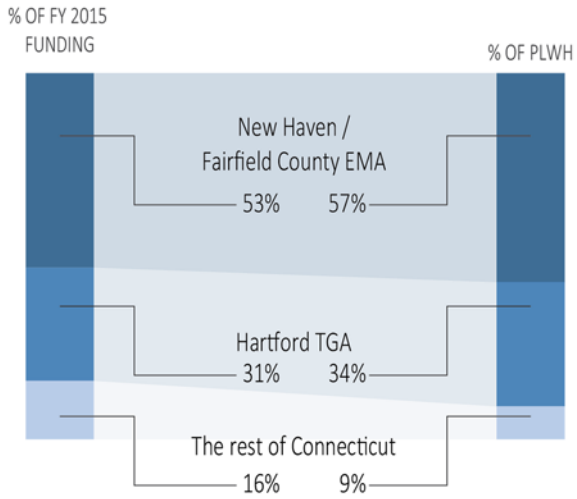


Table 3. Jurisdictional HIV Resource Inventory

Public Funding Source	EMA / TGA / Balance of State (BOS)	FY 2015 Funding		Prevention Services						Core Medical-related Services													Supportive Services																		HIV Care Continuum				
		$	% (of total)	Non-Occupational Post-Exposure Prophylaxis (nPEP)	Outreach Testing & Linkage (OTL)	Expanded Testing Initiative (ETI) – Routine	Syringe Service Programs (SSP)	Partner Services	Effective Behavioral Interventions (EBI)	Outpatient/Ambulatory Medical Care	AIDS Drug Assistance Program	AIDS Pharmaceutical Assist.	Oral Health Care	Early Intervention Services	Health Insurance Premium/ Cost-Sharing Assistance	Home Health Care	Home & Community-based Health Services	Hospice Services	Mental Health Services	Medical Nutrition Therapy	Medical Case Management	Substance Abuse Services – Outpatient	Non-medical Case Management	Child Care Services	Emergency Financial Assistance	Food Bank/Home-delivered	Health Education/Risk Reduction	Housing Services	Legal Services	Linguistic Services	Medical Transportation Services	Outreach Services	Psychosocial Support Services	Referral for Health Care/ Supportive Services	Rehabilitation Services	Respite Care	Substance Abuse Services – Residential	Treatment Adherence	HIV Testing	HIV/AIDS Education	HIV-Diagnosed	Linkage to Care	Retained in Care	Antiretroviral Use	Viral Load Suppression
Part A	NHV/FF	$ 4,978,217	5.3%							X			X	X	X				X		X	X			X	X		X			X						X					X	X	X	X
	HTF	$ 2,870,663	3.1%							X			X	X	X				X		X	X	X		X	X		X			X		X						X		X	X	X	X	X
Part B	NHV/FF	$ 1,509,136	1.6%							X			X	X	X				X	X	X				X	X		X			X		X									X	X		X
	HTF	$ 1,467,975	1.6%							X			X	X	X				X	X	X				X	X					X											X	X		X
	BOS	$ 9,350,771	10.0%							X	X		X		X				X	X	X		X		X	X		X			X		X									X	X	X	X
Part C	NHV/FF	$ 2,469,802	2.6%							X			X	X					X	X	X		X		X		X				X	X							X		X	X	X	X	X
	HTF	$ 644,570	0.7%							X			X						X		X	X	X				X			X	X	X							X		X	X	X	X	X
	BOS	$ -	0.0%																																									
Part D	NHV/FF	$ 463,408	0.5%							X									X	X	X		X				X				X	X									X	X	X	X	X
	HTF	$ 96,715	0.1%		X					X										X	X										X										X	X	X	X	X
	BOS	$ -	0.0%																																									
Part F (HRSA)	NHV/FF	$ 163,461	0.2%																																					X				
	HTF	$ 225,846	0.2%																																					X				
	BOS		0.0%																																									
Federal Prev. Funding (CDC)	NHV/FF	$ 1,453,129	1.6%		X	X	X	X	X																																X	X			
	HTF	$ 713,491	0.8%		X	X	X		X																																X	X			
	BOS	$ 71,655	0.1%		X				X																																X				
SAMHSA	NHV/FF	$ 630,129	0.7%																			X	X					X				X										X	X		
	HTF	$ 375,866	0.4%																			X	X					X				X										X	X		
	BOS	$ 99,494	0.1%																			X	X					X				X										X	X		
HOPWA	NHV/FF	$ 1,755,010	1.9%																									X															X		
	HTF	$ 1,084,150	1.2%																									X															X		
	BOS	$ 217,492	0.2%																									X															X		
State Prev. Funding (DPH)	NHV/FF	$ 2,391,936	2.6%	X	X	X	X	X	X																																X	X			
	HTF	$ 1,322,850	1.4%	X	X	X	X		X																																X	X			
	BOS	$ 184,414	0.2%	X	X				X																																X	X			
Medicaid / Medicare	NHV/FF	$ 33,585,116	35.9%							X		X	X		X		X	X	X	X	X	X																			X	X	X	X	X
	HTF	$ 20,622,440	22.1%							X		X	X		X		X	X	X	X	X	X																			X	X	X	X	X
	BOS	$ 4,713,701	5.0%							X		X	X		X		X	X	X	X	X	X																			X	X	X	X	X

Totals			
	NHV/FF	$ 49,399,344	53%
	HTF	$ 29,424,566	31%
	BOS	$ 14,637,527	16%
	TOTAL	$ 93,461,437	100%

57% of PLWH in Connecticut reside in NHV/FF EMA
35% of PLWH in Connecticut reside in HTF TGA

92% of PLWH live in one of the Ryan White Areas

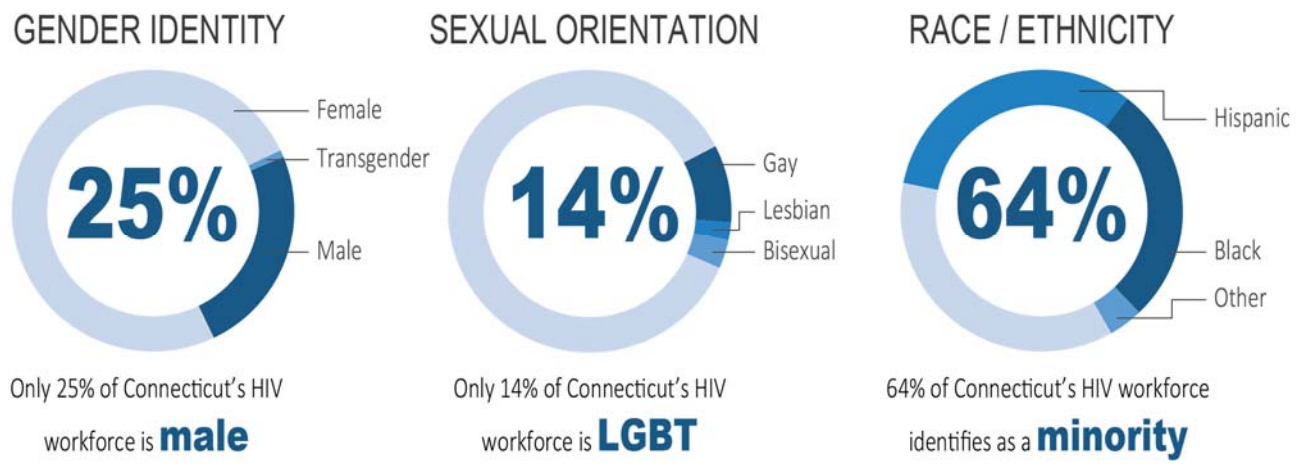
Connecticut's HIV Workforce Capacity

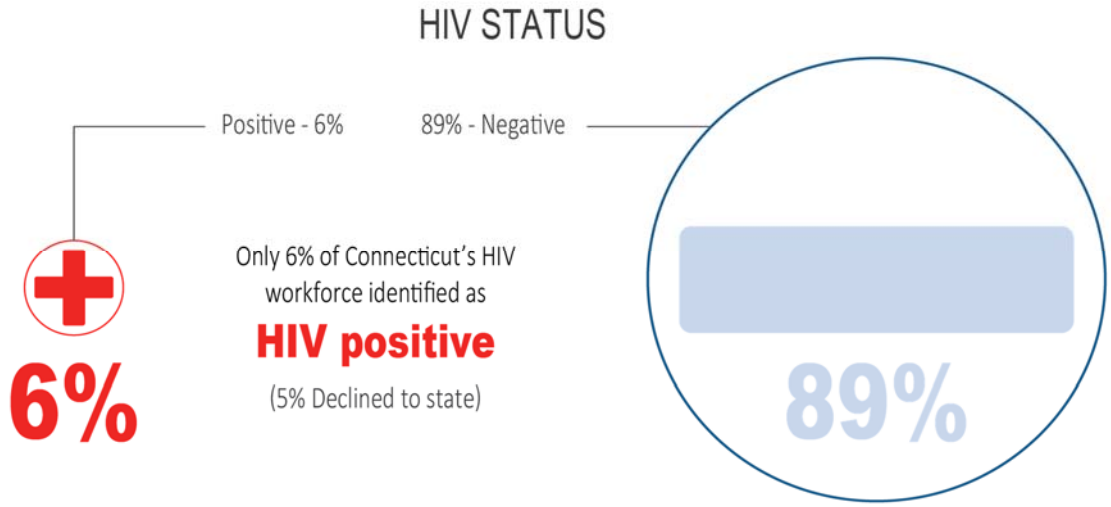
In the spring of 2015, representatives from the State's HIV Funders Collaborative, with CHPC input, implemented the first ever survey of the state's HIV/AIDS workforce. The electronic survey was sent to 349 individuals that make up the core of Connecticut's publicly funded HIV/AIDS workforce. Two hundred and forty eight (248) people responded to the survey, representing a 71% response rate.

The survey contained methodological limitations. However, the high response rate allows funders and planners to create general, point-in-time impressions about the workforce in terms of gender, race, ethnicity, sexuality, geography, education, and experience. The appendix contains a full summary.

In summary, survey results indicated the workforce is predominantly female (74%) and straight/heterosexual (85%), and the majority of respondents indicated their race/ethnicity as Black/Hispanic/other (64%). Only 6% of survey respondents indicated they were HIV positive. The majority of respondents (65%) indicated they hold a bachelor's degree or higher. A majority (55%) of respondents also indicated they have provided HIV prevention/care for 10 years or more. Seventy percent (70%) of respondents indicated they had taken a cultural diversity/sensitivity training within the past twelve months. The survey revealed emerging themes and provided a sense of direction for planning efforts. The figures below offer a brief overview of the survey results:

Self-Reported HIV Workforce Demographic Characteristics





The HIV workforce experiences high turnover rates and difficulty attracting qualified candidates to fill positions, and these trends apply to medical care as well. Unfortunately, even with access to care, PLWH may not be connected to a physician with an extensive background in the virus. The New England AIDS Education and Training Center (AETC) works within its funding capability to recruit and train physicians to treat PLWH. Connecticut boasts a high number of physicians (non-specific to HIV), suggesting a sound infrastructure with sufficient workforce capacity overall. Please see Figures 24 - 27 for a look at how Connecticut compares to a median value representing all states; Connecticut ranked between 3rd and 12th in the following categories, nationwide[4]:

Figure 24. Total Active Physicians in Connecticut per 100,000 Population

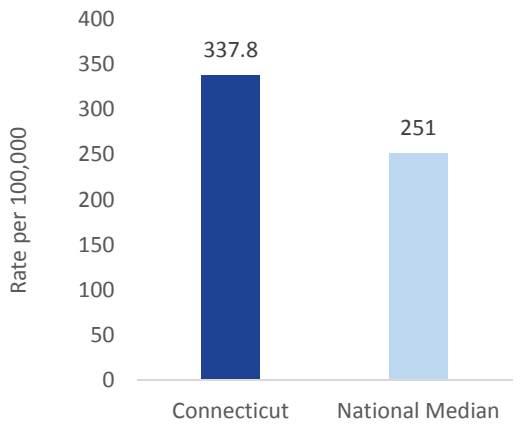


Figure 25. Total Active Patient Care Physicians in Connecticut per 100,000 Population

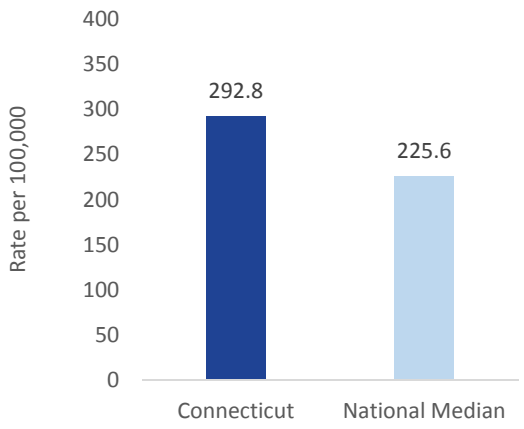


Figure 26. Total Active Primary Care Physicians in Connecticut per 100,000 Population

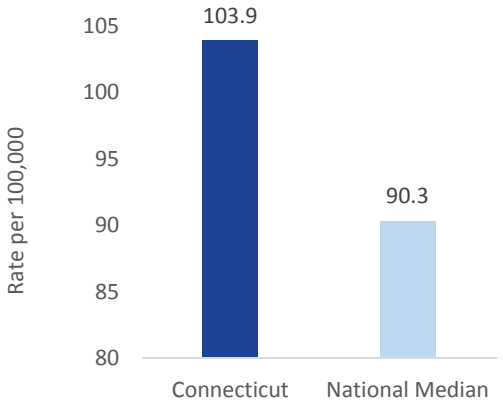
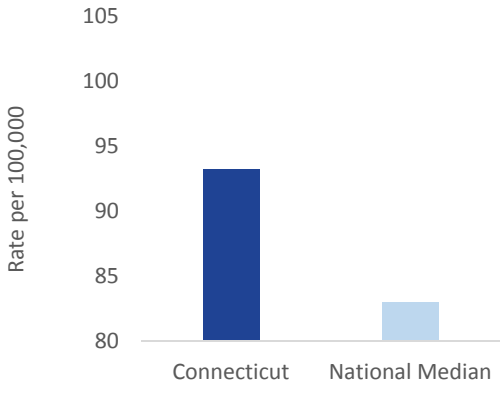


Figure 27. Total Active Patient Care Primary Care Physicians in Connecticut per 100,000 Population



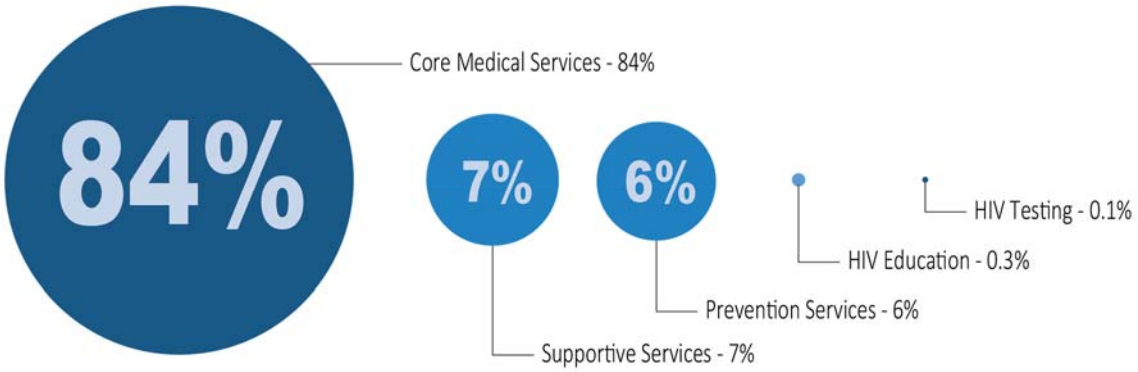
[4] Data from 2015 State Physician Workforce Data Book, AAMC

HIV Prevention, Care, and Treatment Services Funding Sources

In Fiscal Year 2015, Connecticut's public funding was representative of diverse sources including: Ryan White Parts A, B, C, D, and F, SAMHSA, HOPWA, as well as Federal prevention funding from the CDC, and State prevention funding from the Connecticut Department of Public Health. Additionally, nearly $59 million in Medicare/Medicaid funding was spent on HIV/AIDS services in Connecticut. See Table 3 on page 29.

Figure 28 shows proportion of funding by type of service.

Figure 28. Funding by type of service



Resource Needs / Service Gaps, and Steps to Secure Them

Several themes emerge from review and discussions about resources, needs and service gaps, chief among which include:

- Increasing the amount of HIV prevention resources and improving collaboration with the stakeholders such as the local departments of public health, the Connecticut State Department of Education and the Department of Mental Health and Addiction Services Prevention and Health Promotion Unit.
- Allocating the Ryan White Part A funding (care) into supportive services (non-core medical) and establishing effective partnerships with other funders in housing, education, workforce development and employment.
- Increasing access to health care – including insurance coverage and support for medication co-pays.
- Positioning service providers to adjust service models and to innovate in the Affordable Care Act environment.
- Supporting workforce development, particularly to improve implementation of evidence-based strategies and promising models.
- Improving data collection systems and increasing communication and collaboration among HIV funders (and other stakeholders).
- Establishing a statewide campaign to end HIV.

The 2017 to 2021 Plan creates pathways to address each of these issue areas, as well as others.

D. Data: Access, Sources, and Systems

Main Data Sources

The Epidemiological Profile exists as the state's comprehensive resource on the current state of the epidemic; its data drives the planning process. The current Epidemiological Profile uses data through 2014.

The DPH convened a funders collaborative to facilitate data access and to coordinate data collection (e.g. financial inventory, workforce survey, planning processes conducted by various stakeholder groups). The 2016 Funders & Leaders Survey was completed by 13 individuals representing publicly funded HIV sources identifying perceived system strengths, weaknesses, and priorities. Please see the Appendix for survey summary results.

In addition to surveys, data sources included eHARS, the HIV surveillance registry, CareWare, the Ryan White case management system, and Evaluation Web, the HIV testing and funding intervention database. The data for HIV care continua for the entire state and for the focus areas (the New Haven Eligible Metropolitan Area (EMA) and the Hartford Transitional Grant Area (TGA)) were derived from eHARS. Using CD4, viral load, or genotype results as markers for care, DPH determines who is a) out of care, b) connected to care, and c) virally suppressed.

Data Policies

DPH uses name based reporting, requiring both detectable and non-detectable viral load laboratory findings. Prior to January 2014, only AIDS defining CD4 results were reportable; Connecticut now mandates the reporting of all CD4 laboratory findings to DPH, improving the ability to capture care continuum data. DPH staff in HIV Surveillance work closely with Prevention and Care on a regular basis to provide data and maps for targeting programs, monitoring trends, and evaluating disparities. The DPH is committed to improving systemic data sharing capabilities, such as participating in the HIV Affinity Group with the Department of Social Services (DSS) to access Medicaid data to improve HIV care and prevention services. The DPH is implementing Program Services Collaboration Integration (PCSI) model; the Plan includes capacity building in this area, as well.

Collaboration

The HIV funders collaborative identified future roles and responsibilities to improve the planning and data collection processes, share best practices, create economies of scale and optimize funding. Please see pages 13-16 for more details on Connecticut's interactive, collaborative, and communicative planning process.

Special Projects: Implementation Science

Since the inception of the DPH lead Connecticut HIV/AIDS Identification and Referral (CHAIR) Task Force, several projects have been implemented throughout the last year. This emphasizes the strong collaboration with DPH's academic research and evaluation partners in Connecticut. The following three projects highlight DPH engagement and collaboration with our partners in regards to evaluating evidence based interventions and identifying newer effective interventions that show promise in improving the quality of current funded efforts. These projects were highlighted at the New England HIV Implementation Science Network 3rd Annual Symposium held on June 2, 2016 and sponsored by the Center for Interdisciplinary Research on AIDS (CIRA) at Yale University and the Center for AIDS Research (CFAR). These data were published in New England HIV Implementation Science Network *Spotlight*.

According to the National Institute of Health (NIH), implementation science is the study of methods to promote the integration of research findings and evidence into healthcare policy and practice; it seeks to understand the behavior of healthcare professionals and stakeholders as a key variable in sustainable uptake, adoption, and implementation of evidence-based interventions (EBIs).

Special Projects (1) - Developing a Comprehensive HIV Care Continuum (HCC) Model in 9 Small Cities[5]

The HCC model is used at local, state, and federal levels to assess PLWH treatment delivery; however, less is known about the use of the model in small United States cities. CT DPH and its partners are assessing HCC data, as well as geospatial and qualitative data, to improve the model for nine small cities located in Connecticut, Massachusetts, and Rhode Island. These efforts will help the cities to more effectively address the service delivery system in their respective communities, as well as provide important information about the state of the epidemic along each continuum step.

As of June 2016, 40 in-depth key informant interviews were conducted with state health department staff and service providers within the nine cities. A coding schema is being developed, and quantitative data analysis is underway. HCC service provider addresses have been geocoded in participating cities, leading to the creation of descriptive maps identifying services and outcomes. These tools will help develop the HCC in these cities, highlighting crucial information about HIV/AIDS treatment delivery and ultimately revealing system gaps.

Please see Figure 29 on page 35 for a look at the Connecticut HCC (also featured on page 25); this will serve as an assessment reference point for smaller communities on a local level.

Special Projects (2) - Project STOP: The Syphilis to PrEP Cascade[6]

Project Syphilis to PrEP (STOP) connects individuals reported to CT DPH for syphilis and partners of newly diagnosed HIV cases to Pre-Exposure Prophylaxis (PrEP). CT DPH disease intervention specialists (DIS) worked to refer all cases reported between September 2015 and March 2016 to a central PrEP navigator, who then provided education and linkage to services for these individuals. Despite improvements to the outreach process, DIS and PrEP navigators encountered the following barriers:

1. Communication related to protocol
2. DIS willingness to conduct referrals
3. Difficulty reaching PrEP candidates
4. Availability of services dependent on area

Within the aforementioned six-month period, 71 individuals were identified as potential candidates for PrEP. Ultimately, twelve individuals reported to CT DPH for either syphilis or as a partner of newly diagnosed HIV case were provided individualized information on PrEP as a method of HIV risk reduction and six were assisted in accessing PrEP medical services. Identifying barriers in the process revealed areas for improvement and introduced possible model refinements. Please see Figure 30 on page 35 for more information.

[5] Team and partners include: Thomas Stopka (Co-PI-Tufts); Lauretta Grau (Co-PI-Yale); Robert Heimer (Co-I-Yale): Amy Nunn (Co-I-Brown). Staff: Marga Hutcheson (Tufts); Caitlin Towey (Brown); Abbie Kundishora (Yale). State Health Departments: MA, RI, CT. Several community based agencies and AIDS service organizations from the nine (9) participant cities also contributed.
[6] Team and partners include: Krystn Wagner (PI-Fair Haven Community Health Center), Daniel Davidson (CT DPH), Sarah Calabrese (Yale), A.C. Demidont (Circle Care Center), Marianne Buchelli (CT DPH), and members of the CT DPH PrEP Workgroup (Peg Weeks and JiangHong Li (Institute for Community Research), Jim Pettinelli and Dini Harsono (Center for Interdisciplinary Research on AIDS at Yale University), Heidi Jenkins (CT DPH)).

Figure 29. Connecticut HIV Care Continuum

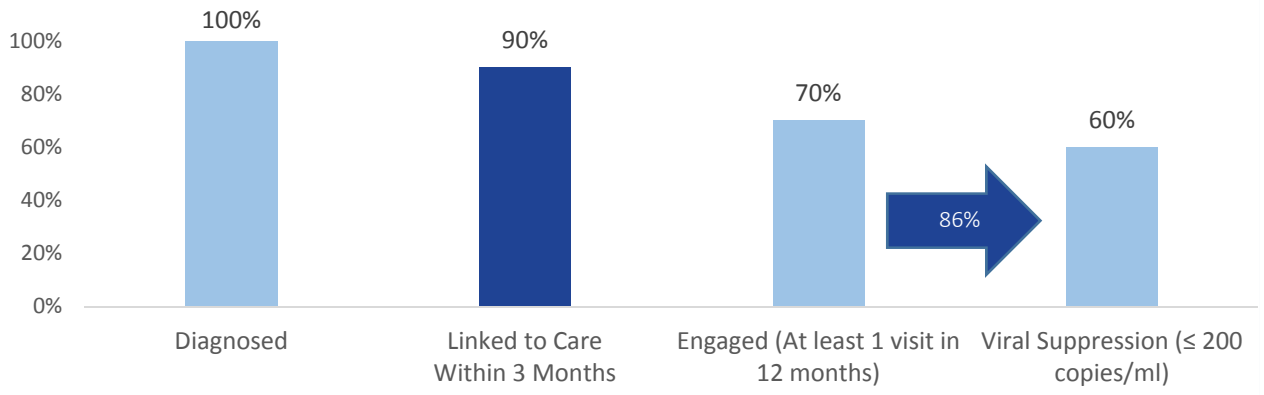
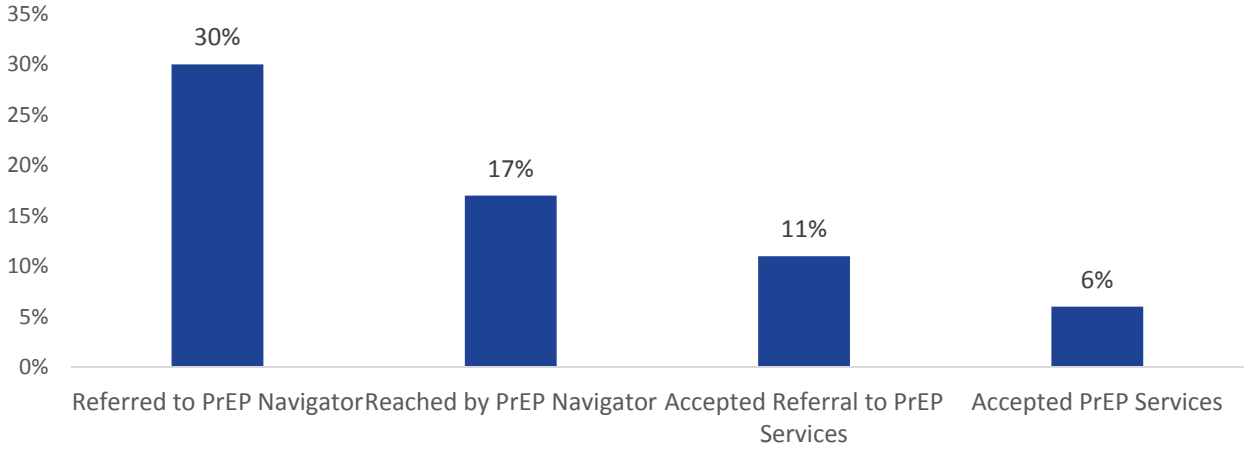


Figure 30. Connecticut's PrEP Candidate Referral Process, 2015-2016*



*Note: Seventy-one individuals were identified as candidates for PrEP (n=71).

Special Projects (3) - Evaluating Alternative Strategies to Prevent Overdose Deaths and New HIV Infections[7]

Connecticut faces a crisis of drug overdose deaths (see page 74 for more details); however, combining naloxone distribution and opioid replacement therapy and/or PrEP has favorable programmatic value. DPH and its partners compared five alternative strategies to combat the crisis:

1. No intervention
2. Naloxone distribution
3. Naloxone distribution + medical replacement therapy
4. Naloxone distribution + PrEP
5. Naloxone distribution + medical replacement therapy + PrEP

In modeling and comparing the outcomes and cost-effectiveness of these five strategies, DPH and its partners noted that while Naloxone distribution has favorable value compared to no intervention, combining it with methadone treatment is high value and even cost-saving compared to no intervention. They also identified that a strategy combining Naloxone distribution, PrEP, and methadone treatment has favorable value, with the potential to save 30 lives in Connecticut after five years (if applied to 3,000 Connecticut drug users).

CT DPH Initiative: Data to Care Strategies

Data to Care (D2C) is a public health strategy that aims to use HIV surveillance data to identify HIV-diagnosed individuals not in care, and either link or reengage them in care and support the HIV Care Continuum to improve health outcomes for PLWH. CT DPH has been working to initiate D2C activities throughout the TB, HIV, STD, and Viral Hepatitis Programs.

DPH requested Technical Assistance (TA) from the CDC to support D2C initiatives. The TA requested was in several areas, including but not limited to Program Introduction and Goals, Operational Steps and Data Needs, Data Quality, Legal Considerations, and Community Engagement. TA will assist DPH in meeting its organization goals by 1) introducing DPH to the operational steps and data needs to successfully implement D2C; 2) identifying the person(s) who will lead implementation and coordination; 3) identifying the number of staff needed to successfully implement D2C; 4) helping select a D2C model that works best for Connecticut; 5) identifying necessary data quality standards; 6) selecting the person(s) with the correct skills, knowledge, and abilities for management; 7) identifying legal and ethical considerations in implementation.

DPH will also be participating in an HIV Health Improvement Affinity Group. The HIV Health Improvement Affinity Group will bring together state public health and Medicaid and Children's Health Insurance Program (CHIP) agencies to collaboratively improve health outcomes for Medicaid and CHIP enrollees living with HIV by identifying opportunities to strengthen the HIV care continuum among these populations. State programs will have an opportunity to learn about and share best and promising approaches with their state peers to improve viral load suppression among people living with HIV who are enrolled in Medicaid and CHIP. The Connecticut team will receive direct TA that 1) supports improved HIV-related outcomes among Medicaid and CHIP enrollees; and 2) builds stronger relationships among state Medicaid/CHIP programs, state public health departments, and other partners (e.g., primary care associations (PCAs); federally qualified health centers (FQHCs), local health departments, and other relevant public and private entities).

[7] Team and partners include: R. Scott Braithwaite (PI); and Jennifer Uyei (N.Y.U. School of Medicine); Marianne Buchelli and Ramon Rodriguez-Santana (CT DPH); Faculty and Staff at the Center for Interdisciplinary Research on AIDS (CIRA) at Yale.

Connections among DPH and other state programs will help improve HIV health outcomes, and will assist in the state's upcoming campaign to end AIDS by reaching the 90-90-90 goal outlined by the Joint United Nations Programme on HIV/AIDS (UNAIDS) (see page 76) that supports state collaborations between public health and Medicaid programs to improve the availability, accessibility, and quality of HIV prevention and care services delivered to HIV-infected Medicaid and CHIP enrollees. This technical assistance opportunity will provide ongoing conference calls with CDC, HRSA, and Centers for Medicare and Medicaid Services (CMS) subject matter experts and will include a face-to-face meeting in the future.

Disease Intervention Specialists (DIS)

DIS are highly skilled public health professionals who assist in protecting the health of HIV infected Connecticut residents by conducting routine public health activities, such as contacting individuals with a reportable infectious disease. Connecticut has the legal and statutory authority to collect information necessary to investigate, prevent and control diseases of public health significance.

Currently, DIS are responsible for locating, counseling and eliciting sexual contacts of persons with sexually transmitted diseases (STDs), including HIV. These investigations are generated through laboratory surveillance reports and referrals. In 2016, CT DPH secured funding to hire additional DIS workers: HIV DIS (H-DIS) and Project Cooperative Re-Engagement Controlled Trial (CoRECT) DIS (C-DIS) (see **Table 4** on page 38). All new DIS will shadow current, seasoned DIS for on the job training, both in the clinical and field settings. They will also receive an overview of the Connecticut Confidentiality Guidelines for HIV/STD/TB/Hepatitis Surveillance Programs 2016, which includes a signed agreement to adhere to all confidentiality procedures. DIS training will occur through a CDC-sponsored DIS Training Center; it will include several online Disease Concept Modules, Partner Services Core Skills Modules, classroom training and Training/Operations for Safety around Field Encounters interactive course. An abbreviated Anti-Retroviral Treatment (ART) and Access to Services training will also be provided to assist behavioral change interventions for clients resistant to returning to care.

All DIS will employ all available electronic state-based and clinic-based information to obtain current locating information on clients. These databases include, but may not be limited to, eHARS, HARMS, STD*MIS/Maven and Lexis Nexis. The DIS will then attempt to locate clients until all available resources have been exhausted. Attempts to locate will be through phone calls, field visits and other mechanisms as available.

All attempts to locate clients will be documented, entered into a confidential database, and maintained in a confidential location. Once the client is located, a secure and confidential conversation will occur. The DIS will confirm the client's identify and verify medical information. Based on the client's need and willingness to return to care, DIS will take steps to secure an appointment and transportation, and schedule any other necessary screenings (e.g., STDs, TB). If the client is unwilling to return to care, DIS will take a different course of action which may include referring the client to an Early Intervention Specialist (EIS) for further ongoing intervention. The DIS will confirm the identity of the client through verification of date of birth, and verification of the person's medical information, including HIV status, last known provider and other pertinent medical information.

All of these D2C activities will poise DPH to be able to respond to an anticipated merging of HIV Prevention and HIV Surveillance grants by CDC in 2018.

Table 4. H-DIS versus C-DIS in Connecticut

HIV Disease Intervention Specialists (H-DIS)	Project Co-Rect Disease Intervention Specialists (C-DIS)
Initially, H-DIS will be working with HIV-positive clients who have been in care and then are determined "out of care," as well as HIV-positive clients who have never received care. They are assigned to the New Haven and Hartford Health Departments and cover assigned areas throughout the state. H-DIS will review the client's care status on an annual basis. If a client who was re-engaged to care in the past falls out of care again, the H-DIS will again be assigned the case for appropriate follow up. H-DIS may also work with these clients to obtain information necessary to locate their sexual and needle sharing partners. Once located, the H-DIS will provide them with risk reduction, health and disease prevention resources and assure appropriate examination and treatment, as necessary. Any partners found to be negative for HIV will be informed of PrEP availability and referred to a PrEP navigator.	Project CoRECT is a 3-year initiative in collaboration with Yale School of Medicine, focusing on locating OOC clients and assuring they return to medical care. Eligible clients are those who have been in care (meaning one medical visit and viral load) for 12 months and then are found OOC (according to the Project CoRECT definition) during the next six months. The primary aim of this project is to evaluate the effectiveness and impact of the C-DIS intervention compared to the Standard of Care, as established by each participating clinic. C-DIS will work with assigned clinics in a predetermined area of the state. The C-DIS will meet regularly with designated clinic staff to review clients who are defined as OOC. Once the list is finalized, a randomization will take place. Those assigned for C-DIS follow-up will be downloaded into a confidential, encrypted tablet utilized by the C-DIS, with all complete locating, demographic and medical information provided.

E. Assessing Needs, Gaps, and Barriers

Statewide Approach to Determining Gaps

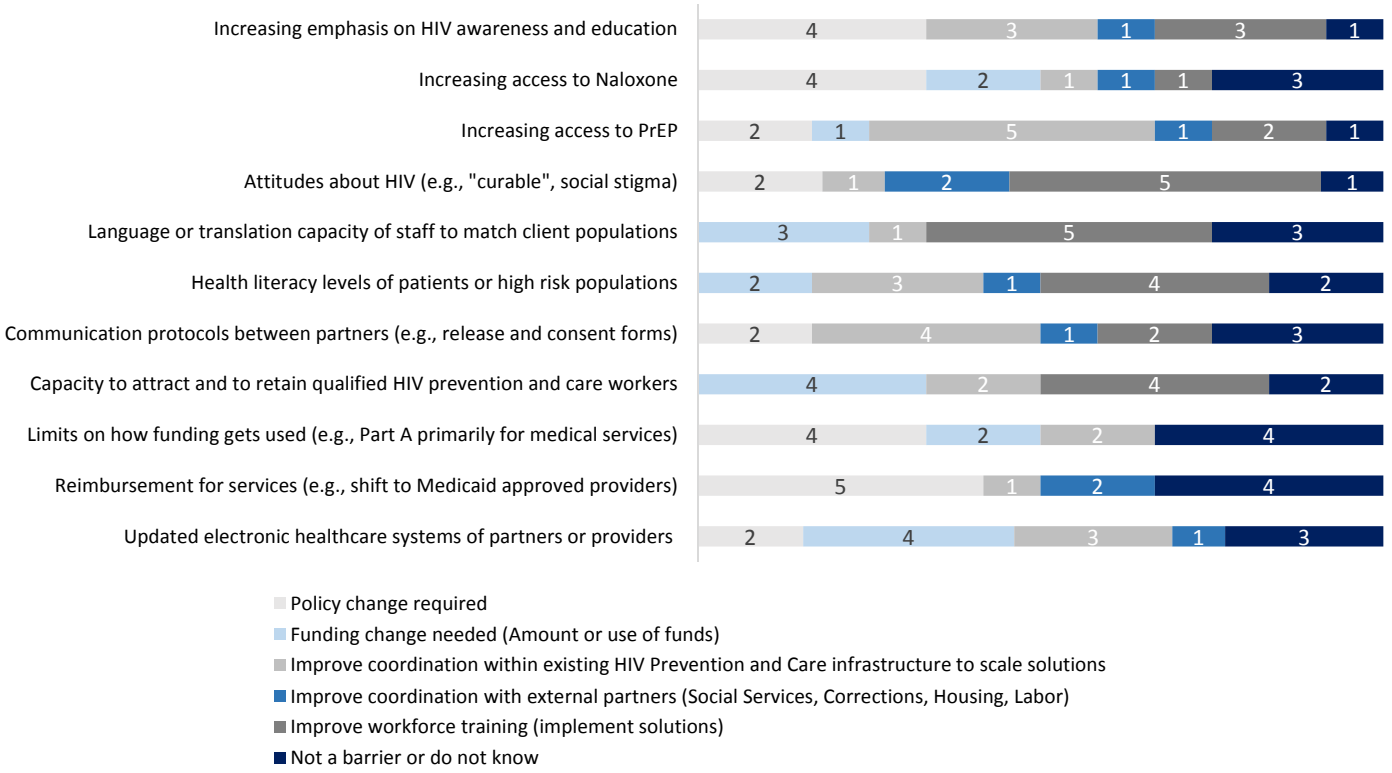
Connecticut's planning process involved countless contributors, representing unique areas of expertise, geographic locations, and background experiences. Despite a wide range of input, the planning process remained clear and direct: analyze data, identify gaps, and discuss solutions. This simple data- and dialogue-driven approach ensures a focused path toward achieving Plan goals. Discussion around needs, gaps, and barriers occurred among different groups in 2015 and 2016, including a few key parties:

CT DPH sets the tone for all HIV planning processes with an emphasis on solving problems and meeting needs. DPH has participated in a range of projects and studies designed to bridge existing gaps, many of which are referenced in the Plan.

The CHPC is committed to ongoing quality improvement in every facet of the planning process. Thus, an emphasis on filling gaps is not only the norm, but the expectation. The Data and Assessment Committee monitors performance indicators, aids in needs assessment tool development, and discusses supportive resources such as housing and employment. The full CHPC also focuses on addressing needs: please see page 77 for information on the CHPC's May 2016 PLWH Panel, which provided a platform to discuss high priority needs.

The HIV Funders Collaborative was convened by the DPH to bring several representatives of publicly funded HIV resources to the table. The Collaborative identified existing gaps through discussion, as well as through a Funders + Leaders Survey. Please see Figure 31 for a glimpse at the funders' perspectives, and visit the Appendix for a full survey summary. The Funders Collaborative will remain involved in Plan implementation activities, including providing input on a 2017 PLWH Needs Assessment.

Figure 31. Perspectives of HIV Funders



Process to Identify HIV Prevention & Care Service Needs of PLWH and Higher Risk Individuals

Connecticut uses several data sources to inform the planning process and to identify needs, gaps, and barriers within its current service delivery system. The state relies on a wide range of sources to support thorough and accurate data collection. Please see Table 5 for more information.

Table 5. Resources Identifying HIV Prevention & Care Service Needs

Primary **Quantitative** Sources	Primary **Qualitative** Sources
2016 Epidemiological Profile of HIV Connecticut's Epi Profile uses data reported through 2014 to reveal current trends statewide and on local levels, and includes information on service delivery gaps for PLWH and people at higher risk for infection.	Connecticut HIV Planning Consortium Consisting of several PLWH and those working in the field, the CHPC boasts a range of perspectives; CHPC actively recruits from diverse regions to broaden the understanding of service gaps throughout the state.
National HIV/AIDS Data and Information Connecticut analyzes data on the national level to stay updated on trends and breakthroughs, provide basis for comparison, and gain wider perspective. Sources include NHAS, CDC, and U.S. DHHS data.	HIV Workforce Survey This survey asked Connecticut's publicly funded HIV workforce to provide geographic, educational, and professional experience information. Please see the Appendix for survey summary results.
CHPC HIV Indicators The CHPC Quality and Performance Measures (QPM) Team of the Data and Assessment Committee (DAC) discusses, identifies, adjusts, and annually updates statewide performance indicators (page 7).	HIV Funders & Leaders Survey This survey asked Connecticut's public funding representatives to provide input on HIV prevention and care service delivery needs. Please see the Appendix for survey summary results.

In 2013, the CHPC conducted a Needs Assessment of more than 1,000 PLWH receiving HIV care services supported by federal funding (e.g., Part A, ADAP). The themes revealed continue to drive planning work:

- Care services identified as "needed and cannot get" include: a) assistance paying for housing; b) dental care; and c) assistance paying for healthcare costs.
- The prevention services identified as "needed and cannot get" include: a) education programs with information on HIV; b) services to help limit a partner's risk; and c) help telling partners about possible exposure to HIV.

The CHPC plans to conduct a statewide Needs Assessment of PLWH in 2017, using recurring themes from statewide surveys and discussions to focus specifically on the state's highest priorities.

Barriers to HIV Prevention and Care Services

HIV is highly concentrated in Connecticut cities linked to low income and low socioeconomic status; most significantly impacted cities include Hartford, New Haven, and Bridgeport. The 2013 PLWH Needs Assessment revealed the following high priority barriers to needed services (listed above):

- Fear that others will find out about HIV status
- Unable to afford services (e.g., co-pays)
- Incomes were too high to qualify for services (i.e., working poor)

The HIV Funders & Leaders survey revealed additional barriers, all of which are addressed in the Plan:

- Insufficient program funding

- Shortage of prevention education initiatives
- Shortage of testing initiatives
- Existing policies / existing HIV prevention and care infrastructure
- Stigma

Meeting HIV Prevention & Care Service Needs of Persons at Risk for HIV

The scope of service needs for persons at risk for HIV and PLWH expands far beyond those of traditional healthcare. Connecticut receives funding from CDC and HRSA to provide prevention and care medical/support services to these populations. Eligible people living with HIV (PLWH) with income less than 100% of the Federal Poverty Level (FPL) can access these services at no cost.

Prevention initiatives include the following:

Outreach, Testing and Linkage (OTL) emphasizes outreach to the highest risk populations, rapid HIV testing, timely linkage to HIV care services, and referrals to prevention services as needed; Hepatitis C Virus (HCV) services have been integrated into OTL.

The Expanded Testing Initiative (ETI) relies on community health centers, emergency departments and outpatient clinics to conduct expanded and integrated opt-out HIV screening or routine testing. An ETI coordinator facilitates coordination of all HIV positive clients to first medical appointments within 90 days. The process includes screening for STDs, HCV, and TB as well as referrals to Partner Services and other prevention services.

Effective Behavioral Interventions

- High Impact Prevention (HIP) Effective Behavioral Interventions (EBI) use combinations of scientifically proven cost-effective, targeted and scalable interventions for maximum impact on the HIV epidemic. The strategies have been proven effective through research studies that showed positive behavioral and/or health outcomes. Interventions target priority populations such as PLWH, MSM, etc.
- Syringe Services Programs (SSP) provide a full array of Drug User Health services to people who inject drugs including but not limited to: access to clean syringes and works, drug treatment referrals, HIV and HCV testing, harm reduction education, overdose prevention training, and naloxone access.
- CT Overdose Prevention Education and Naloxone (OPEN) Access CT provides education and training on how to prevent opiate-related overdoses through Naloxone provision and administration. These services are provided through existing HIV Prevention Programs.
- Partner Services (PS) refer to a range of services offered to persons with HIV or other sexually transmitted diseases (STD) and their sexual or needle-sharing partners. PS can improve health on individual and community levels by identifying persons, confidentially notifying their partners of their possible exposure, and providing persons and their partners a range of medical, prevention, and psychosocial services. DPH Disease Intervention Specialists (DIS) provide assistance with delivering positive test results, notifying and testing partners and making linkages to other services.
- DPH implements 4th Generation HIV testing. The DPH Laboratory began 4th Generation HIV testing on all HIV specimens submitted to the state lab beginning July 1, 2015. DPH HIV testing programs referred to as Outreach, Testing and Linkage (OTL) programs began 4th Generation rapid HIV testing in the field using the newly CLIA waived 4th Generation HIV rapid test, Alere Determine, in the fall of 2015. This new 4th Generation rapid HIV Test is the first Clinical Laboratory Improvement Amendments (CLIA) waived HIV screening tool that can detect p24 antigen in and HIV antibodies; this enables identification of acute HIV infections, at roughly 15 days after exposure, so that linkages to HIV care services will occur sooner.

Care initiatives include the following:

The Connecticut AIDS Drug Assistance Program (CADAP) is a pharmaceutical assistance program that pays for medications approved by the U.S. Food and Drug Administration (FDA) on its formulary to treat HIV and HIV disease related conditions. The Connecticut Department of Social Services, in partnership with the Connecticut Department of Public Health, administers the program. CADAP provides assistance with health insurance payment through its Connecticut Insurance Premium Assistance (CIPA). The program requires verification of HIV/AIDS by a medical provider, proof of Connecticut residency, health insurance status, and income less than 400% of the FPL.

Transitional Linkage into the Community (Project TLC) assists PLWH ready for release from, or recently released from, Connecticut's correctional system with linkages and referrals to community services, including CADAP, core medical and support services, medical transportation, and referrals for individuals 30-60 days following release.

The statewide HIV Medication Adherence Program (MAP) helps PLWH adhere to their HIV medication and treatment regimens. Licensed staff provides bio-psychosocial assessments, individualized treatment plans, health education, as well as follow up and referral to support services. Adherence services help clients remain in care, obtain viral load suppression, and improve health outcomes. (See Medication Adherence Program information.)

The Statewide Medical Case Management (MCM) programs assist PLWH with income levels of 300% FPL or less to enter and remain in medical care through bio-psychosocial assessments, individualized care plans, advocacy, and referrals for core and support services including health insurance.

Medical Nutrition Therapy Programs provides client nutritional health assessments, individualized nutritional plans, and nutritional counseling for PLWH. Licensed registered dieticians/nutritionists manage the programs. Clients can access nutritional supplements and nutritional food to maintain healthy weight, reduce side effects from certain medications, and improve their health outcomes.

The Department of Mental Health and Addiction Services offers Infectious Disease Services in the context of substance abuse treatment. Risk reduction plans get developed for high risk patients. Plans include HIV counseling and testing as well as services for Hepatitis C and tuberculosis; all HIV seropositive clients develop a treatment plan determining their HIV needs and priorities. Prevention/case management services and education are offered to clients as well as their families and significant others.

Connecticut receives approximately $3 million in Housing Opportunities for Persons with AIDS (HOPWA) program funding (fiscal year 2015). HOPWA provides housing assistance and related support services for low-income persons with HIV/AIDS and their families. CTHousingSearch.org represents a free resource for finding and listing housing anywhere in Connecticut. Property providers across the state can post apartments and houses for rent at any time. A subdirectory shows resources specifically for persons with disabilities. Visit www.cthousingsearch.org for additional information.

Access Health CT is the state health insurance exchange administered by the State of Connecticut to meet the requirements of the federal Affordable Care Act. The exchange provides individuals, families and small businesses with a range of qualified, approved health plans from brand name carriers. Visit www.accesshealthct.com for additional information.

ONLINE SERVICE INFORMATION

For a listing of Statewide HIV/AIDS Services see HIV Care, Prevention and Support Services by County. The Guide, available on the United Way of Connecticut's 2-1-1 website, provides comprehensive information about specific HIV/AIDS services in Connecticut.

For more information on supportive resources meeting the needs of PLWH and those at high risk, please see Featured Resources & Initiatives on pages 66-76.

Service Delivery Analysis

Analyzing needs helps statewide planners identify successes and challenges within the service delivery system. Connecticut's Plan optimizes its service delivery strengths, addresses its weaknesses, embraces and maximizes statewide opportunities, and remains cognizant of all potential threats. Please see Table 6 on page 44 for a Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis of the current service delivery system.

Table 6. SWOT Analysis Summary

STRENGTHS

Connecticut HIV Planning Consortium (CHPC)

- Integrated prevention and care planning in 2008
- Commitment by DPH to convene diverse stakeholders including PLWH
- CHPC national model for statewide HIV planning groups
- Significant PLWH input/representation

Involvement of PLWH

- PLWH comprise 50% of CHPC members and serve as leaders
- CHPC environment supports parity and equity
- Plan places emphasis on peer models

Strong Implementation Infrastructure

- 169 local health departments
- 13 community health centers at 35+ locations
- Strong partners including state agencies, Ryan White Part A, B, C, D, F, HOPWAA and Center for Interdisciplinary Research on AIDS (Yale) experts

HIV Prevention and Care Services

- Openness to innovate in response to emerging needs (e.g., PrEP, Narcan, syringe exchange, partner services)
- Ryan White funded programs produce outcomes at or above national standards
- Robust ADAP program and drug formulary

WEAKNESSES

Coordination and Communication

- No county government; must coordinate efforts across 169 towns
- Uneven practices in data collection and data sharing across partners
- Patchwork of online resources difficult to navigate
- Use of social media in formative stages
- Limited involvement of payers

HIV Prevention and Care Services

- Scaling effective models to engage PLWH who do not know status
- Developing and scaling effective models that connect PLWH with housing and employment opportunities
- Use of peer-driven or peer-supported strategies in formative stages; need mechanisms to support & scale
- Limited investment on prevention including state and local education partners

HIV Workforce

- Limited training opportunities in core competencies and/or cultural sensitivity; no career pathways
- Aging workforce
- Workforce diversity (e.g., race, ethnicity, age, PLWH)

OPPORTUNITIES

Statewide Campaign to End HIV

- DPH Commissioner launched effort to develop campaign to end HIV
- Use public health model and stakeholder engagement; CHPC will play a leading role

Data to Care Initiatives

- DPH continues to build analytic capacity to support data-driven planning at statewide, regional and town levels and to integrate databases
- DPH supports special initiatives to locate PLWH who have fallen out of care and link them to appropriate services (using Disease Intervention Specialists who protect patient confidentiality/privacy in accordance with Connecticut laws)

Social and Digital Media

- Communications work group in formative stages
- Pilot projects using social media

Workforce Training

- Emphasis on supporting peer-driven models
- Emerging effort to include PLWH in quality improvement
- Efforts underway to create career pathways that include stackable credentials for Community Health Workers and Substance Abuse Prevention Specialists

HIV Funders Collaborative

- HIV funders assemble to coordinate funding, data collection, data sharing and training, to inform policy development and to share and scale effective models

THREATS

Access to Care

- 6% of Connecticut residents remain uninsured
- Insurers exiting Health Exchange
- Healthcare costs continue to increase
- Healthcare provider consolidations
- Funding reductions at federal, state and local levels

Poverty

- Almost 11% of Connecticut residents earn incomes below the poverty line
- Disparities exist in poverty rates: 27.6% for Latinos; 24.0% for African Americans; 18.8% for Asian Americans and 8/1% for Whites
- Income inequality ratio of 18.2 (share of income for top 20% of households v 20%) ranks near worst

Other

- Social stigma as a barrier to care and a hindrance to public conversation and education
- High housing costs; limited affordable housing
- Hunger and food insecurity
- Aging population, including PLWH and workforce (clinical and front-line staff)
- Turnover and lower earning potential within the HIV workforce, including leaders at community-based organizations

Acknowledging gaps enables Connecticut's planners to target their efforts. Please see Figure 32 on page 45 for remaining gap analysis, as identified by Connecticut's HIV planners.

Figure 32. Current HIV Service Delivery System Gaps

Health disparities and outcomes

- Black males were diagnosed at roughly 8 times the rate of white males in 2014
- Hispanic males were diagnosed at roughly 4 times the rate of white males in 2014
- Highest diagnosis rate in 20-29 year old males based on cases reported between 2010 and 2014
- Of all female diagnoses reported in 2014, 72% identified as Black or African American
- Priority populations include Black/African American/Latino males and females, HCV co-infected, late testers, the aging population, among others (see page 22).

HIV Workforce training

- Job descriptions and hiring protocols vary widely and may not focus on core competencies
- HIV core competencies training occurs inconsistently and primarily "on the job"
- No "market place" or digital exchange that promotes and supports hiring in this field
- Wide range of professional development practices and supports for workers in the field
- Limited cultural sensitivity training

Absence of clearly articulated career path development (i.e., certifications and credentials)

Stakeholder Engagement

- Insurance providers
- Partners associated with social determinants of health (e.g., workforce, housing)
- Partners associated with education and training

Communication

- No current statewide campaign to end HIV
- Varied and informal communication networks
- Limited capacity and funding to support digital initiatives
- Limited training on and use of social media platforms

Data Collection and Sharing

- Inconsistent data collection practices
- Limited capacity for data set analysis (agency, state levels)
- Minimal data-driven planning at local levels (e.g., use care cascades to understand roles of partners in a community)
- Data sharing protocols uneven or under-developed (e.g., consent and release forms)
- Duplicative data entry across partners

Supporting and Scaling Effective Models

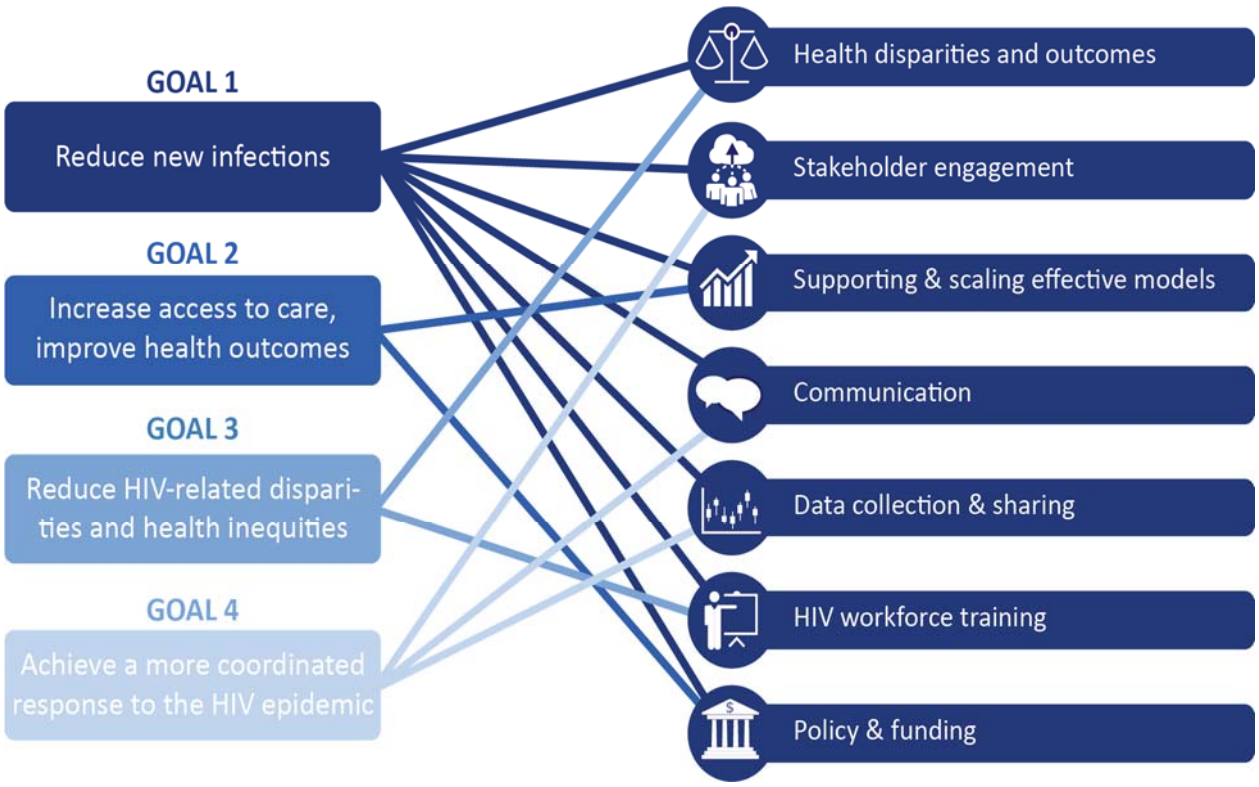
- Engaging PLWH who are unidentified
- Pre-Exposure Prophylaxis (PrEP)
- Peer-driven outreach strategies
- Social media strategies
- Quality improvement
- Care coordination across support services
- Addressing health literacy and language barriers

Policy and Funding

- n-PEP not available outside realm of sexual assault
- Communication protocol between partners
- No mandated sexual education in public school system health curriculums
- Increasing funding support for prevention
- Increasing funding for marketing and communications
- Increasing funding for workforce training
- Increase funding to build data collection, analytic capacity

Connecticut is highly equipped to implement the Plan over the next five years, and possesses a strong and capable healthcare infrastructure; however, remaining priority gaps are addressed several times within each of the Plan's four goals. Figure 33 demonstrates the relationship between the Plan goals and system gaps.

Figure 33. HIV Plan Response to Service Delivery System Gaps



SECTION II.

INTEGRATED HIV PREVENTION AND CARE PLAN

How were goals determined?

- *Connecticut's four goals align with those of the National HIV/AIDS Strategy (NHAS).*

How were measurable objectives selected?

- *Objectives represent statewide indicators and HIV indicators from Connecticut's Statewide Health Improvement Plan (SHIP) to ensure consistent priority measures across the state.*
- *Objectives were discussed by DPH staff, CHPC co-chairs, the HIV Funders Collaborative, and the full CHPC.*

How were activities categorized?

- *The Integrated Plan's activities are categorized into thematic groups, including, but not limited to the following:*
  - *Marketing & Communications*
  - *Outreach, Engagement & Training*
  - *Policy Development & Sustainability*

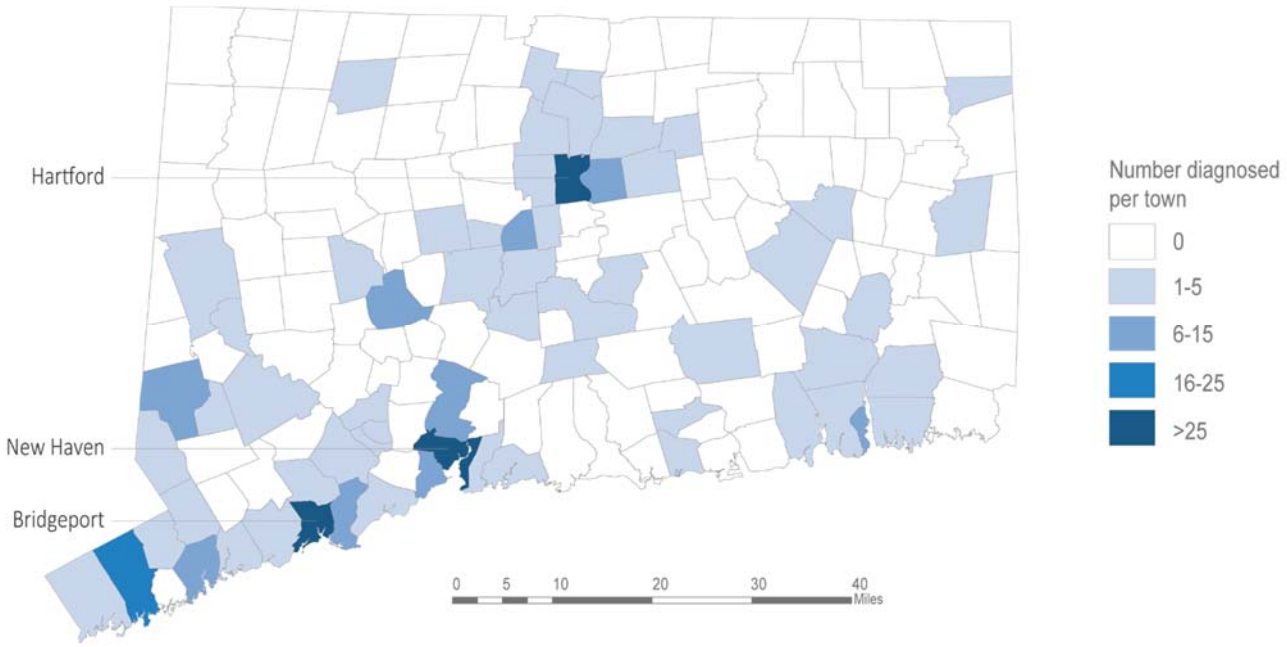
Specific Plan highlights?

- *The Plan focuses on data- and dialogue-driven solutions, peer-to-peer outreach models, and unprecedented statewide initiatives such as standardized workforce trainings, among other plans.*

Goal 1.	Reduce new infections.
Objective 1.1.	Decrease the number of new infections by 25%, from 291 in 2014 to 218 in 2021.
Objective 1.2.	Increase number of people being tested through CT funded initiatives (Routine testing, Outreach Testing & Linkage or OTL) from 13,579 in 2014 to 15,000 in 2021.
	See pages 49 and 50 for Goal 1 focus areas, activities, and other details.

In 2014, 291 HIV cases were diagnosed in Connecticut at an overall rate of 8.1 per 100,000 people. Of those cases, black males were diagnosed at a rate of approximately 8 times that of white males and Hispanic males were diagnosed at a rate of approximately 4 times that of white males. Of the 79 females diagnosed in 2014, 72% classified as Black or African American. Between 2010 and 2014, most frequent diagnoses were among 20-29 year old males.[8]

Figure 34. Newly Diagnosed HIV Infection Cases (N=291), Connecticut, 2014 (as of 2015)



Implementation partners include:

CT DPH, all Ryan White Parts, Positive Prevention CT, and DMHAS.

[8] See appendices for full Epidemiological Profile.

Goal 1. Reduce New Infections

Objective 1.1 Decrease the number of new infections by 25%, from 291 in 2014 to 218 in 2021.

Focus Area	Priority Activities	Outcomes	Implementers
A. Strengthen statewide communication platform to deliver prevention and health promotion messaging	Marketing & Communications o Position www.positivepreventionct.org as a primary gateway for information to the HIV community & the general public o Refresh content regularly on www.positivepreventionct.org o Use social media channels and marketing campaigns to reach priority populations & into geographic hotspots; integrate with statewide campaign (see goal 3.1); infuse other topics such as HCV Outreach, Engagement & Training o Train and deploy PLWH and peers on social media and outreach to engage priority populations in focus groups, community listening sessions; message development; and social marketing campaigns o Provide tools and coordinate digital event calendars (e.g., speakers lists, communication templates) for prevention and risk reduction events (e.g., HIV Awareness Day, testing days) o Increase involvement of prevention stakeholders with the CHPC committees and statewide plan (e.g., engage local health departments and partners using evidence-based strategies such as "Making Proud Choices" that promotes safe sex) Policy Development & Sustainability o Promote mandatory sexual education as part of the health education curriculum (partner with GLSEN and True Colors)	• Website traffic • Social marketing analytics (e.g., # likes) • Attendance at events • # social marketing campaigns in geographic hot spots • # peers trained • # listening sessions • # venues engaged (e.g., schools, churches, summer programs) • # programs that integrate HCV	• CT DPH • All Ryan White Parts • Positive Prevention CT Other partners may include: local Health Departments; True Colors, Connecticut State Department of Education; AIDS Life Campaign; Area Health Education Centers (AHECs); Hartford Youth HIV Identification and Linkage to Care (HYHIL); churches; Department of Corrections (re-entry population); Department of Mental Health & Addiction Services; school-based health clinics; Department of Children & Families; GLSEN; True Colors
B. Increase access to PrEP and n-PEP	Marketing & Communications o Use marketing and social media campaigns to increase awareness of PrEP, benefits of PrEP and how to access PrEP o Publish a digital resource inventory of PrEP providers & resources Outreach, Engagement & Training o Train HIV program staff, other peers and staff – including PLWH (e.g., community health workers, substance use, syringe exchange, healthcare system navigators, and clinical staff about PrEP, potential PrEP candidates, and PrEP services and supports Service Delivery Improvements o Review and refine clinical delivery systems to offer and deliver PrEP; start with priority populations (e.g., MSM, transgender) o Identify opportunities to apply non-clinical support services for individuals on PrEP to improve risk reduction, facilitate medication adherence and retain in care *(*care models in prevention services).* o Expand access to n-PEP beyond sexual assault	• Digital resource inventory • Marketing content • # social media campaigns • # peers and staff trained to conduct outreach; # trained to administer & support PrEP • # programs offering PrEP • Risk reduction protocols and plan (standards)	• DPH • All Ryan White Parts Other partners may include: community health centers; local health departments; Positive Prevention CT; Community Based Organizations; Connecticut HIV/AIDS Information & Referral Task Force (CHAIR); True Colors; AHECs; HYHILC
C. Promote "Treatment as Prevention"	Marketing & Communications o Develop "treatment as prevention" messages and content for www.positivepreventionct.org o Use social media channels and marketing campaigns to reach priority populations and geographic hotspots; See Goal 1; Objective 1.1 "prevention and health promotion messaging" o Integrate "treatment as prevention" into statewide campaign; see goal 3.1. Outreach, Engagement & Training o Train service delivery staff (& peers) on Treatments as Prevention o See Goal 2 activities that increase access into healthcare; linkage to HIV services & medication; and promote viral suppression	• See outcomes for Objective 1.1.A (communications platform) • See outcomes for Goal 2 • See outcomes for Goal 3.1	• CT DPH • All Ryan White Parts • Positive Prevention CT Other partners shown in Goals 1.1.A; 2; and 3.1

Goal 1. Reduce New Infections

Objective 1.2 Increase number of people being tested through CT funded initiatives (Routine testing, Outreach Testing & Linkage or OTL) from 13,579 in 2014 to 15,000 in 2021.

Focus Area	Priority Activities	Outcomes	Implementers
A. Improve evidence-based HIV outreach, testing and linkage services	Marketing & Communications / Outreach and Engagement o See activities under Objective 1.1, Focus Area A Service Delivery Improvements o Implement most recent HIV testing technology; provide training as warranted o Refine OTL services to reach high risk populations; increase capacity of these models to include peer-driven approaches o Implement Couples HIV Testing and Counseling o Implement Social Networks Strategy and connect to Goal 1.1A. o Link to Treatment Adherence services (Goal 2.2.B; 2.2.C) o Expand and integrate routine testing and OTL with Hepatitis C Virus (HCV) education and screening activities	• # staff trained on latest generation of testing • # OTL service use reflect high risk populations • # couples receive HIV testing and counseling • # events with combined HCV/HIV testing • # tested for HCV • # tested for HIV/HCV coinfection • See Goal 1.1.A. • See Goal 2.2.B. • See Goal 2.2.C.	• CT DPH Other partners may include: Local health departments, community health centers, private practices, hospitals; Department of Corrections, Department of Mental Health & Addictions Services; substance abuse treatment providers; insurance companies; Department of Social Services (Medicaid/Medicare)
B. Increase access to clean needles and syringe exchange services	Marketing & Communications o Conduct awareness and education campaigns to broaden access to clean syringes (and naloxone distribution) Outreach, Engagement & Training o Conduct training and/or informational workshops for and with relevant partners such as DMHAS, CT Health Exchange, CT law enforcement Service Delivery Improvement o Conduct analysis of syringe exchange services model and improve all aspects of program (e.g., best practices, surveillance, evaluation) o Enhance and Scale the DPH Pharmacy Initiative for syringe access and naloxone distribution and community distribution Policy Development & Sustainability o Conduct policy work to increase access to syringe services, harm reduction information and overdose prevention	• See also Goal 1.1.A. • Pharmacy resource packet • Policy change(s)	• CT DPH • DMHAS Other partners may include: pharmacies; Local health departments; community health centers, private practices; hospitals; Department of Corrections; substance abuse treatment providers

Goal 2. Increase access to care and improve health outcomes for PLWH.

Objective 2.1. Increase linkage to HIV care in newly diagnosed persons (aged 13+) from 91% in 2014 to 95% in 2021.

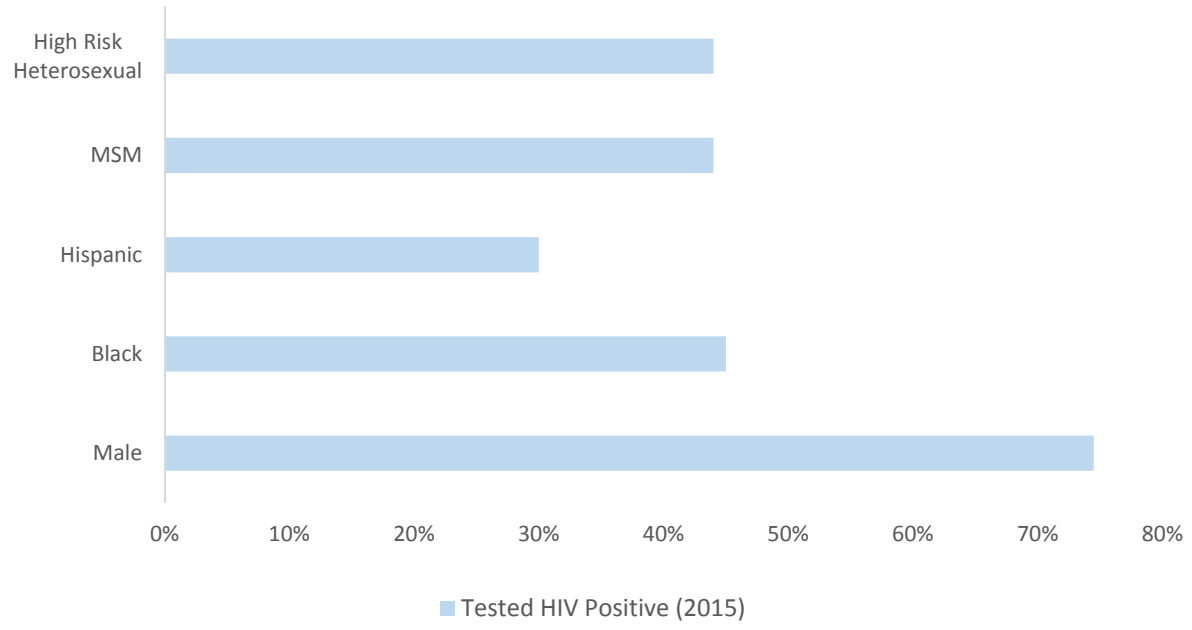
Objective 2.2. Increase number of people being tested through CT funded initiatives (Routine testing, Outreach Testing & Linkage or OTL) from 13,579 in 2014 to 15,000 in 2021.

See pages 52 and 53 for Goal 2 focus areas, activities, and other details.

In 2015, 58,423 HIV tests were conducted in Connecticut. Despite the virus's disproportionate impact on males, only 48% of all those tested in 2015 were male. Most of these individuals identified their risk factor as high risk heterosexual. When asked to identify their race/ethnicity, roughly 31% of those tested identified as white, 29% identified as Black, and 29% identified as Hispanic.

Of the tests conducted throughout the state in 2015, 94 confirmed newly diagnosed individuals (representing 0.16% of those tested) with HIV. Of the newly diagnosed cases, 74.5% were male. Please see Figure 35 for more demographic information on individuals diagnosed with HIV in 2015.

Figure 35. Demographic Summary of Individuals Tested HIV Positive in Connecticut, 2015



Implementation partners include:

CT DPH, all Ryan White Parts, Positive Prevention CT, DSS, DOC, CADAP, CIRA, the CHPC, the CT TCQ Team, and DMHAS.

Goal 2. Increase access to care and improve health outcomes for PLWH

Objective 2.1. Increase linkage to HIV care in newly diagnosed persons (aged 13+) from 91% (2014) to 95% (2021).

Focus Area	Priority Activities	Outcomes	Implementers
A. Promote and facilitate access to healthcare *(high risk populations & PLWH)*	Marketing & Communications o Deliver prevention and health promotion messages including importance of accessing care (See Goal 1.1.A) o Promote statewide health exchange: Access Health CT using communications platform (Goal 1.1.A) o Promote CIPA Program for PLWH (income 138-400% Federal Poverty Level) Outreach, Engagement & Training o Train HIV prevention and care staff as well as PLWH and peer groups about Access Health CT, healthcare navigators (for enrollment), and other programs such as Connecticut Insurance Premium Assistance (CIPA) (See Goal 3.1.C) Service Delivery Improvements o Improve Outreach, Testing & Linkage models (See Goal 1.2.A) o Refine positioning of CIPA program to promote impact Collaboration & Partnerships o Support efforts that address barriers to care (e.g., medical transportation; innovative delivery methods for rural populations such as telehealth)	• # staff and peers trained • # individuals enrolled in CIPA • # clients accessing support services (e.g., RW Part A and Part B) • Increase number of clients with viral load suppression from 84% to 90% in 2021 • 95% of newly diagnosed adult and adolescent clients with Linkage to HIV Medical Care • See Goal 1.1.A.	• CT DPH • All Ryan White Parts • Positive Prevention CT Other partners may include: Local health departments, community health centers, private practices, hospitals; Department of Corrections, Department of Mental Health & Addictions Service; substance abuse treatment providers; insurance companies; Department of Social Services (Medicaid/Medicare)
B. Strengthen access to care initiatives, including re-engagement in care, for PLWH and priority populations	Marketing & Communications o Promote access to care initiatives using statewide communications platform (See Goal 1.1.A) Outreach, Engagement & Training o Infuse peer-driven components into evidence-based models Service Delivery Improvements o Strengthen emphasis on late testers data collection to drive future access to care initiatives; See Outreach Testing & Linkage objectives (Goal 1.2.A) o Strengthen Transitional Linkage into the Community Project for PLWH transitioning from the corrections system o Field test innovative models such as the Urgent Care Outreach Program or the Data to Care initiatives such as Project CoRECT and State DIS which uses HIV surveillance data to identify PLWH not in care and re-engage them *(*includes private insurance and RW patients)* Collaboration & Partnerships o Increase level of CHPC partnership with partners that target high risk populations such as Department of Social Services and Department of Mental Health and Addiction Services as well as Part C providers o Strengthen program collaboration services integration model (PCSI) (see Goal 4.2.A) such as implementing more robust HIV and HCV co-infection surveillance and data mining methods and/or DSS Medicaid Affinity Forums o Promote PCSI model with other service delivery agencies such as Strengthen DMHAS Infectious Disease Services in substance abuse treatment programs; integrate with HCV testing and care to address co-infection *(*includes service delivery & provider training/education)*	• Improvement in % late testers who are diagnosed with AIDS • # individuals re-engaged in care via Data to Care initiatives • # PSCI models within DPH and across other state agencies and local health departments • # HIV programs that adapt PCSI models, and which component (STD, TB, hepatitis) • # of RW eligible clients with completed referral to Medical Case Managers (85%) • See Goal 1.1.A. • See Goal 1.2.A.	• CT DPH • Part C • DSS • DMHAS • DOC Other partners may include: Local health departments, community health centers, private practices, hospitals; substance abuse treatment providers; insurance companies

Goal 2. Increase access to care and improve health outcomes for PLWH			
Objective 2.2 Increase viral load suppression among persons in HIV medical care from 86% (2014) to 90% (2021).			
Focus Area	**Priority Activities**	**Outcomes**	**Implementers**
A. Optimize and Increase Resources Available to Impact PLWH	Marketing & Communications o Promote and encourage participation in Implementation Research via New England Implementation Science Network and CIRA (Yale) or special studies related to reducing viral loads or use of Peer Health Advocates; apply lessons learned into funding practices and training Service Delivery Improvement o Strengthen the Statewide Medical Case Management (MCM) programs (PLWH < 300% FPL) o Facilitate care coordination models (e.g., Medical case management, medication adherence) that improve housing stability, participation in employment and training, and improved health outcomes (See Goal 3.1.B.; Goal 3.2.B; and Goal 3.2.C) o Field test data integration and sharing partnerships that benefit PLWH (and providers) such as Part A Hartford (Careware) and HOPWA (HMIS system) Collaboration & Partnerships o Partner in service detailing projects that lead to improve service coordination across agencies and funders *(*includes private insurance providers, hospitals, health departments)* o Share program outcomes and use data to inform funding discussions, support applications for additional funding, and to support statewide campaign (See Goal 3.2.A) Policy Development & Sustainability o Conduct annual assessment of HIV funding in CT	• # partners in special studies • # reports or white papers that promote service optimization and improvements in health outcomes • Amount and type of funding for HIV prevention and services in CT • See Goal 1.1.A. • See Goal 3.1.B. • See Goal 3.2.B. • See Goal 3.2.C.	• CT DPH • CADAP • All Ryan White Parts • CIRA • CHPC Other partners may include: Local health departments, community health centers, private practices, hospitals; Department of Corrections, Department of Mental Health & Addictions Service; substance abuse treatment providers; insurance companies; Department of Social Services (Medicaid/Medicare)
B. Strengthen Connecticut AIDS Drug Assistance Program	Service Delivery Improvements a. Refine ADAP program administration to assure compliance with federal funders and standards b. Strengthen the statewide HIV Treatment Adherence Program c. Examine list of authorized medications (e.g., consider removal of older medications that might be toxic) d. Assess the extent to which ADAP program and medication adherence programs can support PrEP models (prevention and care integration)	• ADAP formulary updates • Utilization reports on services and costs • Advisory group • Recommendations related to PrEP or other medications	• CT DPH • Ryan White Part B Other partners may include: private insurance companies, DSS, community health centers, private practices, hospitals; Department of Corrections, Department of Mental Health & Addictions Service; HRSA; CDC
C. Strengthen capacity to implement quality improvement initiatives *(related to PLWH in-care and to increase retention in care)*	Service Delivery Improvements o Improve site monitoring & compliance visits to encourage data quality and meaningful use of data by contractors o Implement Cross Part Collaborative clinical data monitoring to improve health outcomes for PLWH o Conduct regular reviews of program data and statewide indicators; refine and position evidence-based strategies to increase impact (See Goal 3.1.B) Collaboration & Partnership o Strengthen program collaboration services integration model (PCSI) (see Goal 4.2.A) such as implementing more robust HIV and HCV co-infection surveillance and data mining methods (e.g., building community care cascades) o Integrate lessons learned into technical assistance, workforce training, and capacity building efforts – including peer-driven components (See also Goal 3.2.C; See Goal 4.2.A.) Policy Development & Sustainability o Work with stakeholders to assess the feasibility of increasing Part B eligibility to 400% matching CADAP so that people accessing medications have unfettered access to core medical and supportive services needed for medication adherence	• Statewide indicators (e.g., viral suppression) • Contract performance (statewide and RW programs) • Alignment of training and technical assistance with site reporting / monitoring • Impact of CHPC quality improvement focus areas	• CT DPH • All Ryan White Parts • CHPC • CT TCQ Team Other partners may include: Local health departments, community health centers, private practices, hospitals; Department of Corrections, Department of Mental Health & Addictions Service;; substance abuse treatment providers; insurance companies; Department of Social Services (Medicaid/Medicare)

Goal 3. Increase access to care and improve health outcomes for PLWH.

Objective 3.1. Reduce new HIV diagnoses by 15% by 2021 in the following groups: men who have sex with men (MSM), and Black/African-American/Latino men and women.

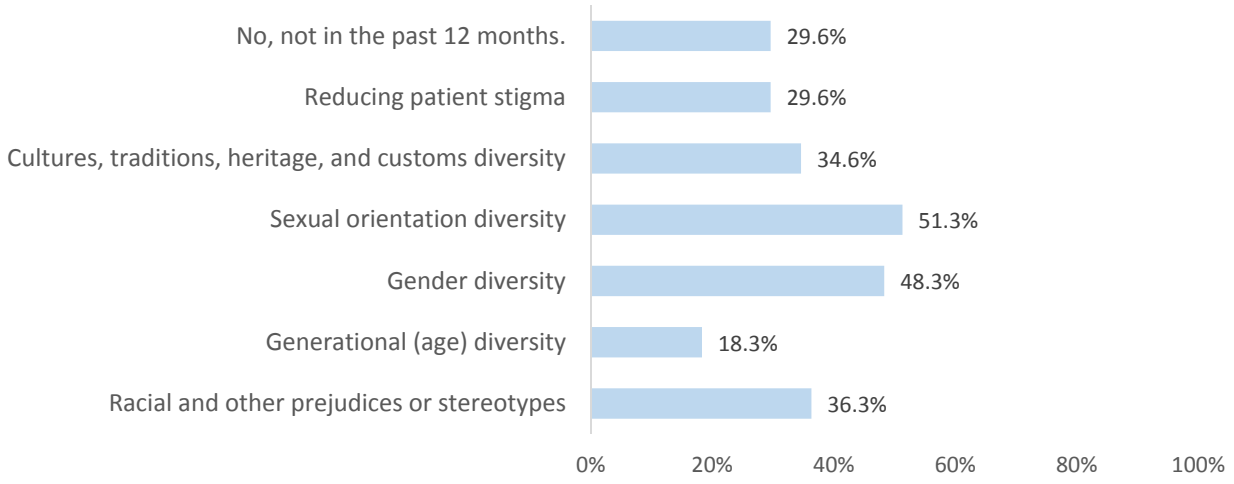
Objective 3.2. Increase involvement in social justice initiatives and partnerships that reduce viral loads to the point of suppression (objective 2.2.) and reduce health disparities in new diagnoses (objective 3.1).

See pages 55 and 56 for Goal 3 focus areas, activities, and other details.

Connecticut has pledged its commitment to addressing health disparities disproportionately targeted by HIV in a number of ways, including identifying a list of high priority populations (page 22), targeted outreach including peer-to-peer model implementation, and an emphasis on HIV workforce cultural competency.

On Connecticut's 2016 HIV Workforce Survey, almost one third of respondents revealed that they had not received any cultural sensitivity training within the past year. Please see Figure 36 for more information, and see the Appendix for full summary survey results.

Figure 36. Publicly Funded HIV Workforce: Self-Reported Cultural Sensitivity Training in Past 12 Months



Implementation partners include:

CT DPH, HIV Funders Collaborative, all Ryan White Parts, the CHPC and its QPM Committee, Connecticut AHEC, the New England AIDS Education and Training Center (NEATC - RP), the statewide campaign taskforce, and CHAIR.

Goal 3. Reduce HIV-related disparities and health inequities

Objective 3.1. Reduce new HIV diagnoses by 15% by 2021 in the following groups: men who have sex with men (MSM), and Black/African-American/Latino men and women.

Focus Area	Priority Activities	Outcomes	Implementers
A. Analyze data sets by income, race/ethnicity and factors relevant to social determinants of health	Marketing & Communication / Education & Awareness o Sponsor or partner in conversations that increase knowledge and promote the relevance of health equity Improve Data Analytics & Meaningful Use o Update HIV epidemiological profiles and care cascades; display data in meaningful ways that inform issues on health equity o Increase capacity to collect and analyze health equity data and implement PSCI (see also Goal 4.2.A) o Use data to identify priority prevention and care populations including low income, MSM, LGBTQ, African-American and Latino females and males, HCV co-infected, youth, and aging PLWH, among others as part of service detailing; quality improvement or service integration / innovation	• Annual updates • Special analysis or white papers related to health equity • Improve capacity of data systems (DPH) • Workshops or events on health equity	• CT DPH • HIV Funders Collaborative • All Ryan White Parts • CHPC Other partners may include: ALL stakeholders; Data Haven (statewide health survey)
B. Introduce and scale effective Evidence Based Strategies to reach high priority populations	Outreach, Engagement & Training o See Goal 3.1.C increase HIV workforce competencies Service Delivery Improvements o Strengthen impact of Women, Infant, Children and youth HIV Services Consortia of Connecticut (WICY-HSCC) and Children, Youth and Family AIDS Network of Connecticut (CYFAN) o Strengthen impact of Early Intervention Services (Ryan White Part C); increase the cohesion of this network and integration with other healthcare system partners Collaboration & Partnership o Establish a CHPC evidence-based strategies stakeholder group to provide input into selecting strategies (e.g., interventions, priorities; peer-led components; culturally & linguistically relevant), supporting implementation (e.g., quality improvement), and assessing impact *(*Adjust approaches based on National Alliance of State & Territorial AIDS Directors (NASTAD) data)* o See Goal 3.2.B & 3.2.C innovation and special initiatives that promote health equity and social justice Policy Development & Sustainability o See Goal 2.2.A increase optimization of funding	• Statewide indicators • Program data • CHPC evidence-based strategies process • Recommended evidence-based strategies (for HIV funders in CT) • See Goal 2.2.A • See Goal 3.1.C • See Goal 3.2.B & 3.2.C	• CHPC • DPH • HIV Funders Collaborative Other partners may include: DMHAS, DSS, DCF, DOC, SDE, health departments, hospitals, insurers, private practices, community health centers, school based health centers
C. Increase HIV workforce competencies and cultural and linguistic capacity to serve priority populations	Improve Data Analytics & Meaningful Use o Conduct regular HIV workforce assessments to understand workforce demographics and mastery of prevention and care competencies; expand into other healthcare workers as relevant (e.g., community health workers / navigators) Workforce Training o Develop competency-based career pathways (include PLWH-driven models) that adhere to CLAS standards; coordinate competencies with other healthcare and health promotion initiatives (e.g., community health workers, DMHAS prevention) o Maintain employment-related resources such as job descriptions, competency-based interviewing, into a (digital) resource library Service Delivery Improvements o Increase the use of PLWH-driven service delivery models (all goals) Collaboration & Partnerships o Establish workforce and training stakeholder group to provide input into workforce assessments, training content (in person, online) and training delivery (used by HIV funders to improve statewide coordination & AETC activities) o Partner and/or co-sponsor events and/or activities that promote the development of HIV prevention and care competencies	• Baseline diversity assessment • Build training content on HIV core competencies & cultural diversity • # individuals complete HIV trainings • HIV workforce competency assessment • Digital resource library supports workforce • Career pathways mapped	• CT DPH • HIV Funders Collaborative • DMHAS • Connecticut Area Health Education Center (AHEC) • CHPC QPM Committee • New England AIDS Education Training Center Regional Program (NEATC-RP) Other partners may include: ALL stakeholders – includes institutions of higher education and workforce investment boards

Goal 3. Reduce HIV-related disparities and health inequities			
Objective 3.2. Increase involvement in social justice initiatives and partnerships that reduce viral loads to the point of suppression (objective 2.2.) and reduce health disparities in new diagnoses (objective 3.1).			
Focus Area	**Priority Activities**	**Outcomes**	**Implementers**
A. Partner in a statewide campaign to end HIV	Collaboration & Partnerships o DPH Commissioner initiates statewide Task Force process; leverages DPH and CHPC stakeholders o Integrate CHPC members and CHPC stakeholders into campaign leadership positions and work groups Marketing & Communications / Education & Awareness o Share information and coordinate communications via CHPC platforms (Goal 1.1.A) Outreach, Engagement & Training o Coordinate and support implementation through listening sessions (peer-supported) special events at the statewide, regional and local levels (Goal 1.1.A) o Use training capacity to develop leaders and champions statewide (Goal 3.1.C)	• Campaign platform • CHPC stakeholders on leadership and implementation teams • # champions • # events • See Goal 1.1.A. • See Goal 3.1.C.	• Task Force • CT DPH • Local Health Departments Other partners may include: ALL stakeholders
B. Partner in core medical / healthcare service delivery initiatives that impacts health equity	Marketing & Communications o See Goal 2.1.A Access to healthcare Service Delivery Improvements o Encourage and promote innovations and pilot projects that adapt successful outreach, engagement and care coordination models for PLWH to address other healthcare priorities (e.g., chronic disease priorities, healthcare literacy, CIRA & New England research efforts) Collaboration & Partnerships o Engage healthcare leaders into the CHPC process and infuse HIV leaders into statewide healthcare improvement policy, planning and implementation processes (e.g., Medicaid Statewide Innovation Model; Statewide Health Improvement Plan) to leverage knowledge and system capacity to serve high risk populations with multiple health issues (See Goal 4.1.A) Improve Data Analytics & Meaningful Use o See Goal 3.1.A (data) and 3.1.B. (evidence-based strategies) Policy Development & Sustainability o See Goal 2.2.A optimize and increase resources to impact PLWH o See Goal 4.2.A PSCI Model	• See Goal 2.1.A. • See Goal 2.2.A. • See Goal 3.1.A. • See Goal 3.1.B. • See Goal 4.1.A • See Goal 4.2.A	• HIV Funders Collaborative • CHPC • CHAIR • CT DPH Other partners may include: ALL stakeholders
C. Partner in supportive service initiatives that impact health equity	Collaboration & Partnership o Develop partner network map that shows cross-pollination of CHPC stakeholders and HIV funders / leaders within priority supportive service initiatives (e.g., housing, employment, mental health, aging, substance abuse treatment, dental, domestic violence) o Develop action agendas to promote integration and collaboration (See also Goal 3.1.A and Goal 3.2.A) *(*this may include opportunities to cross train other agency staff in HIV competencies (Goal 3.1.C))* o Leverage the CHPC as a mechanism to provide input into the action agendas and/or to accelerate one or more priority collaborations that result in field testing a model, cross-training staff, improved data sharing, and/or another mutually agreeable outcome (e.g., regional events that promote community partnerships) *(*See also Goal 4.1.A. CHPC stakeholders; Goal 4.2.A PSCI)* Policy Development & Sustainability a. See Goal 2.2.A. optimize and increase resources available to impact PLWH (e.g., service detailing across collaborations)	• Partner network map • Priority action agenda areas (tie in with Plan priorities and statewide campaign) • See Goal 1.1.A. • See Goal 2.2.A. • See Goal 3.1.A. • See Goal 3.1.C. • See Goal 3.2.A. • See Goal 4.1.A. • See Goal 4.2.A.	• HIV Funders Collaborative • CHPC • All Parts Other partners may include: ALL stakeholders

Goal 4. Achieve a more coordinated statewide response to the HIV epidemic.

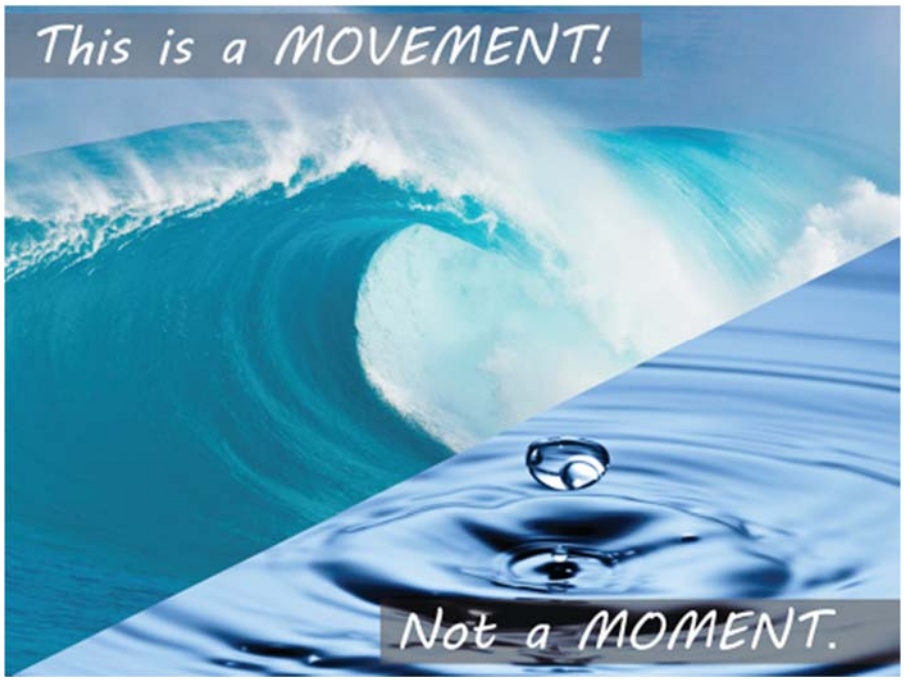
Objective 4.1. Build capacity of Connecticut HIV Planning Consortium to develop and advance statewide planning efforts as well as to diffuse and sustain effective models.

Objective 4.2. Increase capacity of HIV stakeholders and partners to implement the Statewide HIV Plan.

See pages 58 and 59 for Goal 4 focus areas, activities, and other details.

Connecticut's planners highlighted statewide communication and collaboration as vital factors in achieving a more coordinated response to the HIV epidemic in Connecticut. The Plan recognizes the fact that several partners and stakeholders must work in conjunction to effectively reduce new cases and connect PLWH to appropriate care. These stakeholders include PLWH, whose voices and experiences are vital to the process. Figure 37 provides a visual associated with Connecticut's planning process. Improving the lives of PLWH and ending the spread of HIV infection are statewide coordinated efforts. Connecticut is proud to boast a wide range of diverse planners who are determined to end the epidemic.

Figure 37. Connecticut's Commitment to Coordinated Planning



Implementation partners include:

CT DPH, the CHPC, Positive Prevention CT, all Ryan White Parts, and the HIV Funders Collaborative.

Goal 4. Achieve a more coordinated statewide response to the HIV epidemic

Objective 4.1. Build capacity of Connecticut HIV Planning Consortium to develop and advance statewide planning efforts as well as to diffuse and sustain effective models.

Focus Area	Priority Activities	Outcomes	Implementers
A. Increase organizational effectiveness of CHPC to conduct planning, coordination and stakeholder engagement	Marketing & Communications o Strengthen communications platform to support statewide Plan (See Goal 4.1.B; see also Goal 1.1.A) Collaboration & Partnership o Convene least eight public CHPC business meetings each year including committees o Update committee structure to support priority planning activities (e.g., workforce, evidence-based work groups, communications) o Position CHPC members and leaders across other leadership groups at the statewide and regional/local levels; encourage collaboration on critical initiatives including the statewide campaign to end HIV Outreach, Engagement & Training o Conduct regular CHPC orientation, leadership training and mentor support program for CHPC members *(*lunch and learn sessions open to public)* o Refresh membership and maintain diverse stakeholders reflective of the epidemic and relevant to statewide HIV Plan (e.g., peer-driven emphasis; prevention and healthcare collaborations; support services; sustainability) Improve Data Analytics & Meaningful Use o Implement meeting dashboard / scorecard to assess process and progress in implementing work plan o Annually review progress on statewide indicators and relevant to participation in other partner initiatives & adjust Plan	• Diversity chart • # additional partners • # persons trained • # distribution • # publications • Size of audience • Feedback • # and type of CHPC members serving on other entities (e.g., CHAIR) • Bylaws • See Goal 1.1.A. • See Goal 4.1.B.	• CHPC • CT DPH Other partners may include: ALL stakeholders
B. Enhance communications and information sharing across CHPC stakeholders	Marketing & Communications o Develop communication plan – including any external stakeholders (e.g., newsletter, websites such as www.positiveprevention.org, statewide campaign) o Maintain a digital resource library for meeting notes, best practices, workforce tools and relevant studies o Increase use of social media to support evidence-based strategies (e.g., social media training); connect to Goal 1.1.A. Outreach, Engagement & Training o Conduct and coordinate community outreach and engagement activities to support involvement of PLWH and implementation of evidence-based strategies as well as statewide campaign to end HIV (e.g., listening sessions)	• Communications plan (2017) • Website capacity and digital resource library (ongoing) • # community events • # PLWH and CHPC members trained to champion HIV efforts and campaign	• CT DPH • Positive Prevention CT • CHPC Other partners may include: ALL stakeholders

Goal 4. Achieve a more coordinated statewide response to the HIV epidemic			
Objective 4.2. Increase capacity of HIV stakeholders and partners to implement the Statewide HIV Plan.			
Focus Area	**Priority Activities**	**Outcomes**	**Implementers**
A. Improve integration of program collaboration services integration model (PCSI)	Marketing & Communications o Engage and update local health department leaders about HIV prevention and care initiatives Service Delivery Improvements o Integrate prevention and care service delivery models o Strengthen program collaboration among HIV, STD, TB and Viral Hepatitis programs Improve Data Analytics & Meaningful Use o Increase capacity to support data-driven planning, monitoring and evaluation Collaboration & Partnerships o Coordinate and build capacity to support training and implementation of evidence-based models Policy Development & Sustainability o Conduct annual policy review of policy and legislation regarding HIV, HCV and STD initiatives; submit recommendations	• Additional capacity for surveillance and data-driven planning • Stakeholders engaged in public health model • Policy changes • Program and contract changes to optimize impact of available resources	• CT DPH • All Ryan White Parts Other partners may include: state agencies; local health departments; contractors involved in service delivery (e.g., community health centers; school-based health centers)
B. Establish HIV Funders Leadership Group	Marketing & Communications o Support statewide campaign to end HIV (See Goal 3.1.A) Collaboration & Partnerships o Formalize HIV resource and policy partnership model (e.g., meeting frequency, roles & responsibilities, measures of success) o Expand partners as warranted (e.g., increase engagement of Part C; insurance providers / DSS; Medicaid ASOs) o Develop annual work plan, roles & responsibilities; take leadership role in workforce development area (See Goal 3.1.C) o Identify protocols for information sharing (e.g., data collection, best practices, training opportunities, funding opportunities) (See Goal 4.2.A) Policy Development & Sustainability o Secure additional resources for prevention and care directly or through stakeholder partnerships (See Goals 2.2.A; Goal 3.2.B; Goal 3.2.C; Goal 4.1.A.; Goal 4.2.A)	• Participation • Meeting feedback • # completed activities • Policy, funding, practice • See Goal 2.2.A. • See Goal 3.1.A. • See Goal 3.1.C. • See Goal 3.2.B. • See Goal 3.2.C. • See Goal 4.1.A. • See Goal 4.2.A.	• CT DPH • HIV Funders Collaborative
C. Review and monitor progress of Plan	Improve Data Analytics & Meaningful Use o Refresh and update epidemiological data and CHPC indicators o Review program level data (e.g., evidence-based strategies, syringe exchange) o Review CHPC meeting feedback across all levels and groups o Review CHPC membership composition and participation on other HIV implementation and stakeholder groups o Identify emerging needs and issues that influence annual update to Plan	• Update submitted to CDC and HRSA • See Goal 4.1.A.	• CHPC • CT DPH

Table 7 on page 60 shows a crosswalk of Connecticut's Plan Focus Areas by priority planning populations. The Plan's goals, objectives, and focus areas are carefully designed to address the needs of identified priority populations in Connecticut. For instance, Goal 1, Objective 1.2, Focus Area B is aimed specifically at assisting the injection drug user priority population.

Table 8 on page 61 shows a crosswalk of Connecticut's goals, objectives, and focus areas by the type of strategy employed to accomplish them. Connecticut's 2017-2021 Plan includes a myriad strategies used in conjunction to achieve Plan goals. For instance, under Goal 1, Objective 1.1, Focus Area A, several strategies are required to strengthen the statewide platform to deliver prevention and health promotion messaging, including: collaboration, communication, organizational development, technology enhancement, and workforce training.

Table 7. Crosswalk of Plan Focus Areas by Priority Planning Populations

Focus Areas of Objectives		Priority Planning Populations (See Section I.A.d.)											
		African American (AA) MSM	HCV co-infected	Heterosexual AA Men & Women	Heterosexual Latinas	Injection Drug Users	Latino MSM	LGBT	PLWH above age 50	PLWH (retain in care)	Youth up to age 24 (prevention)	Un- or under-insured	Late Testers
Goal 1. Reduce New Infections													
Obj. 1.1	**A.** Strengthen statewide platform to deliver prevention and health promotion messaging	●	●	●	●	●	●	●	●	●	●	●	●
	B. Increase access to PrEP and n-PEP	●		●	●	●	●	●			●	●	
	C. Promote "Treatment as Prevention"	●	●	●	●	●	●	●	●	●	●	●	●
Obj. 1.2	**A.** Improve evidence-based HIV outreach, testing and linkage services	●		●	●	●	●	●			●	●	●
	B. Increase access to clean needles and syringe exchange services					●					●		
Goal 2. Increase access to care and improve health outcomes for PLWH.													
Obj. 2.1	**A.** Promote and facilitate access to healthcare	●	●	●	●	●	●	●	●	●	●	●	●
	B. Strengthen access to care initiatives for PLWH		●						●	●		●	●
Obj. 2.2	**A.** Optimize/increase resources that impact PLWH		●						●	●		●	●
	B. Strengthen Connecticut ADAP		●						●	●		●	
	C. Increase capacity to implement quality improvement initiatives		●						●	●		●	
Goal 3. Reduce HIV-related disparities and health inequities													
Obj. 3.1	**A.** Analyze data sets by income, race/ethnicity and factors relevant to social determinants of health	●	●	●	●	●	●	●	●	●	●	●	●
	B. Introduce and scale effective Evidence Based strategies to reach high priority populations	●	●	●	●	●	●	●	●	●	●	●	●
	C. Increase HIV workforce competencies & cultural / linguistic capacity to serve priority populations	●	●	●	●	●	●	●	●	●	●	●	●
Obj. 3.2	**A.** Partner in a statewide campaign to end HIV	●	●	●	●	●	●	●	●	●	●	●	●
	B. Partner in core medical / healthcare service delivery initiatives that impact health equity	●	●	●	●	●	●	●	●	●	●	●	●
	C. Partner in supportive service initiatives that impact health equity	●	●	●	●	●	●	●	●	●	●	●	●
Goal 4. Achieve a more coordinated statewide response to the HIV epidemic													
Obj. 4.1	**A.** Increase organizational effectiveness (planning, coordination and stakeholder engagement)												
	B. Enhance communications and information sharing across CHPC stakeholders	●	●	●	●	●	●	●	●	●	●	●	●
Obj. 4.2	**A.** Improve integration of program collaboration services integration model (PCSI)	●	●	●	●	●	●	●	●	●	●	●	●
	B. Establish HIV Funder Leadership Group												
	C. Review and monitor progress of Plan												

Table 8. Crosswalk of Plan Focus Areas by Type of Strategy

	Focus Areas of Objectives	Type of Strategy								
		Collaboration	Communication	Data Systems	Organizational Development	Policy Development	Service Delivery	Technology Enhancement	Workforce Training	Sustainability
Goal 1. Reduce New Infections										
Obj. 1.1	**A.** Strengthen statewide platform to deliver prevention and health promotion messaging	x	x		x			x	x	
	B. Increase access to PrEP and n-PEP		x			x	x		x	x
	C. Promote "Treatment as Prevention"		x		x			x	x	
Obj. 1.2	**A.** Improve evidence-based HIV outreach, testing and linkage services	x		x			x		x	x
	B. Increase access to clean needles and syringe exchange services	x	x			x	x			x
Goal 2. Increase access to care and improve health outcomes for PLWH										
Obj. 2.1	**A.** Promote and facilitate access to healthcare	x	x			x			x	
	B. Strengthen access to care initiatives for PLWH	x	x				x		x	
Obj. 2.2	**A.** Optimize & increase resources that impact PLWH				x	x	x			x
	B. Strengthen Connecticut ADAP	x					x			x
	C. Increase capacity to implement quality improvement initiatives	x			x		x	x		
Goal 3. Reduce HIV-related disparities and health inequities										
Obj. 3.1	**A.** Analyze data sets by income, race/ethnicity and factors relevant to social determinants of health	x		x	x					
	B. Introduce and scale effective Evidence Based strategies to reach high priority populations	x	x				x	x	x	
	C. Increase HIV workforce competencies and cultural / linguistic capacity to serve priority populations	x	x			x	x		x	
Obj. 3.2	**A.** Partner in a statewide campaign to end HIV	x	x		x	x	x			x
	B. Partner in core medical / healthcare service delivery initiatives that impact health equity	x	x		x	x	x	x		x
	C. Partner in supportive service initiatives that impact health equity	x	x		x	x	x	x		x
Goal 4. Achieve a more coordinated statewide response to the HIV epidemic										
Obj. 4.1	**A.** Increase organizational effectiveness to conduct planning, coordination and stakeholder engagement	x	x	x	x	x	x	x	x	x
	B. Enhance communications and information sharing across CHPC stakeholders	x	x					x		
Obj. 4.2	**A.** Improve integration of program collaboration services integration model (PCSI)	x	x	x	x	x	x	x	x	x
	B. Establish HIV Funder Leadership Group	x		x		x	x	x		x
	C. Review and monitor progress of Plan	x								x

B. Collaborations, Partnerships, and Stakeholder Involvement

HIV Prevention and Care Ecosystem

Connecticut's HIV prevention and care ecosystem contains numerous statewide, regional and local networks and hundreds of institutions and organizations delivering services. The Connecticut Department of Public Health staff members participate within and across these networks and position the CHPC as a nexus for statewide HIV prevention and care planning. All of these stakeholder groups, and many more not described – particularly those at the local levels such as the Mayor's Task Forces on AIDS – play a critical role in statewide HIV planning and implementation.

Connecticut HIV Planning Consortium (CHPC)

The CHPC exists to create a coordinated statewide prevention and care system in which the rate of new infections is reduced, and those living with and affected by HIV can access appropriate services. The CHPC represents the forum for statewide HIV planning using a public health model that engages diverse stakeholders including PLWH. Pages 8-12 describe the CHPC. The majority of CHPC members participate on several other statewide, regional or local collaborative efforts within the HIV prevention and care ecosystem.

The Department of Public Health (DPH)

The Connecticut Department of Public Health (DPH) serves as the lead agency in the state for coordination of HIV care and prevention services addressing the HIV/AIDS epidemic, as well as the control, monitoring and prevention of sexually transmitted diseases (STD), tuberculosis (TB), and viral Hepatitis C. Six programs within the TB, HIV, STD and Viral Hepatitis Section fall under the direct supervision of the TB, HIV, STD and Viral Hepatitis Section Chief. DPH places a priority on training and analytic services that build capacity of statewide, regional and local partners to perform more effectively and achieve their goals and objectives to reduce the transmission and negative impact of HIV/AIDS.

The DPH:

- Plays a critical role in activating the involvement of local public health departments and districts throughout the state on topics related to outreach, testing and linkage to care.
- Supports statewide messaging and communication work including Positive Prevention CT (see description below).
- Organizes and encourages collaboration among partners within geographic regions and provides training and analytic support (e.g., epidemiological profiles, surveillance data, program evaluation results).
- Facilitates policy development discussions across stakeholders on topics such as the inclusion of sex education in health education curriculum.

The Cross Part Collaborative (CPC)

Originally a free-standing group of Ryan White partners, the Cross Part Collaborative (CPC) conducted Plan-Do-Study-Act (PDSA) cycles on care indicators, identifying best practices among providers. The CPC and CHPC assessed the extent to which the CHPC could provide a more robust environment to support the quality assurance work – and even to begin applying the principles to prevention work. In January 2016, the CHPC integrated the CPC work into the Quality Performance Measures team, including conducting PDSA cycles during the fall of 2016.

Connecticut HIV/AIDS Identification and Referral (CHAIR)

The Connecticut HIV/AIDS Identification and Referral (CHAIR) Task Force creates a venue to discuss implementation issues associated with outreach, testing and linkage (OTL) models and services and applies approaches such as community mapping, social networking, social media targeting, workforce training, and evidence-based strategies for OTL. Partners include: DPH HIV Prevention Program staff; The Connecticut HIV/AIDS Identification and Referral (CHAIR) Task Force; The Connecticut HIV Planning Consortium (CHPC) Data and Assessment Committee (DAC); HIV Prevention Services Funded Agencies; Consumers & Clients; CIRA; CT DPH STD program; Disease Intervention Specialists (DIS); CT DPH HIV Surveillance Program; and Healthcare and Support Services.

AIDS LIFE Campaign (ALC)

The AIDS Legislative Initiative and Funding Effort (LIFE) Campaign, a program of AIDS Connecticut, convened in 1992, has been Connecticut's leading statewide group that focuses on all of the policy-related issues impacting people living with and at high risk for HIV/AIDS – including prevention and education, such as syringe services programs; supportive services; health care, such as Medicaid and CADAP; and promoting housing as a structural intervention in HIV prevention and care. A strong cross-over membership exists between CHPC and ALC.

Connecticut Governor Malloy Speaks at AIDS Awareness Day Events

OPEN Access CT

The DPH Overdose Prevention Education and Naloxone (OPEN) Access campaign exists to address drug user health and provide access to harm reduction services for injection drugs users. The program provides overdose education, training, and access to naloxone for clients who utilize HIV prevention services in CT, including syringe access services. The programs collaborating with DPH on this initiative are doing so with support in terms of supplies but without specific funding for the services.

PrEP Provider Network

DPH maintains a list of clinical providers offering PrEP services. The list can be accessed at http://www.ct.gov/dph/lib/dph/aids_and_chronic/prevention/pdf/prep_services.pdf, and is searchable by zip code through Emory University's newly launched https://preplocator.org/. DPH offers support to this network of providers through "PrEP mobilization" and PrEP Workgroup meetings, and by offering a "Putting PrEP into Practice" lunch-and-learn for primary care providers. Further capacity building activities will follow in 2017. The PrEP Provider Network and the PrEP Workgroup are examples of successful collaboration and engagement around an important HIV Prevention tool, without funding to develop or sustain efforts.

Positive Prevention CT

Positive Prevention CT Offers Online Resources Relevant to HIV Prevention and Care

Click here to find a testing site near you.

Positive Prevention CT represents a group of HIV prevention providers and consumers funded by the CT Department of Public Health to create social marketing / health communication strategies targeting men who have sex with men (MSM) in Connecticut. The group's mission involves informing, educating and empowering the MSM population in Connecticut through these campaign strategies. Positive Prevention CT provides a potential platform for the Plan goals involving communication. It also offers resources related to PCSI, STDs, and HCV, among other topics. Visit www.positivepreventionct.org for more information about Positive Prevention CT.

Areas to Improve Stakeholder Engagement

The planning process revealed several areas in which the CHPC must improve stakeholder engagement, particularly to increase the likelihood of accomplishing goals related to health equity and services that reach beyond core HIV prevention and care yet hold significant impact on HIV health outcomes such as: employment, housing, mental health and substance abuse treatment, and workforce development. Priority stakeholders include:

- Local departments and districts of public health (Goals 1, 2, 3)
- Connecticut State Department of Education (Goal 1, prevention; Goal 3, statewide campaign)
- Department of Housing (Goal 3, partner initiatives)
- Department of Social Services - Medicaid (Goal 2, access to care + dental; Goal 3, health equity analysis)
- Area Health Education Centers (Goal 3, workforce development)
- Department of Corrections and Alternative to Incarceration Initiatives (Goal 1, OTL; Goal 2, access to care; Goal 3, reduce disparities)
- Department of Labor / Workforce Investment Boards (Goal 3, workforce development and partner initiatives for employment)
- Institutions of Higher Education Professional Programs (Goal 2, access to care – including dental)
- Ryan White Part C Federally Qualified Community Health Centers to improve overall coordination and facilitate quality improvement (Goals 1, 2, 3)
- Community leaders including faith community, student groups and PLWH (Goal 1, communication, prevention & testing; Goal 3, statewide campaign)

Methods of Engagement, Partnership & Collaboration

The CHPC model offers a range of methods to engage partners depending upon the level of interest and availability of time and resources. For example:

- CHPC holds public meetings in publicly accessible places.
- CHPC meeting processes encourage everyone (members and non-members) to participate in discussions, particularly at the committee level.
- CHPC reviews membership diversity quarterly and recruits new members to reflect the epidemic and to represent diverse stakeholder groups and geographic areas.

2016 Presentations by CHPC Partners

- Positive Prevention CT
- Cultural Sensitivity Training & Discussion
- Department of Mental Health and Addiction Services (DMHAS) Employability Resources
- Connecticut State Health Improvement Plan (SHIP) 2020 Dashboard

- CHPC invites partners to deliver presentations at CHPC meetings. These presentations increase awareness and strengthen networks, creating a foundation for higher levels of collaboration in the future.
- CHPC members provide mentoring and receive leadership training. CHPC encourages members to join other statewide, regional and local stakeholder groups in the HIV prevention and care ecosystem.
- DPH staff members, CHPC members and CHPC support staff reach out and engage partners and expert resources to complete critical planning and communication tasks.
- CHPC coordinates specific outreach opportunities in areas where the CHPC would like to increase participation or learn more about the current circumstances affecting PLWH.

The Plan places an emphasis on increasing partnerships and improving communication across stakeholders. The emerging statewide campaign activities will lead to more "listening sessions" at the community level and will create opportunities for partnership improvement.

The CHPC places great emphasis on its relationships with several federally funded HIV/AIDS service organizations. The featured resources and initiatives on pages 66 - 76 represent a variety of partners and projects linked to the CHPC and vital to the overall planning process and implementation. Please note that these pages provide merely a "glimpse" of the resources and groups in supportive of, and in partnership with, the CHPC.

C. Featured Resources & Initiatives

Ryan White: Part A

Part A funds primarily medical care and essential support services in the New Haven Eligible Metropolitan Area (2 counties) and the Hartford Transitional Grant Area (3 counties), cities with very high rates of PLWH and those at high risk. Ninety-one percent of PLWH in Connecticut reside in one of the two Ryan White Part A areas. Of Connecticut's 5 cities with the highest rate of PLWH, 4 are located in one of the Ryan White Part A areas (see Figure 39).

% PLWH by race	Hartford TGA	New Haven EMA
Black	29.1%	37.8%
Hispanic	39.2%	30.0%
White	30.3%	30.2%

Figure 38. HIV Continuum of Care, Hartford TGA, New Haven EMA, 2014

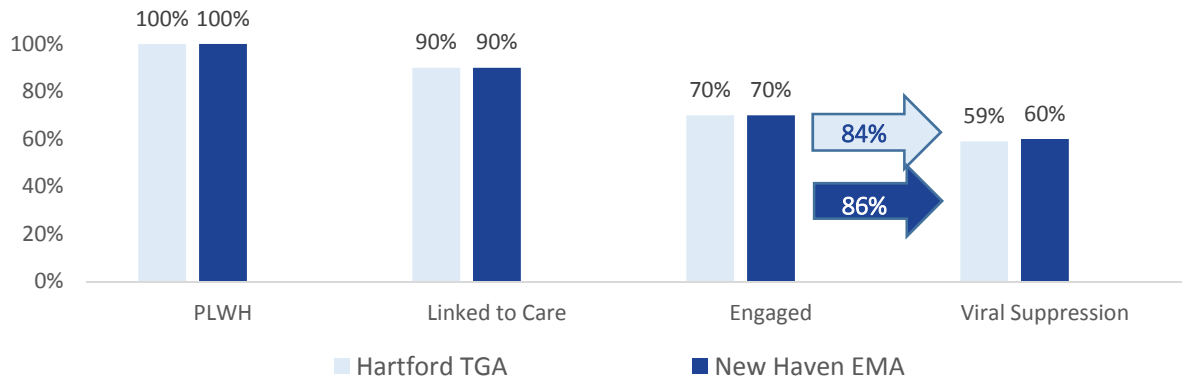


Figure 39. Social Determinants of Health in 4 Ryan White Part A Cities with Highest Number of PLWH

	PLWH*	Below Poverty**	High school graduate or higher**	Bachelor's degree or higher**
Bridgeport	903.0	23.6%	74.4%	16.5%
Hartford	1,495.5	34.4%	70.3%	15.0%
New Haven	1,114.5	26.4%	82.3%	33.6%
Waterbury	671.5	24.2%	79.5%	16.0%
Connecticut	**298.2**	**10.5%**	**89.5%**	**37.0%**

* = Prevalence rate per 100,000 people based on 2014 census estimates
** = Source: 2014 American Community Survey 5-year estimates
Note: see 2014 American Community Survey 5 year estimates tables: S1501, S1701 for margin of errors

Ryan White: Part B

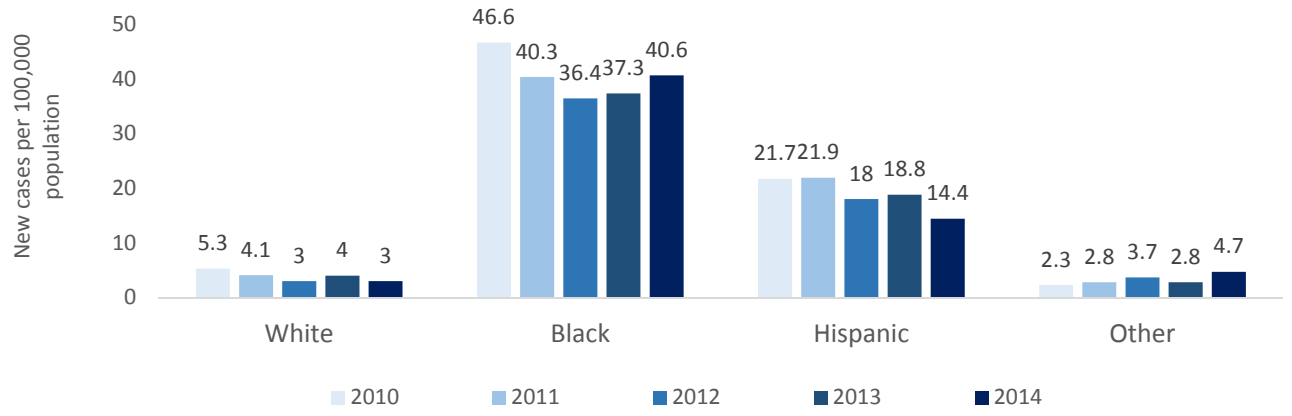
Ryan White Part B funds services including, but not limited to, the following:

Outpatient/Ambulatory Health Services	Medication Adherence Programs
Early Intervention Services	Medical Nutritional Therapy
Health Insurance Continuation	Housing
Assistance with Medical Visits	Psychosocial Support Services

The Connecticut AIDS Drug Assistance Program (CADAP) is a pharmaceutical assistance program available through Ryan White Part B that pays for medications approved by the U.S. Food and Drug Administration (FDA) on its formulary to treat HIV and HIV disease related conditions. The CT Department of Social Services (DSS), in partnership with the CT DPH, administers the program. CADAP provides assistance with health insurance assistance payment through its Connecticut Insurance Premium Assistance (CIPA). The program requires verification of HIV/AIDS by a medical provider, proof of Connecticut residency, health insurance status, and income less than 400% of the Federal Poverty Level.

Part B implemented the Minority AIDS Initiative (MAI), which targeted low income Black and Hispanic individuals (see **Figure 40** for the diagnosis rate within these populations) who were unaware, out-of-care, and HIV positive. The project provided these individuals with outreach and educational services. A challenge for Part B: Most of these individuals qualified for Medicaid, and not CADAP (as payer of last resort).

Figure 40. Rate of newly diagnosed HIV cases by race/ethnicity, Connecticut, 2010-2014



The Part B program focuses on expanding and integrating Ryan White services in geographic areas not covered by Part A programs.

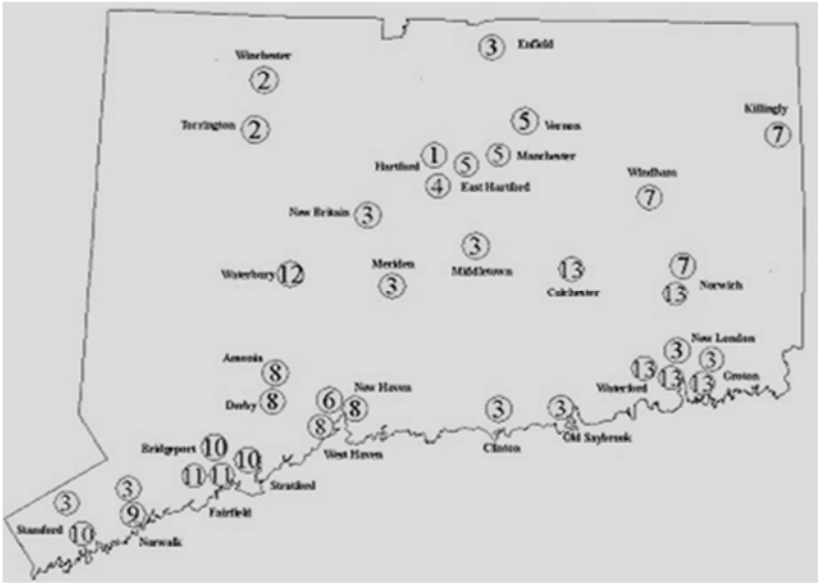
Part B Medical Nutrition Therapy Programs have provided quality services including comprehensive nutritional assessments, individualized nutritional plans, health education, and supplement distribution to Ryan White clients.

Ryan White: Part C

Ryan White Part C funds **Early Intervention Services (EIS)** to support the delivery of comprehensive primary health care in an outpatient center for PLWH at 13 Community Health Centers. **Early Intervention Services** refer to specific activities designed to identify individuals who are HIV+ and not currently receiving care, and get them into care as quickly as possible.

Outpatient/Ambulatory Services	Behavioral Health Outpatient Care
Early Intervention Services	Substance Abuse Outpatient Care
Prevention Outreach	Medical Case Management
Mental Health Services	Treatment Adherence
Early Intervention Services	Prevention Outreach

Figure 41. Community Health Centers in Connecticut



1. Charter Oak Health Center

2. Community Health & Wellness Center of Greater Torrington

3. Community Health Center, Inc.

4. Community Health Services, Inc.

5. East Hartford Community HealthCare, Inc.

6. Fair Haven Community Health Center

7. Generations Family Health Center

8. Cornell Scott-Hill Health Center

9. Norwalk Community Health Center

10. Optimus Health Care

11. Southwest Community Health Center

12. StayWell Health Care, Inc.

13. United Community & Family Services

Featured Health Center:

Southwest Community Health Center is located in Bridgeport, Connecticut. In January 2017, three Southwest employees will be members of the CHPC. Services include primary medical care/OB-GYN, medical case management, HIV testing and counseling services, and others.

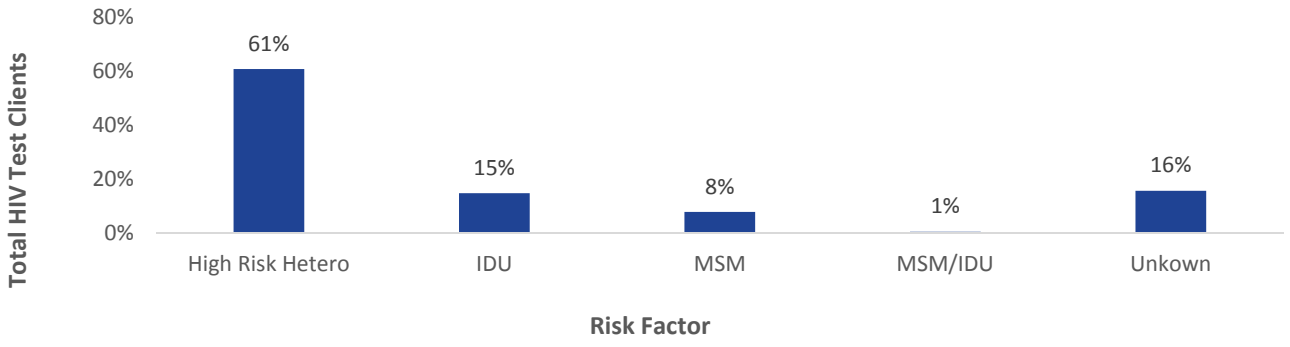
Ryan White: Part D

Ryan White Part D funding supports the 1) Women, Infant, Children and Youth HIV Services Consortia of Connecticut (WICY-HSCC) and 2) Children, Youth and Family AIDS Network of Connecticut (CYFAN). Connecticut has participating CYFAN agencies in Bridgeport, Hartford, New Haven, Willimantic, and Torrington. Ryan White Part D grantees provide family-centered primary medical care, including the following services:

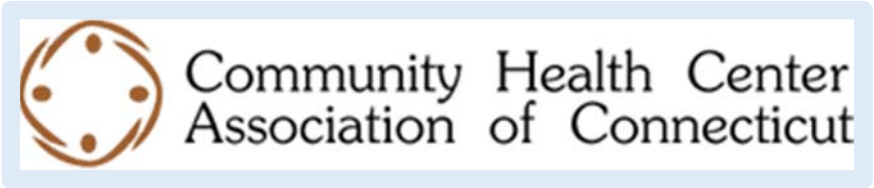
Outpatient/Ambulatory Health Services	Treatment Adherence Services
Early Intervention Services	Outreach, Testing and Linkage to Care
Medical Nutrition Therapy	Non-Medical Case Management
Mental Health Services	Health Education/Risk Reduction
Medical Case Management	Medical Transportation Services

Many of the patients tested for HIV are those who are living with HIV and unaware of their status, or those who are not yet infected but at high risk based on behavioral or demographic factors. In 2015, Outreach, Testing and Linkage (OTL) clients were tested and their risk factors were recorded. See Figure 42 below to see the most common risk factors represented in OTL HIV Test clients.

Figure 42. OTL Clients HIV Test by Risk Factor, 2015



The Community Health Centers Association of Connecticut (CHCACT) offers HIV/AIDS primary care services, coordination of the Perinatal HIV Transmission Project, medical case management services (intensive child and youth centered), mental health services, outreach services, and a range of support groups targeted toward infected and affected children, youth, and their families. Please click here to visit the CHCACT Website.



Ryan White: Part F - AIDS Education & Training Center (AETC)

Connecticut has two AETC Programs funded by Ryan White Part F: University of Connecticut and Yale University, and is part of a nationwide network of eight regional education centers (established in 1987). Connecticut's programs are part of the New England AETC, University of Massachusetts.

AETC Program goal: to provide education and clinical training opportunities for health care providers addressing effective counselling, diagnosis, treatment, care management of individuals living with HIV/AIDS, and to assist in prevention efforts.

AETC Program offerings include:

Adherence	HIV and Nutrition
Pre-Exposure Prophylaxis (PrEP)	Cultural Competency
Post-Exposure Prophylaxis (PEP)	Opportunistic Infections
Reproductive Health	HIV Home Test Training
Antiretroviral Treatment	Clinical HIV Manifestations

The AETC Program is administered by the Health Resources and Services Administration (HRSA) with Ryan White Part F funding. The project serves CT, ME, MA, NH, RI, and VT.

Practice Transformation Project
2015 - 2019

Practice Transformation refers to a process of change in the organization and delivery of primary care to advance quality improvement, patient-centered care, and characteristics of high performing primary care. The AETC Practice Transformation Project, running until 2019, will implement projects to support and facilitate practice transformation in selected clinics in order to improve patient outcomes along the HIV care continuum by integrating principles of the patient-centered medical home model and integrated HIV care and behavioral health services.

The Connecticut AETC has been on the forefront of providing trainings on Ebola (2014), PrEP (2012), and Zika (2016), among others.

Center for Interdisciplinary Research on AIDS (CIRA)

Established in 1997, the Center for Interdisciplinary Research on AIDS (CIRA) is New England's only National Institute of Mental Health (NIMH) funded research center. CIRA supports innovative, interdisciplinary research that combines behavioral, social and biomedical approaches, focused on the implementation of HIV prevention and treatment and the elimination of HIV disparities.[9] CIRA scientists and affiliated staff provide expert assistance to partners across the HIV prevention and care ecosystem. Several CHPC members and DPH staff members participate directly in CIRA processes, such as:

The New England HIV Implementation Science Network aims to improve HIV prevention and treatment in small urban areas with a high prevalence of HIV. Stakeholders learn of innovations and best practices and also receive support in assessing the validity of these models. Several partners play significant roles in implementation research and/or the implementation of federal grants that address high priority populations.

The Community Advisory Board (CAB) includes persons living with and affected by HIV/AIDS, representatives from the private sector, local and state health departments, community-based organizations (CBOs), AIDS service organizations, educational institutions, and others working or volunteering in the HIV/AIDS field. CAB serves as one of four advisory bodies to the Center, providing community perspectives on its activities.

Members of the New England HIV Implementation Science Network discuss strategies to slow the spread of HIV/AIDS at an annual symposium June 2, 2016. (Source: CIRA)

CIRA-affiliated projects include:

- Implementing PrEP in a Family Planning Setting
- Intervention to encourage HIV Testing and Counseling among Adolescents
- HIV Prevention Needs Among Unstably Housed Youth in Small Urban Areas
- Examining Multilevel System Dynamics Affecting HIV Community Viral Load

[9] The Center for Interdisciplinary Research on AIDS (CIRA) was established in 1997 and is currently New England's only National Institute of Mental Health (NIMH) funded AIDS research center. CIRA brings together scientists from 25 different disciplines and three institutions including Yale University, The Institute for Community Research and the Center for Health, Intervention, and Prevention. At Yale, faculty from five different schools participate in CIRA, including the Yale School of Public Health, Yale School of Medicine, Yale Law School, Yale Graduate School of Arts & Sciences, and Yale School of Nursing.

Connecticut's Local Health Departments

Connecticut's existing healthcare infrastructure is strong. Approximately 95% of the state population is served by a full time local health agency. Connecticut residents can obtain information about their local health department by visiting the CT DPH website.

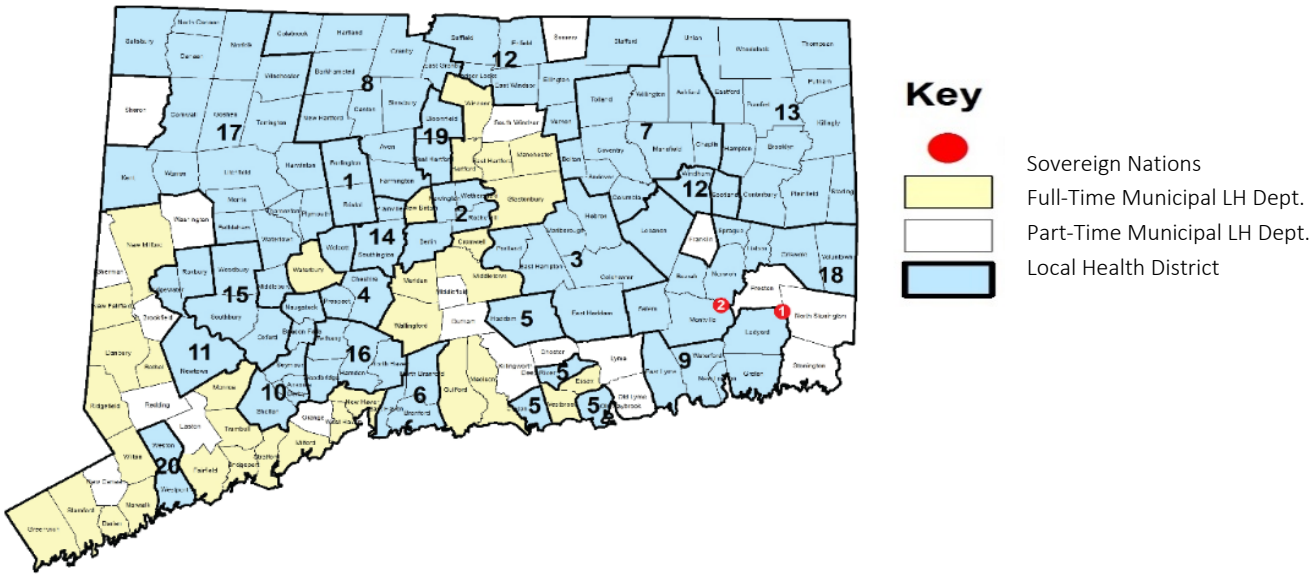
Figure 43. Connecticut's Local Health Departments, 2016

Connecticut's Local Health Departments*	# of Towns	Population (2014 Estimates)	Percentage
Full Time	149	3,416,785	95%
Municipal	33	1,745,141	48%
Districts (20)	116	1,671,644	47%
Part Time	20	179,892	5%
Total	169	3,596,677	100%

*July 2016 data

- Connecticut's local public health infrastructure encompasses a mixture of municipal health departments and regional health districts (i.e., local health agencies).
- Connecticut has a decentralized local public health system: local health agencies are autonomous and under the jurisdiction of the towns/municipality or health district served.
- Currently, Connecticut has 73 local health agencies serving Connecticut's population.
- Of these agencies, 53 employ a full time director of health, and 20 employ a part-time director of health.

Figure 44. Local Health Departments and Districts, July 2016



Connecticut's HIV Funders Collaborative

In August 2016, Funders Collaborative members agreed to continue meeting in the future to aid the CHPC in planning as well as support continued Plan implementation. Currently a data source convened by and in conjunction with DPH, the Funders Collaborative role will be discussed by the CHPC ad hoc Charter Committee in 2017 and considered for possible CHPC partnership.

The Funders Collaborative identified itself as Lead Implementer in the following Integrated Plan focus areas:

Objective 3.1: Reduce new HIV diagnoses by 25% by 2021 in the following groups: MSM and Black/African-American men and women. Focus Areas A, B, and C

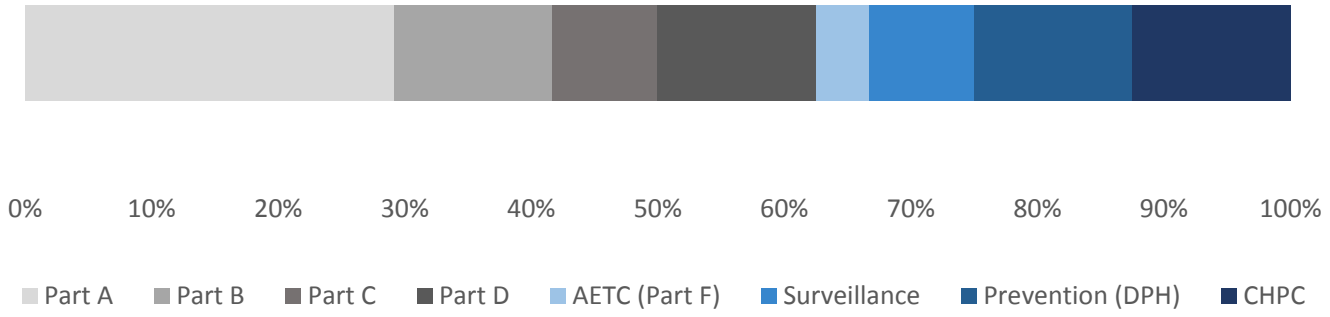
Objective 3.2: Increase involvement in social justice initiatives and partnerships that reduce viral loads to the point of suppression (obj. 2.2) and reduce health disparities in new diagnoses (obj. 3.1). Focus Areas B, C

Objective 4.2: Increase capacity of HIV stakeholders and partners to implement the Statewide HIV Plan. Focus Area B

Figure 45. HIV Funders Collaborative Meetings, 2015-2016

Group Values	Communication		Leadership		Collaboration		Data-driven process				
Individuals or groups complete designated tasks (e.g., produce Epi Profile) →											
Tasks	Review guidance, begin planning		Prioritize tasks, identify leads, create tools		Implement surveys, collect and analyze data		Discuss goals, objectives, focus areas for CHPC consideration based on data				
Meeting date	11/18	12/17	1/15	2/10	3/11	4/11	5/10	6/6	7/1	7/14	8/3

Figure 46. HIV Funders Collaborative Representation, 205-2016
Note: some individuals represent multiple stakeholders.



CT DPH: Overdose Prevention

Connecticut continues to experience a significant increase in opioid-related deaths (due to both prescription drug misuse and heroin use). Overdose (OD) deaths from opioid drugs have nearly doubled in Connecticut from 248 in 2011 to 485 in 2014, according to a 2015 report from Yale's Center for Interdisciplinary Research on AIDS (CIRA) and AIDS CT. In 2015, opioid overdoses caused 700 deaths in Connecticut.

DPH - and more specifically, the HIV Prevention Program - is uniquely poised to address the crisis due to its long and successful history of providing service to individuals who inject drugs.

In June 2016, the City of New Haven declared a public health emergency after 15 overdoses throughout the city were linked to a batch of heroin. DPH sent 700 doses of Narcan, a medicine used to reverse overdose effects, to the City to replenish supplies.

Governor Malloy announced the creation of a strategic planning process to guide a response to the opioid crisis. This plan, led by partners at Yale, will be completed in October 2016 and will be presenting during a DPH-sponsored Overdose Prevention Conference.

Senator Blumenthal help roundtable discussions across the state with law enforcement officials, first responders, addiction specialists, elected officials and several other related parties. He produced a report called *Opioid Addiction: A Call to Action* which includes a range of recommendations to help solve the crisis.

DPH Drug User Health Program

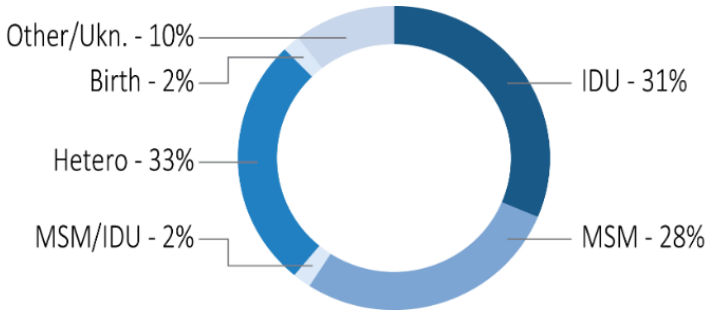
This program seeks to reduce morbidity and mortality associated with HIV, viral hepatitis, and other blood borne infections contracted via injection drug use. Components include:

- Syringe Services Programs (SSPs), which include provision of clean syringes, Harm Reduction Education, HIV and Hepatitis C testing/screening, and referrals to drug treatment, STD screening, and other ancillary services. Operate in Bridgeport, Hartford, New Haven, and Willimantic.

- CT Overdose Prevention Education and Naloxone (OPEN) Access CT, developed to educate and train residents on how to prevent opiate-related overdoses through Naloxone provision and administration. DPH has distributed over 9,000 overdose prevention kits and reversed 60 overdoses since 2014.

- A Pharmacy Initiative has expanded access to syringes in the state. DPH implemented an assessment tool and conducted interviews on pharmacy staff knowledge and practice around syringe exchange purchase and possession and OD prevention laws. Almost 800 Pharmacy packets were mailed out in 2015.

Figure 47. HIV Prevalence in Connecticut, Transmission Mode



"[OPEN Access CT] is an important part of the multifaceted response to improve opioid prescribing practices to prevent addiction, expand access to effective treatment for those who are addicted, increase use of naloxone to reverse overdoses."

- Marianne Buchelli, MPH, MBA, CHES

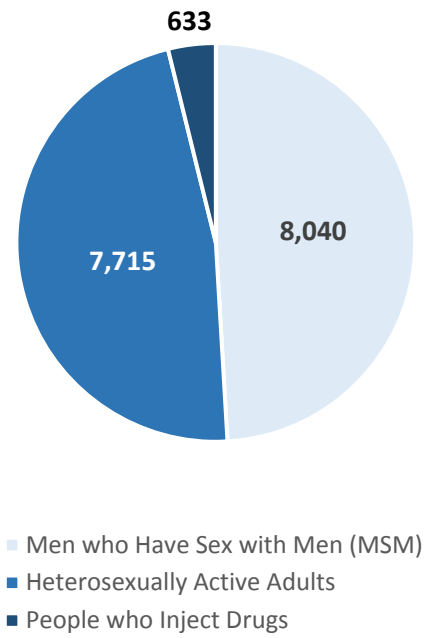
CT DPH: PRE-EXPOSURE PROPHYLAXIS (PrEP)

Pre-Exposure Prophylaxis, also known as PrEP, is a new HIV prevention tool in which people who do not have HIV infection take a daily pill containing medication to reduce their risk of HIV infection. PrEP has been proven safe and effective in preventing sexual acquisition of HIV (including men who have sex with men (MSM) and heterosexually active men and women). The Centers for Disease Control and Prevention (CDC) is evaluating PrEP's effectiveness in preventing HIV infection among individuals exposed to HIV through drug injection.

While PrEP is a promising and much-needed supplementary prevention method, it is not for everyone. PrEP is an intensive approach requiring strict adherence to medication and regular HIV testing, meant to be used in combination with other proven HIV prevention methods. DPH is currently exploring how the characteristics of PrEP users in Connecticut compare to the population at highest risk for HIV infection, or the "PrEP-eligible" population. A sample of clinical PrEP sites are providing DPH with feedback on current PrEP clients. Estimates suggest that Connecticut has as many as 16,388 "candidates" who may be eligible for PrEP based on high risk behaviors (Figure 48). Please see below for more information on some of Connecticut's statewide PrEP efforts and initiatives.

- CT DPH piloted a program with an intern/PrEP consultant to 1) assess strategies for expanded PrEP uptake and 2) develop DPH capacity to fund/manage PrEP-supportive services.
- DPH hosts a PrEP workgroup, which includes clinical providers, community partners, and PLWH from a range of regions, including areas of the state with no previous PrEP providers (e.g., Torrington, Connecticut).
- PrEP services are now included in all of the Category B funded sites statewide.
- DPH offers a "Putting PrEP into Practice" training module to clinical providers as needed or wanted.
- At the end of the most recent reporting period, 257 patients were enrolled in PrEP programs that report to the state , a number that will increase with PrEP provider expansion.
- The DPH HIV Prevention Program plans to pilot funded PrEP Navigation services at select sites, amending existing contracts for 2017.
- DPH coordinated a day-long overview of "PrEP Navigation" as an intervention to support PrEP initiation and maintenance to funded agencies and has a 3-day workshop scheduled for October 2016.

Figure 48. Estimated Number of PrEP "Candidates" in Connecticut



For more information and a list of local medical PrEP services in Connecticut, please click here.

CT DPH: Planning a Campaign to End HIV

In 2016, CT DPH Commissioner Dr. Raul Pino launched an effort to develop a statewide campaign to end HIV in Connecticut. The CDC has declared HIV a winnable battle. Thanks to advances in research, a range of highly effective strategies exist to achieve such a victory. Treatment as Prevention (TasP) and Pre-exposure prophylaxis (PrEP) are just two tools that, when implemented within comprehensive HIV care and prevention programs, significantly reduce new HIV infections and improve health outcomes for PLWH and partners.

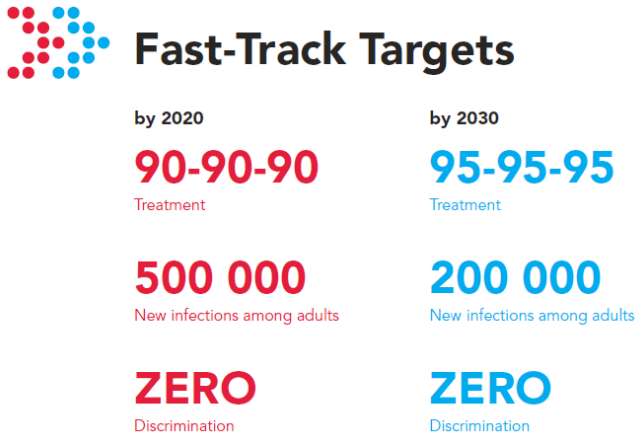
The Connecticut Department of Public Health (DPH) is on the fast track to identifying a Taskforce responsible for developing a Statewide Plan to End HIV by 2030. State and local health department heads have begun discussing future plans which include engaging diverse stakeholder participation, including PLWH, in a targeted Taskforce to launch the initiative. Key to this endeavor are mobilization of community partners and active participation.

The Taskforce will be charged to develop a Plan to End HIV in Connecticut which directly supports statewide attainment of the 90-90-90 Joint United Nations Programme on HIV/AIDS (UNAIDS) Fast-Track strategy to end the AIDS epidemic by 2030. The UNAIDS Programme was called on in December 2013 to support country- and region-led efforts to establish new targets for HIV treatment scale-up beyond 2015. In response, stakeholder consultations on new targets have been held around the world. At the global level, stakeholders assembled in a variety of thematic consultations focused on civil society, laboratory medicine, pediatric HIV treatment, adolescents and other key issues. Powerful momentum is now building towards a new narrative on HIV treatment and a new, final, ambitious, but achievable target:

- By 2020, 90% of all PLWH will know their status.
- By 2020, 90% of all people diagnosed with HIV infection will receive sustained antiretroviral therapy (ART).
- By 2020, 90% of all people receiving ART will have achieved viral suppression.

In addition to CT state and local leaders, the Connecticut HIV/AIDS Information and Referral Task Force (CHAIR), the full CHPC, and the Quality and Performance Measures (QPM) Team of the CHPC Data and Assessment Committee (DAC) have begun discussions around this initiative. The campaign will use the public health model framework and rely on stakeholder engagement. Please see Figure 49 for the UNAIDS campaign's "big picture," serving as a guideline and inspiration for Connecticut.

Figure 49. UNAIDS Fast Track Targets[10]



[10] UNAIDS Fast-track strategy to end the AIDS epidemic by 2030

D. People Living with HIV (PLWH) and Community Development

CHPC membership composition represents the HIV epidemic in Connecticut; please refer to page 9 or the Appendix for more details. By engaging the voices of PLWH, the CHPC maintains clear sight on the group's charge: to create a coordinated system reducing the rate of new infections, and connecting PLWH to appropriate services. The CHPC values PLWH input at full meetings and on the committee level as an indispensable planning resource.

Figure 50. CHPC Hosts a PLWH Panel on Employment, Housing & Aging with HIV

At the May 18, 2016 meeting, the CHPC hosted a "Persons Living with HIV Panel" (see **Figure 50**) and three individuals shared their experiences in certain priority areas: 1) Aging with HIV, 2) Stable Housing, and 3) Employment. These topics were selected intentionally to gain more insight into priorities for the Plan. The panelists shared their stories and participated in a question-and-answer session with the audience.

The CHPC offers a mentoring program and provides training opportunities for CHPC members on a multitude of topics. Past examples include topics such as gender identification and leadership development. CHPC members actively participate on committees and contribute significantly on critical tasks such as developing content for the newsletter. Increasingly, more opportunities for PLWH to engage in training emerge as a result of HIV funders' commitment to more actively involve consumers.

Training of Consumers on Quality Plus Team

Greetings everyone, Peta-Gaye Nembhard, André L. McGuire and Alice Ferguson Connecticut Training of Consumers on Quality Plus Team (CT TCQ Plus Team) attended a National Quality Center (NQC) Training in June. This training was meant to assist PLWHA to more fully participate in the Quality Improvement programs of our states planning bodies. As part of this commitment, we are inviting you to attend a one day training scheduled for September 28, 2016 in which we seek to increase the number of PLWHA that actively participate in local quality management committees or regional quality improvement activities.

Excerpt from invitation letter dated August 1, 2016 authored by the CT TCQ Plus Team members*
(*one of whom serves as CHPC co-chair)

The Plan calls for a commitment to implement evidence-based strategies that involve a peer-driven component or involve peer-driven staff as well as to develop a career pathway that allows PLWH to build workforce competencies and to increase the diversity and cultural and linguistic capacity of the HIV prevention and care workforce.

SECTION III

MONITORING AND IMPROVEMENT

Who is involved in monitoring processes?

- *DPH, CHPC Committees, and CHPC co-chairs, among other parties*

What components are monitored annually?

- *Measurable objectives (CHPC performance indicators, Statewide Health Improvement Plan HIV indicators)*
- *Plan content (e.g., service descriptions, resources, initiatives)*
- *Epidemiological data*

How does DPH monitor planning and aspects of Plan implementation?

- *DPH is the lead agency for coordination of HIV prevention and care resources*
- *Six (6) programs within the TB, HIV, STD and Viral Hepatitis Section fall under the direct supervision of the TB, HIV, STD and Viral Hepatitis Section Chief.*

SECTION III. MONITORING AND IMPROVEMENT

A. Process to Update Planning Bodies and Stakeholders

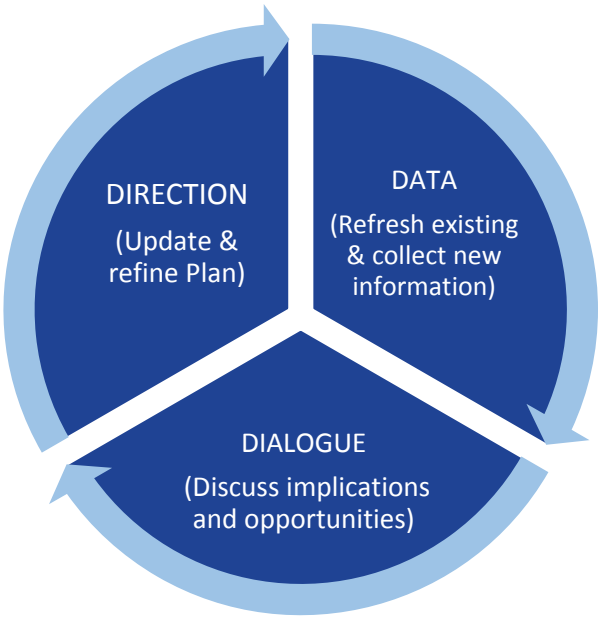
The DPH and CHPC review and update the Plan on an annual basis. The SMART objectives, indicators and other program measures create a platform to assess progress (see section B on page 80).

Committees review data sets and coordinate any additional studies. For example, the Quality and Performance Measures Team will focus on quality improvement processes and the Needs Assessment Projects Team will continue to pursue more in-depth studies related to PLWH out-of-care or more specifically, those out-of-care who are not virally suppressed.

The CHPC will review and refine its structure during 2017 to support Plan implementation with an emphasis on areas related to communication and supporting evidenced-based practices (including peer-driven strategies).

The HIV Funders Collaborative will assist in ongoing data collection to better understand HIV prevention and care workforce competencies.

Figure 51. CHPC Annual Process to Review & Update Plan



The CHPC leadership team will develop and update a tracking tool specific to monitoring Plan implementation. The CHPC will review progress and refine the Plan annually.

In its commitment to transparency, parity, and communication, the CHPC emphasizes sharing data - both existing data in support of this document as well as those collected and refreshed in future years - with its diverse community stakeholders. Community-level sharing is a vital component to Connecticut's statewide planning process.

B. Plan to Monitor and Evaluate Plan Implementation

Each objective was selected by Connecticut's planning leaders from either the existing CHPC indicators or the existing DPH Statewide Health Improvement Plan (SHIP) 2020 HIV indicators to ensure statewide alignment on priority measures. All indicators representing Plan objectives are tracked consistently and refreshed annually.

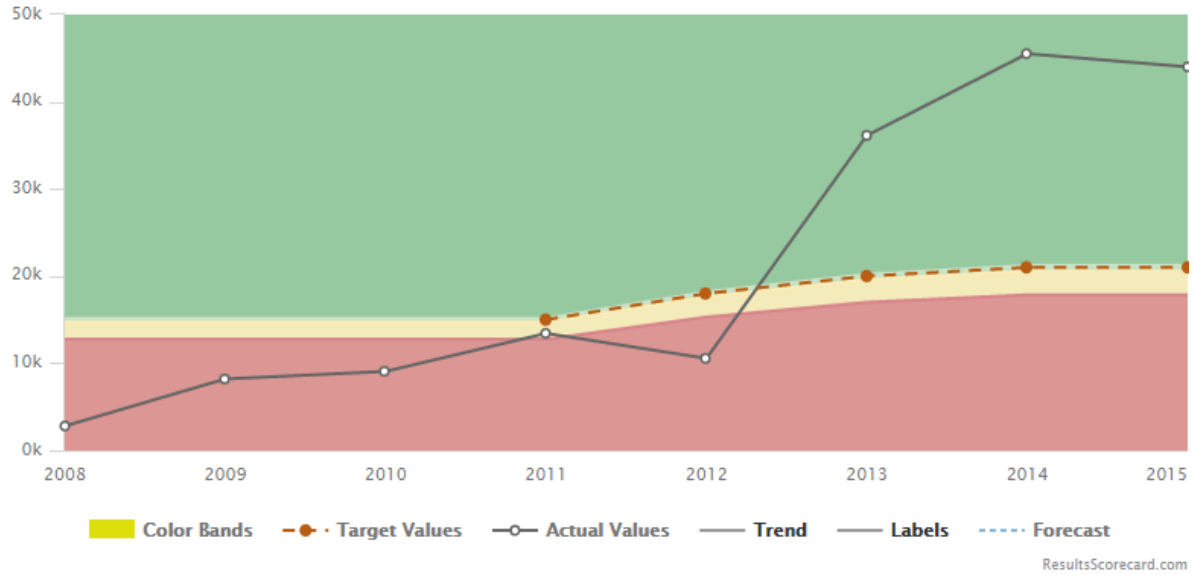
The Epidemiological Profile data serves as a comprehensive resource with DPH epidemiologists refreshing the data annually and posting the data tables online.

The CHPC and DPH have identified 11 performance indicators (page 7) to measure progress towards Plan goals. The appendix contains a description of each indicator and the measurements. The CHPC Quality and Performance Measures Team developed these indicators over a three-year period and continues to revise and update them annually. The group will continue to develop indicators relevant to prevention work.

Several Plan objectives reference the State Health Innovation Plan (SHIP) HIV indicators, monitored by DPH. The CHPC and other relevant groups will receive updates on all Plan indicators throughout the monitoring process. These indicators can be viewed online via the "Healthy Connecticut 2020 Performance Dashboard."

The CHPC will rely on these data sets, as well as information from the HIV Funders Collaborative and other stakeholders, to assess the Plan's implementation status.

Figure 52. Number of HIV Testing Events in Connecticut: Funded Expanding Testing Initiative (ETI) Programs.
Source: Healthy Connecticut 2020 Performance Dashboard



Story Behind the Curve

Between 2008 and 2015, a total of 169,683 HIV tests have been conducted by CT DPH HIV Prevention Program's funded agencies conducting routine HIV testing in healthcare settings. From 2012 to 2014, a quantum leap occurred in the number of HIV tests conducted due to ETI interventions' coordinators successfully increasing the number of HIV testing sites within their organizations.

C. Strategy to Utilize Surveillance / Program Data to Assess Health Outcomes

The Connecticut Department of Public Health serves as the lead agency in the state for coordination of HIV care and prevention services addressing the HIV/AIDS epidemic, as well as the control, monitoring and prevention of sexually transmitted diseases (STD), tuberculosis (TB), and viral Hepatitis (B and C). Six programs within the TB, HIV, STD and Viral Hepatitis Section fall under the direct supervision of the TB, HIV, STD and Viral Hepatitis Section Chief.

Figure 53. Relationship to the Connecticut Department of Public Health

Connecticut Department of Public Health

Lead agency in the state for coordination of HIV care and prevention services

1. The **Health Care and Support Services Unit (HCSS)**, which oversees Ryan White Part B care programs and services for People Living with HIV (PLWH).
2. The **HIV Prevention Unit**, which oversees prevention services and interventions for people infected or at high risk of HIV infection.
3. The **HIV/AIDS Surveillance Unit**, which oversees data collection on HIV and AIDS in Connecticut (as well as measures such as TB and HCV) and is responsible for producing the state's Epidemiological Profile, as well as monitoring trends and emerging issues and populations.
4. The **Sexually Transmitted Diseases Control Program**, which investigates, screens and monitors the occurrence of STDs.
5. The **Tuberculosis Control Program**, which collaborates with health care providers and municipal health departments to conduct surveillance for TB disease and latent TB infection, screening, treatment, and control activities.
6. The **Viral Hepatitis Program**, which monitors, reports, investigates and provides education, surveillance and information on viral hepatitis C.

This new coordination and linkage of programs positions the Department of Public Health to advance Program Collaboration Service Integration (PCSI), specifically TB, HIV, STD and Hepatitis Programs. The PSCI model addresses interrelated health issues through the development and implementation of integrated planning, service delivery, results-based accountability, quality improvement, and communications, among other factors that facilitate comprehensive delivery of services, promote healthy lifestyles, and improve quality of life and health outcomes. DPH places a priority on training and analytic services that build capacity of statewide, regional and local partners to perform more effectively and achieve their goals and objectives to reduce the transmission and negative impact of HIV/AIDS.

HIV surveillance/ program data will be utilized to identify HIV-positive clients who have been in care (defined as one documented viral load) for 12 months, and then determined to be out of care for longer than the following 12 months. The information is then provided to an EIS or HIV-Disease Intervention Specialist (H-DIS) to identify and work with clients who have fallen out of care. The databases include, but may not be limited to, eHARS, HARMS< STD*MIS/MAVEN and Lexis Nexis.

HIV surveillance data will also be utilized to identify HIV-positive clients who have not received care 12 months after initial diagnosis. The information is shared with either an EIS or H-DIS. Program data will also be utilized to determine community viral load suppression of HIV clients who are recipients of Ryan White core medical and support services including coordination of services to ensure retention in care. MCMs will review caseloads at least every 3 months to identify potential clients who may be at risk of falling out of care, and will pass this information to the EIS or H-DIS for appropriate follow up.

SECTION IV

SUBMISSION AND REVIEW PROCESS

When did planning occur?

- *The 2016 planning year formally began in January 2016, but the Plan incorporates work from the past five (5) years.*
- *Planning meetings occurred throughout the year among DPH staff, CHPC members and leaders, the HIV Funders Collaborative, and others.*

How did the vote occur?

- *Twenty-four (24) CHPC members voted at their August 17, 2016 business meeting after a review and discussion.*
- *The Plan was unanimously approved by concurrence.*

What was the approval process?

- *CHPC leaders implemented a "snapshot view" planning process in which they revealed planning progress to the full CHPC on a monthly basis, thus ensuring familiarity with Plan content.*

SECTION IV. SUBMISSION AND REVIEW PROCESS

The Plan builds upon the foundation of more than five years of integrated prevention and care planning tasks conducted under the auspices of the CHPC, chief among which include the development of statewide performance indicators.

CHPC members and diverse stakeholders including PLWH participated in the 2017 to 2021 Plan development process that began in September 2015 with the review of the National HIV/AIDS Strategy. DPH convened an HIV Funders Collaborative and the group agreed to develop and submit one Integrated HIV Prevention and Care Plan on behalf of several jurisdictions using the CHPC as forum for statewide HIV prevention and care planning. The HIV Funders Collaborative members provided input on several planning parameters (e.g., the type of HIV Care Continuum, scope of the initial workforce survey).

The CHPC and its committees met monthly January through August 2016 with the primary focus on activities related to Plan development. The HIV Funders Collaborative met monthly as well to facilitate access to data and to assist in shaping the focus areas and objectives and aligning activities with resources. The CHPC members began discussing objectives and activities in April 2016; the June meeting included break-out sessions to discuss content relevant to each Goal.

In July 2016, the CHPC members received a full presentation and review of the data relevant to the Plan and a working copy of the Plan goals, objectives, focus areas and priority activities. CHPC members received revisions to the Plan goals and objectives as soon as the document was finalized in early August. CHPC members received a full copy of the Plan to review prior to the CHPC meeting on August 17, 2016.

The CHPC members reviewed and discussed the Plan document at the August 17, 2016 meeting and clarified any outstanding issues. The CHPC held a written vote to approve the Plan with CHPC members able to identify (in writing) any remaining reservations with the Plan. Of 24 total votes, 24 CHPC members voted to approve the Plan, 0 voted to not approve and 0 voted to abstain.

Of the members who voted to approve, the following concerns or reservations were identified:

1. *"Goal 1, Objective 1.2. The number of people being tested should not be 15,000 in 2021 but much higher."*

2. *"Would like to see socio-economic + social determinants PLWHA. Would like to see available resources + private + public funding. Concerned that the 'Funders Group' does not adhere to CT State Statuses (FOI) + Denver Principles + is making decisions that affect the lives of PLWHA. Concerned at disparity between RW Parts."*

The CHPC co-chairs committed to addressing the reservations. DPH and CHPC staff members completed a final review and copy edit of the Plan, not altering any goals or objectives. The DPH submitted the document and a full set of attachments to federal funders on or before September 30, 2016, including a letter from the CHPC co-chairs and confirmation by the required partners.

LETTER OF CONCURRENCE FROM CHPC CO-CHAIRS

September 30, 2016

Theresa McDarmont, Public Health Advisor
Centers for Disease Control and Prevention
Prevention Program Branch/ Division of HIV/AIDS Prevention
National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention

Dear Ms. McDarmont:

Connecticut's HIV prevention and care stakeholders chose the option of preparing and submitting one Integrated HIV Prevention and Care Plan on behalf of several jurisdictions (e.g., the State, the Part A jurisdictions of the State, CDC funded jurisdictions in the State). This letter confirms:

- The inclusion of each HRSA and CDC-funded jurisdiction in the development and submission of this Plan.
- The unanimous approval for *Connecticut's 2017-2021 Integrated HIV Prevention and Care Plan* ("Plan") by the members of the Connecticut HIV Planning Consortium (CHPC).

The Plan aligns with and conforms to the Ryan White HIV/AIDS Program (RWHAP) Comprehensive Plan/SCSN; uses the National HIV/AIDS Strategy (NHAS) 2020 as an organizational framework for goals and objectives; and meets or exceeds the recommendations from the Division of HIV/AIDS Prevention of the Centers for Disease Control and Prevention (CDC) and the HIV/AIDS Bureau of the Health Resources and Services Administration (HRSA) Jurisdictional Plan guidance for years 2017-2021.

The Connecticut HIV Planning Consortium (CHPC) represents Connecticut's statewide integrated prevention and care planning body with a mission to reduce HIV transmission in Connecticut. The CHPC members represent persons living with HIV and AIDS (PLWHA) as well as community-based healthcare, human services and HIV service organizations; administrators from Ryan White Parts A, B, C, D, and F; and government agencies, among others. The CHPC, in partnership with the Connecticut Department of Public Health (DPH), develops (and updates) the Plan, and uses the planning process to facilitate collaboration and coordination across diverse stakeholders - including PLWHA.[11]

The CHPC's integrated prevention and care planning process features three (3) CHPC committees each containing a core group of CHPC members, stakeholders, resource partners, and staff (including those from the Connecticut Department of Public Health TB, HIV, STD & Viral Hepatitis Program). These committees host discussions by inviting a range of perspectives and experiences to the table. The full CHPC conducts presentations and discussions on other topics related to the epidemic on state and national levels, thus identifying priorities and driving plan development through dialogue.

Connecticut's Integrated HIV Prevention and Care Plan 2017-2021 was driven by quantitative data, including epidemiological data through 2015, statewide indicator data, and survey results; and qualitative data, including dialogue on local and state levels, written survey responses, and PLWHA input. The goals, objectives, and activities were established with the intent to: a) align the Plan with the NHAS 2020; and b) best address people at all stages of the HIV/AIDS care continuum (diagnosis, linkage to care, and viral suppression) as well as those at high risk for HIV infection. The Plan includes a statewide coordinated statement of need/needs assessment; the integrated prevention

[11] CHPC encourages public participation. Public participants of the CHPC do not vote on plans or plan updates. Public participants represent a range of diverse stakeholders with invaluable impact on the process.

and care plan including goals, objectives, and activities; the monitoring and improvement process; and the submission and review process.

The CHPC members voted on the document via written ballot at their August 17, 2016 business meeting. Of the twenty-four (24) members in attendance, twenty-two (22) members voted for concurrence without reservations and two (2) members voted for concurrence with reservations. The reservations called for additional discussion and potential refinement of the plan in the following areas:

> *"Goal 1, Objective 1.2. The number of people being tested should not be 15,000 in 2021 but much higher."*
>
> *"Would like to see socio-economic + social determinants PLWHA."*
>
> *"Would like to see available resources + private + public funding. Concerned that the 'Funders Group' does not adhere to CT State Statuses (FOI) + Denver Principles + is making decisions that affect the lives of PLWHA. Concerned at disparity between RW Parts."*

CHPC co-chairs acknowledge these reservations and confirm that each of these will be addressed during plan implementation. For example, the Plan calls for a higher level of engagement and data from non-public partners (e.g., insurance companies). A higher level of stakeholder engagement from non-public funding partners represent critical first steps to addressing the first two reservations. The CHPC will review its organizational structure during the first part of the 2017 planning year and make adjustments necessary to support implementation. This will include clarifying the roles and responsibilities of the advisory group of funders convened by DPH to facilitate data sharing and systems level discussions relevant to the planning process.

The CHPC concurrence vote results confirmed that the Plan accurately described: a) the Consortium's integrated HIV prevention and care planning process; and b) the goals, objectives, and activities established to reduce the impact for Connecticut residents infected with or affected by HIV, as well as to address those at high risk for HIV infection. The unanimous approval reflects the involvement and investment of CHPC members and stakeholders in the plan development process, the transparency and inclusiveness of the plan development process, the effective use of qualitative and quantitative data sets to drive planning, and the Plan review and discussion process (including committee meetings, planning body discussions, and mentoring sessions to assist new CHPC members).

The CHPC and its stakeholders will continue to update the plan in several ways including refreshing data sets, sharing emerging information about activities, and adjusting measures as the HIV service delivery system evolves. The CHPC emphasizes reader accessibility through straightforward language and clear infographics, and will remain committed to this format per each update. Plan updates will occur on an annual basis.

Please contact us directly to answer any questions about the Plan document or Connecticut's statewide integrated HIV prevention and care planning process. We look forward to your feedback on Connecticut's 2017-2021 Integrated HIV Prevention and Care Plan, and to continuing to update, refine, and improve the plan over the next five (5) years.

Sincerely,

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APPENDIX

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- *HIV Financial Resources Inventory (Public Funding)*
- *September 2016 CHPC Newsletter*
- *2016 Epidemiological Profile of HIV in Connecticut*

APPENDIX

2016 Member List

Includes current members as of August 2016

1. Kathryn Auguste, Southwest Community Health Center, Fairfield County
2. Clifford Batson, Hartford County
3. Charles Capers, Hartford County
4. Tom Butcher, New Haven/Fairfield Ryan White Office, New Haven/Fairfield County
5. Sarah Butterfield, Windham County
6. Carmen Cruz, New Haven County
7. Gina D'Angelo (co-chair), CT Department of Public Health, Statewide
8. Zenaida Falcon, Hartford County
9. Nilda Fernandez, UConn Health Center / CT Children's HIV Program, Hartford County
10. Carl Ferris, New Haven County
11. Ann Galloway Johnson, Waterbury Health Department, New Haven County
12. Rev. Alexander Garbera, New Haven County
13. Blaise Gilchrist, CT Children's Medical Center, CHPC Youth Advisory Group, Hartford County
14. Linda Guillorn, CT Department of Mental Health and Addiction Services, Statewide
15. William Knox, New London County
16. Ronald Lee, New Haven County
17. Keyvin Lewis, Stay Well Health Center, New Haven County
18. Andrea Lombard, CT Department of Public Health Hepatitis Program Coordinator, Statewide
19. Aurelio Lopez (co-chair), AIDS Connecticut, Statewide
20. André McGuire (co-chair), Hartford County
21. Pamela Parks, New Haven County
22. Kathyleen Pitner, Community Health Center Association of Connecticut, Statewide
23. Priscilla Pitts, New Haven County
24. Willy Quesada, Southwest Community Health Center, Fairfield County
25. Madeline Rodriguez, Latino Community Services, Hartford County
26. Brian Sibilio, University of Connecticut, New Haven County
27. Roberta Stewart, AIDS Project Greater Danbury, Fairfield County

CHPC Acronyms & Definitions

ACA: Affordable Care Act ("Obamacare")

ACO: Accountable Care Organization. A healthcare organization characterized by a payment and care delivery model that seeks to tie provider reimbursements to quality metrics and reductions in the total cost of care for an assigned population of patients.

ADAP: AIDS Drug Assistance Program. ADAPs provide HIV-related prescription drugs to low-income people with HIV/AIDS who have limited or no prescription drug coverage. ADAPs receive funding under Ryan White Part B. Connecticut's ADAP is called CADAP.

AETC: AIDS Education and Training Center. The training arm of the Ryan White HIV/AIDS Program. A national network of leading HIV experts who provide locally based, tailored education, clinical consultation and technical assistance to healthcare professionals and healthcare organizations to integrate high quality, comprehensive care for those living with or affected by HIV. Connecticut has the Connecticut AETC.

AHEC: Area Health Education Center. The Connecticut AHEC Network works throughout Connecticut to improve access to basic health care by linking local community groups with the resources of the University of Connecticut Health Center and other health professions training programs.

AIDS: Acquired Immune Deficiency Syndrome

AIDS CT: AIDS Connecticut. A statewide coalition of organizations that provide services to people living with HIV/AIDS in Connecticut.

AIDS LIFE: The AIDS Legislative Initiative and Funding Effort Campaign is Connecticut's only statewide group that focuses solely on all of the policy-related issues impacting people living with and at high risk for HIV/AIDS.

APNH: AIDS Project New Haven. An AIDS Service Organization that serves the New Haven area.

ART: Antiretroviral Therapy. Medications that treat HIV. The drugs do not kill or cure the virus, but when taken in combination they can prevent the growth of the virus.

ASO: AIDS Service Organization. A community based organization that provides support for people living with HIV and AIDS.

BRFSS: Behavioral Risk Factor Surveillance System. A telephone survey that tracks health risks in the United States. It is administered and supported by the CDC and conducted by state health departments. LINK www.cdc.gov/brfss/index.htm

CADAP: Connecticut AIDS Drug Assistance Program. A pharmaceutical assistance program that pays for HIV/AIDS medications and other drugs that may prevent the serious deterioration of health in persons living with HIV and AIDS.

CBO: Community Based Organization. An organization that is representative of a community or a significant segment of a community, and is engaged in meeting human, educational, environmental, or public safety community needs.

CCMC: Connecticut Children's Medical Center.

CD4 count: A lab test that measures the number of CD4 T lymphocytes (CD4 cells) in a sample of your blood. In people with HIV, it is the most important laboratory indicator of how well your immune system is working and the strongest predictor of HIV progression.

CDC: US Centers for Disease Control and Prevention. The Federal agency responsible for monitoring, planning and implementing public health activities for the US. **CHAIR:** CT HIV/AIDS Information and Referral Task Force.

CHPC Acronyms & Definitions (Cont.)

CHC: Community Health Center. Network of health centers funded by HRSA to provide family-oriented primary and preventive health care services for people living in rural and urban medically underserved communities.

CHCACT: Community Health Centers Association of Connecticut

CHPC: Connecticut HIV Planning Consortium. The combined care and prevention HIV planning body in Connecticut.

CHIP: The Center for Health/HIV Intervention and Prevention (CHIP). A research center at the University of Connecticut dedicated to the study of the dynamics of health risk behavior and processes of health behavioral change in individuals and targeted at-risk populations.

CHTC: Couples HIV Testing and Counseling. A program in which two or more persons who are in—or are planning to be in—a sexual relationship receive all elements of HIV testing and counseling together.

CIPA: Connecticut Insurance Premium Assistance Program. A health insurance premium assistance program sponsored by the Departments of Social Services and Public Health for eligible Connecticut AIDS Drug Assistance Program (CADAP) clients who have health insurance approved by CIPA.

CIRA: Center for Interdisciplinary Research on AIDS of Yale University. CIRA brings together scientists to support the conduct of interdisciplinary research focused on the prevention of HIV infection.

CLI: Community Level Interventions. Community-level interventions seek to change attitudes, norms, and values of an entire community/target population as well as social and environmental context of risk behaviors of the target population/community.

CMS: Centers for Medicare and Medicaid Services. Part of the U.S. Department of Health and Human Services (HHS) that administers Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and parts of the Affordable Care Act (ACA).

CPC: Cross Part Collaborative. A Quality Improvement initiative for Ryan White Funded Grantees in Connecticut.

CYFAN: Children, Youth and Family AIDS Network of Connecticut

DAC: Data and Assessment Committee of the CHPC.

DCF: Connecticut Department of Children and Families.

DHAP: Division of HIV/AIDS Prevention. CDC division charged with the mission of preventing HIV infection and reducing the incidence of HIV-related illness and death.

DIS: Disease Intervention Specialist. DIS personnel conduct voluntary interviews with patients to obtain the names and contact information of their sexual partner(s) and then use that information to contact a patient's sexual partner(s) and inform them of their potential exposure to an STD or HIV.

DMHAS: Connecticut Department of Mental Health and Addiction Services.

DRUG USER HEALTH: (As defined by the National Alliance of State & Territorial AIDS Directors (NASTAD)): A scope of services that underlines a harm reduction philosophy that emphasizes "meeting drug users where they are" by providing services, harm reduction activities and support that addresses drug users' structural and social barriers.

DOC: Connecticut Department of Correction

DPH: Connecticut Department of Public Health

CHPC Acronyms & Definitions (Cont.)

DSS: Connecticut Department of Social Services

EBI: Effective Behavioral Interventions. Programs and activities that have been scientifically proven to be effective in HIV prevention.

eHARS: Enhanced HIV/AIDS Reporting System. A browser-based application provided by the CDC to collect, manage and report HIV/AIDS cases surveillance data to CDC.

EHR: Electronic Health Record

EIIHA (Pronounced ee-ha): Early Identification of Individuals with HIV/AIDS

EIS: Early Intervention Services. Activities designed to identify individuals who are HIV+ and get them into care as quickly as possible.

EMA: Eligible Metropolitan Area. Under the Ryan White HIV/AIDS Treatment Modernization Act, metropolitan areas with a cumulative total of more than 2000 cases of AIDS during the most recent 5-year period and a population of 50,000 or more.

EMR: Electronic Medical Record

EPI: Epidemiology, Epidemiological. The study of incidence, distribution, and control of diseases in a population.

ERLI: Early Referral & Linkage Initiative protocol promotes collaboration and culturally competent, psychologically and developmentally appropriate, and linguistically specific client referrals by HIV/OTL staff and HIV Medical Case Managers.

ETI: The Expanded Testing Initiative relies on community health centers, emergency departments, and outpatient clinics to conduct expanded and integrated opt-out HIV screening or routine testing.

FDA: Food and Drug Administration

FPL: Federal Poverty Level. The set minimum amount of gross income that a family needs for food, clothing, transportation, shelter and other necessities. In the United States, this level is determined by the Department of Health and Human Services. FPL varies according to family size. A family's FPL determines their eligibility for certain programs, such as ADAP.

FQHC: Federally Qualified Health Centers must serve an underserved area or population, offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program, and have a governing board of directors.

GBAPP: Greater Bridgeport Area Prevention Program. An AIDS Service Organization that serves the Bridgeport area.

GLBT(Q): Gay, Lesbian, Bisexual, and Transgender (Questioning)

HAB: HIV/AIDS Bureau. The federal Health Resources and Services Administration (HRSA) HIV/AIDS Bureau.

HCSS: Health Care and Support Services. The branch of the Connecticut Dept. of Public Health's AIDS & Chronic Diseases Section which is responsible for Part B of the Modernization Act.

HCV or HEP C: Hepatitis C Virus

HHS: U.S. Department of Health and Human Services

HIP: High Impact Prevention strategies

HIV: Human Immunodeficiency Virus

CHPC Acronyms & Definitions (Cont.)

HOPWA: Housing Opportunities for Persons with AIDS Program to devise long-term comprehensive strategies for meeting housing needs of persons living with HIV/AIDS.

HPV: Human papillomavirus is a viral infection that is passed between people through skin-to-skin contact.

HRA of New Britain: Human Resources Agency of New Britain.

HRSA: Health Resources and Services Administration. The Federal agency concerned with programs involving expanding access to comprehensive, quality health care.

ID: Infectious disease

IDU: Injection drug user

LCS: Latino Community Services. An AIDS Service Organization that serves the Hartford area.

LGBT(Q): Lesbian, Gay, Bisexual, and Transgender (Questioning)

MAC: Membership and Awareness Committee of the CHPC.

MAI: Minority AIDS Initiative. National initiative to provide resources to reduce the spread of HIV/AIDS & improve health outcomes for PLWH/A within communities of color.

MAP: The statewide Medication Adherence Program helps PLWH adhere to their medication regimens.

MCM: The Statewide Medical Case Management programs assist PLWH with income levels of 300% FPL or less to enter and remain in medical care through bio-psychosocial assessments, individualized care plans, advocacy, and referrals for core and support services including health insurance.

MIS: Management Information System

MSM: Men who Have Sex with Men. Includes men who identify as Gay and those who do not.

NAP Team: Needs Assessment Projects Team, a sub-group of the CHPC Data and Assessment Committee.

NAPWA: National Association of People with AIDS. Nationwide organization that advocates on behalf of all people living with HIV and AIDS.

NASEN: North American Syringe Exchange Network

NASTAD: National Association of State and Territorial AIDS Directors. A non-profit national association of state health department HIV/AIDS program directors.

NHAS: National HIV/AIDS Strategy

NIH: National Institutes of Health. Federal agency responsible for funding and carrying out research to acquire new knowledge to help prevent, detect, diagnose, and treat disease and disability.

NMAC: National Minority AIDS Council. NMAC's mission is to develop more equitable and capable responses to the crisis of HIV/AIDS in America's communities of color.

nPEP: Non-Occupational Post Exposure Prophylaxis.

OD: Overdose

CHPC Acronyms & Definitions (Cont.)

ONAP: Office of National AIDS Policy. Part of the White House Domestic Policy Council tasked with coordinating the continuing efforts of the government to reduce the number of HIV infections across the U.S. The Office emphasizes prevention through wide-ranging education initiatives and helps to coordinate the care and treatment of citizens with HIV/AIDS.

OPEN Access CT: Overdose Prevention Education and Naloxone Access CT. A DPH initiative focused on providing statewide training, education, informational resources and Naloxone distribution for people who access DPH funded Syringe Services Programs.

OTL: Outreach, Testing, and Linkage to Care. An initiative consisting of condom distribution, education, rapid HIV testing and linking individuals to care services through participating outreach sites community.

POL: Popular Opinion Leader. An Evidence-Based Intervention.

Part A: Ryan White Modernization Act section, formerly Title I of the Ryan White CARE Act. Funds Eligible Metropolitan Areas and Transitional Grant Areas.

Part B: Ryan White Modernization Act section, formerly Title II of the Ryan White CARE Act. Funds states to provide health care and support services.

Part C: Ryan White Modernization Act section, formerly Title III of the Ryan White CARE Act.

Part D: Ryan White Modernization Act section, formerly Title IV of the Ryan White CARE Act. Funds support services for women, infants, children & youth.

Part F: Ryan White Modernization Act section, formerly Title V of the Ryan White CARE Act. Comprises Special Projects of National Significance (SPNS), AIDS Education and Training Centers (AETC), dental programs, and the Minority AIDS Initiative (MAI).

PCSI (pronounced "pixy"): Program Collaboration and Service Integration. A mechanism for organizing and blending interrelated health issues, activities, and prevention strategies to facilitate comprehensive delivery of services.

PDCA: Plan–Do–Check–Act. An iterative four-step management method used for the control and continuous improvement of processes and products.

PEMS: The Program Evaluation and Monitoring System is a tool that CT DPH and Community-based Organization grantees can use to assess their HIV prevention strategies

PEP: Post-Exposure Prophylaxis. Taking anti-HIV medications as soon as possible after you may have been exposed to HIV to try to reduce the chance of becoming HIV positive.

PLWA: People Living with AIDS

PLWH: People Living with HIV

PLWHA: People Living with HIV/AIDS

PrEP: Pre-Exposure Prophylaxis. A way for people who do not have HIV but who are at substantial risk of getting it to *prevent* HIV infection by taking a pill every day.

PS: The Partner Services program uses a confidential protocol by trained field staff to locate, screen, and treat partners without divulging the identity of the infected patient.

CHPC Acronyms & Definitions (Cont.)

PSA: Public Service Announcement

PWID: Persons Who Inject Drugs

PWP: Prevention With Positives, Prevention With Persons With HIV

QA: Quality Assurance. The process of identifying problems in service delivery, designing activities to overcome these problems, and following up to ensure that no new problems have developed and that corrective actions have been effective.

QI: Quality Improvement. An ongoing process of monitoring and evaluating activities and outcomes in order to continuously improve service delivery.

QM: Quality Management.

QPM Team: Quality and Performance Measures Team. A subgroup of the CHPC Data and Assessment Committee (DAC).

RFP: Request for Proposals

RWPC: Ryan White Planning Council

SAMHSA: U.S. Substance Abuse and Mental Health Services Administration.

SCSN: Statewide Coordinated Statement of Need. The SCSN is a mechanism for addressing key HIV/AIDS care issues and enhancing coordination across CARE Act programs and titles.

SDE: Connecticut State Department of Education

SHIP: Connecticut State Health Improvement Plan.

SIM: Medicaid State Innovation Model. A broad stakeholder effort under the Affordable Care Act (ACA) to transform healthcare delivery and health for Connecticut's residents.

SNS: Social Networking Strategy. An evidence supported approach to recruiting high-risk people into testing by using peers to reach out to their social networks.

SPNS (Pronounced "spins"): Special Projects of National Significance. The SPNS Program advances knowledge and skills in the delivery of health and support services to underserved populations diagnosed with HIV infection.

SSP: Syringe Services Program (formerly called syringe exchange program or SEP)

STD: Sexually Transmitted Disease

STI: Sexually Transmitted Infection

TA: Technical Assistance

TB: Tuberculosis

TGA: Transitional Grant Area. Under the Modernization Act, TGAs are cities that have between 1000 - 1999 cumulative AIDS cases in the past 5 years.

USCA: United States Conference on AIDS

WAD: World AIDS Day (December 1)

WiLLOW: Women Involved in Life Learning from Other Women. A small group, skill-training intervention for women living with HIV.

CHPC Member Diversity Grid (January 2016)

Data-Driven Portion Based on CDC Guidance and Epidemiologic Profile

Categories	Current Membership	Goal[1]	Members Needed	% Short of Goal
Total	**32**	**30[2]**	**0**	**--**
Consumer/Provider[3]				
Consumer (HIV+)	15	15	0	--
Provider	18	15	0	--
Priority Populations[4]				
HIV+	15	15	0	--
MSM	8	8	0	--
IDU	3	11	**8**	**73**
Heterosexual	20	11	0	--
Gender				
Female	14	10	0	--
Male	18	20	**2**	10
Race/Ethnicity[5]				
Black[6]	14	10	**0**	--
Hispanic or Latino	7	10	**3**	30
White	11	10	0	--

[1] Goals are based on the CT Department of Public Health Epidemiological Profile – data on people living with HIV or AIDS
[2] The target range in the CHPC Charter is 35 to 42 members, but CHPC leaders want the membership to be roughly 30.
[3] The CHPC has an internal goal of having its membership be 50% consumers (HIV+ individuals) and 50% non-consumers/providers (non-HIV+ individuals)
[4] Categories are not mutually exclusive, so total may be larger than # of members.
[5] Categories are not mutually exclusive, so total may be larger than # of members.
[6] Black includes African-American, African, Caribbean-American, West Indian, Haitian, etc.

CHPC Member Diversity Grid (January 2016) (Cont.)

AGE				
<29[7]	2	2	0	--
30-39	4	4	0	--
40-49	7	9	2	22
50+	19	15	0	--
County[8 9]				
Fairfield	5	8	**3**	38
Hartford	13	9	0	--
Litchfield	0	1	1	**100**
Middlesex	0	1	1	**100**
New Haven	11	9	0	--
New London	2	2	0	--
Tolland	0	0	0	--
Windham	1	1	0	--
Department of Corrections[10]	2	3	1	50

[7] The CPG Youth Advisory Group, which represents people age 21 and younger, is in addition to the goal for individuals 29 and younger. The goal for individuals 29 and younger was increased by 1 based on the assumption that the there are more young people living with HIV/AIDS than the PLWHA data used to generate membership goals indicates.
[8] Categories are not mutually exclusive, so total may be larger than # of members.
[9] Members who work in one region and live in another region are categorized according to their work region
[10] The Department of Corrections is represented by former inmates.

CHPC Member Diversity Grid (January 2016) (Cont.)

Non-Data-Driven Portion Based on CDC Guidance and Required Categories

Funding Source	# of Members
Part A	9
Part B	8
Part C	4
Part D	6
Part F Provider (Dental, SPNS, AETC)	0
Prevention Funds	11
Required Partners	**# of Members**
New Haven/Fairfield TGA Part A Grantee	1
Hartford TGA Part A Grantee	0
State of Connecticut Part B Grantee	1
Part C Grantee	1
Part D – Connecticut Primary Care Consortium	1
Part F – Dental Reimbursement Program	0
Part F – AIDS Education & Training Centers	0
CT Department of Social Services (CADAP)	1
CT Department of Mental Health and Addiction Services	1
CT Department of Correction	0
CHPC Youth Advisory Group Graduates (2)	1
Sexual Orientation	**# of Members**
Heterosexual	21
Gay Man	8
Lesbian	0
Bisexual	2
Occupation	**# of Members**
State health dept. HIV / AIDS staff	1
State health dept. hepatitis staff	1

CHPC Member Diversity Grid (January 2016) (Cont.)

State health dept. STD / STI staff	0
State health dept. tuberculosis staff	0
Local health dept. HIV prevention/STD treatment staff	2
State education agency	2
Local education agency	1
Non-governmental STD agency	1
Non-governmental TB agency	0
Non-governmental substance abuse prevention & treatment	1
Non-governmental mental health services	2
Non-governmental homeless shelters	1
Non-governmental prisons/corrections	0
Non-governmental HIV care and social services	12
Non-governmental education agency	2
Medical doctor	0
Business community	2
Labor community	0
Faith community	4
Community member	33
Field of Expertise	**# of Members**
Health Planning	10
Behavioral Science	6
Social Science	4
Program Evaluation	10
Epidemiology	2

HIV Funders Collaborative Survey Results

*In April 2016, **13** individuals representing various statewide funders completed a survey related to the **strengths and weaknesses** of the HIV prevention and care service delivery system.*

What are the top three **strengths** of the HIV prevention & care service delivery system?

Themes:

- Collaboration & communication
- Integrated care & prevention
- Quality of services
- Data systems

What are the top three **opportunities** to make improvements in the HIV prevention & care service delivery system, or to address gaps?

Themes:

- Public outreach
- Funding opportunities
- Improving existing resources
- Improving services (e.g., training)

What are the most notable **unintended consequences**, if any, for PLWH & their access to care as a result of ACA implementation?

Themes:

- Financial problems (e.g., coverage changes)
- Provider problems (e.g., must change providers for coverage)
- Other (e.g., enrollment difficulties)

What are the most notable **unintended consequences**, if any, for high risk populations (prevention) as a result of ACA implementation?

Themes:

- Financial problems (e.g., affordability of premiums)
- Services problems (e.g., ability to access PrEP due to lack of provider knowledge)
- Change in prevention landscape/approach

What are the top three **weaknesses** of the HIV prevention & care service delivery system?

Themes:

- Collaboration & communication
- Funding decreases
- Reach of services to patients
- Workforce diversity
- Attitudes & stigma

What is your best example of improving your service delivery system during the past 12-18 months?

Themes:

- Develop/implement trainings
- Data-related improvements (e.g., universal data system)
- Specific projects (e.g., campaigns)

Describe how, if at all, routine testing has affected the service delivery system.

Themes:

- Positive impact: more patients identified and thus more patients entering care
- Insufficient impact: not sufficiently reaching the highest risk populations

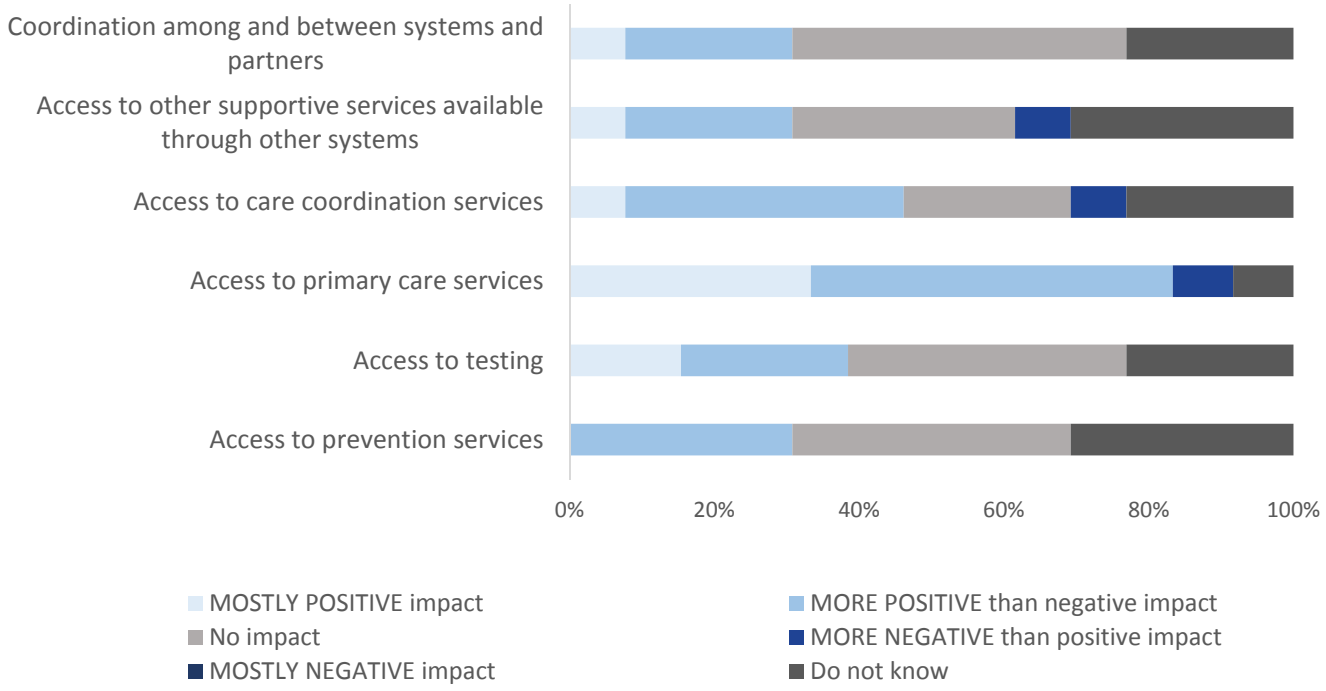
Describe the impact, if any, that the availability of PrEP has had on the services you provide.

Themes:

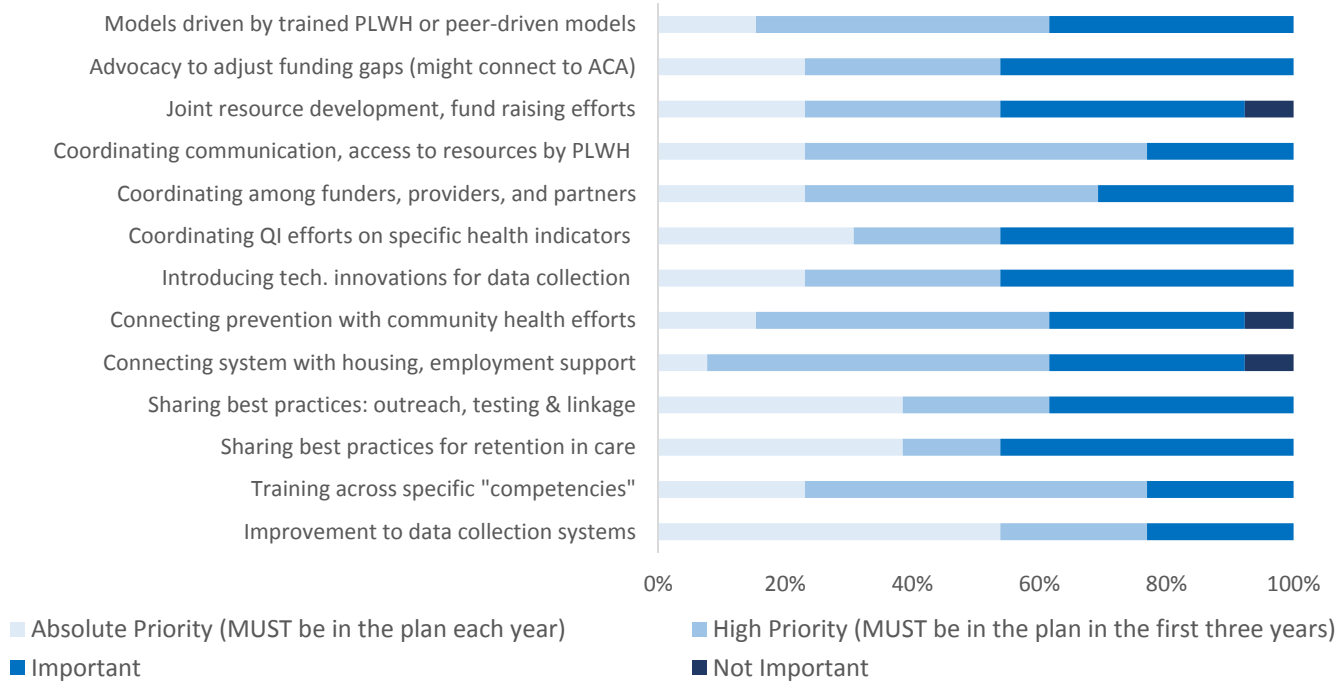
- Positive impact: highly effective at preventing HIV, crucial in responding to victims of sexual assault
- Some impact: resource are limited

HIV Funders Collaborative Survey Results (Cont.)

Rate the impact of the ACA implementation on the HIV prevention and care service delivery system.



Rate the priority of each of these strategies to improve the HIV prevention and care service delivery system.

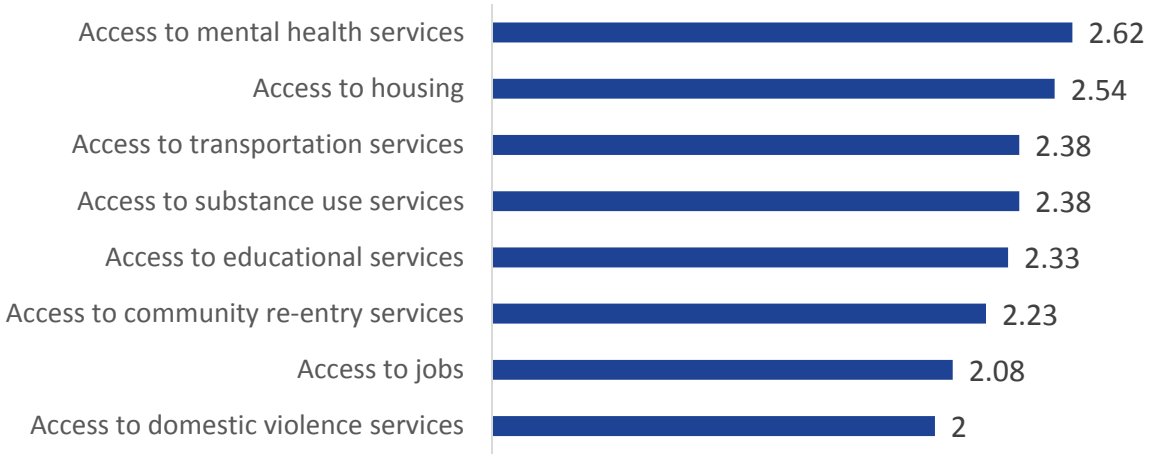


HIV Funders Collaborative Survey Results (Cont.)

Where do you place the primary emphasis on your partnership building for non-primary health care services?

(Items ranked on a scale of 0-3)

Weighted average of responses (ranked in order):



Please select the best way to address barriers that impede optimal care delivery in the HIV prevention and care service delivery system. If you do not face a barrier listed, please identify that as well.

The following reveals the **most common** response among survey respondents.

Policy change required

- Increasing emphasis on HIV awareness and education
- Increasing access to Naloxone
- Limits on how funding gets used (e.g., Part A primarily for medical services)
- Reimbursement for services (e.g., shift to Medicaid approved providers)

Funding change needed (amount or use of funds)

- Updated electronic healthcare systems of partners or providers
- Capacity to attract and to retain qualified HIV prevention and care workers ("tied")

Improve coordination within existing HIV Prevention and Care infrastructure to scale solutions

- Increasing access to Pre-Exposure Prophylaxis (PrEP)
- Communication protocols between partners (e.g., release and consent forms)

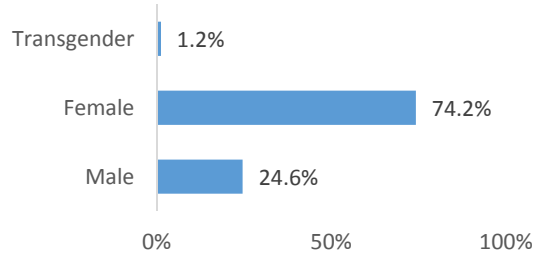
Improve workforce training (implement solutions)

- Attitudes about HIV (e.g., "curable," social stigma)
- Language or translation capacity of staff to match client populations
- Capacity to attract and to retain qualified HIV prevention and care workers ("tied")
- Health literacy levels of patients or high risk populations

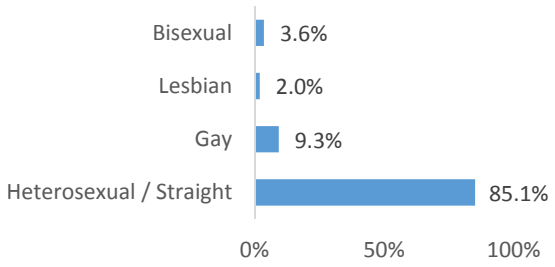
HIV Workforce Survey Results

Total of 248 survey submissions (71% response rate)

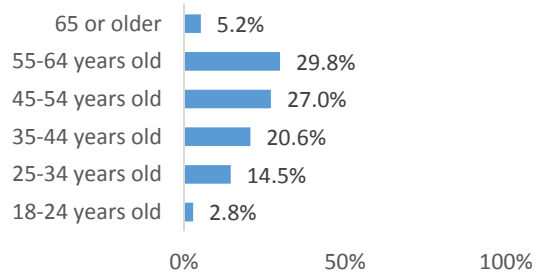
What is your gender identity? (n=248)



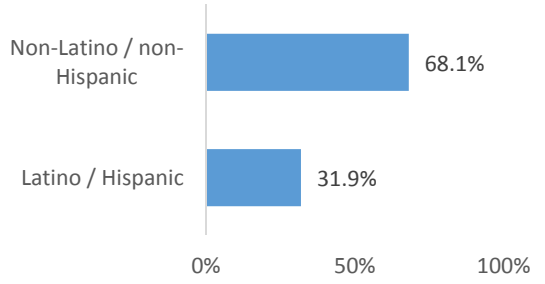
What is your sexual orientation? (n=248)



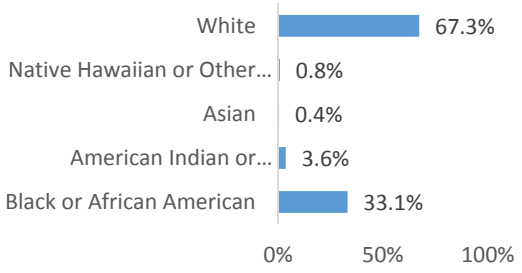
What is your age? (n=248)



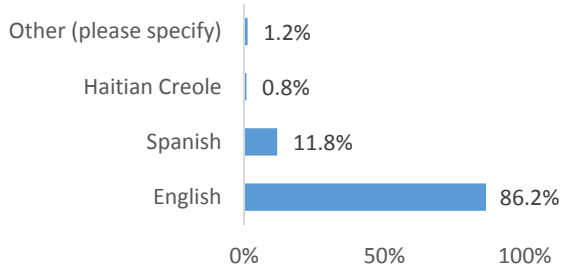
What is your ethnicity? (n=248)



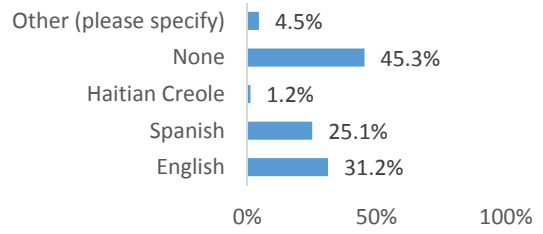
What is your race? (n=248)



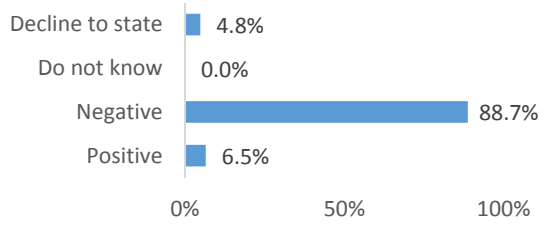
What is your primary language? (n=246)



What other languages are you fluent in? (n=247)

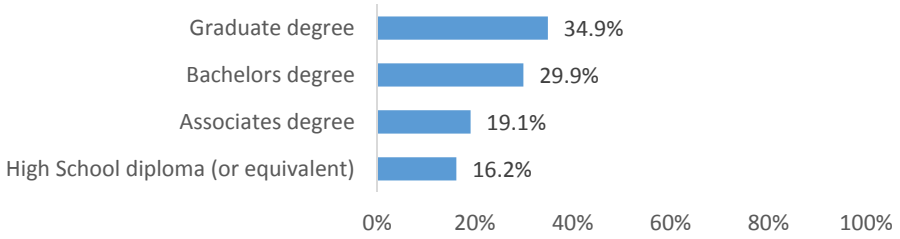


What is your HIV status? (n=248)

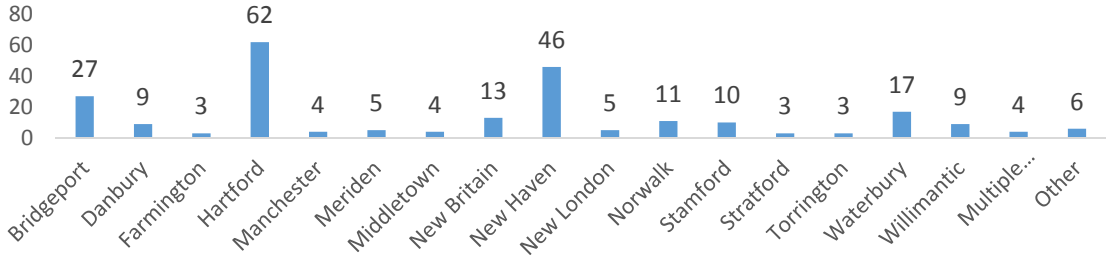


HIV Workforce Survey Results (Cont.)

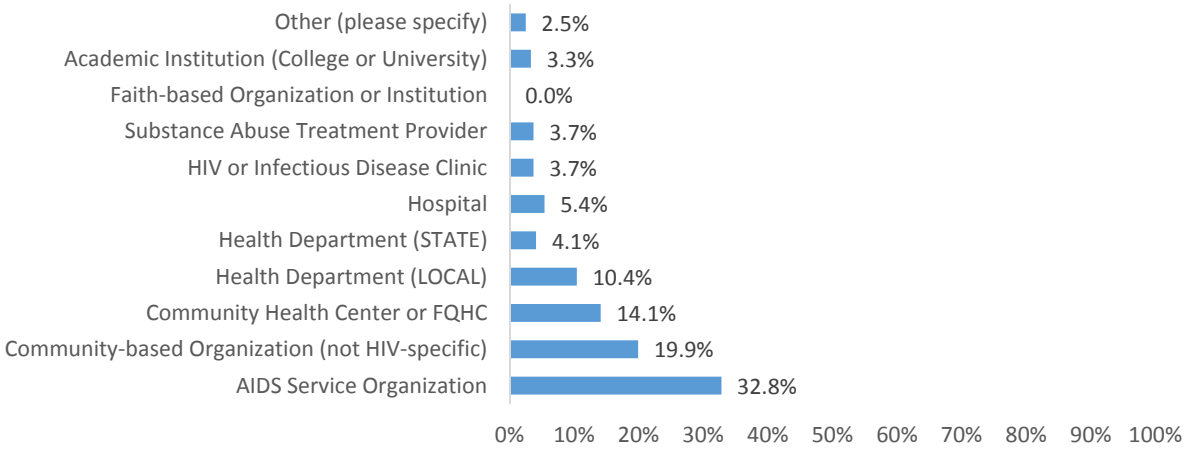
What is your highest level of education completed? (n=241)



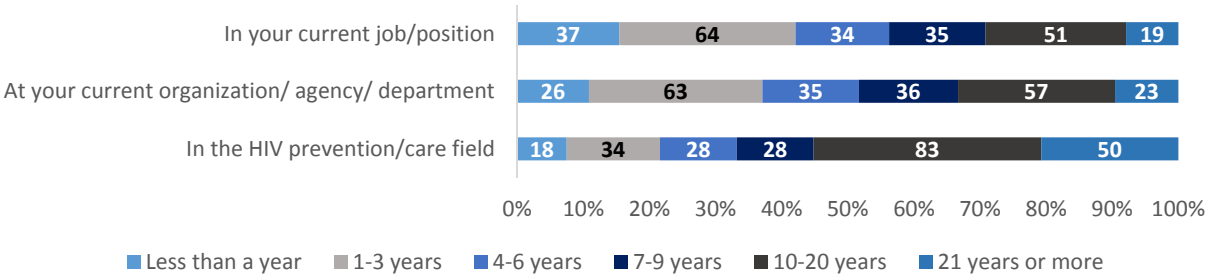
In what town is your office located? (n=241)



What best describes the type of organization you work for? (n=241)

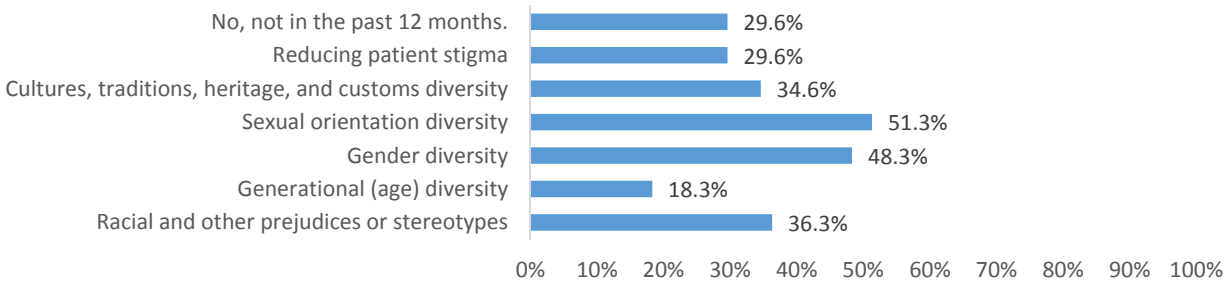


How long have you been providing HIV prevention and/or care? (n=241)

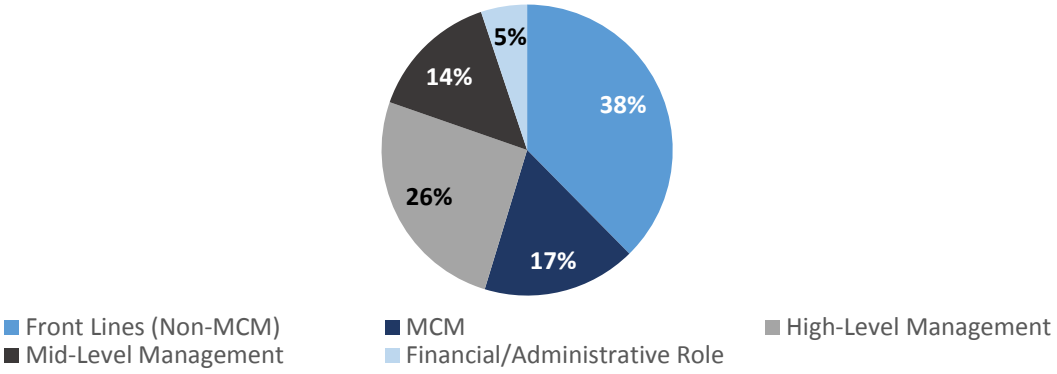


HIV Workforce Survey Results (Cont.)

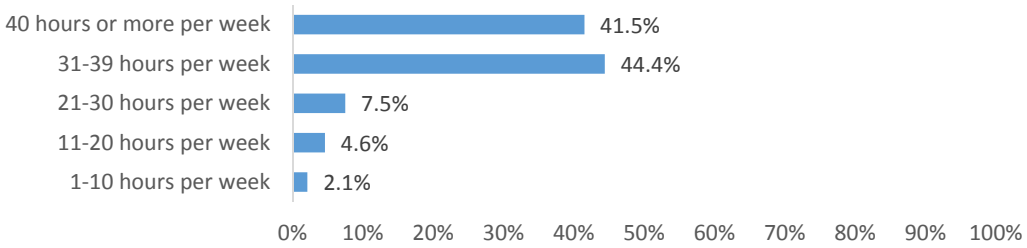
In past 12 mos., have you completed cultural diversity/sensitivity training on any of the following? (n=240)



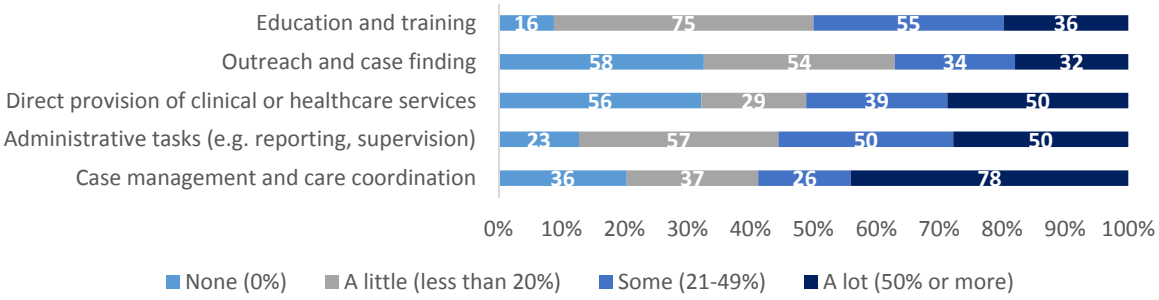
What is your job title? (n=234)



How many hours per week are you employed in your current position? (n=241)

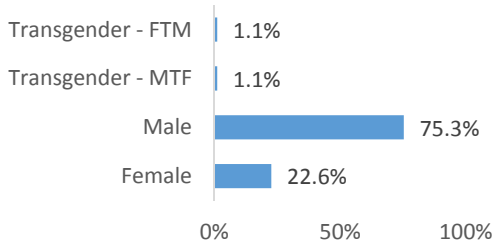


Please estimate the percentage of time you spend doing the following tasks: (n=186)

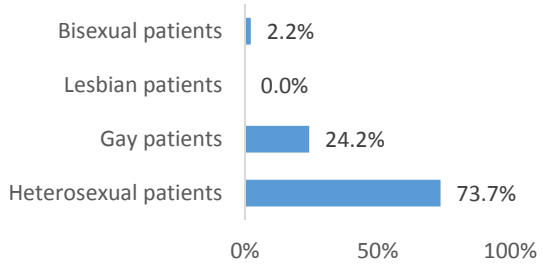


HIV Workforce Survey Results (Cont.)

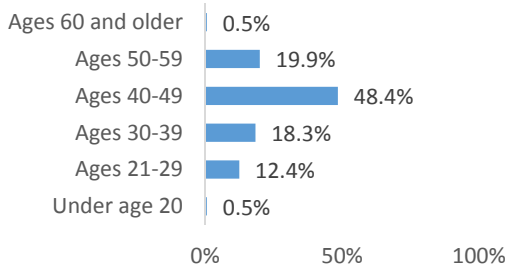
What is the MOST COMMON gender of your patients? (n=186)



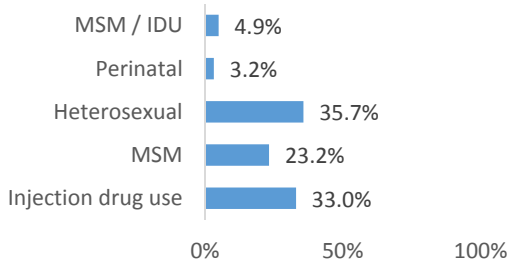
What is the MOST COMMON sexual orientation of your patients? (n=186)



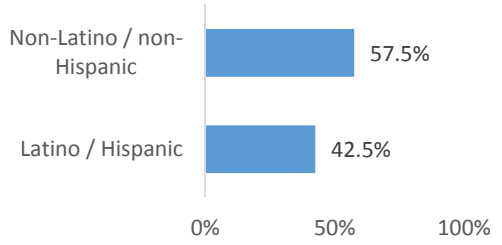
What is the MOST COMMON age range of your patients? (n=186)



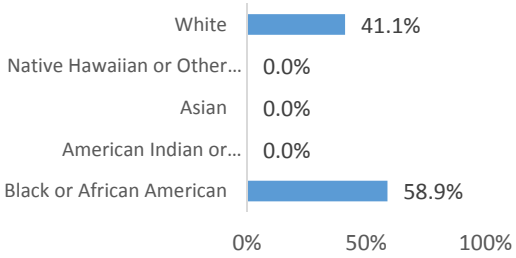
What is the MOST COMMON HIV risk factor of your patients? (n=185)



What is the MOST COMMON ethnicity of your patients? (n=186)



What is the MOST COMMON race of your patients? (n=185)

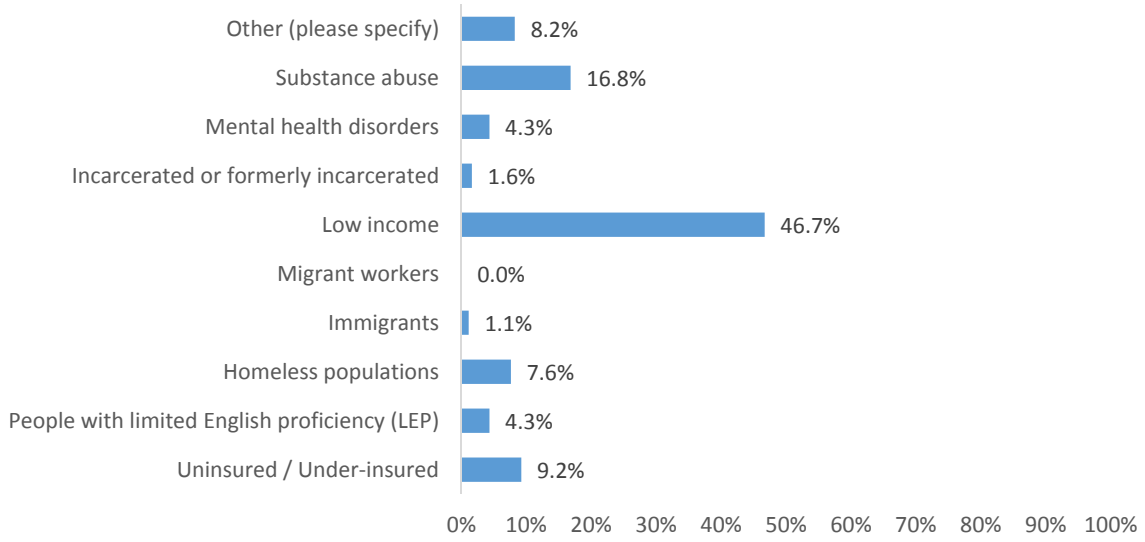


What percentage of your patients are undocumented Americans? (Please write only a whole number between 0 and 100) (n=185)

Average Response = Estimated 6.8% of patients are undocumented Americans

HIV Workforce Survey Results (Cont.)

Which of the following groups do you MOST OFTEN work with? (n=184)



What percentage of your patients are persons living with HIV/AIDS (PLWH)? (Please write only a whole number between 0 and 100) (n=186)

Average Response = 74.5% of patients are persons living with HIV/AIDS (PLWH)

Do you have any comments or suggestions regarding HIV/AIDS prevention and care in Connecticut? If so, please briefly respond in the text box below. (n=59)

Emerging Themes:

Need to increase prevention outreach *(e.g., MSM, older adults, teen, PrEP, condom use)*

General service needs *(e.g., more funding into care, prevention, nutrition)*

Lack of diversity (particularly racial diversity) in current service delivery system roles

HIV Financial Resources Inventory (Public Funding)

Public Funding Source	EMA / TGA / Balance of State (BOS)	FY 2015 Funding		Prevention Services						Core Medical-related Services														Supportive Services																	HIV Testing	HIV/AIDS Education	HIV Care Continuum				
		$	% (of total)	Non-Occupational Post-Exposure Prophylaxis (nPEP)	Outreach Testing & Linkage (OTL)	Expanded Testing Initiative (ETI) – Routine	Syringe Service Programs (SSP)	Partner Services	Effective Behavioral Interventions (EBI)	Outpatient/Ambulatory Medical Care	AIDS Drug Assistance Program	AIDS Pharmaceutical Assist.	Oral Health Care	Early Intervention Services	Health Insurance Premium/ Cost-Sharing Assistance	Home Health Care	Home & Community-based Health Services	Hospice Services	Mental Health Services	Medical Nutrition Therapy	Medical Case Management	Substance Abuse Services – Outpatient	Non-medical Case Management	Child Care Services	Emergency Financial Assistance	Food Bank/Home-delivered	Health Education/Risk Reduction	Housing Services	Legal Services	Linguistic Services	Medical Transportation Services	Outreach Services	Psychosocial Support Services	Referral for Health Care/ Supportive Services	Rehabilitation Services	Respite Care	Substance Abuse Services – Residential	Treatment Adherence			HIV-Diagnosed	Linkage to Care	Retained in Care	Antiretroviral Use	Viral Load Suppression
Part A	NHV/FF	$ 4,978,217	5.3%							X			X	X	X				X		X	X			X	X		X			X						X						X	X	X	X
	HTF	$ 2,870,663	3.1%							X			X	X	X				X		X	X	X		X	X		X			X		X						X		X	X	X	X	X
Part B	NHV/FF	$ 1,509,136	1.6%							X			X	X	X				X	X	X				X	X		X			X		X									X	X		X
	HTF	$ 1,467,975	1.6%							X			X	X	X				X	X	X				X	X					X											X	X		X
	BOS	$ 9,350,771	10.0%							X	X		X		X				X	X	X		X		X	X		X			X		X									X	X	X	X
Part C	NHV/FF	$ 2,469,802	2.6%							X			X	X					X	X	X		X		X		X				X	X							X		X	X	X	X	X
	HTF	$ 644,570	0.7%							X			X						X		X	X	X				X			X	X	X							X		X	X	X	X	X
	BOS	$ -	0.0%																																											
Part D	NHV/FF	$ 463,408	0.5%							X									X	X	X		X				X				X	X									X	X	X	X	X
	HTF	$ 96,715	0.1%		X					X										X	X										X										X	X	X	X	X
	BOS	$ -	0.0%																																											
Part F (HRSA)	NHV/FF	$ 163,461	0.2%																																					X						
	HTF	$ 225,846	0.2%																																					X						
	BOS		0.0%																																											
Federal Prev. Funding (CDC)	NHV/FF	$ 1,453,129	1.6%		X	X	X	X	X																																	X	X			
	HTF	$ 713,491	0.8%		X	X	X		X																																	X	X			
	BOS	$ 71,655	0.1%		X				X																																	X				
SAMHSA	NHV/FF	$ 630,129	0.7%																			X	X					X				X											X	X		
	HTF	$ 375,866	0.4%																			X	X					X				X											X	X		
	BOS	$ 99,494	0.1%																			X	X					X				X											X	X		
HOPWA	NHV/FF	$ 1,755,010	1.9%																									X																X		
	HTF	$ 1,084,150	1.2%																									X																X		
	BOS	$ 217,492	0.2%																									X																X		
State Prev. Funding (DPH)	NHV/FF	$ 2,391,936	2.6%	X	X	X	X	X	X																																	X	X			
	HTF	$ 1,322,850	1.4%	X	X	X	X		X																																	X	X			
	BOS	$ 184,414	0.2%	X	X				X																																	X	X			
Medicaid / Medicare	NHV/FF	$ 33,585,116	35.9%							X		X	X		X		X	X	X	X	X	X																				X	X	X	X	X
	HTF	$ 20,622,440	22.1%							X		X	X		X		X	X	X	X	X	X																				X	X	X	X	X
	BOS	$ 4,713,701	5.0%							X		X	X		X		X	X	X	X	X	X																				X	X	X	X	X

Totals			
	NHV/FF	$ 49,399,344	53%
	HTF	**$ 29,424,566**	**31%**
	BOS	$ 14,637,527	16%
	TOTAL	$ 93,461,437	**100%**

57% of PLWH in Connecticut reside in NHV/FF EMA
35% of PLWH in Connecticut reside in HTF TGA

92% of PLWH live in one of the Ryan White Areas

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Medical Marijuana

Catch Pokémon – Not STDs

CHPC
CONNECTICUT HIV PLANNING CONSORTIUM

September 6, 2016

Newsletter Committee

Kat Auguste
Carmen Cruz Santos
Carl Ferris
Ann Galloway Johnson
Blaise Gilchrist
Reggie Knox
Ronald Lee
Aurelio Lopez
Pamela Parks
Priscilla Pitts

HIV/AIDS Planning News & Notes

Connecticut in the Spotlight at National Ryan White Conference

Connecticut has been at the forefront of HIV care, treatment and prevention for many years, with innovative models and processes. Our success has been evident in a decrease in AIDS-related deaths, lower numbers of new HIV cases and individuals living longer, healthier lives with HIV. Although we have made many strides, we still have populations impacted by HIV more than others. Therefore, HIV and AIDS service agencies and other stakeholders continue to develop and tweak systems to bring HIV to zero. It is befitting that three Hartford Transitional Grant Area (TGA) Ryan White Part A funded agencies were invited to present at the 2016 National Ryan White Conference on HIV Care and Treatment in Washington, DC in August. The chosen Connecticut programs and topics were:

City of Hartford Health and Human Services

Peta-Gaye Nembhard MS BA, Systems Analyst presented on ***Forward Momentum: Accelerating Access to Care and Improving Quality through a Centralized Data System***, where she talked about how the centralized CAREWare system has helped to shape the HIV/AIDS service delivery system in Local and State jurisdictions, as well as how data are used in the Part A Hartford Quality Management and Priority Setting processes.

AIDS Connecticut

Housing Support Services (HSS) is an innovative program which provides specialized intensive case management services to HIV-positive clients with complex housing issues. HSS has been offered in the Hartford TGA for roughly 17 years, evolving over time from strictly a supportive service to a program able to tie program activities to medical outcomes. Key services include assisting clients to maintain affordable housing, short-term budgeting assistance, and representative payee services. HSS is designed for individuals with a history of chronic homelessness or instability due to substance use, mental health issues, or cognitive limitations.

University of Connecticut Health/ Connecticut Children Pediatric, Youth and Family HIV Program

The Phenomenal Women Peer to Peer Psychosocial Group (***PWPPPG***) model utilizes a hybrid of adapted core components from the evidence-based 12-step recovery program Narcotics Anonymous (NA) and best practices from UConn program models. The 12 steps guide peer-participants to a "healthier me" through the integration of Health Resources and Services Administration performance measures into the group setting. For example, peer-participants who verify attending HIV outpatient/ambulatory care medical appointments, having mental/oral health screenings, and obtaining viral load suppression earn charms as acknowledgements for improved health outcomes (like key chains used as NA sobriety-time acknowledgements). This effective and cost efficient peer-to-peer group model was developed for and by HIV-positive women and program staff to address a gap in services identified by clients and staff. The model's core elements are adaptable to serve all vulnerable populations. ***PWPPPG*** addresses needs specific to populations living with HIV in a safe, supportive and confidential environment.

CT HIV Planning Consortium Update

Connecticut's Integrated HIV Prevention and Care Plan

2017 - 2021

In August, Connecticut HIV Planning Consortium (CHPC) members approved ***Connecticut's Integrated HIV Prevention and Care Plan for 2017-2021***. The Plan aligns with the National HIV/AIDS Strategy, and identifies four goals: 1) Reduce new infections; 2) Increase access to care and improve health outcomes for people living with HIV; 3) Reduce HIV-related disparities and health inequities; and 4) Achieve a more coordinated statewide response to the HIV epidemic. The State Department of Public Health (DPH) and the diverse organizations that receive federal and state HIV prevention and care funding will use the Plan as a reference point for improving the service delivery system, and the CHPC will conduct annual updates. Contact Gina D'Angelo at 860-509-8130 or gina.dangelo@ct.gov for an electronic copy of the Plan.

Six CHPC members who completed their first year of service received certificates of recognition. These members completed a new member orientation, attended monthly CHPC meetings, and participated in the mentoring program and the CHPC lunch and learn program. These member support programs help ease the transition of new members into a complex planning process. The CHPC thanks the CHPC members who served as mentors. The CHPC will offer these same member support programs to new CHPC members who will begin in January 2017.

In August, DPH Commissioner Dr. Raul Pino spoke to the CHPC about the need to energize, incentivize, and inspire people in the fight against HIV, and articulated a goal to reduce new cases of HIV by 20-25% over the next three years.

After taking some time off, the CHPC will meet again in January 2017. Join us!

Department of Public Health Corner

HIV Prevention Contractors to Pilot Interventions in 2017

Over the next several months, some HIV prevention contractors will be trained on how to implement new interventions and/or strategies into their funded prevention programs. Therefore, 2017-2018 will serve as a bridge year between funding cycles to allow Connecticut to test drive the following initiatives:

Couples HIV Testing and Counseling (CHTC) is a paradigm shift in the way HIV testing services have traditionally been offered in the U.S. CHTC occurs when two or more persons who are in or are planning to be in a sexual relationship receive all elements of HIV testing and counseling together. This includes HIV prevention counseling, receipt of test results, and linkage to follow-up services.

Social Network Strategy (SNS) is a peer-driven recruitment intervention that identifies high-risk individuals and provides them with HIV testing and linkage services. This recruitment strategy is used for reaching persons who are unaware of their HIV infection by using their existing social networks. Recruiters who are HIV-positive or high-risk negative persons are enlisted to identify and recruit persons from their social, sexual, or drug-using networks who may be at risk for HIV and link them to testing.

Drug User Health is defined by the National Alliance of State & Territorial AIDS Directors (NASTAD) as a scope of services that underlines a harm reduction philosophy that emphasizes "meeting drug users where they are" by providing services, harm reduction activities and support that addresses drug users' structural and social barriers. It includes three components; Syringe Services, Overdose Prevention, and Harm Reduction Education.

PrEP Navigation entails identifying people who would benefit from Pre-Exposure Prophylaxis (PrEP), linking them to medical services, and assisting them as they initiate PrEP. As PrEP Navigation is a new intervention, a training course in "PrEP Navigation" will provide an important orientation on the core components of the intervention for contracted agency staff implementing PrEP pilot projects in 2017.

Community Corner

Going Back to Work

By Ron Rouse

For a person living with HIV (PLWH), going back to work is a big step forward, and for me it was the best therapy ever. However, choosing the right job is key, so make sure it's something you like or are good at. For me it was the HIV/AIDS field.

Before going back to work, I highly recommend having a strong support network of family, friends, and health care professionals, along with a secure roof over your head if possible. This way one can focus on doing the job at hand with minimal distractions or stress. Although I worked full-time, part-time gives more flexibility to tend to medical appointments and other affairs. Be realistic about your goals and know your limitations. You don't have to wear your HIV status on your sleeve, but be mindful of exposing yourself to germs, bacteria, or toxic materials to protect a compromised immune system. There is still a lot of stigma, so disclose your status cautiously, but without being an isolationist. Be a team player, rely on your experience, and give it your best. Be as well-rounded as possible to strengthen your worth and position. Remember, you cannot please every-one all the time, so choose your battles wisely. There will always be obstacles, but with patience and perseverance you should be able to overcome most of them.

For me, working has restored much-needed pride and dignity, and a sense of self-worth and value. Working in the HIV field has helped me stay abreast of groundbreaking information about the virus, enabling me to better advocate for my own heath care as well as for others as I give back to the community to which I owe so much.

In closing, I say to jump into work, embrace it, prosper from it, and live with it. Take care and be safe.

Involving PLWH in Quality Improvement

Peta-Gaye Nembhard, Alice Ferguson and André McGuire

People living with HIV (PLWH) are necessary at all decision-making tables, including state and local Quality Improvement (QI) committees. The Connecticut Training of Consumers on Quality Plus Team therefore trains PLWH to play a lead role in QI planning conversations.

In June, Peta-Gaye Nembhard, André McGuire and Alice Ferguson attended a National Quality Center training meant to assist PLWH to more fully participate in QI activities.

On September 28, PLWH will attend a one-day training covering basic QI terminology and the skills required to become a PLWH QI champion, including addressing specific aspects of HIV care, identifying ways to engage in clinical QI activities, and being aware of HIV care and treatment terminology.

For information on future opportunities, call André McGuire at 860-778-4017.

Remembering Orlando

Waterbury honors those lost in the Pulse nightclub shooting. The small sign says "Love Wins."

Marijuana in Connecticut

An October 2015 report by the U.S. Centers for Disease Control and Prevention stated, "Public health concerns about the recreational use of marijuana among adolescents is related, in part, to the potential for harm to individual users and the potential for marijuana to be a 'gateway' to the use of tobacco and other illicit drugs or substances." Is marijuana a gateway drug to more harmful substances? The short answer is that it can be, as can many other substances, including alcohol. Also, most people ingest marijuana by smoking it, which can cause harmful carcinogens to enter the body.

What we in the HIV/AIDS field really want are the benefits. Marijuana has been used to treat pain, appetite loss and nausea for chemotherapy patients, and has been prescribed to treat Crohn's disease, multiple sclerosis, epilepsy, anxiety disorders, and depression, among other conditions. In January 2016, three new Connecticut dispensaries were approved, bringing the number of dispensaries in the state to nine. In May 2016, Governor Malloy signed legislation giving clearer language to doctors about who can receive a marijuana prescription. Clearly, the state is going in the direction of pro-marijuana legislation, but we are not there yet, as it is not legal. Marijuana possession has been "decriminalized" in Connecticut to a misdemeanor, but those caught with half an ounce or less without a valid registration card are fined $150, with subsequent possession offenses bringing harsher penalties.

With all of this in mind, this writer asked several consumers: "How do you personally feel about marijuana?" Many argued that it should be legalized due to how many people use it and it "being natural." Folks listed the benefits of marijuana in their lives and said they would rather their kids smoke "weed" than drink alcohol. Many noted that alcohol-related deaths seem to happen every weekend, yet you never hear about deaths related to marijuana. For now, the debate rages on.

For more information about medical marijuana, visit the State Department of Consumer Protection's Medical Marijuana Program webpage.

Could Medical Marijuana Ease What Ails You?

By Susan Hernandez

Adapted from HIVplusmag.com

Like many people living with HIV (PLWH), I have medication-related symptoms like nausea, loss of libido, and fatigue, as well as age-related problems including migraines, insomnia, myofascial pain syndrome, irritable bladder, and worst of all, a chronic unrelenting pain condition. When people suggested I try medical marijuana, I scoffed. But the thing about chronic unrelenting pain is, you'll do anything to try to stamp it out, which means in addition to common sense treatments like exercise, good nutrition, and meditation, I've been prescribed over 30 pharmaceuticals, including narcotics. Only heavy narcotics combined with a salt soak and massage has ever lowered my pain threshold below a four on the doctor's infamous pain scale.

Studies on marijuana's impact on medical conditions like HIV and many others have generally shown good results. A 2005 study showed that medical marijuana users were three times as likely to adhere to their antiretroviral medications. A 2007 study showed that cannabis successfully treated neuropathic pain and loss of appetite in PLWH.

Dope doesn't sound too terrible after all of this, but pot cards require a doctor's recommendation, and many HMOs and insurance companies don't allow their doctors to prescribe marijuana. I tried HelloMD, and I'm thrilled I did. Here's how it works: you log on to HelloMD, fill out a membership form, pay fees, and connect to a doctor via a live video service. The doctor asks questions, and if s/he sees fit, writes you a medical marijuana recommendation. If approved, you can take the recommendation, print it, and go to a dispensary that day.

I started small, experimented with different products, and waited until I knew more about the impact of cannabis on my body before I stepped up my intake. I took home ordinary prescription bottles, each with 1 gram of pot inside, something for morning, lunch, and nighttime. In my new cannabis-using treatment regime, I've never been what you'd imagine as high. I did get something I haven't had in years, as well: unexpectedly sweet pain relief.

Upcoming HIV/AIDS Prevention and Care Planning Meetings

See the next page for contact information for planning meetings

September

Monday	Tuesday	Wednesday	Thursday	Friday
			1 • 10 New Haven/ Fairfield Planning Council (NH/FF PC) Strategic Planning and Assessment (SPA) Committee • 12 NH/FF PC Quality Improvement (QI) Committee	2
5	6 • 10 Danbury Consortium	7 • 9:30 Bridgeport Consortium	8	9 • 9:30 NH/FF PC Executive Committee • 10:30 NH/FF PC Membership & Finance (MF) Committee • 12 NH/FF PC
12 • 10 Positive Prevention CT	13 • 9:30 CT HIV/ AIDS Identification & Referral (CHAIR) Task Force • 12 New Haven Mayor's Task Force on AIDS (MTFA) • 1 Norwalk/Stamford Consortium	14	15	16
19	20 • 1:30 Hartford PC Steering Committee	21	22	23
26 • 12 NH HIV Care Continuum	27 **National Gay Men's HIV/AIDS Awareness Day**	28	29	30

October

Monday	Tuesday	Wednesday	Thursday	Friday
3 • 10 Positive Prevention CT	4 • 10 Danbury Consortium • 1:30 Hartford PC Continuum of Care	5 • 9:30 Bridgeport Consortium • Hartford Planning Council & committees • 10:30 Hartford Positive Empowerment Committee (PEC)	6 • 10 NH/FF PC SPA • 12 NH/FF PC QI	7
10	11 • 9:30 CHAIR Task Force • 12 New Haven MTFA • 1 Norwalk/Stamford Consortium	12	13	14 • 9:30 NH/FF PC Executive • 10:30 NH/FF PC MF Cmte • 12 NH/FF PC
17	18 • 1:30 Hartford PC Steering Committee	19	20	21
24 • 12 NH HIV Care Continuum	25	26	27 **9-4 Overdose Prevention Conference**	28

November

Monday	Tuesday	Wednesday	Thursday	Friday
31	1 • 10 Danbury Consortium • 1:30 Hartford PC Continuum of Care	2 • 9:30 Bridgeport Consortium • Hartford PC & committees • 10:30 Hartford PEC	3 • 10 NH/FF PC SPA Committee • 12 NH/FF PC QI Committee	4 • 9:30 NH/FF PC Executive Cmte • 10:30 NH/FF PC MF Committee • 12 NH/FF Planning Council
7 • 10 Positive Prevention CT	8 • 9:30 CHAIR Task Force • 12 NH MTFA • 1 Norwalk/ Stamford Consortium • 1:30 Hartford PC Steering Committee	9	10	11 •
14	15	16	17	18
21	22	23	24	25
28 • 12 NH HIV Care Cont.	29	30		

Contact Information for Planning Meetings

Hartford Planning Council + Positive Empowerment	860-688-5818
New Haven/Fairfield Planning Council	877-336-5503
New Haven Mayor's Task Force on AIDS	203-946-8351
Norwalk/Stamford Consortium	203-855-9535
AIDS LIFE Campaign	860-247-2437 x319
Danbury Consortium	203-778-2437
CT HIV/AIDS Identification & Referral Task Force	203-764-8454
Bridgeport Consortium	203-576-9041
Windham Area Task Force	860-423-4534
Positive Prevention CT	860-247-2437 x315
Overdose Prevention Conference	860-509-8053

More meeting information - www.guardianhealth.org/calendar/calendar.htm

Catch Pokémon – Not STDs

By Dr. Richard Torres

Dr. Richard Torres and Friends

The term STD refers to all sexually transmitted diseases, including Chlamydia, Gonorrhea, Syphilis, Genital Herpes, HIV, Venereal Warts, Trichomonas, Chancroid and many more. Pokémon, on the other hand – if you haven't heard – is the Japanese game that has caught the attention of everyone on the planet.

STDs are some of the most common infections in the U.S., and Genital Human Papilloma Virus (HPV) is the most common sexually transmitted infection, affecting more than 14 million people newly diagnosed every year. The spread of STDs in America has risen, especially for women, young people, men who have sex with men and the elderly. These groups are seeing a resurgence due to unprotected sex and involvement with many partners.

One factor which makes the epidemic of STDs such an important public health crisis is that some STDs have no symptoms. For example, up to 90% of men and up to 70% of women infected with Chlamydia have no symptoms! Women with other STDs like Trichomonas and Gonorrhea may not be aware of their disease.

There can be serious consequences when a person catches one or more STDs. They cause physical illness, psychological distress, economic costs and social conflict. In addition, there are no cures for Genital Herpes or HIV, meaning these diseases unfortunately last a lifetime. So get yourself together, educate yourself, and protect yourself. Tell your friends, your partners and loved ones you want them to catch Pokémon – not STDs!

About the Author: Dr. Richard Torres is an Internist, HIV and Transgender Health Care Specialist at Southwest Community Health Center in Bridgeport and an Associate Professor of Medicine at the Yale School of Medicine.

DPH is an equal opportunity provider. Call 860-509-7801 if you require aid/accommodation to participate fully and fairly.

Visit www.ct.gov/dph for requests for proposals and other DPH information

Project STOP

This PrEP candidate identification and linkage model identified PrEP candidates who had a known HIV+ partner or recent bacterial STI, educating at-risk people about PrEP and connecting people to PrEP medical services

Connecticut Department of Public Health
TB, HIV, STD &Viral Hepatitis Section

Epidemiological Profile of HIV in Connecticut

-2016-

The *Epidemiological Profile of HIV in Connecticut* is published every three years by HIV Surveillance, within the TB, HIV, STD & Viral Hepatitis Section, Department of Public Health, Hartford, CT.

Data are presented for diagnosis of HIV infection reported to DPH through December 2015.

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Suggested citation

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This report was prepared by Suzanne Speers, MPH, Data Manager, HIV Surveillance, TB, HIV, STD & Viral Hepatitis, Connecticut Department of Public Health.

Abbreviations:

AAMR	Age adjusted mortality rate
AIDS	Acquired immunodeficiency syndrome
CDC	Centers for Disease Control and Prevention
CI	Confidence interval
DPH	Department of Public Health
EMA	Eligible metropolitan area
HCV	hepatitis C virus
HIV	Human immunodeficiency virus
IDU	Injection drug user
MSM	Men who have sex with men
PLWH	People living with HIV or AIDS
STD	Sexually transmitted diseases
TGA	Transitional grant area

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Executive Summary

Since 1981, over 20,000 HIV cases have been reported in Connecticut residents and of these almost half have died. The Department of Public Health (DPH) monitors HIV disease through a system of reporting by laboratories and providers. Information gathered through this system is used to analyze trends to determine who is at risk for infection and where services need to be provided. Each year funding from state and federal sources provide prevention services for infected people and others at high risk, HIV medications, housing support, syringe exchange, HIV testing, and other services.

The HIV Epidemiological Profile provides information about the trends and distribution of HIV to planning groups, DPH staff whose mission is to allocate prevention and care funding and other interested parties. Additional information about HIV and annual updates to the data provided here can be found on the DPH website (www.ct.gov/dph/HIVsurveillance).

A quick look at HIV in Connecticut:

- As of December 2014, 10,727 people were living with HIV in Connecticut (298 per 100,000) based on address at diagnosis. HIV is found disproportionately among certain groups including blacks and Hispanics who, although they make up only 23% of Connecticut's population, comprise 66% of all HIV cases.
- During 2010–2014, 1,658 HIV disease cases were newly diagnosed and reported to DPH. Of these, 50% were in men who have sex with men (MSM), 14% in injection drug users (IDU), and 34% in persons with heterosexual contact (risks percentages adjusted for unknown risks). Over the last ten years, 2005–2014, there has been a 75% decrease in IDU reported as the mode of transmission.
- Thirty-one percent of newly diagnosed cases during 2010–2014 met the criteria of AIDS at diagnosis, meaning they have likely been infected for many years. The ongoing 'late tester' concern supports the need for more widespread HIV testing.
- Data from the HIV and STD surveillance systems continue to point to ongoing transmission of syphilis and HIV in MSM. During 2010–2014, 274 syphilis cases were in MSM, 84% of all cases reported. Importantly, 40% of these men were co-infected with HIV.
- Seventy percent of people diagnosed with HIV through 2013 and currently living in Connecticut based on last known residence were engaged in care in 2014.
- In 2014, 91% of adolescents and adults diagnosed with HIV were linked to care within 3 months of their diagnosis.
- People are living longer with HIV due to the advances in medications. There is a statistically significant difference ($p<.0001$) between the mean age of death in 1993 (mean=39 years) vs the mean age of death in 2014 (mean=56 years).

Section I: Connecticut's People

Table 1: Estimate for the population of Connecticut by age group, sex, race, and Hispanic ethnicity: July 1, 2014

	Race (non-Hispanic ethnicity)								Hispanic		
	White		Black		American Indian		Asian / Pacific Islander		All Races		
Age Group	M	F	M	F	M	F	M	F	M	F	Total
<1	10,329	9,809	2,511	2,422	52	52	1,062	1,047	4,828	4,659	**36,771**
1-4	43,538	41,331	10,164	9,786	320	356	4,479	4,540	19,247	18,905	**152,666**
5-9	62,180	59,330	13,479	12,953	316	313	5,997	6,085	25,193	24,320	**210,166**
10-14	73,515	69,273	14,141	13,700	332	349	5,705	5,911	24,027	22,869	**229,822**
15-19	82,870	79,407	15,893	14,914	353	371	5,308	5,733	24,490	22,932	**252,271**
20-24	77,026	71,745	17,242	15,927	380	349	5,978	6,177	26,052	22,910	**243,786**
25-29	68,889	65,739	13,963	13,889	299	271	6,678	7,311	23,490	21,351	**221,880**
30-34	65,680	66,210	12,553	13,490	281	301	7,534	8,304	22,842	22,237	**219,432**
35-39	62,555	64,010	11,503	12,896	255	299	7,156	7,987	20,808	20,965	**208,434**
40-44	74,764	77,934	11,867	13,534	267	269	6,798	7,625	18,883	19,071	**231,012**
45-49	92,112	96,011	12,429	14,370	339	350	5,620	6,148	16,791	17,992	**262,162**
50-54	106,934	111,541	12,149	14,405	365	347	4,861	5,126	14,098	15,265	**285,091**
55-59	105,604	109,643	10,432	12,004	320	335	3,881	4,215	10,531	11,642	**268,607**
60-64	87,290	92,593	7,409	9,143	241	267	2,876	3,421	7,134	8,280	**218,654**
65-69	70,284	77,475	5,377	7,525	170	195	2,190	2,587	5,092	6,208	**177,103**
70-74	50,007	57,826	3,700	5,409	115	110	1,637	1,659	3,095	4,256	**127,814**
75-79	33,316	42,914	2,396	3,875	71	78	924	1,015	2,106	2,854	**89,549**
80-84	25,743	37,516	1,446	2,697	37	67	526	695	1,136	1,809	**71,672**
85+	27,112	55,150	1,158	2,624	43	72	326	516	1,054	1,730	**89,785**
All	**1,219,748**	**1,285,457**	**179,812**	**195,563**	**4,556**	**4,751**	**79,536**	**86,102**	**270,897**	**270,255**	**3,596,677**

Source: Backus, K, Mueller, LM (2015) State-level Bridged Race Estimates for Connecticut, 2014, Connecticut Department of Public Health, Health Statistics & Surveillance, Statistics Analysis & Reporting, accessed 3/2/2016**.** Accessed at **http://www.ct.gov/dph/cwp/view.asp?a=3132&q=488836**

Table 2: Town populations (n=169), Connecticut, US census, 2014 estimates

Town	Pop	Town	Pop	Town	Pop
Bridgeport	147,612	Monroe	19,867	Easton	7,631
New Haven	130,282	Montville	19,635	Middlebury	7,591
Stamford	128,278	Waterford	19,427	Old Lyme	7,575
Hartford	124,705	Bethel	19,372	Durham	7,348
Waterbury	109,307	East Lyme	19,140	Lebanon	7,309
Norwalk	88,145	Ansonia	18,959	Westbrook	6,902
Danbury	83,784	Wilton	18,692	New Hartford	6,812
New Britain	72,878	Stonington	18,512	Essex	6,612
West Hartford	63,324	Avon	18,421	Killingworth	6,490
Greenwich	62,610	Madison	18,259	Marlborough	6,430
Hamden	61,422	Plainville	17,801	Beacon Falls	6,055
Fairfield	61,347	Killingly	17,172	Willington	5,934
Bristol	60,570	Brookfield	17,055	Bethany	5,531
Meriden	60,293	Wolcott	16,716	Harwinton	5,531
Manchester	58,106	Seymour	16,537	Columbia	5,454
West Haven	54,905	Colchester	16,192	North Stonington	5,288
Milford	53,358	Suffield	15,814	East Granby	5,212
Stratford	52,734	Ellington	15,795	Canterbury	5,088
East Hartford	51,033	Plainfield	15,135	Bolton	4,952
Middletown	47,043	Ledyard	15,121	Preston	4,748
Wallingford	45,074	Tolland	14,872	Deep River	4,571
Enfield	44,626	North Branford	14,322	Middlefield	4,424
Southington	43,815	New Fairfield	14,149	Lisbon	4,342
Shelton	41,295	Cromwell	14,113	Chester	4,316
Norwich	40,178	Orange	13,955	Ashford	4,259
Groton	40,167	Clinton	13,129	Salem	4,184
Trumbull	36,578	Oxford	12,914	Pomfret	4,179
Torrington	35,190	East Hampton	12,874	Sterling	3,773
Glastonbury	34,754	Derby	12,768	Barkhamsted	3,705
Naugatuck	31,659	Windsor Locks	12,565	Sherman	3,671
Newington	30,685	Coventry	12,419	Salisbury	3,665
Cheshire	29,250	Griswold	11,916	Bethlehem	3,501
Vernon	29,098	Plymouth	11,914	Washington	3,487
Windsor	29,069	Stafford	11,881	Andover	3,272
East Haven	29,044	East Windsor	11,423	North Canaan	3,214
Branford	28,225	Granby	11,310	Sprague	2,980
Newtown	28,152	Somers	11,303	Goshen	2,914
Westport	27,561	Winchester	10,929	Kent	2,910
New Milford	27,474	Weston	10,388	Sharon	2,725
New London	27,374	Canton	10,345	Bozrah	2,622
Wethersfield	26,446	Old Saybrook	10,217	Voluntown	2,593
Mansfield	25,977	Prospect	9,723	Lyme	2,389
South Windsor	25,823	Woodbury	9,719	Morris	2,314
Farmington	25,627	Burlington	9,576	Chaplin	2,262
Ridgefield	25,205	Hebron	9,564	Roxbury	2,201
Windham	25,005	Portland	9,444	Hartland	2,129
Simsbury	23,975	Putnam	9,416	Franklin	1,984
North Haven	23,909	Redding	9,309	Hampton	1,859
Guilford	22,413	Thompson	9,308	Eastford	1,734
Watertown	22,046	East Haddam	9,127	Scotland	1,694
Darien	21,689	Woodbridge	8,925	Bridgewater	1,675
Bloomfield	20,819	Haddam	8,333	Norfolk	1,655
Berlin	20,610	Litchfield	8,264	Colebrook	1,445
New Canaan	20,314	Brooklyn	8,254	Warren	1,427
Rocky Hill	20,094	Woodstock	7,860	Cornwall	1,398
Southbury	19,881	Thomaston	7,683	Canaan	1,195
				Union	846

Section I.I: Social Determinants of Health

Table 3: Socio-economic data in 5 cities with the highest rate of PLWH, 2014

	People living with HIV[1] Rate	Below poverty[2] %	High school graduate or higher[2] %	Bachelor's degree or higher[2] %
Bridgeport	903.0	23.6	74.4	16.5
Hartford	1,495.5	34.4	70.3	15.0
New Haven	1,114.5	26.4	82.3	33.6
New London	697.7	25.3	81.2	21.1
Waterbury	671.5	24.2	79.5	16.0
Connecticut	**298.2**	**10.5**	**89.5**	**37.0**

[1] Prevalence rate per 100,000 people based on 2014 census estimates
[2] Source: 2014 American Community Survey 5 year estimates
Note: see 2014 American Community Survey 5 year estimates tables: S1501, S1701 for margin of errors

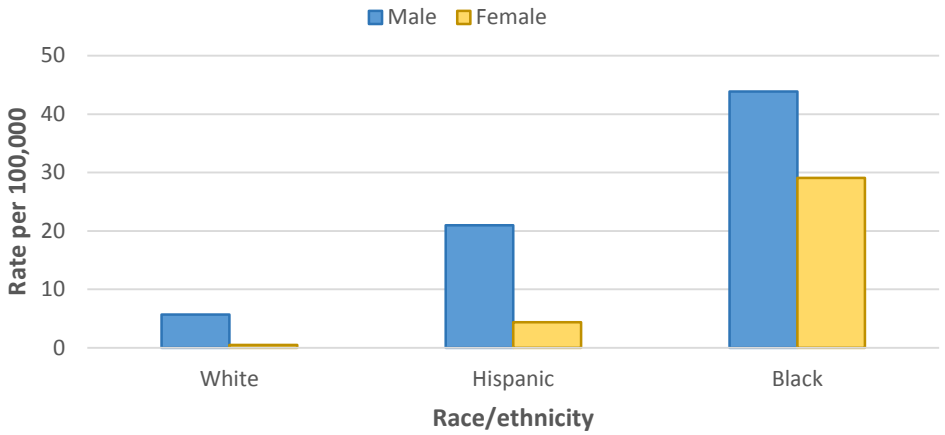
Table 4: Percent uninsured by race and ethnicity in 5 cities with the highest rate of PLWH, 2014

	White %	Black %	American Indian or Alaska Native %	Asian %	Native Hawaiian/ Pacific Islander %	Other race alone %	Two or more races %	Hispanic (all races) %
Bridgeport	39.2	27.9	0.6	4.0	0.1	25.9	2.2	51.5
Hartford	37.0	34.1	0.7	2.6	0.0	21.6	4.1	50.7
New Haven	39.2	28.5	0.4	5.1	0.2	25.4	1.3	50.4
New London	10.5	15.4	0.0	19.0	0.0	21.4	3.0	15.7
Waterbury	58.5	19.8	0.1	4.0	0.0	13.1	4.5	38.9
Connecticut	**61.6**	**14.5**	**0.4**	**5.4**	**0.1**	**15.6**	**2.5**	**32.6**

Source: 2014 American Community Survey 5 year estimates
Note: see 2014 American Community Survey 5 year estimate table: S2702 for margin of errors

Section II: Newly Diagnosed HIV

Figure 1: Rate of HIV diagnoses by race/ethnicity and sex, Connecticut, 2014



Source: HIV surveillance registry through 2015 and State-level Bridged Race Estimates for Connecticut, 2014
Note that reported numbers less than 12, which is the case for white females above (and accompanying rates and trends) based on these numbers, should be interpreted with caution because the numbers have underlying relative standard errors greater than 30% and are considered unreliable.

In 2014, 291 HIV cases were diagnosed in Connecticut, 212 males and 79 females, an overall rate of 8.1 per 100,000 people. Of those cases, black males were diagnosed at a rate of approximately 8 times that of white males and Hispanic males were diagnosed at a rate approximately 4 times that of white males. The disparity among females was also significant with 72% of the females diagnosed classified as black or African American.

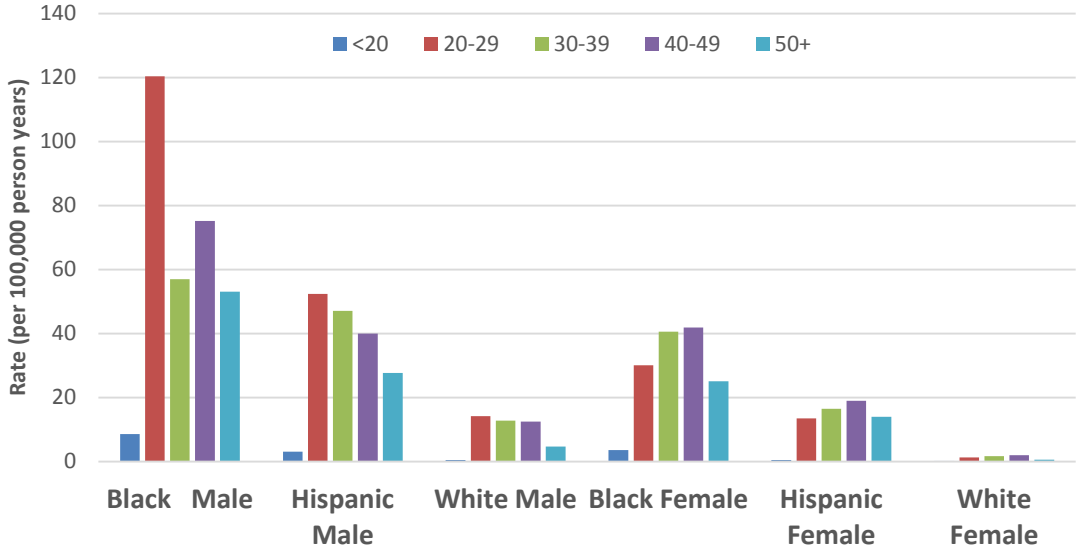
Table 5: Rate of newly diagnosed HIV by age and sex, Connecticut, 2010–2014

	Male					Female				
	2010	2011	2012	2013	2014	2010	2011	2012	2013	2014
<20	2.1	2.6	1.5	2.8	1.3	**	**	**	1.1	1.2
20–29	32.9	43.5	26.9	33.9	29.2	10.6	7.4	9.1	4.5	5.3
30–39	26.1	22.1	27.9	22.4	22.7	13.3	10.3	7.5	5.6	7.8
40–49	30.4	22.0	20.2	23.8	16.3	13.0	9.7	5.5	6.9	7.5
50–59	15.6	12.2	12.0	15.7	11.9	6.7	5.4	4.3	4.6	6.7
60+	7.7	5.0	3.7	4.8	4.9	1.2	2.0	1.4	1.9	1.6

Source: HIV surveillance registry through 2015 and corresponding census or census estimates.
Note that reported numbers less than 12, which is the case for aged <20 males and females and females 60+ above (and accompanying rates and trends) based on these numbers, should be interpreted with caution because the numbers have underlying relative standard errors greater than 30% and are considered unreliable.
** suppressed data due to small cell sizes.

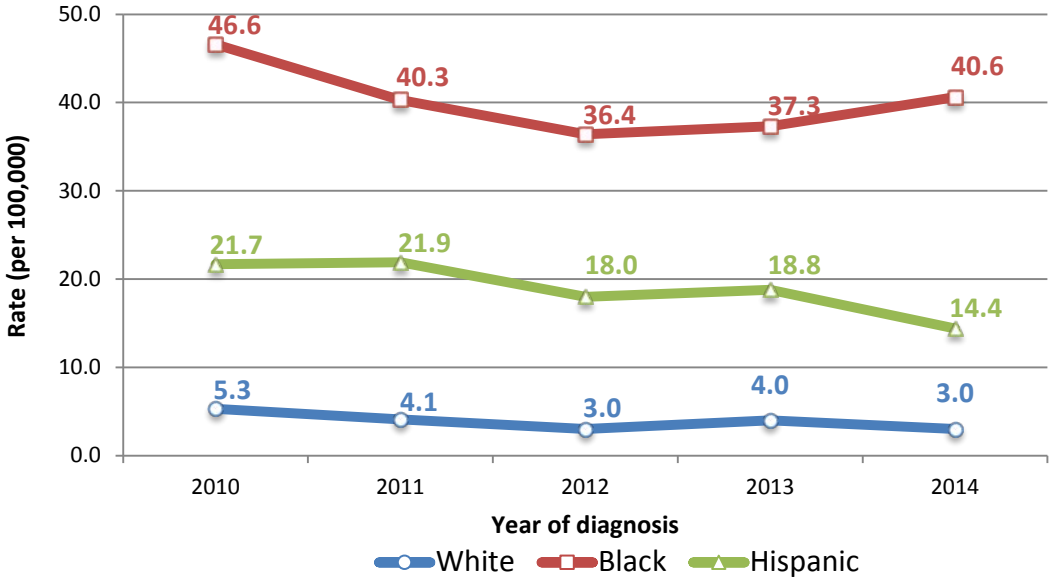
Between the years, 2010–2014, the highest rate of HIV diagnosis consistently was seen in 20–29 year old males, followed by 30–39 year old males and 40–49 year old males.

Figure 2: Rate of newly diagnosed HIV by race, sex, and age, Connecticut, 2010–2014



Source: HIV surveillance registry through 2015 and State-level Bridged Race Estimates for Connecticut, 2010. Note the reported numbers less than 12, which is the case for white females aged <20 and 20–29 years, white males aged <20, and Hispanic females aged <20 (and accompanying rates and trends) based on these numbers, should be interpreted with caution because the numbers have underlying relative standard errors greater than 30% and are considered unreliable.

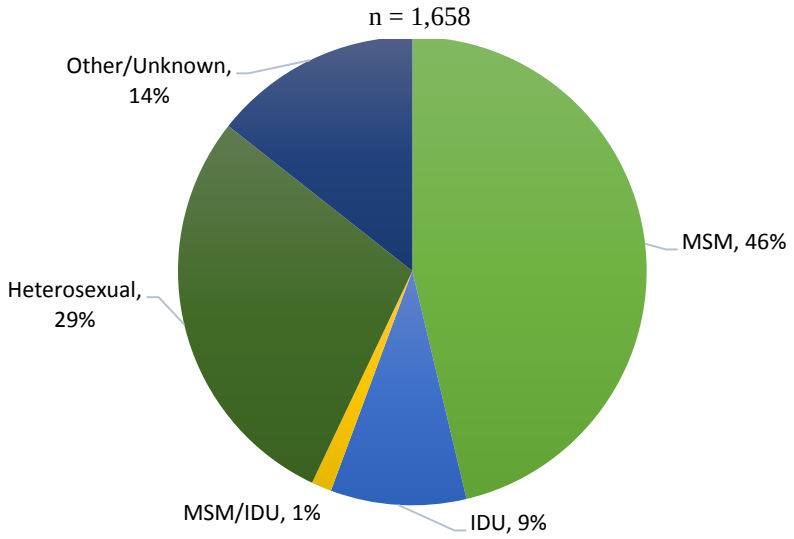
Figure 3: Rate of newly diagnosed HIV by race, Connecticut, 2010–2014



Source: HIV surveillance registry through 2015 and 2010 census table P4.

As also noted in 2014 in Figure 1, the five year trend above depicts a continuous disparity in HIV diagnosis based on race. Although there has been a downward trend in the rates of HIV diagnosis in all races, blacks or African Americans still maintain the largest burden.

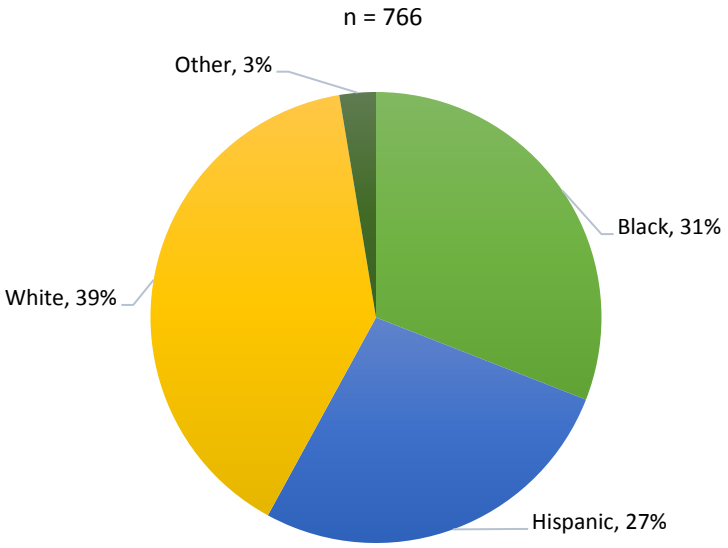
Figure 4: Newly diagnosed HIV by transmission category, Connecticut, 2010–2014



Source: HIV surveillance registry through 2015

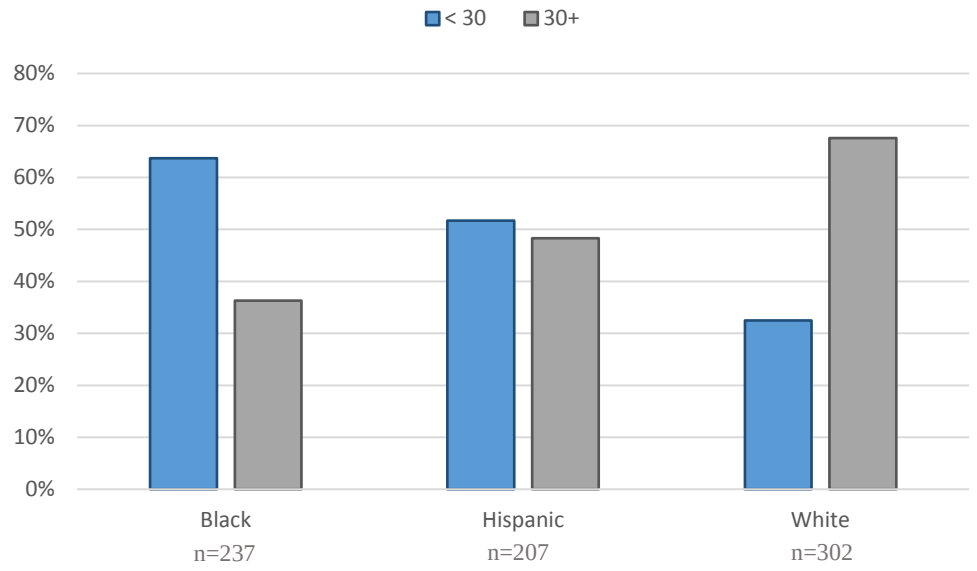
Consistent with what is being seen nationally, gay and bisexual men are most affected by the burden of HIV over the last several years. There has been a significant decrease in the number of IDU acquiring HIV, from 47% in 2003 to 13% in 2014, based on the multiple imputation or adjusted risk method.

Figure 5: HIV diagnosis in MSM by race, Connecticut, 2010–2014



Source: HIV surveillance registry through 2015

Figure 6: HIV diagnosis in MSM by race and age group, Connecticut, 2010–2014



Source: HIV surveillance registry through 2015

Connecticut is seeing a large number of young gay and bisexual men of color acquiring HIV over the last several years. Sixty-four percent of black MSM that were infected with HIV during 2010–2014 were under 30 as were 52% of Hispanic MSM. In contrast, the majority (68%) of white MSM were over 30.

According to a 2016 study by Bernstein et al., of the adult male population residing in Connecticut in 2013, 3.2% had had sex with another man in the past 5 years which is less than the overall percentage of adult men in the US who were MSM (3.9%). The Hartford TGA had the largest metropolitan population of MSM in Connecticut (51.1% of all MSM in the state). Of the adult men in the Hartford TGA, an estimated 4.9% were MSM. [1]

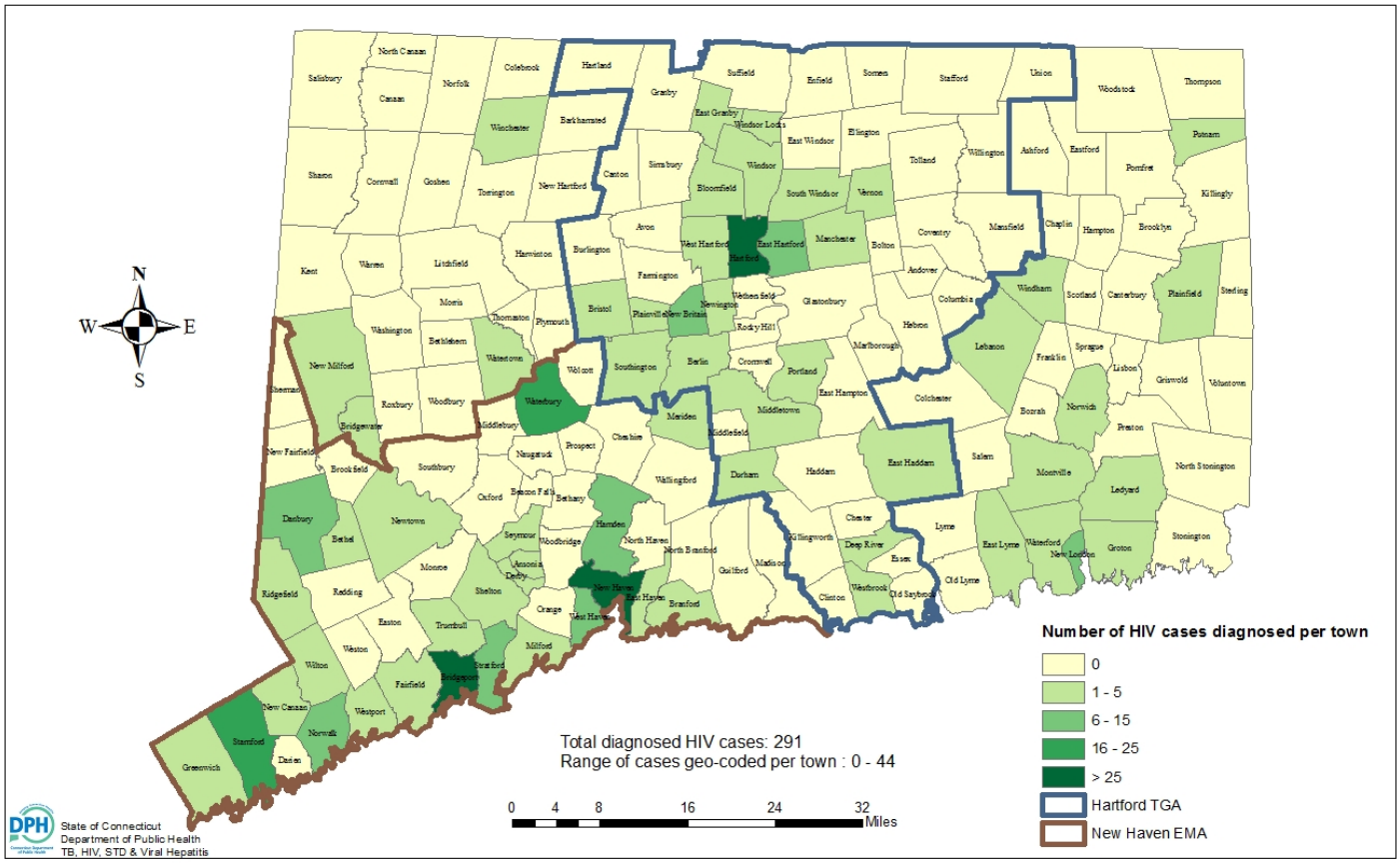
Table 6: Prevalence estimate of diagnosed and undiagnosed HIV among MSM, Connecticut, 2012

	MSM living with HIV infection		MSM living with undiagnosed HIV infection	
	N	Rate per 100 MSM	N	Rate per 100 MSM
Connecticut	4,600	10.57	710	1.63

Source Rosenberg ES, Grey JA, Sanchez TH, Sullivan PS, Rates of Prevalent HIV Infection, Prevalent Diagnoses, and New Diagnoses Among Men Who Have Sex With Men in US States, Metropolitan Statistical Areas, and Counties, 2012–2013, JMIR Public Health Surveill 2016;2(1):e22, Table 3.

[1] Grey JA, Bernstein KT, Sullivan PS, Purcell DW, Chesson HW, Gift TL, Rosenberg ES. Estimating the population sizes of men who have sex with men in US states and counties using data from the American Community Survey. JMIR Public Health Surveill 2016;2(1):e14. DOI: 10.2196/publichealth.5365

Figure 7: Newly diagnosed HIV by town of residence at diagnosis, Connecticut, 2014



Source: HIV surveillance registry through 2015

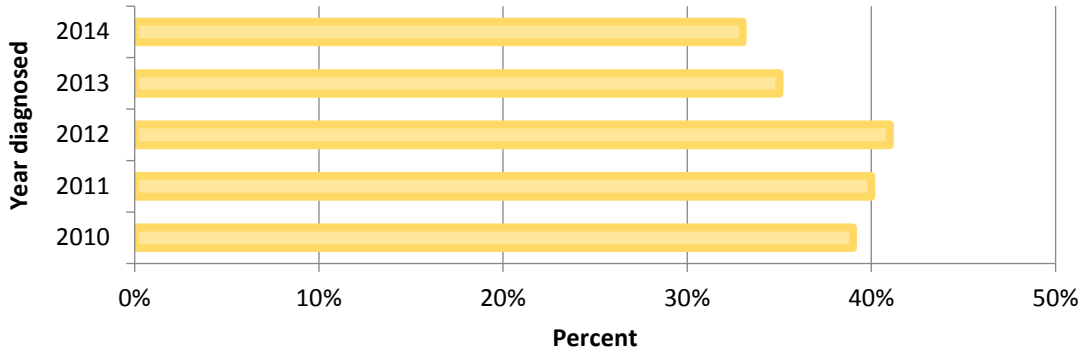
As is seen with people living with HIV, the highest numbers of new diagnoses are found in residents of Connecticut's largest cities. During 2010–2014, the following cities had greater than 50 cases diagnosed in their residents: Bridgeport, Hartford, New Britain, New Haven, Stamford and Waterbury. Please see the following table for descriptive statistics for towns with 10 or more newly diagnosed cases during 2010–2014.

Table 7: HIV cases diagnosed during 2010–2014 by city of residence, sex, race/ethnicity, and risk, Connecticut

		Sex		Race/Ethnicity				Risk					
	Total	Male	Female	Black	Hispanic	White	Other	IDU	MSM	MSM/ IDU	Hetero	Pedi	Other/ Unknown
Residence at diagnosis	N	%	%	%	%	%	%	%	%	%	%	%	%
Total	1,658	74.8	25.2	40.7	27.4	29.9	2.1	9.3	46.2	1.4	28.5	0.2	14.4
Hartford	245	69.8	30.2	44.1	42.4	12.7	0.8	16.3	42.9	2.4	24.5	0	13.9
Bridgeport	193	61.1	38.9	58.5	30.1	9.8	1.6	10.4	31.6	0	37.8	0	20.2
New Haven	153	73.9	26.1	62.7	22.2	11.8	3.3	8.5	45.8	2	35.3	0	8.5
Waterbury	112	75	25	40.2	33.9	24.1	1.8	15.2	50	0	25.9	0.9	8
Stamford	76	72.4	27.6	51.3	32.9	14.5	1.3	5.3	38.2	0	32.9	0	23.7
New Britain	62	67.7	32.3	33.9	53.2	9.7	3.2	11.3	37.1	0	40.3	0	11.3
Norwalk	48	83.3	16.7	33.3	35.4	29.2	2.1	2.1	60.4	0	25	0	12.5
East Hartford	45	73.3	26.7	64.4	22.2	8.9	4.4	8.9	40	0	28.9	0	22.2
Danbury	44	63.6	36.4	45.5	43.2	9.1	2.3	0	50	2.3	38.6	0	9.1
Hamden	44	72.7	27.3	63.6	11.4	20.5	4.5	11.4	40.9	2.3	36.4	0	9.1
West Haven	40	80	20	52.5	20	25	2.5	5	47.5	0	40	0	7.5
Middletown	30	76.7	23.3	43.3	16.7	40	0	3.3	63.3	0	30	0	3.3
New London	28	60.7	39.3	39.3	28.6	32.1	0	14.3	35.7	0	35.7	0	14.3
Norwich	27	63	37	37	3.7	55.6	3.7	0	37	3.7	44.4	0	14.8
Manchester	26	73.1	26.9	38.5	3.8	53.8	3.8	3.8	61.5	0	19.2	0	15.4
Meriden	24	83.3	16.7	16.7	25	58.3	0	20.8	54.2	4.2	8.3	0	12.5
Stratford	24	70.8	29.2	66.7	8.3	25	0	0	41.7	0	41.7	0	16.7
Greenwich	21	90.5	9.5	14.3	9.5	71.4	4.8	4.8	47.6	14.3	9.5	0	23.8
Bloomfield	20	65	35	80	5	15	0	15	45	0	25	0	15
Bristol	18	88.9	11.1	11.1	27.8	61.1	0	0	72.2	0	16.7	0	11.1
East Haven	17	88.2	11.8	29.4	41.2	29.4	0	11.8	52.9	0	17.6	0	17.6
Windsor	17	76.5	23.5	41.2	17.6	41.2	0	23.5	29.4	5.9	17.6	0	23.5
Shelton	14	92.9	7.1	14.3	21.4	64.3	0	0	57.1	0	28.6	14.3	0
Fairfield	12	66.7	33.3	8.3	33.3	58.3	0	8.3	33.3	0	33.3	0	25
Groton	12	91.7	8.3	0	25	58.3	16.7	0	41.7	8.3	25	0	25
Milford	11	81.8	18.2	9.1	18.2	72.7	0	9.1	18.2	0	27.3	0	45.5
Torrington	11	90.9	9.1	18.2	9.1	63.6	9.1	0	63.6	9.1	27.3	0	0
Naugatuck	10	90	10	30	30	40	0	10	80	0	10	0	0
West Hartford	10	100	0	10	0	80	10	0	70	0	10	0	20
Windham	10	80	20	10	80	10	0	40	30	0	20	0	10
Other towns	254	88.6	11.4	11.8	15	70.9	2.4	5.5	58.3	1.6	18.9	0	15.7

Source: HIV surveillance registry through 2015

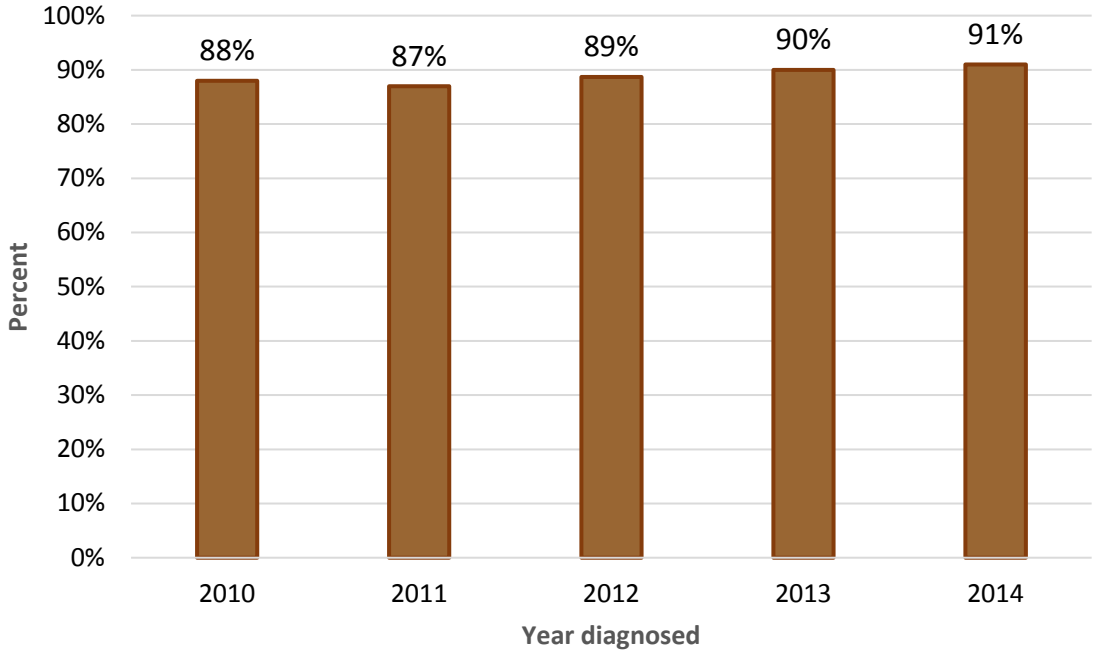
Figure 8: Transitioning to AIDS within 1 year of HIV diagnosis, Connecticut, 2010–2014



Source: HIV surveillance registry through 2015

A mean of 38% of cases diagnosed with HIV, presented with AIDS or transitioned to AIDS within a year of their HIV diagnosis during 2010–2014 (range 33–41%). Over the five year period, the percentage of "Late Testers" has trended downward. There was a statistically significant difference in mean age at diagnosis between the "Late testers" and others diagnosed, with late testers having a mean age of 43 years vs 36 years of others diagnosed. In addition, "Late testers" tended to have a transmission category of heterosexual sex with a high risk partner ($p<0.001$). There was no statistical significant difference between race and sex for HIV diagnosis and AIDS within 1 year of diagnosis.

Figure 9: Adults and adolescents linked to care within 3 months of their HIV infection diagnosis, Connecticut, 2010–2014



Source: HIV surveillance registry through 2015

Section III: DPH funded - HIV Testing

- Since 1986, the DPH has funded HIV counseling and testing sites throughout Connecticut.
- DPH supports two different types of CDC-funded HIV testing components. Initiated in 2012, the first HIV testing component is Outreach, Testing and Linkage (OTL), which targets specific high risk populations at non-clinical sites. The second HIV testing component is Expanded Testing Initiative (ETI) which began in 2007 and annually tests all individuals during their visit to a funded HIV clinical setting (the individual has the option to opt-out of the HIV test).
- The goals of these HIV testing components are to:
    - Identify newly HIV diagnosed positives;
    - Provide newly HIV diagnosed positives with their test result;
    - Identify previously diagnosed HIV positives who fell out of care;
    - Refer and link all HIV diagnosed positive persons to HIV medical care;
    - Assure screening for HCV, STD and TB
    - Refer and link all HIV diagnosed positive persons to Partner Services (PS);
    - Refer and link all HIV diagnosed positive persons to HIV Prevention Services;
    - Refer and link all pregnant HIV diagnosed positive females to prenatal care;
    - Provide all HIV diagnosed people with information and tools in order to reduce HIV risk behaviors.
    - Refer high risk negative persons to Prevention Services
- HIV testing data was collected using EvaluationWeb® (XPEMS) and data measures were used to monitor the extent to which these goals were achieved.

HIV testing data for 2015:

- 58,423 HIV tests were conducted. Of these, 94 (0.16%) were confirmed newly diagnosed positive persons and 24 (0.04%) were previously diagnosed persons.
- 28,291 (48%) of all HIV testing clients were male, 17,861 (31%) white, 16,821 (29%) black and 17,036 (29%) Hispanic.
- The majority of clients were classified as high-risk heterosexuals and having an unknown risk factor (94%). Other client risks included IDU (4%), MSM (2%), and MSM/IDU (0.14%).
- Of the 94 newly HIV diagnosed positive persons in 2015, 70 (74.5%) were male, 22 (23.4%) white, 42 (45%) black and 28 (30%) Hispanic. The risk category of the newly HIV diagnosed positive persons included: 41 (44%) MSM, 41 (44%) high risk heterosexual and 4 (4%) IDU.
- The newly diagnosed seropositivity rate by risk category was: 3% MSM, 0.44% high risk heterosexual and 0.18% IDU.
- 37,710 (65%) of all HIV testing clients were age 20–39 years old. The newly diagnosed seropositivity rate by age group was: 0.15% (20–29 years old), 0.16% (30–39 years old), 0.22% (40–49 years old) and 0.28% (50–59 years old).
- Connecticut's CDC funded-HIV testing statistics from prior years can be requested from the DPH HIV Prevention Program.

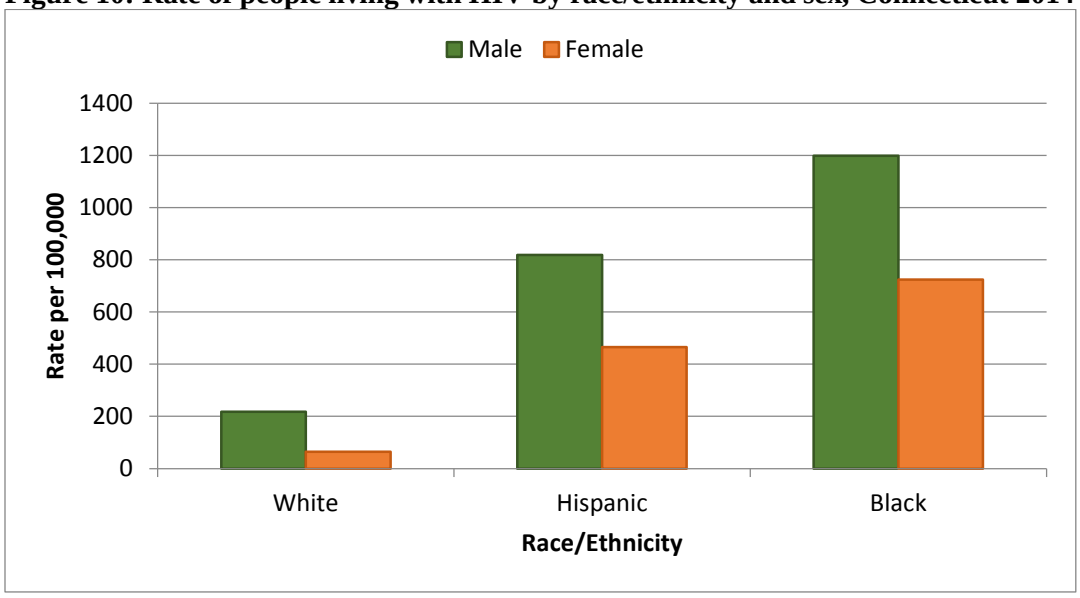
Table 8: HIV Testing at OTL and ETI Sites, Connecticut, 2015

Characteristics	Number of OTL clients HIV test	Number of ETI clients HIV test	OTL and ETI columns total	Number of **newly** diagnosed positives	Number of **previously** diagnosed positives	Newly diagnosed seropositivity rate[1]
Sex						
Male	11,176	17,115	28,291	70	19	0.25%
Female	2,758	27,301	30,059	24	5	0.08%
Transgender-MTF	11	10	21	--	--	--
Transgender-FTM	4	7	11	--	--	--
Transgender-Unspecified	1	1	2	--	--	--
Unknown Gender	2	37	39	--	--	--
Race						
White	4,829	13,032	17,861	22	2	0.12%
Black	4,653	12,168	16,821	42	10	0.25%
Hispanic	4,113	12,923	17,036	28	12	0.16%
Asian	131	796	927	1	--	0.11%
AI/AN[2]	40	112	152	--	--	--
Native Hawaiian/ PI[3]	11	82	93	--	--	--
More than one race	94	89	183	--	--	--
Don't know /Declined	81	5,269	5,350	1	--	0.02%
Age group (years)						
13–19	649	2,904	3,553	--	1	--
20–29	5,140	17,567	22,707	34	9	0.15%
30–39	3,934	11,069	15,003	24	10	0.16%
40–49	2,327	6,015	8,342	18	2	0.22%
50–59	1,523	4,518	6,041	17	1	0.28%
60 and over	377	2,343	2,720	1	1	0.04%
Unknown	2	55	57	--	--	--
Risk						
High Risk Heterosexual	8,491	917	9,408	41	5	0.44%
IDU	2,073	122	2,195	4	--	0.18%
MSM	1,108	247	1,355	41	15	3.03%
MSM/IDU	83	2	85	--	--	--
Unknown	2197	43,183	45,380	8	4	0.02%
Total	13,952	44,471	58,423	94	24	0.16%

[1] Number of newly HIV diagnosed positives divided by the number of OTL and ETI columns total
[2] American Indian/Alaskan Native
[3] Native Hawaiian/Pacific Islanders
Source: EvaluationWeb® (XPEMS)

Section IV: People Living with HIV (PLWH)

Figure 10: Rate of people living with HIV by race/ethnicity and sex, Connecticut 2014



Source: HIV surveillance registry through 2015 and State-level Bridged Race Estimates for Connecticut, 2014

In Connecticut, there are 10,727 people living with HIV based on diagnosis address, a rate of 298 per 100,000 people. As with newly diagnosed cases of HIV, Connecticut continues to see racial disparities in people living with HIV. Black or African American males and Hispanic males are living with HIV at a rate approximately 6 and 4 times that of white males respectively. Black or African American females and Hispanic females are living with HIV at rates 11 and 7 times those of white females, respectively.

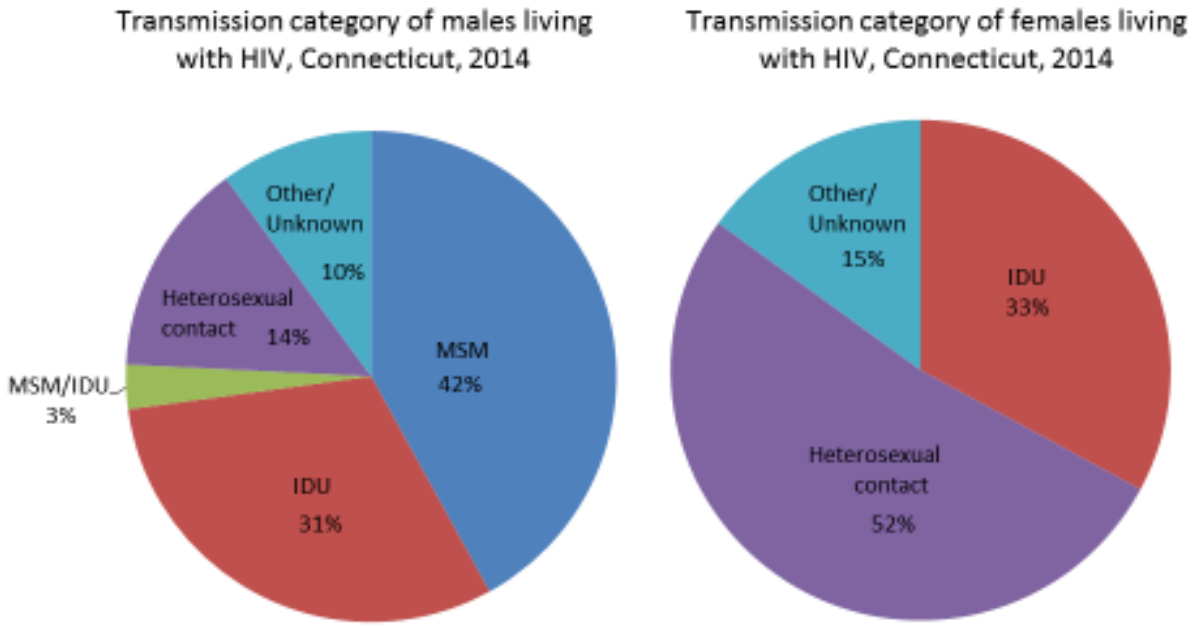
Table 9: Persons living with HIV by age, Connecticut 2014

	Males		Females	
Age (years)	N	Rate	N	Rate
<20	28	6.2	22	5.1
20–29	511	212.9	169	74.9
30–39	824	390.2	428	197.5
40–49	1,744	727.1	1,106	436.6
50–59	2,645	982.6	1,261	443.2
60+	1,408	409.3	581	134.9
Total	7,160	408.1	3,567	193.6

Source: HIV surveillance registry through 2015 and 2010 census table P12
Rate per 100,000 people

Unlike the newly diagnosed HIV population in Connecticut, the largest rate of people living with HIV is seen for both males and females in the 50–59 year age group.

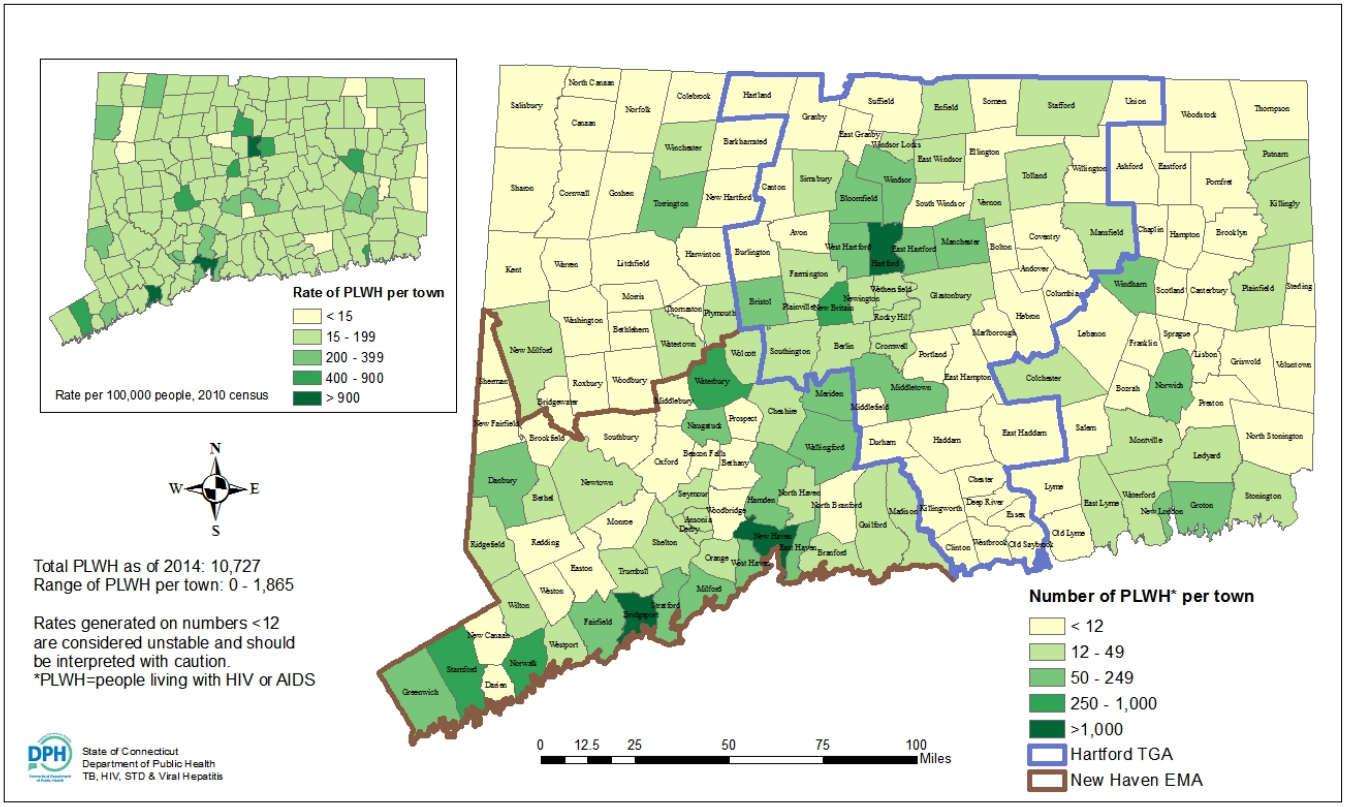
Figure 11: People living with HIV by transmission category, Connecticut, 2014



Source: eHARS data through 2015

Overall in 2014, 31% of people living with HIV in Connecticut have a transmission category attributed to injection drug use, followed by MSM at 28% and heterosexual sex with a high risk partner at 27%. The above charts reflect gender specific risk and describes males with 42% of the risk attributed to MSM and 31% to IDU while female risk predominately is attributed to heterosexual sex with a high risk partner at 52%.

Figure 12: Prevalent HIV infection by residence at diagnosis, Connecticut, 2014



Source: HIV surveillance registry through 2015 and 2010 census

Although most cities and towns in Connecticut are touched by the burden of HIV infection, the highest rates of people living with HIV correspond with Connecticut's three largest cities: Bridgeport, Hartford, and New Haven. Of all people living with HIV, 43% were living in these 3 cities. The rates of people living with HIV in the Hartford TGA and New Haven EMA respectively are 298 and 347 per 100,000 persons. The following 10 towns have a rate of greater than 400 per 100,000 of people living with HIV.

Table 10: Ten towns with the highest rate of people living with HIV, Connecticut, 2014

Town	Population	Prevalence Number	Rate per 100,000
Hartford	124,775	1,865	1,494.6
New Haven	129,779	1,452	1,118.8
Bridgeport	144,229	1,333	924.2
New London	27,620	191	691.6
Waterbury	110,366	734	665
New Britain	73,206	403	550.6
Bloomfield	20,486	88	429.6
Stamford	122,643	524	427.2
East Hartford	51,252	217	423.4
Windham	25,268	107	423.4

Source: HIV surveillance registry through 2015 and 2010 census.

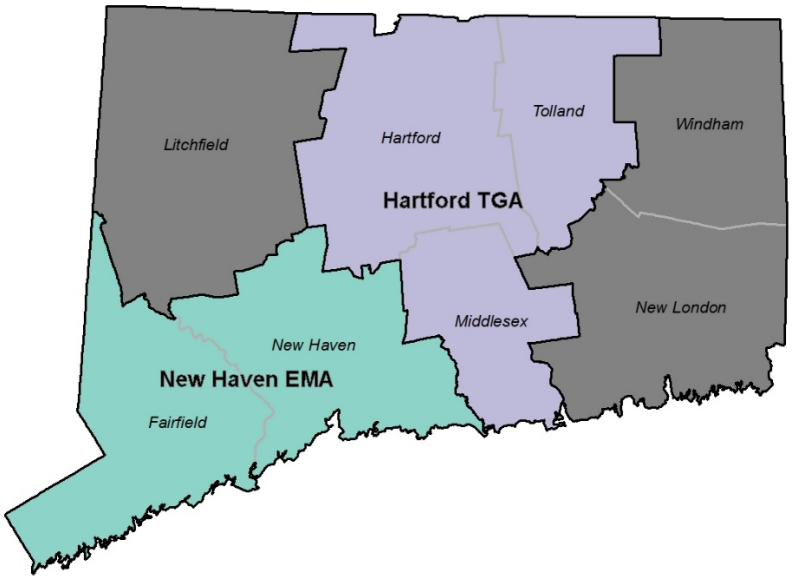
Table 11: Estimated[a] HIV prevalence among persons[b] aged ≥13 years at diagnosis, undiagnosed HIV infection, and percentages of those with diagnosed HIV infection

		Prevalence [c]		Undiagnosed HIV		% of diagnosed HIV	
Characteristics [d]	**year**	**N**	**95% CI**	**N**	**95% CI**	**%**	**95% CI**
Overall	2009	15,800	(15,500-16,200)	1,700	(1,100-2,100)	89	(86.7-92.8)
	2010	15,800	(15,500-16,100)	1,500	(850-1,900)	91	(87.8-94.0)
	2011	15,800	(15,300-16,200)	1,400	(670-1,800)	91	(88.2-95.1)
	2012	15,800	(15,100-16,200)	1,300	(680-1,900)	92	(88.5-95.7)
	2013	15,800	(15,100-16,400)	1,300	(530-2,000)	92	(87.4-96.0)
Female	2009	5,300	(5,100-5,500)	340	(0-620)	94	(88.7-99.3)
	2010	5,300	(5,100-5,500)	280	(0-570)	95	(90.0-99.5)
	2011	5,300	(5,100-5,500)	240	(0-530)	96	(90.6-99.4)
	2012	5,300	(5,000-5,500)	210	(0-550)	96	(90.7-99.6)
	2013	5,300	(5,000-5,500)	200	(0-610)	96	(89.8-99.5)
Male	2009	10,500	(10,200-10,800)	1,300	(740-1,700)	88	(84.0-92.1)
	2010	10,500	(10,200-10,900)	1,200	(630-1,700)	89	(84.7-93.3)
	2011	10,500	(10,100-10,800)	1,100	(560-1,600)	90	(85.2-94.3)
	2012	10,500	(10,100-10,800)	1,100	(560-1,600)	90	(85.3-93.8)
	2013	10,600	(10,200-11,000)	1,100	(550-1,700)	90	(85.2-94.0)
Black	2009	5,100	(4,900-5,300)	710	(320-1,000)	86	(80.5-92.1)
	2010	5,100	(4,900-5,300)	650	(260-970)	87	(82.1-93.0)
	2011	5,100	(4,900-5,300)	610	(190-930)	88	(83.1-94.0)
	2012	5,100	(4,800-5,400)	580	(120-920)	89	(83.9-94.6)
	2013	5,100	(4,800-5,400)	550	(40-930)	89	(84.4-96.1)
Hispanic or other	2009	5,600	(5,400-5,800)	450	(170-850)	92	(85.8-95.9)
	2010	5,600	(5,300-5,800)	420	(130-860)	93	(85.9-96.6)
	2011	5,500	(5,300-5,800)	380	(70-850)	93	(86.5-97.3)
	2012	5,500	(5,300-5,800)	370	(10-850)	93	(87.0-97.9)
	2013	5,600	(5,400-5,800)	360	(0-830)	94	(87.6-98.2)
White	2009	5,200	(4,900-5,400)	490	(30-820)	91	(85.3-97.7)
	2010	5,200	(4,900-5,400)	420	(0-760)	92	(86.6-98.4)
	2011	5,100	(4,800-5,300)	380	(0-750)	93	(86.8-98.3)
	2012	5,100	(4,800-5,300)	400	(0-830)	92	(85.7-98.0)
	2013	5,100	(4,800-5,400)	380	(0-840)	93	(86.1-97.9)
Hetersexual contact	2009	4,700	(4,500-4,900)	670	(310-940)	85.7	(80.7-90.8)
	2010	4,800	(4,600-4,900)	580	(230-860)	87.9	(82.8-92.3)
	2011	4,800	(4,600-5,000)	540	(220-850)	88.8	(83.2-93.8)
	2012	4,800	(4,600-5,000)	510	(150-860)	89.4	(83.6-94.6)
	2013	4,800	(4,600-5,100)	500	(120-870)	89.6	(83.9-95.8)
IDU or MSM/IDU or Other	2009	6,200	(5,900-6,400)	0	(0-200)	100	(94.3-97.1)
	2010	6,000	(5,700-6,200)	0	(0-150)	100	(94.1-96.4)
	2011	5,900	(5,600-6,100)	0	(0-140)	100	(93.8-96.0)
	2012	5,700	(5,400-6,000)	0	(0-130)	100	(93.7-95.7)
	2013	5,600	(5,300-5,900)	0	(0-100)	100	(93.6-95.4)
MSM	2009	4,900	(4,700-5,100)	980	(640-1,200)	80	(75.7-85.0)
	2010	5,000	(4,800-5,200)	910	(560-1,200)	81.8	(77.5-87.2)
	2011	5,100	(4,900-5,300)	840	(470-1,200)	83.5	(77.9-89.1)
	2012	5,200	(5,000-5,500)	830	(440-1,200)	84	(78.5-89.9)
	2013	5,400	(5,100-5,600)	790	(360-1,200)	85.4	(79.4-91.5)

[a] Estimates were derived by using back-calculation. Estimates were rounded to the nearest 100 for numbers >1,000 and to the nearest 10 for numbers <1,000 to reflect the uncertainty inherent in statistical estimates.
[b] Include persons whose most recent known address or residence at death is in Connecticut by 12/31/2013.
[c] Persons living with diagnosed or undiagnosed HIV infection.
[d] Some subgroups might be grouped together to meet the sample size criteria.

Section V: Ryan White Grant Areas

Figure 13: Ryan White Grant Areas, Connecticut, 2014



Connecticut has two Part A Ryan White Service Areas: Hartford TGA and New Haven EMA. Of the 20,997 HIV infections reported during 1981–2014, 7,310 were residents of the Hartford TGA and 11,874 were residents of the New Haven EMA, totaling 91% of cases diagnosed in Connecticut.

Table 12: People living with HIV by risk, sex, race, and age, Hartford TGA, 2014

	IDU		MSM		MSM/IDU		Heterosexual		Pedi		Other/ Unknown		Total	
	N	Row %	N	Row %	N	Row %	N	Row %	N	Row %	N	Row %	N	%
Total	1278	35.4	964	26.7	76	2.1	861	23.9	57	1.6	374	10.4	3610	100
Sex														
Male	870	35.5	964	39.4	76	3.1	289	11.8	23	0.9	227	9.3	2449	67.8
Female	408	35.1	0	0.0	0	0	572	49.3	34	2.9	147	12.7	1161	32.2
Race/Ethnicity														
Black	360	34.3	207	19.7	22	2.1	318	30.3	12	1.1	131	12.5	1050	29.1
Hispanic	662	46.8	212	15	31	2.2	370	26.1	35	2.5	106	7.5	1416	39.2
White	246	22.5	522	47.7	23	2.1	163	14.9	10	0.9	130	11.9	1094	30.3
Other	10	20.0	23	46.0	0	0.0	10	20.0	0	0.0	7	14.0	50	1.4
Current Age (years)														
<20	0	0.0	2	22.2	0	0.0	0	0.0	7	77.8	0	0.0	9	0.2
20–29	5	2.2	134	57.8	1	0.4	32	13.8	47	20.3	13	5.6	232	6.4
30–39	69	16.7	164	39.8	12	2.9	110	26.7	3	0.7	54	13.1	412	11.4
40–49	337	34.5	245	25.1	24	2.5	255	26.1	0	0.0	116	11.9	977	27.1
50–59	606	45	288	21.4	29	2.2	298	22.1	0	0.0	127	9.4	1348	37.3
60+	261	41.3	131	20.7	10	1.6	166	26.3	0	0.0	64	10.1	632	17.5

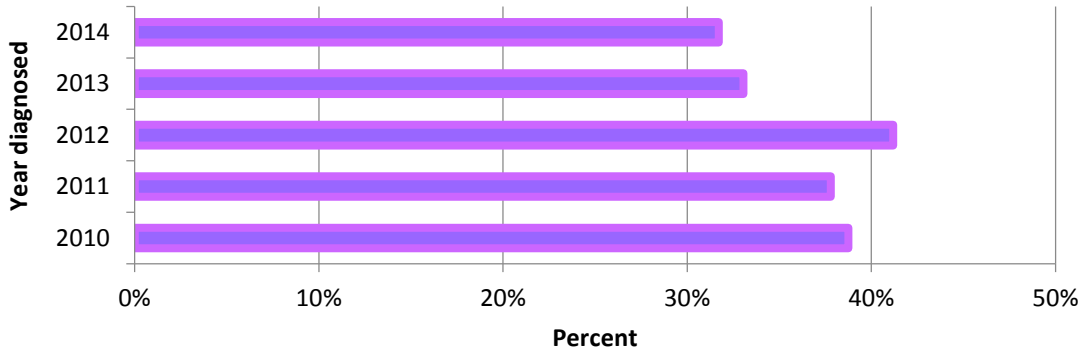
Source: HIV surveillance registry through 2015

Table 13: Recently diagnosed HIV infection by age, sex, race, and risk, Hartford TGA, 2010-2014

Years	<20		20–29		30–39		40–49		50–59		60+		Total	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Total	16	100	165	100	124	100	142	100	104	100	38	100	589	100
Sex														
Male	15	93.8	134	81.2	96	77.4	103	72.5	71	68.3	26	68.4	445	75.6
Female	1	6.3	31	18.8	28	22.6	39	27.5	33	31.7	12	31.6	144	24.4
Race/Ethnicity														
Black	10	62.5	61	37	35	28.2	47	33.1	54	51.9	12	31.6	219	37.2
Hispanic	4	25	56	33.9	51	41.1	36	25.4	21	20.2	13	34.2	181	30.7
White	2	12.5	44	26.7	36	29	56	39.4	28	26.9	13	34.2	179	30.4
Other	0	0.0	4	2.4	2	1.6	3	2.1	1	1	0	0	10	1.7
Risk														
IDU	0	0.0	10	6.1	9	7.3	21	14.8	19	18.3	8	21.1	67	11.4
MSM	14	87.5	120	72.7	64	51.6	52	36.6	31	29.8	3	7.9	284	48.2
MSM/IDU	0	0.0	2	1.2	4	3.2	3	2.1	0	0.0	0	0.0	9	1.5
Heterosexual	1	6.3	25	15.2	31	25	39	27.5	33	31.7	15	39.5	144	24.4
Other/Unknown	1	6.3	8	4.8	16	12.9	27	19	21	20.2	12	31.6	85	14.4

Source: HIV surveillance registry through 2015

Figure 14: Transitioning to AIDS within 1 year of HIV diagnosis, Hartford TGA, 2010–2014



Source: HIV surveillance registry through 2015

Table 14: People living with HIV by risk, sex, race, and age, New Haven EMA, 2014

	IDU		MSM		MSM/IDU		Heterosexual		Pedi		Other/ Unknown		Total	
	N	Row %	N	Row %	N	Row %	N	Row %	N	Row %	N	Row %	N	%
Total	1828	29.6	1700	27.5	108	1.7	1757	28.4	125	2	665	10.8	6183	100
Sex														
Male	1150	28.3	1700	41.8	108	2.7	635	15.6	69	1.7	403	9.9	4065	65.7
Female	678	32.0	0	0.0	0	0.0	1122	53.0	56	2.6	262	12.4	2118	34.3
Race/Ethnicity														
Black	733	31.3	387	16.5	31	1.3	867	37.1	62	2.7	259	11.1	2339	37.8
Hispanic	618	33.3	430	23.2	31	1.7	548	29.5	44	2.4	185	10	1856	30.0
White	446	23.9	847	45.3	41	2.2	315	16.8	16	0.9	205	11	1870	30.2
Other	31	26.3	36	30.5	5	4.2	27	22.9	3	2.5	16	13.6	118	1.9
Current Age (years)														
<20	0	0.0	8	22.2	0	0.0	2	5.6	24	66.7	2	5.6	36	0.6
20–29	8	2.1	199	51.3	4	1	64	16.5	82	21.1	31	8	388	6.3
30–39	94	12.9	292	40.2	15	2.1	222	30.5	18	2.5	86	11.8	727	11.8
40–49	460	28.0	403	24.5	23	1.4	533	32.4	1	0.1	225	13.7	1645	26.6
50–59	826	37.4	526	23.8	49	2.2	609	27.6	0	0.0	200	9	2210	35.7
60+	440	37.4	272	23.1	17	1.4	327	27.8	0	0.0	121	10.3	1177	19.0

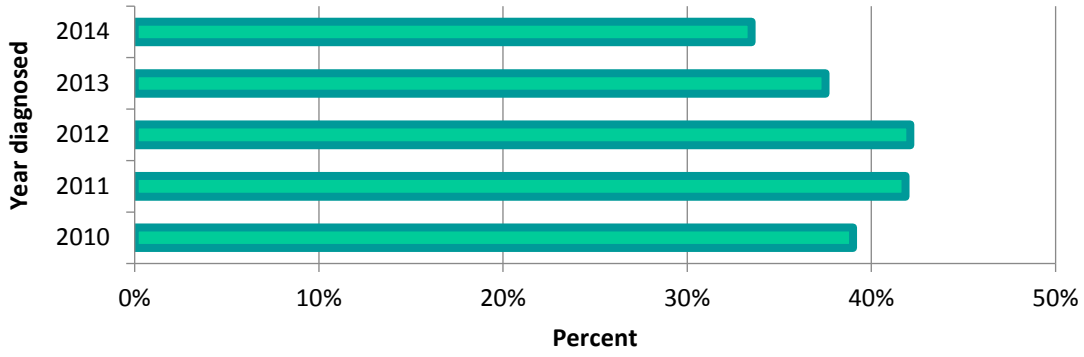
Source: HIV surveillance registry through 2015

Table 15: Recently diagnosed HIV infection by age, sex, race, and risk, New Haven EMA, 2010–2014

Years	<20		20–29		30–39		40–49		50–59		60+		Total	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Total	41	100	259	100	196	100	227	100	126	100	68	100	917	100
Sex														
Male	29	70.7	216	83.4	137	69.9	159	70.0	89	70.6	49	72.1	679	74
Female	12	29.3	43	16.6	59	30.1	68	30.0	37	29.4	19	27.9	238	26
Race														
Black	25	61	129	49.8	78	39.8	102	44.9	59	46.8	31	45.6	424	46.2
Hispanic	12	29.3	79	30.5	64	32.7	55	24.2	25	19.8	10	14.7	245	26.7
White	4	9.8	46	17.8	45	23.0	65	28.6	41	32.5	27	39.7	228	24.9
Other	0	0.0	5	1.9	9	4.6	5	2.2	1	0.8	0	0.0	20	2.2
Risk														
IDU	2	4.9	6	2.3	10	5.1	29	12.8	27	21.4	3	4.4	77	8.4
MSM	24	58.5	175	67.6	95	48.5	66	29.1	35	27.8	15	22.1	410	44.7
MSM/IDU	0	0.0	3	1.2	4	2.0	1	0.4	1	0.8	1	1.5	10	1.1
Heterosexual	5	12.2	57	22	66	33.7	82	36.1	45	35.7	32	47.1	287	31.3
Other/Unknown	10	24.4	18	6.9	21	10.7	49	21.6	18	14.3	17	25	133	14.5

Source: HIV surveillance registry through 2015

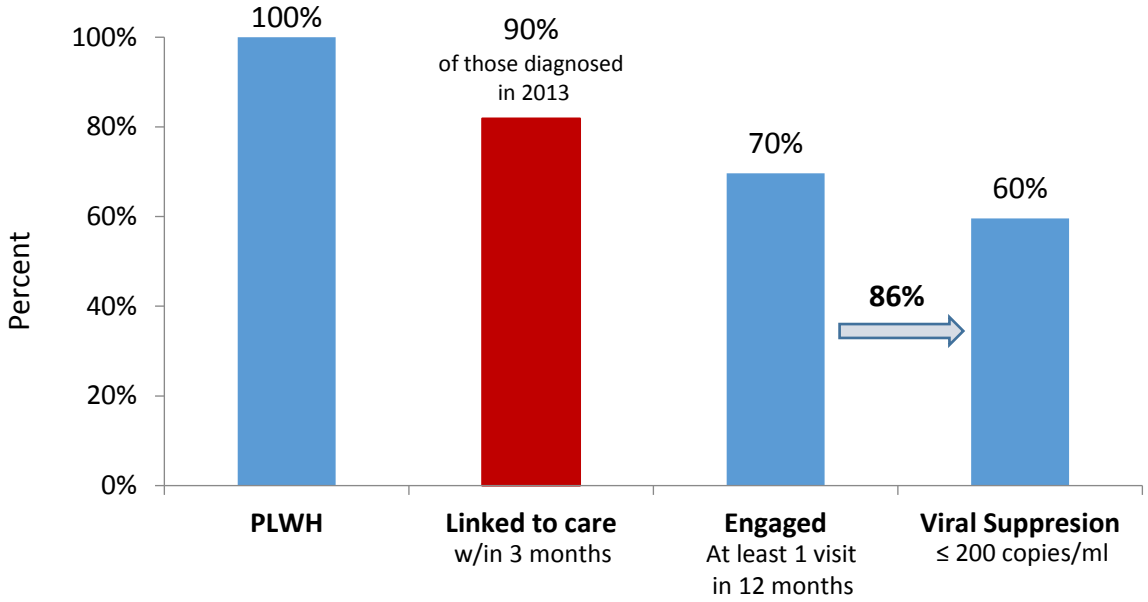
Figure 15: Transitioning to AIDS within 1 year of HIV diagnosis, New Haven EMA, 2010–2014



Source: HIV surveillance registry through 2015

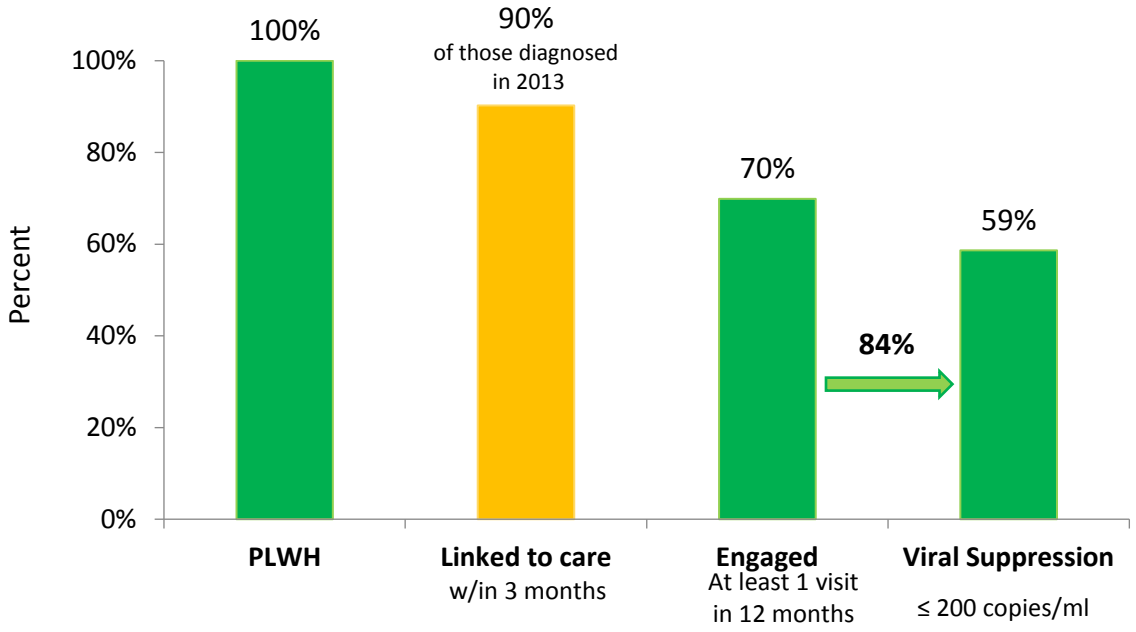
Section VI: Continuum of Care

Figure 16: HIV continuum of care, Connecticut, 2014



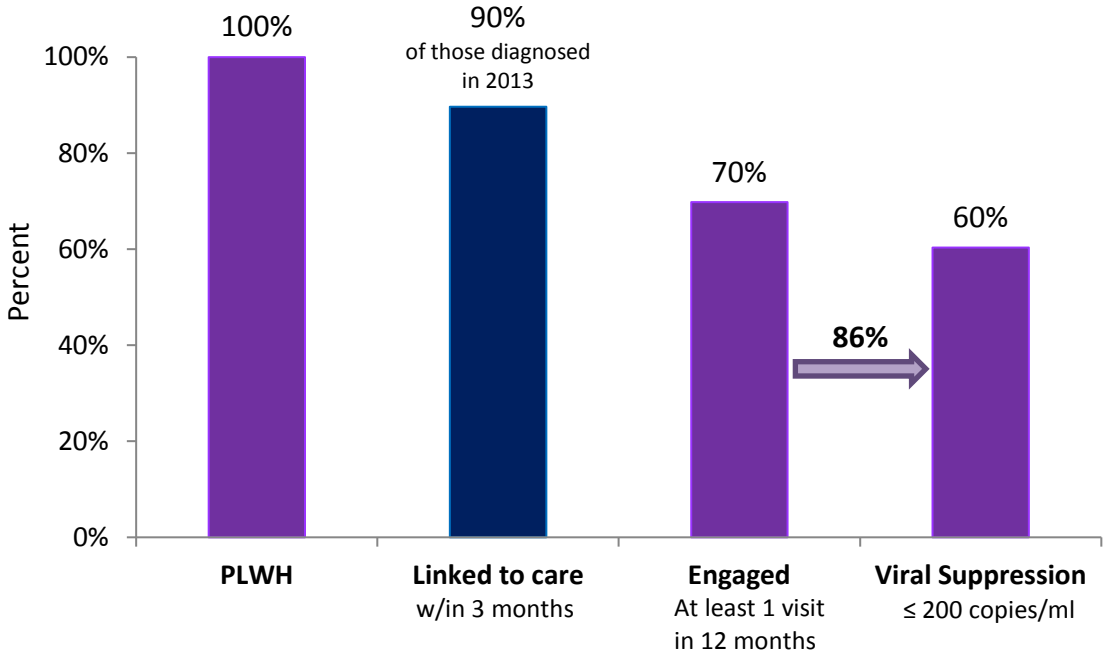
Based on persons receiving HIV care in 2014 among persons ≥13 years old at diagnosis, resided in Connecticut (based on residence of diagnosis) and diagnosed with HIV infection through 2013 and living with HIV on 12/31/2014. Persons who have at least one CD4, viral load or HIV-1 genotype test are considered as receiving HIV care. Tests that have been done in the same month are considered as one care visit. The overall HIV population is overestimated because cases are only followed up for 11 months after 12/31/2014. CDC suggests that every case should be followed up at least 18 months to collect death certificate information.
Source: HIV surveillance registry through 2015.

Figure 17: HIV continuum of care, Hartford TGA, 2014



Based on persons receiving HIV care in 2014 among persons ≥13 years old at diagnosis, resided in the Hartford TGA (based on residence of diagnosis) and diagnosed with HIV infection through 2013 and living with HIV on 12/31/2014. Persons who have at least one CD4, viral load or HIV-1 genotype test are considered as receiving HIV care. Tests that have been done in the same month are considered as one care visit. The overall HIV population is overestimated because cases are only followed up for 11 months after 12/31/2014. CDC suggests that every case should be followed up at least 18 months to collect death certificate information.
Source: HIV surveillance registry through 2015.

Figure 18: HIV continuum of care, New Haven EMA, 2014



Based on persons receiving HIV care in 2014 among persons ≥13 years old at diagnosis, resided in the New Haven EMA (based on residence of diagnosis) and diagnosed with HIV infection through 2013 and living with HIV on 12/31/2014. Persons who have at least one CD4, viral load or HIV-1 genotype test are considered as receiving HIV care. Tests that have been done in the same month are considered as one care visit. The overall HIV population is overestimated because cases are only followed up for 11 months after 12/31/2014. CDC suggests that every case should be followed up at least 18 months to collect death certificate information.
Source: HIV surveillance registry through 2015.

Table 16: Continuum of care of adolescents and adults by select characteristics, Connecticut 2014

Characteristics	Diagnosed	≥1 care visit	≥2 care visits at least 3 months apart	% of persons who have ≥2 care visits	% ≥2 care visits amongst persons have ≥1 care visit	% suppression among persons with ≥1 VL
Sex						
Male	6,884	4,660	3,750	54.47	80.47	88.80
Female	3,900	2,852	2,293	58.79	80.40	83.26
Age (years) on 12/31/2013						
13–24	319	224	175	54.86	78.13	68.35
25–34	1,017	683	514	50.54	75.26	79.20
35–44	2,074	1,375	1,052	50.72	76.51	84.06
45–54	4,019	2,839	2,282	56.78	80.38	87.62
55–64	2,636	1,890	1,594	60.47	84.34	90.12
65+	719	501	426	59.25	85.03	94.09
Race/ethnicity						
Black	3,576	2,577	2,098	58.67	81.41	83.87
Hispanic	3,564	2,399	1,960	54.99	81.70	84.87
White	3,460	2,394	1,869	54.02	78.07	91.35
Other	184	142	116	63.04	81.69	91.42
Transmission category						
MSM	2,787	1,925	1,491	53.5	77.45	90.45
IDU	3,457	2,394	2,001	57.88	83.58	86.25
MSM and IDU	200	144	114	57	79.17	87.41
Heterosexual contact	3,033	2,293	1,851	61.03	80.72	84.71
Other	198	124	107	54.04	86.29	65.85
Unknown	1,109	632	479	43.19	75.79	88.15
Total	**10,784**	**7,512**	**6,043**	**56.04**	**80.44**	**86.70**

Number and percentage of persons receiving HIV care between 01/01/2014 through 12/31/2014 among persons who were ≥13 years old on 12/31/2013, resided in Connecticut (based on residence of HIV disease diagnosis), diagnosed with HIV infection through 12/31/2013 and living with HIV on 12/31/2014.
Source: HIV surveillance registry through 2015

Based on residence at disease diagnosis, 60% of adolescents and adults living with HIV in Connecticut are virally suppressed. That number increases to 86% for those engaged in care in 2014. The people living with HIV that are not in care are more likely to be male (p<.0001), Hispanic (p<.0001), and more likely to have had an unknown risk factor (p<.0001) and be aged 35–44 years (p<.0008).

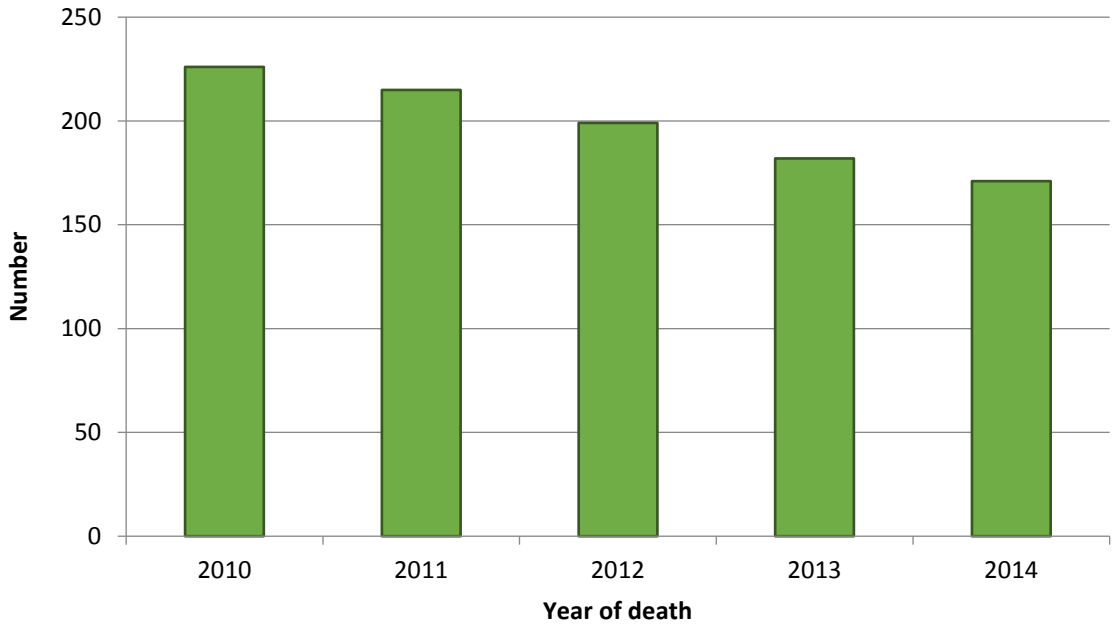
Section VII: Deaths

Tables 17: HIV as the primary cause of death by race and sex, Connecticut, 2008–2012

	Both Sexes			Males			Females		
	No. of deaths	Crude rate	AAMR	No. of deaths	Crude rate	AAMR	No. of deaths	Crude rate	AAMR
Black	195	11.0	11.09	120	14.2	15.26	75	8.1	7.87
Hispanic	130	5.6	6.93	82	7.0	9.10	48	4.1	4.96
White	142	1.1	0.93	101	1.6	1.36	41	0.6	0.54
Total (all races)	470	2.6	2.35	303	3.5	3.10	167	1.8	1.66

Crude and age-adjusted mortality rate per 100,000 population. Age adjusted using 2000 U.S. standard million
Source: Backus K, Mueller L. (2015) Age-Adjusted Mortality Rates for Connecticut, 2008–2012. Hartford, CT: Connecticut Department of Public Health. Accessed at http://www.ct.gov/dph/mortality

Figure 19: Trends in deaths among HIV infected people, Connecticut, 2010–2014



Note: Deaths in the most recent year are preliminary and may not be completely reported.
Source: HIV surveillance registry through 2015

Although HIV is still an important cause of death in Connecticut, it is not ranked among the top 15 causes. People infected with HIV are continuing to live longer lives with medication adherence. There is a statistically significant reduction in the age adjusted mortality rate from HIV disease as the underlying cause from 4.19 during 2003–2007 to 2.35 during 2008–2012. Since 1981, 20,997 HIV cases have been reported with 10,270 (49%) known to have died through 2014.

Section VIII: Behavioral Risks

Table 18: HIV risk and prevention results, Connecticut BRFSS, 2014

	Condoms Discussed for HIV Prevention			At Risk for Contracting HIV			Ever Tested for HIV		
Demographics	**%**	**95% C.I.**		**%**	**95% C.I.**		**%**	**95% C.I.**	
Total	15.4	14.0	16.8	26.7	25.2	28.3	35	33.4	36.6
Age (years)									
18–34	36.7	32.5	40.9	38.5	34.3	42.7	42.0	38.0	46.0
35–54	12.0	10.2	13.7	33.9	31.2	36.6	49.7	46.9	52.5
55+	4.4	3.4	5.3	13	11.5	14.4	16.4	14.8	17.9
Gender									
Male	15.2	13.1	17.4	28.5	26.2	30.8	33.8	31.4	36.1
Female	15.6	13.8	17.5	25.1	23.0	27.2	36.1	33.9	38.3
Race/Ethnicity									
White	10.6	9.1	12	27.5	25.7	29.3	29.5	27.8	31.3
Black	25.8	20.6	31.1	29.7	23.6	35.7	52.5	46.6	58.4
Hispanic	36.6	31.1	42	22.1	17.6	26.7	53.6	48.2	58.9
Income									
Less than $35,000	24.2	21.1	27.2	18.9	16.2	21.6	41.5	38.3	44.7
$35,000–$74,999	12.6	9.9	15.2	26.3	23.0	29.6	33.2	29.9	36.6
$75,000 and more	10.0	8.0	12.0	36.0	33.3	38.8	34.5	31.9	37.1
Insurance Status									
Insured	14.5	13.1	15.9	26.7	25.1	28.4	34.4	32.7	36.0
Not Insured	26.7	20.4	33	27.7	21.7	33.7	42.3	35.6	49.0
Disability									
Yes	18.4	15.1	21.6	18.9	15.7	22.1	40.1	36.4	43.8
No	14.7	13.1	16.2	28.6	26.8	30.4	33.7	31.9	35.4
Education									
HS graduate or less	20.6	18.0	23.3	21.0	18.4	23.6	35.3	32.4	38.2
More than HS education	12.2	10.6	13.7	30.5	28.5	32.4	34.7	32.9	36.6

Source: Stone, CL, Brackney, M. (2016) Health Indicators and Risk Behaviors in Connecticut: Results of the 2014 Connecticut Behavioral Risk Factor Surveillance Survey, Connecticut Department of Public Health, Hartford, Connecticut, p.56-57. Accessed at www.ct.gov/dph/brfss
Note: Please see BRFSS report regarding methods for survey.

Highlighting just a few results in the BRFSS report: compared to their counterparts in Connecticut, the prevalence of participating in activities that are high risk for contracting HIV was significantly greater for high-income residents earning at least $75,000 and $35,000–74,999 annually and in young and middle aged adults (age groups: 18–34 years, 35–54 years). The prevalence of being tested for HIV was significantly greater for non-Hispanic Blacks and Hispanics adults and adults without health insurance as compared to their state counterparts.

Additionally, a separate behavioral survey, the Connecticut School Health Survey, is conducted among Connecticut youth. This survey is conducted in consenting schools with high school students, grades 9–12. Questions about sexual and drug use activity are included in the questionnaire. A complete report of findings for the 2013 report is available on the DPH website (www.ct.gov/dph/cshs).

A few results relevant to HIV risk factors from the 2013 Youth Behavioral Component:

- 2.4% of surveyed youth had used a needle to inject an illegal drug into their bodies 1 or more times during their life
- 41.1% of surveyed youth had sexual intercourse
- 60.7% of surveyed youth who had sexual intercourse during the past 3 months used a condom during the last sexual intercourse
- 7.9% of surveyed youth describe themselves as gay or lesbian or bisexual

Section IX: Sexually Transmitted Diseases

Table 19: Chlamydia, gonorrhea, and primary and secondary syphilis, Connecticut, 2010–2014

	Chlamydia		Gonorrhea		Syphilis	
Year	N	Rate	N	Rate	N	Rate
2010	12,692	355	2,568	72	99	3
2011	13,662	381	2,450	68	67	2
2012	13,521	376	2,197	61	81	2
2013	12,962	360	2,935	82	53	1
2014	13,134	365	2,223	62	87	2

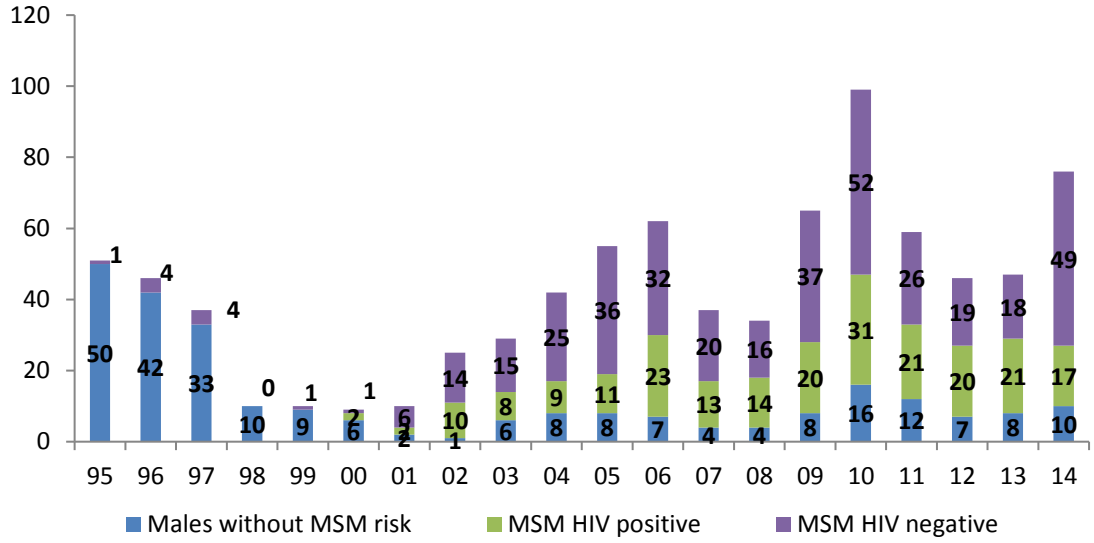
Source: Connecticut STD Control Program, STD*MIS data and CDC Bridged-Race Population Estimates, intercensal population estimates (released by NCHS on 7/26/2012); postcensal population estimates (released by NCHS on 10/26/2012); postcensal population estimates (released by NCHS on 6/30/2015). Rates per 100,000 population.

Table 20: Chlamydia, gonorrhea, and primary and secondary syphilis by county, Connecticut, 2014

	Chlamydia		Gonorrhea		Syphilis	
County	N	Rate	N	Rate	N	Rate
Fairfield	2,844	301	450	48	20	2
Hartford	4,002	446	747	83	22	2
Litchfield	278	150	43	23	0	0
Middlesex	300	182	48	29	3	2
New Haven	3,859	448	689	80	35	4
New London	822	300	87	32	7	3
Tolland	244	161	38	25	0	0
Windham	299	256	16	14	0	0
Total	**13,134**	**365**	**2,223**	**62**	**87**	**2**

Source: Connecticut STD Control Program, STD*MIS data and CDC Bridged-Race Population Estimates, intercensal population estimates (released by NCHS on 7/26/2012); postcensal population estimates (released by NCHS on 10/26/2012); postcensal population estimates (released by NCHS on 6/30/2015). Rates per 100,000 population. Rates based on counts <12 are considered unstable and should be interpreted with caution.

Figure 20: Number of male primary and secondary syphilis cases with MSM risk and HIV positive status, Connecticut, 1995–2014



Source: Connecticut STD Control Program, STD*MIS

Over the last 10 years, syphilis cases have been predominately in MSM. Since 2002, the percentage of male cases with known MSM risk has ranged from 79%–96%. HIV testing is offered to all syphilis cases.

Section X: Hepatitis C

Table 21: Positive hepatitis C test results, Connecticut, 2010–2014

	Confirmed		Unconfirmed		Total
Year Reported	N	Row %	N	Row %	N
2010	1,963	96.8	65	3.2	2,028
2011	1,942	97.9	42	2.1	1,984
2012	2,112	97.9	46	2.1	2,158
2013	2,077	99.0	21	1.0	2,098
2014	2,416	99.2	13	0.5	2,429
Total	10,510	98.3	187	1.7	10,697

Source: Hepatitis C surveillance registry through 2014

Table 22: Rate of hepatitis C, past or present by age and sex, Connecticut, 2010–2014

Age	Sex	2010	2011	2012	2013	2014
<15	Male	0.6	1.2	0.9	0.6	1.2
	Female	0.3	1.5	0.9	1.2	1.5
15-19	Male	7.0	2.3	8.5	9.3	5.4
	Female	8.2	5.7	10.7	17.2	9.0
20-29	Male	67.1	84.0	88.8	102.6	127.5
	Female	64.1	66.4	85.7	89.9	108.8
30-39	Male	79.3	96.4	102.5	121.5	130.5
	Female	45.4	42.2	54.1	56.0	75.7
40-49	Male	118.4	94.3	105.5	102.9	88.4
	Female	57.4	52.5	54.9	50.7	47.2
50-59	Male	172.1	153.7	162.3	129.5	155.3
	Female	69.9	68.1	67.7	63.6	72.9
60+	Male	52.6	60.0	56.8	65.5	102.7
	Female	21.0	22.7	29.2	27.0	33.5

Source: Hepatitis C surveillance registry through 2014 and 2010 census.

It is estimated that 3.5 million people are currently infected with hepatitis C in the United States, the majority of whom were born from 1945–1965 (baby-boomers). In 2012, CDC expanded its testing recommendations to include a one-time hepatitis C test for all baby boomers to assist in early diagnosis and treatment of the virus. Connecticut's 2010–2014 data parallels the national data in which the largest percentage of people diagnosed with past or present HCV are in the baby boomer cohort. During 2010–2014, among HCV positive Connecticut residents, males over the age of 19 years were disproportionately affected by HCV as compared to females over 19 years.

Table 23: Estimated number and percentage of people living with HIV-HCV co-infection by gender, race/ethnicity, age, and HIV transmission category, Connecticut, 2014

	IDU		MSM		MSM/IDU		Heterosexual		Other/Unk[2]		Total
	N	%	N	%	N	%	N	%	N	%	N
Gender											
Male	807	70	149	13	49	4	92	8	64	6	1,161
Female	346	69	---	---	---	---	127	25	32	6	505
Race											
Black	332	68	37	8	13	3	80	16	29	6	491
Hispanic	494	72	48	7	18	3	92	13	32	5	684
White	315	66	62	13	18	4	46	10	34	7	475
Other[3]	12	75	2	13	---	---	1	6	1	6	16
Age at report of co-infection (years)											
<20	1	20	---	---	---	---	---	---	4	80	5
20–29	85	66	18	14	4	3	16	13	5	4	128
30–39	358	72	44	9	17	3	61	12	19	4	499
40–49	502	72	60	9	15	2	87	12	35	5	699
50+	207	62	27	8	13	4	55	16	33	10	335
Total	1,153	69	149	9	49	3	219	13	96	6	1,666

[2]Other/unknown transmission category includes perinatal
[3]Other race includes Asians, Asian Pacific Islanders, and multi-racial
Source: HIV surveillance registry through 2015 and HCV surveillance registry through 2014.

A match was performed using the HIV and HCV surveillance registries to estimate co-infection of people living with HIV. Using SAS 9.4 (SAS Institute, Cary, NC), electronic datasets limited to people reported to still be living, were extracted from each of the registries. The HIV file was further limited to cases diagnosed between 1994–2014 to correspond to the date range of the HCV registry. As a result, 51,017 cases of people living with probable or confirmed HCV and 8,481 cases of people living with HIV were included in the subset for matching. Matching between databases was conducted according to a standard sequence. The first match used exact first name, last name, and date of birth. Additional matches were performed using SOUNDEX, a code based on substitution of numbers for certain letters of the patient last name, and date of birth as follows: a) SOUNDEX and exact date of birth; b) SOUNDEX and month and year of birth, and; c) SOUNDEX and year of birth. Cases identified using the less exact SOUNDEX and incomplete dates of birth were evaluated manually to confirm the cases were the same. It is estimated that 20% of people living with HIV are co-infected with HCV and 3% of people living with HCV are co-infected with HIV.

Appendix 1

HIV Surveillance Methods

- Most Connecticut tables and graphs herein combine HIV and AIDS into "HIV disease" or simply, "HIV". The initial year of diagnosis indicates the year first diagnosed with HIV infection regardless of HIV or AIDS status at the time of the diagnosis.

- ***Uses of surveillance information:*** The primary purpose of the DPH HIV Surveillance Program is to systematically collect, analyze, interpret, and disseminate information about HIV trends in Connecticut. This information is used by a variety of state and federal agencies to develop policies and allocate funding for local prevention and care needs. Surveillance information is also used by media, local health departments, non-governmental organizations and agencies, hospitals, physicians, students, and others. Other important functions of the surveillance system at the state and national level include monitoring national HIV strategy goals, estimating incidence of HIV infection, identifying cases of public health importance, and monitoring genetic variants and drug-resistant strains.

- ***Reportable diseases:*** Connecticut law requires DPH to maintain lists of reportable diseases and reportable laboratory findings. The lists include approximately 60 diseases and conditions of public health importance. Information is collected about each person with a disease or condition on the list. Reports are generated by the provider who diagnoses the disease and the laboratory that performs the test associated with the disease.

- ***HIV surveillance:*** AIDS has been on the list of reportable diseases since the early 1980s. HIV (not AIDS) was added to the reportable disease list in 2002. HIV viral load test results were made reportable in 2006, HIV genotype sequence was made reportable in 2009 and all CD4 results in 2015. HIV is reported when an individual is confirmed to be HIV positive. Subsequent reports are made with additional testing by viral load or CD4. The AIDS case definition consists of either HIV positive with a low CD4-positive cell count (below 200 cells/microliter or less than 14% of total lymphocytes), or HIV positive and a diagnosis with one of several opportunistic infections or conditions (for example, *Pneumocystis carinii* pneumonia, wasting, or cervical carcinoma). DPH maintains a computerized registry of HIV cases (eHARS).

- ***Stage of disease:*** The current HIV case definition includes criteria for staging at the time of initial diagnosis. HIV cases may be HIV (non AIDS) or HIV Stage 1 (CD4 >500), HIV Stage 2 (CD4 200–500), or HIV Stage 3 (AIDS) (CD4 <200). A case will be classified by the highest stage they attain at any time. Cases will not be reclassified at lower stages if their clinical condition improves.

- ***Information collected about HIV cases:*** Various demographic and medical information is collected about each HIV case including: laboratory test dates, sex, race, town of residence, exposure category, AIDS indicator diseases, treatment status, pregnancy status, vital status, country of birth, and provider information. Additional information about some of these data elements is below.

- ***Year of report and diagnosis:*** HIV cases may be diagnosed in years prior to the year in which they were reported. The year of report is based on the date that the case was first reported to the DPH. The year of diagnosis is based on the earliest date in eHARS which is indicative of confirmed HIV infection. Most surveillance reports use the year of diagnosis.

Annual surveillance reports are based on cases diagnosed up through December 31 of a specified year, allowing at least an additional 12 months for more complete reporting of newly diagnosed cases.

- ***Sex:*** For each case of HIV, information is collected about 'Sex at Birth' as well as enhanced information about gender ('Current Gender Identity'). Options include 'Male,' 'Female,' 'Transgender Male-to-Female,' 'Transgender Female-to-Male,' and 'Additional Gender Identity.' Very few cases are reported with other than male or female sex. There are never cases with unknown sex. If a case is reported without sex, follow-up is conducted to obtain it.
- ***Race/ethnicity:*** For each HIV case, race and ethnicity information is collected. Race categories include: 'White,' 'Black,' 'Asian,' 'Native Hawaiian or other Pacific Islander,' and 'American Indian/Alaska Native.' Ethnicity is coded as 'Hispanic' or 'Not Hispanic' and entered into a separate variable from race. Cases can be of more than one race. 'Black' is used as shorthand to save space for the more complete description used by the US Census, 'Black or African American' and Hispanic is used as shorthand for 'Hispanic or Latino.' The majority of HIV cases are reported as white, black, or Hispanic but very small numbers of other race categories are also reported and categorized as 'Other' in HIV tables unless specific analyses are conducted. Also, 'Multirace' can be reported and is included in 'Other' unless specifically included in analysis. Race and ethnicity are collected in separate fields and can be analyzed separately but because most Hispanic cases are Hispanic-white or Hispanic with no race reported, any case reported as Hispanic will be in the Hispanic category regardless of race. There are never cases with unknown race/ethnicity. If a case is reported without race or ethnicity, follow-up is conducted to obtain it.
- ***Residence:*** The city of residence in HIV tables refers to the city where the case resided at the time of their initial diagnosis. With ongoing laboratory reporting of CD4 and viral load, more recent addresses can be reported and are included in eHARS. There are never cases with unknown initial city of residence. If a case is reported without city, follow-up is conducted to obtain it.
- ***Age:*** Information about age is presented in two ways, age at diagnosis and current age of PLWH. Current age refers to age at the time the data was created for analysis, typically December 31 of the specified year. Cases 0–13 years of age are considered 'children' and cases ≥13 are considered 'adults and adolescents.' Upper age group categories have been added as the number of cases in those age groups increases. There are never cases with unknown age. If a case is reported without age, follow-up is conducted to obtain it.
- ***Country of birth:*** Information about country of birth is collected but poorly reported. This information is not always available to providers. An analysis of country of birth was previously provided (QuickStat, June 10, 2009) and shows that for the majority of cases where country of birth was known, US was reported followed by Puerto Rico and then smaller percentages for Haiti and Jamaica and many others. For cases reported between 2005–2014, 35% where missing country of birth.
- ***Exposure categories:*** For each case of HIV, information is collected about the most likely way in which the person acquired HIV infection. This information may not always be available, especially for recently reported cases. The provider may not have reported the information, or the patient may not have volunteered the information to the provider, may not have returned to the diagnosing provider, may not be in care, may have moved to another state, or may have died. When the exposure category is unknown, HIV tables and graphs classify these cases in a separate category, 'Oth/unk.' Over time, after additional follow-up

with providers, many of these cases will be reclassified into one of the known exposure categories. Essentially, all HIV cases are found to fall into one of the known risk categories when it is possible to make a complete risk assessment.

In the HIV surveillance system, HIV cases are only counted once in a hierarchy of exposure categories. Persons with more than one risk category are classified in the exposure category listed first in the hierarchy, except for men with both a history of sexual contact with other men and injecting drug use. They are in a separate category.

- ***Men who have sex with men (MSM)* –** Males who report having sexual contact with males (homosexual contact) and males who report sexual contact with both males and females (bisexual contact).
- ***Injection drug use (IDU)* –** Persons who have injected non-prescription drugs.
- ***Heterosexual contact* –** Persons who have had heterosexual contact with a person with HIV infection or who is at high risk of HIV infection (IDU, bisexual male).
- ***Other* –** Other exposure categories include received clotting factor or hemophilia/coagulation disorder, transfusion recipient, transplant recipient, and worker in a health care or clinical laboratory setting. Due to low numbers, these cases are classified together as 'Oth/unk' in HIV tables and graphs.

- ***Opportunistic infections:*** There are 26 opportunistic infections or conditions (not all are infections) that, together with HIV infection, indicate development of AIDS (or HIV Stage 3). These are also referred to as 'AIDS indicator diseases.' Many of these diseases result from impaired immunity. Having one of these diseases does not necessarily indicate that the person has HIV infection. The HIV surveillance system collects information on the disease(s) that are reported with the initial diagnosis of AIDS. Indicator diseases that are subsequently diagnosed are not systematically monitored.

- ***HIV in children:*** Information specific for pediatric cases of HIV (<13 years of age) are also collected. A pediatric case report form is used to collect this information. For each case of perinatal HIV exposure, a medical record extraction is conducted for the mother-child pair. Information collected about the mother includes demographics, risk behavior, HIV testing information, and adequacy of prenatal care. Information collected about the infant includes HIV preventive treatment, testing information and final HIV status.

- ***Death:*** Reported cases are assumed to be alive unless specifically confirmed to be dead. Information about death is obtained from several sources. DPH Vital Records provides year end data and periodically comprehensive data for matching against the HIV registry to update case vital status and import cause of death. Also, the CDC provides data from the Social Security Master Death file as well as the National Death Index to permit the identification of deaths among Connecticut HIV cases that occur in other states. Due to the lag in reporting death information is analyzed at least 12 months after the most recent diagnosis year.

- ***Incidence estimation:*** Connecticut has participated in HIV Incidence Surveillance since 2005. The data collected by this project contributes to the national estimate of HIV incidence and also allows for a Connecticut estimate to be generated. The estimate is based on results of a laboratory test conducted on remnant diagnostic specimens that indicates whether the person has been infected in the past six months. The test is licensed only for surveillance (not clinical) use because of the high false positive and high false negative rates for individuals. A statistical model adjusts for this as well as the testing history of the demographic and

behavioral risk group characteristics of the case yielding a more reliable population estimate. The estimate is conducted yearly.

- ***Molecular HIV surveillance:*** Since 2009 Connecticut has participated in an HIV surveillance project whose aims are to characterize genotype and resistance patterns of HIV in newly diagnosed cases. Surveillance is based on the laboratory reporting of the genome sequence in the *pol* region of HIV by laboratories.

Appendix 2

Description of Data Sources

Data source	Description of methods	Strengths and limitations
HIV Surveillance Registry	Provider and laboratory reporting of HIV infection is required. eHARS is the HIV surveillance registry. Additional information about HIV surveillance data can be found at the following website: www.ct.gov/dph/HIVsurveillance	Strengths: • Statewide data • Includes information about demographics and risk factors for infection • Can be matched with other databases (STD, death, HCV) Limitations: • Information about recent cases tends to be incomplete for a period of time
Hepatitis C Surveillance Registry	Laboratory findings for hepatitis C are laboratory reportable. Acute hepatitis C cases are physician reportable. Additional information about hepatitis C can be found at the following web site: www.ct.gov/dph/Hepatitis	Strengths • Statewide data Limitations: • Information about residence and demographics is incomplete • Difficult to detect new infections
Sexually Transmitted Diseases Surveillance Registry	Chlamydia, gonorrhea, syphilis, chancroid, and neonatal herpes are required to be reported to DPH by laboratories and providers. DPH staff follow-up on all newly diagnosed syphilis cases to collect additional information about contacts, demographics, and behavioral characteristics. Additional information about STDs can be found at the following web site: www.ct.gov/dph/std	Strengths: • Statewide data • Includes information about demographics and risk factors (syphilis) for infection • Interviews in the context of partner services are conducted with all syphilis cases and have established MSM as a primary risk factor Limitations: • Information about recent STD cases may be incomplete

Vital Records	Death data - Vital records supplied data about deaths in Connecticut. Included is information about primary and secondary causes of death. Information about deaths is provided through the Death Certificate reporting process. Death data for Connecticut can be found at the following website: www.ct.gov/dph/mortaltity	Strengths: • Statewide data • Includes information about persons with HIV who die. • Matching with eHARS can update vital status of HIV/AIDS cases Limitations: • This data can be several years out of date due to time needed to complete reporting.
Behavioral Risk Factor Surveillance System (BRFSS)	The BRFSS is an ongoing telephone survey of adults conducted in all 50 states and coordinated by the CDC in Atlanta, GA. Households are randomly selected and contacted by a contractor who conducts most interviews in the evenings and on weekends. Once an interviewer reaches a household, a random selection of adult household members is made to choose one person to participate in the survey. Listed and unlisted residential telephone numbers are included in the sample, and in 2011, approximately fifteen percent of the interviews were completed by way of cellular telephones. The questionnaire changes somewhat from year-to-year and state-to-state to meet changing needs and address state specific priorities. The BRFSS originally collected data on health behaviors related to the leading causes of death, but has since been expanded to include issues related to health care access, utilization of preventive health services, and to address emerging issues such as cigar smoking or diet pill use. At the end of each year, data are compiled and adjusted to be representative of all adults in the state, and returned to states for analysis. Data for all states are available via the CDC BRFSS website. Information about the BRFSS in Connecticut can be found at the following website: http://www.ct.gov/dph/BRFSS	Strengths: • Statewide data • Includes information about demographics and risk factors for HIV • Includes information about HIV testing • Data are weighted to population characteristics Weaknesses: • Telephone survey. • Difficult to reach populations and groups which represent small percentages of the population will be contacted infrequently
Connecticut School Health Survey	The Connecticut School Health Survey (CSHS) is comprised of the Youth Tobacco Component (YTC) (PDF) and the Youth Behavior Component (YBC) (PDF). These two school surveys have been co-administered since 2005. The YTC is a school-based survey of students in grades 6 - 12, with randomly chosen classrooms within selected schools, and is anonymous and confidential. The YBC is also a school-based survey of students, but only of high-school grades 9 - 12 and it, too, is anonymous and confidential. Information about the CSHS in Connecticut can be found at the following website: http://www.ct.gov/dph/CSHS	Strengths • Conducted biennially • Describes prevalence of health-risk behaviors among youths • Asses trends over time • Nationally comparable data • Statistically significant sample size Limitations • Schools need to volunteer to be sampled • Questions can change year to year