Connecticut HIV Prevention and Care Plan
2017 – 2018 Update

Connecticut Department of Public Health Commissioner Dr. Raul Pino leads a question and answer session at the June 2017 CHPC meeting.

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2018 PLAN UPDATE

Why update the plan?

- *Federal HIV prevention and care funders require DPH and the CHPC to update the plan each year.*
- *The update process creates an opportunity to identify any changes in the data, to review implementation progress and to make any "mid-course corrections".*

Are we making any changes to the plan after the first seven (7) months of implementation?

- *The goals, objectives, focus areas and priority activities remain the same.*
- *The CHPC's statewide indicators now reflect targets for 2021.*
- *The update includes priority action items for 2018. These action items address CHPC priorities and respond to feedback from federal funders who reviewed the plan.*

What are some examples of 2018 priority activities?

- *Getting to Zero (G2Z) Campaign focusing on 5 most impacted cities*
- *Statewide needs assessment survey*
- *Additional indicators to monitor HIV prevention efforts*
- *Expanding and enhancing peer support provider models*

Purpose

The Connecticut HIV Planning Consortium (CHPC) holds primary responsibility to: a) develop Connecticut's Integrated HIV Prevention and Care Plan and b) assess progress and update the plan each year – including the identification of any mid-course corrections. The CHPC members unanimously approved Connecticut's Integrated HIV Prevention and Care Plan 2017-2021 on August 17, 2016.

The plan features four goals, each of which align with the National HIV/AIDS Strategy:

1. Reduce new infections.
2. Increase access to care and improve health outcomes for persons living with HIV (PLWH).
3. Reduce HIV health disparities and health inequities.
4. Achieve a more coordinated response to the HIV epidemic.

During the first seven months of plan implementation, the CHPC aligned its work to support the achievement of plan goals. This document reflects upon the success from 2017 (January through August) and identifies plan priorities for 2018.

Methodology

The CHPC leaders and project staff members assembled relevant information to assess progress during the early stages of plan implementation. Primary sources of information included:

- CHPC data indicators
- Epidemiological updates
- Implementation updates from lead implementation partners (e.g., Ryan White Parts)
- Participant feedback from CHPC meetings (CHPC members and public participants)
- Feedback about strengths and weakness of the plan from reviewers associated with the Centers for Disease Control and Prevention (CDC) and the Health Resources and Services Administration (HRSA)
- Input from members of the Connecticut HIV Funders Collaborative

At the July 19, 2017 CHPC meeting, CHPC members and public participants reviewed early implementation progress, identified potential mid-course corrections and discussed plan priorities for 2018. Project staff members organized the information into this plan update.

Approval Process

CHPC members received electronic and/or written copies of the Plan Update prior to the August 2017 CHPC meeting. On August 16, the CHPC members voted by written ballot to approve the Connecticut HIV Prevention and Care Plan 2017-2018 Update. Of 27 CHPC members present at the meeting, 27 members (100%) voted to approve the plan update and priorities for 2018.

Plan Goals, Objectives and Areas of Focus

Table 1 shows the plan goals, objectives and focus areas. Visit www.cthivplanning.org to view the plan.

Table 1. Summary of plan goals, objectives and focus areas

Goals	Objectives	Focus Areas
1. Reduce New Infections	1.1 Decrease the number of new infections by 25%, from 291 in 2014 to 218 in 2021.	• Strengthen statewide communication platform to deliver prevention and health promotion messaging • Increase access to PrEP and n-PEP • Promote "Treatment as Prevention"
	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.	• Improve evidence-based HIV outreach, testing and linkage services • Increase access to clean needles and syringe exchange services
2. Increase access to care and improve health outcomes for PLWH	2.1. Increase linkage to HIV care in newly diagnosed persons (aged 13+) from 91% (2014) to 95% (2021).	• Promote and facilitate access to healthcare (high risk populations & PLWH) • Strengthen access to care initiatives, including re-engagement in care, for PLWH and priority populations
	2.2 Increase viral load suppression among persons in HIV medical care from 86% (2014) to 90% (2021).	• Optimize and Increase Resources Available to Impact PLWH • Strengthen Connecticut AIDS Drug Assistance Program • Strengthen capacity to implement quality improvement initiatives (related to PLWH in-care and to increase retention in care)
3. Reduce HIV-related disparities and health inequities	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.	• Analyze data sets by income, race/ethnicity and factors relevant to social determinants of health • Introduce and scale effective Evidence Based Strategies to reach high priority populations • Increase HIV workforce competencies and cultural and linguistic capacity to serve priority populations
	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).	• Partner in a statewide campaign to end HIV • Partner in core medical / healthcare service delivery initiatives that impacts health equity • Partner in supportive service initiatives that impact health equity
4. Achieve a more coordinated statewide response to the HIV epidemic	4.1. Build capacity of CHPC to develop and advance statewide planning efforts as well as to diffuse and sustain effective models.	• Increase organizational effectiveness of CHPC to conduct planning, coordination and stakeholder engagement • Enhance communications and information sharing across CHPC stakeholders
	4.2. Increase capacity of HIV stakeholders and partners to implement the Statewide HIV Plan.	• Improve integration of program collaboration services integration model (PCSI) • Establish HIV Funders Leadership Group • Review and monitor progress of Plan

CHPC Indicators

Table 2 (page 6) shows the CHPC indicators that serve as the high level "data dashboard" for the statewide plan. The dashboard confirms that the statewide implementation partners contributed to outcomes that met or exceeded goals to reach by 2015 (set in the previous plan).

Mid-Course Corrections Unnecessary after the First Seven Months of Implementation

The CHPC will not make any mid-course corrections to the plan. After seven months of implementation, the plan remains relevant and responsive to the epidemic and other factors and addresses recommended action items identified by plan reviewers associated with the CDC and/or HRSA.

Table 2. CHPC Indicators to Monitor Progress	2015 Goal	Met	2021 Goal
1. HIV Positivity Rate (Biological): Number of newly diagnosed (dx) in the 12-month calendar year per 100,000 people.	315 newly dx	√	218 newly diagnosed
2. Seropositivity Rate (Service / Access): Number of OTL and ETI HIV positive tests in the 12-month calendar year.	0.2% ETI; 0.3% OTL	√	0.2% ETI; 0.3% OTL
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.	85%	√	90%
4. Linkage to HIV Care (Biological): Number of persons who attended a routine HIV medical care visit within 3 months of HIV diagnosis.	90%	√	95%
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.	65%	√	TBD based on more recent data
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.	35%	√	30%
7. Antiretroviral Therapy Among Persons in HIV Medical Care (Service / Access): Number of persons with HIV diagnosis who are prescribed ART in the 12-month calendar year.	95%	√	97%
8. Partner Services (Service / Access): Number of newly diagnosed interviewed (i.e., linked) by Partner Services.	95%	√	95%
9. Housing Status (Service / Access): Number of persons with an HIV diagnosis who were stably housed in the 12-month calendar year.	80%	√	TBD based on baseline data using new definition for "housing stability"
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])	**TBD**	**TBD**	**TBD**
11. Disparities in New HIV Diagnoses: Number of newly diagnosed (dx) in the 12-month calendar year for each of the following: Men who have sex with men (MSM), Black / African American / Latino men and women.	**N/A**	**N/A**	Reduce new HIV dx by 15% for each priority population.

2018 Plan Priorities

Table 3 identifies the implementation priorities for 2018. These priorities address recommended action items identified by plan reviewers associated with the CDC and/or HRSA.[1] These priorities include cross-cutting initiatives that impact multiple goals and objectives and will result in measurable changes to the CHPC indicators.

Table 3. 2018 Plan Priorities Crosswalk

	Blue Shading Denotes Objectives Affected by 2018 Plan Priorities							
Data 2 Care Initiative to increase clients linked or re-engaged in care	**1.1**	1.2	**2.1**	**2.2**	**3.1**	**3.2**	**4.1**	4.2
Priority because: DPH initiative + necessary component to help state reach zero new infections								
2018 milestone: DPH present initial project data / outcomes to the CHPC								
Promotion, exploration, funding, implementation of peer support models	1.1	1.2	**2.1**	**2.2**	**3.1**	3.2	**4.1**	4.2
Priority because: Evidence-based approach to reducing new cases and improving health disparities								
2018 milestone: Present NAP Team briefing paper with peer model recommendations to the CHPC								
Getting to Zero (G2Z) Campaign with focus on five (5) most impacted cities	**1.1**	**1.2**	2.1	**2.2**	**3.1**	**3.2**	**4.1**	4.2
Priority because: Cross-cutting initiative to link PLWH to care, suppress VL, reduce infections, spread awareness								
2018 milestone: G2Z Commission co-chairs present initial project data / outcomes to the CHPC								
Conduct phase 2 of HIV workforce survey	1.1	1.2	**2.1**	**2.2**	**3.1**	3.2	**4.1**	**4.2**
Priority because: next steps of ongoing process (first of three (3)-part survey administered 2016)								
2018 milestone: Second iteration of workforce survey administered								
Conduct comprehensive needs assessment in late 2017 and early 2018	1.1	1.2	**2.1**	**2.2**	**3.1**	3.2	**4.1**	**4.2**
Priority because: CDC + HRSA recommendation, statewide agreement to conduct "deep dive" on known gaps								
2018 milestone: Needs Assessment tool completed by January 2018								
Conduct community outreach, education, and communication	**1.1**	**1.2**	**2.1**	2.2	**3.1**	**3.2**	**4.1**	4.2
Priority because: Increase awareness, increase # individuals being tested, catalyst to reaching zero new infections								
2018 milestone: Feature 2-3 guest speakers at CHPC to speak about syringe services / testing / other resources								
Shape the role and charge of the HIV Funders Collaborative	1.1	1.2	2.1	2.2	3.1	**3.2**	**4.1**	**4.2**
Priority because: Statewide emphasis on data- and resource-sharing to maximize prevention and care efforts								
2018 milestone: Expansion of HIV Funders Group to at least 3-5 new members representing supportive services								
Add indicators to monitor HIV prevention efforts	**1.1**	**1.2**	2.1	2.2	**3.1**	3.2	**4.1**	4.2
Priority because: Changing public health landscape to focus on HIV prevention; better understand prevention population								
2018 milestone: Addition of at least one (1) new CHPC indicator related to prevention (e.g.,PrEP)								
Emphasize the voices of PLWH within quality improvement efforts	1.1	1.2	**2.1**	**2.2**	**3.1**	3.2	**4.1**	**4.2**
Priority because: State commitment to focus on the voices of PLWH								
2018 milestone: 3rd CHPC PLWH Panel + peer support model progress + CHPC member diversity + training & empowerment								

[1] The recommended action items by HRSA reviewers were contained in the Plan (e.g., statewide needs assessment, additional data analysis on social determinants of health / disparities). The table does not reflect all of the implementation work for 2018 by partners and stakeholders.

2017 PROGRESS

Did the CHPC meet its previously set goals?

- *Stakeholder engagement continues to increase (page 9)*
- *CHPC reports progress on statewide data indicators (page 7)*
- *Progress occurs across each plan goal (pages 10 to 17)*

How can I stay updated on the CHPC's progress?

- *In June of 2017, the CHPC launched its website that contains information about statewide events, links to the statewide community calendar, past meeting materials, CHPC community photographs, background documents (e.g., Integrated Plan, CHPC Charter), staff contact information, and more. Visit www.cthivplanning.org.*

Stakeholder Engagement – The Heart of the CHPC Process

The CHPC prides itself on creating an inclusive, respectful and productive statewide planning community. At the end of each meeting, CHPC members complete feedback forms. One question asks individuals to share a word or phrase that they feel best describes their meeting experience. Figure 1 reflects every response submitted during 2017, with the size of the word correlated with the frequency with which it was used.

Figure 1. Analysis of "What One Word Describes Your Experience at the CHPC meeting today?

Table 4 shows select information about the CHPC process. In June 2017, the CHPC had 51 members of the public in attendance (its largest turnout of the year). The meetings feature committee work, expert presentations and panel discussions relevant to plan topics. Table 5 shows examples of partner and stakeholder events that occur outside of CHPC meetings. The recent launch of the CHPC website will increase visibility and communication across the HIV community.

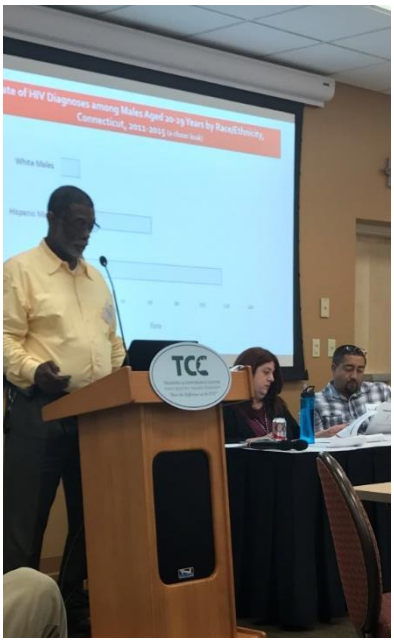
Table 4. CHPC by the Numbers (January 1, 2017 to August 31, 2017)

7	86%	256	22	97%
CHPC Meetings	CHPC member attendance	Cumulative number of public participants	New member applications (for 2018)	Overall satisfaction rating (CHPC members + public)

Table 5. Examples of HIV Partner and Stakeholder Events

JAN	2017 legislative session began 1/4 AIDS CT, Hartford RW Office, and HOPWA held case manager training 1/24
FEB	AIDS Connecticut held Oscars viewing fundraiser 2/27 CT DPH hosted a three (3)-part drug user health training FEB-APR
MAR	Elsie Cofield Women and Girls HIV/AIDS Awareness Awards 3/10 True Colors Conference at the University of Connecticut 3/17-3/18 CADAP Advisory Group Meeting in Hartford 3/29
APR	HYHIL Consortium Women & Girls HIV/AIDS Awareness Day 4/21 AIDS Walk New Haven 5-k, games, and food 4/22 Dining for Life in New Haven; portion of restaurants' proceeds to APNH 4/27 New Haven Mayor's Task Force on AIDS Legislative Breakfast at City Hall 4/28
MAY	HRSA visit to Ryan White Part B office 5/9-5/10 Annual AIDS Awareness Day at State Capitol 5/10 Hepatitis Testing Day events in Bridgeport, Hartford, New Haven, others 5/19
JUN	CT DPH Annual HIV Prevention Meeting 6/16 National HIV Testing Day Events statewide 6/27 Shiloh Baptist Church (Hartford) outdoor service with follow-up services including testing, education, supportive services, other resources JUN-AUG
JUL	Meeting to discuss Mayor's Task Force on AIDS 7/11 PrEP outreach event at 2017 Jazz Festival in Hartford 7/15 Several outreach events statewide on World Hepatitis Day 7/28

CHPC community co-chair André McGuire presents prevalence data alongside fellow co-chairs Gina D'Angelo and Aurelio Lopez



*Note that this list represents a small sample of projects, events, and meetings from 2017.

Goal 1. Reduce New Infections

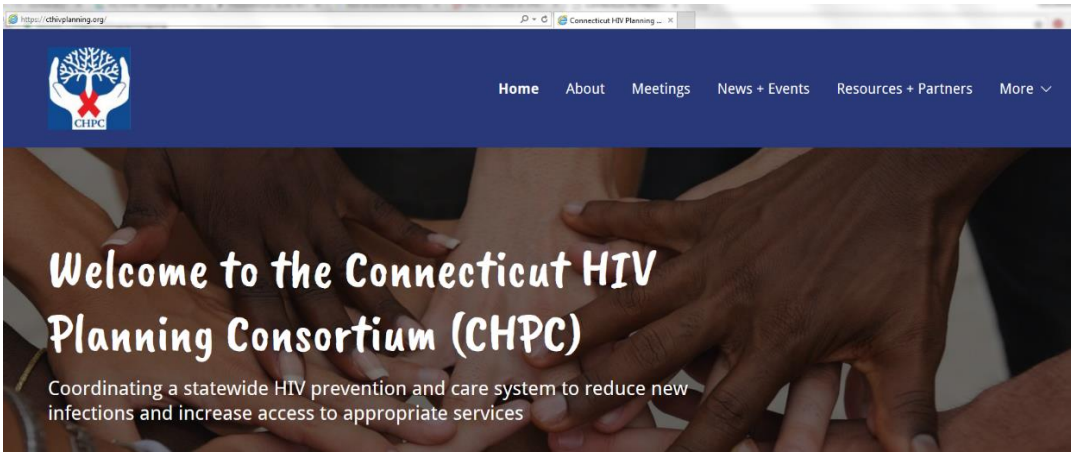
Objective 1.1 Decrease the number of new infections by 25%, from 291 in 2014 to 218 in 2021.

Focus Area A Strengthen statewide communication platform for prevention and health promotion messaging

Social marketing. Positive Prevention CT (www.positivepreventionct.org) promotes social marketing campaigns, spreads awareness, promotes testing, and publicizes outreach events.

CHPC website. Figure 2 shows the landing page from the CHPC website launched in June 2017. The site contains information about statewide events, links to the statewide community calendar, past meeting materials, CHPC community photographs, background documents (e.g., Integrated Plan, CHPC Charter), staff contact information, and more. Visit www.cthivplanning.org.

Figure 2. A Screen Shot of the Landing Page on the CHPC Website



Focus Area B Increase access to PrEP and n-PEP

DPH convenes a PrEP workgroup every two months to discuss outreach, education and awareness. This group provides input into the development of a PrEP case management tool and helps DPH circulate PrEP toolkits to providers across the state. During 2017, DPH launched several prevention pilot projects including: Drug User Health Initiative; Testing Strategies – Testing Together & Social Networking; and PrEP Navigation Projects.

Focus Area C Promote Treatment as Prevention ("T as P")

Policy. As a result of a policy-change effort, Syphilis and HIV testing for pregnant women will be administered individually to ensure women testing positive for either receive adequate treatment, thus improving their health and reducing the risk of perinatal infection.

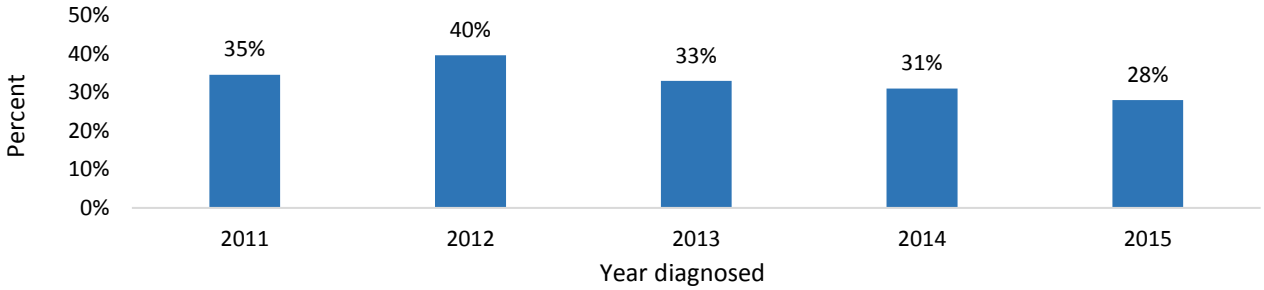
PLWH Panel. The PLWH Panel, held at the August CHPC meeting, included stories and experiences from six (6) panelists related to achieving viral suppression; conducting outreach; participating in and facilitating support groups; sharing their status with friends and family members; and their strong involvement in a wide range of quality improvement initiatives, planning bodies, and other stakeholders groups. One hundred percent of CHPC meeting participants who submitted a feedback form after the panel rated it positively.

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

Focus Area A Improve evidence-based HIV outreach, testing and linkage services

Routine testing. **Figure 3** shows that Connecticut continues to encounter a high late tester population. DPH will convene a stakeholders group to explore and improve routine screening processes. Additionally, more hospitals now provide routine HIV screenings and DPH continues to expand training for prevention providers on topics such as in nontraditional outreach methods, HIV testing training on Social Networking Strategy (SNS) and Couples HIV Testing and Counseling (CHTC).

Figure 3. Late Testers in Connecticut, based on data through December 2016



Integrated testing. DPH staff members work with all HIV testing providers to integrate HCV screenings which improve health and reduce health disparities and inequities.

Work groups. A robust network of regional and statewide work groups promote HIV testing. For example, a Positive Prevention CT workgroup focuses on social marketing strategies and engagement initiatives (e.g., prevention and testing messages for Black MSM).

Outreach. Agencies and organizations across the state offer ongoing testing opportunities. See page 9 for a sample of 2017 outreach events, many of which offered testing and education around testing.

Come Give us Life *was a Hartford event targeting transgender individuals and MSM with activities and HCV and HIV testing.*	*The African American Caucus + HYHIL Consortium celebration for Black AIDS Awareness Day was called* ***"I love my life… we love our lives."***	*A Hartford National Women and Girls HIV/AIDS Awareness Day event featured a Double Dutch clinic dubbed* ***Jump for Health****.*

Focus Area B Increase access to clean needles and syringe exchange services

Policy. As a result of DPH led policy changes, the formerly titled "syringe exchange services" was altered to "syringe services program." The program was expanded to increase access to clean syringes for people who inject drugs by allowing for secondary exchange within the drug using network. Also, though the state's healthcare infrastructure may not be able to support a mandatory testing law at this time, mandatory testing remains a future policy goal.

Goal 2. Increase Access to Care and Improve Health Outcomes for PLWH

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

Focus Area A Promote and facilitate access to healthcare (*high risk populations & PLWH*)

Expanded services. Ryan White Part B expanded Early Intervention Services (EIS) to non-Transitional Grant Area (TGA) and non-Eligible Metropolitan Area (EMA) areas of the state (New London County & New Milford in Litchfield County), effective April 1, 2017. Non-Medical Case Management / Patient Navigator Services were added in 2017 statewide to ensure linkage to care for the newly diagnosed, those who have never been in care, or those returning to care.

Disease Intervention Specialists (DIS). CT DPH hired and trained regional DIS in 2017 in alignment with the state commitment to reduce and ultimately eliminate new infections. State DIS were hired at the Hartford and New Haven Health Departments and have been interviewing people newly diagnosed with HIV and referred for partner services, as well as locating their partners in both HIV and syphilis cases.

Project Cooperative Re-Engagement Controlled Trial (CoRECT). Project CoRECT represents one intervention utilizing state DIS. Project CoRECT will occur in the Hartford, New Haven, and Norwalk Health Departments; DIS will work with 23 providers to generate lists of those clients who were in care for 12 months, followed by a six-month out-of-care period. The DIS will locate these clients and work with them until they are fully re-engaged.

Focus Area B Strengthen access to care initiatives, including re-engagement in care, for PLWH + priority populations

Data 2 Care (D2C). Data 2 Care will involve DIS outreach and data mining, and will allow DPH to conduct public health surveillance to extract datasets to match and monitor viral loads and identify HIV+ individuals who fell out of care or were never in care and link or re-engage them in care; support PLWH along the HIV care continuum; and employ a strategy promoted by CDC and already implemented in a number of health departments nationally. Potential benefits include suppressing high viral loads (VL) in PLWH to both improve the quality of life of clients and reduce transmission of HIV, and increasing the general understanding of the health benefits of HIV treatment.

Other evidence of progress include:

- New Haven Part A EMA reported a 9% increase in EIS clients meeting the EMA's performance measure standard in the last year as compared to the previous year.
- The City of Hartford's HIV/HCV co-infection project aims to augment the care service delivery model by adding patient navigation to bridge outreach activities and consumer access to care.
- AIDS Project New Haven (APNH) and other organizations have committed to helping its staff better understand the respective roles within the agency, to gain a more holistic sense of service delivery and to aid in "warm handoffs" across different members of the agency's workforce.
- Frontline staff groups on regional and state levels convene regularly to discuss, promote, and improve access to care from the frontline perspective.

Collaborations. Collaborative efforts across organizations linking community-based organizations (CBO) and researchers help the state in its effort to link PLWH to care. For example, Project Spark is a research study funded by the National Institutes of Health (NIH) that will occur at ACT and AIDS Project Greater Danbury (APGD) in 2018. The project aims to test the effectiveness of an evidence-based brief intervention (BI) employing motivational interviewing for substance use within community-based HIV/AIDS service organizations relative to usual care (UC).

Objective 2.2 Increase VL suppression among PWLH in HIV medical care from 86% in 2014 to 90% in 2021.

Focus Area A Optimize and increase resources available to impact PLWH

HIV Funders Collaborative. The HIV Funders Collaborative convenes representatives of publicly funded HIV resources to provide high-level input on planning items, review datasets, create tools, and share resources. The group meets every other month. The Funders Collaborative leads several high-priority tasks as advised by CDC and HRSA, including the needs assessment, workforce assessment, data analysis relevant to social determinants of health and health disparities, and pursuit of data sets from private insurance providers.

Ryan White Part B. DPH administers Part B funding and recently issued a $6.8 million request for proposals which resulted in the expansion of services: a) across the HIV continuum of care, such as the expansion of Medical Case Management services to Litchfield County; and b) into New London and Litchfield counties in the following areas: Early Intervention Services (EIS); non-Medical Case Management (non-MCM); substance abuse services.

Focus Area B Strengthen Connecticut AIDS Drug Assistance Program

Connecticut AIDS Drug Assistance Program (CADAP). The CADAP formulary was expanded on June 1, 2017 to include the latest antiretroviral (ARV) medication known as Isentress - HD. A new data management component results in data sharing with DSS, CADAP, and CIPA, and facilitates the timely submission of the Annual CADAP Service Report and the ability to analyze service utilization data and VL suppression rates for the ADAP participants.

91% of CADAP clients in the state have achieved viral load suppression

*According to HRSA Data

Focus Area C Strengthen capacity to implement QI initiatives *(PLWH in-care and to increase retention in care)*

Quality Improvement. The CHPC QPM Team integrated the Cross Part Collaborative (CPC) to promote deeper conversations around quality improvement, including the identification and monitoring of important Plan-Do-Study-Act (PDSA) cycles for key measures. The QPM Team now delivers statewide webinars to discuss quality improvement. This effort represents one strand of an ongoing quality improvement discussion.

PLWH Involvement. The August 2017 PLWH Panel, hosted by the CHPC, featured a panelist who discussed her role in QI initiatives as both a person living with the disease who is also a member of the HIV workforce.

Data 2 Care (D2C). DPH is developing a proposed D2C initiative to connect or re-engage PLWH to care (page 12).

Surveillance. As of January 2017, DPH has the capability to monitor and generate service utilization data in real time. As of June 2017, the DPH HCSS Unit has gained access to the DSS data warehouse. This will allow DPH the ability to monitor CADAP service utilization, including by CIPA.

Claims data, data sharing, and data systems. A Memorandum of Agreement (MOA) between DPH and the Department of Social Services (DSS) on CADAP grants the DPH surveillance team access to the DSS data warehouse via Business Intelligence (BI) software and the all-payer claims database (APCD). This data access helps connect individuals to the appropriate care. An HIV Affinity Work Group increases routine HIV and HCV screenings through Medicaid provider sites and implements mechanisms at DPH to match DSS Medicaid clients who are HIV positive with DPH reported VL to ensure Medicaid provider compliance with viral load testing (HEDIS Measure). This ensures Medicaid providers are in compliance with viral load testing and management requirements and guidelines.

Goal 3. Reduce HIV-Related Health 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

Table 6 illustrates how the CHPC analyzes and reviews data by income, race/ethnicity, and other factors relevant to social determinants of health.

Table 6. Increasing data analysis by race/ethnicity and factors relevant to social determinants of health

Group	2011 Actual Diagnoses	2015 Actual Diagnoses	% change 2011-2015	2021 Goal (15% decrease) in Diagnoses
MSM	169	134	-21%	114
Black men	95	61	-36%	52
Hispanic men	71	64	-10%	54
Black women	37	38	3%	32
Hispanic women	36	16	-56%	14

Focus Area B Introduce and scale effective Evidence Based Strategies to reach high priority populations

Peer Models. The CHPC will support expansion of peer support models based on existing efforts in Connecticut and across the nation. In 2017 the CHPC reviewed existing programs, as well as a range of other resources and developed a briefing paper with high-level peer model implementation recommendations. The paper will help funders and agencies set standards for HIV peer programs and workers including core competencies, success measures, and training modules. Agencies including the UCHC/CCMC Pediatric, Youth and Family HIV Program, Human Resources Agency (HRA) New Britain, AIDS CT, and others are implementing and sustaining Peer Models.

Other evidence-based interventions (EBI) include Popular Opinion Leaders, which targets MSM youth and young adults of color and will be implemented at the UCHC/CCMC Program.

Approach. Connecticut commits to increasing and promoting trauma-informed practices in prevention education.

Focus Area C Increase HIV workforce competencies and cultural and linguistic capacity to serve priority populations

Cultural competence. The Ryan White Part B program supports an array of HIV workforce development trainings to increase HIV workforce competencies and cultural and linguistic capacity to serve priority populations. The Part B program seeks technical assistance from HRSA to develop an RFP in support of this initiative. The capacity building training will create career pathways to enhance stackable credentials for clinical and non-clinical HIV service providers. This will give HIV service providers the capacity to attract and to retain qualified HIV prevention and care workers.

Diversity workgroups. DPH is developing online training modules on cultural competence when working with the LGBT Community: 1. Sexuality and HIV; 2. Gender Training; 3. Welcoming Services.

The End+ Disparities project will reduce disparities among PLWH by focusing on MSM of color; Black and Latina women; transgender individuals; and youth (13-24).The initiative promotes the application of QI interventions to increase viral suppression rates for disproportionately affected HIV sub-populations. Providers will implement PDSA projects to improve viral load.

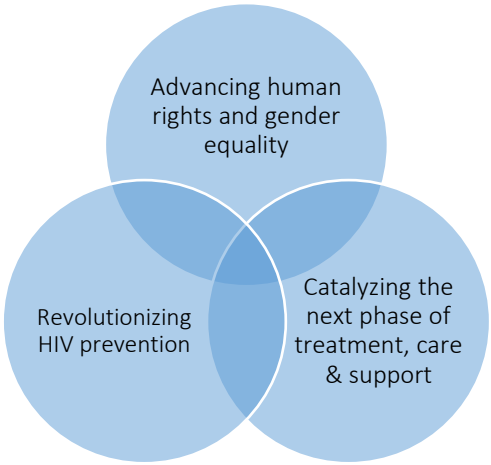
Training. The New England AIDS Education and Training Center provided 287 types of training in 2017. Topics included opt-out testing; transgendered health; and HIV/HCV coinfection. Some of faculty involved were peers.

Objective 3.2 Increase involvement in social justice initiatives and partnerships that reduce VL 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

Connecticut's Getting to Zero (G2Z) Campaign to end AIDS is loosely modeled on the Joint United Nations Programme on HIV/AIDS (UNAIDS) campaign of the same name. Figure 4 shows the UNAIDS three (3) strategic directions guiding priority-setting.[2] The campaign will focus on New Haven, Hartford, Bridgeport, Waterbury, and Stamford as they represent the five (5) cities with the highest incidence rates. Campaign efforts will focus on young MSM and communities of color.

Figure 4. UNAIDS Getting to Zero Strategic Directions



Connecticut's Getting to Zero Commission

- 2016-17: DPH convened meetings with representatives from **local Health Departments** and affected communities.
- These meetings led to a **Call to Action**, including the establishment of a **Commission** to develop a G2Z Plan.
- Stakeholders appointed **Commission co-chairs** and made recommendations for Commission members to DPH Commissioner Pino.
- The **Campaign** will take one (1) year.

Focus Area B Partner in core medical / healthcare service delivery initiatives that impact health equity

The D2C initiative will allow DPH to conduct public health surveillance to extract datasets to match and monitor viral loads and to identify HIV positive individuals who are not in care or were never in care. Providers across the state are transitioning into health service delivery more strongly resembling community-based care. Community-based organizations (CBO) that specialize in HIV service delivery are positioning themselves to provide other health services. The HIV Funders Group discussions center on strategies to maximize and improve service delivery initiatives.

Uninsurable populations. Connecticut will revitalize its discussion around strategies to promote and improve the health of individuals who are unable to obtain health insurance.

Focus Area C Partner in supportive service initiatives that impact health equity

Commitment to partners. Cities across Connecticut provide outreach and testing through partnerships with mental health treatment; homeless services; immigrant services; domestic violence shelters; and others.

[2] http://www.unaids.org/sites/default/files/sub_landing/files/JC2034_UNAIDS_Strategy_en.pdf

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 to conduct planning, coordination, stakeholder engagement

CHPC Committee Accomplishments / Highlights (2017)

Quality Performance Measures Team

- Successfully integrated the Cross Part Collaborative into QPM Team
- Planned and executed STI screening webinar
- Elected a new leader for 2018

Membership and Awareness Committee

- Planned, launched CHPC website
- Produced three (3) CHPC newsletters
- Ongoing monitoring of member issues and mentorship
- Elected new leaders for 2018

Needs Assessment Project Team

- Developed a comprehensive briefing paper with high-level recommendations for HIV peer provider model implementation for funders, agencies, and other
- Elected a new leader in 2017 (mid-year)

ad hoc Charter Review Committee

- Reviewed CHPC Charter and submitted recommendations
- Identified future need to assess alignment of CHPC mission / vision with dynamic service delivery landscape
- Elected a new leader for 2017

CHPC Meetings - Featured Presentations / Guests (2017)

- DPH Commissioner Dr. Raul Pino & Section Chief of DPH Tuberculosis (TB), HIV, STD & Viral Hepatitis Programs Heidi Jenkins led a question and answer session
- PrEP 101: The Basics
- Overdose and Naloxone Education Training
- Center for Interdisciplinary Research on AIDS (CIRA) - Implementation Science
- PLWH Panel: Consumer voices in the service delivery landscape
- Connecticut Children's Medical Center (CCMC) Peer to Peer Psychosocial Model

Focus Area B Enhance communications and information sharing across CHPC stakeholders

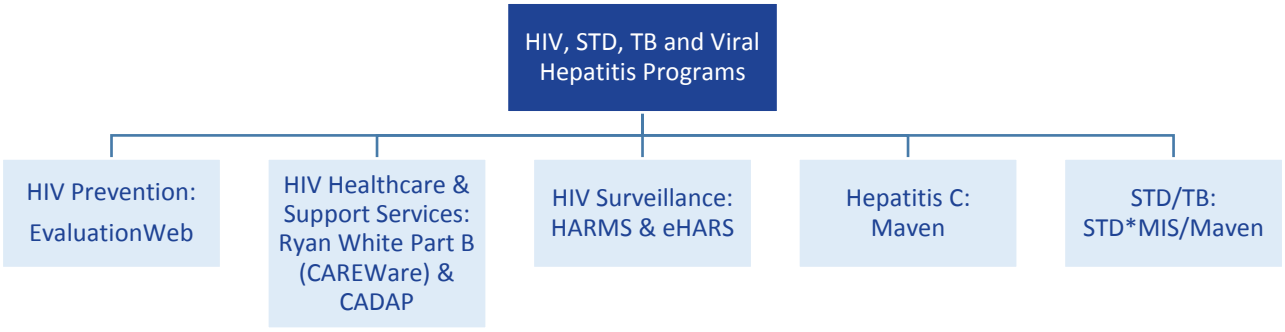
Online resources. The Positive Prevention website (www.positivepreventionct.org) serves as an outlet to share information and communicate to statewide stakeholders. Connecticut's Statewide HIV Community Calendar (http://www.guardianhealth.org/calendar/calendar.htm), updated and maintained regularly by individuals affiliated with the CHPC, is a reliable resource for events and other opportunities. The newly established CHPC website (www.cthivplanning.org) aims to combine these valuable resources to serve as a portal of information, data, resources, and event details, as well as to promote and support the CHPC community.

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)

PCSI Model. Figure 5 shows how DPH aligns its programs, data sharing and data systems to facilitate the sharing and use of surveillance data, particularly in the changing landscape with the emergence of high-risk population prevention methods. DPH guidelines will comply with the CDC Data Security and Confidentiality Guidelines.

Figure 5. DPH Alignment of Data Systems



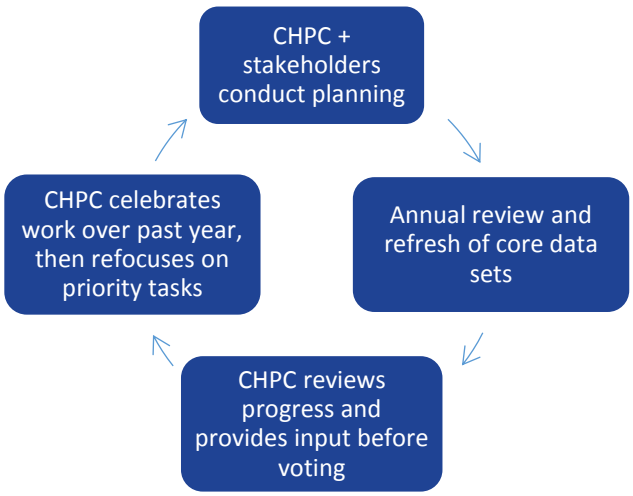
Focus Area B Establish HIV Funders Leadership Group

HIV Funders Collaborative. The Funders Collaborative met five (5) times between December 2016 and August 2017. The group positioned itself to lead the upcoming statewide needs assessment and will meet monthly during the process. The group holds ongoing discussions about expanding and strengthening its presence, including strategies to engage additional funding partners such as the Department of Mental Health and Addiction Services (DMHAS), the Department of Labor (DOL), clinical partners, research partners, housing (Housing Opportunities for People with AIDS (HOPWA) and the Department of Housing (DOH)), Federally Qualified Health Centers (FQHC), and others partners and stakeholders.

Focus Area C Review and monitor progress of Plan

Figure 6 outlines the annual assessment and monitoring process used by the CHPC to identify progress and issues as well as make mid-course corrections to the statewide plan.

Figure 6. Process to Monitor the Plan



Acronyms

ADAP: AIDS Drug Assistance Program.

AIDS: Acquired Immunodeficiency Syndrome.

APBD: AIDS Project Greater Danbury.

APCD: All-Payer Claims Database.

APNH: AIDS Project New Haven.

BI: Business Intelligence.

CADAP: Connecticut AIDS Drug Assistance Program.

CBO: Community-Based Organization.

CDC: Center for Disease Control and Prevention.

CHPC: Connecticut HIV Planning Consortium.

CHTC: Couples HIV Testing & Counseling.

CIPA: Connecticut Insurance Premium Assistance (program).

CPC: Cross-Part Collaborative.

D2C: Data 2 Care.

DAC: Data and Assessment Committee (of the CHPC).

DIS: Disease Intervention Specialist.

DMHAS: Department of Mental Health & Addiction Services.

DOH: Department of Housing.

DOL: Department of Labor.

DPH: Department of Public Health.

DSS: Department of Social Services.

EBI: Evidence-Based Intervention.

eHARS: enhanced HIV/AIDS Reporting System.

EIS: Early Intervention Specialist.

EMA: Eligible Metropolitan Area.

ETI: Expanded Testing Initiative.

FQHC: Federally Qualified Health Center.

G2Z: Getting to Zero (Campaign).

HEDIS: Healthcare Effectiveness Data and Information Set.

HCSS: Health Care & Support Services.

HCV: Hepatitis C Virus.

HIV: Human Immunodeficiency Virus.

HOPWA: Housing Opportunities for People with AIDS.

HRSA: Health Resources and Services Administration.

HYHIL: Hartford Youth HIV Identification and Linkage Consortium.

LGBT: Lesbian Gay Bisexual Transgender.

MAC: Membership Awareness Committee (of the CHPC).

MCM: Medical Case Management.

MOA: Memorandum of Agreement.

MSM: Men who have Sex with Men.

NAP Team: Needs Assessment Projects Team (of the CHPC).

NEAETC: New England AIDS Education Training Center.

NIH: National Institute of Health.

Non-MCM: Non-Medical Case Management.

nPEP: non-occupational Post-Exposure Prophylaxis.

OTL: Outreach, Testing and Linkage.

PCSI: Program Collaboration and Service Integration.

PDSA: Plan-Do-Study-Act.

PLWH: Persons Living With HIV.

PrEP: Pre-Exposure Prophylaxis.

Project Co-RECT: Project Cooperative Re-Engagement Controlled Trial.

QPM Team: Quality and Performance Measures Team (of the CHPC).

RW: Ryan White (Program).

SNS: Social Networking Strategy.

SSP: Syringe Services Program.

STI: Sexually Transmitted Infection.

TGA: Transitional Grant Area.

T as P: Treatment as Prevention.

TB: Tuberculosis

UC: Usual Care.

VL: Viral Load.