State of Connecticut

Comprehensive Jurisdictional Plan for HIV Care and Prevention

2012-2015

June 8, 2012

CHPC
CONNECTICUT HIV PLANNING CONSORTIUM

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Acknowledgements

Connecticut's 2012-2015 Comprehensive Jurisdictional Plan for HIV Care and Prevention represents a collaborative effort by various representatives of Ryan White Parts, the State of Connecticut Department of Public Health (DPH), the Connecticut HIV Planning Consortium (CHPC), State agencies, provider agencies, PLWHA, and public participants from across the Connecticut. These partners all share a profound commitment to ensuring that a comprehensive continuum of care and prevention exists for residents of Connecticut.

We dedicate this plan to Janis Spurlock (1955 - 2011).

Janis, a Health Program Supervisor in the HIV Prevention Unit at the Connecticut Department of Public Health, will forever be known as one of Connecticut's leading champions of and ambassadors for reducing the spread and impact of HIV/AIDS. Peace be her journey.

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Executive Summary

Overview

The Connecticut Department of Public Health (DPH) is the lead state agency in Connecticut for coordination of care and prevention services addressing the HIV/AIDS epidemic. The agency is the center of a comprehensive network of public health services, and is a partner to local health departments for which it provides advocacy, training and certification, technical assistance and consultation, and specialty services such as risk assessments that are not available at the local level. The agency is a source of accurate, up-to-date health information to the Governor, the Legislature, the federal government and local communities. This information is used to monitor the health status of Connecticut's residents, set health priorities, and evaluate the effectiveness of health initiatives. The agency is a regulator focused on health outcomes, maintaining a balance between assuring quality and administrative burden on the personnel, facilities, and programs regulated.

The mission of the Connecticut Department of Public Health is to protect and improve the health and safety of the people of Connecticut by:

- Assuring the conditions in which people can be healthy
- Promoting physical and mental health
- Preventing disease, injury, and disability

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 hepatitis B and C. Six programs within the Infectious Disease Section are under the direct supervision of Connecticut's AIDS Director:

a) The Health Care and Support Services Unit (HCSS), which oversees Ryan White Part B care programs and services for People Living with HIV/AIDS (PLWHA).

b) The HIV Prevention Unit, which oversees prevention services and interventions for people infected or at high-risk of HIV infection.

c) The HIV/AIDS Surveillance Unit, which oversees data collection on HIV and AIDS in Connecticut and is responsible for producing the state's Epidemiological Profile, as well as monitoring trends and emerging issues/populations.

d) The Sexually Transmitted Diseases Control Program, which investigates, screens and monitors the occurrence of STDs.

e) 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.

f) The Hepatitis B and C Program, which monitors, reports, investigates and provides education, surveillance and information on viral hepatitis B and C.

Formerly the AIDS & Chronic Diseases Section, the realignment into the Infectious Diseases Section (IDS) became effective June 1, 2012. This new coordination and linkage of programs moves the Department of Public Health even more closely in alignment with Program Collaboration Service integration (PCSI).

The Health Care and Support Services Unit (HCSS) is responsible for the administration and oversight of the Ryan White Part B grant, the Connecticut AIDS Drug Assistance Program (CADAP), the Connecticut Insurance Premium Assistance (CIPA) Program, the Minority AIDS Initiative (MAI), the non-medical Transitional Case Management program (transitional linkage to the community), and the Medication Adherence Programs (MAP). Its vision is to ensure that People Living with HIV/AIDS (PLWHA) in Connecticut maintain and improve linkages to an array of comprehensive health care services that foster self-efficacy and promote optimal health outcomes. Its mission is to ensure access to and retention in quality health care and related services for all persons living with HIV/AIDS in the state.

The HIV Prevention Unit seeks to: 1) prevent HIV infection among individuals at risk for HIV; 2) increase knowledge of sero-status among those who are HIV infected but unaware of their infection; and, 3) through HIV prevention interventions, support collaboration and coordination of services for individuals living with, or at risk for HIV. To do this, the HIV Prevention Unit contracts with public, private, and community based organizations to provide services to people at high risk of acquiring or transmitting HIV and respond to an ever changing epidemic.

In 2007, Connecticut merged its two statewide planning bodies – the Connecticut HIV Prevention Community Planning Group (CPG) and the Statewide HIV Care Consortium (SWC) – into one integrated planning body for care and prevention, the Connecticut HIV Planning Consortium (CHPC). The CHPC's primary mission to conduct statewide planning and to facilitate information sharing across local, regional and statewide programs involved in HIV/AIDS care and prevention service delivery.

The DPH charged the CHPC to develop this 2012-2015 statewide Comprehensive Plan for the delivery, monitoring, and assessment of HIV Care and Prevention services that informs policy as well as Ryan White Part B and Prevention funding decisions implemented by DPH. ***The defining feature of this Plan is the full integration of care and prevention planning into one comprehensive statewide health planning document and a proactive action plan to address care and prevention service needs and gaps based on the recommendations contained in the 2012 Statewide Coordinated Statement of Need (SCSN).***

This combined 2012-2015 Connecticut Comprehensive Jurisdictional Plan for HIV Care and Prevention is a culmination of collaborative efforts which included active participation by Connecticut's two Ryan White Part A Programs (the Greater Hartford TGA and the New Haven/Fairfield EMA), funded statewide care and prevention service providers, PLWHA, representatives from Ryan White Parts C, D and F (Connecticut AIDS Education and Training Center) and other state department agencies (Department of Correction, Department of Social Services, and Department of Mental Health and Addiction Services).

Identifying Gaps and Assessing Needs in Connecticut

Connecticut, New England's second smallest state, has a diverse population of approximately 3,500,000, an 8.0% unemployment rate, a median household income of $64,032 and a statewide poverty rate of 12%.[1] . Statewide population distribution is 71.2% white (non-Hispanic), 13.4% Hispanic/Latino origin, 10.1% black, and 5.3% other. The state consists of eight counties, of which Hartford, New Haven and Fairfield contain 75% of the population. The three largest cities, Bridgeport, New Haven and Hartford, also contain the highest percentage of black and Hispanic populations, and approximately 45% of People Living with HIV/AIDS (PLWHA) reside in these cities. Although one of the richest states in America, with approximately 83% of its municipalities above the national average per capita income, Connecticut shows a great disparity in statewide income. It has many enclaves of poverty that are often overshadowed by rich communities. Higher incidences of poverty, unemployment, crime, substance use, homelessness, violence, inadequate or insufficient housing, and co-morbidities impact heavily on PLWHA in larger cities. Inadequate transportation and fewer support services and health care facilities define Connecticut's rural towns and communities.

The economic recession has hit Connecticut families hard. Connecticut experienced one of the largest declines in income (6.1%), second only to Nevada. One in five households in CT is "asset poor," meaning the household's financial assets are so low that the family could not survive for three months if family income was interrupted. The median value of a home is $157,000, requiring a monthly mortgage payment of $1,265 -- unaffordable to 60% of Connecticut households.

The 2010 Statewide Needs Assessment survey identified housing as the primary support service gap. In 2009, the New Haven/Fairfield EMA identified lack of housing as the number one service that PLWHA needed but were unable to get, and lack of housing served as a barrier for PLWHA to see their doctor. HIV prevalence is three (3) to nine (9) times higher among persons who are homeless or unstably housed. Approximately 60% of PLWHA have experienced homelessness after being diagnosed. Affordable, stable, and supportive housing increases the ability of PLWHA to access and stay in care, reduce high risk behaviors, and adhere to medication regimens. Unstable housing is strongly associated with increased HIV risk behavior, co-infection and development of drug resistant strains of HIV, treatment failure, falling out of care, increased morbidity and mortality, and declining health. According to the Connecticut's 2011 Point in Time Count, 3,756 people were living in Connecticut homeless shelters, and of these 22% (828) were children. Half of all sheltered people in Connecticut in 2011 were in Hartford, Bridgeport and New Haven. In 2008, there were an estimated 1,400 PLWHA households in the state, and 10% of individuals living in shelters reported as HIV-positive. In 2010, of sheltered adults 6% reported as HIV-positive, and in the capital city, Hartford, 8% reported as HIV-positive. Given the stigma and fear around HIV status disclosure, it can be assumed that these figures are in fact much higher.

Socioeconomic status shapes social and individual factors that affect the care of People Living with HIV/AIDS (PLWHA), the risk of HIV infection, and the probability of relying on publicly funded health care services. Poverty is particularly associated with increased morbidity and premature mortality. Poverty rates in Connecticut's cities vary from 32% in Hartford, the capital and Connecticut's poorest city, to 11.6% in Danbury. Statewide, the poverty rate for Hispanics (23.6%) and African Americans (21.1%) was significantly higher than for white, non-Hispanic Connecticut residents (5.9%).[2] Although Connecticut's largest cities experience unemployment rates much higher than the state average, unemployment

[1] 2011 Economic Development Data & Information for Connecticut and Western Massachusetts
[2] 2011 U.S. Census Data

continues to increase in rural and suburban towns. High unemployment places numerous stressors on individuals and families – loss of health insurance, loss of homes, repossessions of personal property, rise in substance abuse and domestic violence, and increased crime. Poverty and unemployment also impact Connecticut's PLWHA, the majority who have incomes under 300% FPL.

Poverty Rate in Connecticut by County and People Living with HIV/AIDS[3]

County	% of Population living in poverty 2010	PLWHA 2010
New Haven	11.6 %	3,253
Hartford	11.3 %	3,239
Windham	11.8 %	197
Fairfield	9.3 %	2,788
New London	8.9 %	523
Tolland	6.4 %	111
Middlesex	6.8 %	242
Litchfield	6.7 %	184
Statewide	**10.1 %**	**10,537**

U.S. Census data indicated that an estimated 12.3% (374,000) of all Connecticut residents under age 65 in 2010 were without health insurance for the entire previous year. Blacks in Connecticut are almost twice as likely as whites to be uninsured; Hispanics were 3.8 times more likely to be without coverage, and non-citizens were 5.6 times less likely to have health insurance than native born Connecticut residents. Connecticut's uninsured are ten times less likely to get care for an injury or illness and seven times less likely to get care for a medical emergency. An increasing proportion of those newly infected with HIV in Connecticut are low-income minorities who cannot afford or do not have private health insurance, and therefore are more likely to already be Medicaid eligible. Most Medicare beneficiaries with HIV are under age 65 and qualify as a result of their disability status; however, many low-income PLWHA may be faced with having their eligibility postponed until they do become disabled. In April 2010, more than 620,000 individuals in the state were enrolled in some form of Medicaid program, and 571,020 were enrolled in Medicare (2011).

HIV Epidemic in Connecticut

Connecticut ranks eighth (8th) among all states in the number of PLWHA. Over 19,000 HIV/AIDS cases have been reported in Connecticut since 1981, and of these more than half (54%) are living with the disease. Blacks and Hispanics comprise slightly more than 20% of Connecticut's population, but make up 65% of all HIV/AIDS cases. Injection Drug Use (IDU) is the largest behavioral risk group in PLWHA at 35%; Men who have sex with men (MSM) risk accounts for 23%, followed by heterosexual sex at 22%. Not only is HIV in Connecticut disproportionate by sex and race/ethnicity, it is also disproportionate by geography with the largest cities having the highest numbers and prevalence rate. Hartford, Bridgeport, and New Haven have a combined 45% of all PLWHA, but only 11% of the state's population. As of 12/31/2010, 82% of Connecticut PLWHA are over the age of 40, which has growing implications for HIV care and support services, HIV prevention, and specialty medical care. Despite the fact that the number

[3]Source: ERS/USDA Data-2010 Poverty rates for Connecticut.

of Connecticut HIV/AIDS cases diagnosed annually has decreased from 851 in 2002 to 407 in 2010, the number of PLWHA has increased by 7% over the past five years.

Connecticut's 2010 Epidemiological Profile of HIV/AIDS reported that of recently diagnosed cases, a significant percentage continue to have AIDS at their initial diagnosis, indicating "late testing" and therefore "lateness to care and treatment." The CDC estimates that an additional 21% of PLWHA are not aware of their status. In Connecticut, this number is estimated at 2,735 undiagnosed/unaware individuals (based on the number of individuals diagnosed and living with HIV as of 12/31/2009). Connecticut's Unmet Need is 33.9% or 3,551 individuals who are "out-of-care."

Sexually Transmitted Diseases**.** Increasing numbers of Chlamydia and gonorrhea cases in older teens and younger adults, particularly in minority populations, have been reported in Connecticut in recent years suggesting the persistence of unprotected sexual activity and the inherent potential for HIV infection. Similarly, the connection between MSM and both syphilis and hepatitis both nationally and in Connecticut, suggests resurgence in high-risk behavior in MSM that has already led to increases in HIV infection.

Hepatitis C. In Connecticut, injection drug use (IDU) is the predominant risk group for both hepatitis C (HCV) and HIV. A match of HIV/AIDS and hepatitis C registries in 2008 identified 2,345 co-infected cases, representing 24% of HIV/AIDS cases and 5% of HCV cases.

Tuberculosis (TB). Although TB cases and rates have decreased among foreign-born and US born persons in 2011, TB continues to be a major source of morbidity and mortality. Eighty-three cases of TB were reported in 2011 in Connecticut (2.3/100,000 population). Sixty-five cases were born outside the United States; forty (48.2%) of all cases were male and 43 (51.8%) were female. Of the reported cases, seven (8.4%) were also HIV co-infected.

Needs. The care and prevention needs of PLWHA corresponding with service and population priorities, targeted effective behavioral interventions (EBI), and counseling and testing initiatives throughout the state are identified by the Data and Assessment Committee of the Connecticut HIV Planning Consortium as well as Part A partners in Greater Hartford and New Haven/Fairfield (NH/FF) counties. Service priorities are specified in the 2012 Statewide Coordinated Statement of Need (SCSN).

Gaps. The following are the identified critical care and prevention service needs and gaps for PLWHA as confirmed by the 2012 SCSN for the two Ryan White Part A areas and the rest of Connecticut: most needed core service – dental, and most needed support service – housing. Other care service needs identified included health insurance assistance, emergency financial aid, help with other medical care, and assistance paying for food. For prevention, the most needed services included support groups with information on HIV prevention, effective behavioral interventions (EBIs), particularly targeting MSM, and Partner Services.

Barriers. Barriers to accessing care and prevention services for PLWHA include inability to pay, fear of revealing status, lack of transportation, housing, income that is too high, substance abuse and mental health issues, and lack of awareness of services/how to access services and benefits. For those individuals identified as out-of-care, the problems continue to be the same in 2012 as they were in 2010, 2008, 2006, 2004 and 2002: barriers of transportation, fear, distrust, lack of knowledge of services, homelessness, lack of insurance, and substance abuse. Ample room still exists for improving social marketing, outreach, linkage and referral efforts about care and prevention service provision and availability throughout Connecticut. HIV prevention and care services are improving and increasing efforts and resources to address the emerging needs associated with specific target populations

including the age group of 50+ years, Hispanic, transgender, migrant workers, populations of African descent (immigrant and undocumented), MSM, IDU, homeless, unawares and youth. Care and prevention must continue to improve cross training, coordination and collaboration among HIV/AIDS medical case managers, comprehensive risk counseling services (CRCS) staff, counseling and testing, Early Intervention Services and Minority AIDS Initiatives Specialists, Disease Intervention Specialists (DIS) and Partner Services, as well as to strengthen primary and secondary prevention efforts, and promote and implement outreach and training regarding HIV, the medical case management model, routine testing, and HIV resources for medical providers.

Community Resources. Connecticut has a broad network of prevention, care and social services that are available to state residents. Connecticut's HIV Service Matrix (see Appendices) serves as a reference of funded care, prevention, substance abuse, mental health, and housing providers throughout the state. The DPH website also contains a listing of prevention, care, STD, chronic disease, and HIV surveillance resources for public information. The Connecticut HIV Planning Consortium, a statewide integrated care and prevention planning body, functions not only as a health planning body, but also serves as a dissemination source of reliable epidemiologic and surveillance data, HIV care, STD, chronic disease, and prevention information, and also links providers into the coordinated continuum of care.

The Connecticut AIDS Drug Assistance Program (CADAP), which has no wait list, or cost containment strategies, enrolled a monthly average of 2,094 unduplicated clients between July 2011 and March 2012 with a monthly average of 1,627 total clients receiving at least one paid prescription. More than 7,000 HIV clients received care services through Ryan White Part A and/or B statewide contractors (e.g. core medical and support services), transitional case management for individuals leaving Connecticut's correctional system and returning to communities (Project TLC), as well as education, outreach and referral services through the Minority AIDS Initiative (MAI) and Early Intervention Services. Through Connecticut's state-funded HIV Medication Adherence Programs (MAP), more than 400 people received medication adherence supportive services and counseling.

Traditionally, the Connecticut Department of Public Health allocates the majority of state and federal funds supporting HIV prevention programs directly into the community so that resources best reach those at greatest need in each area of the state. The DPH HIV Prevention Unit currently funds forty-two contractors in communities across the state to conduct HIV Counseling, Testing and Referral (CTR), Expanded and Integrated (Routine) Testing, Comprehensive Risk Counseling Services (CRCS), Drug Treatment Advocacy (DTA), Effective Behavioral Interventions (EBIs), a Perinatal HIV Transmission Program, and Syringe Exchange Programs (SEP). DPH also funds a contractor to facilitate the HIV prevention community planning process and coordinate logistics.

DPH has funded community based organizations (CBOs) to conduct CTR statewide since the late 1980s. Currently, DPH funds contractors through two grants; one to implement traditional CTR Services including Rapid Testing, and another to implement Expanded and Integrated (Routine) Testing. Protocols and training developed by DPH ensure all testing programs meet established standards. DPH has also funded CBOs to implement CRCS, formerly known as Prevention Case Management (PCM). Currently, nine programs are located at CBOs, hospitals, and health departments to provide intensive risk reduction and behavior modification counseling through multiple sessions with PLWHA or those at high risk of contracting HIV.

Through state and federal funds, DPH has contracted with CBOs to implement EBIs targeting priority populations for the past eight years. Interventions include Healthy Relationships, Information and Enhanced AIDS Education, The Effects of HIV/AIDS Intervention Groups for High Risk Women, Intensive AIDS Education in Jail, MPowerment, RESPECT, Risk Avoidance Partnership, Safety Counts, SISTA, Spiritual Self-Schema Therapy, Street Smart, Together Learning Choices (TLC) and VOICES/VOCES. Training and technical assistance has been provided to all funded programs and DPH staff members serve as Intervention Specialists or Trainers. Federal funds support a Perinatal Prevention Program aimed at identifying women of child bearing age at risk for HIV and unaware of their status. Services provided include, but are not limited to, HIV and pregnancy testing, risk reduction planning, case management and outreach. Finally, state funds support Syringe Exchange Programs (SEP) in CT. Under state law, provision is made for SEPs to operate in the three cities with the highest number of AIDS cases among injection drug users. SEPs have been overseen by HIV Prevention staff since their inception in the early 1990s.

Integrating Care and Prevention – Where Do We Go and How Do We Get There?

Pursuant to Section 2617(b) 4) of the Ryan White Care Act, Connecticut has developed a comprehensive plan for the prioritization, organization and delivery of HIV health care and support services to be funded under Ryan White Part B. The Centers for Disease Control and Prevention's (CDC) *Guidance for HIV Prevention Community Planning (2012)* defines the CDC's expectations of health departments and HIV prevention community planning groups in implementing community planning.

The DPH shares the responsibility with representatives of affected communities and other technical experts in the development of a comprehensive HIV care and prevention jurisdictional plan. With the integration of Connecticut's two statewide planning bodies in October 2007 into the Connecticut HIV Planning Consortium (CHPC), these two separate planning processes and documents have been integrated into a Comprehensive Jurisdictional Plan for HIV Care and Prevention. A Data and Assessment Work Group of the CHPC championed the development of the 2012-2015 Action Plan.

Convened by the DPH, the CHPC conducted statewide planning meetings to facilitate and share information across local, regional and statewide programs involved in HIV/AIDS service delivery to assist in the development of the 2012-2015 Comprehensive Plan. This multi-year, statewide Comprehensive Plan informs policy, Ryan White Part B and Prevention funding decisions and prioritizations implemented by DPH, and has a defining feature that aligns with HRSA and CDC expectations to integrate care and prevention while establishing an improved infrastructure for ascertaining priorities for the allocation of funds.

The CHPC in partnership with DPH will continue to focus on the following:

Collaborative Planning	Improve Service Delivery	Increase Public Awareness and Education
▪ Conducting an integrated Statewide Needs Assessment for Prevention and Care targeting the in-care and out-of-care populations ▪ Updating the HIV/AIDS Service Matrix ▪ Identifying needs, gaps, and priorities in care and prevention ▪ Strengthening partner (agency) participation at CHPC meetings/processes and expanding collaboration with other partners ▪ Adjusting CHPC membership and processes as warranted to advance the mission	▪ Promoting early identification of people unaware of their HIV status (EIIHA) and link them to prevention or care services ▪ Promoting access to HIV Care & Prevention Services including priority areas ▪ Promoting proven capacity building across all Ryan White Parts and Prevention ▪ Promoting the communication and coordination of training for care and prevention providers across all Ryan White Parts, Prevention, and other relevant stakeholders ▪ Promoting the regular collection and meaningful use of quality and performance measures for prevention and care to inform planning and enhance service delivery	▪ Strengthening partnerships with the CT AIDS Education and Training Center (CAETC) and National HIV/AIDS Training Center to provide training and continuing education for medical practitioners, their staff, and HIV service providers ▪ Promoting awareness of resources and educational opportunities for PLWHA ▪ Supporting comprehensive sexuality education for youth and young adults ▪ Promoting coordinated social media/marketing and public awareness initiatives.

The following recommendations were developed to inform the allocation and use of prevention and care resources for service delivery in the State of Connecticut for PLWHA and were revised by the SCSN Work Group (a working group of the CHPC's Data and Assessment Committee) during October – December 2011. Data reviewed to develop these recommendations included the 2010 Statewide Needs Assessment and the Connecticut 2010 Epidemiological Profile of HIV/AIDS. In developing the recommendations, the CHPC considered the National HIV/AIDS Strategy (NHAS) which has three primary goals: 1) reducing the number of people who become infected with HIV, 2) increasing access to care and optimizing health outcomes for people living with HIV, and 3) reducing HIV-related health disparities.

Process Recommendations

1. Promote innovative strategies, interventions, social marketing and the use of technology to affect behavior change and address barriers to care and prevention.
2. Enhance and expand collaborations across and within State Agencies and service organizations to ensure PLWHA get the services they need.

Service Improvement Recommendations

3. Ensure state funds are directed toward effective behavioral interventions targeting priority populations.
4. Develop strategies to ensure data collection measures are achieved and used for quality improvement.
5. Ensure compliance with protocols and standards for care and prevention services funded by the Department of Public Health.
6. Maximize training resources for service providers by collaborating with multiple partners.

Emerging Issues Recommendation

7. Implement the strategies of the Connecticut HIV/AIDS Identification and Referral Task Force (CHAIR), to identify, and refer the unaware population to HIV testing, education, care and prevention programs.

The 2012-2015 Connecticut Comprehensive Jurisdictional Plan for HIV Care and Prevention is a living document; will serve as a roadmap for care and prevention; and will be updated annually. This plan reflects Connecticut's vision and values regarding how best to deliver HIV/AIDS care and prevention services, particularly in light of cutbacks in federal, state and local resources. Connecticut's plan is the result of a collaborative and cooperative process with various statewide partners and stakeholders regarding service delivery, care and prevention gaps, barriers to care, sharing of resources, efficiencies of scale and avoidance of duplicative efforts. The plan is compatible with existing state and local service plans (Greater Hartford TGA and New Haven/Fairfield EMA), the DPH CDC Prevention application, as well as the 2012 Statewide Coordinated Statement of Need (SCSN), the National HIV/AIDS Strategy (NHAS), Healthy People 2020 and the Affordable Care Act (ACA).

The Connecticut HIV Planning Consortium (CHPC)

The Connecticut HIV Planning Consortium (CHPC), formed officially in October 2007, serves as the State's integrated HIV care and prevention planning body. Its first public meeting occurred in December 2007. CHPC integrates the mission and functions of the Statewide HIV Care Consortium and the Connecticut HIV Prevention Community Planning Group. The CHPC includes diverse stakeholders from PLWHA, community based AIDS service organizations (ASO), Ryan White Parts A, B, C, D and F, and governmental agencies. Both former planning bodies began their statewide work in 1994. As the new combined statewide planning body, CHPC, like its predecessors, fulfills both HRSA and CDC requirements relating to membership, diversity, parity, inclusion and representation, in addition to requirements regarding development of a comprehensive plan, prioritization of populations, and statewide planning processes and collaborations. Figure 1 (page 16) shows the organizational structure of the CHPC.

Diversity**.** The CHPC Charter allows for up to 42 members. Currently, 28 members represent the cultural and geographic diversity of Connecticut's HIV epidemic, as well as both care and prevention arenas. The CHPC sets a membership composition goal of 50% PLWHA and 50% provider; presently that goal stands at 40% PLWHA and 60% Providers. 39% of members are white, 18% Hispanic and 43% /African American. 35% of CHPC members report a gay, lesbian or bisexual orientation. (See CDC Diversity Chart of CHPC membership in Appendix.)

Members actively participate in all CHPC meeting-related activities, as well as serve on one of the two committees, Data and Assessment Committee (DAC) or Membership Awareness Committee (MAC). Additional opportunities to participate exist through an Ad Hoc Charter Review committee and a DAC Work group.

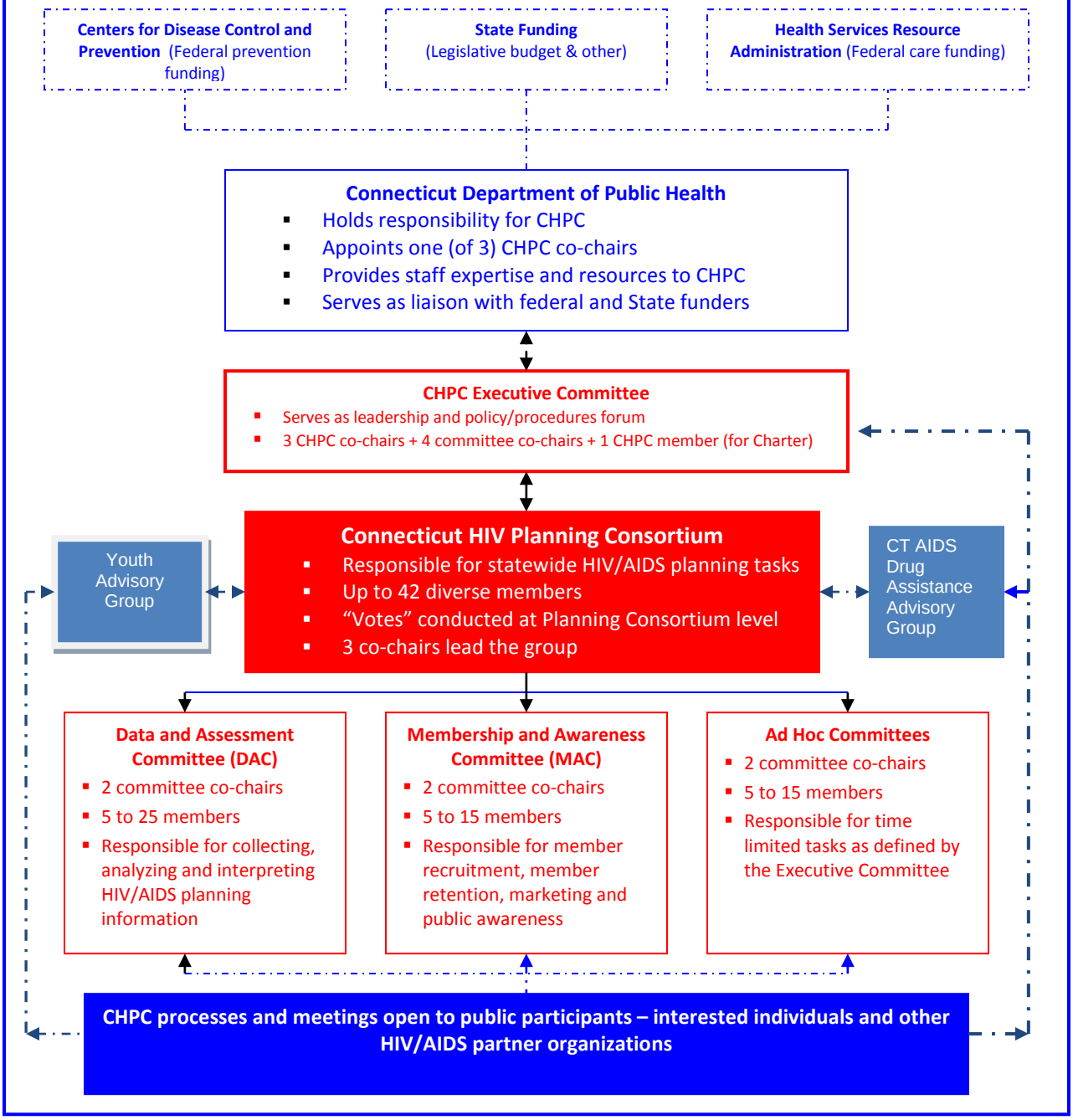
To encourage public participation in the planning process, CHPC convenes meetings in New Haven, Connecticut which is centrally located with good access to public transportation. CHPC supports member involvement, participation and attendance by working to eliminate potential barriers such as transportation. Should a member require interpretation or translation services, qualified personnel are made available to meet individual needs.

In 2011, the CHPC MAC with help from the DAC focused on developing HIV Community Forums to:

- Allow the CHPC to hear from people living with PLWHA and community based organizations (CBOs) about the needs and barriers to services for PLWHA in the community
- Inform community members and agency staff about the CHPC and encourage broader public participation in open CHPC meetings
- Inform community members and agencies about the range of services and resources available in their area and inform agencies about the service needs of PLWHA.

The first Forum was held in October 2011 with the next series of forum scheduled for the fall of 2012 (and more to follow in coordination with a statewide needs assessment process).

Figure 1. CHPC Organizational Structure



CHPC values the importance of public participation and input both at full meetings and during committees. Meeting agendas contain a section specifically designed to elicit public comment and information-sharing about statewide and local programs and initiatives as well as emerging needs/issues. To further increase public awareness and involvement, CHPC's MAC publishes a quarterly HIV Newsletter in both Spanish and English. It contains information about recent CHPC meetings, a community corner, DPH updates, monthly planning meeting calendars, and statewide activities and events. The newsletter is sent via email and hard copy to more than 400 individuals and agencies. (The appendix contains a sample HIV Newsletter.)

CHPC Leadership and Committees**.** Effective and participatory leadership plays a critical role in Connecticut's planning process. Equal and shared responsibilities, mutual respect, collaboration and cooperation are trademarks of CHPC's leadership. The CHPC is led by two elected community co-chairs and a DPH designated co-chair. Together the co-chairs share meeting and committee responsibilities, and alternate chairing of the monthly co-chair, executive committee and full CHPC meetings.

To assist the CHPC Co-Chairs in their leadership roles and responsibilities, the Executive Committee, which consists of two co-chairs from each of the committees, as well as the Charter Advisor, meets with the CHPC Co-Chairs following each monthly meeting. As the governing body of the CHPC, the Executive Committee is charged with the operation and oversight of CHPC activities and issues as well as strategizing for the future.

The Executive Committee reviews meeting feedback forms (CHPC members and public participants) immediately after each meeting and discusses any issues related to process, leadership, and/or meeting climate. The Executive Committee receives a "meeting dashboard" the week following the meeting. The meeting dashboard summarizes the meeting feedback (quantitative and qualitative) and shows a point in time and cumulative record for other important indicators such as attendance and member supports. (See Appendix for example of the meeting dashboard.) Finally, the CHPC co-chairs and DPH liaisons, along with CHPC staff, meet monthly to review larger strategic issues (e.g., timeline, leadership development, feedback from federal project officers or new federal guidance).

It is in the CHPC committees that the work of the CHPC really sees its development and completion. The CHPC has a clearly defined organizational structure which consists of two standing committees, the Executive Committee, and specifically designated ad hoc committees and work groups. The standing committees are Data and Assessment (DAC) and Membership and Awareness (MAC). Committees are comprised of two co-chairs who equally share roles and responsibilities as well as 6-15 members each. CHPC co-chairs rotate on a quarterly basis between the committees. Staffing for committees including the full CHPC is provided by Cross Sector Consulting, as contractor.

The Data and Assessment Committee plays an integral role in planning as a result of its involvement in the statewide needs assessment, ongoing review of data (e.g., epidemiological profiles), the development of the Statewide Coordinated Statement of Need, and more recently, the establishment of quality and performance indicators. The Membership and Awareness Committee focuses on membership recruitment, retention, and outreach/engagement. The Membership and Awareness Committee uses a Newsletter and Community Forums, among other initiatives to advance their work.

CHPC Member Recruitment and Retention**.** Potential members are recruited through community information forums, Ryan White Part A Planning Councils, word of mouth, CHPC monthly meetings, newsletters, and agency or current CHPC member referrals. Maintenance of an active and diverse membership is the responsibility of the MAC. The committee has developed new membership

information and application packets to recruit members, and is planning community forums to promote the activities of the CHPC and raise awareness. MAC works closely with staff to monitor membership diversity as required by the CDC Guidance for Community Planning. CHPC is currently processing membership applications for new member terms beginning in November 2012. New members will each serve a term of two years, which is renewable for an additional two year term.

To be considered for CHPC membership, an individual must first complete a membership application form, and, if selected, an additional CHPC Member form. Members are selected through an administrative process, using a scoring system that takes into account the CHPC's need for diversity and representation from different geographic areas, risk groups, age, gender and race/ethnicity. All new CHPC members receive orientation training. The CHPC also values ongoing community planning training for its members, and attempts to provide opportunities (based on budgetary restrictions) for members to attend national and regional seminars and conferences related to HIV prevention and care.

CHPC Meeting Structure**.** CHPC convenes 6 public meeting annually in New Haven. Cross Sector Consulting, a New Haven-based consulting firm and contractor for the CHPC, coordinates all meeting logistics and provides comprehensive project support. Each meeting follows an agenda, approved by the Executive Committee. Meetings are conducted using the CHPC charter, policy and procedures and a modified version of Robert's Rules of Order.[4] Voting in committee is generally by consensus, although ballot and/or hand votes are used by the full CHPC for approval of meeting summaries, voting on membership and CHPC co-chairs, approval of the Statewide Coordinated Statement of Need (SCSN), Comprehensive Plan and respective updates, and Concurrence.

The CHPC and its committees meet on the third Wednesday of each scheduled month from 9:00 a.m. to 2:00 p.m., followed by Executive Committee from 2:15 -3:30 p.m. Public participants are always encouraged to attend and participate in committees. Meetings are evaluated for process and content through feedback forms distributed to CHPC members and public participants. Evaluations are reviewed by the CHPC Co-chairs and Executive Committee to address and resolve meeting issues and concerns. Since its first meeting in December 2007, CHPC evaluations have been extremely positive and level of satisfaction very high (e.g. average of 95% or better) in respect to diversity, openness, participation, inclusion, task accomplishment, organization and positive environment.

At Each CHPC meeting, time is reserved for community presentations. In 2011 and 2012, select presentations included: Connecticut HIV/AIDS Identification and Referral (CHAIR) Task Force, National HIV/AIDS Strategy (NHAS), CHPC Charter, Operations and Procedure Changes, Connecticut HIV Community Forums, AIDS Project Hartford Prevention and Harm Reduction Programs, Comprehensive Plan 2012-15 Action Plan, HIV/AIDS Funding Streams, Project REACH (targeting elders over age 50) and CT DPH Surveillance.

Youth Representation**.** The Youth Advisory Group (YAG) creates an opportunity to give youth a voice in the HIV planning process. In 2010, a new youth category was added to our member requirements. CHPC Youth Advisory Group graduates who age out of the Youth Group (into their 20's) are now eligible to apply for membership on the CHPC. This provides an opportunity for youth who wish to remain a part of HIV planning to transition into the adult planning body while allowing the CHPC to gain young voices. In 2011-2012, two Youth Advisory Group graduates formally joined the CHPC. The young people participating on the Youth Advisory Group are a diverse group. Thirty Seven (37) youth participated over

[4] The term "modified" recognizes that the CHPC uses a standard, simple process that promotes inclusion (v. exclusion that can occur when complex procedures are not known equally as well by all participants).

the 2010-12 period. Recruited from all corners of Connecticut, 60% are from cities, 19% from rural areas and 22% from suburban areas; 84% were in high school and 16% were in college and/or working. 49% are African-American; 25% Latino and 26% White (we did not ask youth to self-identify). Females represent 57% of the group and males 43%. 22% are members of gay-straight alliances or related groups. Forty one percent (41%) of the youth are HIV prevention peer educators and a number have personal experiences with HIV/AIDS (e.g., family members or friends living with HIV/AIDS).

The YAG develop the youth component of the prevention plan as well as organize outreach and education activities, events, and strategies – including the use of social media. In 2010-2011, the YAG produced public service announcements targeting teens. The digital products were shared with media outlets and posted on the internet (e.g., YouTube; facebook). The YAG produced a youth magazine (see Appendix) for distribution at youth centers and high schools, among others. Also, the YAG developed interactive presentations such as, "Give Us the Facts: Improving HIV Prevention and Sex Education".

The developmental process allows youth to discuss the materials, recognize diverse perspectives, learn more about the issues from content experts, and create interactive (i.e., role playing) activities that build individual skills as well as create opportunities to engage other youth audiences. For example, the YAG presented at the 2012 True Colors conference. True Colors is a nonprofit organization that works with other social service agencies, schools, organizations, and within communities to ensure that the needs of sexual and gender minority youth are recognized and competently met. The True Colors conference represents the largest LGBT youth conference in the country with more than 2,000 attendees. Nine YAG members presented and other CHPC members attended. YAG members prepared several interactive vignettes including Katie's Story: Misinformation and Consequences; Abuse; Love Triangle; Student-Teacher Dialogue; and Parent-Youth Dialogue.

Section 1: Where Are We Now?

A. Description of Connecticut's HIV/AIDS epidemic

1. Calendar Year 2010 Epidemiological profile

In the thirty-year history of HIV in Connecticut, 19,821 cases of HIV infection have been reported with 9,284 (47%) deaths. Of the cumulative reported cases, 70% were male and 30% female, 36% white, 35% black, and 28% Hispanic. Injection Drug Use (IDU) represents the highest reported mode of transmission at 44%, followed by Men who have sex with men (MSM) at 23%, heterosexual at 19%, and 13% in other or unknown categories (Table 1).

Table 1. Summary of HIV Surveillance data, Connecticut 2011 updated through 12/31/2011

Characteristics	Diagnosed 2010	PLWH	Total
Total (N)	407	10,537	19,821
Gender			
Male	71%	66%	70%
Female	29%	34%	30%
Race /Ethnicity			
White	34%	34%	36%
Black	39%	33%	35%
Hispanic	26%	32%	28%
Other	2%	1%	1%
Age group			
0-12 years	0%	0%	1%
13-19	3%	1%	1%
20-29	24%	5%	15%
30-39	21%	12%	39%
40-49	29%	33%	30%
50+	22%	49%	13%
Risk			
IDU	18%	42%	48%
MSM	44%	27%	26%
MSM/IDU	2%	2%	3%
Hetero	36%	27%	22%
Pediatric	0%	2%	1%
Other/Unknown	0%	0%	1%

10,537 people reported living with HIV infection (PLWH) (294 per 100,000) at the end of 2010 (Table 2). Connecticut ranks eighth (8th) among all states in the number of PLWHA. Of the PLWHA, 66% are male, 34% female, 34% are white, 33% black, and 32% Hispanic. IDU is the largest behavioral risk group in PLWH (36%). Heterosexual risk accounts for 22% of PLWH and 23% are MSM. HIV prevalence is disproportionately distributed in Connecticut with the rate in males twice as high as females; six times higher in blacks than in whites; and five times higher in Hispanics than in whites. As of December 2010,

blacks and Hispanics comprised approximately 20% of Connecticut's population, yet represented 65% of all PLWHA.

- *People living with HIV (non-AIDS).* As of 12/31/2010, 3,302 CT residents were reported living with HIV (non-AIDS). Of these, 63% were male, 37% female; 35% white, 31% black, and 32% Hispanic; 25% were MSM, 27% IDU, 21% heterosexual, and 24% other/unknown. Of PLWH, 30% were <40 years of age, 33% were 40-49, and 36% were 50+.

- People living with AIDS. As of 12/31/2010, 7,235 people were known to be living with AIDS. Of these, 67% were male, 33% female; 33% white, 34% black, and 32% Hispanic; 22% were MSM, 41% IDU, 23% heterosexual and 11% were other/unknown. Of PLWA, 12% were <40 years of age; 33% were 40-49, and 55% were 50+.[5]

PLWH also tend to be older than the general population with 82% over the age of 40 (compared with 50% of the population). Only 6% of PLWH are under the age of 30 (compared with 39% of the population). The "aging of HIV" in Connecticut holds growing implications for HIV core medical and support services, medication adherence, HIV prevention and specialty medical care. Despite the fact that the number of HIV/AIDS cases diagnosed annually in Connecticut has decreased from 834 in 2002 to 407 in 2010 (51% decrease), the number of prevalent cases (PLWHA) has steadily increased over the past five years. During 2009-2010, the number of PLWHA increased by 2%.

Not only is HIV in Connecticut disproportionate by sex and race/ethnicity, it is also disproportionate by geography with the largest cities having the highest numbers and prevalence rates. Hartford (N=1,926), New Haven (N=1,504), and Bridgeport (1,314) have a combined 45% of all PLWH but only 11% of the state's population. The combined prevalence rate in these three cities is 1,216/100,000, a rate 7.1 times higher than the combined rate in all other towns in Connecticut (179/100,000).

Connecticut's cities will face significant differences in distribution of risk profile with some cities predominantly IDU and others predominantly MSM. Hartford is 49% IDU and 13% MSM and Windham is 55% IDU and 14% MSM. Conversely, Greenwich is 50% MSM and 15% IDU, Milford is 49% MSM and 15% IDU, Wallingford is 49% MSM and 16% IDU, and West Hartford is 46% MSM and 18% IDU. No cities or towns have over 40% heterosexual risk.

[5] During 2009-2010, 543 AIDS cases were reported; of these 71% were male, 29% female, 30% white, 35% black, 34% Hispanic, 22% were IDU, 30% MSM, 20% heterosexual, and 27% were reported with other/unknown risk. All percentages are consistent with long-standing trends.

Table 2.[6] People living with HIV: sex and age group by race/ethnicity, Connecticut, 2012

		Race/ethnicity							
		White		Black		Hispanic		Total	
Sex	Age group	N	Rate	N	Rate	N	Rate	N	Rate
Female	20-29	33	24.1	84	308.5	68	170.8	185	90.6
	30-39	110	79.5	193	754.1	225	582.9	528	260.8
	40-49	360	172.0	506	1,734.9	416	1,379.2	1,327	488.0
	50-59	316	145.9	447	1,960.5	387	1,834.9	1,150	441.4
	60-69	84	54.4	132	905.8	111	959.5	327	181.1
Subtotal		903	105.5	1,362	1,141.0	1,252	866.4	3,517	314.1
Male	20-29	113	79.3	197	734.9	138	317.9	448	210.7
	30-39	263	195.2	191	837.8	340	875.6	794	404.3
	40-49	846	420.5	561	2,237.4	786	2,473.4	2,193	849.8
	50-59	1,010	482.9	841	4,304.7	682	3,529.3	2,533	1,021.4
	60-69	380	266.5	290	2,633.5	180	1,913.3	850	521.5
Subtotal		2,612	314.7	2,080	1,976.7	2,126	1,489.3	6,818	632.4
Total		3,515	410.8	3,442	2,883.6	3,378	2,337.6	10,335	470.3

Data from HIV and STD Surveillance systems also indicate higher rates of syphilis and HIV transmission in MSM. During 2002-2010, 441 syphilis cases were reported in MSM, and 36% of those cases were co-infected with HIV. The number of HIV /AIDS cases with IDU as a risk factor has decreased in recent years. During 2002-2010, the number of IDU risk cases decreased from approximately 400 in 2002 to 76 in 2010. As a result of the decrease in new IDU-related cases, other transmission categories (e.g. MSM and heterosexual) reflect a higher percentage of new cases.

Recently Diagnosed: Connecticut HIV/AIDS

During 2006 – 2010, 2,061 HIV cases were diagnosed in Connecticut. Of these, 71% were male, 30% were female; 32% white, 37% black, 30% Hispanic, 1.2% Asian, and 1% other or multiracial; <1% were under 13 years of age, 13% were 13-24, 76% 25-54, and 11% 55+ years of age; 41% MSM, 26% IDU, 2% MSM/IDU, 32% heterosexual risk, and less than 1% other or unknown. (See Table 1 for the distribution of cases diagnosed in 2010.)

- Trend in PLWH, diagnoses, death. During 2002 – 2010, the number of PLWH increased from 8,741 to 10,537, an increase of 21%. The number of people diagnosed with HIV decreased from 834 to 407, a decrease of 51%. The number of deaths in people with HIV infection decreased

[6] Connecticut Department of Public Health, HIV Surveillance Program, 2012

from 320 to 182 per year. During 2003-2007 the underlying cause of death in people with HIV infection was HIV disease (59% of deaths), cardiovascular disease (9%), drug overdose (5%), lung cancer (3%), and numerous other causes at less than 3% per cause.

- Trend in sex. During 2006 – 2010, the number of males ranged from 252 to 329 with no discernible trend and the number of females ranged from 91 to 145 with no discernible trend.

- Trend in race/ethnicity. During 2006 – 2010, the number of white HIV cases ranged from 102 to 149. The number of black HIV cases ranged from 137 to 158 with no discernible trend. The number of Hispanic cases ranged from 93 to 164 with no discernible trend.

- Trend in risk group. During 2002-2010, the number of IDU decreased from 395 to 76 with the number of MSM ranging from 141 to 219 with no discernible trend and the number of heterosexual decreasing from 250 to 148.

Monitoring progress towards National HIV/AIDS Strategy goals

CDC has provided state HIV surveillance programs with analysis tools with which to monitor progress towards the National HIV/AIDS Strategy goals. This system will enable the DPH HIV Surveillance Program to provide information about subsets of PLWH who may benefit from additional case management or HIV medication adherence services.

- HIV viral load suppression. Of the 10,052 HIV cases included in the analysis who were over 13 years of age, diagnosed by the end of 2009, living through the end of 2010, and who had at least one viral load test during 2010, 76% were categorized as having HIV suppression (<200 copies per ml). This percentage varied by age from 52% of 13-24 year olds to 88% of those 65 or older; 72% of blacks, 73% of Hispanics, and 83% of whites; 81% of MSM, 73% of IDU, and 75% of heterosexuals; and, 77% of males and 73% of females.

- PLWH in care. Of the 10,052 HIV cases included in the analysis who were >13 years of age who were diagnosed by the end of 2009 and living through the end of 2010, 65% had at least one care visit during 2010, 53% had two or more care visits at least three months apart. A care visit is defined as the report of a HIV VL or CD4 to DPH during the period specified. Percentages having at least one care visit ranged from 63% to 73% among the various demographic and behavioral subsets. (See Table 3)

- Newly diagnosed linkage to care. Of the 405 newly diagnosed HIV cases in 2010 who were over the age of 13 years, 85% were linked to care within three months, 89% within six months, and 92% by one year after diagnosis. The three-month percentages are notably different for blacks 79% vs. whites 95%, 85% in heterosexuals vs. 91% in IDU; 76% in 13-24 year olds and 100% in those 65 or older. (See Table 4)

Estimating the prevalence of HIV in MSM

Although prevalence rates have not previously been calculated for behavioral risk groups because the denominators are unknown, CDC has recently released an estimate that 4% (95% CI: 2.8%-5.3%) of males over the age of 12 have had sex with males in the last five years. Using this estimate, 55,000 males in this age range in Connecticut are MSM. With 2,261 HIV-positive PLWH who are MSM an estimated 4% of MSM in Connecticut are HIV-positive (4,100/100,000).

Late testers

High proportions of newly diagnosed HIV infection cases continue to have AIDS at or soon after their initial diagnosis suggesting that they are 'late' in disease progression. Of the 468 HIV cases diagnosed in 2007, 27% of cases met the criteria for AIDS at diagnosis and an additional 7% became AIDS by 12 months after diagnosis.

HIV incidence

DPH participates in the national HIV Incidence Project, providing remnant HIV specimens for incidence testing. Results from the latest estimation (2011) indicate the number of HIV infections in Connecticut was 418 (95% CI: 238, 597) in 2006, 475 (292, 659) in 2007, 350 (168, 533) in 2008, and 402 (168, 637) in 2009 with no discernible trend. Due to small cell sizes in the estimation process, there are large confidence intervals around these estimates.

HIV resistance variants

DPH participates in the Variants Atypical and Resistant HIV Surveillance (VARHS) project and collects the DNA sequence in the pol region of the HIV genome for newly diagnosed cases that receive the test within three months of diagnosis. Since 2008 when the project began, 151 sequences have been selected for analysis. Of these, 20 (13%) were resistant strains with 18 (12%) resistant in one class, one (1%) in two classes and one (1%) in three classes of medication.

Table 3. PLWH receiving HIV care between 01/01/2010-12/31/2010 among persons who were 13+ years old on 12/31/2009, diagnosed with HIV infection through 12/31/2009 and living with HIV on 12/31/2010 (CDC SAS programming).

Characteristics	PLWH	1+ care visit between 01/01/2010 through 12/31/2010 N	1+ care visit between 01/01/2010 through 12/31/2010 (%)	Number with 2+ care visits between 01/01/2010 through 12/31/2010 at least 3 months apart	% with 2+ care visits between 01/01/2010 through 12/31/2010 at least 3 months apart among the overall population	% with 2+ care visits between 01/01/2010 through 12/31/2010 at least 3 months apart among persons who have 1+ care visit between 01/01/2010 through 12/31/2010
Total	10,052	6,555	65.2%	5,368	53.4	81.9
Sex						
Male	6,630	4,193	63.2%	3,409	51.4	81.3
Female	3,422	2,362	69.0%	1,959	57.3	82.9
Age group						
13-24	303	193	63.7%	155	51.2	80.3
25-44	3,483	2,202	63.2%	1,710	49.1	77.7
45-64	5,878	3,929	66.8%	3,299	56.1	84.0
65+	388	231	59.5%	204	52.6	88.3
Race/ethnicity						
Black	3,258	2,208	67.8%	1,834	56.3	83.1
Hispanic	3,256	2,049	62.9%	1,690	51.9	82.5
White	3,405	2,202	64.7%	1,769	52.0	80.3
Other	133	96	72.2%	75	56.4	78.1
Risk						
MSM	2,240	1,424	63.6%	1,118	49.9	78.5
IDU	3,745	2,382	63.6%	2,000	53.4	84.0
MSM/IDU	183	115	62.8%	100	54.6	87.0
Heterosexual	2,240	1,579	70.5%	1,314	58.7	83.2
Other/unknown	1,644	1,055	64.2%	836	50.9	79.2
MSM						
Black	382	253	66.2%	195	51.1	77.1
Hispanic	441	284	64.4%	222	50.3	78.2
White	1,370	853	62.3%	675	49.3	79.1
Male IDU						
Black	861	565	65.6%	487	56.6	86.2
Hispanic	1,036	595	57.4%	494	47.7	83.0
White	553	363	65.6%	305	55.2	84.0
Female IDU						
Black	433	306	70.7%	249	57.5	81.4
Hispanic	436	270	61.9%	228	52.3	84.4
White	396	258	65.2%	217	54.8	84.1
Male HET						
Black	334	221	66.2%	186	55.7	84.2
Hispanic	222	154	69.4%	127	57.2	82.5
White	158	106	67.1%	83	52.5	78.3
Female HET						
Black	584	414	70.9%	352	60.3	85.0
Hispanic	583	421	72.2%	354	60.7	84.1
White	336	246	73.2%	198	58.9	80.5

TABLE 4. Number of newly diagnosed persons linked to care within 3, 6 and 12 months

Number and percentage of persons linked to care[c] within 3, 6, and 12 months[d] of their HIV infection diagnosis among persons who were >=13 years of old at diagnosis, residing in Connecticut and diagnosed with HIV infection between 01/01/2010 through 12/31/2010, by selected characteristics - based on HIV surveillance data reported through 01/25/2012.

	Persons diagnosed with HIV infection	Persons linked to care within 3 months of diagnosis		Persons linked to care within 6 months of diagnosis		Persons linked to care within 12 months of diagnosis[e]	
Characteristics	No.	No.	%	No.	%	No.	%
Total	**405**	**345**	**85.2**	**362**	**89.4**	**371**	**91.6**
Sex							
Male	290	254	87.6	263	90.7	269	92.8
Female	115	91	79.1	99	86.1	102	88.7
Age at diagnosis							
13-24	55	42	76.4	47	85.5	48	87.3
25-44	206	173	84.0	182	88.4	188	91.3
45-64	130	116	89.2	119	91.5	121	93.1
>=65	14	14	100.0	14	100.0	14	100.0
Race/ethnicity							
Black/African American	159	132	83.0	141	88.7	145	91.2
Hispanic/Latino	101	83	82.2	84	83.2	87	86.1
White	138	124	89.9	131	94.9	133	96.4
Other[a]	7	6	85.7	6	85.7	6	85.7
Transmission category							
Male-to-male sexual contact (MSM)	148	132	89.2	137	92.6	143	96.6
Injection drug use (IDU)	42	38	90.5	38	90.5	38	90.5
MSM and IDU	5	5	100.0	5	100.0	5	100.0
Heterosexual contact[b]	92	78	84.8	83	90.2	85	92.4
Other/unknown	118	92	78.0	99	83.9	100	84.8
MSM							
Black/African American	38	30	79.0	33	86.8	35	92.1
Hispanic/Latino	29	25	86.2	25	86.2	27	93.1
White	78	74	94.9	76	97.4	78	100.0
Injection drug use (male)							
Black/African American	7	7	100.0	7	100.0	7	100.0
Hispanic/Latino	10	9	90.0	9	90.0	9	90.0
White	6	6	100.0	6	100.0	6	100.0
Injection drug use (female)							
Black/African American	6	6	100.0	6	100.0	6	100.0
Hispanic/Latino	7	4	57.1	4	57.1	4	57.1
White	6	6	100.0	6	100.0	6	100.0
Heterosexual contact (male)							
Black/African American	26	22	84.6	23	88.5	23	88.5
Hispanic/Latino	9	8	88.9	8	88.9	8	88.9
White	6	6	100.0	6	100.0	6	100.0
Heterosexual contact (female)							
Black/African American	26	21	80.8	24	92.3	25	96.2
Hispanic/Latino	14	13	92.9	13	92.9	14	100.0
White	10	7	70.0	8	80.0	8	80.0

[a]Multiple race, American Indian/Alaska Native, Asian, Native Hawaiian/Other Pacific Islander, and unknown race.
[b]Heterosexual contact with person known to have, or to be at high risk for, HIV infection.
[c]Persons who have at least one CD4 or viral load test during a specific time period are considered as linked to care during that time.
[d]The months difference is calculated between diagnosis date of HIV infection and sample collection date, and only year and month are used in calculation.
[e]Numbers are underestimated for persons linked to care within 12 months of diagnosis because not every lab test result has at least 3 months after the test was done to allow that it was reported to local health departments. The end of the evaluation time period (12/31/2010) is only 12 Months before the PERSON-based dataset was exported from eHARS. CDC suggests that this date should be at least 15 months before the creation date of PERSON-based dataset.

Sexually transmitted diseases

In 2011, 16,135 reported cases of Chlamydia, gonorrhea and syphilis occurred in Connecticut. High numbers of Chlamydia and gonorrhea cases in older teens and younger adults, particularly in minority populations, have been reported in Connecticut in recent years suggesting the persistence of unprotected sexual activity and the inherent potential for HIV infection. Similarly, the connection between MSM and both syphilis and hepatitis A and B nationally and in Connecticut, suggests resurgence in high-risk behavior in MSM.

- Syphilis**.** Early syphilis (primary, secondary and early latent) causes significant complications if left untreated and facilitates the transmission of HIV. Prior to 2000 the incidence of syphilis (SY) had been decreasing to low levels. Since then there has been a reemergence of syphilis. At the close of 2010, early stage syphilis (ESY) in CT increased 43% over the previous year (2009) bringing the total to 149 cases in 2010. In 2011, the number of reported ESY cases took a downward trend decreasing 38% (92 cases) from 2010. MSM continue to account for the majority of cases: 80.5% in 2010 and 78% in 2011. Of special concern was the 36% SY cases in 2010 and 42% of 2011 cases that were also co-infected with HIV. The proportion of infectious SY cases by race/ethnicity among all orientations in 2011 was 42% white, 34% black and 24% Hispanic. Among MSMs only, whites made up 33%, blacks 40% and Hispanics 27%. The median age of an MSM with infectious (primary and secondary) SY in 2010 was 36.5 years old, compared to 31 years old in 2011. The DPH STD Program staff attempt to interview *all* reported SY cases and contacts, which includes risk behavior questions and the offer of an HIV test.

- Chlamydia and Gonorrhea. In 2011, 2,458 Gonorrhea (GC) cases were reported, a slight 4% decrease from 2010 with 2,568 cases. Sixty percent (60%) of 2011 cases were reported among 10-24 years olds and nearly 56% of all reported cases were female. Forty six (46%) of cases were reported among blacks, 13% among Hispanics and 11% among whites. In 2010, a pilot project was undertaken in which 10,379 GC cases reported during years 2005-2008 were matched with the HIV/AIDS registry by last name, first name and date of birth. One hundred forty-five (145) matches were found in 129 individuals co-infected with HIV. Of note, 62.1% of matched cases received their GC diagnosis after their HIV diagnosis indicating that HIV positive individuals who knew their status were engaging in high-risk sexual behavior. This project became permanent in January 2011 with every GC case now matched with the HIV/AIDS registry. In 2011, 2,441 GC cases were queried against the HIV/AIDS database, with 49 (2%) co-morbid cases found (HIV/GC). In 2011, 13,585 (provisional) cases of Chlamydia were reported, a 7% increase over 2010 with 12,694 cases. Females accounted for 72% of CT cases. Over 72% of reported cases were among 10-24 years old and more than 31% of all cases were black, followed by whites (17%) and Hispanics (15%). As with gonorrhea, high case rates of Chlamydia were reported in Hartford, Bridgeport, and New Haven– three cities with the highest HIV/AIDS cases. Waterbury also reported high rates of Chlamydia and GC.

Hepatitis C (HCV)

Most people in the United States who are infected with hepatitis do not know it; about 75% of people infected with hepatitis C are unaware. IDU is a major risk factor for HCV and HIV in CT. The State has had mandatory hepatitis C reporting since the early 1990's. During 2004-2011, 203 acute (recent) hepatitis C cases were reported in CT. Of the 177 cases for which risk information was obtained, 128

(72%) had a history of IDU or street drugs. Importantly, of the 128 HCV-positive IDU, 53% were under the age of 30 and 8% under the age of 20. Seventy-nine percent (79%) were white, 18% Hispanic and 3% black/other.

In August 2008, the HIV/AIDS and HCV registries were electronically "matched" in order to identify cases reported in both registries and to help define a co-infection cohort. The HIV/AIDS registry was limited to cases with dates of diagnosis between 1994 through 2007 to correspond to the date range of the HCV registry. A total of 9,816 HIV/AIDS cases and 46,185 anti-HCV positive cases databases identified 2,345 co-infected cases. These 2,345 "matched cases", represented 24% of HIV/AIDS cases and 5% of HCV cases. Of this co-infected cohort, 70% were male; 32% black, 31% white and 37% Hispanic. The most common risk factor was IDU (76%). Of the 3,911 (40%) cases identified as IDU in the HIV/AIDS registry, 1,847 (47%) were also co-infected with HCV. Notably 47% of HIV-positive IDUs were co-infected with HCV, highlighting the need for both HIV and HCV testing for IDUs and integrated care and prevention services.

Tuberculosis (TB)

Although tuberculosis cases and rates have decreased among foreign-born and US born persons in 2011, TB continues to be a major cause of morbidity and mortality. The Centers for Disease Control and Prevention (CDC) reported that in 2011 a total of 10,521 new TB cases were reported in the US, an incidence of 3.4 cases per 100,000 population, which is 6.4% lower than the 2010 rate (*Morbidity and Mortality Weekly Report, March 23, 2012/ 61 (11); 181-185)*. Despite the decrease in TB rates, foreign-born and racial/ethnic minorities continue to be affected disproportionately. TB particularly affects persons living in crowded conditions and in poverty (e.g. homeless and injection drug users) and individuals with immunosuppressive conditions like HIV. Although TB is a preventable and curable disease, 83 cases of TB were reported in Connecticut in 2011 (case rate: 2.3/100,000 population). This is a decrease of 2.4% from 2010 (85 cases). Sixty-five (78.3%) of CT's TB cases were born outside the United States or Puerto Rico/US territories, with two of the highest reporting foreign countries being India and Haiti. Forty (48.2%) of TB cases were male and 43 (51.8%) were female. Of the reported TB cases, seven cases (8.4%) were also HIV co-infected. One case (1.2%) met CDC criteria for multi-drug resistance.

Perinatal HIV

In 1993, HIV infection in children less than 13 years of age was made reportable to the Connecticut Department of Public Health. During 1993-2010, 1,000 newborns were exposed to HIV at delivery in Connecticut (average=56/year). Of these, 932 (93%) were reported with a final HIV status and of these 63 (7%) have been reported to be infected with HIV.

In 1999, Connecticut implemented legislation requiring HIV testing to be offered to all pregnant women on entry into prenatal care in the first trimester with the offer of a second test in the third trimester. If the woman declined testing, the law required testing to be offered at delivery. If testing was again declined then HIV testing became mandatory for the newborn. Testing legislation increased the prenatal testing rate from 28% before implementation to 95% after. Prior to the HIV testing legislation (1993-1999), 55 (14.0%) of exposures resulted in infection and after (2000-2010), 8 (2%) infections were reported.

Of the 63 children with perinatal infection, 11 (18%) were reported dead by 2010. By race/ethnicity, 21 (33%) were Hispanic, 32 (51%) black, and 10 (16%) white. By city of residence at birth, 17 (27%) resided in Hartford, 12 (19%) in New Haven, nine (14%) in Stamford, six (10%) in Bridgeport, four (6%) in

Waterbury and 13 (21%) in 13 other towns. The increased prenatal testing rate ensures timely identification and treatment of HIV-positive pregnant women. Also, improvements in treatment during the same period contributed to prevention of perinatal transmission. Successful prevention of perinatal HIV infection demonstrates the potential for testing and treatment to effect reduction in HIV transmission generally.

2. Unmet Need

Table 5 shows the current model for estimated unmet need for primary care services in the state of Connecticut. Connecticut's unmet need estimate as of data ending 12/31/2010 is based on electronic viral load (VL) reporting implemented by the State in 2006. A majority of VL reports are electronically matched and imported directly into the HIV/AIDS Surveillance Unit's eHARS data registry though some paper and manual reporting continues. VL, however, is only one component of the measure. CT estimates unmet need largely using VL since the percentage of people on drug therapy getting CD4 counts and not a VL is small. CT requires CD4 reporting only if it is diagnostic of AIDS (<200 count or <14%). The estimate includes available CD4 data.

HRSA defines unmet need as a person who has "the need for HIV-related health services among individuals who know their HIV status but are not receiving regular primary health care." Regular HIV-related primary health care is defined as evidence of viral load testing, CD4 counts, or provision of antiretroviral medications in a given 12-month period. The 2010 Unmet Need in Connecticut is 33.9%. The term "unmet need" is used only to describe the unmet need for HIV-related primary health care, and is not considered a service gap." Unmet need has decreased in CT since 2007 (38%) and the result may be linked to the MCM model, the DPH requirement for CD4/VL reporting every six months, promotion of referral tracking and follow-up, and cross program collaboration with Parts A and C as well as outreach, MAI and EIS services to locate and identify individuals out-of care (OOC) and reconnect them to HIV care.

Needs of Individuals aware of their HIV-positive status but not in care

Connecticut's out-of-care (OOC) information is obtained through various sources (e.g. surveys, identification of OOC individuals by EIS and MAI, DPH VL reports, focus groups and needs assessments). CT's 2010 In-Care HIV Surveillance Report indicated that 33.9% of PLWHA statewide who know their status are OOC. Statewide, more males than females, more Hispanics than blacks or whites, more MSM than Heterosexuals and IDUs and younger individuals (e.g. 25-44 years) are OOC. Previous statewide and regional Unmet Need reports indicated that a significant percentage of OOC persons report homelessness or having been homeless or incarcerated at some point in the most recent 12 months. CT's 2007 SCSN Update documented that barriers for OOC persons continue to be: transportation, language, not feeling sick, housing, fear, distrust of medical providers, lack of insurance, mental health and substance abuse issues and lack of or limited income. Poverty is also a major factor affecting an individual's in-care status. DPH's HIV Surveillance Unit has begun mapping diagnosed HIV/AIDS cases and poverty rates by zip code. Cities and zip codes with high poverty rates are also sites of high prevalence, and, one can assume also high numbers of OOC individuals. Hartford, Bridgeport and New Haven, CT's three largest cities each have high poverty rates and also more than 45% of all HIV/AIDS cases.

Table 5. Unmet Need Framework Table as of December 31, 2010[7]

Column 1	Column 2	Column 3	Column 4	Column 5
Population Sizes		**Value**		**Data Source(s)**
Row A.	Number of persons living with AIDS (PLWA), as of 12/31/2010	7,083		eHARS
Row B.	Number of persons living with HIV (PLWH)/non-AIDS/aware, as of 12/31/2010	3,402		eHARS
Row C.	Total number of HIV+/aware as of 12/31/2010	10,485		eHARS
Care Patterns				**Data Source(s)**
Row D.	Number of PLWA who received the specified HIV primary medical care during the 12-month period (01/01/2010-12/31/2010)	4,731		eHARS Viral Load and CD4 data
Row E.	Number of PLWH/non-AIDS/aware who received the specified HIV primary medical care during the 12-month period (01/01/2010-12/31/2010)	2,203		eHARS Viral Load and CD4 data
Row F.	Total number of HIV+/aware who received the specified HIV primary medical care during the 12-month period (01/01/2010 – 12/31/2010)	6,934		eHARS Viral Load and CD4 data
Calculated Results			**%**	**Calculation**
Row G.	Number of PLWA who did not receive the specified HIV primary medical care	2,552	33.2%	Value = A – D. Percent = G/A
Row H.	Number of PLWH/non-AIDS/aware who did not receive the specified HIV primary medical care	1,199	35.2%	Value = B – E. Percent = H/B
Row I.	Total HIV+/aware not receiving the specified HIV primary medical care (quantified estimate of unmet need)	3,551	33.9%	Value = G + H. Percent =(1 - F/C)

[7] Includes persons ever diagnosed with HIV or AIDS through the end of December 2010 and were alive by the end of 12/2010 and whose laboratory information (CD4 or VL results) was reported between JAN2010 –DEC2010

OOC individuals are also reflective of Connecticut's HIV epidemic as a whole: minorities are disproportionately out of care. Re-engaging these populations into care requires focused and collaborative efforts among all Ryan White Parts and HIV Prevention Services; targeted outreach strategies and Early Intervention Services (EIS) efforts; culturally and population specific HIV care information and interventions; equitable access to care; adequate transportation; and supportive services (e.g. emergency financial assistance, housing). Statewide, the following efforts are used to locate OOC PLWHA and re-engage them: street and peer outreach; Hartford's Part A and Part B's EIS programs, mobile health van outreach; Part B's Minority AIDS Initiative (MAI) program targeting minority populations; Project TLC, targeting newly released inmates transitioning into the community; linkages and referrals between counseling/testing sites, STD clinics, drug treatment facilities, Partner Services, and medical case managers (MCMs); implementation of rapid testing in health centers, emergency departments, Substance Abuse Treatment facilities, and the state's syringe exchange program (SEP).

Connecticut uses the unmet need framework to prioritize services, address gaps, allocate resources, and define collaborations with Ryan White and non-Ryan White funded providers to avoid duplication of efforts. It also uses the data to identify populations most at risk for being out-of-care (e.g. males, black, Hispanic, MSM, IDU, etc) and target outreach, prevention, testing, education, and MAI and EIS initiatives to engage/re-engage them into care. In FY 2011, DPH funded EIS services in New Haven and New Britain and expanded MAI outreach/education initiatives to target minority populations in the Greater Hartford TGA (Hartford, Middlesex and Tolland Counties). Part A in Greater Hartford funds EIS programs in various sectors of the TGA that provide outreach, education, HIV testing, linkage, and referral to care for OOC and unaware. Part A in New Haven/Fairfield funds five regional EIS specialists through its Minority AIDS Initiative, who also offer outreach, education referral, linkage, and testing services to both unaware and out-of-care populations. DPH will continue to maintain its collaborations with Substance Abuse Treatment facilities, STD clinics, community health centers, as well as EIS and MAI outreach services to shelters, half-way houses, food pantries and high-risk areas to engage/re-engage both individuals unaware of their HIV status and OOC persons.

3. EIIHA Estimate

CDC estimates that nationally, 21% of HIV infected people are unaware of their infection. This means that in Connecticut, with 10,537 confirmed PLWH, there are an additional 2,800 PLWH who are not aware of their infection. Nationally, the CDC has also reported that the percentage of PLWH who are unaware of their infection varies in different behavioral and demographic subgroups. For example, male PLWH are slightly more likely to be unaware of their status than female PLWH (21% vs. 18%, respectively). In other PLWH subgroups, 21% of blacks, 19% of whites,19% of Hispanics, 22% of MSM, 14% of male IDU, 14% of female IDU, 25% of male heterosexuals, 20% of female heterosexuals, 59% of PLWH aged 13-24, and 11% of PLWH 65 or older are unaware of their positive HIV status (MMWR; June 3, 2011; Vol. 60, No. 21).

- Hartford TGA. Of the estimated 4,546 PLWH in the Hartford TGA, 3,592 are aware of their infection and 954 are unaware.
- New Haven EMA. Of the estimated 7,646 PLWH in the New Haven EMA, 6,041 are aware of their HIV infection and 1,606 are unaware.

The estimated number of living CT HIV positive individuals, unaware of their status as of 12/31/2009, is 2,735 (Estimated Back Calculation).

B. Current Continuum of Care/Prevention Services (See appendix for service matrix)

1. Ryan White funded Programs

Vital core medical, supportive, and prevention services (e.g. Comprehensive Risk Counseling Services, targeted interventions, routine testing, outreach, linkage and referral, and Partner Services) are provided to people living with HIV/AIDS (PLWHA) and their families through various HIV/AIDS service organizations (ASOs) and Ryan White funded Part A-F funded programs. These Ryan White services include, but are not limited to: medical and non-medical case management, primary medical care, oral health, mental health, medical nutrition therapy, substance abuse-outpatient and inpatient, AIDS pharmaceutical assistance, Early Intervention Services (EIS), medication adherence programs, medical nutritional therapy, Minority AIDS Initiatives, health insurance premium, medical transportation, housing, food bank/meals, linguistic services, psychosocial support, legal services, and related emergency financial assistance (EFA). (See Table 6)

Eligible PLWHA can access Ryan White core medical and supportive services throughout the state at no cost to them. Client eligibility for Ryan White Part A and B services is an income at or below 300% FPL, proof of HIV status, and Connecticut residency. Individuals with income at or above 301% FPL can access medical case management services only, and all PLWHA with an income at 400% FPL or less can access the Connecticut AIDS Drug Assistance Program (CADAP) formulary.

The federal Ryan White Program provides funding to the various Ryan White Parts in Connecticut to develop, organize, coordinate, and operate more effective and cost-efficient systems for the delivery of essential core medical and support services to people living with HIV/AIDS (PLWHA) and their families. Connecticut's Ryan White Parts collaborate with one another to provide the following services:

- Part A provides funding through designated grantees (Chief Elected Officials) to eligible metropolitan areas (EMA) and transitional grant areas (TGA) disproportionately affected by the HIV epidemic. In Connecticut, these Part A programs are the New Haven/Fairfield County EMA and the Greater Hartford TGA area (including Hartford, Middlesex and Tolland Counties). Services provided include ambulatory/outpatient, medical case management, mental health and substance abuse outpatient and inpatient, oral health, Early Intervention Services, AIDS Pharmaceutical Assistance (local), health insurance premium, non-medical case management, food bank, housing, legal services, medical transportation, and medication adherence.

- Part B provides funding through the CT DPH to improve the quality, availability and organization of HIV/AIDS core medical and support services. Included in this is the Connecticut AIDS Drug Assistance Program (CADAP), a pharmaceutical assistance program that pays for FDA approved HIV/AIDS antiretroviral and other drugs for persons living with HIV/AIDS and Connecticut Insurance Premium Assistance (CIPA) Program. Part B funds ambulatory/outpatient, oral health, Early Intervention Services, medication adherence programs, medical nutritional therapy, mental health, medical case management, non-medical case management, food bank, housing, linguistics services, medical transportation and psychosocial support services. Part B funds providers in the Part A TGA and EMA areas, but prioritizes its funding allocations to three counties, Windham, New London and Litchfield, which do not receive Ryan White Part A funds.

- Part C directly funds public and private organizations for Early Intervention Services (EIS) grants to reach people newly diagnosed with HIV as well as ambulatory/outpatient care, medical case management, dental, mental health and substance abuse services, HIV counseling and testing, and risk reduction counseling. Part C also funds Capacity Development and Planning Grants to support organizations in planning and service delivery and in building capacity to provide services. In Connecticut, federally qualified ambulatory/outpatient medical clinics (e.g. Community Health Centers) are the recipients of these Part C grant awards.

- Part D funds public and private organizations directly to provide medical care, family-centered case management, outreach and community-based services to children, youth, women and their families living with HIV/AIDS. Children, Youth & Family AIDS Network (CYFAN), a program of Community Health Center Association of Connecticut (CHCATC), receives Part D funding to provide family support/case management services to HIV infected/exposed and affected children and their families through community health centers and hospitals in the cities of Willimantic, Bridgeport, New Haven and Hartford. CYFAN provides coordination of maternal-child health care and facilitates early entry into care for HIV positive women.

- Part F funds the Connecticut AIDS Education and Training Centers Program (CAETC) that provides training, consultation, and information to providers and consumers. The CAETC hosts numerous statewide HIV Forums on issues relating to health care, medications, prevention, and emerging issues and collaborates closely with the DPH in providing training for medication adherence nurses, medical case managers, and medical providers.

Additional Ryan White funded and State supported services provided to PLWHA in Connecticut include:

- AIDS Drug Assistance Program - The Connecticut AIDS Drug Assistance Program (CADAP) can help pay for many Food and Drug Administration (FDA) approved HIV drug treatments. There is no asset limit and the eligibility is 400% of the Federal Poverty Level (FPA). Physician verification of HIV/AIDS diagnosis and Connecticut residency are required. The program is administered by the Connecticut Department of Social Services (DSS) via a Memorandum of agreement (MOA) with the Department of Public Health (DPH), Ryan White Part B.

- Connecticut Insurance Premium Assistance (CIPA) Program – CIPA is a health insurance program funded through CADAP (Part B) for individuals living with HIV/AIDS who are CADAP eligible (400% FPL, Connecticut resident, proof of HIV). CIPA will help pay health insurance premiums for eligible individuals who have or can get coverage through a CIPA-approved health insurance policy. CIPA will pay up to a maximum of $1,500 per month for an insurance premium.

- Charter Oak Health Plan – State of Connecticut program, funded through the Department of Social Services, offers health insurance coverage for uninsured adults of all incomes who do not qualify for the Connecticut Pre-Existing Condition plan or Husky Health. Monthly premiums are based on household size and income.

- Connecticut Pre-Existing Condition Insurance Plan (PCIP) –PCIP, funded through the Department of Social Services, is designed for individuals who have a qualifying pre-existing health condition such as high blood pressure, diabetes, kidney, and HIV. An individual must be a Connecticut resident and have been uninsured for the past six months. Premium is one amount per month per individual and is not based on income.

- Children Youth and Family AIDS Network of Connecticut (CYFAN) – CYFAN of the Community Health Center Association of Connecticut (CHCACT), funded through Part D, provides adolescent/pediatric HIV care, HIV case finding and intensive medical case management services to adolescent/pediatric consumers with HIV and their family members.

- Transitional Linkage into the Community (Project TLC) - Project TLC, funded through Part B, is a statewide program designed to assist HIV positive individuals ready for, or recently released from Connecticut's correctional system with linkages and referrals to community-based and core medical services, including the Connecticut AIDS Drug Assistance Program (CADAP). Project TLC provides transitional medical case management, medical transportation and referrals for 30-60 days follow release.

- Medication Adherence Programs - The Connecticut Department of Public Health (Part B) funds statewide Medication Adherence Programs that provide HIV medication adherence services to support any resident living with HIV who is considering starting HIV treatment or is having difficulty adhering to their HIV medication regimen. The programs are staffed by licensed professionals who assist clients to maximize the potential benefits of their medications, cope with side effects, HIV disease and co-morbidities. Staff provides bio-psychosocial assessments, individualized treatment plans, client education, as well as follow up and referral of clients to medical care and support services. Currently programs are located in Hartford, Manchester, Stamford, New Haven, New Britain, New London, Farmington, Waterbury and Willimantic.

- Infectious Disease Services (Department of Mental Health and Addiction Services) are offered in the context of substance abuse treatment to clients who are already admitted to a particular program. Each high risk admission mutually develops a risk reduction plan. HIV counseling and testing is offered in the context of this plan, and all HIV seropositive clients develop a treatment plan determining their HIV needs and priorities. Counseling and testing is also offered for Hepatitis C as well as Tuberculosis and referrals are made if appropriate. Prevention/case management services and education are offered to clients as well as their families and significant others.

- Connecticut AIDS Residences, funded through State AIDS Housing funds and HOPWA, offer shelter and services to people with symptomatic HIV disease who are homeless or in danger of being such and have a substance abuse problem. They provide support, training, case management, and a variety of other individualized programs both in the residence as well as in the community.

Table 6. Ryan White Part A & B funded - HIV care & support service inventory

	Part B	Part A NH/FF[2]	Part A Hartford[1]	Totals
Core Medical Services Sub-total	**$2,615,864**	**$4,249,592**	**$2,403,157**	**$9,268,613**
a. Outpatient /Ambulatory Health Services	$166,189	$1,043,961	$865,399	$2,075,549
b. AIDS Drug Assistance Program (ADAP) Treatments		-	-	
c. AIDS Pharmaceutical Assistance (local)		-	$50,000	$50,000
d. Oral Health Care	$125,293	$98,027	$110,246	$333,566
e. Early Intervention Services	$92,514	$183,138	$161,871	$437,523
f. Health Insurance Premium & Cost Sharing Assistance		$42,481	$33,292	$73,773
g. Home Health Care		-	-	
h. Home and Community-based Health Services		-	-	
i. Hospice Services		-	-	
j. Mental Health Services	$55,458	$675,729	$147,495	$878,682
k. Medical Nutrition Therapy	$6,460	-	-	$6,460
l. Medical Case Management (+ Treatment Adherence)	$2,169,950	$1,256,802	$854,361	$4,281,113
m. Substance Abuse Services–outpatient		$949,454	$180,493	$1,129,947
n. Medication Adherence Programs		-	-	
Support Services Sub-total	**$470,390**	**$1,303,425**	**$685,654**	**$2,462,926**
a. Case Management (non-Medical)	$277,540		$102,809	$380,349
b. Child Care Services			-	
c. Emergency Financial Assistance	$95,429	$189,286	$33,875	$318,590
d. Food Bank/Home-Delivered Meals	$50,820	$253,445	$79,622	$383,887
e. Health Education/Risk Reduction			-	
f. Housing Services	$7,018	$300,523	$288,884	$596,425
g. Legal Services			$31,705	$31,705
h. Linguistics Services	$7,076		$12,633	$19,709
i. Medical Transportation Services	$29,207	$100,060	$136,126	$265,393
j. Outreach Services			-	
k. Psychosocial Support Services	$3,300		-	$3,300
l. Referral for Health Care/Supportive Services			-	
m. Rehabilitation Services			-	
n. Respite Care			-	
o. Substance Abuse Services - residential		$460,111		460,111
p. Treatment Adherence Counseling			-	
q. Minority AIDS Initiative (Part B Only)	$122,641		-	$122,641
Total Service Dollars	**$3,086,254**	**$5,553,012**	**$3,0088,811**	**$11,728,082**

Ryan White Funded Services

Ryan White Part B	
Service Category	Provider
Core Medical Services	
Outpatient/Ambulatory	Alliance for Living (New London), Waterbury Health Department (Waterbury & Torrington), Windham Regional Community Council (Willimantic), AIDS Project Hartford (Hartford and Manchester), Central Area Health Education Center (Hartford), Community Health Center –Oasis (Middletown), AIDS Project Greater Danbury (Danbury), Family Centers - Stamford, Family Services Woodfield (Bridgeport), Hispanos Unidos (New Haven & Meriden), Mid-Fairfield AIDS Project (Norwalk)
Early Intervention Services	Human Resources Agency (New Britain), AIDS Project New Haven (New Haven)
Medication Adherence Programs (ADAP Flexibility)	Alliance for Living, AIDS Project Hartford, Family Centers-Stamford, Human Resources Agency, University of Connecticut Health Center (Farmington)
Medical Case Management	Alliance for Living, Waterbury Health Department, Windham Regional Community Council, AIDS Project Hartford, Central Area Health Education Center, CT Children's Medical Center (Hartford), Human Resources Agency, Latino Community Services (Hartford), University of Connecticut Health Center, AIDS Project Greater Danbury, AIDS Project New Haven, Family Centers-Stamford, Family Services Woodfield, Hispanos Unidos, Mid-Fairfield AIDS Project, Optimus Health Center, Waterbury Health Department
Medical Nutrition Therapy (Supplemental)	Human Resources Agency, AIDS Project New Haven, Family Centers-Stamford, Mid-Fairfield AIDS Project, Alliance for Living
Mental Health	Alliance for Living, AIDS Project New Haven, Family Centers-Stamford, Mid-Fairfield AIDS Project, Alliance for Living
Oral Health	Alliance for Living, Waterbury Health Department, Windham Regional Community Council, Central Area Health Education Center, Community Health Center-Oasis, Hartford Gay & Lesbian Health Collective, Family Centers-Stamford, Family Services Woodfield, Hispanos Unidos, Mid-Fairfield AIDS Project
Connecticut AIDS Drug Assistance Program	Department of Social Services – Pharmacy Unit
Support Services	
Non-Medical Case Management	AIDS Project Hartford (Transitional Case Management)
Emergency Financial Assistance	Alliance for Living, Windham Regional Community Council, AIDS Project Hartford, Central Area Health Education Center, CT Children's Medical Center, Community Health Center-Oasis, Human Resources Agency, AIDS Project New Haven, Family Centers-Stamford, Family Services Woodfield, Hispanos Unidos, Mid-Fairfield AIDS Project
Food Bank/Home delivered meals	Alliance for Living, Windham Regional Community Council, AIDS Project Hartford, Community Health Center-Oasis, Human Resources agency, AIDS Project New Haven, Family Centers-Stamford, Family Services Woodfield, Mid-Fairfield AIDS Project
Housing	AIDS Project Greater Danbury, AIDS Project New Haven
Linguistics	Latino Community services
Medical Transportation	Alliance for Living, AIDS Project Hartford, Central Area Health Education Center, Community Health Center-Oasis, Human Resources agency, University of Connecticut Health Center, AIDS Project Greater Danbury, AIDS Project New Haven, Family Services Woodfield, Mid-Fairfield AIDS Project
Psycho-social Support	Alliance for Living, AIDS Project New Haven
Minority AIDS Initiative	Central Area Health Education Center

2. Non-Ryan White Funded Programs

HIV Prevention Services

The DPH HIV Prevention Unit currently funds 42 contractors to carry out prevention activities throughout the state. Activities include: Outreach and HIV Counseling, Testing and Referral (CTR), Expanded and Integrated (Routine) Testing, Comprehensive Risk Counseling Services (CRCS), Drug Treatment Advocacy (DTA), Effective Behavioral Interventions (EBIs), a Perinatal HIV Transmission Program, and Syringe Exchange Programs (SEP). Through a mix of state and federal dollars, DPH has been funding community based organizations to conduct HIV prevention interventions statewide since the late 1980s. DPH partners with the CT HIV Planning Consortium (CHPC) to set prevention priorities and then act on service recommendations from the planning body, using them as a basis for Requests for Proposals (RFPs) that are released to procure services in communities across the state.

The Connecticut DPH places a large emphasis on funding the implementation of EBIs, particularly those from the Diffusion of Effective Behavioral Interventions (DEBI) Project. For the past eight years, DPH has been contracting with community based organizations to implement EBIs including: Healthy Relationships, Information and Enhanced AIDS Education, The Effects of HIV/AIDS Intervention Groups for High Risk Women, Intensive AIDS Education in Jail, MPowerment, RESPECT, Risk Avoidance Partnership, Safety Counts, SISTA, Spiritual Self-Schema Therapy, Street Smart, Together Learning Choices and VOICES/VOCES.

A vast array of prevention services are provided to PLWHA and those at highest risk of acquiring HIV in communities across the state. Agencies that provide prevention services are required to target CHPC priority populations for services and to tailor services to the needs of those populations. Programs that have been implemented in the recent past have been either evidence based or those with a procedural guidance. The following is a list of Core Prevention Services:

- CTR - Counseling, Testing and Referral has traditionally been a strategy for prevention and care that allows people to experience risk reduction counseling and learn their HIV status, while facilitating behavior change. DPH maintains contracts with twenty-two (22) organizations in local communities throughout the state to provide CTR to individuals who are at high risk for HIV and belong to any of the CHPC identified priority populations. These DPH funded organizations include local health departments, community based organizations, community health centers, hospitals, and the Department of Correction. All contractors provide HIV prevention counseling and testing at multiple sites, including non-traditional outreach venues.

- ETI - Through the Expanded and Integrated HIV Testing for Populations Disproportionately Affected by HIV Initiative, DPH works with clinical sites across the state. Sites include outpatient clinics, hospital emergency departments, community health centers, STD and substance abuse facilities to conduct routine HIV screening for their patients. Connecticut revised its HIV informed consent legislation in July of 2009 to allow for opt-out testing. Prior to this revision, clinical sites were legally only able to offer HIV testing. Since the law has changed to facilitate opt-out testing, DPH is working with clinical sites to operationalize routine screening. DPH offers technical assistance and training opportunities for the development of individualized protocols and scripts for opt-out testing.

- CRCS -Comprehensive Risk Counseling Services is an intensive multi-session individual level risk reduction intervention for people who are HIV+ or at high risk of becoming infected. CRCS is intended for clients with multiple complex problems that inhibit them from being able to prioritize HIV prevention. DPH currently funds a total of seven (7) CRCS programs located in Danbury, Hartford, New Haven, New London, and Stamford.

- DTA – Drug Treatment Advocacy is a critical prevention intervention designed to help individuals enter drug treatment to help them recover and reduce their risk of HIV infection and the risk to their partners. DPH funds nine (9) DTA programs in Danbury, Hartford, New Haven, Norwalk, Waterbury, Willimantic, and Stamford.

- EBI –Effective Behavioral Interventions are evidence based program models that target specific priority populations with HIV prevention messages. DPH has been supporting EBIs for the past two funding cycles. Currently, DPH funds approximately twenty (20) contractors to implement fifteen (15) different EBIs. Training and technical assistance is provided to contractors and DPH has Intervention Specialists assigned to each EBI to monitor implementation with fidelity to core elements.

- SEP – Syringe Exchange is an effective component of a comprehensive strategy to prevent HIV by distribution of sterile needles or syringes and “works” to injection drug users. Connecticut was a forerunner in the development and implementation of Syringe Exchange Programs as injection drug use had driven Connecticut’s epidemic for many years. DPH currently funds four (4) SEP programs in Bridgeport, Danbury, Hartford and New Haven.

DPH Funded HIV Prevention Services (through December 31, 2012)

HIV Prevention Services	
Prevention Services	**Provider**
HIV Counseling Testing& Referral (CTR)	AIDS Project Greater Danbury, AIDS Project Hartford, Community Health Center (Middletown), ConnectiCOSH (Migrant Farms), GBAPP (Bridgeport), Hartford Gay & Lesbian Health Collective (Hartford/Middletown),Hockanum Valley Community Council, Human Resources Agency (New Britain), Latino Community Services (Hartford), City of Meriden Health Department, New Haven Health Department, Norwalk Health Department, Perception Programs, Stamford Health Department, UCONN Correctional Managed Health Care (DOC), Waterbury Health Department; Waterbury Health Department Torrington Satellite Office, William Backus Hospital (Norwich)
Comprehensive Risk Counseling Services (CRCS)	AIDS Project Greater Danbury, AIDS Project Hartford, Cornell Scott Hill Health Center (New Haven), Hartford Gay & Lesbian Health Collective (Hartford/Middletown), Lawrence & Memorial Hospital (New London), Stamford Health Department, Yale University
Drug Treatment Advocacy (DTA)	AIDS Project Greater Danbury, AIDS Project Hartford, Central Area Health Education Center (Hartford), Cornell Scott Hill Health Center; Liberty Community Services (New Haven), Mid-Fairfield AIDS Project; Perception Programs (Willimantic), Waterbury Health Department, Shelter for the Homeless (Stamford)
Syringe Exchange Programs (SEP)	AIDS Project Greater Danbury, AIDS Project Hartford, Bridgeport Health Department, New Haven Health Department
DEBIs and EBIs	
Healthy Relationships A five session group level intervention for PLWHA to help them identify and reduce stress around disclosure of status and having safer sexual relationships.	Central Area Health Education Center, Hartford Gay & Lesbian Health Collective (Hartford), Hispanos Unidos (New Haven), Meriden Health Department, Waterbury Health Department, Waterbury Heath Department Torrington Satellite Office
Information and Enhanced AIDS Education Consists of two, one- hour HIV/AIDS information sessions and six, one- hour enhanced sessions that focus on personal susceptibility, situational analysis and skill building. Participants also get individual health education consultations.	Stamford Health Department
Latinas en Accion A group level intervention designed to prevent HIV in high-risk women.	Hispanos Unidos
MPowerment A community level intervention for young men who have sex with men (MSM). It uses a combination of informal and formal outreach, discussion groups, creation of safe spaces, social opportunities, and social marketing to reach MSM with HIV prevention and risk reduction messages.	Hartford Gay & Lesbian Health Collective, Interfaith AIDS Ministry of Greater Danbury, Waterbury Health Department,
Peer-no-Peer Outreach to MSM An HIV prevention activity targeting MSM. Peers are trained to deliver message to their social networks.	Hartford Gay & Lesbian Health Collective

Project Respect An individual, client-focused HIV prevention counseling intervention focused on goal setting.	AIDS Project Hartford, Hockanum Valley Community Council
Riker's Health Advocacy Program (RHAP) A program model based on problem solving techniques as well as dispersing knowledge about general health, transmission and prevention of HIV/AIDS, drug abuse and sexual behavior.	Community Partners In Action – Beyond Fear (Statewide)
Risk Avoidance Partnership A project designed to train active drug users as peer/public health advocates to bring a structured, peer- led intervention into sites where they and their drug using social networks use illicit drugs.	Hartford Dispensary (Hartford)
Safety Counts A cognitive behavioral intervention to reduce HIV/HCV risks among active drug users. Through group and individual sessions, goal setting and testing for HIV and HCV are encouraged.	Bridgeport Health Department, ConnectiCOSH, Human Resources Agency, Latino Community Services, New Haven Health Department, Perception Programs
SISTA A peer-led program to prevent HIV infection among African American women. It is a five session group level, gender and culturally relevant intervention designed to increase condom use.	AIDS Project Hartford, AIDS Project New Haven, Waterbury Health Department, Greater Bridgeport Adolescent Pregnancy Prevention Program
Spiritual Self-Schema Therapy An eight session manual guided therapeutic program that aims to increase motivation for prevention. It integrates a cognitive model of "self" within a Buddhist psychology framework suitable for people of all faiths. The goal is to help use their own beliefs to reduce their risks.	Latino Community Services
Street Smart An eight session group level intervention that is a skills building program to help runaway and homeless youth practice safer sexual behaviors and reduce substance use.	AIDS Project Hartford, AIDS Project New Haven, Stamford Health Department
Together Learning Choices (TLC) TLC is a small group level intervention that targets young people aged 13-29 that are living with HIV/AIDS. It helps them identify ways to improve health care, reduce risky behaviors and improve quality of life.	CT Children's Medical Center (Hartford)
VOICES/VOCES Video Opportunities for Innovative Condom Education and Safer Sex is a single session, group level intervention, designed to increase condom use among heterosexual African American and Latino men and women who visit STD clinics.	Community Health Center (Middletown), ConnectiCOSH, Hispanos Unidos, Latino Community Services, Meriden Health Department, New Haven Health Department, Waterbury Health Department

In addition to funding the above HIV prevention services, the HIV Prevention Unit has current and future collaborations with many internal and external organizations and departments to maximize resources and ensure unduplicated services. The following is a summary of collaborations that enhance the DPH Comprehensive HIV Prevention Program:

- CDC Directly Funded CBOs**.** In 2010, DPH was made aware of several CBOs in the state of Connecticut that applied for direct funding from CDC. The majority of these organizations are also funded through DPH. DPH reviewed the CBO's program plans that were submitted to CDC and provided the requested letters of support. Latino Community Services in Hartford was awarded funding to provide Comprehensive Risk Counseling Services (CRCS) and Healthy Relationships to PLWHA. This CBO is an active participant on planning councils and the CHPC. DPH will offer to provide training to the directly funded CBO on other available services such as Partner Services and will work to maintain collaborative relationships with them.

- HIV/AIDS Care Programs**.** The Connecticut HIV Planning Consortium (CHPC) has operated a fully integrated care and prevention planning body since 2007. DPH followed this direction by designating two training staff positions shared between the HIV Prevention Unit and the Health Care and Support Services Unit that oversees Ryan White B funding. These staff members, critical to prevention and care service integration and although no longer split funded between the units, have primary responsibility for the integrated prevention and care training activities and oversight of the Early Referral and Linkage Initiative (ERLI) that involves both prevention and care contractors. Since January 2010, the HIV Prevention Unit and the Health Care and Support Services Unit (HCSS), have been working to ensure that HIV positive clients are linked from prevention to care services. DPH also works to ensure that positive clients seen by Ryan White medical case managers are assessed for prevention needs and receive the appropriate referrals. DPH continues to work with contracted prevention and care programs to assure adherence to the ERLI protocol that outlines the process for referring and documenting linkage of HIV positive clients between prevention and care programs. Documentation of referrals and outcomes are monitored by DPH staff through site visits and quarterly reports. Many contracted prevention programs are co-located with Ryan White Care programs and facilitate successful linkages of HIV positive clients to prevention and care services.

- Surveillance Programs**.** The HIV Prevention Unit works closely with the HIV Surveillance Unit of DPH and relies upon that program to provide data to inform HIV prevention activities. Between January 1, 2010 and June 30, 2010 the HIV Surveillance Unit completed and released the 2010 Epidemiologic Profile of HIV/AIDS in Connecticut. This document describes the HIV/AIDS epidemic in Connecticut and is used by the CHPC to determine the priority populations and related interventions to be funded through federal money in Connecticut. The HIV Prevention Data Team has also developed a protocol with the HIV Surveillance Unit so that HIV positive tests being reported through the CTRS system can be cross checked to determine if they are new cases reported through the Surveillance system. This protocol maintains all of the confidentiality and privacy precautions required for the Surveillance system.

- CHPC**.** In addition to the DPH co-chair who also supervises the Health Care and Support Services (HCSS) unit, the HIV Prevention Unit has designated a Health Program Associate as a liaison between the CHPC and DPH. With this structure, CHPC and DPH have formed a true partnership in developing the Jurisdictional Plan and in the implementation of that plan in terms of HIV/AIDS care and prevention service delivery recommendations.

- CHAIR**.** The CT HIV/AIDS Identification and Referral Task Force (CHAIR) is co-chaired by a DPH Prevention Unit staff member. Additional DPH staff representing the HIV and STD programs are involved with the development of strategies to ensure identification of unawares and protocols for timely linkage to care and support services.

- Substance Abuse Prevention and Treatment Programs**.** In 2011, as part of the Expanded and Integrated Testing Initiative (ETI), DPH provided rapid tests and free laboratory services to nine (9) substance abuse treatment programs funded through the Department of Mental Health and Addiction Services. Hepatitis C screening is also conducted at these drug treatment centers through DPH. In addition, many HIV Prevention contractors conduct EBIs and CTR in substance abuse treatment programs.

- Juvenile and Adult Correction Settings**.** DPH maintains a Memorandum of Agreement (MOA) with the Department of Correction and UConn Correctional Managed Health Care for the provision of CTR in all of CT's correctional facilities. The MOA also includes support groups for HIV positive inmates facilitated by HIV prevention counselors and educational orientation sessions. DPH contracts with Community Partners in Action to conduct the Rikers Island Effective Behavioral Intervention in Correctional Settings. Through the community-level intervention contractor, Concerned Citizens for Humanity, DPH provides discharge packets to all inmates leaving Corrections – including a list of all of DPH-funded care and prevention resources as well as condoms. A number of prevention contractors also conduct interventions such as DEBIs and CTR in Alternative Incarceration Centers in local communities.

- Program Collaboration and Service Integration (PSCI)**.** DPH supports and coordinates integrated hepatitis, TB and STD screening and Partner Services for HIV infected persons, in line with recommendations provided in the PCSI White Paper (2009) and the White Paper*, Establishing a Holistic Framework to Reduce Inequities in HIV, Viral Hepatitis, STD's, and Tuberculosis in the United States (2010).* PCSI efforts will focus on Disease Intervention Specialist (DIS) activities. The DIS will assure that all assigned newly diagnosed HIV positive clients who are interviewed for partners will be offered testing for other STDs, HBV, HCV, and TB. All providers will be made aware of the need to support, coordinate and provide integrated hepatitis Band C, TB, and STD testing and ensure linkage to HIV medical care.

- Hepatitis Prevention Programs**.** The Adult Viral Hepatitis Prevention Coordinator (AVHPC) collaborates and works with HIV Prevention Staff to integrate activities (e.g., using PCSI and syndemic models) to: 1) maximize the public health impact; 2) monitor health status to identify common community health problems; 3) inform, educate and empower people with overlapping risk behaviors and risk factors for HIV and HCV; 4) convene and collaborate with community partners in order to mobilize them to promote healthy communities and behaviors related to HIV and HCV; 5) target populations where health inequities are evident and also ensure culturally competent educational messages and materials in order to help reduce health disparities; 6) promote early identification and linkage to care in order to early interventions and better health outcomes; 7) promote the development of consistent and reasonable policies in order to promote the decrease in the transmission of infections; and 8) evaluate the effectiveness of interventions and population-based services in order to maximize program effectiveness. Specific activities to date include but are not limited to; training for HIV prevention contractors, technical assistance and support to CTR sites and STD clinics doing HIV and HCV testing, as well as integrating information into the EBI programs (Street Smart, Safety Counts, MPowerment, and Holistic Health Recovery) and

facilitating hepatitis B vaccinations in HIV+ persons through collaborations with immunizations and HIV.

- Tuberculosis (TB) Clinics and Programs**.** Collaboration and coordination with the Tuberculosis (TB) Program consists of TB public health nurses working with local health departments and local TB clinics to offer HIV testing to TB patients with unknown HIV status. Those infected are referred to the STD Control Program for DIS follow up. All active cases of TB are assigned to a case manager who works in collaboration with local health department staff. Collectively, this staff assures that all TB cases are offered testing for HIV. All TB patients who are infected with HIV are referred to a DIS for partner services.

- Local Universities and Schools of Public Health**.** DPH collaborates with local universities and schools of public health such as the University of Connecticut, Southern Connecticut State University, and Yale. In recent years, DPH has collaborated with Yale School of Medicine's Center for Interdisciplinary Research (CIRA) on a number of initiatives. Staff members from DPH participate on advisory committees for CIRA's Multi-level HIV/AIDS Intervention Network Trial (MINT). CIRA is one of the five National Institute of Mental Health (NIMH) sponsored AIDS Behavior Research Science Centers. The role of these centers is to develop and test multi-level, multi-faceted HIV Prevention approaches. Two specific areas of focus have been HIV testing in clinical settings and partner notification. CIRA and DPH have collaborated in efforts to increase the awareness of and use of the partner services by private providers.

- State/Local Education Agencies**.** DPH collaborates with the State Department of Education (SDE) on Connecticut's Coordinated School Health Initiative and the Connecticut School Health Survey (Youth Risk Behavioral Survey - YRBS). DPH HIV Prevention staff members continue to serve as members of the SDE's Coordinated Health Education Cadre of trainers. This cadre provides professional development and curricula training to school personnel and health educators on issues related to HIV and STDs. This year, a DPH staff member and trainer for the cadre co-trained teachers at schools within the DCF system on how to implement a CDC curriculum. The project was part of a block grant through DPH. The SDE, STD Control Program, Hepatitis Program, and HIV Prevention Unit also continue to collaborate on the development and evaluation of the *Tell Me What you See* Program which is a collaborative effort to provide an arts-based curricula to schools to supplement their lessons on HIV, STD, and Hepatitis.

- Other Community Groups, Businesses, and Faith-based Organizations**.** Certain DPH prevention funded contractors have faith- based initiatives and work with local churches to provide education regarding HIV and testing events through faith communities. One contractor, Greater Bridgeport Adolescent Pregnancy Program, has been an active participant in the national Balm of Gilead's Black Church Week of Prayer for the Healing of HIV/AIDS.

Other non-Ryan White Funded Care and Prevention Services

Organizations, systems and providers throughout CT recognize the importance of collaboration to creatively respond to the needs of PLWHA. The shared vision creates an effective care and prevention system in which the rate of new HIV infections is significantly reduced and those who are living with and affected by HIV/AIDS are connected to appropriate care and support services. Compared to many other states, Connecticut provides not only important entitlements, but also a diverse range of medical, social, and prevention services and resources for its residents. Connecticut's HIV care and prevention resources are targeted to high-risk areas and populations, and services are tailored to the area to the extent

possible based on HIV surveillance and needs assessment data. As the payer of last resort, Connecticut's Ryan White Part A and B funding is used as a safety net to ensure access to quality HIV/AIDS care in its Part A TGA and EMA and the rest of the state. CT's Ryan White funded services for PLWHA are supported through a broad linkage and collaboration with non-Ryan White funded HIV care, prevention, and social services delivery systems including:

- State of Connecticut Department Social Services (DSS). DSS provides supportive services in collaboration with the CT DPH to people living with HIV, including the CADAP and CT Insurance Premium Assistance (CIPA) Program. The agency offers a broad range of services for the elderly, persons with disabilities, families and individuals. DSS administers housing assistance, emergency assistance, child care assistance, the supplemental nutrition assistance program (SNAP),the CT-Pre-Existing Condition Insurance Plan and the Charter Oak plan for uninsured, CONNPace, HUSKY Healthcare for Uninsured Kids and Youth, Medicaid and Medicaid for Low-Income Adults (MLIA), energy assistance and employment and training programs.
- State of Connecticut Department of Mental Health and Addiction Services (DMHAS) is the State agency that promotes and administers comprehensive, recovery-oriented services in the areas of mental health treatment and substance abuse prevention and treatment, which includes special populations such as individuals living with HIV/AIDS. HIV Services are offered in the context of substance abuse treatment to clients who are already admitted to a particular program. Each high risk admission mutually develops a risk reduction plan. HIV counseling and testing is offered in the context of this plan, and all HIV seropositive clients develop a treatment plan determining their HIV needs and priorities. Prevention/case management services and education are included as well.
- State of Connecticut Department of Children and Families (DCF) is the State agency that provides a wide variety of services for children and their families including child protection, behavioral health, juvenile justice and prevention services. For this population DCF may provide substance abuse, mental health, and other medical services. Three DCF run schools in Connecticut now implement, *Making Proud Choices – A Safer Sex Approach to HIV, STD, and Teen Pregnancy Prevention*, which is a CDC approved program with evidence of effectiveness.
- State of Connecticut Department of Correction (DOC) provides safe, secure, and humane supervision of offenders with opportunities that support successful community reintegration. DOC provides HIV counseling and testing, prevention as well as care and support services for inmates with HIV/AIDS. The CT Prevention Unit funds the University of Connecticut Correctional Managed Health Care to provide Counseling, Testing and Referral (CTR). HIV-positive inmates receive medically supervised treatment, and are connected to the Ryan White Part B funded program Project TLC (Transitional Linkage to the Community), which assists PLWHA leaving the correctional system with reintegration into the communities to which they are returning.
- State of Connecticut Department of Education (SDE) provides educational programs, leadership and curriculum development, planning, evaluation, assessment and data analyses to residents and organizations in Connecticut. DPH collaborates with the SDE in providing training for school personnel and health educators on issues related to HIV and STDs. The SDE, STD Control Program, Hepatitis Program and HIV Prevention Unit collaborated to develop the "Tell Me What You See" project, a supplemental educational package that provides a functional knowledge and art-based component to help students gauge their understanding of STDs, Hepatitis A, B, C and HIV/AIDS.

- Connecticut Cross Part Collaborative (CPC), a HRSA and National Quality Center (NQC) sponsored initiative, improves linkages between all CT Ryan White Parts (A-D) and providers. The CPC has collaborated across all Parts to improve overall quality of care for HIV clients and serves as the State's primary group to ensure the provision of quality of care for PLWHA.
- Connecticut HIV/AIDS Identification and Referral (CHAIR) Task Force was created from a recommendation made by the CHPC in 2010 to support the identification, linkage and referral of individuals living with HIV/AIDS, but unaware of their status, to care and prevention. In 2010, the task force, institutions, and Ryan White Parts A-F and Prevention developed the following goals: 1) Develop and coordinate state and local strategies to identify people who are unaware of their HIV-positive status and link them to care, 2) Foster collaboration between Ryan White A and B and Prevention, and 3) Coordinate data collections, identify data needs, and evaluate approaches for identifying people who are unaware of their status, and link them and their patient-level data with community viral load.

Community-based organizations (CBO) and non-profits also provide HIV health care and prevention services to vulnerable and disproportionately affected populations as a measure of filling the gap in disparate health-related services. Ryan White Part A and B funded core medical and support services continue to be coordinated with other Ryan White Parts (C, D, and F), Federally Qualified Health Centers (FQHC), local providers (e.g. transportation, housing) and social service agencies. Connecticut's thirty acute care hospitals have a long tradition of providing not only excellent medical, emergency and surgical care to PLWHA, but also state-of-the-art diagnostics, support, prevention and educational services to individuals and communities throughout the state.

In 2009, Connecticut hospitals spent:

- $245.5million on uncompensated care
- -$102.5 million in charity care, and,
- -$143 million of care that had to be "written off" for patients without insurance

The Connecticut Hospital Association 2010 Annual Report

The state's fourteen (14) federally qualified community health centers, funded directly through Ryan White Part C, further address the health-care and prevention needs of the state's low-income, medically underserved and racial/ethnic populations who live in poverty. They provide such services as ambulatory primary health care, dental, behavioral health, HIV counseling, testing and referral, chronic disease management, wellness activities, HIV clinics, outreach and community education, prevention counseling and case management for high-risk individuals, and outpatient Early Intervention Services (EIS) for HIV-positive individuals.

Connecticut's 12 Community Action Agencies, funded to meet the needs of low-income individuals in rural and urban areas including PLWHA, provide such needed services as energy and heating assistance, homeless shelters, food programs, eviction prevention, supportive housing, behavioral health, alternatives to incarceration programs, HIV prevention and counseling, case management, substance abuse counseling and employment and training.

In addition to the medical and social service providers indicated, more than sixty-four statewide sites provide substance abuse day treatment, twenty-eight locations provide assistance statewide to help ex-offenders re-enter communities, and more than seventy statewide organizations and agencies provide assistance in obtaining supportive housing for individuals at risk for homelessness.

3. How RW funded care/services interact with non RW funded services to ensure continuity of care and prevention

Ryan White funded (e.g. Part B) and HIV Prevention services are fully integrated into the larger health care and support services delivery network and collaborate on a statewide basis with other private, public, state and federally funded programs and State agencies. These relationships are documented through Memoranda of Understanding (MOU), Memoranda of Agreement (MOA), letters of agreement and/or contractual/consultant agreements. Part B, through an MOU with the Department of Correction and the University of Connecticut Health Center (Correctional Managed Health Care), provides non-medical case management services to HIV-positive inmates transitioning out of Connecticut's correctional facilities into cities and towns throughout the state. Via the MOA with the Department of Social Services, DPH (Part B) coordinates the Connecticut AIDS Drug Assistance Program (CADAP) and the Connecticut Insurance Premium Assistance (CIPA) Program for PLWHA who meet the eligibility requirements (400%, CT residency, proof of HIV status).

Connecticut requires its Early Intervention Services (EIS) providers to coordinate required outreach, identification, linkage and referral services via Letters of Agreement with non-traditional sites, including homeless shelters, food pantries, and community and faith-based organizations. These agreements increase opportunities for HIV testing, outreach, education and linkage of out-of care and newly diagnosed persons to medical care and support services. Through a vital collaboration with the Department of Mental Health and Addiction Services, PLWHA are recipients of comprehensive, recovery-oriented mental health and substance abuse services, including inpatient/outpatient mental health treatment, outpatient and intensive day treatment substance abuse services, alternative living centers, inpatient detoxification programs, and methadone and suboxone programs.

DPH (Part B) is also a key player in the newly organized Connecticut Integrated Eligibility Project. Aware that the Affordable Care Act of 2010 will have a wide ranging impact on the delivery of health services to the citizens of Connecticut, State agencies, including the Departments of Developmental Services (DDS), Children and Families (DCF), Public Health (DPH), Social Services (DSS) and Mental Health and addiction Services (DMHAS) together with the CT's Health Insurance Exchange, Office of Policy and Management (OPM) and Department of Administrative Services, have come together to begin the process of investigating a single, statewide eligibility system that would link all health and human services agencies through a coordinated data base that would contain eligibility rules for the state's many unique programs. Once established, this data tool would be used in a pre-screening mode to help identify other programs for which an individual could be eligible and also exist as a repository of data that could be shared among agencies (with appropriate screens and security) that could assist agencies in identifying individuals and family groups for additional services and programs.

4. How the system has been affected by state and local budget cuts and how the Ryan White and Prevention programs have adapted

State and local budget reductions, and decreases in HRSA and CDC funding for both care (Parts A and B) and DPH Prevention have had direct and indirect impacts on Connecticut's service delivery. Combined with the increased national focus on the "unaware population," national and state economic crises, an 8% statewide unemployment figure, rising homelessness and uninsured populations, disparities in health care, particularly among minorities, as well as the aforementioned reductions in State and Federal funding, the Ryan White care and HIV prevention systems have had to adapt in challenging and innovative ways.

Connecticut's Part B programs are coordinated with other public funding to: 1) ensure that Ryan White funds are payer of last resort, 2) maximize the number and accessibility of available services, and 3) reduce duplication of effort. Ryan White services are linked with other State and Federal funding streams and share a vision that has emerged as a result of the integration of statewide care and prevention planning bodies. Organizations, systems, and providers all recognize the importance of collaboration and cooperation to creatively respond to the needs of PLWHA as well as to reductions in program funding. Decisions to use Part B funds for programs also funded by Part A are based on the overall need for these services. Programs funded by both Parts A and B are carefully monitored to maximize resources and avoid duplication of effort.

In 2006 when the CARE Act was reauthorized and Connecticut's Part A programs received substantial reductions, DPH, through state funding, was able to bridge the gap and assist in providing allocations to maintain service delivery throughout the Part A catchment areas. However, state funds were no longer available in 2009 due to the recession, this funding ended, and Part A programs along with Part B had to refocus attention to the 75/25 mandate and allocate resources in a different manner. This focus on core medical services has had positive outcomes in terms of unmet need and linking and keeping PLWHA in care, as well as in identifying, informing and referring newly diagnosed persons to immediate care and prevention. Part B's priority has always been to ensure that core medical and support services are provided in counties not funded through Ryan White Part A. Historically this has included three rural counties (Windham, New London and Litchfield) where health care facilities and services are not as abundant or accessible as in suburban and urban areas.

Despite state budget cuts in the past to care services, Part B has been able to maintain its funding of these rural programs and specific Part A area programs, with only minimal programmatic reductions. However, with the continuing budget crisis in Connecticut in 2012, additional rescissions were made to the state-funded AIDS services line, resulting in reductions to Part B contractors, particularly affecting medication adherence programs. Through Part B supplemental funding to Connecticut in 2009, 2010, and 2011, dollars were designated to address core medical service needs and gaps and also fund six agencies to provide medical nutrition therapy. When the state-funded medical insurance program for persons with HIV/AIDS, CT Insurance Assistance Program for AIDS Patients (CIAPAP), was eliminated, Part B bridged the gap with CT Insurance Premium Assistance (CIPA) Program, funded through CADAP.

Reductions in the State AIDS Services fund has not only impacted care programs (e.g. medication adherence programs and mental health services for children, youth and families affected by HIV) but also HIV prevention programs including syringe exchange, prevention education interventions, and drug treatment advocacy. As a result of the National HIV/AIDS Strategy and its focus on identification of individuals who are not aware of their HIV status, the CDC has redefined its prevention priorities to focus on utilization of the highest-impact prevention strategies (HIP). Under this new strategy, CDC will

fund health departments in a 75/25 split, with 75% of funds being allocated to core prevention programs (e.g. HIV testing, Prevention with Positives, Condom Distribution and Policy Initiatives) and 25% to interventions for high risk populations (DEBIs/EBIs), social marketing, and pre-exposure and non-occupational exposure prophylaxis (PrEP and nPEP). This new approach has dramatically changed Connecticut's current prevention landscape. The new CDC strategy has also included reallocation of federal prevention funding dollars nationally, resulting in a substantial reduction for Connecticut and a requirement of more defined geographic targeting of resources. With the new CDC directives targeting areas with the highest number of infections, DPH has used its most recent RFP to allocate funding throughout the state with an emphasis on the three major cities – Hartford, New Haven and Bridgeport.

This restructuring of funding will have an impact on programs in smaller cities and rural areas currently funded for prevention services. However, DPH is planning to use some state funds to address high-risk behavior in targeted populations as well as address prevention needs in underserved areas. A close linkage with Part A and B programs will also assist to bridge the gap in addressing prevention with positives, condom distribution, identification of HIV unaware individuals and linkage to medical care. In return, HIV outreach, testing, and linkage (OTL) contractors will provide resources for Part A and B EIS throughout the state (e.g. rapid testing, outreach, data collection, and linkage and referrals of newly diagnosed).

C. Description of Need

1. Care & Prevention Needs

Ryan White Parts A-F and Prevention providers in the State have collaboratively addressed the varied prevention and care service needs and gaps for PLWHA. All individuals living with HIV disease in Connecticut, based on client eligibility, have access to a broad spectrum of Ryan White services and prevention programs at little to no cost. Further, there are no wait lists or cost containment strategies for the CADAP so clients receive immediate access to HAART and HIV-disease related medications.

In 2010, the State conducted a collaborative statewide prevention and care needs assessment using a survey tool that targeted in-care PLWHA in Connecticut. The 2010 Needs Assessment Survey provided a positive picture of the way in which the State (Ryan White Parts and Prevention) is providing care and prevention services to PLWHA. Of the 1,198 validated survey respondents, 99% were shown to be in care by HRSA standards, 96% received care in the last 12 months, and 98% received a CD4 count and VL test within the last 12 months. Survey respondents indicated the following:

Service Needs	Care and Support Service Needs and Uses
18% need help with dental care 18% need housing assistance 16% need help paying for health insurance 16% need emergency financial help 12% need help with other medical care 12% need assistance paying for food	• Most used service: Primary Care (85%) • Least used service: Child Care (3%) • Most needed core service: Dental (18%) • Least needed core service: Home Health Care (2%) • Most needed non-core service: Housing (18%) • Least needed non-core service: Child Care (2%)

These data also corroborate with what the Part A programs in CT defined as care needs in their own catchment area assessments (e.g. dental, housing, food). The New Haven/Fairfield EMA has also included outpatient substance abuse and mental health counseling as additional service needs. In Parts A and B, housing was indicated as an essential service need, and is key due to the connection between stable housing and entry and retention into HIV medical care.

According to the 2010 Needs Assessment Survey, 66% of PLWHA respondents are not using partner services and 57% are not using risk reduction services - showing a need for prevention for positives to reduce infections and co-infections. In the 12 months after testing positive for HIV, survey respondents indicated:

- 10% reported having sex without a condom
- 7% had unprotected sex with someone HIV positive
- 7% injected drugs
- 5% had unprotected sex with someone HIV negative
- 5% had unprotected sex with someone using drugs
- 5% shared needles

The following table[8] illustrates the Prevention and Service needs in Connecticut and existing barriers to services:

Prevention Service Needs		Prevention Service Barriers	
Most Used services	**Most Needed Services**	**Always a problem**	**Sometimes a problem**
• 42% Support Groups • 36% Condom distribution & information • 28% Comprehensive Risk Counseling Services • 25% Services that help your partner his/her risk • 20% Drug treatment services • 16% Specific prevention programs (DEBIS, EBIS)	• 7% Specific prevention programs (DEBIS, EBIS) • 6% Support Groups with information on HIV prevention	• 8% Transportation • 6% Substance Abuse • 5% Unaware of services • 5% Don't know where	• 26% Transportation • 16% Unaware of services • 13% Don't know where • 12% Substance Abuse

Prevention service needs also exist in prevention support services targeting MSM, Latina and black heterosexual women, transgender, high-risk youth (e.g. lesbian and gay), risk reduction services and information, and partner services.

[8] Source: 2010 Statewide Needs Assessment Survey

2. Capacity development needs in historically underserved communities and rural communities

Ensuring access to quality health care across the continuum of care from prevention, screening and diagnosis to treatment and end-of-life care is key to eliminating health disparities and improving quality of life for all individuals living with HIV/AIDS. Public health research shows that a wide variety of health outcomes are influenced by social factors such as poverty, socioeconomic status, educational attainment, social support, stress, discrimination and environmental exposures. Health disparities are evidence of inequalities in these social factors.[9] Reaching underserved populations and HIV-positive individuals in rural settings and assisting them in accessing care and prevention services continues to remain a challenge in the State.

The Connecticut Office of Rural Health (CT ORH) defines rural as all towns in a designated Micropolitan Statistical Area with a population of less than 15,000 and those towns in Metropolitan Statistical Areas with a population of less than 7,000. There are a total of 65 rural towns in the state. Inadequate or unreliable transportation, unaffordable or non-Medicaid accepting dental programs and oral health providers, limited prevention resources including syringe exchange programs, fewer mental health treatment services, inconsistent routine HIV testing by primary care providers, long distances to health care facilities, few infectious disease doctors and specialty medical care, and insufficient or available housing are some of the areas of need and disparities reported in historically underserved communities and rural areas in Connecticut. Because racial and ethnic diversity is increasing in Connecticut's rural areas, capacity development is needed to address cultural and language disparities for minority populations in accessing and remaining in medical care. More bi-cultural, bilingual physicians and medical care providers are necessary to address the health care and HIV prevention needs of underserved communities, particularly non-English speaking populations and migrant/undocumented populations. Health literacy also plays a large role in individuals accessing care, HIV testing and prevention and remaining in care for underserved communities.

Several studies have shown that HIV positive persons with low health literacy are more likely to encounter the following barriers: less preventive care, increased use of the Emergency Department for services, poorer health outcomes, less HIV knowledge, lower CD4 count, poor medication adherence, increased co-morbidities and mortality, and more hospitalizations. Expanded cultural sensitivity and health literacy instruction for care and prevention providers is needed to address the health disparities of HIV-positive MSM, transgender and intersex individuals, foreign-born and undocumented, and sexual minorities. These communities may find it hard to receive or afford appropriate health care and information, and existing health information is often limited, outdated or inaccurate. Sexual and gender minority sub groups, particularly those residing in rural areas, each have diverse health issues and risk levels that affect one group more than another. Among these populations, discrimination, harassment by family, community and peers, lack of support groups and violence can lead to serious physical and mental health concerns and outcomes. Medical providers often lack information, knowledge or experience with these populations, indicating a need for capacity development in the medical community regarding lesbian, gay, MSM, transgender and intersex individuals and their health care and prevention needs.

[9] Source: Connecticut 2009 Health Disparities Report

Dental care and health insurance are also disparities in underserved and rural communities. Many dentists are unwilling to provide services to individuals who have Medicaid and/or living with HIV, and dental services in rural areas are limited or at far distances. Although Connecticut has improved its Medicaid reimbursement rates for dentists thus recruiting more specialists willing to provide services, other recent Medicaid restrictions limit cleanings, fillings and replacement of dentures. Insurance is a major concern for unemployed and low-income PLWHA. Connecticut has implemented health insurance programs that provide coverage to persons with pre-existing conditions (e.g. cancer, HIV, diabetes, etc.); however, the premiums, out-of-pocket costs, and deductibles are still out of reach for many PLWHA. Part B, through CADAP, has offered a solution through its Connecticut Insurance Premium Assistance (CIPA) Program, which provides health insurance purchase and health insurance continuation to CADAP eligible PLWHA, particularly those persons residing in rural areas.

According to the Health Resources and Services Administration (HRSA), the nation's health system faces a growing demand for health care, particularly primary care (e.g. primary care providers, primary care nurse practitioners and physician assistants, dental, mental health and pediatric health providers). Connecticut's Primary Care Office (PCO), through a cooperative agreement with HRSA, works with health care providers and communities to improve access to care for the underserved, by recruiting and retaining providers to practice in Federally designated shortage areas. A number of efforts have been undertaken to address persistent healthcare workforce shortages. In 2009, the Connecticut General Assembly established the Sustinet Board of Directors, charged with preventing and remedying state-wide, regional and local shortage of necessary medical personnel, including physicians, nurses and allied health professionals. Despite Connecticut's forward thinking initiatives, the State still experiences capacity development needs including: 1) lack of or decreasing numbers of physicians specializing in HIV disease treatment (e.g. retirement, etc.), 2) lower starting wages for primary care physicians than for specialists, 3) limited or inadequate State incentives to attract providers to underserved or rural areas or family practice, 4) difficulties in adequately staffing clinics and hospitals in underserved and rural communities, 5) need for more minorities in the health care workforce to better address the concerns of Connecticut's growing racially and ethnically diverse populations, 6) on-going nursing shortage despite recruitment efforts and scholarship/loan repayment incentives, and 7) need for education and training opportunities to assist foreign-trained providers to become licensed.

Part B has always historically prioritized its funding allocations to rural counties not served by Part A. These counties are Windham, New London and Litchfield. Through Part B base and supplemental funding, Connecticut has funded additional medical case management staff, medication adherence programs and medical nutrition therapy programs throughout these areas to address service delivery and care gaps.

3. Description of Gaps in Care & Prevention

The State's primary method for identifying service gaps in care and prevention is a statewide needs assessment survey of PLWHA who are in-care. This every three-year statewide survey includes all Ryan White Parts, CADAP and HIV Prevention. More than 2,400 English and Spanish needs assessment surveys were distributed to 34 Ryan White and prevention funded providers, and to all CADAP recipients. Over 1,600 surveys were returned, of which 1,198 were deemed valid and analyzed by the DPH HIV Surveillance Unit. Ninety-nine percent of survey respondents reported being in care according to HRSA standards, 96% received care in the last 12 months, 98% received both a CD4 count and Viral Load test within the last 12 months. No significant gaps were noted but areas of need were identified. As in previous Needs Assessment Surveys (2005, 2008), commonalities of consistent needs exist – dental care, health insurance premium premium/co-pays, mental health and substance abuse treatment (inpatient and outpatient), housing, transportation, emergency financial assistance and food bank.

Although Parts A and B jointly fund a Hartford-based dental clinic for PLWHA who would otherwise not have access to dental care because of lack of insurance or rejection by non-Medicaid accepting dentists, dental care, particularly specialized treatment is still at a premium.

Because Connecticut had not increased dental Medicaid reimbursement rates since 1993, the state had one of the lowest reimbursement rates in the nation as of 2006, which discouraged dentists from participating in Medicaid and taking Medicaid patients. In 2008, through the efforts of various oral health advocacy organization and several dental professional organizations, the State Legislature and Governor appropriated $20 million for increasing reimbursement fees paid to dentists for services. As an outcome, more dentists began accepting Medicaid patients. Health Centers throughout the state have also expanded their oral health care programs. In 2012 as the state continued to balance its budget, changes were again made to dental services which adult Medicaid patients could receive: 1) Periodic oral exams and dental cleanings were limited to once every year instead of every six months, 2) Dentures could only be replace every seven years instead of every five, and, 3) Limits were imposed on the types of fillings and number of dental x-rays a patient could have in a 12-month period. Although progress has been made in addressing the dental care needs of PLWHA, a need still remains for specialty and advanced dental services, including root canals, bridge work, and oral surgery.

The following table shows needed care services, based on data from the 2010 Needs Assessment, by location as compared to the entire state

Care service by % needed	Hartford TGA	New Haven / Fairfield EMA	Rest of CT (3 non Part A counties)	State
Medication payment other than CADAP	7.5%	8%	8%	23.5%
Help paying for health insurance	18%	14%	15%	47%
Emergency Financial Assistance	16%	15%	16%	47%
Housing Assistance	19%	19.6%	112%	39.6%
Dental	16.5%	19%	15.5%	51%

D. Description of priorities for allocation of care and prevention funds

1. Size and demographics of the population living with HIV/AIDS

CT's Ryan White Parts A-D funded programs and services provide access to quality core medical and support services to PLWHA throughout the State. Service prioritization and funding in the Greater Hartford TGA, the New Haven/Fairfield EMA, and the rest of the State (Part B) is based on the size, demographics and needs of PLWHA within those areas. (See HIV Care and Service Inventory.)

2012 Top Five Priority Service Funding Categories

Hartford TGA	New Haven/Fairfield EMA	Part B
• Outpatient/ambulatory ($865,339) • Medical case management ($845,361) • Housing ($288,884) • Substance abuse-outpatient ($180,493) • Mental health services ($161,871)	• Medical case management ($1,256,802) • Outpatient/ambulatory ($1,043,961) • Substance abuse-outpatient ($949,454) • Mental health services ($675,729) • Substance abuse-inpatient ($460,111)	• Medical case management ($2,167,985) • Non-medical case management ($277,540) • Outpatient/ambulatory ($166,725) • Oral Health Care ($109,272) • Early Intervention Services ($107,399)

The Greater Hartford TGA reports 3,589 persons infected with HIV. Of these 1,156 were living with HIV (not AIDS) and 2,423 with AIDS. Of PLWH, 65% were male and 35% were female; 35% were White, 25.5% black, and 38.3% Hispanic. Route of transmission is IDU (30.7%), heterosexual sex (18.3%) and MSM (27.2%). [Note: Between 2009 and 2010 the percentage of HIV infection attributable to MSM in the TGA has increased 20%.] 68.9% of PLWH are over the age of 40 (34.4% are over the age of 50). Of PLWA, 67.6% are male and 32.4% female; 41% are Hispanic, 29.6% black and 28.6% white. IDU is the primary mode of transmission (46.1%). Of PLWA 87.8% are over 40 (52.4% are over the age of 50).

In the TGA, the number one funded priority is outpatient/ambulatory followed by medical case management, both services which serve to provide an early connection to care and engagement/retention in regular HIV primary care. The third priority area is housing, which, in every Hartford needs assessment survey or focus group appears consistently as one of the top three service needs.

In the **New Haven-Fairfield Counties EMA**, there has historically been a close balance among the three major race and ethnic groups influenced by the dominant historic exposure category of Injection Drug Use. Of the 6,055 PLWHA in the EMA, 65.2% are male and 34.8% female; 32.3% are white, 37.5% black and 28.8% Hispanic. Injection drug use accounted for 34.1% of cases followed by heterosexual transmission at 23.8% and MSM at 22.9%. Sixty-eight percent (68%) of cases are over 40, with 35% over 50 years of age.

In the EMA, the number one funded service is medical case management, followed by outpatient/ambulatory. This is in alignment with the EMA's 2009-2011 Comprehensive Plan which indicated that two of the Planning Council's primary goals are to: 1) increase access to care, and 2) reduce/eliminate disparities. The EMA has also ranked substance abuse-outpatient and mental health

services as priority three and four based on needs assessment surveys and focus groups conducted with PLWHA in the EMA's five funded regions.

Part B has historically prioritized its funding allocations to three regions of the state that do not receive Ryan White Part A funds – Windham, Litchfield and New London Counties. All three are rural in nature, have limited and often inaccessible transportation systems, unaffordable and often inadequate housing, fewer Infectious Disease physicians, specialty medical care providers and health care facilities, and fewer support and social services. Dental care is also an issue in rural areas because of providers who do not accept Medicaid or are not willing to provide service to individuals living with HIV. Ryan White Part B also funds services in the EMA and TGA areas, but with consideration given to existing Part A services and service needs and gaps (e.g. medication adherence, medical nutrition therapy).

The three counties, although reporting fewer PLWHA than in the EMA/TGA areas, nevertheless, have unique and distinct characteristics from the larger urban areas. Litchfield County with 184 individuals living with HIV disease reports 79.3% of cases as white, 9.8% as Hispanic and 8.2% as black. Transmission risk is 32.6% MSM, 26.1% IDU and 14.7% heterosexual contact. Sixty-seven percent (67%) of cases are over the age of 40 with 35% over the age of 50. New London County reports 523 PLWHA, of which 50.3% are white, 26.4% are black and 20.7% are Hispanic. MSM accounts for 30.6% of cases followed by IDU at 29.4% and heterosexual at 23.1% More than 70% of PLWHA are over 40 years of age, with 37% over age 50. Windham County, termed the "quiet corner of the state, but also acknowledged as the "heroin capitol of Connecticut," reports 197 PLWHA of which 51.8% are white, 35.5% Hispanic and 12.2% black. IDU drives the infection at 45.2% of the cases, followed by MSM at 20.8% and heterosexual at 18.3%. Sixty-five percent (65%) of PLWHA are over the age of 40 with 35% over the age of 50.

Part B has prioritized medical case management as the number one service, followed by non-medical case management (transitional case management for HIV-positive inmates transitioning out of CT's correctional institutions), and outpatient/ambulatory.

Future allocation of **HIV Prevention** resources and services will be significantly different from the current scope of services due to a shift in HIV prevention funding allocation across the nation. The federal HIV prevention funding formula has been revised, as recommended in the National HIV/AIDS Strategy, to ensure that funding goes to jurisdictions with the greatest need. As a result, Connecticut's core funding was reduced effective January 1, 2012 from approximately $6.1 million to between $4.5 and $4.9 million. Connecticut's federal HIV prevention funding allocation will be reduced further over the next couple of years to between $3.2 and $3.5 million in 2014.

In light of federal funding reductions, DPH funding allocation will also be delayed and awards reduced. Contractors will be notified of awards by June 2012, however new contracts will not begin until January 2013. Rather, all current prevention contracts will be extended through December 2012. This additional six months will give DPH and community contractors time to transition to the new model of high impact HIV prevention and determine ways of maximizing dwindling resources. During the transition period, DPH will work with contractors awarded funding to obtain the necessary technical assistance and training to be fully operational by January 2013. The DPH prevention unit is in the process of developing prevention performance standards and monitoring tools with which to measure program success. Anticipated funding cuts in 2014 will be based on contractor performance during 2013.

In addition to funding level changes, CDC has shifted prevention priorities as well to more closely align with the National HIV/AIDS strategy. New breakthroughs in HIV Prevention Research have created exciting opportunities toward eliminating the HIV epidemic in the United States. The 2015 strategy goals are:

1) Reducing the annual number of new HIV infections, HIV transmission rate and percentage of people living with HIV who know their serostatus

2) Increasing access to care and improving health outcomes for people living with HIV by linking newly diagnosed patients with clinical care within three months of their HIV diagnosis and increasing the number of Ryan White HIV/AIDS Program clients in continuous care and with permanent housing

3) Reducing HIV-related health disparities by improving access to prevention and care services for all Americans and increasing the proportion of HIV diagnosed gay and bisexual men, Blacks, and Latinos with undetectable viral load by 20%

In order to be successful in its efforts, DPH recognizes the need for HIV care and prevention to work closely together along with other stakeholders to identify new cases of HIV and to streamline services to support a better continuum of care and prevention services. Research shows that if PLWHA are in care they are less likely to transmit the virus. Also, just knowing one's status prompts people to change their behaviors and therefore makes them less likely to infect others. Hence, a concerted effort between prevention and care needs to be made to ensure people know their status and get the care they need to stay healthy and not spread the virus to others. Comprehensive Prevention for Positives and high risk negatives will remain a critical piece of HIV prevention as will outreach efforts including condom distribution to ensure those most at risk of disease acquisition and or transmission are being reached.

In light of the CDC's shift in direction, the DPH HIV Prevention Unit developed and released four new RFPs in December 2011 that more closely align with High Impact Prevention (HIP). HIP utilizes a combination of scientifically proven, cost effective and scalable interventions to target the right populations in the right geographic areas as certain populations have been proven to carry a larger burden of HIV disease than others. In order for HIV prevention to be effective at reducing new infections, it must also address disparities and work toward health equity in those harder hit populations.

Specifically, DPH will allocate at least 75% of core prevention funding to four areas: 1) HIV testing, 2) comprehensive prevention with positives, 3) condom distribution, and 4) policy initiatives. It will also allocate 25% of core prevention funding to evidence based interventions for 1) HIV negative persons at highest risk, and 2) social marketing, media and mobilization. Some EBIs will continue to be funded to reach priority populations identified by the CHPC. The new direction for HIV prevention and Connecticut's revised funding will require programmatic and infrastructure changes at both the state and community level.

2. Future Scope of Prevention Services

Outreach, Testing and Linkage (OTL)

OTL will replace the formerly funded traditional Counseling, Testing and Referral (CTR) programs placing a larger emphasis on outreach to the highest risk populations and testing to determine HIV status. HIV testing in outreach settings will be done primarily through rapid testing. Connecticut Department of Public Health Disease Intervention Specialists (DIS) will be available to those providing testing to assist providers with delivering positive test results and making linkages to other services, particularly Partner Services. Through OTL, counseling and testing services are delinked.

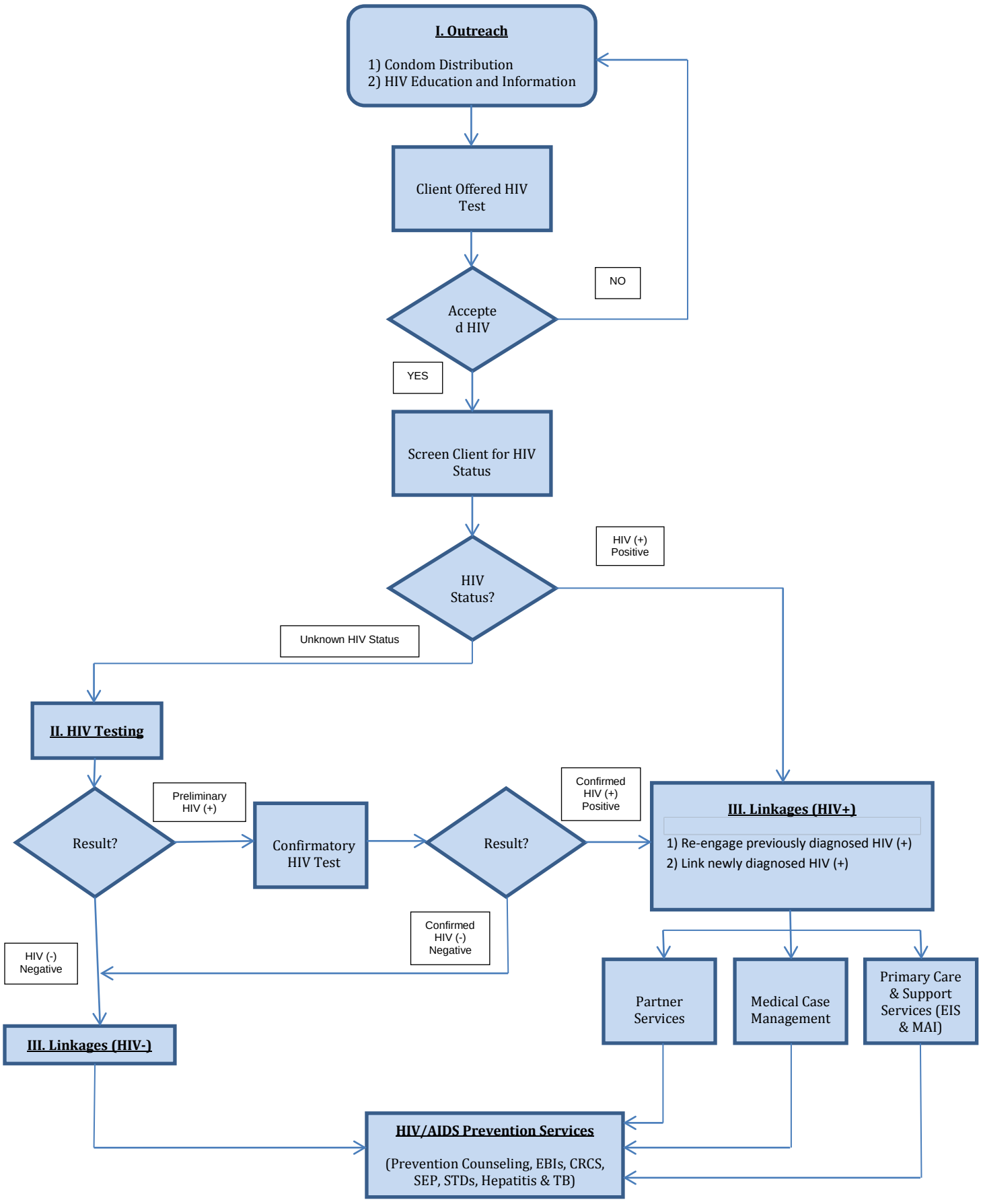
The primary responsibility of OTL staff will be to conduct outreach and testing of designated priority populations, however they will also refer or link individuals they encounter and test to appropriate care and prevention services. Individuals testing HIV+ or HIV- will be linked to appropriate medical, social, and/or prevention services. In particular, OTL staff will assess the individuals need for Comprehensive Risk Counseling Services (CRCS) and/or Prevention Counseling. Individuals in need of risk reduction counseling will be referred to screening. Individuals will be linked to CRCS if they are at high risk for HIV and have complex issues that prevent them from prioritizing HIV prevention. Other individuals in need of less comprehensive risk reduction and counseling services may be linked to prevention counseling. In addition, targeted condom distribution to people living with HIV/AIDS and individuals at high risk of contracting HIV will be provided as a part of OTL. The flow chart on the following page outlines a model for implementation of Outreach, Testing and Linkage (OTL) Service Delivery.

Condom Distribution

DPH coordinates a Community Distribution Center to prioritize condom distribution for HIV positive persons and individuals at highest risk of acquiring HIV infection. Condoms will be regularly sent to Infections disease physicians; Ryan White MCMs; Community Health Centers, STD Clinics, Hospitals, AIDS Service Organizations, and Community Organizations funded by DPH that serve priority populations identified by the CHPC. Condoms will be distributed to HIV positive persons and those at greatest risk of infection during outreach and other prevention service activities. DIS workers will carry and distribution condoms to persons testing HIV positive and their partners. Condom distribution efforts will be concentrated in areas of the state where highest risk persons are located based on HIV surveillance and STD data.

Effective Behavioral Interventions (EBI)

To align with the National HIV/AIDS Strategy (NHAS), the DPH will fund fewer Effective Behavioral Interventions (EBI), and will target populations at greatest risk for HIV as well as those populations that have been disproportionately impacted by the disease. Interventions will focus on PLWHA, MSM, IDU and African American and Latina Heterosexual Women. In the future all funded EBIs must include an outreach component, the goal of which is to engage members of targeted populations, to disseminate HIV prevention information including condoms, to raise awareness, create visibility of the program, and make appropriate referrals and linkages to other services.


I. Outreach
1) Condom Distribution
2) HIV Education and Information
Client Offered HIV Test
Accepted HIV
NO
YES
Screen Client for HIV Status
HIV Status?
HIV (+) Positive
Unknown HIV Status
II. HIV Testing
Result?
Preliminary HIV (+)
Confirmatory HIV Test
Result?
Confirmed HIV (+) Positive
III. Linkages (HIV+)
1) Re-engage previously diagnosed HIV (+)
2) Link newly diagnosed HIV (+)
Confirmed HIV (-) Negative
HIV (-) Negative
III. Linkages (HIV-)
Partner Services
Medical Case Management
Primary Care & Support Services (EIS & MAI)
HIV/AIDS Prevention Services
(Prevention Counseling, EBIs, CRCS, SEP, STDs, Hepatitis & TB)

Expanded Testing Initiative (ETI)

Based on Connecticut's surveillance data, DPH will primarily focus routine testing efforts in health care settings in the three cities with the highest HIV rates and the highest rates of Black/African American and Hispanic populations. Sites will receive funding to hire a service coordinator to monitor routine testing implementation and manage reporting requirements; along with testing kits/supplies and DPH laboratory services. When funding for this program ends, it is expected that routine testing will have been fully integrated into the health care setting, and the service coordinator position can be eliminated as CDC reporting requirements end.

Syringe Exchange Programs (SEP)

DPH will be funding three SEP programs, one in each of the three major cities with the heaviest amount of HIV disease burden. In addition, contractors implementing EBIs that target IDU will be able to integrate syringe exchange services into their programs. This will ensure that more injection drug users have access to clean injection equipment to further prevent HIV and hepatitis transmission among themselves and their social networks.

Policy Initiatives

DPH will continue to address policies related to HIV prevention on a state and local level using data and evidence based practice as a guide. Recently, DPH successfully worked to align HIV testing consent laws with CDC's recommendations for opt-out testing. DPH also successfully worked with community partners to revise and update Connecticut's syringe exchange statute to remove burdensome requirements and facilitate syringe exchange expansion in CT. The DPH prevention unit has a designated staff person to track legislative issues pertaining to HIV/AIDS through the Statescape System.

In addition, DPH will collaborate with local communities, HIV/AIDS partners and advocates, state agencies and other entities to align existing structures, policies and regulations within Connecticut to create an enabling environment for HIV prevention. Some of the issues that are tentatively to be addressed include: 1) Working to influence local policy in a rural Connecticut town with a large injection drug using population, 2) working with DOC to implement routine testing in correctional facilities, 3) partnering with the state Department of Education to support efforts to encourage communities to include comprehensive sexuality education as a part of all health curriculum, and 4) advancing routine testing in health care settings by exploring and addressing barriers identified by health care providers.

E. Description of Barriers to Care & Prevention

1. Routine Testing

In 2009 the Connecticut State Legislature revised its statutes regarding the State's HIV testing Consent Law to align it with the CDC's Revised Recommendations for HIV Testing for Adults, Adolescents and Pregnant Women in Health-Care Settings (2006). The revised law: 1) eliminates the requirement for separate written or oral consent for HIV testing and allows general consent for the performance of medical procedures or test, 2) eliminates the requirement for extensive pre-test counseling, 3) adds a requirement that an HIV test subject upon receipt of the test result be informed about medical services and local HIV support services, and 4) eliminates the requirement that laboratories have written consent prior to performing HIV related tests. The goal of these revisions was to expand and routinize HIV testing in health care settings.

Specific goals of Connecticut's EIIHA's strategy relating to routine testing are to: (a) improve DPH's ability to identify newly infected persons, ensure the provision of test results, provide and track referrals and linkages to medical care, core and support services for persons testing positive and to risk reduction services for persons testing negative, (b) expand HIV testing in non-health care settings (e.g. Outreach, Testing and Linkage), opt-out testing in health care facilities (e.g. Community Health Centers, outpatient clinics, hospital emergency departments and private urban medical practices) and implement routine testing in correctional facilities to increase the number of individuals aware of their HIV status, and (c) improve the percentage of clients with a preliminary HIV-positive test who receive their confirmatory test results and are linked to medical care, prevention, medical case management and support services.

DPH has increased its efforts to identify newly infected persons by ensuring that HIV Testing services are offered in a variety of sites, both traditional and non-traditional, and by cross training providers (including EIS staff). Increased linkages throughout the HIV testing, Prevention and Care systems continue to provide clients with greater options to test and receive referrals and linkages to medical care, MCM, prevention and support services. Through CDC funding for Expanded and Integrated HIV Testing for Populations Disproportionately Affected by HIV, DPH provides resources (e.g. rapid test kits, free lab services, and technical assistance) to clinical sites, including community health centers, college health services, a health care van, Department of Mental Health and Addiction Services (DMHAS) treatment facilities, STD clinics, and hospital emergency departments, to provide routine HIV screening. Through a FY 2010 Memorandum of Agreement (MOA) with the Department of Correction, DPH also funded Counseling, Testing and Referral in twenty correctional facilities.

Despite DPH's increased efforts to promote the implementation of routine testing, provider and client related barriers still exist. Many private medical doctors have still not included routine HIV testing as part of their general screening practices and do not regularly discuss HIV testing with their patients. Patients, particularly older adults, also do not request HIV testing as a routine part of their physical examinations, whether it is because of fear, stigma, complacency or lack of awareness or information about HIV and infection. In addition, many private physicians have not familiarized themselves about local HIV resources or support services, crucial information to supply to a newly diagnosed patient. Incomplete or lack of referral of newly diagnosed individuals to these services can act as a major barrier to ensuring a continuum of care and prevention services.

Data collection requirements have been one barrier that DPH will try to manage by funding service coordinators to manage the data collection and reporting as well as to show clinicians easy ways to work with them in the future. More education is also needed to inform clinicians that opt-out testing is

covered by Medicaid and Medicare in all settings that that it is just a matter of knowing how to code the services. DPH intends to educate clinicians to alleviate misunderstands about the implementation of routine testing. On-going marketing efforts, rather than limited, time sensitive campaigns, are being developed to educate both clinicians and the general public to break down the walls of misinformation, stigma, and fear and promote HIV as a part of preventive medicine

2. Program Related Barriers

Status quo funding for Part B, reduced funding for Connecticut's two Part A programs, and declining CDC HIV Prevention funds to the State serve as barriers to program expansion. The Federally mandated 75/25 split between core medical and support services also acts as a barrier to care and prevention because of the restriction on provision of needed support services (e.g. housing, transportation, emergency financial assistance, food). Long-waiting times at health centers and clinics, lack of transportation in rural areas as well as undependable medical transportation services also serve as program barriers to individuals needing to access care and prevention. As there will be fewer prevention resources in the future, funded prevention contractors will be expected to enhance collaborations to ensure though linkages that people have access to the services they need. For example, going forward there will only be one CRCS program in Hartford, Bridgeport and New Haven respectively and one additional in each of the counties that must serve all residents in the county minus the city.

3. Provider Related Barriers

Providers are required by all Ryan White Parts A-D to support CAREWare and other data sharing information and processes (e.g. collection of client-level data, input of client data into charts and CAREWare, report generation, etc.) in addition to their regular medical case management and core medical service provision responsibilities. This reporting mandate places time constraints on providers with high-case loads and has resulted, at-times, in wait-lists, despite providers' best efforts to address client needs. Systems of triage have been established to allow for client flow through the system, but can serve as a barrier in keeping or reconnecting a client to care and prevention services. Decreased funding for both Prevention and Care contractors also places a burden on service delivery and staff retention. State rescissions to Syringe Exchange Programs, HIV Prevention Initiatives, Medication Adherence and Medical Case Management programs have applied pressure to programs to do more with less.

Program concern about future ability to maintain sustainability also acts as a barrier to service delivery and barriers to care for PLWHA. Prevention providers will experience a change in direction as prevention priorities and services are shifting. A greater emphasis on outreach and testing of high risk populations in communities will exist to ensure that state funded programs are finding people who are unaware of their HIV status and are linked to care. Prevention providers will be expected to go back to the days of traditional street outreach to revamp efforts and increase sero-positivity rates and get more people into care and prevention services. Agencies may need to hire staff with such expertise and knowledge of target communities or retrain current staff for new roles.

4. Client Related Barriers

Barriers for PLWHA in accessing care related services include inability to pay, fear of revealing status, stigma, co-morbidities and severe disorders of mental health and substance abuse, aging population with increased health-associated issues and limited income, foreign-born, undocumented (fear of deportation), unfamiliar with location of services, incarceration history, domestic or partner violence, Medicaid restrictions, no insurance, lack of housing and inadequate or undependable transportation,

and income too high to qualify (for clients with FPL greater than 300%). For those individuals identified as out-of-care, barriers to care, reported in 2002, 2008 and 2010 assessments, were the same: barriers of transportation, fear, distrust, lack of knowledge of services, homelessness, lack of insurance and substance abuse and mental health issues. The biggest client related barrier for prevention services is people not feeling vulnerable to HIV or feeling they do not need HIV prevention services. This is true for PLWHA and high risk seronegatives. Another barrier is a general lack of knowledge that HIV prevention services exist and how to access them. Innovative strategies like social networking and targeted social media campaigns as well as old fashioned outreach may help to educate people on what services are available.

F. Evaluation of 2009 Comprehensive Plan

The 2009-2012 Comprehensive Plan was written in collaboration with the DPH AIDS and Chronic Diseases Section (ACDS), in partnership with the CHPC, PLWHA, Ryan White Parts A-F, Prevention and Care service providers and other State department agencies. It has been updated annually since 2009 with input from CHPC members and participants.

Connecticut continued to make significant progress toward addressing the goals and objectives of the CHPC's Action Plan (2009-2012) during 2011. The community planning process ensured community input in planning for HIV care and prevention service delivery. The Action Plan was carried out in multiple ways: by the CHPC committees and its ad hoc committees, through members and participating agencies, and through DPH. Pages 62 to 65 summarize the progress by objective.

Under the current funding agreement with CDC and HRSA, DPH continued to work toward specific and measurable goals and objectives for each funded prevention and care activity including Community Planning. The overarching community planning goals relating specifically to the community planning process were:

- By December 2011, at least 50% of the CHPC membership will be comprised of PLWHA.
- By December 2011, CHPC membership will agree that at least 90% of key attributes of an HIV planning process have occurred.
- By December 2011, 75% of CDC funded prevention activities listed in DPH's application to CDC will be specified as a priority population or intervention in the CHPC's comprehensive prevention plan.

The goals and objectives relating to care and prevention activities as outlined by the CHPC in the 2009-2012 Action Plan are identified in tables in the appendix, which provide a summary of successes made during the past two years toward accomplishing the objectives of the Action

Plan; including an assessment of challenges and lessons learned. This 2009-2012 Action Plan served as the foundation for the development of the CHPC 2012-2014 Action Plan and the groundwork for the 2012-2015 Connecticut Comprehensive Jurisdictional Plan for HIV Care and Prevention.

2009-2012 Action Plan Successes and Challenges			
Objectives: Collaboration	**2012Anticipated Outcomes**	**Successes as of 8/2011**	**Challenges/lessons learned**
1. Implement a fully collaborative statewide needs assessment for both in care and/or out-of-care in 2010 to allow for uniformity and strength of data, the CHPC, its members and partners (Ryan White Parts A, B, C, D, F/SPNS) and prevention. This will involve the examination of timelines to meet federal guidance for each Part, to ensure each group receives their data in a timely fashion. The survey will be developed in full cooperation with direct input from all Ryan White Parts and prevention.	▪ Collaborative needs assessment process updated with full engagement of all Ryan White Parts and Prevention, consumers, and CHPC membership. ▪ Federal timelines for planning observed (Parts A and B). ▪ New survey methods developed and implemented.	▪ Completed fully collaborative statewide needs assessment for in care and prevention. ▪ Completed analysis of needs assessment data for development of SCSN. ▪ Obtained additional qualitative information for SCSN through partner efforts (Parts A,C, D). ▪ Engaged all Ryan White Parts and DPH prevention to evaluate data needs and timelines. ▪ Developed a RW funded providers survey targeting contractors and medical providers. ▪ Piloted prevention survey that targeted HIV negative individuals. ▪ Updated Statewide Medical Case Management standards and Outcome measures (03/11)	▪ Focus groups not conducted as part of the needs assessment process. Propose holding focus groups to reach specific populations to obtain qualitative data for planning purposes and the SCSN. ▪ Provider survey not implemented because of change in focus. Propose conducting a survey of funded contractors concerning needs, gaps, and services. ▪ Needs Assessment survey only administered directly, not via on-line method. Propose to utilize both direct and internet-based process in future Needs Assessment. ▪ Lack of resources on the part of contractors in marketing the prevention survey produced an incomplete picture of the knowledge and needs of HIV negative individuals. Propose developing updated survey methods and utilize online and/or portable tablets for data collection.
2. Collaborate with all stakeholders to develop a model for a service matrix analysis process to further understand the HIV/AIDS prevention and care landscape. This will include services, utilization, and epidemiology. The service matrix analysis should drive the Part B and Prevention RFP process, and inform the Ryan White Parts A, C, D, F in their planning processes.	▪ Service Matrix model developed with input from all stakeholders. ▪ DPH Prevention RFP is reflective of new CDC Application and guidance.	▪ Service Matrix template developed. ▪ Service Matrix utilized by providers to complete 2011 Prevention RFP. ▪ Realignment of DPH Part B funding cycles with Federal cycles. ▪ DPH utilized Service Matrix in developing Prevention and Part B RFPs in 2010 and 2011.	▪ 2011 DPH Prevention RFP was a success but was later retracted due to new CDC FOA with changes in allocation and focus. New RFP will be issued in 2012 reflective of CDC directives. ▪ Service matrix not updated in 2010 and 2011 because of lateness in receipt of federal funding from HRSA. Matrix will be updated in 2012 and will be more inclusive of information from Part C and D and other federal funding sources (e.g. SAMSHA, HOPWA).

Objectives: Service Capacity	Anticipated Outcomes by 2012	Successes as of 8/2011	Challenges/lessons learned
3. Create a procedure to collect, analyze, monitor and share with stakeholders client level data to provide the most accurate picture of HIV/AIDS in Connecticut among all Ryan White Parts and Prevention.	▪ Client level data is retrievable and de-duplicated via CAREWare and PEMS. ▪ Client level data is reported through CT AIDS Drug Assistance Program (CADAP) (funded through a SPNS grant). ▪ Provider survey, using online process, is conducted regarding client level data and information assessed and shred. ▪ Connecticut has the most complete picture of HIV/AIDS in CT. ▪ CT provides on-going training on CAREWare and PEMS for providers via webinars and 1:1 TA. ▪ CAREWare user manual posted on DPH website for easy accessibility by contractors.	▪ Successful transition by Care and Prevention to new data collection systems (CAREWare and PEMS). ▪ Monthly CAREWare Conference call among Ryan White Parts to discuss updates and monitoring. ▪ PEMS and CAREWARE training, troubleshooting and TA making marked improvement in contractor reporting. ▪ Unmet needs estimate updated annually based on most current viral load information. ▪ Unaware Estimates completed for Parts A and B.	▪ PEMS and CAREWare data systems unable to communicate. Develop system to share data between Care and Prevention to verify referrals and client status. ▪ Data not entered in a timely fashion into data systems. Providers to be more closely monitored and corrective action plans initiated for non-compliance. ▪ Clients not clearly informed regarding CAREWare process of data sharing. Train providers to explain CAREWare processes thoroughly to clients to obtain buy-in. ▪ CAREWare trainings not sufficient to meet data input needs of providers. Develop a user manual for posting on DPH website.
4. Explore methods to address barriers to services.	▪ New methods are identified to address barriers to care and prevention services. ▪ Community Forums conducted in high incidence city and rural location. ▪ Conduct out-of-care survey using EIS specialists and MAI specialists. ▪ Participate in National Quality Center's 12 month In+Care Campaign and develop strategies with providers to retain clients in care. ▪ Utilize findings from CHAIR to address service barriers.	▪ Planning and development of the HIV Community Forums ▪ CHAIR proposed and developed, and maintains monthly meetings. ▪ DPH discusses cost/benefit analysis of raising Ryan White client eligibility from 300% to 400% FPL. ▪ Two community education outreach efforts conducted (New Haven and Norwalk) in 2010. ▪ Continued collaboration between care and prevention and STD units regarding identification of unaware.	▪ Challenges exist for providers related to service delivery due to pending funding changes at the federal/state levels. Propose more co-location of services and sharing of resources between Ryan White Parts. ▪ MAI services previously only operated in one location. Expand MAI services throughout the contractor TGA. ▪ Locating out-of-care individuals has been difficult to address their barriers to staying in care. Work with MAI and EIS to reconnect out-of-care to define barriers and link with care.

Objectives: Public Awareness and Training	Anticipated Outcomes by 2012	Progress as of 8/2011	Challenges/lessons learned
5. Provide training and continuing education for medical practitioners on risk assessment and risk reduction, secondary prevention and available HIV care and prevention services to link all individuals to appropriate HIV care and prevention services and applicable state services.	▪ Medical practitioners are effectively informed and trained about HIV care and prevention services and applicable state services through collaborative effort with CAETC.	▪ CHAIR (Connecticut HIV/AIDS Identification and referral) first proposed in February 2010 and implemented by DPH Prevention Unit as a means to develop strategies to identify people unaware of their HIV status and link, them to care and to support and increase referrals and use of the partner notification program. ▪ Integrated HIV Care & Prevention Provider Training conducted January – June 2010. ▪ Legislative action passed on routine HIV testing (7/1/09). ▪ DPH developed messages to disseminate to medical providers (on website). ▪ Resource service inventory available on DPH website. ▪ Social marketing campaigns conducted with bus cards, radio spots in Spanish and English – multi-generational (June 2009). ▪ Coordination of trainings (providers/consumers) ongoing.	▪ Providing training to medical providers presented numerous difficulties. Connect with CAETC to co-sponsor trainings for medical providers throughout CT and utilize more direct mail and email information.
6. Provide ongoing training to medical case managers (MCMs) on the medical model and clinical practices, and available resources and services within the state.	▪ MCMs in Connecticut will receive ongoing training on the medical model, clinical practices, and available resources and services with the state. Training schedule developed through December 2011. ▪ Annual MCM meeting and Supervisor Training ▪ MCMs trained in risk assessment and partner notification.	▪ Annual Part B MCM and Prevention meetings held August 2011. ▪ Distribution list for MCM developed to update on information and resources (services, legislative changes). ▪ Ongoing partnership with “Train Connecticut” to explore web based training. ▪ Medical case management core standards aligned across Ryan White Parts. ▪ Hartford TGA survey of Part A & B MCMs. ▪ Coordination of training opportunities for all AIDS service providers. ▪ Conducted social marketing campaigns on routine testing targeting specific populations ▪ Collaborated with New England AIDS Training Center trained providers on routine testing within legal parameters.	▪ Resources: free speakers, sites and food. Coordinate with CAETC to sponsor trainings. Link in with more public sites and utilize internal agency trainers. ▪ Non-alignment of assessment forms across Parts. Obtain buy-in from Parts on standard forms for MCMs.

Section II: Where Do We Need to Go?

A. Plan to meet 2009 challenges

Although numerous challenges were identified in the 2009-2012 Action Plan, substantial successes were achieved in:

- Cross-Part and agency wide collaboration and cooperation
- Streamlining of the continuum of care and service delivery systems
- Data collection and sharing in prevention and care units and HIV Surveillance
- Updated Standards of Care for Medical Case Management and Protocols for Early Intervention Strategies, Medication Adherence and Medical Nutritional Therapy
- Implementation of quality management processes
- Performance Measure monitoring
- Implementation of the CT HIV/AIDS Identification and Referral (CHAIR) Task Force to implement strategies to identify people unaware of their HIV status
- Integration of Care and Prevention Provider Trainings
- Revision of CT's routine testing legislation (2009)
- Implementation of social marketing campaigns on routine HIV testing

Challenges focused on the need for broader-based agency collaboration as well as community coordination in care and prevention service delivery, wider utilization of on-line technology and social marketing in administering and marketing the Statewide Needs Assessment as well as in Prevention and routine HIV Testing messages, increased quality management initiatives in health care and prevention planning, programming and service delivery, data collection systems that can "talk to each other", regular reporting on performance measures, data collection and outcome measures in relation to care and prevention, and coordinated strategies to identify and inform individuals unaware of their HIV status and connect them to care, as well the reconnection to care of out-of-care PLWHA.

These challenges are addressed in the 2012-2015 CHPC Action Plan, which embodies Connecticut's commitment and readiness to "increase the coordination of HIV care and prevention programs across the Federal government and between Federal agencies and State, territorial, tribal and local governments" (National HIV/AIDS Strategy, 2011). The 2012-2015 Action Plan, which forms the foundation for the 2012-2015 Comprehensive Plan, aligns with the National HIV/AIDS Strategies (NHAS) as well as with accompanying Federal Implementation Plan action steps:

- NHAS Goal 1 of "reducing new HIV infections" aligns with the Action Plan Goals 1 and 3
- NHAS Goal 2 of "increasing access to care and prevention and improving outcomes for people living with HIV" aligns with Action Plan Goals 1 and 2
- NHAS Goal 3 of "reducing HIV-related health disparities" aligns with Action Plan Goals 1 and 2.

Connecticut's Comprehensive Plan for HIV Care and Prevention, 2012-2015, addresses prevention and care services and places the state in a solid position for advancing and addressing the NHAS, Healthy People 20/20 and the Affordable Care Act (ACA).

Page 67 shows a logic model for the Action Plan. Pages 68 to 73 provide additional detail about organized around the three goals along with respective objectives and outcomes. Each objective is broken out into action steps, person(s) responsible, time frame and accomplishments. The three goals of the Plan are:

1) To facilitate statewide collaboration to maximize resources, identify and document the needs of people living with HIV/AIDS and those most at risk and to develop and implement a responsive HIV Care and Prevention Plan,

2) To promote targeted changes in HIV/AIDS Prevention and Care service delivery systems to improve health outcomes and the quality of life for PLWHA and those unaware of their HIV status, and,

3) To increase public awareness and education efforts that support prevention, early identification, and access to information and resources by providers, PLWHA and those unaware of their HIV status.

Connecticut's Logic Model

Mission

Create a coordinated statewide care and prevention 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

Goals

Facilitate statewide collaboration to maximize resources, identify and document the needs of people living with HIV/AIDS and those most at risk and to develop and implement a responsive HIV Care and Prevention plan

Promote targeted changes in HIV/AIDS Prevention and Care service delivery system to improve health outcomes and the quality of life for PLWH/A and those unaware of their HIV status

Increase public awareness and education efforts that support prevention, early identification, and access to information and resources by providers, PLWH/A and those unaware of their HIV status

Objectives

1. Conduct an integrated Statewide Needs Assessment for Prevention and Care targeting the in-care and out-of-care populations
2. Update the HIV/AIDS Service Matrix
3. Identify needs, gaps and priorities
4. Strengthen partner (agency) participation at CHPC meetings / processes and expand collaboration with other partners
5. Adjust CHPC membership and processes as warranted to advance the mission

1. Promote early identification of people unaware of their HIV status and link them to prevention or care services
2. Promote access to HIV Care & Prevention Services including priority areas
3. Promote proven capacity building practices across all Parts & Prevention
4. Promote the communication and coordination of training for care and prevention providers across all Ryan White Parts, Prevention and other relevant stakeholders
5. Promote regular collection and meaningful use of quality and performance measures for prevention and care to inform planning & enhance service delivery

1. Strengthen partnerships with Connecticut AIDS Education and Training Center (CAETC) and National HIV/AIDS Education Training Center (NAETC) to provide training & continuing education for medical practitioners, their staff and HIV service providers
2. Promote awareness of resources and educational opportunities for PLWH/A
3. Support comprehensive sexuality education for youth and young adults
4. Promote coordinated social media/marketing and public awareness initiatives

Outcomes

- Needs Assessment Findings (SCSN) disseminated
- Service Matrix disseminated
- Gaps Analysis disseminated
- Protocols for maximizing resources disseminated
- Comprehensive Plan disseminated
- Stakeholders added to CHPC process
- Resource lists and service protocols shared
- Healthy People, National HIV/AIDS Strategy and Affordable Care Act addressed

- Partner Services usage bolstered
- Formerly unawares accessing services
- Resources in response to CHPC priorities & recommendations maximized and increased
- Processes streamlined to increase quality of care and prevention services, referrals and training
- Healthy People, National HIV/AIDS Strategy , Early Identification of Individuals with HIV/AIDS and Affordable Care Act addressed
- Identification of quality & performance measures
- Field test of quality/performance reports to CHPC

- Increase collaborations to ensure that adequate training and educational opportunities occur
- Increase PLWHA access to information and services
- HIV/AIDS resources and services information disseminated
- Efforts to disseminate age appropriate and evidence based information regarding comprehensive sexuality education increased
- Targeted social marketing initiatives for priority populations and the general public conducted
- Healthy People, National HIV/AIDS Strategy , Early Identification of Individuals with HIV/AIDS and Affordable Care Act addressed

Goal 1. Facilitate statewide ***collaboration*** to maximize resources, identify and document the needs of people living with HIV/AIDS and those most at risk and to develop and implement a responsive HIV Care and Prevention plan				
Objective	**Action Steps**	**Lead Partner / Staff**	**Time Frame**	**Accomplishment**
1. Conduct an integrated Statewide Needs Assessment for Prevention and Care targeting the in-care and out-of-care populations	• Establish Data and Assessment work group • Establish objectives/timelines (across stakeholder data needs) • Research evidence-based methods / survey protocols • Develop and test survey tools • Train survey administrators, implement survey, collect data and analyze results • Discuss / interpret and publish findings • Develop and conduct Community Forums to obtain qualitative information • Incorporate qualitative and quantitative information into Plan	CHPC DAC, CTDPH staff, CHPC staff	Completed by 2012 and 2014	• Survey instruments designed, disseminated and analyzed • Survey protocol developed and disseminated • In-care needs assessment completed and analyzed • Out of care needs assessment completed and analyzed • SCSN (in-care and out-of care) completed and disseminated • Community Forums completed, input analyzed and findings included in SCSN • Community input through stakeholder processes
2. Update the HIV/AIDS service matrix	• Gather data across Ryan White Parts, Prevention and other relevant stakeholders regarding funding, targeted populations and interventions • Update service matrix and publish findings	CTDPH staff, CHPC staff	Completed by 2012 and updated annually	• HIV/AIDS service matrix completed • Matrix disseminated to stakeholders and posted on DPH website
3. Identify needs, gaps and priorities	• Review 211 resource directory, SCSN findings and service matrix • Compare needs assessment findings with service matrix to identify gaps • Review Community Forum information and stakeholder input • Publish / share findings	CTDPH staff, CHPC DAC, CHPC staff	Completed by 2012 /ongoing	• Needs, resources and gaps defined • CHPC recommendations reflected in service matrix • Recommendations made to DPH regarding findings • Findings shared with stakeholders

Goal 1. Facilitate statewide ***collaboration*** to maximize resources, identify and document the needs of people living with HIV/AIDS and those most at risk and to develop and implement a responsive HIV Care and Prevention plan				
Objective	**Action Steps**	**Lead Partner / Staff**	**Time Frame**	**Accomplishment**
4. Strengthen partner participation at CHPC meetings / processes and expand collaboration w/ other partners	• Identify new and existing stakeholders to advance the mission of CHPC and partners relevant to advancing the Comprehensive Plan • Engage stakeholders in CHPC involvement and initiatives • Promote awareness of CHPC in the greater community through Community Forums, PSAs and other innovative media initiatives	CHPC, CTDPH staff, CHPC staff	Completed by 2014	• New collaborations defined • Innovative service delivery models supported • Increased Partner Services • Increased resources (coordination of state and local strategies) to strengthen the service delivery continuum • Expanded community awareness of CHPC
5. Adjust CHPC membership and processes as warranted to advance the mission	• Review CHPC membership in relation to the CDC diversity grid • Implement leadership development and member training/education • Create Ad Hoc committees and work groups to complete CHPC planning processes • Foster collaboration and referral networks within and across HIV/AIDS community organizations	CHPC MAC, CTDPH staff, CHPC staff	2012/ ongoing	• CHPC membership reflects balance of providers and consumers and is reflective of the epidemic • CHPC members well informed of processes • Increased CHPC member/ public participant participation • Presentations by Ryan White Parts, Prevention & other relevant stakeholders • Ad Hoc and work groups created, and work towards their meeting goals

Goal 2. Promote targeted changes in HIV/AIDS Prevention and Care *service delivery* system to improve health outcomes and the quality of life for PLWH/A and those unaware of their HIV status				
Objective	**Action Steps**	**Lead Partner / Staff**	**Time Frame**	
1. Promote early identification of people unaware of their HIV status and link them to prevention or care services	• Review Epidemiological profile, EIIHA matrices and CHAIR recommendations • Define unaware populations from respective data • Develop strategies and collaborate with Ryan White Parts, Early Intervention Services, and Prevention to identify and inform unaware individuals of their status • Inform, educate, refer and link individuals made aware of their HIV status with care and prevention services • Link/refer to Partner Services	CT DPH staff, Ryan White Parts, Prevention, CHAIR	2012/ ongoing	• Unaware individuals identified • Collaborative strategies developed and implemented • Individuals identified, informed of their status and linked to appropriate services • Increased utilization of the Partner Services program
2. Promote access to HIV Care & Prevention Services including priority areas	• Review SCSN data regarding needs and gaps • Define priority areas • Identify resources and stakeholders to address priority areas • Develop strategies to promote access to care and prevention services and priority areas through traditional and non- traditional points of entry • Review information on quality and performance measures for prevention and care (see Action Step #5)	CT DPH staff, Ryan White Parts, Prevention, & other stakeholders	2012/ ongoing	• Priority areas defined • Resources and stakeholders identified • Strategies identified to promote access to care and prevention services • Introduce regular reporting on prevention and care quality and performance measures (See Action step #5)
3. Promote the communication and coordination of training for care and prevention providers across all Ryan White Parts and Prevention	• Review and compare current training offerings for care and prevention providers • Review and compare care and prevention training needs assessment tools and data • Collaboration among partners to create a mechanism for communicating training opportunities	CT DPH staff, Ryan White Parts, Prevention, CPC, CAETC, DMHAS & other training partners	2012/ ongoing	• Trainings reviewed and coordinated • Training needs and offerings disseminated

Goal 2. Promote targeted changes in HIV/AIDS Prevention and Care *service delivery* system to improve health outcomes and the quality of life for PLWH/A and those unaware of their HIV status				
Objective	**Action Steps**	**Lead Partner / Staff**	**Time Frame**	
4. Promote uniform processes to offer client centered services and completed referrals	• Review existing client service protocols and forms • Recommend standardized client centered service protocols and forms to reduce paperwork for clients and service providers • Use approved data systems to identify and track service referrals • Encourage use of agency referral completion system to document completed referrals • Explore the development of a referral tracking system between Care and Prevention • Create and update statewide description of available prevention interventions and care services to providers and use for referrals • Assess client satisfaction with service delivery and referrals	CT DPH staff, Ryan White Parts, Prevention, CPC and other relevant stakeholders	2012/ ongoing	• Standardized client centered service protocols and forms developed • Increased use of data systems • Agency referral completion system disseminated and utilized • Statewide description of available prevention interventions and care services distributed • Client satisfaction survey included in Needs Assessment survey
5. Promote regular collection and meaningful use of quality and performance measures for prevention and care to inform planning & enhance service delivery	• Identify initial set of quality and performance measures • Assess feasibility of collecting and reporting on a subset of quality and performance measures • Identify areas of improvement / gaps in data collection (and provide feedback to appropriate partners responsible to facilitate data collection) • Field test a report / update format and share proto-type with the CHPC for additional input • Identify recommendations for future actions on how to enhance the collection and meaningful use of quality and performance measures (particularly in the context of health care reform)	CT DPH Staff, Ryan White Parts, Prevention, and other relevant stakeholders	2012 / ongoing	• Quality and performance measures identified for prevention and care • Partners facilitate through contract language and/or training improved data collection (e.g., timely, complete reporting) • Partners share (present or publish) regular quality and performance measure reports for prevention and care • Partners identify recommendations for future actions

Goal 3. Increase *public awareness and education* efforts that support prevention, early identification, and access to information and resources by providers, PLWH/A and those unaware of their HIV status				
Objective	**Action Steps**	**Lead Partner / Staff**	**Time Frame**	**Accomplishment**
1. Strengthen partnerships with CAETC and NAETC to provide training & continuing education for medical practitioners, their staff and HIV service providers	• DPH to organize meetings with CAETC and NAETC training staff to discuss and plan collaborative trainings for medical practitioners, their staff and HIV service providers • DPH, CAETC and other HIV providers develop statewide education schedules and protocols for training medical providers • CAETC and DPH develop training brochures and disseminate to statewide medical providers, staff and HIV service providers • DPH, CAETC and other HIV providers implement trainings, evaluate trainings and update as needed	CHPC, CT DPH staff, Ryan White Parts, Prevention, CHPC staff, CAETC, NAETC, Other relevant partners such as CARC & DMHAS	2012 and ongoing	• Partnerships improved between DPH, CAETC and NAETC • Collaborative training developed and implemented for medical practitioners, their staff and HIV services providers • Medical practitioners, their staff and HIV service providers are knowledgeable concerning risk assessment and reduction, secondary prevention, and routine testing • Training calendar created with appropriate contact information
2. Promote awareness of resources and educational opportunities for PLWH/A	• Develop a bilingual survey to determine the needs of PLWH/A • Create survey process and protocols • Implement and analyze survey • Share results of the survey with stakeholders • Create a mechanism for communicating educational opportunities	CHPC, CT DPH staff, Ryan White Parts, Prevention, DMHAS, CHPC staff, PLWH/A, and other relevant partners such as CARC	2012 and ongoing	• Survey developed and implemented • Survey is analyzed and information disseminated • Educational needs and offerings disseminated

Goal 3. Increase *public awareness and education* efforts that support prevention, early identification, and access to information and resources by providers, PLWH/A and those unaware of their HIV status				
Objective	**Action Steps**	**Lead Partner / Staff**	**Time Frame**	**Accomplishment**
3. Support comprehensive sexuality education for youth and young adults	• Recommend that DPH partner with the State Department of Education (SDE) and Healthy Teens Coalition to promote comprehensive sexuality education in schools • Promote the utilization of evidence-based curricula • Promote the initiatives of the Health Interactive Project regarding Sexually Transmitted Infections (STI)/HIV presentations and screenings in high schools • Support HIV testing and STI awareness at school based health centers • Support HIV messaging campaigns via social marketing to youth and young adults	CHPC (Youth Advisory Group), CT DPH staff, Ryan White Parts and Prevention, CHPC staff, PLWH/A and other relevant partners such as SDE	2012 and ongoing	• Partnership with SDE developed • HIV/STI screening and presentations increased • Curricula developed and utilized • Social marketing campaigns conducted • STI initiatives supported • Adult education, collegiate services and student centers, engaged in comprehensive sexuality education • Partner with Healthy Teens Coalition
4. Promote coordinated social marketing/media and public awareness initiatives	• Promote education and public awareness around HIV care and prevention initiatives using social media tools • Promote DPH's targeted social marketing campaign and help implement on a statewide basis • Update DPH Website/211 and HIV News and Notes to assure most current information and resources • Plan and conduct HIV Community Forums	CHPC, CT DPH staff, Ryan White Parts, Prevention, CHPC staff, PLWH/A, and other relevant partners	2012 and ongoing	• Social media tools utilized to support education and public awareness around HIV care and prevention initiatives • Social marketing campaigns completed • DPH and 211 websites updated

B. 2012 Proposed Care & Prevention Goals

Connecticut's Part B Clinical Quality Management Program is an integral component in the Health Care and Support Services (HCSS) Unit. The mission of Connecticut's CQMP is to assure access to and retention in quality, client centered health care and related services for all Connecticut PLWHA in accordance with the U.S. DHHS, HRSA /HAB Regulations, and the National HIV/AIDS Strategy. Its vision is to promote optimal health outcomes for individuals living with HIV, reducing new HIV infections, and reducing HIV-related health disparities. The CQMP's purpose is to provide a mechanism for the objective review, evaluation and continuing improvement of Connecticut's Part B funded services.

Part B program goals, which are reflective of the 2012-2015 Action Plan Goals include:

1) Ensure access, retention, reconnection and maintenance of PLWHA and out-of-care PLWHA in client centered health care, support services and prevention to reduce morbidity and mortality and improve health outcomes

2) Ensure that Core Medical and support services are easily accessible and readily available

3) Ensure that funded service providers adhere to the Ryan White Part B HRSA monitoring standards, HAB Performance Measures and CAREWare client level data reporting requirements, PHS Guidelines for PLWHA, and the Statewide MCM Standards of Care

4) Improve and increase the identification, informing, and referral of PLWHA who are unaware of their HIV positive status to medical care, medical case management and HIV prevention services (HIV testing, Partner Services, and Diffused Effective Behavioral Interventions)

5) Promote regular and on-going collaborations with Ryan White Parts, Prevention, and the STD Unit as well as other state agencies (DMHAS, DOC and DSS) and community organizations in relation to data collection and meaningful use of quality and performance measures (e.g. data reporting, collection and sharing) to inform planning and enhance service delivery

6) Increase collaborations across Prevention and Care to ensure that adequate training and educational opportunities exist and occur for providers, prevention and care staff, PLWHA and other relevant stakeholders

7) Reduce HIV-related health disparities and improve health literacy for PLWHA

The HIV Prevention Program Goals reflective of the 2012-2015 Action Plan are

1) To increase the proportion of HIV infected persons in Connecticut who know their HIV status through ongoing marketing of services and implementation of Outreach Testing and Linkage initiatives

2) To increase the proportion of HIV infected persons who are linked to care and prevention services through training as well as improved mechanisms to track, trend and report referrals and linkages

3) To expand the implementation of HIV Outreach, Testing and Linkage services in order to reduce new infections through enhanced outreach and coordination with other programs

4) To provide linkage to HIV care, treatment, and prevention services for persons testing HIV positive or currently living with HIV/AIDS by collaborating with stakeholders to maximize the number of people identified for partner services, identify positives in and out of care, and coordinate behavioral and risk reduction screening activities

5) Offer referral and linkage to other medical and social services such as mental health, substance abuse, housing, safety/domestic violence, corrections, legal protections, income generation, and other services as needed for HIV positive persons

6) To provide condoms to PLWHA and people at very high risk for HIV infection through a targeted condom distribution plan

7) To support efforts to align structures, policies, and regulations with optimal HIV prevention, care, and treatment and to create an enabling environment for HIV prevention efforts by implementing new strategies and forging new collaborations

8) To facilitate statewide collaboration to maximize resources, identify and document the needs of PLWHA and those most at risk and to develop and implement a responsive HIV care and prevention plan

9) To increase public awareness efforts that support prevention, early identification of HIV infection and access to information and resources by providers, PLWHA and those unaware of their status

10) To provide quality HIV related training and capacity building assistance opportunities to all DPH funded care and prevention providers across the state

C. Goals regarding individuals Aware of their HIV status but not in care (Unmet need)

Reconnecting out-of-care HIV-positive individuals and those aware of their status but not in care to care is a complex process involving many environmental, personal, social, emotional, and physical considerations. Because of homelessness, lack of insurance or inadequate insurance, incarceration, unemployment, lack of finances, mental health issues and injection and other drug use, HIV-positive out-of-care individuals often are difficult to locate, may not actually feel sick, are stigmatized or fearful to return to care because of medication side effects. Other HIV positive individuals in good health, do not have adverse HIV disease side-effects, have stable lives, and know their status but choose not to connect to care fall below the radar and are difficult to identify and connect to care.

The Part B program goals regarding individuals Aware of their HIV status but not in care are to:

1) Increase the number of newly diagnosed individuals entering care within 3 months of initial diagnosis.

2) Provide consistent access to health care and support services throughout the state for newly diagnosed individuals to ensure continuous and timely care.

3) Improve and expand on collaborations between Early Intervention Specialists (EIS), Medical Case Managers (MCM), Minority AIDS Initiative (MAI) Specialists and Outreach, Testing and Linkage (OTL) to locate, re-engage and re-connect out-of-care individuals to medical care and support services.

4) Target individuals with undetectable viral load and ensure their connection and maintenance in care.

HIV Prevention Goals regarding re-engagement in care for out-of-care persons and connection to care for individuals aware of their HIV status are:

1) Coordinate efforts and interactions between Outreach, Testing and Linkage (OTL) and Comprehensive Risk Counseling Services (CRCS) staff with EIS, MAI and MCMs to ensure linkage, referral and engagement of individuals aware of their status into or re-connected to care

2) Increase collaborations between syringe exchange program staff, EIS, MAI, and Transitional Linkage into the Community (Project TLC) staff to identify and re-engage out-of care individuals into care and medical case management

3) Improve efforts to connect HIV positive individuals, co-infected with another STD who is interviewed by Partner Services, and indicates a never in care or out-of-care status to EIS, CRCS and MAI

4) Promote referral, reconnection and linkage to care for HIV positive individuals with high risk behaviors through CRCS staff

5) Coordinate efforts with Juvenile and Adult Correctional facilities to identify HIV-positive individuals and ensure their linkage and connection to care on release into the community

6) Promote efforts with the Department of Mental Health and Addiction Services Substance Abuse Treatment programs to identify HIV positive persons and connect them with medical case management and medical care.

D. Goals regarding EIIHA (unaware)

Connecticut's Part B EIIHA strategy to identify, inform, refer and link individuals with HIV who are unaware of their status to medical care and support services is multifaceted and involves numerous DPH programs (e.g. Prevention, STD and Surveillance), other state agencies (e.g. DMHAS, DOC), RW Parts A, C, D, and community collaborations. CT's FY 2012 EIIHA Matrix, a unique collaboration between care and prevention, will target the following Populations: a) Individuals tested confidentially, b) Persons who received preliminary HIV positive result only (no confirmatory test), c) Partners of HIV+ individuals, d) Older Adults (50+), e) White MSM (ages 18-40), f) MSM of Color (ages 18-40), g) African American IDU (ages 18-40) and h) Hispanic IDU (ages 18-40).

Connecticut's EIIHA goals are consistent with the three primary NHAS goals to: reduce the number of people who become infected; increase access to care and optimize health outcomes for people living with HIV; and reduce HIV-related health disparities. Further goals are to:

1) Improve DPH's ability to identify newly infected persons, ensure the provision of test results, provide and track referrals and linkages to medical care, core and support services for persons testing positive and to risk reduction services for persons testing negative (Goals 1, 2)

2) Expand HIV testing in non-health care settings (e.g. Outreach, Testing and Linkage), opt-out testing in health care facilities (e.g. Community Health Centers, outpatient clinics, hospital emergency departments and private urban medical practices) and implement routine testing in correctional facilities to increase the number of individuals aware of their HIV status (Goals 1-3)

3) Improve the percentage of clients with a preliminary HIV-positive test who receive their confirmatory test results and are linked to medical care, prevention, medical case management and support services (Goals 1-3)

4) Increase the use of Partner Services for newly diagnosed persons and their partner(s), (Goal 1,2)

5) Continue provision of HIV testing in STD clinics and improve referrals and linkages to medical care, MCM and prevention services (Goals 1-3)

6) Increase the proportion of HIV-infected persons in CT who know their status (Goal 1)

7) Increase collaborations between prevention, STD and care services (EIS, MAI, ERLI, OTL, Partner Services, Prevention for Positives,) as well as expand coordination, referrals and linkages with DMHAS, community health centers, emergency departments, social service agencies and private medical and infectious disease doctors (Goals 1-3)

8) Ensure access to care, reduce disparities to care, and improve health outcomes of individuals with HIV (Goals 2-3)

9) Educate the public regarding HIV, testing, and the importance of knowing one's HIV status (NHAS Goal 1)

HIV Prevention goals regarding individuals unaware of their HIV status are:

1) Expand HIV testing in non-healthcare settings including non-traditional venues to target hard to reach IDU's, MSM and heterosexual racial/ethnic minorities disproportionately impacted by HIV

2) Ensure provision of test results, particularly to clients testing HIV positive and assure a direct referral and linkage to medical care, EIS and /or MCM

3) Provide information and capacity building assistance for health care providers on implementing opt-out HIV testing for their patients

4) Promote implementation of routine or opt-out HIV testing of all patients 13-64 in health care settings

5) Support implementation of routine or opt-out HIV testing, through and MOA, in Connecticut correctional facilities

6) Facilitate voluntary testing for STDs HBV, HCV, and TB in conjunction with HIV testing and include referral and linkage to appropriate HIV care and prevention services

7) Collaborate with the STD Program and community based organizations to maximize the number of persons tested and identified as candidates for Partner Services

E. Proposed solutions to closing the gaps in care and prevention

As previously stated, the state's primary method for identifying gaps in care and prevention is a statewide needs assessment of PLWHA who are in-care. Other sources of qualitative information include client and provider surveys, focus groups and local and regional needs assessments. The CT 2010 Needs Assessment Survey did not indicate any significant gaps in either care or prevention, but specific areas of need were identified – dental care, health insurance premium/co-pays, mental health and substance

abuse treatment (outpatient and in-patient) housing, transportation, emergency financial assistance, food bank, information regarding location and availability of services, specific prevention programs targeting MSM, Latina and black heterosexual women, transgender and high-risk youth, and HIV support groups.

Proposed solutions to closing these gaps and addressing these needs in care and prevention include:

1) Ensuring that newly HIV diagnosed individuals and those persons living with HIV are familiar with care and prevention service availability, locations, accessibility, client eligibility and available benefits

2) Improving collaborations, information and sharing of resources (services and resources among non-funded Ryan White and Prevention providers (e.g. social service, housing, and faith-based organizations)

3) Enhancing collaborations between all prevention and care service providers to ensure that people can access the services they need and that actual linkages are made.

4) Incorporating prevention and broader risk reduction counseling in the Medical Case Management initial assessment and care plan

5) Collaborating more closely with Connecticut's Part A programs in allocating resources throughout the TGA and EMA areas to assure continuity of services

6) Updating and marketing of CT's 2-1-1 HIV Resource Guide

7) Developing a resource directory for Emergency Departments, Community Health Centers and private physicians regarding Ryan White and Prevention Services and providers.

F. Proposed solutions for addressing overlaps in care

Historically, Connecticut has presented with few to no overlaps in care because of its highly developed system of collaboration and cooperation with Ryan White Parts A – D. Ryan White Programs freely share information regarding which providers are funded for what services as well as the funding amounts so that effective funding decisions can be made to avoid duplication of efforts. Shared planning, the participation of Part A and B Program Managers on respective Planning Councils and the statewide HIV Planning Consortium, jointly funded programs, well established referral networks, and cross training of prevention and care providers assist in managing overlaps in care.

While there may have been some overlaps in HIV prevention services in the past, there is no longer room for it due to funding restrictions. Through the funding allocation process, DPH is ensuring that there are prevention services concentrated in each of the cities with the largest burden of HIV disease but also that there are services dispersed across the state so that people in need have access to them. Geographic location of proposed service is considered in order to ensure non-duplication of services in the future.

G. Proposed and On-going Coordinating Efforts: Care and Prevention

Through Connecticut's Cross Part Collaborative (CPC), an initiative of the National Quality Center and HRSA, cross collaboration occurs across all Ryan White Parts A-F on quality management, assessment of

HAB Performance Measures, quality improvement projects, data sharing, training, and state-wide planning regarding EIIHA.

DPH has increased efforts to identify newly infected persons by ensuring that HIV Testing services are offered in a variety of sites, both traditional and non-traditional, and by cross training providers (including EIS staff). Improved linkages throughout the HIV testing, Prevention and Care systems continue to provide clients with greater options to test and receive referrals and linkages to medical care, MCM, prevention and support services. DPH supports other testing and counseling services such as those through the EIS, by providing training on the Waived Rapid Testing and Counseling Services, with an emphasis on enhancing referral mechanisms to ensure linkage of HIV+ individuals into care. Part B MCMs and DMHAS substance abuse providers statewide have been cross trained in identifying, informing, referring and linking individuals to care and supportive services, including Partner Services.

Through CDC funding for Expanded and Integrated HIV Testing for Populations Disproportionately Affected by HIV (African Americans and Hispanics), DPH provides resources (e.g. rapid test kits, free lab services and TA) to clinical sites, including community health centers, college health services, a health care van, DMHAS treatment facilities, STD clinics and hospital emergency departments, to provide routine HIV screening. Through a FY 2010 Memorandum of Agreement (MOA) with the Department of Correction, DPH funded Counseling, Testing and Referral in twenty correctional facilities.

In 2012, DPH continues to fund twenty-one (21) statewide agencies to provide Ryan White core medical and support services and twenty-two (22) HIV Prevention contractors, including community based organizations, local health departments, community health centers and hospitals, to provide HIV Counseling, Testing and Referral services. These programs outreach into communities by conducting testing in non-traditional settings to reach individuals unaware of their HIV status with a focus on hard-to-reach IDUs and MSMs. Care and prevention services are co-located at many of these sites and staff is cross-trained. This one stop approach facilitates referrals between prevention and care. Contractors are encouraged to collaborate with other RW Parts, Prevention, DMHAS and other clinical and support-service agencies within their respective catchment areas to ensure identification of HIV unaware individuals, early referral to care and treatment, and coordination of HIV prevention interventions for PLWHA.

Proposed Care and Prevention Coordination Efforts

Part A Services

- Development of a Statewide Standard for Early Intervention Services
- Convene cross Part (A, B and C) quarterly EIS staff and provider meetings
- Improve eligible client referrals to the CT Insurance Premium Assistance (CIPA) Program
- Develop and coordinate standardized MCM trainings
- Standardize MCM, client and service delivery forms

Part C Services

- Improve collaborations between Part B and Part C EIS Staff regarding HIV-unaware individuals and referrals to care and MCM

- Increase placement of Part B MCMs at Community Health Centers to provide one-stop multi-care programs
- Develop working relationships between Part B EIS specialists and Community Health Centers not funded for EIS to ensure referrals and linkages to MCM for newly HIV diagnosed individuals
- Collaborate on HIV medication adherence counseling and medical nutrition therapy for clients in need

Part D Services

- Coordinate MCM trainings for Part D MCMs
- Develop collaborations between Part D MCMs and health centers/hospitals and EIS staff to coordinate referrals for newly HIV diagnosed women and youth to MCMs
- Partner with Part D funded programs in the area of Nutritional Counseling/Medical Nutrition Therapy with a focus on HIV – positive women and youth

Part F Services (CT AIDS Education and Training Center)

- Coordinate with CAETC to provide training regarding EIS and MCM services to private medical providers
- Collaborate with CAETC on educational opportunities and trainings for Medication Adherence Nurses, HIV Nurses and MCMs
- Collaborate on trainings for PLWHA regarding HIV disease, medication adherence, and HIV resources

Private Providers (non-Ryan White funded)

- Improve communications with private medical practitioners regarding EIS, MCM and Ryan White services
- Develop Ryan White information, training and resource sharing with non-Ryan White funded community and faith-based organizations
- Develop and Coordinate informational trainings with Parole and Probation Programs regarding Ryan White Programs and referrals of HIV –positive clients for MCM, CIPA and EIS
- Encourage networking among MCMs and local/regional non-Ryan White service providers to improve information sharing and referrals for Ryan White eligible clients

Prevention Programs including Partner Services and Prevention with Positive Initiatives

- Improve and increase MCM, EIS and MAI referrals of HIV-positive individuals to Partner Services
- Implement referral tracking system between Care and Prevention Units and providers
- Promote training of EIS and MAI Specialists in rapid testing to ensure linkage of HIV-positive persons into care and prevention/partner services (supplement not supplant)

- Improve MCM referrals of HIV-positive individuals into Prevention for Positives Initiatives including CRCS and EBI
- Develop resource list of funded Ryan White providers and Prevention Providers (e.g. CRCS, DEBIs, Syringe Exchange, Counseling and Testing) for use by prevention and Ryan White funded programs for client referrals and resources
- Maintain collaboration with the CT HIV/AIDS Identification and Referral (CHAIR) task force in promoting and implementing efforts and strategies regarding EIIHA, Partner Services and linkages to care and prevention

Substance Abuse Treatment Programs and Facilities

- Improve collaboration with DMHAS funded substance abuse treatment programs to ensure referrals of HIV-positive clients to EIS and MCM

STD Programs

- Implement referral mechanism between Care Providers and Disease Intervention Specialists (DIS) for linkage of STD /HIV diagnosed individuals to MCMs and EIS
- Coordinate training on STDs for MCMs, EIS and MAI Specialists for client referrals

Medicare/ Medicaid

- Improve referral of eligible Ryan White clients to Medicare and Medicaid for Low Income Adults (LIA)

Children's Health Insurance Program (HUSKY: Healthcare for Uninsured Kids and Youth)

- Coordinate informational sessions for MCMS, EIS and MAI Specialists to promote enrollment in HUSKY

Community Health Centers (CHC)

- Expand relationships with community health centers in regards to EIS, MAI, EIIHA and MCM

Section III: How Will We Get There?

Strategies, Plan, Activities, Timelines

Connecticut's strategies to close gaps in care and prevention, address the needs of individuals aware of their HIV status but not in care, as well as the needs of people unaware of their HIV status and special populations, and coordinate efforts to ensure optimal access to care and prevention are outlined in the 2012-2015 Action Plan (Section II) and are reinforced by the 2012 Proposed Care and Prevention Goals (Section II).

Key: Outreach, testing and Linkage (OTL), Medical Case Management (MCM), CT HIV Planning Consortium (CHPC), Department of Mental Health and Addiction Services (DMHAS), Department of Social Services (DSS), CT HIV/AIDS Information and Referral (CHAIR) Task Force, Early Intervention Services (EIS), Minority Aids Initiative (MAI), Comprehensive Risk Counseling Services (CRCS), CT AIDS Education and Training Center (CAETC)

A. Addressing closing gaps in care and prevention

The 2010 Needs Assessment Survey did not indicate any significant gaps in either care or prevention, but did identify certain specific needs.

Action Plan Goal 1: *Facilitate statewide collaboration to maximize resources, identify and document the needs of PLWHA and those most at risk and to develop and implement a responsive HIV Care and Prevention plan.*

CT Part B Goal 2: *Ensure that Core Medical and support services are easily accessible and readily available.*

HIV Prevention Goal: (Jurisdictional Plan Component): *Promote targeted changes in HIV/AIDS Care and Prevention service delivery to improve health outcomes and quality of life for PLWHA and those unaware of their status.*

Objective	Activities	Responsible Parties	Timeline
Close care and preventions gaps in the State	1. Compare statewide and local needs assessment survey findings along with the Service Matrix (Appendix) annually to identify service gaps	Part B Grantee and Prevention Unit, CHPC	2012-2015
	2. Improve collaborations, information and sharing of resources and funding across Ryan White Parts, Prevention, State agencies and other non-Ryan White and Prevention funded organizations to ensure gaps in care and prevention are addressed	Part B Grantee and Prevention Unit, CHPC, DMHAS, DSS, community and faith-based organizations, CHAIR, funded care and prevention providers (MCMs, EIS and MAI)	Annually and on-going 2012-2015
	3. Focus efforts on providing information on service availability, locations, accessibility, available benefits and client eligibility for newly diagnosed and PLWHA	Part B Grantee and Prevention Unit, funded care and prevention providers (MCMs, MAI and EIS), community and faith based organizations, CHPC, State Agencies	Annually and on-going 2012-2015

B. Addressing the needs of individuals aware of their HIV status but not in care

Part B's strategy to address the needs of individuals aware of their HIV status but not in care: falls under Goal 1 and supports Goal 2 of the 2012-2015 Action Plan.

Action Plan Goal 2: *Promote targeted changes in HIV/AIDS Prevention and Care service delivery systems to improve health outcomes and the quality of life for PLWHA and those unaware of their status.*

CT Part B Goal 1: *Ensure access, retention, reconnection and maintenance of PLWHA and out-of-care PLWHA in client-centered health care, support services and prevention to reduce morbidity and mortality and improve health outcomes.*

HIV Prevention Goal: (HIV Testing Component): *Increase the proportion of people living with HIV who are linked to care and prevention services.*

Objective	Activities	Responsible Parties	Timeline
Reduce unmet need in CT and connect/reconnect people aware of their HIV status to care and prevention	1. Utilize EIS Specialists to engage and re-engage individuals lost to care and connect those aware of their HIV status but not in care into care and prevention	Medical case Managers, EIS Specialists; Partner Services, Outreach, Testing and Linkage, CRCS	Current and ongoing 2012-2015
	2. Minority AIDS Intervention Specialists to identify and refer out-of-care minority individuals to MCM and CADAP	Medical Case Managers, MAI Specialists	Current and ongoing 2012-2015
	3. MCMs remain engaged with reconnected/connected clients to ensure continuity of care	Medical case managers, EIS Specialists, MAI Specialists	Current and ongoing 2012-2015
	4.Improve referral mechanisms between care and prevention providers. Document, track, trend, and report on HIV positive referrals made to medical care and other services.	Medical case Managers, EIS Specialists; Partner Services, Outreach, Testing and Linkage, CRCS, DPH	Current and ongoing 2012-2015

C. Addressing the needs of individuals unaware of their HIV status

Part B's strategy to address the needs of individuals unaware of their HIV status falls under Goal 4 and supports Goals 2 and 3 of the 2012-2015 Action Plan.

Action Plan Goal 2: *Promote targeted changes in HIV/AIDS Prevention and Care service delivery systems to improve health outcomes and the quality of life for PLWHA and those unaware of their status.* **Goal 3:** *Increase public awareness and education efforts that support prevention, early identification and access to information and resources by providers, PLWHA and those unaware of their HIV status*

CT Part B Goal 4: *Improve and increase identification, informing and referral of PLWHA who are unaware of their HIV-positive status to medical care, medical case management, and HIV prevention services*

Prevention Goal: ***Increase the proportion of HIV positive persons who know their HIV status.***

Objective	Activities	Responsible Parties	Timeline
Reduce the estimated unaware percentage (21%) of HIV-positive but unaware of status persons in CT and connect them to care and prevention	1. EIS Specialists collaborate with key points of entry, OTL, CRCS, Partner Services, Syringe Exchange Programs and MAI Specialists to identify HIV positive but unaware individuals and link to care and prevention.	EIS Specialists, Community partners (MOAs), MAI Specialists, Partner Services, OTL, Syringe Exchange, CRCS	Current and on-going 2012-2015
	2. EIS Specialists provide outreach and education to community groups and organizations, including faith-based and social service groups regarding HIV education, testing, resources and knowing one's HIV status.	EIS Specialists, Community Organizations and faith based and social service agencies	Annually and on-going 2012-2015
	3. EIS Specialists provide supplemental HIV testing in high drug traffic areas, shelters, non-traditional points of entry where CDC funded HIV testing not available.	EIS Specialists, HIV Counselors and Testers	Annually and on-going 2012-2015
	4. EIS Specialists refer and link newly aware HIV-positive individuals to medical case managers, CRCS, Partner Services.	EIS Specialists, CRCS, Partner services	Annually and on-going 2012-2015
	5. EIS Specialists refer newly aware HIV-negative individuals to CRCS and prevention partners.	EIS Specialists, CRCS, Prevention partners	Annually and on-going 2012-2015
	6. EIS Specialists follow-up with newly diagnosed individuals and accompany the person to Medical case management or medical care appointments.	EIS Specialists, Medical case managers, Medical Providers	Annually and on-going 2012-2015
	7. Develop and implement an ongoing marketing plan to increase visibility of HIV testing services.	DPH HIV Prevention Unit; Community Distribution Center	2012 and on-going
	8. Implement Outreach, Testing and Linkage services in high incidence areas.	DPH HIV Prevention Unit, HIV Prevention Contractors	2013 and ongoing
	9. Enhance testing mechanisms for persons who test for HIV to get their results and integrate databases to track and trend persons who receive confirmed HIV results.	DPH HIV Prevention and Care Units, Care and Prevention Providers, DIS	2012 and on-going

D. Addressing the needs of special populations

Part B's strategy to address the needs of special populations falls under Goals 1, 2, 4 and 7 and supports all three goals of the 2012-2015 Action Plan.

Action Plan Goals: Goal 1: *Facilitate statewide collaboration to maximize resources, identify and document the needs of PLWHA and those most at risk and to develop and implement a responsive HIV Care and Prevention plan;* **Goal 2:** *Promote targeted changes in HIV/AIDS Prevention and Care service delivery systems to improve health outcomes and the quality of life for PLWHA and those unaware of their status.* **Goal 3:** *Increase public awareness and education efforts that support prevention, early identification and access to information and resources by providers, PLWHA and those unaware of their HIV status*

CT Part B Goals: Goal 1: *Ensure access, retention, reconnection and maintenance of PLWHA and out-of-care PLWHA in client-centered health care, support services and prevention to reduce morbidity and mortality and improve health outcomes.* **Goal 2:** *Ensure that Core Medical and support services are easily accessible and readily available.* **Goal 4:** *Improve and increase identification, informing and referral of PLWHA who are unaware of their HIV-positive status to medical care, medical case management, and HIV prevention services.* **Goal 7:** *Reduce HIV-related health disparities and improve health literacy for PLWHA*

HIV Prevention Goal: *Support implementation of Effective Behavioral Interventions for PLWHA and High Risk Negatives (e.g. HIV+, MSM, IDU, African American and Latina Heterosexual Women)*

Objective	Activities	Responsible Parties	Timeline
Provide culturally and population specific client-centered HIV care and prevention services to identify and address the needs of special populations (e.g. adolescents, injection drug users, MSM, Transgender, homeless, HIV-positive, former inmates, ethnic and racial minorities disproportionately impacted)	1. Develop cultural and special population trainings, materials and resources for MCMs, EIS, MAI, Partner Services, HIV Counseling and Testing and OTL to address barriers to care and prevention and improve cultural sensitivity regarding indicated special populations	Ryan White Part B and Prevention, STD Unit, HCSS and Prevention Training Coordinators, RW Parts	Current and on-going 2012-2015
	2. Utilize EIS, MAI and OTL to connect with key points of entry/ gatekeepers into special populations and provide outreach, education, testing, referral and linkage to health care and prevention	EIS, MAI, OTL, RW Parts, MCMs	Current and expand beginning 2013-2015
	3. Promote the initiatives of the Health Interactive Project (HIP) regarding sexually transmitted infection/HIV presentations and screenings in high schools	Prevention, STD Unit, EIS, OTL, HIP, State Department of Education (SDE), local high schools	Current and ongoing Expand in 2013,
	4. Implement HIV testing and STD awareness at school based health centers	DPH, SDE, STD Unit, OTL, Prevention, EIS,	On-going and expand 2013
	5. Utilize HIV Youth Advisory Group to sponsor HIV prevention presentations in their schools and community-based youth organizations	Prevention, HIV Youth Advisory Group, local schools, community-based youth organizations, True Colors	On-going and expand beginning Winter 2013
	6. Collaborate with Syringe Exchange Van to provide counseling, testing, information and linkage to care and prevention for IDUs	Needle Exchange Van, EIS, MAI, OTL, MCMs	Winter 2013 and on-going
	7. Expand collaborations with DMHAS funded substance abuse treatment program	Part B providers, Prevention, EIS, MAI, OTL, MCMs	On going

(Continued) **Provide culturally and population specific client-centered HIV care and prevention services to identify and address the needs of special populations (e.g. adolescents, injection drug users, MSM, Transgender, homeless, HIV-positive, former inmates, ethnic and racial minorities disproportionately impacted)**	8. Utilize EIS, MAI, OTL to connect with housing support services, Coalition to End Homelessness, homeless shelters, food pantries and soup kitchens to reach homeless populations and refer to testing, care and prevention	EIS, MAI, OTL, Coalition to End Homelessness, housing support services, MCMs, Prevention	Winter 2013 and on-going
	9. Utilize EIS and OTL to provide outreach, testing, linkage and referral to MSM through connections at bars, adult bookstores, and house parties	EIS, OTL	On-going
	10. EIS, OTL to partner with STD and Disease Intervention Specialists (DIS) in linking to MSMs via internet websites and chatrooms/blogs	EIS, OTL, STD Unit, DIS	Winter 2013 and on-going
	11. Develop relationships with Connecticut TransAdvocacy Coalition, The TwentyClub and other gender identity organizations to facilitate education, information, outreach and connection to care and prevention	CHPC, Part B and Prevention, EIS, MAI, Ryan White Providers, OTL, MCMs, TransAdvocacy Coalition and The TwentyClub gatekeepers	Winter 2013 and on-going
	12. EIS, MAI, and OTL to coordinate with Part B funded Transitional Linkage to the Community (Project TLC) to connect with HIV-positive individuals being released from CT correctional facilities into communities to ensure continuity to care and prevention	EIS, MAI, OTL, Project TLC	Fall 2013 and on-going
	13. EIS, OTL and MAI to develop collaborations with probation, parole and bail bond to identify HIV-positive individuals and link to care and prevention	EIS, MAI, OTL, Judicial Department (probation), Department of Correction (parole), bail-bond programs	Winter 2013 and on-going
	14. Contract with community agencies to implement EBIs with targeted populations (MSM, IDU, HIV +, AA, and Latina women) in various community settings.	DPH Prevention Unit, Contract Managers, funded provider	2013 and on-going
	15. Provide or secure CBA and TA including training to contracted agencies implementing EBIs to ensure provider capacity.	DPH Prevention Unit; Contract Managers; Contracted providers	2013 and on-going
	16. Monitor and evaluate EBIs to ensure target #'s are met and interventions are implemented with fidelity to core elements	DPH Prevention Unit; Contract Managers	2012 and on-going

E. Activities to implement the proposed coordinating efforts

Strategies to address the proposed coordinating efforts among respective partners encompass the full range of goals that fall under the 2012-2015 action Plan as well as the CT Part B goals.

Action Plan Goals: Goal 1: *Facilitate statewide collaboration to maximize resources, identify and document the needs of PLWHA and those most at risk and to develop and implement a responsive HIV Care and Prevention plan;* **Goal 2:** *Promote targeted changes in HIV/AIDS Prevention and Care service delivery systems to improve health outcomes and the quality of life for PLWHA and those unaware of their status.* **Goal 3:** *Increase public awareness and education efforts that support prevention, early identification and access to information and resources by providers, PLWHA and those unaware of their HIV status*

CT Part B Goals: Goal 1: *Ensure access, retention, reconnection and maintenance of PLWHA and out-of-care PLWHA in client-centered health care, support services and prevention to reduce morbidity and mortality and improve health outcomes.* **Goal 2:** *Ensure that Core Medical and support services are easily accessible and readily available.* **Goal 4:** *Improve and increase identification, informing and referral of PLWHA who are unaware of their HIV-positive status to medical care, medical case management, and HIV prevention services.* **Goal 5:** *Promote regular and on-going collaborations with Ryan White Parts, Prevention and the STD Unit as well as other state agencies and community organizations in relation to data collection and the meaningful use of quality performance measures to inform planning and enhance service delivery.* **Goal 6:** *Increase collaborations across Prevention and Care to ensure that adequate training and educational opportunities exist and occur for providers, prevention and care staff, PLWHA and other relevant stakeholders,* **Goal 7:** *Reduce HIV-related health disparities and improve health literacy for PLWHA*

Prevention Goal: Support integrated hepatitis, TB and STD screening, and Partner services for HIV-infected persons, as recommended in the *Program Collaboration and Service integration (PCSI) white Paper (2009)* and the *White Paper Establishing a Holistic Framework to Reduce Inequities in HIV, Viral Hepatitis, STDs and Tuberculosis in United States (2010).*

Program	Proposed Coordination	Activities	Timeline and Responsible Parties
Part A	Development of a Statewide Standard for EIS	Coordinate a meeting between Parts A and B to develop statewide standards and tools for EIS	Fall –Winter 2012
	Convene cross Part Quarterly EIS staff and provider meetings	Coordinate with Part A New Haven to establish quarterly meeting of all EIS Specialists and providers(Parts A-C)	Winter 2013 and on-going Ryan White Part A –C EIS Staff and Providers
	Improve eligible client referrals to CIPA	Provide informational trainings regarding CIPA, client eligibility and disseminate applications to MCMs, EIS, MAI and RW funded providers	Expand Fall 2012 and ongoing Ryan White Providers, MCMs, MAI, EIS, CADAP
	Develop and coordinate standardized MCM trainings	Coordinate a meeting of Part and B Program Managers, Training Coordinators and standardize pre-requisite, basic, intermediate MCM trainings	Winter 2012 and ongoing Part A and B Program Managers and Training Coordinators
	Standardize MCM, client and service delivery forms	Coordinate a meeting with Part A and B program managers, QM staff and Data Managers to discuss and standardize MCM, client, and service delivery forms	Winter 2012 and on-going Part A and B Program Managers, QM staff and Data Managers

Program	Proposed Coordination	Activities	Timeline and Responsible Parties
Part C	Improve collaborations between Part B and C EIS regarding HIV-unaware and referrals to care and MCM	Organize a meeting between Part B and C EIS providers and staff	January 2013 and on-going Part B Grantee, Part B and C EIS Providers
	Increase siting of Part B MCMs at Community Health Centers to provide one-stop multi-care programs	Schedule a meeting with community health centers to discuss placement of Part B MCMs at sites	January 2013 Part B Grantee staff and Community Health Centers
		Include in RFP for 2014, contractors siting of MCMs at community health centers	Summer 2013- April 2014 Part B Grantee
	Develop working relationship between Part B EIS and Community Health Centers not funded for EIS to ensure referrals and linkages to MCMs for newly diagnosed individuals	Part B funded EIS providers to develop letters of agreement with Community Health Centers for EIS and MCM referrals	Fall-Winter 2012 and on-going Part B EIS funded providers and EIS staff
	Collaborate on HIV medication adherence counseling and medical nutrition therapy	Coordinate a meeting between Part B MAP and MNT programs and adherence and nutritional programs at Community Health Centers to discuss cross-referrals	Winter 2012 and on-going Part B Grantee, Part B MAP and MNT Programs and Staff, Community Health Center adherence and nutritional directors
Part D	Coordinate MCM trainings for Part D MCMs	Collaborate with Part D Program Manager to coordinate training of MCMs	Fall 2012 and on-going Part B Training Coordinator, Part D Program Manager, QM Manager
	Collaborate between Part D MCMs and health centers / hospitals and EIS staff to coordinate MCMs referrals of newly diagnosed women/youth	Work with Part D grantee and sub-grantees and Part B EIS to develop referral tools and tracking for client referrals	Winter 2013 and on-going Part B and D Grantees and providers, EIS Staff, QM Manager
	Partner with Part D funded programs in Nutritional Counseling/Medical Nutrition Therapy for HIV-positive women and youth	Coordinate a meeting between Part B MAP and MNT programs and adherence and nutritional programs at Part D sites	Winter 2013 and on-going Part B Grantee, Part B MAP and MNT Programs and Staff, Part D adherence and nutritional programs
Part F	Coordinate with CAETC on training regarding EIS and MCM services for private medical providers	Develop training materials in conjunction with CAETC concerning EIS and MCM services for medical providers and include in annual required MD HIV training	Winter 2013 and on-going CAETC, Part B Grantee and Training Coordinator, QM Manager
	Collaborate with CAETC on education and training for Medication adherence Nurses, HIV nurses and MCMs	Expand training opportunities for MAP and HIV Nurses and increase training opportunities for statewide MCM trainings in collaboration with CAETC	Spring 2013 and on-going CAETC, Part B Training Coordinator, QM Manager
	Collaborate with CAETC on trainings for PLWHA on HIV disease, medications, treatment and HIV resources	Develop in collaboration with CAETC statewide trainings for PLWHA and organize regional training sites in collaboration with regional funded providers	Spring 2013 and on-going CAETC, Part B Training Coordinator, QM Manager, funded statewide providers, Planning Councils, CHPC

Program	Proposed Coordination	Activities	Timeline and Responsible Parties
Private Providers (non-Ryan White)	Improve communications with private medical practitioners regarding EIS, MCM, and MCM services	Organize list of private medical providers and develop informational brochure for distribution via regular mail and email	Summer 2013 and on-going Part B Grantee, QM Manager, CADAP
	Coordinate Ryan White information, training and resource sharing with non-Ryan White funded providers and organizations	Organize list of non-Ryan White and prevention service providers (e.g. social services, faith-based, community-organizations) and develop information brochure regarding RW and HIV Prevention services and disseminate via email and regular mail	Spring 2013 and on-going Part B Grantee, Training Coordinator, 2-1-1 Info Line, DSS, DMHAS, DCF, Community Based Organizations
	Develop and implement informational trainings with probation and parole programs regarding Ryan White Programs and Services	Coordinate a meeting with regional probation and parole directors and Part B Training Coordinator, QM Manager and Program Manager	January 2013 and on-going Part B Program Manager, Training Coordinator, QM Manager, probation and parole directors
	Enhance networking among MCMs and local/regional non-Ryan White providers	Incorporate additional community-based, faith based and social service providers in trainings for MCMs	Winter 2013 and on-going Part B Training Coordinator, MCMs, non-funded providers
Prevention Programs (including Partner Services and Comprehensive Prevention with Positives)	Improve and increase MCM, EIS and MAI referrals of HIV-positive individuals to Partner services	Provide training to MCMs, EIS and MAI on referral process to Partner services	Fall 2012 and on-going Part B Training Coordinator, DIS staff, MCMs, EIS and MAI
	Implement referral tracking system between Care and Prevention Units and providers	Enhance CAREWare subset for tracking referrals and coordinate with Prevention data system	Fall 2012 and on-going Part B QM Manager and Data Manager; Prevention QM and Data Managers
		Provide training to Prevention providers and staff and Part B MCMs regarding referral tracking	January 2013 Part B and Prevention Data Managers, Training Coordinators, MCMs, Prevention providers
	Train EIS and MAI in rapid testing to ensure linkage of newly diagnosed persons into care and prevention (supplement)	Organize rapid-test training and tracking for EIS and MAI through Prevention counseling and Testing staff and providers	Fall/Winter 201 2 and ongoing EIS and MAI Staff, HIV Prevention Counseling and Testing
	Improve MCM referrals to Prevention for Positives (CRCS and EBIs)	Provide training and information to MCMs regarding CRCS and Prevention for Positive and referral resources	Fall 2012 and on-going Part B and Prevention Training Coordinators, MCMs
	Develop resource list of funded Care and Prevention Providers and disseminate to care and prevention funded providers	Develop and update Service Matrix of Care and Prevention Providers and distribute to funded providers via email and website posting	Summer 2012 and on-going (annually) Part B, CHPC and Prevention, DPH web-master
	Collaborate with CHAIR in promoting and implementing strategies regarding EIIIHA, Partner Services and linkages to care and prevention	Assign Part B staff to participate in monthly CHAIR meetings	June 2012 Part B Grantee, Part B staff
		CHAIR to present monthly report at statewide planning meetings and planning councils	August 2012 and on-going CHAIR co-chairs, CHPC, Part A Planning Councils

Program	Proposed Coordination	Activities	Timeline and Responsible Parties
Substance Abuse Treatment Programs	Improve collaboration with DMHAS funded substance abuse treatment programs to ensure referrals to EIS and MCM	Organize training between DMHAS funded substance abuse treatment programs and EIS and MAI staff	January 2o13 and on-going DMHAS Program Manager, Part B Training Coordinator, EIS and MAI; DMHAS treatment programs
STD Program	Implement referral mechanism between Care providers and DIS for referral of STD/HIV diagnosed persons to MCM and EIS	Develop referral tool to coordinate linkage of STD/HIV diagnosed persons to EIS and MCM	June 2012 and on-going STD Program Director, Part B, QM Manager, Prevention and Care Training Coordinators, DIS, EIS and MCM
	Coordinate training on STDs and Partner services for MCMs, EIS and MAI	Incorporate STD training and information into combined MCM, EIS and MAI annual meetings	Fall 2012 and on-going Part B Training Coordinator, STD Program Director, DIS, EIS, MCM and MAI
Medicare/Medicaid	Improve referral of eligible Ryan White clients to Medicaid and Medicaid for Low Income Adults (LIA)	Incorporate training on Medicaid LIA and Medicaid/Medicare updates into MCM pre-requisite and basic trainings	Fall 2012 and on-going Part B Training Coordinator, QM Manager, DSS Staff, MCMs
Children's Health Insurance Program (HUSKY)	Coordinate information sessions for MCMs, EIS and MAI to promote HUSKY enrollment	Incorporate training and information on HUSKY into annual MCM pre-requisite and basic training	Fall 2012 and on-going Part B Training Coordinator, DSS staff, MCMs
Community Health Centers	Expand relationships with community health centers	See Part C Activities	See Part C timeline and Responsible Parties
HIV, hepatitis, TB and STD Programs	Assure that all newly diagnosed HIV positive clients (including those co-infected with another STD) who are interviewed for partners will be offered testing for other STDs, HBV, HCV, and TB Ensure that all providers are aware of the need to support, coordinate or provide integrated testing and assure access to HIV medical care for clients. Collaborate with MCMs, Ryan White medical providers, OTL staff and prevention counselors to assure linkages to services and that clients attend first medical visits.	DIS DIS; contracted providers DIS; Ryan White providers, OTL and prevention counselors, MCMs	2012 and on-going 2013 and on-going 2012 and on-going

F. How the Plan addresses Healthy People 2020

Connecticut's Comprehensive Plan for HIV Care and Prevention, in conjunction with the integration of prevention and care services, objectives and goals, is aligned with the Healthy People 2020 initiatives, in particular objectives HIV-1 –HIV 7 (reducing the number of new HIV diagnoses, HIV infections, HIV transmission, and AIDS cases among adolescents, adult heterosexuals, MSM and IDUs), HIV 9-12 (increasing diagnoses before progression to AIDS, increasing proportion of individuals who receive HIV care and treatment, increasing survival rates following an AIDS diagnosis and reducing deaths from HIV infection), and, HIV 13, 14 and 17 (increasing proportion of unaware individuals who know their status; increase testing and increase condom use in sexually active persons).

The Connecticut Department of Public Health's Health Care & Support Services' Quality Management program's mission is to assure access to and retention in quality health care and related services for all persons living with HIV/AIDS, and, to ensure that Connecticut's PLWHA maintain and improve linkages to an array of comprehensive health care services that foster self-efficacy and promote optimal health outcomes (e.g. alignment with NHAS primary goals). Through Connecticut's Medication Adherence and Medical Nutrition Therapy Programs, PLWHA are assisted in staying adherent to medication regimens and also improving their nutritional status, which can greatly impact disease progression, HIV transmission, the development of opportunistic infections, the increase in CD4 counts and decrease in VL. Through these programs and services, ARV therapies and other medications provided through CADAP, PLWHA are not only assisted in delaying the progression from HIV to AIDS and staying in-care, but also living healthier lives (HIV- 3, 9-12).

HIV prevention initiatives, such as the rapid and routine HIV testing of individuals in primary medical and non-clinical settings, condom distribution, and EIS initiatives and strategies has resulted in the referral of individuals who test HIV+ into the care system through the early referral and linkage initiative (ERLI), the identification, notification and referral of HIV unaware individuals into care and prevention services, and the referral of OOC individuals back into the care continuum, MCM, and CADAP (HIV 1-7, 13,14 and 17). DPH-funded HIV prevention programs for positives focus on reducing the number of new HIV cases as well as encouraging condom use, and avoidance of high risk behaviors (HIV 1-3 and HIV 17). CT's Project TLC provides transitional case management, HIV education, outreach and referral for HIV-positive inmates pre-and post-release into communities, and connects individuals to medical care, community-based services and CADAP, thus aligning with HIV 1-7, 10 and 17.

Connecticut also continues to work toward reducing the burden of HIV, TB and STDs throughout the state. Part B and CDC-funded prevention programs have made an impact in containing the spread of gonorrhea, syphilis, and congenital syphilis. Prevention efforts are in place and outreach initiatives are being implemented to reduce the burden of syphilis, particularly in MSM. (STD 1-10) Connecticut's tuberculosis testing initiatives have further helped to reduce the number of TB cases in '09 by 3.1% from 2008 (95 cases vs. 98). In relation to the Objective HIV 8 (to reduce new cases of perinatally acquired HIV infection), Connecticut has made remarkable progress. HIV infection via mother-to-child has been reduced from 55 cases in 1993 to zero in 2010. Part B programs and services also address access to health services (AHS-1: Increasing the proportion of persons with health insurance) through its Connecticut Insurance Premium Assistance (CIPA) program which helps PLWHA continue health insurance as well as purchase CIPA approved health insurance, and Oral Health Access to Preventive Services (OH-7-8) through its Part B funded Oral Health Care program targeting PLWHA.

G. How the Plan Reflects the Statewide Coordinated Statement of Need (SCSN)

Connecticut's 2012 Statewide Coordinated Statement of Need (SCSN) was developed through the Data and Assessment Committee (DAC) of the CT HIV Planning Consortium (CHPC). This was a fully collaborative process both in the development and implementation of the statewide needs assessment survey and in the analysis and review of resulting data. Partners involved in all phases of the process included Ryan White Parts A,B,C, D and F, PLWHA, providers of HIV prevention and care services, community-based organizations and other state agencies (DOC and DMHAS) with a focus on the HIV in-care positive population.

PLWHA played a key role in the development of survey questions, as well as in the implementation of the survey at various funded statewide agencies and as respondents to the survey. The survey was also mailed directly to CADAP clients in a confidential package and response document. The SCSN was presented and shared at a public meeting on January 19, 2011, approved unanimously by CHPC members, and disseminated to members of the CHPC, participants at CHPC meetings and to individuals who provided the data and/or completed the needs assessment surveys.

The SCSN informs the CHPC in the development of key recommendations for its Comprehensive Plan, and serves as a reference point for DPH as it develops Requests for Proposals (RFP) for HIV prevention and care services to ensure alignment of efforts with the National HIV/AIDS Strategy and ensure that prevention and care resources are more strategically concentrated in communities at highest risk for HIV infection and prevalence. A new statewide needs assessment process will be implemented beginning in September 2012 with roll-out of the survey to care and prevention providers and CADAP clients in March 2013. Data analysis will begin in May 2013 with the production of a 2013 Statewide Coordinated Statement of Need by fall 2013.

The 2012-2015 Comprehensive Plan further reflects the SCSN in the recommendations put forth in the SCSN to inform the allocation and use of resources for care and prevention service delivery in the State of Connecticut for PLWHA. Data reviewed to develop these SCSN recommendations as well as the Comprehensive Plan were based on the 2010 Statewide Needs Assessment Survey and the Connecticut Epidemiological Profile of HIV/AIDS in Connecticut 2010, as well as recent data from the HIV Surveillance Unit, the Cross Part Collaborative and CHAIR.

In developing the following recommendations, Connecticut considered the National HIV/AIDS Strategy and its three primary goals:

<u>Process Recommendations</u>

1. Promote innovative strategies, intervention, social marketing and the use of technology to affect behavior change and address barriers to care and prevention.
2. Enhance and expand collaborations across and within State Agencies and service organizations to ensure PLWHA get the services they need.

<u>Service Improvement Recommendations</u>

3. Ensure state funds are directed toward effective behavioral interventions targeting priority populations.
4. Develop strategies to ensure data collection measures are achieved and used for quality improvement.

5. Ensure compliance with protocols and standards for care and prevention services funded by the Department of Public Health.

6. Maximize training resources for service providers by collaborating with multiple partners.

Emerging Issues Recommendation

7. Implement the strategies of the Connecticut HIV/AIDS Identification and Referral Task Force (CHAIR), to identify, and refer the unaware population to HIV testing, education, care and prevention programs.

Current Efforts to Address the SCSN Recommendations

Connecticut DPH's Health Care and Support Services and Prevention Units are working in collaboration with Ryan White Parts and community-based organizations to link individuals to care and prevention who are unaware of their status. DPH remains committed to providing services that are culturally sensitive, geographically accessible and offer one-stop shopping and flexible hours. The Department works diligently to strengthen the system of care linkages through co-location of services, cross training of care and prevention staff, referral strategies among substance abuse treatment, mental health treatment, outreach, testing and linkage (OTL), Comprehensive Risk Counseling Services (CRCS), Partner Services, MCMs, EIS Specialists and medical providers. CT DPH will continue to increase and expand efforts, resources and strategies to engage and bring into care and prevention minority populations, MSM, undocumented individuals, unaware populations, immigrants, transgender, and at risk youth.

H. How the Plan is coordinated with and adapts to changes that will occur with the implementation of the Affordable Care Act (ACA)

Connecticut is well positioned to address the future challenges and opportunities will occur with roll-out of the ACA in 2014. ACA is slated to be the most comprehensive reform to the United States' health care system since the passage of Medicare and Medicaid in 1965. It will reform the health care delivery system to ensure that everyone has health care as well as improve its quality and value. The Act includes provisions to eliminate disparities in health care, strengthen public health and health care access, invest in the expansion and improvement of the health care workforce and encourage prevention and patient wellness. Two ACA provisions that went into effect in 2010 already are having an impact in CT: 1) more individuals have been covered through Medicaid, and 2) CT's Community Health Centers have received millions of dollars to expand resources, capacity and services to address the health care needs of state residents.

The state has also made major strides in addressing health care reform:

- Connecticut was the first state to receive federal approval to expand Medicaid under the ACA. Known as Medicaid for Low-Income Adults (LIA) the program is open to residents aged 19 to 64 whose income is below 56% FPL, and it provides full Medicaid health coverage including long-term care, home health care, and non-emergency transportation. Persons whose incomes exceed the 56% FPL may qualify for Medicaid for Low-Income adults through the Medicaid "spend-down" process.

- Connecticut's Ryan White Part B, through a unique collaboration with the Department of Social services, that administers the CADAP, implemented the CT Insurance Premium Assistance (CIPA)

Program to assist CADAP eligible clients (400% FPL) with health insurance premium payments. Through CIPA, an approved CADAP client can receive assistance in paying for and maintaining health insurance premiums, as well as in purchasing a CIPA approvable health insurance plan. More than 150 PLWHA have already benefitted from the opportunities available through CIPA.

- Connecticut's Pre-Existing Condition Insurance Plan (CT PCIP), which rolled out in 2011, also provides insurance coverage, available at an affordable rate, to individuals with a pre-existing conditions including HIV. CIPA works closely with CT PCIP to ensure that PLWHA who cannot afford the monthly premium costs can have their premiums paid through CIPA.
- In 2010, Connecticut residents who hit the Medicare prescription drug coverage gap, referred to as the "donut hole" received $250 tax-free rebates.
- In 2011, seniors received a 50% discount on covered name brand prescription drugs in the "donut hole."
- Lifetime limits on coverage have been removed from private insurance policies.
- Young adults can now stay on their parents' plan until their 26th birthday.
- Nearly all of the Medicare beneficiaries in the state can receive certain preventive services like mammograms and colonoscopies, as well as an annual wellness visit with their doctor without paying coinsurance and deductibles.
- Connecticut's Medication Adherence and Medical Nutrition Therapy programs address and emphasize prevention and wellness for PLWHA, one of the components of the ACA.

In 2014, ACA will eliminate the Medicaid disability requirement and will provide access to Medicaid for individuals and families below 133% FPL. This will open up health insurance and health care access to many Connecticut PLWHA waiting for an AIDS diagnosis to become Medicaid eligible. According to the spring 2011 edition of *achieve,* nearly 30% of people with HIV are uninsured and up to 59% are not in regular care. The elimination of this Medicaid eligibility restriction will open the doors to many low-income people with HIV who either have no insurance or inadequate coverage. This will greatly change the role of Ryan White programs, which have been the primary providers of HIV care, treatment and services for more than twenty years.

The future of HIV care in Connecticut must include integration of Ryan White services into newly created health care systems. Fortunately, in CT, Ryan White Parts and HIV care delivery systems already have close linkages and collaborations with Federally Qualified Health Centers as HIV Medical providers in addition to other clinical services (e.g. mental health and substance abuse treatment facilities). Although the ACA will have an impact on Ryan White programs nationally, CT has positioned itself to address these challenges through ongoing and expanded collaborations and shared resources with other non-Ryan White funded programs, community-based organizations and state agencies.

I. How the Plan addresses the goals of NHAS

Connecticut's Comprehensive Plan is consistent and compliant with the three primary NHAS goals: 1) to reduce the number of people who become infected, 2) to increase access to care and optimize health outcomes for people living with HIV, and 3) to reduce HIV-related health disparities. The 2012-2015 Action Plan, which forms the foundation for the 2012-2015 Comprehensive Plan, aligns with the National HIV/AIDS Strategies (NHAS) as well as with accompanying Federal Implementation Plan action steps:

- NHAS Goal 1 of "reducing new HIV infections" aligns with the Action Plan Goals 1 and 3
- NHAS Goal 2 of "increasing access to care and prevention and improving outcomes for people living with HIV" aligns with Action Plan Goals 1 and 2
- NHSA Goal 3 of "reducing HIV-related health disparities" aligns with Action Plan Goals 1 and 2.

The goals of Connecticut's EIIHA and prevention strategies are to: (a) improve DPH's ability to identify newly infected persons, ensure the provision of test results, provide and track referrals and linkages to medical care, core and support services for persons testing positive and to risk reduction services for persons testing negative (NHAS Goals 1, 2), (b) expand HIV testing in non-health care settings (e.g. Outreach, Testing and Linkage), opt-out testing in health care facilities (e.g. Community Health Centers, outpatient clinics, hospital emergency departments and private urban medical practices) and implement routine testing in correctional facilities to increase the number of individuals aware of their HIV status (NHAS Goals 1-3), (c) improve the percentage of clients with a preliminary HIV-positive test who receive their confirmatory test results and are linked to medical care, prevention, medical case management and support services (NHAS Goals 1-3), (d) increase the use of Partner Services for newly diagnosed persons and their partner(s), (NHAS Goal 1,2), (e) continue provision of HIV testing in STD clinics and improve referrals and linkages to medical care, MCM and prevention services (NHAS Goals 1-3), (f) increase the proportion of HIV-infected persons in CT who know their status (NHAS Goal 1), (g) increase collaborations between prevention, STD and care services (EIS, MAI, ERLI, OTL, Partner Services, Prevention for Positives,) as well as expand coordination, referrals and linkages with DMHAS, community health centers, emergency departments, social service agencies and private medical and infectious disease doctors (NHAS Goals 1-3), (h) ensure access to care, reduce disparities to care, and improve health outcomes of individuals with HIV (NHAS Goals 2-3), and (i) educate the public regarding HIV, testing, and the importance of knowing one's HIV status (NHAS Goal 1).

Through Connecticut's strong collaborations between prevention and care units, linkages have been created to increase access to medical care through referrals and linkages via Outreach, Testing and Linkage (OTL), Comprehensive Risk Counseling Services, ERLI, and Partner Services. As a result of these linkages, individuals identified as HIV+ have received and will continue to receive earlier access to medical care and treatment, which will optimize health outcomes and serve to reduce health care disparities.

J. Response to unanticipated changes and budget cuts

Connecticut DPH and Part B have endured numerous state rescissions and always been able to maintain programs and service delivery without a major impact to contractors and programs. Because Connecticut supplements, but not supplants, its Ryan White Part B funded contracts with State AIDS service funds, budget cuts are absorbed through state dollars, which do not affect the federally funded core medical services. Part B also coordinates with its Part A partners in targeting resources and funding to avoid duplication of effort. While Part B prioritizes its funding allocations to non- EMA/TGA areas, it also supports other Part A funded programs throughout the State. Part B funding, however, is allocated to service categories generally not funded through Part A or in support of Part A programs to address specific service needs and gaps (e.g. Medical Case Management, Oral Health, Emergency Financial Assistance).

Dependent on the future of HIV Prevention funding to Connecticut, Parts A and B will need to collaborate even more closely in resource allocation to ensure that the needs of PLWHA are met. In January 2013, new Connecticut HIV Prevention contracts will be implemented. The number of those contracts has been substantially reduced from prior years. Part B has been assured that it will receive notification of its contractors who may be recipients of reduced or no Prevention funding in June 2012, so that it can work with these providers to assess agency viability and fiscal sustainability. Should an agency be forced to close, Part B will work closely with other Part A and B providers in the geographic catchment area to address the gaps and reallocate Part B funds accordingly.

Section IV: Monitoring and Evaluation

A. Plan to monitor and evaluate progress in achieving proposed goals and identified challenges

Connecticut's plan to monitor and evaluate progress in achieving proposed goals (see Section II B 2012 Proposed Care and Prevention Goals) and identified challenges (Section II A: Challenges) involves a coordinated effort on the part of Part B and Prevention Data collection, Management and Monitoring Systems, Care and Prevention Contract Managers, funded care and prevention providers, HIV Surveillance, and the statewide planning consortium. HCSS conducts rigorous budget and programmatic monitoring and site visits with its contractors three times a year. These site visits include administrative, fiscal/programmatic and comprehensive client chart audits. If a contractor is found to be out of compliance with programmatic or fiscal requirements, a corrective action plan to address the issues and concerns is developed with a defined deadline for correction of deficiencies. HCSS staff also conducts random audits of client files to review for fiscal compliance (e.g. payer of last resort, appropriate use of funds, eligibility, adherence to standards of care and documentation of HRSA HIV/AIDS Bureau (HAB) Performance Measures).

DPH requires its Part B funded contractors to adhere to a minimum set of administrative policies, procedures and Medical Case Management (MCM) standards of practice and care to assure that PLWH/A receive appropriate, accessible and timely core medical and support services. Funded agencies are required to collect client level data (CLD), enter it into the CAREWare data system and submit quarterly reports that include a program narrative, aggregate CLD and aggregate Performance Measures. These Performance Measures are issued by HRSA to monitor the care provided to clients and data entry processes. Currently Part B documents the following HAB HIV Clinical Performance Measures: 1) Two or more medical visits per year, 2) CD4 count in the last six months, 3) PCP Prophylaxis, 4) Prescription of HAART, 5) ARV for pregnant women, 6) Hepatitis B Vaccination, 7) Hepatitis C Screening, 8) Syphilis Screening, 10) TB Screening, 11) HIV Risk Counseling, 12) Hepatitis B Screening, 13) Mental health screening, and 14) Substance Abuse Screening. A Quality Improvement Audit Tool, used by HCSS Contract Managers during site visits, measures the contractor's overall performance in collecting and recording performance measures, client assessment forms, eligibility documents, CD4 and Viral Load (every six months), screenings, referrals, case conferencing, and care plans.

The DPH Prevention Quality Management measures that are currently in place provide guidance for HIV Prevention staff and contracted prevention providers to systematically monitor the quality of services offered to clients in communities. To ensure the quality of HIV prevention programs, a staff member from the HIV Prevention Unit is assigned to each contractor to provide administrative oversight of their contract, which includes addressing budgetary concerns. In addition, a staff member is designated to serve as an Intervention Specialist for each funded Effective Behavioral Intervention. The Intervention Specialist is responsible for observing interventions and conducting process monitoring to ensure that they are being implemented with fidelity. Reports are written based on monitoring that includes observations and recommendations that are shared with program coordinators. Prevention Unit staff conduct quarterly site visits in order to monitor the progress of funded programs. Site visit tools will be streamlined to be more performance based. HIV Prevention staff will continue provide technical assistance to all contractors on the interventions they are conducting and requests capacity building assistance through CDC's Capacity Request Information System (CRIS) as appropriate.

DPH is in alignment with the National-level Objectives and Performance Standards for HIV testing, and uses them to measure HIV testing and linkage activities. All contractors conducting HIV testing are required to be trained as necessary (e.g., Rapid test training using Oraquick or Clearview). Random chart reviews are required on a quarterly basis by program coordinators/managers and conducted annually by DPH HIV Prevention QM staff. Continuous Quality Improvement (CQI) includes systematic activities designed to ensure services are delivered effectively and that any errors are detected and corrected to avoid adverse outcomes. New standards will be developed for the implementation of Outreach, Testing and Linkage (OTL) as well as the new model for screening people for CRCS and Prevention Counseling to ensure contractors are implementing services according to the OTL flow chart in Section II.

The HIV Prevention unit is currently writing new contract language for future prevention services and developing prevention performance measure standards to align with the requirements of the most recently released RFPs and CDC Reporting, Monitoring and Evaluation Guidelines. Monitoring tools will be developed and implemented to hold prevention contractors accountable. Technical assistance and training will be provided to ensure provider capacity to deliver services and to ensure an understanding of the standards to which they will be held.

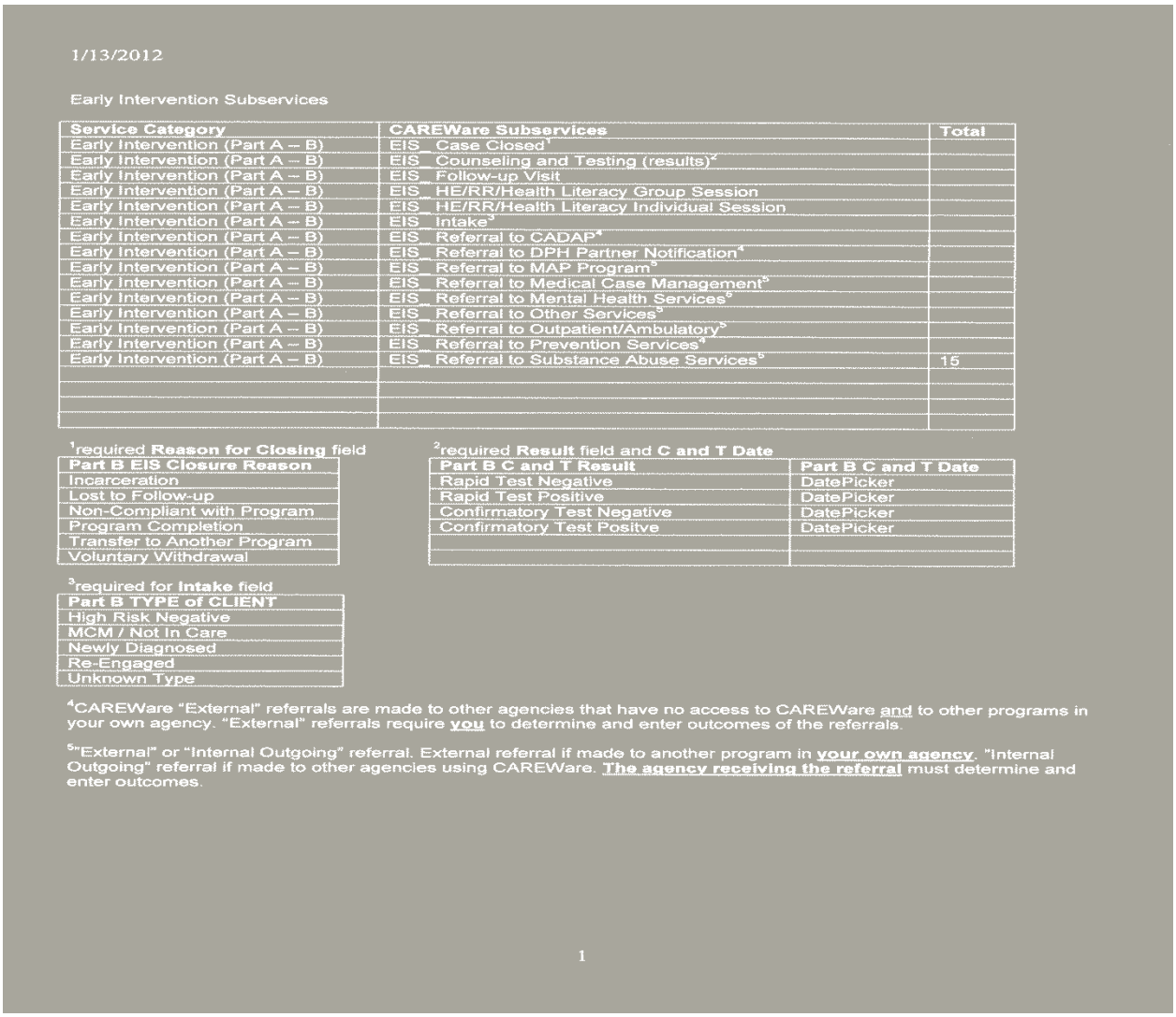
Progress in achieving goals will be monitored through collaborations and cooperation between Care and Prevention and will be reported on a quarterly basis during statewide CT HIV Planning Consortium (CHPC) meetings. Challenges identified from the 2009-2012 have been addressed with coordinating activities, timelines and outcomes in the 2012-2015 Action Plan.

B. Assessing the impact of the EIIHA initiative (EIS)

CT's EIIHA strategy to identify, inform, refer and link individuals with HIV who do not know their status to medical care and support services is multifaceted and involves DPH programs (e.g. Prevention and STD programs), other state agencies (e.g. DMHAS), Ryan White Parts A and C and community collaborations. The goals of CT's EIIHA's strategy include: (a) improving DPH's ability to identify newly infected persons, ensuring the provision of test results, providing and tracking referrals and linkages to care/prevention services for persons testing positive and to risk reduction services for persons testing negative, (b) expanding HIV testing in non-traditional settings and correctional facilities to increase the number of individuals aware of their HIV status, (c) improving the percentage of clients with a preliminary HIV-positive test who receive their confirmatory test results and are linked to medical care, prevention, medical case management and support services, (d) increasing the use of partner notification services to newly diagnosed persons and their partner(s), (e) continuing provision of HIV testing in STD clinics and improving referral and linkage to care and prevention services, (f) increasing the proportion of HIV-infected persons in CT who know their status, (g) increasing collaborations between prevention and care services (EIS, MAI, Outreach, Testing and Linkage, Partner Services, CRCS) as well as expanding coordination, referrals and linkages with DMHAS, the STD Unit, community health centers, emergency departments, social service agencies and private medical and infectious disease doctors, (h) ensuring access to care, reducing disparities to care, and improving health outcomes of individuals with HIV, and (i) educating the public regarding HIV and testing and the importance of knowing HIV status.

EIS is a newly prioritized and funded service for CT's Ryan White Part B program. Beginning 04/1/2011 DPH funded two contractors for EIS that are required to provide all four components of EIS: (a) universal testing and counseling in diverse locations (not necessarily funded through Part B), (b) referral for services whether the individual tests negative or positive, (c) health literacy and health education regarding risk behaviors, and (d) access and linkage to medical care. In addition DPH requires EIS

Specialists to collaborate with Partner Notification, CRCS, ERLI, Part A, prevention services and medical case managers. EIS Specialists are required to collect and report the following data in CAREWare:



1/13/2012

Early Intervention Subservices

Service Category	CAREWare Subservices	Total
Early Intervention (Part A – B)	EIS_Case Closed[1]	
Early Intervention (Part A – B)	EIS_Counseling and Testing (results)[2]	
Early Intervention (Part A – B)	EIS_Follow-up Visit	
Early Intervention (Part A – B)	EIS_HE/RR/Health Literacy Group Session	
Early Intervention (Part A – B)	EIS_HE/RR/Health Literacy Individual Session	
Early Intervention (Part A – B)	EIS_Intake[3]	
Early Intervention (Part A – B)	EIS_Referral to CADAP[4]	
Early Intervention (Part A – B)	EIS_Referral to DPH Partner Notification[4]	
Early Intervention (Part A – B)	EIS_Referral to MAP Program[5]	
Early Intervention (Part A – B)	EIS_Referral to Medical Case Management[5]	
Early Intervention (Part A – B)	EIS_Referral to Mental Health Services[5]	
Early Intervention (Part A – B)	EIS_Referral to Other Services[5]	
Early Intervention (Part A – B)	EIS_Referral to Outpatient/Ambulatory[5]	
Early Intervention (Part A – B)	EIS_Referral to Prevention Services[4]	
Early Intervention (Part A – B)	EIS_Referral to Substance Abuse Services[5]	15

[1]required **Reason for Closing** field

Part B EIS Closure Reason
Incarceration
Lost to Follow-up
Non-Compliant with Program
Program Completion
Transfer to Another Program
Voluntary Withdrawal

[2]required **Result** field and **C and T Date**

Part B C and T Result	Part B C and T Date
Rapid Test Negative	DatePicker
Rapid Test Positive	DatePicker
Confirmatory Test Negative	DatePicker
Confirmatory Test Positve	DatePicker

[3]required for **Intake** field

Part B TYPE of CLIENT
High Risk Negative
MCM / Not In Care
Newly Diagnosed
Re-Engaged
Unknown Type

[4]CAREWare "External" referrals are made to other agencies that have no access to CAREWare and to other programs in your own agency. "External" referrals require **you** to determine and enter outcomes of the referrals.

[5]"External" or "Internal Outgoing" referral. External referral if made to another program in **your own agency**. "Internal Outgoing" referral if made to other agencies using CAREWare. **The agency receiving the referral** must determine and enter outcomes.

1

EIS staff is also required to establish Memoranda of Understanding (MOU) with key points of entry to facilitate access to care for those who test positive or are reconnected to care. Funded providers must maintain a client record system that collects and maintains information about EIS client demographics, assessments, referrals, linkages, testing, and health education/literacy activities. Through a collaboration with the Prevention Unit, EIS Specialists will be able to document and report on numbers of HIV tests and positives, as well as where and when EIS testing occurs. Each contractor must monitor and evaluate program activities and outcomes, perform Quality Assurance audits on client files to assure compliance with data collection, and report on client data and outcome indicators on a quarterly basis to the State. The narrative program to accompany the data report must include the following information: 1) A sum of client data, 2) Outreach Activities, and 3) Strengths and barriers of program to date. Progress notes in the client record will be completed by EIS Staff at least monthly and will include information regarding referrals (internal and external), linkages, client progress and transition to another program or service (e.g. MCM, CRCS, Partner services). Contract Managers will conduct three annual site visits to monitor compliance, outcomes, and data collection.

In addition, Part B EIS collaborates with Part A New Haven/Fairfield EMA through participation in triennial EIS summits. During these summits EIS Specialists discuss plans, baselines developed through chart audits, and showcase initial results of program activities as well as results. Grantee and Contract Managers also review CAREWare and compare Client Charts to document compliance and assess impact of the program on identification of unaware individuals, referral to care and prevention and reconnection of out-of-care HIV positive persons into medical care. EIS Strategies and Standards of Care will also be reviewed on an annual basis to ensure program integrity and coordination of effort.

Timeline for implementing the monitoring and evaluation process

Review of the goals and activities will be assessed and monitored by the Data Manager, Quality Improvement Team, Contract Managers, EIS and the CHPC.

CARE GOALS/ACTIVITIES				
1. Ensure access, retention, reconnection and maintenance of PLWA and out of care PLWHA in client centered health care, support services and prevention to reduce morbidity and mortality and improve health outcomes				
Activities	**Timeline**			**Responsible Party**
	2012/2013	**2014**	**2015**	
a. Increase number of unaware persons who learn of their HIV status	●	●	●	Early Intervention Services (EIS), Outreach, Testing, and Linkage (OTL) staff, MAI, Partner Services
b. Increase number of newly diagnosed PLWHA who are linked to care and support services	●	●	●	EIS, MAI, MCM, MAP, OTL, Partner Services
c. Increase number of newly diagnosed PLWHA who are linked to prevention for positives services	●	●	●	EIS, MAI, MCM, MAP, OTL, Partner services
d. Monitor CD4 and VL tests to identify out-of care or non-adherence status	●	●	●	Part B Quality Management Team, MCMs, and MAP
e. Utilize EIS Specialists to locate and reconnect out-of-care individuals to care	●	●	●	EIS, MCMs,
2. Ensure that core medical and support services are easily accessible and readily available				
Activities	**Timeline**			**Responsible Party**
	2012/2013	**2014**	**2015**	
a. Increase the number of newly diagnosed PLWHA who enter medical services within 3 months of diagnosis	●	●	●	Medical Case Mangers (MCMs) Medication Adherence Providers (MAP), EIS, MAI, OTL
b. Increase the number of PLWHA who enter support services within 3 months of diagnosis	●	●	●	Medical Case Mangers (MCMs) Medication Adherence Providers (MAP), EIS, MAI, OTL
c. Increase the number of PLWHA who enter medical services within 6 months of diagnosis	●	●	●	Medical Case Mangers (MCMs) Medication Adherence Providers (MAP), EIS, MAI, OTL
d. Monitor CD4 and VL tests to identify PLWHA who are late to care	●	●	●	Part B Quality Management Team, MCMs, and MAP

CARE GOALS/ACTIVITIES (continued)

3. Ensure that funded providers adhere to Ryan White Part B HRSA Monitoring Standards, HAB Performance Measures (PM) and CAREWare client level data reporting requirements, PHS Guidelines for PLWHA, and the Statewide MCM Standards of Care

Activities	Timeline			Responsible Party
	2012/2013	2014	2015	
a. Plan and develop contractual site visit schedule with HIV care providers	●	●	●	Part B QM Team, Contract Managers, Part B Providers
b. Conduct contractual site visits to monitor adherence to HRSA standards, HAB PM, CAREWare reporting requirements, PHS Guidelines, and MCM standards of care	●	●	●	Part B QM Team, Contract Managers
c. Develop Quality Management Reports to highlight programmatic performance with standards of care and performance measures	●	●	●	Part B QM Team, Data Manager, Contract Managers

4. Improve and increase the identification, informing and referral of PLWHA who are unaware of their HIV positive status to medical care and HIV prevention services (Testing, PS, and DEBIs)

Activities	Timeline			Responsible Party
	2012/2013	2014	2015	
a. Increase number of unaware persons who have an HIV Test	●	●	●	EIS, MAI, Outreach, Testing, Linkage (OTL) staff, PS
b. Increase number of unaware persons who receive HIV Test Results	●	●	●	EIS, MAI, and Outreach, Testing, Linkage (OTL) staff, PS
c. Increase number of newly diagnosed PLWHA who are linked to medical care, support and prevention services	●	●	●	EIS, MAI, and Outreach, Testing, Linkage (OTL) staff

5. Promote regular and on-going collaborations with Ryan White Parts, Prevention, the STD Unit , other state agencies and community organizations in relation to data collection and meaningful use of quality and performance measures to inform planning and enhance service delivery

Activities	Timeline			Responsible Party
	2012/2013	2014	2015	
a. Develop framework for statewide strategy that includes the identification, testing, treatment, and linkage of HIV positives into the Care and Prevention system	●	●	●	Part B participation in: CHAIR Task Force, CHPC, and Cross Part Collaborative (CPC), Part B providers
b. Designate Part B staff to serve as liaisons at the following groups/meetings: CHAIR Task Force, CHPC, Data Assessment Committee (DAC), Cross Part Collaborative (CPC), Part A Planning Councils, Mayor's Task Force	●	●	●	Part B , Ryan White Part A,C, and Ds , STD, Planning Council, CHPC, CHAIR, CPC, Mayor's Task Force
c. Incorporate the outcome of collaborations into required HRSA progress and annual reports	●	●	●	Part B grantee

CARE GOALS/ACTIVITIES (continued)				
6. Increase collaborations across Prevention and Care to ensure that adequate training and educational opportunities exist and occur for providers, prevention and care staff, PLWHA and other relevant stakeholders				
Activities	**Timeline**			**Responsible Party**
	2012/2013	**2014**	**2015**	
a. Incorporate required relevant HIV training into Prevention and Care standards and contracts	●	●	●	Part B , Ryan White Part A,C, and Ds , STD, CAETC, Prevention
b. Share training and educational opportunities with care, prevention, and stakeholder staff on a regular basis	●	●	●	Part B , Ryan White Part A,C, and Ds , STD, CAETC, Prevention, funded providers
c. Train new & seasoned MCM/MAP/OTL/EIS/MAI and Housing provider staff	●	●	●	Part B , Ryan White Part A,C, and Ds , STD, CAETC, Prevention, MCM, MAI, EIS, OTL, MAP,
7. Reduce HIV-related health disparities and improve health literacy for PLWHA				
Activities	**Timeline**			**Responsible Party**
	2012/2013	**2014**	**2015**	
a. Increase number of black and Latino/a PLWHA screened for Hepatitis A-C, STDs, and TB, who are linked to services	●	●	●	EIS, MAI, and Outreach, Testing, Linkage (OTL), STD
b. Increase number of MSM PLWHA screened for Hepatitis A-C, STDs, and Tuberculosis (TB) who are linked to services	●	●	●	EIS, MAI, and Outreach, Testing, Linkage (OTL) ,STD
c. Screen PLWHA for Health Literacy every six months at follow-up	●	●	●	MCM staff
d. Provide annual Health Literacy Training for new and seasoned HIV care providers	●	●	●	Part B Training Coordinator and Quality Manager

PREVENTION GOALS/ACTIVITIES				
1. HIV Testing - Increase the proportion of HIV infected persons in CT who know their HIV status.				
Activities	**Timeline**			**Responsible Party**
	2012/2013	**2014**	**2015**	
a. Develop and implement an ongoing marketing plan to increase the visibility of HIV testing services.	●	●	●	OTL and DIS Staff
b Implement Outreach, Testing and Linkage services in high incidence areas in CT.	●	●	●	OTL and DIS Staff
c. Enhance testing mechanisms for persons who test for HIV to get their results.	●	●	●	OTL and DIS Staff
d. Integrate databases in order to track and trend persons who receive confirmed HIV test results.	●	●	●	
2. HIV Testing – Increase the proportion of HIV infected persons who are linked to care and prevention services.				
Activities	**Timeline**			**Responsible Party**
	2012/2013	**2014**	**2015**	
a. Train OTL and DIS staff to provide positive test results	●	●	●	DPH Contract Managers and DIS staff
b. Improve referral mechanisms of HIV positive referrals made to medical care	●	●	●	DPH Contract Managers and DIS staff
c. Document, track, trend, and report on completed HIV positive referrals to medical care	●	●	●	DPH Contract Managers and DIS staff
d. Document, track, trend and report on HIV positive referrals made to MCM services	●	●	●	DPH Contract Managers and DIS staff
e. Document, track, trend and report on HIV positive referrals made to STD, HBV, HCV, and TB.	●	●	●	DPH Contract Managers and DIS staff
3. HIV Testing – Expand the implementation of HIV Outreach, Testing and Linkage services in order to reduce new HIV infection.				
Activities	**Timeline**			**Responsible Party**
	2012/2013	**2014**	**2015**	
a. Assist OTL service providers programs in coordinating outreach strategies	●	●	●	DPH Contract Managers and DIS staff
b. Distribute condoms to funded OTL service providers	●	●	●	DPH Contract Managers and DIS staff
c. Train OTL and CRCS staff to educate people on proper condom use.	●	●	●	DPH Contract Managers and DIS staff
d. Collaborate and coordinate with STD and community based programs to maximize the number of people tested and identified as candidates for Partner Services.	●	●	●	DPH Contract Managers and DIS staff

PREVENTION GOALS/ACTIVITIES (continued)

4. Comprehensive Prevention with Positives – Provide linkage to HIV care, treatment, and prevention services for those persons testing HIV positive or currently living with HIV/AIDS.

Activities	Timeline			Responsible Party
	2012/2013	2014	2015	
a. Collaborate and coordinate with medical providers, HIV specialists, and prevention staff to utilize data to maximize the number of persons identified as candidates for partner services.	●	●	●	DPH Contract Managers and DIS staff
b. Collaborate and coordinate with medical providers, HIV specialists, HIV support staff and prevention staff to utilize data to identify out of care persons.	●	●	●	DPH Contract Managers and DIS staff
c. Coordinate behavioral and clinical risk screening (risk reduction) activities via CRCS, EBI, Prevention counseling and or medication adherence support.	●	●	●	DPH Contract Managers and DIS staff

5. Comprehensive Prevention with Positives – Offer referral and linkage to other medical and social services such as mental health, substance abuse, housing, safety/domestic violence, corrections, legal protections, income generation and other services as needed for HIV positive persons.

Activities	Timeline			Responsible Party
	2012/2013	2014	2015	
a. Collaborate and coordinate with DTD programs, and HIV and or STD surveillance programs to utilize data to maximize the number of persons identified as candidates for Partner Services.	●	●	●	DPH, DIS, MCM, EIS, MAI Staff
b. Partner with non-health department providers, including CBOs and private medical treatment providers, to identify more opportunities to provide Partner Services	●	●	●	DPH, DIS, MCM, EIS, MAI Staff

6. Condom Distribution - Provide condoms to HIV+ people and people at very high risk for HIV infection.

Activities	Timeline			Responsible Party
	2012/2013	2014	2015	
a. Distribute condoms to HIV positive people and people at very high risk of HIV infection.	●	●	●	DPH, OTL, and CRCS Staff
b. The Community Distribution Center will maintain a database that includes information in who received condoms, the quantity and how often condoms were distributed.	●	●	●	DPH, CdC, OTL, and CRCS Staff
c. Disseminate 50,000 female condos and 2,000,000 male condoms to HIV+ and HIV- persons at high risk for infection through Ryan white case managers, community health centers, CBOs, infectious disease practitioners, and local venues.	●	●	●	DPH, OTL, and CRCS Staff

PREVENTION GOALS/ACTIVITIES (continued)

7. Policy Initiatives - To support efforts to align structures, policies, and regulations with optimal HIV prevention, care and treatment and to create an enabling environment for HIV prevention efforts by implementing new strategies and forging new collaborations.

Activities	Timeline			Responsible Party
	2012/2013	2014	2015	
a. Collaborate with community partners on state and local policy issues.	●	●	●	DPH, Community Collaborators and State Agencies
b. Work locally to influence policy change to allow for syringe exchange.	●	●	●	DPH, Community Collaborators
c. Work to implement routine testing in correctional facilities.	●	●	●	DPH, Community Collaborators and State Agencies (DOC)
d. Partner with State Department of Education (SDE) to support comprehensive sexuality education locally.	●	●	●	DPH, Community Collaborators and State Agencies (SDE)
e. Advance routine testing in health care settings by exploring barriers identified by healthcare providers.	●	●	●	DPH, Healthcare Providers

8. Jurisdictional HIV Prevention Plan - Facilitate a statewide collaboration to maximize resources, identify and document the needs of PLWHA and those most at risk and to develop and implement a responsive HIV care and prevention plan for CT.

Activities	Timeline			Responsible Party
	2012/2013	2014	2015	
a. Strengthen and expand collaborations with new and existing stakeholders.	●	●	●	DPH and CHPC
b. Engage new participants in the community planning process to advance the mission of the CHPC and the goals of the Action Plan.	●	●	●	DPH and CHPC

9. Jurisdictional HIV Prevention Plan – Promote targeted changes in HIV/AIDS Care and Prevention service delivery to improve health outcomes and the quality of life for PLWHA and those unaware of their HIV status.

Activities	Timeline			Responsible Party
	2012/2013	2014	2015	
a. Collaborate with Ryan white Parts, EIS, and Prevention to identify and inform unawares and link them to services.	●	●	●	DPH Training staff
b. Review training offerings and create a mechanism for communicating opportunities.	●	●	●	DPH Staff, Community Partners, Other Stakeholders
c. Strengthen and streamline common processes for client services and referrals.	●	●	●	DPH Staff, DPH Prevention and Care Contractors

PREVENTION GOALS/ACTIVITIES (continued)				
10. Jurisdictional HIV Prevention Plan – Increase public awareness and education efforts that support early identification, and access to information and resources by providers, PLWHA and those unaware of their status.				
Activities	**Timeline**			**Responsible Party**
	2012/2013	**2014**	**2015**	
a. Organize meetings with CAETC and NAETC to discuss plans to collaborate trainings for medical providers and HIV service providers	●	●	●	DPH Staff, CAETC, and NAETC Staff, HIV Service Providers
b. Collaborate to develop statewide education schedules and protocols	●	●	●	DPH Staff, CAETC, and NAETC Staff, HIV Service Providers
c. DPH, CAETC and other HIV providers implement trainings, evaluate and update as needed.	●	●	●	DPH Staff, CAETC, and NAETC Staff, HIV Service Providers
d. Develop and implement a survey to identify educational needs of PLWHA	●	●	●	DPH, HIV Training Providers
e. Share results of survey and identify training opportunities	●	●	●	DPH, HIV Training Providers
f. Create a mechanism for communication educational opportunities.	●	●	●	DPH, HIV Training Providers
g. Partner with SDE and other stakeholders to promote comprehensive sexuality education in schools and local communities	●	●	●	DPH, Youth Advisory Group, SDE, Community Partners
h. Promote education and public awareness around HIV initiatives using social media tools	●	●	●	DPH, CLI contractor, HIV Care and Prevention Programs
i. Promote DPHs targeted social marketing campaigns	●	●	●	DPH, CLI contractor, HIV Care and Prevention Programs
j. Update DPH website, 211, and CHPC newsletter to assure most current information disseminated	●	●	●	DPH, CHPC
k. Plan and conduct HIV community forums to provide jurisdictional plan and promote HIV initiatives	●	●	●	DPH, CHPC, Community Partners

PREVENTION GOALS/ACTIVITIES (continued)

11. Capacity Building and Technical Assistance – To provide quality HIV related training and capacity building assistance to all DPH funded HIV Care and Prevention staff across the state.

Activities	Timeline			Responsible Party
	2012/2013	2014	2015	
a. Plan, Revise and facilitate Core trainings twice a year for new staff. This includes: HIV Testing, HIV 101, STDs, HEP a, b, c, Sexual Assault, Domestic Violence, Substance Abuse 101, Cultural Competency, Partner Services and Legal Basics of HIV.	●	●	●	DPH Training Staff
b. Plan, implement and facilitate the following trainings: Fundamentals of Waived Rapid Testing and Outreach Testing and Linkage, and Fundamentals of CRCS	●	●	●	DPH Training Staff
c. Conduct annual Capacity building Training Needs Assessment Survey, analyze the data and then plan and implement trainings.	●	●	●	DPH Training Staff
d. Implement capacity building training needs assessments and monitor needs through field observations, site visits and quarterly reports.	●	●	●	DPH Staff
e. Secure capacity building assistance and training for all prevention contractors in need through the DPH or CDC CRIS System.	●	●	●	DPH Staff

12. Effective Behavioral Interventions for High Risk Negatives – Support the implementation of EBIS for People at high risk of acquiring HIV (Partners of PLWHA, MSM, IDU, and African American and Latina Heterosexual Women)

Activities	Timeline			Responsible Party
	2012/2013	2014	2015	
a. Contract with community organizations to implement EBIS with targeted populations in various community settings	●	●	●	DPH Staff, Prevention Providers
b. Provide or secure CBA and TA including training to contracted organizations implementing EBIs to ensure provider capacity.	●	●	●	DPH Staff, Prevention Providers, CBA and TA Providers, Trainers
c. Monitor and evaluate EBIS to ensure target numbers are met and interventions are implemented with fidelity.	●	●	●	DPH Staff

1. Improved use of Ryan White client level data

Beginning in 2010 Ryan White program grantees and respective service providers have used a new biannual data collection and reporting system to report information on their programs and the clients they serve to the HIV/AIDS Bureau (HAB). This report, the Ryan White HIV/AIDS Program Services Report (RSR), will consist of the Grantee Report, the Service Provider Report and the Client Report. The Client Report, to be completed by each service provider, will capture client level data such as client demographics (unique identifier, date of birth, race/ethnicity, gender, including recording of Transgender subgroup, Federal Poverty Level, housing status, HIV/AIDS status, risk factor, sources of medical insurance, etc.) as well as HIV clinical information, and HIV Care medical and support services received. The most recent HRSA Performance Measurement outcomes have also been included in this Client Report.

Connecticut currently collects client level data through the CAREWare reporting system. In an outstanding example of collaboration, every Ryan White Grantee and Sub-grantee now has access to and enters data into a single central server housed by the City of Hartford. This system collects all of the client level data required by HRSA/HAB, including all the Performance Measures recommended by HRSA. This includes the following client level data: HIV Status, AIDS Status, Viral Load, CD4 Count, whether the client is on ARVs, and core medical and support services. Through the use of internal processes built into the software, providers are able to, with the client's permission, share information on the client's health and service status. This improves our ability to provide the best care possible to our clients.

Beginning in October 2012, client level and grantee level data collection and reporting will also be conducted through Connecticut's AIDS Drug Assistance Program (CADAP). The ADAP Data Report (ADR) will include client demographics such as gender, age, race/ethnicity, insurance type, homelessness and ADAP service utilization including formularies, medications, insurance participation and client billing services.

Connecticut's Centralized Program Evaluation and Monitoring System (CPEMS) is a data reporting tool designed to strengthen monitoring and evaluation of HIV prevention programs. CPEMS is a secure internet browser-based software program for data entry and reporting. To have access to CPEMS, all users need to be eAuthenticated at Level 3. The software was first released in 2004 and allows grantees to collect agency, community planning and program plan data as well as enter client-level data. Unique identifiers are used in place of client names.

CPEMS ensures that CDC receives standardized, accurate and thorough program data from health departments, and community-based organization grantees. The data helps HIV prevention stakeholders examine program fidelity, monitor use of key program services and behavioral outcomes, and calculate and report the program performance indicators. Some of the data collected include agency information, program plan details, client demographics, referral outcomes, HIV test results, behavioral outcomes, community planning priority populations, and interventions among others.

DPH contract agency CPEMS users have been trained and receive ongoing technical assistance from DPH staff serving as CPEMS Administrators on how to properly enter information into the system and maintain confidentiality of client-level data. There are currently two DPH staff persons, who monitor the use of CPEMS at contract agencies. These DPH CPEMS Administrators provide technical assistance to contract agency CPEMS Users and generate reports on service delivery for contract managers. They set

up interventions, assign user roles, update site and worker information, and set up/reset logins. DPH CPEMS Administrators provide ongoing education to sites on the importance of keeping challenge phrases and login passwords private. Thus far, there have been no documented or reported breaches of confidentiality. The CDC is planning to decommission CPEMS. As of January, 2012, the CDC does not have an official date for when CPEMS will no longer be available for local use. The CDC hopes to have a new system identified before the next data submission in the fall 2012.

DPH contract agency who are implementing the Counseling, Testing and Referral (CTR) intervention use EvaluationWeb (XPEMS) as the HIV testing data reporting tool. XPEMS is an online data collection and reporting system specifically for HIV Prevention and HIV Counseling and Testing data. The XPEMS database system collects the same data required by the CDC's Program Evaluation Monitoring System (CPEMS). To have access to XPEMS, all users need to be eAuthenticated at Level 2.

2. Use of data in monitoring service utilization

Contract Managers review Provider's client-level core medical and support service data in CAREWare to determine whether number and services provided to clients are appropriate to the Provider's contract prior to site visits (audits). Feedback is given to Providers at the site visit including notification of any recommendations/corrective action(s) if needed. HCSS is able to track client core and support service utilization in CAREWare to evaluate use of core and support services, make sure that services are reaching the target population, identify unmet service need(s), and prioritize funding. Data is used to adjust funding levels for these services for the next contract period. Contract Managers review CAREWare Reimbursement log data with each agency's programmatic report to ensure that Ryan White funds are used according to the HRSA/HAB Policy Notice 10-02: Eligible Individuals and Allowable Uses of Funds for Discretely Defined Categories of Services.

DPH HIV Prevention Unit Contract Managers will review data that gets documented on all client prevention services. Contract language is under development that includes specific outcome measures that contractors will be required to report to DPH (e.g. number of targets reached, number of cycles/sessions implemented, etc.) Contractors are required to use a secure, web-based system that collects, reports and analyzes CDC-required National HIV Program Monitoring and Evaluation (NHM&E) data. All Contractor staff will be required to attend training on system use. Data collection and submission activities include but are not limited to:

a) Collection of all CDC-required Centralized Program Evaluation and Monitoring (CPEMS) data variables in accordance with CDC-specified data collection requirements

b) Adherence to the data security and confidentiality polices and user authentication requirements related to the use of the reporting system

c) Submission of all Department funded intervention data that are collected via EvaluationWeb or any other identified data collection/reporting system selected by DPH or CDC

d) Entry of all HIV Test Form and Intervention Data in a timely manner

e) Submission to the designated Department contact copies of all HIV Test Forms by the date required

f) Participation if selected in administering pre and post intervention surveys as well as six month follow-ups to individuals participating in EBIs

3. Measurement of clinical and prevention outcomes

The mission of the **Health Care & Support Services'** (HCSS) Clinical Quality Management Program (CQMP) is to assure access to and retention in quality, client centered health care and related services for all PLWHA in accordance with the U.S. DHHS, HRSA/HAB Regulations and the National HIV/AIDS Strategy. Its vision is to promote optimal health outcomes for individuals living with HIV, reducing new HIV infections, and reducing HIV-related health disparities. The CQMP's purpose is to provide a mechanism for the objective review, evaluation and continuing improvement of CT's Part B funded services. The CQMP goals are to:

1) Increase access, retention, and maintenance of PLWHA in care

2) Link PLWHA to client centered health care and support services

3) Reduce morbidity and mortality of PLWHA through improved health outcomes

4) Ensure that funded service providers adhere to the Ryan White Part B HRSA monitoring standards, PHS Guidelines for PLWHA, and the Statewide MCM Standards of Care

5) Identify, inform, and refer PLWHA who are unaware of their HIV positive status to medical care and HIV prevention services (testing & counseling)

The CQMP has a comprehensive quality assurance mechanism to assess the degree that Part B-funded programs meet their contractual obligations and comply with the HCSS standards. Three quality improvement audit instruments quantify audit results: *Administrative Site Visit, Client Record/CAREWare Audit,* and *Part B Quality Improvement (QI) Audit* tools. The first instrument measures contractor compliance with Standards of Care. The second instrument evaluates the client record for adherence to the Medical Case Management (MCM) Standards of Care and collection of client level data (CLD) including HAB Clinical Performance Measures. The following Performance Measures are monitored: HAB Measure #1: medical visits, HAB Measure #2: CD4 count, DPH Measure #2A: Viral load, HAB Measure #3: PCP Prophylaxis, HAB Measure #4: AIDS on HAART, HAB Measure #5 ARV for Pregnant women, HAB Measure #8: Hepatitis B vaccination, HAB Measure #9: Hepatitis C screening, HAB Measure #10: HIV Risk Counseling, HAB Measure #13: Syphilis screening, HAB Measure#14 TB screening, HAB Measure #17 Hepatitis b Screening, HAB Measure #21 Mental Health Screening, and HAB Measure #23 Substance Abuse Screening. The QI Audit Tool measures the contractor's overall performance and scores a random sampling of client records.

Since July '07, Part B funded MCMs have been required to collect CD4 and viral load (VL) lab tests, date of last primary care visits and core referral outcome data. This information has resulted in a relatively mature body of data to assess some of the HRSA Core Performance Measures. CT has completed its seventh year collecting VL and CD4 tests from Part B-funded contractors. Contractors are required to collect these lab results at a minimum of every six months. DPH queries the submitted data to determine the rates that VL and CD4 tests are entered in the data system and the intervals at which these data are entered. This establishes a baseline to measure contractor compliance with the requirement and assists with identifying the number of Part B clients who are engaged in care.

In 2011, most site visits included feedback from chart audits regarding: (a) clients that have no or old (>six months) lab results, (b) clients taking HAART, (c) clients with outdated assessment form and care plan > six months, (d) number of clients with and without primary care visits, and (e) number of referrals made, completed, verified and pending for core services. The feedback was provided to ensure that relevant data was collected and entered in the client record/database, and, to help funded agencies identify clients with missing or inconsistent data in order to rectify reporting deficiencies.

RW Part B funded agencies are also required to collect CLD, enter it into CAREWare, and submit quarterly reports that include a program narrative, aggregate service and aggregate HAB Performance Measures. Agencies are expected to use the Performance Measures to monitor the care given to their clients and their own agency data entry processes.

The following Quality Improvement activities have been completed to improve service delivery and clinical outcomes: 1) improvement of client care and reporting of HAB & DPH performance measures (PM) 01 (Medical Visit), 02 (CD4 count), 02A (VL), 03 (PCP Prophylaxis), 04 (AIDS on HAART), 05 (ARV for pregnant women), 08 (Hepatitis vaccination), 09 (Hepatitis C screening), 10 (HIV Risk Counseling), 13 (Syphilis screening), 14 (TB screening), 17 (Hepatitis B Screening), 21 (Mental Health Screening), and 23 (Substance Abuse Screening), by 5-6% in the MCM & MAP programs; and, 2) improving the reporting of PMs in the CAREWare database over time (2012) for the MCM and MAP programs, which includes providing on site TA for providers in CAREWare data entry. For the future, DPH will continue to track and monitor Clinical Performance Measures related to: primary care visits; PCP prophylaxis for clients with CD4 $\leq$ 200; HAART for clients with CD4 counts $\leq$ 500; CD 4 testing; Syphilis, Hepatitis C, TB screening, pregnancy ARV prophylaxis, HIV Risk Reduction, Hepatitis B Screening, Mental Health Screening and Substance Abuse Screening. Monitoring of these data, using periodic reports reviewed by CQMP staff together with the staff of funded providers, will facilitate the quality improvement of client care at all levels.

The following table shows the improvement in Performance Measure scores entered in CAREWare and is an indication and measurement of clinical outcomes for both Medical Case Management and Medication Adherence

MCM	Viral Load	CD4	2 Care Visits	AIDS on HAART	ARV if Preg	CD4<200 + PCP Prophyl	Hep B Vac	Hep C Scr	Syphilis Test	TB Scr	Avg
2009	55%	55%	39%	72%	100%	29%	13%	53%	33%	27%	48%
2010	61%	62%	52%	83%	100%	49%	21%	71%	48%	60%	61%
2011	69%	69%	62%	92%	100%	59%	35%	92%	68%	87%	76%
% change 2009-'10	11%	13%	33%	15%	0%	69%	62%	34%	45%	122%	40%
% change 2009- '11	25%	25%	59%	28%	0%	103%	169%	74%	106%	222%	81%
MAP											
2009	70%	70%	53%	74%	---	35%	16%	55%	42%	29%	49%
2010	74%	75%	63%	90%	100%	66%	38%	84%	66%	73%	73%
2011	88%	88%	73%	98%	100%	79%	53%	95%	82%	90%	82%
% change '2009-'10	6%	7%	19%	22%		89%	138%	53%	57%	152%	60%
% change '2009- '11	26%	26%	38%	32%		126%	231%	73%	95%	210%	95%

Part B contractors (as shown in the table below) continue to improve their scores on performance measures selected for quality improvement. Although the rates on a few of the measures still need improvement, notably the hepatitis B vaccine rate (35%), contractors have made considerable progress. The average score shows another 12-15% improvement over the increases achieved last year (13-21% over 2009). This has resulted in an overall improvement since 2009 of 28-33% in these scores. In addition, in 2010 HCSS introduced four more performance measures on which to focus QI efforts. These included hepatitis B screening, HIV risk counseling, Mental Health Screening and Substance Abuse Screening. The following table shows the baseline (as of the end of 2010) values and the results of the focus on these measures in the current year. Results showed a 21-28% average achievement increase in contractors' scores as compared to 2010 baseline scores.

MCM	HepB Screen since Dx	Annual HIV Risk Counseling	Annual Mental Health Screening	Annual Substance Abuse Screening	Average Score
2010	36%	68%	55%	51%	53%
2011	81%	89%	79%	76%	81%
% change 2010-2011	125%	31%	44%	49%	53%
MAP					
2010	55%	67%	56%	47%	56%
2011	65%	89%	78%	74%	77%
% change 2010-2011	18%	33%	39%	57%	38%

The Connecticut DPH ***HIV Prevention Unit's Quality Management Program (QMP)*** is committed to the ongoing monitoring and evaluation of all funded HIV Prevention activities. QMP staff regularly assesses the quality of HIV related prevention services by reviewing programmatic, fiscal, and clinical/non clinical performance. In alignment with the National HIV AIDS Strategy (NHAS), the HIV Prevention Unit's QMP overall goals are to:

- Reduce New HIV Infections
- Increase Access to care and improve health outcomes for people living with HIV
- Reduce HIV Related Health Disparities

The QMP staff is currently developing a comprehensive Quality Management Plan which will outline the goals, objectives, and strategies for measuring adherence to DPH and CDC quality performance measures. The plan includes information on the collection of outcomes (process, formative), performance indicators, and measures that contractors will be required to report to DPH. Contractors are required to report and submit data through the HIV Test Forms, quarterly reports, and entered into the required database (XPEMS/EvaluationWeb) in a timely manner. All contractors will be monitored for adherence to DPH HIV Prevention Unit Data and CDC required National HIV Program Monitoring and Evaluation (NHM&E) standards. The CDC required NHM&E standards provide guidance on the collection and reporting of program information, client-level data (CLD) and program performance indicators.

The QMP staff coordinates a variety of monitoring and evaluation activities. QMP staff members are trained on quality management and improvement principles and are familiar with care-related HRSA HAB QI Performance Measures. In addition, staff will be trained on formative evaluation (for adaptation and program planning), and work plan development to assist contractors with program planning and progress with meeting goals and objectives for real-time reporting. Formative evaluation will be used with contractors to assure that the right target populations are reached and appropriate services are planned. During the implementation of HIV prevention interventions, DPH staff will conduct Process Monitoring and Process Evaluation of all funded programs, as these are critical steps to ensuring that services planned get delivered to target populations and that they are delivered with fidelity to core elements and or procedural guidance.

DPH QMP data from 2010

The DPH HIV Prevention Unit has been collecting the following performance indicators. The table below represents data from 2010.

2010 HIV Testing Indicators	Total Number
1. Total number of HIV Tests ***conducted*** (12/31/10)	24,268
2. Total # ***informed*** of their HIV status (HIV Positive and Negative)	23,568
3. Total # ***not informed*** of HIV Positive Tests	700
4. Total # of HIV Positive Tests	90
5. Total # of HIV Positive ***informed*** of their HIV Status	87
6. Total # of HIV Positive ***referred*** to medical care	78
7. Total # of HIV Positive ***linked*** to medical care	N/A
8. Total # of HIV Positive Tests ***NOT Informed*** of their HIV status	3
9. Total # of HIV negative Tests	24178
10. Total # of HIV negative ***informed*** of their HIV status	23481
11. Total # of HIV negative ***referred*** to services	N/A
12. Total # of HIV negative ***NOT informed*** of their status	697

The QMP staff is developing improved mechanisms for the qualitative review of prevention services and outcomes. New mechanisms include improved contract language, programmatic site visit audit tools, quality improvement (QI) tools and forms, and quarterly reporting forms. In particular, pre and post-test surveys as well as six month follow up surveys will be implemented with individuals participating in the EBIs. While collecting such information will not yield statistically significant information, it may provide insight into the impact of funded behavioral interventions. All QMP staff will be trained to utilize XPEMS and EvaluationWeb for quality improvement and evaluative purposes.

The following is a chart of preliminary Performance Indicators/Measures that the DPH QMP staff will use to measure all components of the DPH's Comprehensive HIV Prevention Program. These indicators align with the CDC's NHM& E Required Variables for reporting. The prevention team will also be developing action steps to improve programs to better align with CDC priorities and the NHAS.

DPH HIV Prevention Component Performance Indicators 2012-2015		
Component	**Activities**	**Performance Indicators**
HIV Testing	• Develop and Implement an ongoing marketing plan to increase visibility of HIV testing services • Implement Outreach, Testing, & Linkage services in high incidence areas in Connecticut • Train OTL and DIS staff to provide HIV-positive test results and link persons to services • Enhance the implantation of routine HIV testing currently at ERs, DMHAS, CHCs and STD clinics • Enhance Routine HIV testing currently at non-DPH funded primary care, outpatient and ER facilities • Improve HIV positive referral and linkage mechanisms to medical care • Document, track, trend, and report on completed HIV positive referrals to medical care, partner services, and ancillary services (e.g. STD, TB, and hepatitis)	# of HIV tests conducted # of persons who test positive # of persons who receive HIV + test results # of persons linked to medical care # of persons linked to PS # of persons linked to ancillary services # of persons who attend first appointment Completed Quantitative data report from DPH Surveillance
Comprehensive Prevention w/ Positives	• Train staff to provide CRCS with HIV positive persons and their partners. • Coordinate behavioral and clinical risk screening (risk reduction) activities via: CRCS intervention/prevention counseling, and medication adherence support.	# of persons reached # of persons linked to HIV care and treatment services. # of out of care persons linked/re-engaged with HIV care and treatment /adherence services Completed Qualitative data report from DPH CRCS program
Condom Distribution	• Distribute condoms to HIV positive people and people at very high risk for HIV infection. • Partner with the community distribution center to maintain a database that includes information on who received condoms, the quantity and how often condoms were distributed.	# of condoms distributed (overall) # of condoms targeted to specific populations (High risk negative/unknown/positive/general population)
Policy Initiatives	• Collaborate with community partners on state and local policy issues. • Work locally to influence policy change to allow for syringe exchange. • Work to implement routine testing in correctional facilities. • Partner with the Dept of Education to support comprehensive sexuality education locally. • Advance routine testing in health care settings by exploring barriers identified by healthcare providers	# of collaborations established # of policy/legislative statutes initiated and accomplished Quantitative data from DPH Policy report and analyses

DPH HIV Prevention Component Performance Indicators 2012-2015		
Component	**Activities**	**Performance Indicators**
EBIs for High Risk Negatives	• Contract with community organizations to implement EBIs with targeted populations (MSM, IDU, HIV +, AA, and Latina Heterosexual females) in various community settings. • Provide or secure CBA and TA including training to contracted organizations implementing EBIs to ensure provider capacity. • Monitor and evaluate EBIs to ensure target #'s are met and interventions implemented with fidelity to core elements.	# of interventions conducted # of people (contacts) reached # of CBA Requests (CRIS) # of TA conducted Completed Qualitative description of the community EBIs
Social Marketing, Media, and Mobilization	• Promote education and public awareness around HIV initiatives using social media tools • Promote DPH's targeted social marketing campaigns • Update DPH website, 211 and CHPC newsletter to assure most current information disseminated • Plan and conduct HIV community forums to inform jurisdictional plan and promote HIV initiatives	# of social media tools used # of social marketing initiatives completed # of community forums completed Completed Qualitative description of the social marketing/ public information services
PrEP and nPEP	• Develop Outreach Plan to educate and promote nPEP services to organizations that work with victims of sexual assault in the community, such as hospitals, and community based organizations. • Promote collaboration with other sexual assault providers and organizations that work with at risk populations. • Develop a mechanism to track and trend the provision of nPEP services for victims of sexual assault	# of persons referred to nPEP services # of persons that access nPEP services Completed Qualitative description of the programmatic structure and activities of nPEP support services
Jurisdictional Planning	• Strengthen and expand collaborations with existing and new partners and stakeholders. • Engage new participants in the community planning process to advance the mission of the CHPC's Action Plan.	#of new collaborations with community partners and stakeholders #of new participants' engaged in CHPC # of Resources, Needs and Gaps identified in the Jurisdictional Plan
Capacity Building and Technical Assistance	• Utilize CDC Capacity Building organizations for the provision of training and continuing education for staff and HIV service providers • Plan, Revise, and Facilitate core trainings twice a year for new staff. • Plan, implement, and facilitate trainings, these include: (a) Fundamentals of Waived Outreach Rapid Testing, and Linkage (OTL) Training; and (b) Foundations of Comprehensive Risk Counseling Services (CRCS) • Conduct annual Capacity Building Trainings Needs Assessment (NA) Survey: (a) Analyze NA Survey Data; and (b) Plan, implement, and facilitate trainings	# of core pre-requisite trainings conducted # of training OTL and CRCS trainings conducted # of Capacity Building trainings developed # of new HIV care and prevention staff (OTL, CRCS, MCM, and DIS staff) that attend trainings # of NA surveys completed
Program	• Update DPH Action Plan (SMART goals,	Completed data collection and

DPH HIV Prevention Component Performance Indicators 2012-2015		
Component	**Activities**	**Performance Indicators**
Planning, Monitoring and Evaluation	objectives, activities, and performance measures/indicators) • Develop and align data collection/reporting mechanisms with CDC requirements (forms, work plans, site visit protocols, and quarterly report documents).	monitoring protocols
Quality Management	• Align DPH Prevention Performance Measures with CDC. • Revise HIV Prevention Services Protocol • Revise DPH HIV Prevention Quality Management Plan • Revise and streamline DPH data collection, quality improvement, and reporting processes.	% of DPH and CDC Performance Measures successfully reported and met Completed Prevention Services Protocol, QM Plan, and data collection tools
PCSI Activities	• Enhance current programmatic structure and activities of the linkage to cares services. • Document, track, trend and report HIV positive referrals and linkages to: o STD o HBV o HCV o TB	# of persons who receive HIV + test results # of persons linked to services # of persons who attend appointment Documented in charts/databases Completed Qualitative description of the programmatic structure and activities of the linkage to care service

The DPH in collaboration with the Connecticut HIV Planning Consortia's (CHPC) Data Assessment Committee (DAC) is developing a plan that will include a set of Quality Indicators and Performance Measures. The plan will identify an initial set of quality performance measures for the following health outcomes: biological health sociopolitical, prevention, care, and behavioral indicators and measures.

The table on the next page summarizes the performance indicators for **biological** and **prevention service** outcomes.

Biological/Health Outcome Indicators		
Indicator	***Definition***	
	Numerator	***Denominator***
AIDS incidence per 100,000	# receiving AIDS diagnosis each year	Total # in population group
AIDS prevalence per 100,000	# living with AIDS	Total # in population group
HIV incidence per 100,000	# of cases of HIV first detected each year	Total # in population group
HIV prevalence per 100,000	# living with HIV infection (including AIDS)	Total # in population group
Syphilis incidence per 100,000	# of primary and secondary Syphilis cases each year	Total # in population group
Hepatitis C incidence per 100,000	# of Hepatitis C cases each year	Total # in population group
Tuberculosis incidence per 100,000	# of TB cases each year	Total # in population group
CD4 T-Cell Count (%)	Average of PLWHA CD4 T-Cell Count	
Viral Load	Average of PLWHA Viral Load	

Prevention Service Indicators		
Indicator	***Definition***	
	Numerator	***Denominator***
# of individuals receive counseling and testing and test positive	# of HIV+ individuals from target population associated with outreach, counseling &Testing services	# of individuals from target population activated by outreach activities
# of PLWHA clients participating in EBI/DEBI for PLWHA %	# of PLWHA participating in EBI/DEBI	Total # of PLWHA in CT by population group
Cultural Competence (transgender)	# of providers with adequate procedures / protocols and trained staff	# of total providers
Prevention utilization by priority groups	# of respondents reached and engaged who fit the target	# of total respondents reached by activities
Syringe distribution per 1000	Syringes distributed in a calendar year by needle exchange programs that are not prohibited by state or local law	Population 18 to 65 years of age
Condom distribution	# of condoms distributed at target locations	Total population in CT
# of newly diagnosed people entered into care at 3, 6, 12 months (%)	# of people newly diagnosed entered into care at 3, 6 & 12 months	Total # of newly diagnosed by population group
# of people with diagnosed HIV Infection who received 2 or more CD4 and viral load tests in the preceding 12 months (%)	# of people with diagnosed HIV infection who received 2 or more CDR and viral load tests in preceding 12 months	# of people living with HIV/AIDS in population group

4. CHPC's Future Endeavors in Quality and Performance Measurement

The CHPC has charged the Data and Assessment Committee to identify a preliminary list of quality and performance measures from the measures and indicators already collected or identified for future data collection by the Connecticut DPH.

The DPH prevention and care staff, including epidemiologists and health care specialists, involved in quality and performance measurement presented quality, performance, and surveillance measures to a Data and Assessment Committee Workgroup. The Data and Assessment Committee Workgroup members identified a subset of quality and performance measures of most interest to the CHPC. These measures include but are not limited to:

- Seropositivity (e.g., total tests, % HIV+, geographic location, testing site)
- Linkage to care
- Late testers (i.e., % of persons who had their first HIV test within one year of an AIDS diagnosis)
- Maintenance in care (i.e., using HAB measures)
- Syringe exchange programs
- Housing stability
- Partner Services

The DPH staff will continue to work with the CHPC to refine the request and begin sharing information on selected measures as early as the fall of 2012. The DPH staff and CHPC leaders will continue to refine the data sharing process and adjust the statewide Needs Assessment process accordingly to support the integrated care and prevention planning process.

End of Comprehensive Jurisdictional Plan Narrative

State of Connecticut

Comprehensive Jurisdictional Plan for HIV Care and Prevention

Appendices

Statewide Coordinated Statement of Need

Service Matrix

Glossary of Terms

CHPC Membership Diversity Chart

Youth Advisory Group Magazine

HIV Newsletter

CHPC Meeting Dash Board

CONNECTICUT HIV PLANNING CONSORTIUM

The 2012 Statewide Coordinated Statement of Need for Connecticut

CHPC
CONNECTICUT HIV PLANNING CONSORTIUM

Produced by: The Connecticut HIV Planning Consortium

for the Connecticut Department of Public Health

AIDS and Chronic Diseases Section

Table of Contents

Preface

The 2012 Statewide Coordinated Statement of Need (SCSN) was developed through the Data and Assessment Committee (DAC) of the Connecticut HIV Planning Consortium (CHPC). This was a fully collaborative process involving Ryan White Parts A, B, C, D and F and providers of HIV/AIDS services in care and prevention. The SCSN was presented and shared at a public meeting on March 21, 2012 and disseminated via email and mail to members of the CHPC, participants of the public meetings, and to persons who provided the data and/or completed needs assessment surveys. Input from all sources was considered in the development of the final report. The SCSN was updated in 2012 to reflect the new HRSA Guidance. It was voted on and approved by the CHPC in April 2012.

In 2010, the new Connecticut Epidemiological Report was released. From January-June 2010 the CHPC conducted a comprehensive Statewide Needs Assessment for both prevention and care. The DAC was charged with developing a survey that would provide information to guide the Connecticut Department of Public Health (DPH) in making informed decisions about funding allocations. Because the planning body operates with open participation from both CHPC members and members of the public, this survey was developed with full input and representation from all sectors. This SCSN is based on the 2010 Connecticut Epidemiological Profile (with 2011 Surveillance updates), the 2010 Statewide Needs Assessment, independent studies conducted by the Ryan White (RW) Part A New Haven/Fairfield EMA and the Greater Hartford TGA, information from RW Parts C, D and F, Prevention, CT data on poverty, housing, food and energy as well as additional reports and information. This document also references comparative national data and considers the President's National HIV/AIDS Strategy. The 2012 SCSN reflects the Early Identification of Individuals Living with HIV/AIDS (EIIHA) legislative requirement, revisions to the HIV/AIDS Surveillance, Parts A in Greater Hartford and New Haven/Fairfield, Parts C, D and F, Prevention, Unmet Need and Unaware Data and Emerging Needs.

The Connecticut HIV Planning Consortium (CHPC) has operated as a fully integrated care and prevention planning body for almost four years. The CHPC consists of members and participants from around the state including People Living With HIV/AIDS (PLWHA), community based AIDS Service Organizations (ASO) representing both care and prevention, Ryan White Parts A, B, C, D and F, the Center for Interdisciplinary Research on AIDS (CIRA), and governmental agencies (e.g. the Department of Social Services, Department of Mental Health and Addiction Services, and the Department of Correction). The CHPC fulfills both HRSA and CDC requirements relating to membership, diversity, parity, inclusion and representation, in addition to requirements regarding development of a comprehensive plan, community services assessments, prioritization of populations, and statewide care and prevention planning processes and collaborations.

The SCSN Report informs the CHPC in the development of key recommendations for its Comprehensive Plan. As the Connecticut Department of Public Health (DPH) AIDS and Chronic Diseases (ACD) Section develops its Request for Proposals (RFP) for HIV prevention services, DPH will look to the CHPC process to assist them in aligning efforts with the National HIV/AIDS strategy to ensure that prevention resources are strategically concentrated in specific communities at high risk for HIV infection and that appropriate effective, and evidence-based approaches are being implemented. This report also

considers the new direction HRSA is taking to identify and inform the unaware population based on EIIHA. CT DPH Surveillance uses HRSA's model to estimate the number of individuals living with HIV who do not know their HIV status. Concurrently, CT's two Part A programs are working with both Part B and the Prevention and STD units to develop strategies, plans and gather additional information on this population within the state.

The 2010 Connecticut Statewide Needs Assessment

The state conducted a fully collaborative statewide needs assessment using one survey targeting People Living with HIV/AIDS (PLWHA) who are in care and live in Connecticut. The 2010 needs assessment process included Parts A, B, C, D, F, Connecticut AIDS Drug Assistance Program (CADAP), and Prevention. The survey was developed by the Data and Assessment Committee and implemented via CADAP mailing and by trained survey implementers through statewide Ryan White and prevention-funded providers.

Limitations

These data are a compilation of formative research efforts conducted over a period of two or more years. Some of the data sources are in no way intended to be portrayed as scientific, but are qualitative measures that serve as an initial gauge of public and professional perceptions, knowledge and behavior. These qualitative measures are incorporated in the assessment of HIV service gaps.

This SCSN is organized in the following order:

(1) The Executive Summary: provides an overall summary of the report.

(2) The surveillance data (State Epidemiological Profile): sets the stage for the overall picture and includes information on demographics and HIV/AIDS data from the most current information used in the state epidemiological reports on the DPH website (as of December 2010).

(3) Data from the Needs Assessment(s) and other existing sources: corroborates the SCSN findings based on various sets of information, highlights emerging issues that impact Connecticut, and finally identifies recommendations and approaches for the provision of services in Connecticut.

Acknowledgement

Sincere appreciation to the people of Connecticut living with HIV/AIDS, the Data and Assessment Committee (DAC), the Statewide Coordinated Statement of Need (SCSN) work group and to all other individuals and service providers who contributed to create a truly collaborative 2012 SCSN.

Note: This updated report reflects the 2010 and 2012 HRSA guidance which increases the emphasis on quality management, oversight and accountability consistent with the reauthorization principles used to strengthen Federal HIV treatment programs. These principles are: 1) focus on primary care and treatment; 2) efforts to increase flexibility to target resources; 3) ensure accountability using sound fiscal management tools to evaluate program effectiveness[1] and 4) the National HIV/AIDS Strategy.

[1] See guidance for Part B grantees on the development of the SCSN, dated June 12, 2008 and May 2011

I. Statewide Coordinated Statement of Need Background & Process

Background: The Statewide Coordinated Statement of Need (SCSN) assists Ryan White programs to identify key issues, set measureable objectives, inform resource allocation decisions, create a Statewide plan, conduct activities to enhance HIV care and service delivery statewide, and enhance coordination of HIV/AIDS care. In alignment with HAB/DSS[2] expectations, which promote "enhancing access to the continuum of services," the State of Connecticut's Care Consortium merged with the HIV Prevention Community Planning Group in 2007 to better integrate services and comply with the requirement as a Ryan White grantee to "build relationships with other Federal and State agencies."[3] The SCSN has been a requirement since the 1996 reauthorization. Connecticut's Part B program is responsible for developing the SCSN for all grantees under Section 2617(b)(4)(F) and per Section 2617(b)(5). The Ryan White HIV/AIDS Treatment Modernization Act of 2006, Section 2617 (b)(6), requires grantees to conduct activities to enhance coordination across Ryan White HIV/AIDS program Parts by mandating participation in the development of the SCSN. Part B programs are required to participate in the SCSN process, and use its findings for comprehensive planning for the delivery of health services (Section 2617(B)(4)(c) and Section 2617(b)(5)). The SCSN is submitted by the Part B grantee to the Health Resources and Services Administration (HRSA). Ryan White Treatment programs fully participate, as required by the Ryan White HIV/AIDS Treatment Modernization Act, in the development of the SCSN and demonstrate consistency with the SCSN in annual HRSA grant applications.

The outcome of the SCSN process is a written document that summarizes needs and service barriers across the state. HRSA guidelines indicate that the SCSN must reflect, without replicating, a discussion of existing needs assessments and should include a brief overview of epidemiological data, a description of the process used to develop the SCSN, information on participants involved in the process, and a description of service needs and identified gaps. The guidelines also state that the SCSN should include broad goals that should not be prioritized but assessed equally. CT's SCSN identifies broad goals and gaps in care needed by people living with HIV/AIDS both in and out of care.

Purpose: The SCSN is a collaboration among all Ryan White Parts, HIV Prevention and providers of HIV/AIDS focused services to identify and address significant HIV care issues related to the needs of PLWH/A through a written statement of need for Connecticut. This effort is meant to maximize coordination, integration, resources, and linkages across the Ryan White HIV/AIDS Program Parts to ensure efficacy and efficiency of funding for HIV/AIDS care and prevention services.

Participation: The SCSN development and update work group consisted of Data and Assessment Committee (DAC) members and public participants. Participants in the process included representatives from the Part A Planning Councils of the Hartford Transitional Grant Area (TGA) and the New Haven-Fairfield Eligible Metropolitan Area (EMA), Part B State Department of Public Health AIDS and Chronic Diseases Section, Department of Social Services (DSS), Connecticut AIDS Drug Assistance Program (CADAP), Connecticut Department of Public Health Sexually Transmitted Disease (STD) Program, the

[2] HIV AIDS Bureau / Division of Service Systems
[3] Ryan White CARE Act Title II Manual Section VII, p. 3. (Note: Title II Manual is still in use and used for Part B.)

Connecticut Department of Mental Health and Addiction Services (DMHAS), the Connecticut Department of Correction (DOC), the Center for Interdisciplinary Research on AIDS (CIRA), Ryan White Parts C and D, and the Connecticut AIDS Education and Training Centers (CAETC), as well as consumers and providers from across the state. This report reflects the input of all these stakeholders.

Process: The SCSN incorporates HIV and AIDS surveillance data, data from the 2010 Needs Assessment process, and additional data and needs assessment information provided by planning bodies and organizations. HIV/AIDS surveillance data is collected by the Connecticut State Department of Public Health HIV/AIDS Surveillance Unit. The Statewide Needs Assessment data is based on a survey administered to People Living with HIV/AIDS (PLWHA) who are in-care across Connecticut. This report is used as a basis for the development of *key outcomes* to be incorporated into the Statewide Comprehensive Plan for HIV Care and Prevention and measured by all entities in the state receiving Ryan White assistance.[4] The SCSN takes into consideration the following HRSA recommended steps:

- Data on HIV cases and AIDS cases is provided through the Connecticut HIV/AIDS epidemiological report. Needs of PLWHA are assessed through the needs assessment results, information provided by planning partners such as focus groups, surveys, planning councils, key informant interviews, Youth Advisory Group interviews and focus groups, and supplementary data from the New Haven EMA and Hartford TGA, Parts, C, D and F, and addressed through mechanisms such as funding and quality assurance.

- Existing available services: The CHPC collaborates with 211 Infoline to create a statewide resource inventory of public and private providers.[5] In creating the Service Matrix, an inventory of resources, the partners considered the total Ryan White resources in the state (Parts A-D), both in the amount of funds and the services being supported by these funds, as well as CDC prevention funds and services, Housing Opportunities for Persons with AIDS (HOPWA) and State AIDS Housing funds.

- Total Ryan White HIV/AIDS Program Resources – the SCSN considers both the amount of funds and the services provided for both care and prevention on a statewide basis.

- Unmet Need and Core Medical Service gaps.[6] Connecticut is providing the estimated unmet need based on viral load data. Electronic reporting of all viral load tests has been in place in CT since 2006.

- Key environmental considerations that impact the HIV/AIDS epidemic and emerging trends are also presented (e.g., housing, poverty).

[4] See Ryan White Treatment Modernization Act 2006, Section 2617 (b)(5) wherein legislation now requires the comprehensive plan to include, "key outcomes to be measured by all entities in the State receiving assistance under this title…"
[5] Note: A partnership with 211 Infoline (since June 2006) allows for an updated service guide and comprehensive list of all services available to PLWH in the state of Connecticut. This list includes contact information, addresses, and hours of operation. The service list is updated in collaboration with DPH and maintained on a regular basis by 211 Infoline.
[6] See May 20,2011 communication from HRSA notifying Part B to update their SCSN with guidance according to the Modernization Act of 2006, the President's reauthorization principles and the National HIV/AIDS Strategy (NHAS): The expectations include: "A list of priorities identified, including addressing Unmet Need and Gaps in Core Medical Services."

Care and Prevention Integration

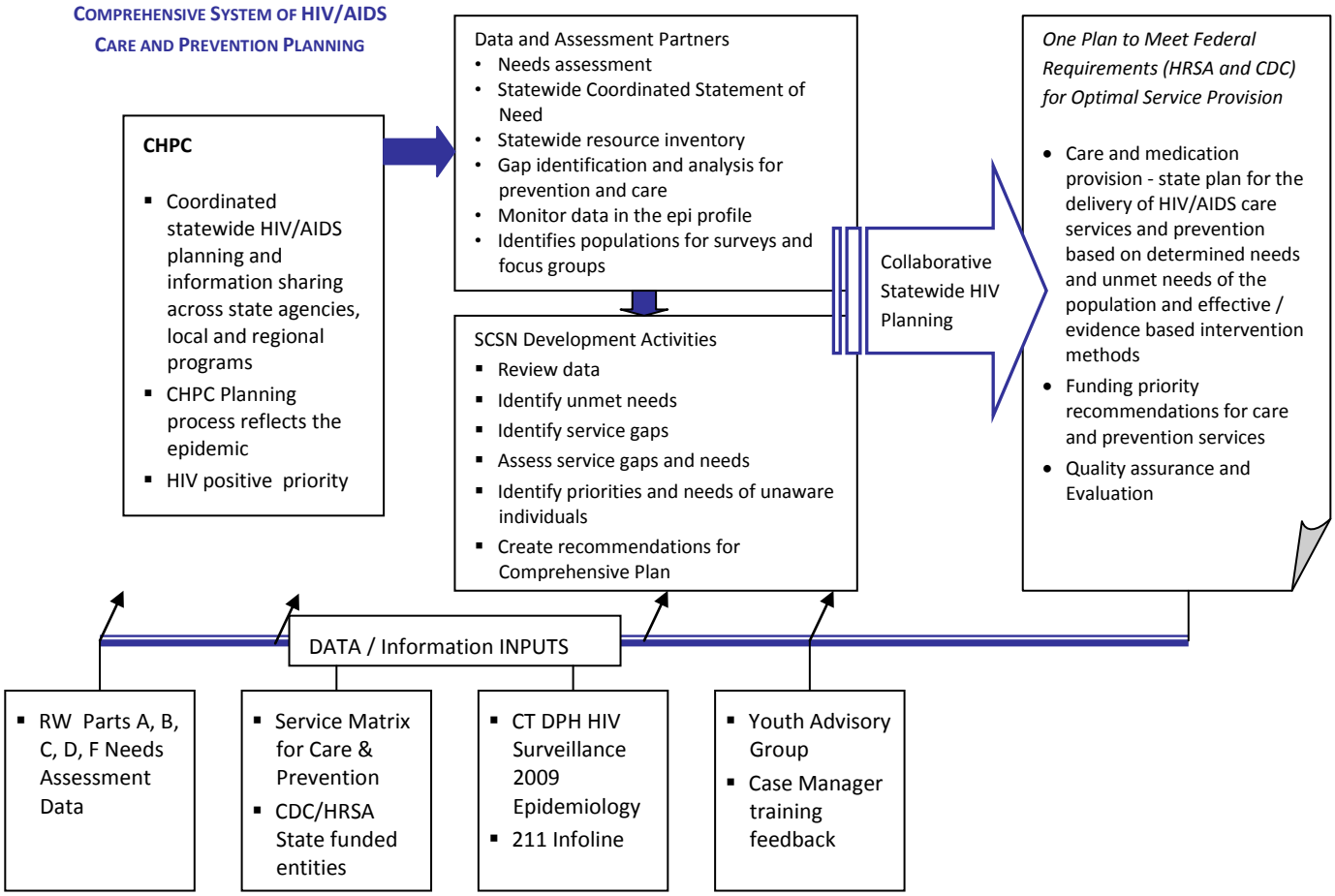
This document is the third SCSN report of the combined care and prevention planning body. The representative membership of the Connecticut HIV Planning Consortium (CHPC) fulfills both HRSA and CDC requirements for planning purposes. The Comprehensive Plan and this statement of need acknowledge that effective prevention means full engagement of the care community and effective care requires full engagement and collaboration with the prevention community. Incorporated within the SCSN is a process that reflects the shared vision of both care and prevention providers. These are detailed in the Comprehensive HIV Care and Prevention Plan. This SCSN represents a collaborative effort among Care and Prevention funded entities and PLWHA to accomplish the goals set forth in the Comprehensive Plan.

Prevention and care information are presented in each section. For example, under services used, information is provided for prevention with data given for the state by TGA, EMA and non TGA/EMAs (those counties not funded with Part A dollars). The presentation of the data in this format allows prevention and care providers and planning bodies to use the information specific to their area. In each section, a brief explanation is provided about the impact prevention may have on care and vice versa. The recommendations consider this impact and the importance of integrating and linking care and prevention services.

SCSN: The Development and Approval Process

The SCSN was developed through the efforts of the Connecticut Department of Public Health AIDS and Chronic Diseases Section Part B, in partnership with the CHPC. The CHPC was charged with the creation of the report and the identification of gaps in services. The CHPC, a fully integrated care and prevention planning group, tasked its Data and Assessment Committee (DAC) with gathering data, creating the report components, and developing a process to gain input and approval from the required partners.

The Committee first determined their data needs by reviewing existing available data. This included the State Epidemiological Report 2010, the 2010 Connecticut Statewide Needs Assessment, and the viral load reports produced by the HIV Surveillance Program.



SCSN Approval Process. The CHPC Data and Assessment committee is responsible for the completion of the SCSN and its approval. The following steps show in chronological order the process used for the development and approval of the 2011 and 2012 updated SCSN.

1. The CHPC Needs Assessment Survey conducted in January –March 2010.
2. CT Epidemiological Report issued in June 2010.
3. CHPC Data and Assessment Committee conducts the review and approval of SCSN data needs and process for input and approval – November-December 2010.
4. An SCSN overview presentation is provided at the CHPC meeting –June 2010.
5. DAC identifies gaps across care and prevention services May – July 2010.
6. DAC convenes work group to review the analyzed data, and identify key needs/issues for PLWH/A – Nov-Dec 2010.
7. SCSN work group reviews analyzed data, identifies key issues, makes proposed recommendations for the 2012-2015 statewide comprehensive plan – Nov-Dec 2010.
8. SCSN work group and DAC approve final review process and create a presentation for CHPC – December 2010.
9. SCSN sent to members and public for input and review – January 2011.

10. SCSN work group and DAC review input – January 2011.
11. CHPC votes on the SCSN at the February 2011 meeting.
12. CHPC re-convenes a SCSN workgroup to update the 2011 SCSN – February 2012
13. SCSN workgroup identifies specific stakeholders to update SCSN sections – February 2012
14. Recommendations from updated 2012 SCSN sent to DAC for approval – March 2012
15. DAC presents the updated SCSN to the CHPC for review and approval – April 2012
16. Updated 2012 SCSN is included in the CT Statewide Comprehensive Plan for Care and Prevention, 2012-2014 and submitted to HRSA and the CDC – June 2012

Service Gaps and Priorities for Connecticut:

The following information represents responses to the 2010 Statewide Needs Assessment from PLWHA. Analyses of responses were grouped by those living in the Hartford TGA, New Haven/Fairfield EMA and the non-EMA/TGA areas (rest of the state) to determine geographical differences. Findings from the 2010 needs assessment revealed no significant differences across the state except for where the New Haven/Fairfield EMA showed a higher need (19%) for dental services, and the Hartford TGA showed a higher need (18%) for Health Insurance Assistance.

Table 1. Connecticut Service Gaps, Priorities and Risk Behavior

Care Service Needs	Care and Support Service Needs	Barriers to Care
1. Dental care 2. Housing assistance 3. Help w/ health insurance 4. Emergency financial help 5. Other medical care help 6. Assistance paying for food	1. Most needed core service Dental 2. Most needed non-core service: Housing	1. Fear of revealing their status 2. Ability to pay 3. Housing 4. Income too high
Risk Behavior: In the 12 months post testing positive for HIV	**Prevention Service Needs**	**Barriers to Prevention Service**
• 10% reported having sex w/out a condom • 7% had unprotected sex w/ someone HIV positive • 7% injected drugs • 5% had unprotected sex w/someone HIV- • 5% had unprotected sex w/ some using drugs • 5% shared needles	Most Needed Services: • Support Groups with information on HIV prevention • Evidence Based Interventions (EBI) and Diffusion of Effective Behavioral Interventions (DEBI interventions) Most Used services: • Support Groups • EBI and DEBI interventions • Condom distribution & information • Comprehensive Risk Counseling Services • Partner services • Drug treatment services	Always and sometimes a problem • Transportation • Substance Abuse • Unaware of services • Don't know where to get services

II. HIV/AIDS Surveillance

Background

AIDS cases have been reportable in Connecticut since 1983. In 2002, HIV (non-AIDS) became reportable and in 2006 HIV viral load results were made reportable. In 2005, the Centers for Disease Control and Prevention (CDC) recognized Connecticut's HIV surveillance system as mature and began including Connecticut data in national analyses. Unmet need (PLWH that are out-of-care), was first calculated in 2003 based on a model established by a state with similar demographics. In 2005, Connecticut received technical assistance recommended by HRSA to develop an approved method for calculating statewide unmet need (Unmet Need Framework). In 2010, Connecticut began developing strategies relevant to Early Identification of Individuals with HIV/AIDS (EIIHA), an initiative that focuses on the identification individuals who are unaware of their HIV infection status. Connecticut's most current HIV surveillance data includes HIV cases diagnosed through the end of 2010 as reported through the end of 2011.

Table 2 represents the cumulative Connecticut data compiled in the most recent full calendar year.

Table 2. Summary of HIV surveillance data, Connecticut, 2011.[7]

Characteristics	Diagnosed 2010	PLWH	Total
Total (N)	407	10,537	19,821
Gender			
Male	71%	66%	70%
Female	29%	34%	30%
Race /Ethnicity			
White	34%	34%	36%
Black	39%	33%	35%
Hispanic	26%	32%	28%
Other	2%	1%	1%
Age group			
0-12 years	0%	0%	1%
13-19	3%	1%	1%
20-29	24%	5%	15%
30-39	21%	12%	39%
40-49	29%	33%	30%
50+	22%	49%	13%
Risk			
IDU	18%	42%	48%
MSM	44%	27%	26%
MSM/IDU	2%	2%	3%
Hetero	36%	27%	22%
Pediatric	0%	2%	1%
Other/Unknown	0%	0%	1%

[7] HIV surveillance information through December 31, 2010 has been updated using data reported through December 31, 2011 and is now available and accessible through the link to the HIV Surveillance Program home page. 2011 HIV surveillance information will be released in January 2013 to allow time for more complete reporting of cases diagnosed in 2011, de-duplication with other states, and reporting of deaths.

HIV/AIDS in Connecticut

In the thirty-year history of HIV in Connecticut, 19,821 cases of HIV infection have been reported with 9,284 (47%) deaths. Of the cumulative reported cases, 70% were male and 30% female, 36% white, 35% black, and 28% Hispanic. IDU represents the highest reported mode of transmission at 44%, followed by MSM at 23%, heterosexual at 19% and 13% in other or unknown categories (Table 1).

There were 10,537 people reported living with HIV infection (294 per 100,000) at the end of 2010 (Table 1). HIV prevalence is disproportionately distributed in Connecticut with the rate in males twice as high as females; six times higher in blacks than in whites; and five times higher in Hispanics than in whites. Rates in various demographic subsets are shown in Table 2. PLWH also tend to be older than the general population with 82% over the age of 40 (compared with 50% of the population). Only 6% of PLWH are under the age of 30 (compared with 39% of the population). IDU is the largest behavioral risk group in PLWH (36%). Heterosexual risk accounts for 22% of PLWH and 23% are MSM.

HIV is also disproportionate by geography with the largest cities having the highest numbers and prevalence rates. Hartford (N=1,926), New Haven (N=1,504), and Bridgeport (1,314) have a combined 45% of all PLWH but only 11% of the state's population. The combined prevalence rate in these three cities is 1,216/100,000, a rate 7.1 times higher than the combined rate in all other towns in Connecticut (179/100,000). The cities of Connecticut also have significant differences in distribution of risk profile with some cities predominantly IDU and others predominantly MSM. Hartford is 49% IDU and 13% MSM and Windham is 55% IDU and 14% MSM. Conversely, Greenwich is 50% MSM and 15% IDU, Milford is 49% MSM and 15% IDU, Wallingford is 49% MSM and 16% IDU, and West Hartford is 46% MSM and 18% IDU. No cities or towns have over 40% heterosexual risk.

People living with HIV/AIDS (PLWHA) Unaware of Their Status:

CDC estimates that, nationally, 21% of HIV infected people are unaware of their infection. This means that in Connecticut, with 10,537 confirmed PLWH, there are an additional 2,800 PLWH who are not aware of their infection. Nationally, the CDC has also reported that the percentage of PLWH who are unaware of their infection varies in different behavioral and demographic subgroups. For example, male PLWH are slightly more likely to be unaware of their status than female PLWH (21% vs. 18%, respectively). In other PLWH subgroups, 21% of blacks, 19% of whites,19% of Hispanics, 22% of MSM, 14% of male IDU, 14% of female IDU, 25% of male heterosexuals, 20% of female heterosexuals, 59% of PLWH aged 13-24, and 11% of PLWH 65 or older are unaware of their positive HIV status (MMWR; June 3, 2011; Vol. 60, No. 21).

- Hartford TGA: Of the estimated 4,546 PLWH in the Hartford TGA, 3,592 are aware of their infection and 954 are unaware.
- New Haven EMA: Of the estimated 7,646 PLWH in the New Haven EMA, 6,041 are aware of their HIV infection and 1,606 are unaware.

Recently Diagnosed: Connecticut HIV/AIDS

During 2006 – 2010, 2,061 HIV cases were diagnosed in Connecticut. Of these, 71% were male, 30% were female; 32% white, 37% black, 30% Hispanic, 1.2% Asian, and 1% other or multiracial; <1% were under 13 years of age, 13% were 13-24, 76% 25-54, and 11% 55+ years of age; 41% MSM, 26% IDU, 2% MSM/IDU, 32% heterosexual risk, and less than 1% other or unknown. Table 1 shows the distribution of cases diagnosed in 2010.

- Trend in PLWH, diagnoses, death: During 2002 – 2010, the number of PLWH increased from 8,741 to 10,537, and increase of 21%. The number of diagnosed with HIV decreased from 834 to 407, a decrease of 51%. The number of deaths in people with HIV infection decreased from 320 to 182 per year. During 2003-2007 the underlying cause of death in people with HIV infection was HIV disease (59% of deaths), cardiovascular disease (9%), drug overdose (5%), lung cancer (3%), and numerous other causes at less than 3% per cause.

- Trend in sex: During 2006 – 2010, the number of males ranged from 252 to 329 with no discernible trend and the number of females ranged from 91 to 145 with no discernible trend.

- Trend in race/ethnicity: During 2006 – 2010, the number of white HIV cases ranged from 102 to 149. The number of black HIV cases ranged from 137 to 158 with no discernible trend. The number of Hispanic cases ranged from 93 to 164 with no discernible trend.

- Trend in risk group: During 2002 – 2010, the number of IDU decreased from 395 to 76 with the number of MSM ranging from 141 to 219 with no discernible trend and the number of heterosexual decreasing from 250 to 148.

Monitoring progress towards National HIV/AIDS Strategy goals

CDC has provided state HIV surveillance programs with analysis tools with which to monitor progress towards the National HIV/AIDS Strategy goals. This system will enable the DPH HIV Surveillance Program to provide information about subsets of PLWH who may benefit from additional case management or HIV medication adherence services.

- **HIV viral load suppression**: Of the 10,052 HIV cases included in the analysis who were over 13 years of age, diagnosed by the end of 2009, living through the end of 2010, and who had at least one viral load test during 2010, 76% were categorized as having HIV suppression (<200 copies per ml). This percentage varied by age from 52% of 13-24 year olds to 88% of those 65 or older; 72% of blacks, 73% of Hispanics, and 83% of whites; 81% of MSM, 73% of IDU, and 75% of heterosexuals; and, 77% of males and 73% of females.

- **PLWH in care**: Of the 10,052 HIV cases included in the analysis who were >13 years of age who were diagnosed by the end of 2009 and living through the end of 2010, 65% had at least one care visit during 2010, 53% had two or more care visits at least three months apart. A care visit

is defined as the report of a HIV VL or CD4 to DPH during the period specified. Percentages having at least one care visit ranged from 63% to 73% among the various demographic and behavioral subsets.

- **Newly diagnosed linkage to care**: Of the 405 newly diagnosed HIV cases in 2010 who were over the age of 13 years, 85% were linked to care within three months, 89% within six months, and 92% by one year after diagnosis. The three-month percentages are notably different for blacks 79% vs. whites 95%, 85% in heterosexuals vs. 91% in IDU; 76% in 13-24 year olds and 100% in those 65 or older.

Estimating the prevalence of HIV in MSM

Although prevalence rates have not previously been calculated for behavioral risk groups because the denominators are unknown, CDC has recently released an estimate that 4% (95% CI: 2.8%-5.3%) of males over the age of 12 have had sex with males in the last five years. Using this estimate, 55,000 males in this age range in Connecticut are MSM. With 2,261 HIV-positive PLWH who are MSM an estimated 4% of MSM in Connecticut are HIV-positive (4,100/100,000).

Late testers

High proportions of newly diagnosed HIV infection cases continue to have AIDS at or soon after their initial diagnosis suggesting that they are 'late' in disease progression. Of the 468 HIV cases diagnosed in 2007, 27% of cases met the criteria for AIDS at diagnosis and an additional 7% became AIDS by 12 months after diagnosis.

HIV incidence

DPH participates in the national HIV Incidence Project, providing remnant HIV specimens for incidence testing. Results from the latest estimation (2011) indicate the number of HIV infections in Connecticut was 418 (95% CI: 238, 597) in 2006, 475 (292, 659) in 2007, 350 (168, 533) in 2008, and 402 (168, 637) in 2009 with no discernible trend. Due to small cell sizes in the estimation process, there are large confidence intervals around these estimates.

HIV resistance variants

DPH participates in the Variants Atypical and Resistant HIV Surveillance (VARHS) project and collects the DNA sequence in the pol region of the HIV genome for newly diagnosed cases that receive the test within three months of diagnosis. Since 2008 when the project was begun, 151 sequences have been selected for analysis. Of these, 20 (13%) were resistant strains with 18 (12%) resistant in one class, one (1%) in two classes and one (1%) in three classes of medication.

Sexually transmitted diseases

In 2009, 14,753 total reported cases of chlamydia, gonorrhea and syphilis were reported. High numbers of chlamydia and gonorrhea cases in older teens and younger adults, particularly in minority populations, have been reported in Connecticut in recent years suggesting the persistence of

unprotected sexual activity and the inherent potential for HIV infection. Similarly, the connection between MSM and both syphilis and hepatitis A and B both nationally and in Connecticut, suggests resurgence in high-risk behavior in MSM.

- Syphilis: Early syphilis (primary, secondary and early latent) causes significant complications if left untreated and facilitates the transmission of HIV. Prior to 2000 the incidence of syphilis had been decreasing to low levels. Since then there has been a reemergence of syphilis. Since 2001, syphilis cases have been predominantly in MSM. The percentage of male syphilis cases that were MSM increased from 2% in 1995 to 96% in 2002. Since 2002, the percentage of male cases with known MSM risk has ranged from 79% to 89%. HIV testing is offered to all syphilis cases. During 2002-09, of the 301 MSM syphilis cases tested for HIV, 108 (36%) have tested HIV positive, ranging from 23% to 48% each year.

- Chlamydia and gonorrhea in Connecticut youth: In 2009, more than 2 out of 3 chlamydia cases (71%) and more than half of gonorrhea cases (59%) were among young people ages 15-24, with the majority in black and Hispanic populations.

Risk behavior in Connecticut youth

The 2009 Connecticut School Health Survey was completed by 2,392 high school students (grades 9-12) in 48 public schools. The percentage of students who were currently sexually active ranged from 14% in 9th graders to 55% in grade 12. Twenty-five percent of students who were sexually active reported using alcohol or other drugs during their last sexual experience and 60% reported using a condom the last time they had sexual intercourse.

Hospitalization of PLWH

DPH Vital Records Section provides information on the trends in hospitalization for PLWH. During 2002 – 2008, the number of hospitalizations with HIV as the first discharge code decreased from 857 in 2002 to 554 in 2008; a decrease of 35%. The total count of hospitalizations where HIV was in the top ten discharge codes was 3,583 in 2002 and 3,417 in 2008.

Hepatitis C

During 2004–2011, 203 acute (recent) hepatitis C cases were reported in Connecticut. Of the 177 cases for which risk information was obtained, 128 (72%) had a history of IDU or street drugs. Importantly, of the 128 HCV-positive IDU, 53% were under the age of 30 and 8% under the age of 20. Seventy-nine percent were white, 18% Hispanic, and 3% black/other. Presence of HCV in IDU is an indication of sharing drug using equipment and suggests ongoing prevention measures will be needed, especially in youth.

Perinatal HIV

In 1993, HIV infection in children less than 13 years of age was made reportable to the Connecticut Department of Public Health. During 1993–2010, 1,000 newborns were exposed to HIV at delivery in

Connecticut (average=56/year). Of these, 932 (93%) were reported with a final HIV status and of these 63 (7%) have been reported to be infected with HIV.

In 1999, Connecticut implemented legislation requiring HIV testing to be offered to all pregnant women on entry into prenatal care in the first trimester with the offer of a second test in the third trimester. If the woman declined testing, the law required testing to be offered at delivery. If testing was again declined then HIV testing became mandatory for the newborn. Testing legislation increased the prenatal testing rate from 28% before implementation to 95% after. Prior to the HIV testing legislation (1993–1999), 55 (14.0%) of exposures resulted in infection and after (2000–2010), 8 (2%) infections were reported.

Of the 63 children with perinatal infection, 11 (18%) were reported dead by 2010. By race/ethnicity, 21 (33%) were Hispanic, 32 (51%) black, and 10 (16%) white. By city of residence at birth, 17 (27%) resided in Hartford, 12 (19%) in New Haven, nine (14%) in Stamford, six (10%) in Bridgeport, four (6%) in Waterbury and 13 (21%) in 13 other towns. Although the increased prenatal testing rate ensures timely identification and treatment of HIV-positive pregnant women, there were also improvements in treatment during the same period that contributed to prevention of perinatal transmission. Successful prevention of perinatal HIV infection demonstrates the potential for testing and treatment to effect reduction in HIV transmission generally.

III. Needs Assessments and Other Data

a) 2010 Statewide Needs Assessment Survey

In 2010, the State conducted a collaborative statewide needs assessment using a survey tool that targeted in-care People Living with HIV/AIDS (PLWHA) in Connecticut. This approach differed from the 2008 needs assessment processes where the two Part A Planning bodies conducted their own needs assessments in their respective areas. The 2010 needs assessment included Parts A, B, C, D, F, CADAP, and Prevention. The survey was developed by the DAC and implemented via a CADAP mailing and Part A & B and prevention funded providers using trained survey implementers.

Over 2,400 English and Spanish needs assessment surveys were distributed to 34 Ryan White and prevention funded providers, and to all CADAP recipients. Over 1,600 surveys were returned and 1,198 surveys were deemed valid and analyzed by CT DPH. 99% of respondents were shown to be in care by HRSA standards, 96% received care in the last 12 months, 98% received a CD4 count within last 12 months, and 98% received a Viral Load test in last 12 months.

Table 3. 2010 Statewide Needs Assessment Survey Demographic Results

Gender	N	%		Year of Birth	%		Race/Ethnicity	%
Male	757	63.19%		19-29	3.9		White	32%
Female	426	36%		30-39	10		Black/African Amer.	34%
Transgender	5	0.42%		40-49	39.6		Hispanic	30%
				50 and over	46.3		Other	4%
Sexual Orientation	**%**						**Source**	**%**
Heterosexual	65%						Litchfield	2%
							New London	7%
Gay	25%						Hartford	25%
							Middlesex	2%
Bisexual	6%						Windham	6%
Other	3%						New Haven	29%
Lesbian	2%						Tolland	2%
							Windham	6%
							Fairfield	27%

Percent of Respondents in Care Receiving Services

Of the individuals surveyed, ninety-six percent (96%) have received medical care for their HIV within the past 12 months. Respondents also reported using the following healthcare and support services in the past 12 months: medical care (84.6%), medical case management (72.6%), medication adherence (23%), CADAP (60%), medication payment other than CADAP (38%), outpatient substance abuse (22%), mental health (38.8%), dental services (54.7%), hospice (3.7%), home health care (7.8%), help paying for insurance (22.8%), early intervention services (26%), personal care/medical equipment (7%), meal planning/nutritional supplements (11.2%), childcare (2.5%), emergency financial help, (27.6%), housing (20.8%), food assistance (44.6%), legal assistance (12.1%), medical transportation (30.8%), interpretation services (10.1%), peer support groups (20.7%), and inpatient substance abuse services (8.6%). Twenty-six percent (26.5%) reported that they pay for their medical care with Medicaid/Title 19 funding.

Survey Respondent Service Needs

Of the 1,198 survey respondents:

- 18% need help with dental care
- 18% need housing assistance
- 16% need help paying for health insurance
- 16% need emergency financial help
- 12% need help with other medical care
- 12% need assistance paying for food

Care and Support Service Needs and Uses

Of the 1,198 survey respondents:

- Most used service: Primary Care (85%)
- Least used service: Child Care (3%)
- Most needed core service: Dental (18%)
- Least needed core service: Home Health Care (2%)
- Most needed non-core service: Housing (18%)
- Least needed non-core service: Child Care (2%)

Problems reported: Survey respondents reported that the problems they face the most include: fear of revealing their status (19%), ability to pay (15%), housing (13%) and their income being too high (12%).

In the 12 months after testing positive for HIV:

- 10% reported having sex w/out a condom
- 7% had unprotected sex w/ someone HIV positive
- 7% injected drugs
- 5% had unprotected sex w/someone HIV negative
- 5% had unprotected sex w/ some using drugs
- 5% shared needles

Table 4. 2010 Needs Assessment Preventions Service Needs and Barriers

Prevention Service Needs		Prevention Service Barriers	
Most Used services:	**Most Needed Services:**	**Always a problem**	**Sometimes a problem**
• 42% Support Groups • 36% Condom distribution & information • 28% Comprehensive Risk Counseling Services • 25% Services that help your partner his/her risk • 20% Drug treatment services • 16% Specific prevention programs (DEBIS, EBIS)	• 7% Specific prevention programs (DEBIS, EBIS) • 6% Support Groups with information on HIV prevention	• 8% Transportation • 6% Substance Abuse • 5% Unaware of services • 5% Don't know where	• 26% Transportation • 16% Unaware of services • 13% Don't know where • 12% Substance Abuse

Needs Assessment Identified Needs (Gaps) and Barriers in Services

The 2010 survey provided a positive picture of the way in which CT is providing services to individuals living with HIV who are in care. No significant gaps were noted but areas of need are identified below.

Needs: The preliminary care and prevention service needs/gaps for PLWH/A as confirmed by the 2010 needs assessment for the two Part A areas and the rest of Connecticut are: (**1) core medical services:** dental care (particularly in New Haven/Fairfield EMA), health insurance continuation, AIDS pharmaceutical assistance, substance abuse-outpatient and mental health; **(2) support services:** food bank, housing-related services, emergency financial assistance, and assistance with other medical care, and **(3) prevention related:** prevention support services, risk reduction services/information, counseling and testing, partner services, early identification of individuals unaware of HIV status and linkage to medical and support services, and referral to specific Diffusion of Effective Behavioral Services (DEBIs) and Evidence Based Interventions (EBIs).

According to the Needs Assessment Survey, 66% of PLWHA respondents are not using partner services and 57% are not using risk reduction services - showing a need for prevention for positives to reduce infections and co-infections. Other items that have been identified as needing further investigation and action based on community input at recent CHPC meetings include: National HIV/AIDS Strategy, Early Identification of Individuals with HIV/AIDS (EIIHA), New Haven Fairfield EMA study on Quality Assurance, Hartford TGA information and focus group data, CDC prevention scenarios report, input from the Center for Interdisciplinary Research on AIDS (CIRA), Cross Part Collaborative information and statewide QM initiatives, recommendations from the CT HIV/AIDS Identification and Referral (CHAIR) group, information, and service delivery needs and gaps for undocumented/migrant workers and the transgender population.

Barriers: Barriers to accessing services include inability to pay, fear of revealing status, housing and income too high to qualify. For those individuals identified as out-of-care, barriers to care reported in 2002, 2008 and 2010 documents were the same: barriers of transportation, fear, distrust, lack of knowledge of services, homelessness, lack of insurance and substance abuse and mental health issues.

Although Connecticut has a broad information base (electronic, web and print), ample room exists for improving social marketing, promoting innovative strategies and interventions and the use of technology to affect behavior change, address barriers to care and disseminate information about care and prevention service provision and service availability throughout Connecticut. HIV prevention and care services continue to address the emerging needs associated with specific target populations as prioritized by the CHPC. The DPH and CHPC are continuing to improve cross training among HIV/AIDS medical case managers, risk counseling and outreach, testing and linkage (OTL) workers as well as partner services, strengthen primary and secondary prevention efforts and provide training regarding HIV, the medical case management model and HIV resources for medical providers. Marketing and information dissemination efforts continue through multiple activities and venues. The Membership and Awareness Committee continues its education outreach in areas of Connecticut that are underrepresented at the CHPC monthly meetings, and has improved the quality and quantity of information in its quarterly newsletter.

Outreach and Education Focus Group Information

CHPC's Membership and Awareness Committee (MAC) and Data and Assessment Committee (DAC) developed questions for consumers as part of its education and outreach activities conducted through the MAC recruiting efforts. Informal conversations introduced the consumer population to the CHPC. The following information should be considered anecdotal (not statistically significant) and used to corroborate the information of the needs assessment.

Needs identified:

- Help with living expenses (e.g., housing, EFA)
- Transportation
- Services for youth

Barriers identified:

- Fear, embarrassment (stigma)
- Homelessness

b) Part A: New Haven/Fairfield EMA & Hartford TGA

This section discusses the needs and plans to address the needs identified by RW Part A Programs in Connecticut. Part A provides emergency assistance to Eligible Metropolitan Areas and Transitional Grant Areas that are most severely affected by HIV/AIDS.

Connecticut continues to maintain two Ryan White Part A programs – the Greater Hartford Transitional Grant Area (TGA), consisting of Hartford, Middlesex and Tolland Counties, and the New Haven/Fairfield Eligible Metropolitan Area (EMA), comprised of New Haven and Fairfield Counties. Both Grantees maintain funding for core medical and support services.

New Haven/Fairfield EMA

In 2010, the New Haven/Fairfield EMA released a special study on the Newly Diagnosed population[8]. The purpose of the survey was to 1) determine factors that lead to delayed entry into HIV treatment and 2) to use the Newly Diagnosed as a cipher for identifying who might be HIV positive but unaware of their HIV status. In 2011, the New Haven/Fairfield EMA developed an Early Intervention Services program to address the EMA's unaware estimate. The Planning Council, in collaboration with the Ryan White Office, developed an Early Intervention Program based on Unaware Specialists. Unaware Specialists are available in each region to coordinate a multi-disciplinary team to identify people of color and others who don't know they are HIV+ and link them to care.

In 2012, the New Haven/Fairfield EMA will conduct two studies to further inform care patterns for two of the EMA's special populations: foreign born and men who have sex with men. Additionally, the EMA is conducting a study analyzing why and how PLWHA return to care after being out of care.

The target sample will be 185 PLWHA or roughly 60 per survey group. 1) *Survey Research:* Conduct surveys of 60 MSM (Males having Sex with Males) and 60 Out of Care returned to care. 2) *Pathway to Care research*: update 2008 and 2009 analysis of pathways to care for all three subgroups with emphasis on date of diagnosis, entry into HIV medical care, use of services to enter and remain in care and for Out of Care returned to care, services and reasons they returned. 3) *Focus Group on Foreign Born*: conduct focus groups at eight (8) provider sites in all five (5) regions known to have a significant number of foreign born clients.

Results from the studies will:

1. Further refine Pathways to Care (sequence of service entry for newly diagnosed to entry into Outpatient/Ambulatory Medical Care and return of Out of Care to care);
2. Emphasize two groups known to comprise high volumes of newly diagnosed (young MSM of color and foreign-born) to further inform Early Intervention Services and detail to enlighten EIS and Outreach on return of out of care to care; and

[8] www.ryanwhitecare.org.

3. Integrate data from the 2011 Chart Review cross-tabbed to both survey results and focus group findings.

4. Be used to inform the New Haven/Fairfield EMA's FY 2013 Priority Setting and Resource Allocation process

5. Be used to inform the New Haven/Fairfield EMA's FY 2012 Comprehensive Plan

Table 5 shows New Haven/Fairfield FY 2012 allocation

Table 5. New Haven/Fairfield FY 2012 allocations

Service Categories		Service Categories	
Core		**Non-Core**	
Outpatient/Amb. Medical Care	$ 1,043,961	Housing Assistance	$ 300,523
Medical Case Management	$ 1,256,802	Substance Abuse (Inpatient)	$ 460,111
Substance Abuse (Outpatient)	$ 949,454	Medical Transportation	$ 100,060
Mental Health	$ 675,729	Emergency Financial Assist.	$ 189,286
Oral Health Care	$ 98,027	Food Bank/Home Del. Meals	$ 253,445
AIDS Pharmaceutical	$0		
Health Insurance	$ 42,481		
Early Intervention Services	$ 183,138		
Total Expenditures			**$ 6,532,956.00**

New Haven/Fairfield Planning for FY 2012

New Haven/Fairfield will allocate all Minority AIDS Initiative (MAI) funding ($461,769) in FY 2012 for Early Intervention Services. In the past MAI funds have been split among medical support, substance abuse, outpatient services, mental health services and services for MSMs. In FY 2012 all MAI funds will be used to identify people unaware of their HIV status in connection with the National HIV Strategy and EIIHA.

Hartford TGA

In 2009, the Hartford TGA commissioned a study of the Early Intervention Services (EIS). The study, conducted by Philips Solutions, examined the effectiveness of the services in reaching and engaging individuals who have fallen out of care, new to care and those who have never entered the care system. Following are the recommendations submitted to enhance the current EIS model for the TGA:

1) **Re-Align Service Definition**: For FY 2011 create and update service definition to cover HIV testing, referral services, linkage to care and health education and literacy focused on originating at key points of entry through the use of linkage agreement and memorandum of understandings (MOUs) to help speed entry into care services.

2) **Outreach Services**: Consider the use of outreach services to address the concerns of the RARE study and the need to reach high risk populations in North and South Hartford.

3) **Service Needs Strategy**: The Planning Council should consider the out-of-care populations as five (5) distinct groups[9] with different needs and work to develop strategies that address the service needs and understanding of the importance of medical care.

4) **Points of Entry Relationships**: The council should attach directives for EIS that forge relationships with important key points of entry that are currently not covered by the current providers. Suggestions based on the results of this study include hospital emergency rooms, STD clinics, jails and prisons, blood/plasma banks and local health departments.

5) **Reducing No-Shows**: The council should develop directives targeting EIS services toward testing sites in an effort to reduce the no-show rate which is also related to the unmet need rate in the state. This would result in the use of EIS for both case findings and patient navigation.

6) **Program Service Models**: The council should consider directives and standards of care that can enhance the use of models of care services that involve the use of peers in the delivery of program services.

7) **Departmental Continuity**: The council should work on ways to develop better collaboration and coordination between EIS, primary medical care and medical case management.

Hartford TGA strategies and priorities for 2012. The TGA's strategy to identify individuals will be bolstered in 2012 through prioritizing EIS services and expanding its collaborations with HIV identification and engagement services, such as Partner Services and improved coordination with other HIV counseling and testing programs at key points of entry.

In April 2011 Hartford TGA held eight (8) focus groups for in and out of care PLWH. Of the 63 total participants, 19 were out of care for more than six (6) months. 73% said that they are getting the help they need 27% reported that they had or are having problems getting the help they need. Housing was the need that is most often not being met. Other barriers included getting medical care, dental care, case management, transportation, glasses, durable medical products, substance abuse/mental health support groups.

[9] The five groups include: unmet need, newly diagnosed, slightly linked to care, late to care, and unaware.

Table 6 shows Hartford's FY 2012 allocations

Table 6. Hartford TGA FY 2012 Allocations by Service Category

Service Category	Base Award	MAI	Total
01 Outpatient/Ambulatory Health Services	$ 740,266	$ 125,133	$ 865,399
03 Medical Case Mgt (incl Treatment Adher)	$ 786,738	$ 67,623	$ 854,361
05 Mental Health Services	$ 147,495	$ -	$ 147,495
06 Early Intervention Services	$ 161,871	$ -	$ 161,871
07 Oral Health Care	$ 110,246	$ -	$ 110,246
08 Substance Abuse Services - Outpatient	$ 180,493	$ -	$ 180,493
10 AIDS Pharmaceutical Assistance (local)	$ 50,000	$ -	$ 50,000
14 Health Ins Premium & Cost Sharing Assist	$ 33,292	$ -	$ 33,292.
02 Housing Services	$ 255,386	$ 33,498	$ 288,884
04 Medical Transportation Services	$ 136,126	$ -	$ 136,126
09 Emergency Financial Assistance	$ 33,875	$ -	$ 33,875
11 Food Bank/Home-Delivered Meals	$ 79,622	$ -	$ 79,622
12 Case Management (non-Medical)	$ 102,809	$ -	$ 102,809
13 Legal Services	$ 31,705	$ -	$ 31,705
16 Linguistic Services	$ -	$ 12,633	$ 12,633
25 Clinical Quality Management	$ 167,641	$ 14,052	$ 181,693
26 Administration	$ 335,283	$ 28,104	$ 363,387
TOTAL	**$ 3,352,848**	**$ 281,043**	**$ 3,633,891**

c) Parts C and D

Part C provides comprehensive primary health care in an outpatient setting for people living with HIV disease. The general service priorities for 2011-2012 across Part Cs in CT include: outpatient and ambulatory health services, Early Intervention Services (EIS), medical nutrition therapy, mental health services, behavioral health/substance abuse outpatient care, medical case management, including treatment adherence services, and prevention outreach. Beginning in 2012, Part C providers (e.g. Community Health Centers) will play a vital role in a continuum of health care delivery as medical homes for PLWHA, particularly in light of the roll-out of the Affordable Care Act in 2014.

Part C Goals[10] for 2012 include:

1) Improving access to health care by expanding availability, particularly to underserved, unaware, vulnerable, and special needs populations
2) Conducting outreach, education and counseling and testing activities to enroll new HIV positive patients
3) Ensure continued engagement in the HIV service and care delivery system for all existing EIS patients
4) Provide comprehensive adherence counseling for patients in need
5) Refer to oral health care services
6) Provide HIV-specific nutrition counseling for active HIV positive patients
7) Provide integrated out-patient substance abuse treatment to HIV positive patients
8) Provide comprehensive mental health counseling services to HIV positive patients
9) Conduct formal performance improvement (PI) activities focused on clinical outcome measure for HIV care annually

In Connecticut, the HIVQUAL Consultant assigned to Ryan White Part C and D has provided quality improvement projects on transitioning youth living with HIV into adult care (priority for Part D providers) and on patient no-show rates/patient retention.

Part D provides family-centered care involving outpatient or ambulatory care for women, infants, children, and youth (WICY) with HIV/AIDS. The Community Health Care Association of Connecticut (CHCACT) is the Part D grantee for the state and allocates funding to the participating health providers of the Children, Youth and Family AIDS Network (CYFAN). Women of child bearing age (through age 44) continue to comprise the majority of WICY patients; they are also the fastest growing segment of the WICY population. The largest increase in this patient population has been in the Greater Hartford area.

The following are programs operating under Part D services:

- **Transitioning Youth Living With HIV/AIDS Into Adult HIV Services:** CHCACT is currently matched with a consultant from the RW Part C/D HIVQUAL Project to facilitate a clinical quality workgroup addressing the topic of adolescent/youth transition into adult HIV services across Connecticut.
- **Patient Retention:** CHCACT is matched with a consultant from the RW Part C/D HIVQUAL Project to facilitate a clinical quality workgroup addressing the topic of patient retention in HIV/AIDS care and treatment services throughout Part D program sites. The workgroup is currently using the HRSA definition(s) for patient retention to establish baseline data reporting and is creating a revised definition of "patient retention" for further examination.
- **Increasing Efforts in the area of Nutritional Counseling:** CHCACT in the 2009/10 RW Part D program year was encouraged by HRSA to increase partner agency capacity in the area of Nutritional Counseling for women, infants, children and youth living with HIV/AIDS. We continue to provide this service through the participating CYFAN providers.

[10] The goals were compiled from two Part Cs and do not reflect goals from all Part C grantees across Connecticut.

Ryan White Part D Patient Outcomes consistent with the SCSN:

1. Encourage community health center partners to make HIV testing a more routine part of primary care services.
2. Provide training and continuing education for medical practitioners on risk assessment and risk reduction, secondary prevention and available HIV care and prevention services.
3. Continue training Medical Case Managers (MCMs) on the medical model and clinical practices, and explore creative ways to inform and educate MCMs of available resources, services, and relevant issues: The CHCACT work plan addresses MCM training to coordinate primary medical care to improve the health and well-being of persons living with HIV/AIDS.

d) Prevention – Department of Public Health

CHPC Target Populations: Setting Priorities. As a combined planning group addressing both prevention and care, the CHPC is charged to identify the highest risk populations and a set of interventions for each population. As required by CDC guidance, the CHPC must vote on the recommended priorities. The DPH uses these approved priorities to develop RFPs and guide funding allocations. The Data and Assessment Committee uses a similar process as the needs assessment development, i.e., identify persons representing Ryan White-funded planning groups, organizations, and recipients (clients) who will share the task of creating a defendable model to create a process for assessing the needs of Connecticut's population living with HIV/AIDS and to link the highest risk populations with a set of interventions for each identified population. (Refer to 2010-2011 Updated Comprehensive Plan for more information.)

On July 21, 2010, the CHPC voted on the following priority populations and interventions:

1. Priority Populations

1. HIV positive
2. White MSM
3. Black Heterosexual
4. Black IDU
5. Hispanic IDU
6. Black MSM
7. Hispanic MSM
8. Hispanic Heterosexual

2. Recommendation: CHPC recommends Counseling, Testing, and Referral Services, OR HIV Testing, and Partner Services as required components for all funded interventions. CHPC also recommends Comprehensive Risk Counseling Services and Syringe Exchange Services for use with priority populations.

3. Selected Interventions by Risk Category (priority populations)

Interventions	HIV positive	White MSM	Black Hetero	Black IDU	Hispanic IDU	Black MSM	Hispanic MSM	Hispanic Hetero
CLEAR	✓							
Explore		✓					✓	
Healthy Relationships	✓							
Holistic Health Recovery Program				✓	✓			
Many Men Many Voices						✓		
Modelo de Intervención Pesicomedica					✓			
MPowerment		✓				✓	✓	
Partnership for Health	✓							
Popular Opinion Leader		✓	✓			✓	✓	
PROMISE		✓	✓	✓	✓	✓	✓	✓
RAPP			✓					✓
Safety Counts				✓	✓			
SHIELD				✓	✓			
SISTA			✓					
Sister to Sister			✓					
TLC	✓							
Willow	✓							

e) Part F – CT AIDS Education & Training Center

Part F provides funds for a variety of programs including the Connecticut AIDS Education and Training Centers Program (CAETC). CAETC supports a network of 11 regional centers and several national centers that conduct targeted, multidisciplinary education and training programs for health care providers treating people living with HIV/AIDS. The CAETC provided a total of 336 trainings (Levels I, II, III, IV and V – see explanation below) in Fiscal Year 2010-2011.

CAETC is located at the Yale University School of Nursing in New Haven, Connecticut, is a federally-funded program through the U.S. Department of Health and Human Services and part of a nationwide network of fifteen regional education centers established in 1987. CAETC is a satellite of the New England AIDS Education and Training Center (NEAETC), University of Massachusetts.

CAETC's mission is to conduct targeted, multidisciplinary trainings for health care providers, to disseminate information on a variety of clinical issues, and to develop HIV provider materials. The goal is to ultimately enhance the competence and willingness of health care providers to diagnose, treat, and manage HIV infection and to offer interventions that will decrease the further spread of HIV infection.

- Level I Didactic Presentation (54)
- Level II Skills Building (5)
- Level III Clinical Training (0)
- Level IV Group Clinical Consultation and Level IIV Individual Clinical Consultation (128)
- Level V Technical Assistance (149)

Gaps: Identified gaps for CAETC include lack of access to dentists and dental hygienists, and local qualified trainers who can provide HIV and Oral Health Education. (Note: this correlates with the identified core service need of dental services particularly for the New Haven/ Fairfield area.)

Funded Approach: CAETC reached a total of 1,622 providers during the fiscal year July 1, 2010 to June 30 2011. Specifically: MDs (734), PAs (25), APRNs (202), RNs (184), Pharmacists (175), Dentists (69), Dental Assistants (26), Community Health Workers (20), Medical Case Managers &Others (187).

CAETC provided trainings in all 8 counties to hospitals, community health centers, ID clinics, substance abuse treatment centers, CT DPH, DMHAS, etc. (for complete list go to www.neaetc.org). Also, CAETC provided 2 programs for the Indian Health Services at The Mashantucket Pequot Tribal Nation.

The budget for Fiscal Year 2010-2011 was $170,000.

f) Youth Advisory Group

The Youth Advisory Group (YAG) is a group of young individuals (ages 15-19) recruited from across the state of Connecticut to work as a component of the Connecticut HIV Planning Consortium and represents the interests of youth across the state. The YAG has been meeting for six years. The following recommendations created by the Youth Advisory Group on how to work with youth were included in the 2009-2012 Comprehensive Plan:

1. Give Youth All the Facts

Prevention. All young people need to know how to protect themselves. Abstinence-only education is not enough. We need to work against the taboo of talking about sex – there should be no sugar-coating of the facts. Information needs to be presented in a real way, not just using medical/clinical terms and statistics. What you learn about HIV prevention should not depend on where you live. Youth from suburban towns noted that parents and schools do not teach all the facts. Parents do not want to see problems ("HIV is not an issue in Fairfield") – but many young people in the suburbs are sexually active, and are engaging in risky behaviors.

With all education, the focus should be on quality – not just one-time events that reach lots of young people but do not change behavior.

Care. Provide youth with up-to-date and detailed information about STD/HIV prevention, medication, and care services for HIV-positive youth. The latter will empower and encourage youth to take more responsibility for their health care and related decisions.

2. Teach Adults How to Engage Youth

Prevention. This is a critical issue for parents, teachers and adults who work with young people.

a) Know the facts and how to engage young people. Teachers and youth workers should know the facts about HIV/AIDS and be trained in how to engage young people (e.g., facilitate effective group discussions, cultural competency). Many parents and teachers grew up before AIDS; they need accurate information.

b) Encourage questions. Adults should not judge youth or make youth feel bad about their decisions. Adults should encourage young people to ask questions, which after all are perfectly natural. There are no "stupid" questions, and young people should not feel stupid for asking about sex and about how to protect themselves.

c) Learn with young people. Promote co-teaching of information with a teacher and peer educator. If a teacher does not know the facts or answer to a question, acknowledge this and find out the answer together with the youth.

a) Promote parent-youth conversations. There need to be many conversations about these topics, not just one parent-child talk about "the birds and the bees." Expand programs like Real Life Real Talk that promote parent-youth dialogue, and other efforts to educate parents on HIV and STDs.

b) Be positive. Parents, teachers and adults should serve as positive role models and be positive in their approach. Encourage young people to learn the information and have the resources, not just for themselves but also to help their friends and peers.

Care. It is critical that programs that provide care have caring, respectful staff. Providers should explain the process step-by-step. Providers should be personable and friendly. "We want to be able to relate to providers." It helps to feel comfortable. It will lead to the development of trust. Several youth shared their negative experience of getting tested where the provider sat behind the desk with a clipboard marking down their answers. "We are more than a list of symptoms on a provider's checklist."

3. Start Younger

Prevention. Young people need to learn about HIV prevention before they become sexually active, which for some can be as young as middle school. At the elementary school level, students can learn about what STDs including what HIV and AIDS are, how to be healthy, and how to make healthy decisions. It is important to teach decision-making skills, which can apply to all health topics, so young people have tools to act on prevention information.

Care. Begin to introduce issues related to HIV when children are in elementary school. Staff can start by teaching children about germs and their body, in addition to teaching about self-esteem and decision making. Talking to HIV-positive youth at a younger age about the body, viruses and why people take medication could reduce the traumatic impact of disclosure. The group agreed that children should be told about their status before they reach adolescence. There should be education around diversity/difference as a means to reduce stigma. Parents should also participate in a parallel learning process as a way to support their children through the disclosure process.

4. Make It Easy for Young People to Participate

Prevention. Most young people will not go out of their way to learn about STDs and HIV. Programs need to bring education to young people and/or use new technologies like texting and websites/blogs that make it easy to access information on demand.

Care. Programs need to provide flexible hours and help youth with transportation. There should be provision or assistance with transportation to and from appointments. Youth should be able to meet with providers in a neutral/comfortable setting. This may help preserve normality. Youth liked the idea of meeting outside the office, as discussed by guest speakers from Yale and Connecticut Children's Medical Center (CCMC). Care services should protect confidentiality and privacy.

5. Involve Youth in Decision-Making

Prevention. We need new laws to implement many of these recommendations. It is critical to expand opportunities for young people to speak with policymakers, legislators, and groups like the Connecticut Board of Education. We also need to bring youth together through existing statewide groups and using technology so youth from different communities can participate.

Care. It's important to involve HIV-positive youth in decision-making opportunities. One example is engaging youth in designing trendy / cool pill cases and involving HIV-positive youth on the impact of medication trials. Getting feedback from HIV-positive youth on the quality of their care as well as obtaining youth insights can be very valuable for improving care. A key challenge in this area is having more HIV-positive youth voices – given issues of confidentiality and still-present stigma.

To be effective, we need both laws and culture change. Schools should be required to teach all the facts, but individuals also need to change how they engage young people in discussions of HIV and healthy behaviors, and more young people need to take the lead in educating their peers.

g) Connecticut AIDS Drug Assistance Program (CADAP)

As of August 2011 Connecticut's AIDS Drug Assistance Program supported 242 HIV and HIV disease related medications and has a responsive service delivery system with seamless linkages to Medicaid/Medicare and other state/federally funded programs with no waiting lists or client caps.

During the State fiscal year (July 1, 2010 - June 30, 2011) CADAP enrolled an average of 2,002 clients of which an average of 1,612 received at least one paid prescription.

The Connecticut Insurance Premium Assistance (CIPA) program was implemented in May of 2011 to provide insurance premium continuation for eligible CADAP clients. In the fall of 2011 CIPA received approval from the Health Resources and Services Administration (HRSA) to also provide Insurance Premium Purchase for eligible CADAP clients. As of February 2012 there are 148 clients being served by this program. CIPA will help pay up to $1,500 per month for health insurance premiums for eligible CADAP clients who have health insurance coverage approved by CIPA. For a health insurance policy to be CIPA-approved, it must cover all medications on the current CADAP Formulary and provide adequate primary care coverage. CIPA cannot pay premiums for individuals with Medicare Part D, Charter Oak Health Plans, health insurance policies that do not cover HIV related services due to pre-existing condition exclusion clause, or policies that have maximum limits on prescription and/or medical benefits.

Identified need: CADAP has been reporting an increase in the total number of clients between 300-400% of the federal poverty level (FPL). The average number of CADAP clients for State Fiscal Year (SFY) 2011 within the 300-400% FPL was 115, which represents an increase of 19 clients in the past year. For SFY 2011, there was an average of 1,070 clients with private insurance (TPL) for all poverty levels up from the average of 1,038 in SFY 2009-2010. Contributing factors to this increase of individuals between 300-400% FPL are job loss, pay decrease, or mandatory furloughs due to the economic downturn, issues which directly affect who can keep and pay for private health insurance.

CADAP Five Year Average	Total Clients Enrolled	Total Paid Cases (@least 1 paid Rx)	Total clients 0-100%FPL	Total Clients 101-200% FPL	Total Clients 201-300% FPL	Total Clients 301-400% FPL	Total New Clients	Total Clients with TPL (Private Insurance)
SFY 2007-2011 Average (July 2006-June 2011)	1,916	1,507	627	1003	391	106	31	1029

h) Other Programs and Information

PLWHA leaving the Correctional System

- **Transitional Linkage into the Community (Project TLC)** is a statewide program designed to assist HIV-positive individuals ready for, or recently released from Connecticut's correctional system with linkages and referrals to community-based and core medical services, including the Connecticut AIDS Drug Assistance Program (CADAP). Project TLC offers transitional case management, medical transportation and referrals to individuals for 30-60 days following release. Upon return into the community, former inmates are connected to medical case management and medical care to ensure their continuity of care. The number of persons with HIV leaving prisons who were connected with TLC totaled 323 in 2011.
- **The University of Connecticut Health Center/Correctional Managed Health Care (UCHC/CMHC) HIV** Prevention Program's data reported that from January 1, 2011 – December 31, 2011 there were 8,763 (or an average of 730 per month) rapid test sessions and 354 (or an average of 30

per month) total refusals. They performed 17,566 Orientation to HIV Services sessions (including HIV 101) for individuals upon intake to the facility and held 106 HIV positive Support Groups sessions.

PLWHA receiving Ryan White Medical Case Management Services

- The number of unduplicated persons receiving Ryan White Medical Case Management services in 2011 totaled 3,518.

Data from DMHAS Counseling and Testing Providers, 2011

Table 7 shows the number of persons served by the Department of Mental Health and Addiction Services counseling and testing providers.

Table 7. DMHAS Infectious Disease Category

Disease Category	Numbers
Infectious Disease Educational Sessions	8,854
Risk Reduction Plans Written	2,933
Referrals for Risk Reduction	1,229
HIV Tests	1,330
HCV Tests	2,128
Entered HIV positive	4,703
Tested HIV positive	35
HIV/HCV Co-infection	3,725

The Connecticut 2009 Health Disparities Report

In 2009, the Connecticut Department of Public Health produced the *Health Disparities Report* to provide the context and descriptions for health disparities by various populations in Connecticut.[11] Health disparities are avoidable differences in health that result from cumulative social disadvantage. Public health research shows that a wide variety of health outcomes are influenced by social factors such as poverty, socioeconomic status, educational attainment, social support, stress, discrimination and environmental exposures. Health disparities are evidence of inequalities in these social factors.

In Connecticut, racial and ethnic diversity is increasing. From 2000-2007, the state's Asian population increased by 38.2% and the Hispanic or Latino population increased by 24.8%. In 2007, the Hispanic or Latino population comprised 11.5% of the Connecticut population, Black or African Americans, 9.3%, Asians, 3.4% and Whites, 74.4%. In its key findings the report noted that diagnosed HIV/AIDS cases for 2001-2005 were most prevalent in persons of Hispanic origin and among Blacks. The groups experienced 7.4 and 6.6 times the rate of HIV/AIDS than Whites. This report supports findings contained

[11] Indicators of health are presented by race, ethnicity, and/or other sociodemographic factors such as education and income level.

in the 2010 Connecticut Epidemiological Profile stating that Blacks, which make up 9% of the population comprise 32% of PLWHA. Similarly Hispanics, making up 11% of the population also comprise 32% of PLWHA. In total minority populations comprise 64% of CT's PLWHA.

Lack of health insurance is an urgent health problem facing many state residents. In CT, Hispanics are about 5.4 times more likely and Blacks 2.7 times more likely to be uninsured than Whites. TB incidence rates among foreign-born persons and racial and ethnic minorities are also higher than incidence among Whites in CT. The TB incidence rate is highest among Asian residents, about 23 times higher than that of Whites in 2000-2005.

Connecticut School Health Survey (CSHS).[12] The survey indicates that CT students are engaging in risky behaviors. These behaviors may lead to youth taking more risks (e.g. contracting STDs). A total of 2,392 students from 48 Connecticut high schools completed the self-administered survey in 2009. Participants were 50.9% male and 49.1% female; 67.5% white, 13.8% black, 14.9% Hispanic, and 3.8% other or multiple race. Respondents were equally distributed among grades 9 to 12. The school response rate was 76% and the student response rate was 84% for an overall response rate of 64%. 29.6% of high school students had sexual intercourse at least once in the past three months (currently sexually active). The percentage of students who were currently sexually active increased from 14.4% in grade 9 to 54.7% in grade 12. Current sexual activity among students increased dramatically in grades 11 and 12 (33.5% and 54.7%).

Of the high school students who were currently sexually active, 59.4% used a condom the last time they had sexual intercourse (Figure 4.2) (95% CI; 54.4-64.1). The percentage using a condom was lowest in 12th grade (48.3%), the grade with the highest percentage of sexually active students.

This information from the CSHS supports the work of the Youth Advisory Group and their recommendations for engaging and reaching young people. The survey also indicates the need for reaching youth as evident by the dramatic increase in sexually active students in 11th and 12th grade and that the lowest percentage using condoms was 12th grade students.

Healthy Connecticut 2010 Final Report.[13] The Healthy Connecticut 2010 Final Report is a summary of progress made during the last ten years to improve the health of Connecticut residents and to eliminate health disparities. It is based on ten Leading Health Indicators identified in the federal Healthy People 2010. These indicators are the major behavioral risk factors, social and physical environmental factors, and other health system factors that are instrumental in shaping the health of both individuals and communities. Of these ten Leading Health Indicators, four are referenced in relation to HIV: alcohol and substance abuse, responsible sexual behaviors, mental health and access to health care.

1. **Alcohol and Substance Abuse:** Alcohol, marijuana, tobacco, cocaine, heroin and misused prescription drugs are the priority substances targeted for prevention efforts in Connecticut.[14] Between 2001 and 2009, current alcohol use (at least one drink in the past 30 days) increased

[12] Connecticut Profile of HIV/AIDS in Connecticut 2010. Connecticut Department of Public Health.
[13] Healthy Connecticut 2010 Final Report. Connecticut Department of Public Health. June 2010.
[14] 2009 Connecticut Strategic Prevention State Epidemiological Profiles, Connecticut Department of Mental Health and Addiction Services, February 2010.

among adults in all populations except Black non-Hispanics. The proportion of white non-Hispanics who drank alcohol was nearly 70% greater than that of Black non-Hispanics. From 1997 to 2009, statistically significant decreases in alcohol consumption occurred overall among male, female, and White non-Hispanic high school students. In 2009, approximately half of all high school students reported drinking alcohol in the past 30 days. Illicit drugs include marijuana/hashish, cocaine and crack, heroin, hallucinogens, inhalants or prescription-type psychotherapeutics used non-medically. In 2007, 8% of Connecticut's population 12 years and older reported using one or more illicit drugs in the past 30 days. Young adults 18-25 years of age consistently had the highest rates of illicit drug use.

2. **Responsible Sexual Behavior.** Risky sexual behavior refers to unprotected sexual intercourse, multiple sex partners, young age at first intercourse, and use of drugs and alcohol before intercourse. It is responsible for unwanted pregnancies and accounts for the majority of HIV and sexually transmitted diseases (STDs). Although the number of HIV cases diagnosed annually in Connecticut has decreased 43% - from 851 in 2002 to 482 in 2007 - the number of all three reportable STDs (chlamydia, gonorrhea, and syphilis) have been increasing. In 2009, 65 cases of syphilis were reported, 31% of which were HIV co-infected. Compared to White non-Hispanic students, Black non-Hispanic and Hispanic students were 60% and 40% more likely to have had sex. Overall, 59% of high school students who had intercourse during the last 3 months reported use of a condom during their last sexual intercourse. In 2009, 5% of high school students reported they had sexual intercourse before the age of 13; 11% had intercourse with four or more people during their life; and, 25% drank alcohol or used drugs before having sex.

3. **Mental Health.** In 2007, one in three Americans 18 years and older had a diagnosable mental disorder. In Connecticut in 2007, mental disorders, excluding alcohol and drug psychoses, accounted for 17,344 hospitalizations (488 per 100,000 population). Adults 25-44 years of age accounted for 39% of these hospitalizations.

4. **Access to Health Care.** Access to quality health care across the continuum of care – from prevention, screening and diagnosis to treatment and end-of-life care – is key to eliminating health disparities and improving quality of life. Health insurance status and type, income, English proficiency, having a regular primary care provider or place of care and availability of facilities and transportation are important predictors of access to health care. In 2009, 92% of white non-Hispanics had health insurance, compared to 80% of black non-Hispanics and 71% of Hispanics. Women and non-Hispanic whites were the most likely to have ongoing care in 2009; men and Hispanics were the least likely.

IV. SCSN General Findings

The information in this section provides a general picture of the survey findings and summarizes priorities of Parts A, B, C, D and F as they relate to the recommendations. The section is organized under the following headings: a. Care and Prevention Services used; b. Care and Prevention Services needed; c. Barriers to care and prevention services for underserved populations; d. out of care and unaware populations, and unmet need; and e. priority needs for underserved populations. Information is shown for the entire state except where specific geographic differences are indicated.

In Care per HRSA Definition: Of the 1198 respondents:

- 99% indicated they were in care by HRSA standards
- 96% reported they received care in the last 12 months
- 98% received a CD4 count within last 12 months
- 98% received Viral Load test in last 12 months

The above data is further corroborated by the DPH HIV Surveillance Unit, which has developed tables indicating the number of persons diagnosed with HIV infection who have been linked to care within three, six and 12 months of diagnosis, as well the number of persons with more than one Viral Load test and more than two care visits in a year. Based on these data:

- Of 405 persons diagnosed with HIV infection between 01/01/2010 and 12/31/2010, 85.19% were linked to care within three months of diagnosis, 89.38% within six months and 91.2% within 12 months.
- Of the 10,052 persons diagnosed with HIV infection through 12/31/2009 and living with HIV on 12/31/2010, 65% had received more than one Viral Load test between 01/01/2010 and 12/31/2010.
- Of the 10,052 persons diagnosed with HIV infection through 12/31/2009 and living on 12/31/2010, 53% had received more than two care visits between 01/01/2010 and 12/31/2010, at least three months apart.

a. Care and Prevention Services Used

Care: From the information compiled through the 2010 Needs Assessment data, **96%** of respondents stated they received medical care within the past 12 months. The table below provides the most used care services. Most individuals surveyed are meeting HRSA required definition of being in care.

Table 8. Ryan White Core Medical Services Most Used

Service Category	% Statewide 2010
Medical Care	85%
Medical Case Management	73%
CADAP	60%
Dental	55%

Prevention: From the information compiled through the 2010 Statewide Needs Assessment, 10% reported having had sex without a condom in the past 12 months. Thirty six percent (36%) of respondents reported using condoms and safe sex information, while 59% reported no need for any condom information or distribution. However, 7% reported they had unprotected sex with someone HIV positive since testing positive for HIV (5% had unprotected sex with someone HIV-).

Table 9. Prevention Services Most Used

Service Category	% Statewide 2010
Prevention support groups	42%
Condom information and distribution	36%
Comprehensive Risk Counseling Services (CRCS)	28%
Services for partners at risk	25%

b. Care and Prevention Services Most Needed

Prevention Services most needed: Of the individuals who responded to this question, only 6% indicated that they need Prevention support groups with information on HIV and only 7% wanted specific prevention programs (DEBIs/EBIs). Although these percentages are small, prevention services for even a small number may reduce the number of individuals being infected or re-infected.

- **2005 and 2008 SCSN** data supports the need for Prevention support groups.

The core service reported as most needed was **Dental services** (18%.) Dental services were most needed in New Haven/Fairfield.

- **2005 and 2008 SCSN data** statewide information support the need for Dental as the most needed service.

The care support services reported as most needed were **housing assistance** (18%); **help paying for health insurance** (16%); and **emergency financial assistance** (16%).

- **2005 and 2008 SCSN data** supports the need for housing related services (30%) and Emergency Financial Assistance (29%).

c. Barriers to Care and Prevention Services

Survey respondents reported that the Care and Prevention services that are **always a problem** include: transportation (8%)[15]; substance abuse (6%); being unaware of services (5%); and not knowing where to get services (5%). Care and Prevention services that are sometimes a problem include: transportation (26%); substance abuse (12%); being unaware of services (16%); and not knowing where to get services (13%). Fear of revealing their status (19%) was the problem individuals faced the most.

- **2005 and 2008 SCSN data** supports the identified barriers as inability to pay; fear of revealing status; lack of transportation; not aware of services or benefits.

d. Unmet Need, Unaware Population, Priority Needs for the Underserved

Unmet Need Estimate. Table 10 (Unmet Need) shows the current model for estimated unmet need for primary care services in the state of Connecticut. Connecticut's unmet need estimate as of data ending 12/31/2010 is based on electronic viral load (VL) reporting implemented by the State in 2006. A majority of VL reports are electronically matched and imported directly into the HIV/AIDS Surveillance Unit's eHARS data registry though some paper and manual reporting continues. VL, however, is only one component of the measure. CT estimates unmet need largely using VL since the percentage of people on drug therapy getting CD4 counts and not a VL is small. CT requires CD4 reporting only if it is diagnostic of AIDS (<200 count or <14%). The estimate includes available CD4 data.

[15] Anecdotal data shows different transportation barriers exist in rural vs. urban areas. Rural transportation barriers include lack of access to public transportation whereas urban barriers include examples such as challenging public transportation routes and schedules.

HRSA defines unmet need as a person who has "the need for HIV-related health services among individuals who know their HIV status but are not receiving regular primary health care." Regular HIV-related primary health care is defined as evidence of viral load testing, CD4 counts, or provision of antiretroviral medications in a given 12-month period. The 2010 unmet need in Connecticut is 33.9%. The term "unmet need" is used only to describe the unmet need for HIV-related primary health care, and is not considered a service gap. Unmet need has decreased in CT since 2007 (38%) and the result may be linked to the MCM model, the DPH requirement for CD4/VL reporting every six months, promotion of referral tracking and follow-up, and cross program collaboration with Parts A and C as well as outreach, MAI, and EIS services to locate individuals out-of care (OOC) and reconnect them to HIV care. Table 11 represents Connecticut's Total In-Care Population of PLWHA based on viral load reporting as of 2010.

Needs of Individuals aware of their HIV-positive status but not in care: CT's out-of-care (OOC) information is obtained through various sources (e.g. surveys, identification of OOC individuals through EIS and MAI, DPH VL reports, focus groups and needs assessments). CT's 2010 In-Care HIV Surveillance Report indicated that 34.8% of PLWHA statewide who know their status are OOC. Statewide, more males than females, more Hispanics than blacks or whites, more MSM than Heterosexuals and IDUs and younger individuals (e.g. 25-44 years) are OOC. Previous statewide and regional Unmet Need reports indicated that a significant percentage of OOC persons report homelessness or having been homeless or incarcerated at some point in the most recent 12 months. CT's 2007 SCSN Update documented that barriers for OOC persons continue to be: transportation, language, not feeling sick, housing, fear, distrust of medical providers, lack of insurance, mental health and substance abuse issues and lack of or limited income. Poverty is a major factor affecting an individual's in-care status. DPH's HIV Surveillance Unit has begun mapping diagnosed HIV/AIDS cases and poverty rates by zip code. Cities and zip codes with high poverty rates are also sites of high prevalence, and, one can assume also high numbers of OOC individuals. Hartford, Bridgeport and New Haven, CT's three largest cities each have high poverty rates and also more than 48% of all HIV/AIDS cases.

OOC individuals are also reflective of CT's HIV epidemic as a whole: minorities are disproportionately out of care. Re-engaging these populations into care requires focused and collaborative efforts among all RW Parts and HIV Prevention Services; targeted outreach initiatives and EIS; culturally and population specific HIV care information, equitable access to care; adequate transportation, and supportive services (e.g. emergency financial assistance, housing). Statewide, the following efforts are used to locate OOC PLWHA and re-engage them: street and peer outreach; Hartford's Part A and Part B's EIS programs, mobile health van outreach; Part B's MAI program targeting minority populations; Project TLC, targeting newly released inmates transitioning into the community; linkages and referrals between counseling/testing sites, STD clinics, drug treatment facilities, Partner Services, and MCMs; implementation of rapid testing in health centers, emergency departments, Substance Abuse Treatment facilities, and the state's syringe exchange program (SEP).

Connecticut uses the unmet need framework to prioritize services, address gaps, allocate resources, and define collaborations with RW and non-RW funded providers to avoid duplication of efforts. It also uses the data to identify populations most at risk for being out-of-care (e.g. males, black, Hispanic, MSM, IDU,

etc) and target outreach, education, MAI and EIS initiatives to engage/re-engage them into care. In FY 2011, DPH funded EIS services in New Haven and New Britain and expanded MAI outreach/education initiatives to target minority populations in the Greater Hartford TGA (Hartford, Middlesex and Tolland Counties). DPH will continue to maintain its collaborations with Substance Abuse Treatment facilities, STD clinics, community health centers, as well as EIS and MAI outreach services to shelters, half-way houses, food pantries and high-risk areas to engage/re-engage both individuals unaware of their HIV status and OOC persons.

Table 10. Unmet Need Framework Table as of December 31, 2010*

Column 1	Column 2	Column 3	Column 4	Column 5
Population Sizes		**Value**		**Data Source(s)**
Row A.	Number of persons living with AIDS (PLWA), as of 12/31/2010	7,083		eHARS
Row B.	Number of persons living with HIV (PLWH)/non-AIDS/aware, as of 12/31/2010	3,402		eHARS
Row C.	Total number of HIV+/aware as of 12/31/2010	10,485		eHARS
Care Patterns				**Data Source(s)**
Row D.	Number of PLWA who received the specified HIV primary medical care during the 12-month period (01/01/2010-12/31/2010)	4,731		eHARS Viral Load and CD4 data
Row E.	Number of PLWH/non-AIDS/aware who received the specified HIV primary medical care during the 12-month period (01/01/2010-12/31/2010)	2,203		eHARS Viral Load and CD4 data
Row F.	Total number of HIV+/aware who received the specified HIV primary medical care during the 12-month period (01/01/2010 – 12/31/2010)	6,934		eHARS Viral Load and CD4 data
Calculated Results			**%**	**Calculation**
Row G.	Number of PLWA who did not receive the specified HIV primary medical care	2,552	33.2%	Value = A – D. Percent = G/A
Row H.	Number of PLWH/non-AIDS/aware who did not receive the specified HIV primary medical care	1,199	35.2%	Value = B – E. Percent = H/B
Row I.	Total HIV+/aware not receiving the specified HIV primary medical care (quantified estimate of unmet need)	3,551	33.9%	Value = G + H. Percent =(1 - F/C)

*Includes persons ever diagnosed with HIV or AIDS through the end of DEC2010 and were alive by the end of DEC2010 and whose laboratory information (CD4 or VL results) was reported between JAN2010 - DEC2010.

Table 11. PLWH receiving HIV care* between 01/01/2010 through 12/31/2010 among persons who were 13+ years old on 12/31/2009, diagnosed with HIV infection through 12/31/2009 and living with HIV on 12/31/2010 (CDC SAS programming).

Characteristics	PLWH	1+ care visit between 01/01/2010 through 12/31/2010 N	1+ care visit between 01/01/2010 through 12/31/2010 (%)	Number with 2+ care visits between 01/01/2010 through 12/31/2010 at least 3 months apart	% with 2+ care visits between 01/01/2010 through 12/31/2010 at least 3 months apart among the overall population	% with 2+ care visits between 01/01/2010 through 12/31/2010 at least 3 months apart among persons who have 1+ care visit between 01/01/2010 through 12/31/2010
Total	10,052	6,555	65.2%	5,368	53.4	81.9
Sex						
Male	6,630	4,193	63.2%	3,409	51.4	81.3
Female	3,422	2,362	69.0%	1,959	57.3	82.9
Age group						
13-24	303	193	63.7%	155	51.2	80.3
25-44	3,483	2,202	63.2%	1,710	49.1	77.7
45-64	5,878	3,929	66.8%	3,299	56.1	84.0
65+	388	231	59.5%	204	52.6	88.3
Race/ethnicity						
Black	3,258	2,208	67.8%	1,834	56.3	83.1
Hispanic	3,256	2,049	62.9%	1,690	51.9	82.5
White	3,405	2,202	64.7%	1,769	52.0	80.3
Other	133	96	72.2%	75	56.4	78.1
Risk						
MSM	2,240	1,424	63.6%	1,118	49.9	78.5
IDU	3,745	2,382	63.6%	2,000	53.4	84.0
MSM/IDU	183	115	62.8%	100	54.6	87.0
Heterosexual	2,240	1,579	70.5%	1,314	58.7	83.2
Other/unkn	1,644	1,055	64.2%	836	50.9	79.2
MSM						
Black	382	253	66.2%	195	51.1	77.1
Hispanic	441	284	64.4%	222	50.3	78.2
White	1,370	853	62.3%	675	49.3	79.1
Male IDU						
Black	861	565	65.6%	487	56.6	86.2
Hispanic	1,036	595	57.4%	494	47.7	83.0
White	553	363	65.6%	305	55.2	84.0
Female IDU						
Black	433	306	70.7%	249	57.5	81.4
Hispanic	436	270	61.9%	228	52.3	84.4
White	396	258	65.2%	217	54.8	84.1
Male HET						
Black	334	221	66.2%	186	55.7	84.2
Hispanic	222	154	69.4%	127	57.2	82.5
White	158	106	67.1%	83	52.5	78.3
Female HET						
Black	584	414	70.9%	352	60.3	85.0
Hispanic	583	421	72.2%	354	60.7	84.1
White	336	246	73.2%	198	58.9	80.5

*Care visit based on report of CD4 or VL test.

Unaware Populations. People living with HIV/AIDS (PLWHA) Unaware of their status as of 12/31/2009: Estimated Back Calculation (EBC Methodology)

Number of individuals diagnosed with HIV and living as of 12/31/2009 in CT = 10,290

Formula: p .21
(1-p) x N = .79 x 10, 290 = 2,735 individuals (undiagnosed): unaware of HIV status

Strategy to Identify Individuals Unaware of their HIV status: CT's EIIHA strategy to identify, inform, refer and link individuals with HIV who are unaware of their status to medical care and support services is multifaceted and involves numerous DPH programs (e.g. Prevention, STD and Surveillance), other state agencies (e.g. DMHAS, DOC), RW Parts A, C, D, and community collaborations. The estimated number of living CT HIV positive individuals, unaware of their status as of 12/31/2009, is 2,735.

In July 2010, the CT HIV Planning Consortium (CHPC) identified eight priority populations in need of appropriate interventions and services. These populations are in order of priority: (1) HIV Positive, (2) White MSM, (3) Black Heterosexual, (4) Black IDU, (5) Hispanic IDU, (6) Black MSM, (7) Hispanic MSM, and, (8) Hispanic Heterosexual. The CHPC also recommended that Counseling, Testing & Referral (CTR) and Partner Services (PS) be required components for all funded prevention interventions and services. Under the new CDC Guidance, CT's HIV prevention focus will be heavily oriented to testing (rapid, routine and opt-out) as well as to Outreach, Testing and Linkage (OTL) efforts in conjunction with the STD Unit and Health Care & Support Services' Early Intervention Services (EIS).

CT's FY 2012 EIIHA Matrix, a unique collaboration between care and prevention, will target the following populations: Individuals tested confidentially, Persons who received preliminary HIV positive result only (no confirmatory test), Partners of HIV+ individuals, Older Adults (50+), White MSM (ages 18-40), MSM of Color (ages 18-40), African American IDU (ages 18-40) and Hispanic IDU (ages 18-40). CT's EIIHA goals are consistent with the three primary NHAS goals to: 1) reduce the number of people who become infected, 2) increase access to care and optimize health outcomes for people living with HIV, and 3) reduce HIV-related health disparities. Through CT's strong collaborations between prevention and care units, linkages have been created to increase access to medical care through referrals and linkages via counseling and testing, outreach, Comprehensive Risk Counseling Services, ERLI, and partner services. As a result of these linkages, individuals identified as HIV+ have received and will continue to receive earlier access to medical care and treatment, which will optimize health outcomes and serve to reduce health care disparities.

CT's EIIHA strategies focus on identifying HIV-infected persons who are unaware of their status. People who know their HIV status are more likely to modify risk behaviors to reduce further transmission. Collaborations with other agencies and organizations are a vital component of the EIIHA strategy since a combined effort increases opportunities for identifying, informing, referring and linking HIV+ unaware individuals with medical care and support services. The transition from traditional counseling and testing sites to non-traditional methods and locations will provide testing access to individuals, who do not or would not access traditional sites. Identifying new HIV+ cases and referring individuals to care and prevention services at an earlier point is crucial to improve health outcomes and reduce further transmission. Increasing and expanding HIV testing access will also assist in reaching disproportionately

affected minority and high-risk populations (e.g. MSM, IDU, Older Adults, Partners of HIV+ Individuals), help reduce disparities, and assist in ensuring enhanced access to medical care.

CDC has indicated that nationally, 21% of individuals living with HIV are unaware of their status. Identifying, informing, referring and linking unaware individuals in CT to medical care, prevention and support services present numerous challenges including: 1) locating individuals who have not been tested in the past 12 months or been informed of their confirmatory status, 2) educating people about HIV, the importance of HIV testing and knowing their status, 3) convincing persons at high risk (e.g. MSMs, IDUs) to be tested and have their status confirmed, 4) following up with individuals who have been tested (confidentially) and confirming their HIV status, and 5) informing HIV+ individuals about the need for partner services.

Additional challenges also include staffing resources to cover nontraditional areas and populations being targeted for testing and outreach; fear, stigma and cultural and religious issues in minority populations; complacency within the general population about HIV testing and HIV transmission; distrust of the medical system and medical providers; substance abuse and mental health concerns; homelessness; minimal cooperation by private medical doctors in implementing routine or opt-out HIV testing in their practices; no current routine HIV testing in CT's correctional facilities; insufficient HIV testing through local health departments and limited resources devoted to HIV; health literacy issues in underserved, minority and undocumented populations; data systems that are not compatible with one another (e.g. CAREWare and XPEMS), lack of understanding and utilization of Partner Services by providers, and limited social marketing targeting HIV testing and knowing one's status.

CT's Part B program plays an active role in promoting routine, rapid and opt-out HIV testing within the state, its Ryan White counterparts, and care and prevention contractors. Part B EIS contractors develop letters of agreement and collaborations with various community and faith-based based agencies, health centers, shelters, HIV testing sites, and social service agencies to provide education about HIV testing, outreach and connection to care for newly diagnosed and OOC individuals. The DPH Prevention Unit and Part B program integrate prevention and care services through integrated trainings and shared oversight of the statewide Early Referral and Linkage Initiative (ERLI). Part B also collaborates with the STD Unit to increase utilization of Partner Services to identify and test partners of HIV+ individuals. Through the Part B funded Transitional Linkage to Care Program, transitional case managers provide counseling and support for HIV+ inmates returning to communities throughout the state. Medical Case Managers (MCM) are also required to track newly diagnosed clients through linkages with Disease Intervention Specialists (DIS), HIV Surveillance and EIS. MCMs are the gatekeepers and coordinate the monitoring of medical care and support services to ensure that clients maintain continuity of care and appropriate referrals. MCMs are trained in risk assessment counseling with their clients and promote testing of high risk HIV+ clients' partners and refer clients to CRCS for prevention education, interventions, and risk reduction strategies.

e. Priorities to ensure underserved populations are accessing care

Reaching underserved populations and HIV-positive individuals and assisting them to access care continues to be a challenge in Connecticut. According to the unmet need estimate from viral load reporting, 65% are in care and 33.9% are out of care. Based on the in care and out of care assessments, the issues confronting both underserved and out-of-care are similar. The one striking difference for those who may be in need of services but are not accessing them is that if they feel healthy they are more likely not to seek care. However, across both populations in Connecticut the issues remain constant and the approach must be to continue to reduce barriers, determine where there are potential gaps in services, and engage providers to work collaboratively across care and prevention services to refer, link people into care and keep them in care.

Several studies have shown that HIV positive persons with low health literacy are more likely to encounter the following barriers: less preventive care, increased use of the Emergency Room for services, poorer health outcomes, less HIV knowledge, lower CD4 count, poor medication adherence, increased co-morbidities and mortality, and more hospitalizations. DPH uses its EIIHA strategy to address health literacy as well as racial and ethnic disparities in accessing HIV medical care and prevention services. DPH contracted Part B's MAI to an agency located in the North-end of Hartford, a heavily populated minority area. This program works closely with the Part A and Part B EIS programs throughout Hartford, Middlesex and Tolland Counties, to identify undiagnosed black and Hispanic individuals, as well as out-of-care minorities and refer/link them to care and CADAP. CT's Part B EIS programs are sited in New Haven and New Britain, areas with large minority populations and underserved communities (e.g. transgender, MSM, IDU and undocumented). According to CT's 2009 statewide estimate of the percentages of persons with HIV infection unaware of their status, blacks and Hispanics represented 66.5%. DPH prevention initiatives focus counseling and testing initiatives targeting unaware black and Hispanic persons through emergency departments, community health centers, STD clinics and mobile health vans. Part B and HIV prevention providers have participated in several cultural trainings including cultural sensitivity training and working with MSMs and the Transgender population. DPH also addresses health literacy concerns of clients through cross training of staff and providers. These culturally competent services that incorporate health literacy have resulted in a greater impact on a client's health knowledge, health status and access to medical services.

Connecticut identifies populations who are most likely to need prevention services by risk category. In 2010, these populations were identified as HIV positive, White MSM, Black Heterosexual, Black IDU, Hispanic IDUs, Black MSM, Hispanic MSM and Hispanic Heterosexual. The recommendation made by the CHPC to DPH regarding Counseling, Testing, and Referral Services, or HIV Testing, and Partner Services as a required component for all funded interventions corroborates findings of the SCSN 2011 and recommendations.

Special populations, including the homeless, sexual and gender minorities (e.g. lesbian, gay, bisexual and transgender), adolescents, immigrants and undocumented and rural health populations also present other unique challenges and needs in accessing health care and prevention services. These are groups

who are "impoverished, disenfranchised, or those who are subject to discrimination, intolerance, subordination and stigma" (Flaskerud et al.2002, Peternelj-Taylor 2005).[16] These individuals may find it hard to receive or afford appropriate health information or health care, and accessible and understandable health information is often limited, outdated, or difficult to find. For individuals living with HIV disease in rural communities, access to transportation to healthcare facilities is an enormous problem, as well as the availability of health care facilities sited in rural communities. Chronic disease management, oral health and mental health services are also difficult to access, especially for low-income rural residents. Many oral health providers in rural communities also do not accept Medicaid, thus forcing many individuals to travel distances to more urban facilities.

HIV prevalence is three to nine times higher among persons who are homeless or unstably housed. The 2010 Statewide Needs Assessment Survey identified housing as the primary support service gap. Lack of housing was identified by the New Haven/Fairfield EMA as the primary service needed by PLWHA but are unable to get, and served as a barrier for PLWHA to see their HIV doctor. Affordable, stable and supportive housing increases the ability of PLWHA to access and stay in care and adhere to medication regimens. Unstable housing is strongly associated with increased HIV risk behaviors, co-infection, treatment failure and increased morbidity and mortality. Chronic homeless persons, most of whom struggle with mental health and substance abuse, are at high risk for HIV infection. According to the 2009 Point In Time Count (PITC) in Connecticut, 6% of all homeless respondents to the survey indicated they had been told they had HIV or AIDS.

Sexual and gender minority sub groups each have diverse health issues and risk levels that affect one group more than another. Among these populations, discrimination, harassment by family, community and peers, or violence can lead to serious physical and mental health concerns. Within in these populations, individuals are not only at high risk for HIV but also other health and mental health conditions, including higher rates of breast and anal cancer, STDs, hepatitis B, influenza, depression and suicide. Transsexual and intersex populations that have undergone surgical sex reassignment experience homelessness, unemployment, discrimination, violence and death, as well as high risk for HIV, STDs and acute illness from injecting "street" hormones. Medical providers also often lack information, knowledge or experience with these populations. [17]

Adolescents are bombarded on a daily basis with substance use, sexual behavior, tobacco and alcohol consumption, and violence. DPH HIV Surveillance reports increasing numbers of gonorrhea and chlamydia cases among 10-24 year olds. Nearly 2,600 cases of gonorrhea were reported in 2009 and of these 69% were reported among blacks and 16% among Hispanics. Over 50% of the cases were reported in Hartford, Bridgeport and New Haven, the three Connecticut cities reporting the highest number of HIV/AIDS cases. Of the nearly 12,000 cases of Chlamydia reported in 2009, 70% were among 10-24 year old and more than 50% were black. Connecticut's School Health Survey indicated that CT students are engaging in risky behaviors, which may lead to them taking more risks (e.g. contracting STDs).

[16] The 2009 Connecticut Health Disparities Report Hartford ,CT: Connecticut Department of Public Health.

[17] To address these issues, the CHPC supports the goals of proposed HRSA demonstration projects, "Enhancing Engagement & Retention in Quality HIV Care for Transgender Women of Color" and "Building a Medical Home for the Multiply Diagnosed HIV-positive Homeless Population."

Immigrants and undocumented persons with limited English proficiency (LEP) have difficulty getting appropriate and culturally competent medical care, which often leads them to defer health care services. Immigrants have numerous cultural, religious, economic and political needs which limit their ability to access health care, or once in care to maintain care. Mental health, trauma, lower income and levels, homelessness or unstable housing, and cultural and linguistic factors place immigrants and the undocumented at high risks for HIV. Fear of deportation, stigma and distrust of doctors place these populations at high risk for co-infections, heart disease, mental illness, depression, co-morbidities and suicide.

CHPC's Data and Assessment Committee continues to discuss prevention services for everyone while acknowledging the need for interventions to target disproportionately impacted and underserved populations and acknowledging the need for a significant influx of funding to increase prevention efforts. For both care and prevention, the emphasis is on reducing barriers and addressing core medical gaps (table below) as identified within this report.

Table 12. Reducing Barriers and Addressing core medical and support needs.

Reduction of barriers	Address core medical and support needs
• Substance Abuse • Transportation • Unaware of Services • Don't know where to get services • Fear of Revealing Status	• Dental • Housing assistance • Help paying for health insurance • Emergency financial assistance

V. HIV/AIDS Services in Connecticut

This section provides a comprehensive picture of HIV/AIDS services and resources in Connecticut. The following pages include CDC funded programs, HRSA funded programs (Parts A, B, D, C and F), and programs administered through state, regional and local entities.

a. Statewide AIDS Service Information

Connecticut provides core medical and supportive services to people living with HIV/AIDS and their families through various HIV/AIDS service organizations (ASOs). Services include, but may not be limited to the following: medical and non-medical case management, primary medical care, oral health, mental health, medical nutrition therapy, substance abuse-outpatient, AIDS pharmaceutical assistance, Early Intervention Services (EIS), health insurance premium, home health care, home and community-based services, hospice, medical transportation, housing, food bank/meals, linguistic services, psychosocial support, legal services, and related emergency financial assistance (EFA). Eligible PLWHA can access these core medical and supportive services throughout the state at no cost to them.

- **AIDS Drug Assistance** - The Connecticut AIDS Drug Assistance Program (CADAP) can help pay for many Food and Drug Administration (FDA) approved HIV drug treatments. There is no asset limit and the eligibility is 400% of the Federal Poverty Level (FPA). Physician verification of HIV/AIDS diagnosis and Connecticut residency are required. The program is administered by the Connecticut Department of Social Services (DSS) via a memorandum of agreement (MOA) with the Department of Public Health (DPH).
- **Connecticut Insurance Premium Assistance (CIPA) Program** – CIPA is a health insurance program funded through CADAP for individuals living with HIV/AIDS who are CADAP eligible (400% FPL, CT resident, proof of HIV). CIPA will help pay health insurance premiums for eligible individuals who have or can get coverage through a CIPA-approved health insurance policy. CIPA will pay up to a maximum of $1,500 per month for an insurance premium.
- **Charter Oak Health Plan** – State of Connecticut program offering health insurance coverage for uninsured adults of all incomes who do not qualify for the Connecticut Pre-Existing Condition plan or Husky Health. Monthly premiums are based on household size and income.
- **Connecticut Pre-Existing Condition Insurance Plan (CPCI)** –CPCI is designed for individuals who have a qualifying pre-existing health condition such as high blood pressure, diabetes, kidney, and HIV. An individual must be a CT resident and have been uninsured for the past six months. Premium is one amount per month per individual and is not based on income.
- **Children Youth and Family AIDS Network of Connecticut (CYFAN**) – CYFAN of the Community Health Center Association of Connecticut (CHCACT) provides adolescent/pediatric HIV care, HIV case finding and intensive medical case management services to adolescent/pediatric consumers with HIV and their family members.
- **Transitional Linkage into the Community (Project TLC)** - Project TLC is a statewide program designed to assist HIV positive individuals ready for, or recently released from Connecticut's correctional system with linkages and referrals to community-based and core medical services, including the Connecticut AIDS Drug Assistance Program (CADAP). Project TLC provides transitional medical case management, medical transportation and referrals for 30-60 days follow release.
- **Medication Adherence Programs:** The Connecticut Department of Public Health funds statewide Medication Adherence Programs that provide HIV medication adherence services to support any resident living with HIV who is considering starting HIV treatment or is having difficulty adhering to their HIV medication regimen. The programs are staffed by licensed professionals who assist clients to maximize the potential benefits of their medications, cope with side effects, HIV disease and co-morbidities. Staff provides biopsychosocial assessments, individualized treatment plans, client education, as well as follow up and referral of clients to medical care and support services. Currently programs are located in Hartford, Manchester, Stamford, New Haven, New Britain, New London, Farmington, Waterbury and Willimantic.
- **Infectious Disease Services** (Department of Mental Health and Addiction Services) are offered in the context of substance abuse treatment to clients who are already admitted to a particular program.

Each high risk admission mutually develops a risk reduction plan. HIV counseling and testing is offered in the context of this plan, and all HIV seropositive clients develop a treatment plan determining their HIV needs and priorities. Counseling and testing is also offered for Hepatitis C as well as Tuberculosis and referrals are made if appropriate. Prevention/case management services and education are offered to clients as well as their families and significant others.

- **Connecticut AIDS Residences** offer shelter and services to people with symptomatic HIV disease who are homeless or in danger of being such and have a substance abuse problem. They provide support, training, case management, and a variety of other individualized programs both in the residence as well as in the community.

b. Entities and Structures for HIV Prevention and HIV Care/Treatment

The DPH works together with various entities in planning, developing and delivering services for persons with HIV/AIDS. Many of the agencies listed also participate as members on the CHPC. These agencies and the service initiatives they have undertaken are as follows:

Connecticut Department of Public Health (DPH):

HIV/AIDS Surveillance and Viral Load Reporting

HIV Counseling, Testing & Referral

Routine HIV Counseling & Testing in Medical Settings (CDC-funded)

HIV Data Management and Support (cPEMS, CAREWare)

HIV Prevention, Education and Interventions (e.g. DEBIs, EBIs, Comprehensive Risk Counseling Services, Social Networks Testing)

Drug Treatment Advocacy (CDTA)

HIV Health Care and Support Services

HIV Prevention: Syringe Exchange Programs (State-funded)

Transitional Linkage to the Community Project (Project TLC)

Perinatal Monitoring Initiative (State-funded)

Medication Adherence Programs (State-funded)

Minority AIDS Initiative (MAI)

Connecticut Department of Corrections (DOC):

HIV Counseling, Testing & Referral (UCHC/CMHC)

HIV Positive Support Groups (UCHC/CMHC)

Inmate Orientations (Health Communications/ Public Information) (UCHC/CMHC)

Intensive AIDS Education in Jail (Rikers Health Advocacy Program) (Community Partners in Action/Beyond Fear Program)

Connecticut Department of Social Services

CONNPace

Connecticut AIDS Drug Assistance Program (CADAP) and Insurance Continuation administered through DSS

Housing Opportunities for Persons with AIDS (HOPWA) Grant

AIDS Residence Programs

Medicaid Managed Care Services

Medicaid (also HUSKY A & B)

Alternate Home Care Program

Connecticut Department of Mental Health and Addiction Services (DMHAS):

Inpatient Psychiatric and Substance Abuse Treatment Services

Community Based Psychiatric Substance Abuse Treatment Services

Shelter Plus Care

Projects for Assistance in Transition from Homelessness (PATH) Services

AIDS Residences

Basic Needs Program

Access to Recovery (ATR)

Connecticut Department of Children & Families (DCF):

Foster Care/Guardianship Services for Children Affected/Infected by HIV

Medically Fragile Children's Program

Child Guidance Clinic

Connecticut Department of Education (SDE):

HIV/AIDS Education: Tell Me What You See (Comprehensive HIV and STD Educational Program)

2009 Connecticut School Health Survey (Youth Behavior Component)

SAMHSA (Directly funded by federal agency):
Hispanic Health Council (ProjectConnect)

Latino Community Services (Latino Faith Partnership for Prevention and Treatment & Project REACH)

CDC (Directly funded by federal agency):

Latino Community Services (HIV Prevention for Positives)

City of Hartford (Early Intervention and STD Surveillance Services)

The following state agencies provide services aimed at reducing discrimination against persons/families with HIV/AIDS:

Connecticut Office of Protection and Advocacy

Connecticut Commission on Human Rights and Opportunities

Connecticut Office of Health Care Advocate

Structure and Planning Related Processes in Place in Connecticut related to HIV/AIDS

Two Part A Planning Councils (Hartford/Middlesex/Tolland and New Haven/Fairfield Counties)

Connecticut Cross Part Collaborative

Activities conducted in Connecticut

- Integration of HIV Care and Prevention Statewide Planning bodies into the Connecticut HIV Planning Consortium (October 2007)
- Monthly public meetings of Connecticut HIV Planning Consortium
- Statewide Collaborative Consumer Needs Assessment Out-of-care
- Statewide Care and Prevention Needs Assessment Survey of TGA, EMA, non-TGA counties and CADAP clients
- Statewide HIV/AIDS Technical Assistance regarding Medical Case Management Standards and Outcome Measures
- Statewide Medical Case Manager training
- Statewide Integration of HIV Care and Prevention Training Program and Continuing Education Programs
- Cross Part Collaborative

Participation of Ryan White Parts

Part A – HIV Emergency Relief Grant Program (Transitional Grant Areas and Eligible Metropolitan Areas)

New Haven/Fairfield EMA:

New Haven/Fairfield Counties Planning Council (Administered by the City of New Haven)

AIDS Project Greater Danbury

AIDS Project New Haven

Bridgeport Hospital

Connecticut Counseling Centers, Inc.

Cornell Scott Hill Health Center

Danbury Hospital

Fair Haven Community Health Center

Family Centers, Inc.

Family Services Woodfield

Greater Bridgeport Adolescent Pregnancy Program

Haelen Center/Hospital of St. Raphael

Hispanos Unidos, Inc.

Independence Northwest

Interfaith AIDS Ministry of Greater Danbury

Liberation Programs, Inc.

Liberty Community Services, Inc.

Mid-Fairfield AIDS Project

Nathan Smith Clinic/Yale Univ.

New Haven Home Recovery

New Opportunities, Inc.

Norwalk Community Health Center

Optimus Health Care

Recovery Network of Programs

Regional Network

Southwest Community Health Center

Stamford Hospital

Staywell Health Care, Inc.

Waterbury Health Department

Waterbury Hospital

Yale University AIDS Program

Yale University Child Study Center

Greater Hartford TGA

Hartford/Middlesex/Tolland Counties Planning Council (Administered by the City of Hartford)
AIDS Project Hartford
Central Area Health Education Center, Inc.
Community Health Center, Inc.
Community Health Services, Inc.
Community Renewal Team
Connecticut AIDS Resource Coalition
Greater Hartford Legal Aid, Inc (AIDS Legal Network)
Hartford Hospital (Brownstone Clinic)
Hartford Gay & Lesbian Health Collective, Inc.
Health Collective East
Human Resources Agency of New Britain
Latino Community Services, Inc.
Mercy Housing & Shelter Corporation
North Central Regional Mental Health Board
Rockville General Hospital
The Hospital of Central CT (THOCC)
UCONN Health Center
UCONN Health Center /Connecticut Children's Medical Center

Part B – HIV Care Grants (DPH administered)

AIDS Project Greater Danbury
AIDS Project Hartford
AIDS Project New Haven
Alliance for Living
Central Area Health Education Center
City of Waterbury Health Department (Waterbury/Torrington sites)
Community Health Center (Middletown)
Family Centers, Inc.
Family Services Woodfield
Hartford Gay & Lesbian Health Collective
Hispanos Unidos
Human Resources Agency of New Britain
Latino Community Services
Mid-Fairfield AIDS Project
Optimus Health Care, Inc.
Stamford Hospital
University of Connecticut Medical Health Center
University of Connecticut Medical Health Center Children's Hospital (CCMC)
Windham Regional Community Council

Part C – Early Intervention Services Grants to State and Primary Care Centers

Community Health Services
Community Health and Wellness Center of Greater Torrington
Community Health Center, Inc.
Cornell Scott Hill Health Center
Fair Haven Community Health Center, Inc.
Generations Family Health Center, Inc.
Optimus Health Care, Inc.
Southwest Community Health Center
Waterbury Hospital Health Center

Part D – Adolescent/Pediatric HIV/AIDS Program Connecticut Health Center Association of Connecticut (CHCACT) – GRANTEE

Bridgeport Hospital
Charter Oak Health Center, Inc.
Community Health Services
Cornell Scott Hill Health Center
Fair Haven Community Health Center, Inc.
Generations Family Health Center, Inc
Optimus Health Care Inc.
Southwest Community Health Center
UCONN Health Center (CCMC)
Yale Child Study Center
Community Health and Wellness of Greater Torrington

Part F AETC

Connecticut AIDS Education and Training Center

United Way 211 Infoline

Information helpline on all public and private providers of HIV related services

Public Health Planning Bodies

New Haven-Fairfield Part A Planning Council
Greater Hartford Part A Planning Council
Connecticut HIV Planning Consortium
Cross Part Collaborative

Consumer Representation by County

Hartford	Fairfield
Litchfield	Middlesex
New Haven	New London
Tolland (tbd)	Windham (tbd)

Part B Provider Agencies

AIDS Project Greater Danbury

AIDS Project Hartford

Alliance for Living

Connecticut AIDS Resource Coalition

Hartford Gay and Lesbian Health Collective

Hispanos Unidos

Latino Community Services

University of Connecticut Children's Medical Center (CCMC)

UCONN Health Center

Part C: Provider Agencies

Southwest Community Health Center

Part D: Provider Agencies

Community Health Center Association of Connecticut (CHCACT)

Part F: Provider Agency

Connecticut AIDS Education & Training Center (CAETC)

Government Agencies

Department of Public Health

Department of Social Services (CADAP)

Department of Mental Health and Addiction Services

Prevention Agencies

The agencies listed below are funded to provide prevention services through June 30, 2012. Programs funded by both Part B and prevention are marked with * and have only one representative on CHPC)

AIDS Project Greater Danbury*

AIDS Project Hartford*

AIDS Project New Haven*

Bridgeport Health Department

Central Area Health Education Center*

Community Health Center-Middletown*

Community Partners in Action-Hartford

Connecticut COSH Health-Newington

Cornell Scott Hill Health Center

Greater Bridgeport Adolescent Pregnancy Program

Hartford Gay and Lesbian Health Collective*

Hartford Dispensary

Hartford Health Department

Hispanos Unidos-New Haven*

Hockanum Valley Community Council-Vernon

Human Resources Agency-New Britain*

Interfaith AIDS Ministries of Greater Danbury

Latino Community Services-Hartford *

Lawrence and Memorial Hospital-New London

Meriden Health Department

Mid-Fairfield AIDS Project-Norwalk*

New Haven Health Department

Norwalk Health Department

Optimus Health Care-Bridgeport*

Perceptions Programs-Willimantic

Shelter for the Homeless- Stamford

Southwest Community Health Center-Bridgeport

Stamford Health Department

UCONN/CT Children's Medical Center (CCMC) - Hartford *

UCONN Correctional Managed Health Care – Farmington*

Waterbury Health Department*

William Backus Hospital – Norwich

Yale New Haven Hospital

Yale University – New Haven

Connecticut AIDS Education & Training Center

Statewide Programs

Project TLC (AIDS Project Hartford)

Connecticut AIDS Resource Coalition

Stamford Health Department

UCONN/CT Children's Medical Center (CCMC) - Hartford

UCONN Correctional Managed Health Care – Farmington

Waterbury Health Department

Waterbury Health Department – Torrington

William Backus Hospital – Norwich

Yale New Haven Hospital

Yale University – New Haven

VI. Emerging Needs, Issues, Trends

This section discusses three issues identified by the SCSN work group that will have bearing on service provision and emerging need in the state of Connecticut for people living with HIV/AIDS. They include: 1) Increased number of persons living at or below 300% federal poverty level, 2) Housing, food and energy concerns, and 3) Client level data. As the CHPC enters its next three year cycle, these factors (reflected in the report recommendations) will be considered when implementing the 2012-2015 Comprehensive Plan.

1. Persons living at or below 300% of the 2009 Federal Poverty Level

Socioeconomic status shapes social and individual factors that affect the care of PLWHA, the risk of HIV infection, and the probability of relying on publicly funded health care services. Poverty is particularly associated with increased morbidity and premature mortality. Although it is the third richest state in America by median household income, with approximately 83% of its municipalities above the national average per capita income, CT shows a great disparity in incomes statewide. It has many enclaves of poverty that are often overshadowed by rich communities with 9.4% of CT residents living below the poverty line (US Census data).

Table 13. 2009 Poverty Rate in Connecticut by County and People Living with HIV/AIDS[18]

County	% of Population living in poverty	PLWH/A[19]
New Haven	12.1	3,266
Hartford	10.2	3,276
Windham	9.4	202
Fairfield	8.3	2,797
New London	7.8	511
County	**% of Population living in poverty**	**PLWH/A**
Tolland	7.0	105
Middlesex	5.3	229
Litchfield	6.4	188

Hartford is one of the ten cities with the lowest per capita incomes in America. Hartford, the poorest city in Connecticut, has a per capita income of $14,528. In Bridgeport, more than 70% of city residents are minorities, and the city-wide poverty rate is over 21%. Bridgeport's unemployment rate at 14% is almost twice that of neighboring communities. However, if Hartford (or similar cities like New Haven and Bridgeport) was combined with its immediate suburbs, it would rank as one of the richest cities in the country. Other similar low-income towns are also located in the eastern part of the state, which is primarily a rural area. Poor and medium wealth households are particularly affected by a very high cost of living. This is due to a combination of expensive real estate, expensive heating for the winters, rising gas prices, and other factors. The Hispanic race/ethnicity population cohort has the highest poverty rate

[18] American Community Survey, 2009 estimates
[19] http://www.ct.gov/dph/cwp/view.asp?a=3135&q=393048.

with 26 percent of residents living in poverty. Children under five years of age are experiencing the most poverty in Connecticut, with 15% living in poverty.

Housing, Food and Energy

A study by the National Energy Assistance Directors Association from 2009, found that Connecticut experienced an increased need for assistance among low income individuals and families. The survey also found that not all applicants were able to access services. These results are in comparison to applications for assistance in past years in Connecticut and nationally. Connecticut saw significantly high rates of assistance application increases in comparison to other states. Other significant findings of the Directors Association report included some of the following information:

- Heating benefits averaged $759.00 for recipients in Connecticut
- 37% of respondents contacted their local social services agency for assistance and 31% of those were able to receive that assistance
- 48% of study respondents stated that annual energy bills were greater than $2,000
- Unaffordable bills caused the following percentages of situations in survey respondents:
    - 29% went without medical or dental care
    - 23% did not take or rationed prescriptions
    - 21% went without food for one day
- 3% of respondents reported becoming sick because their home was too hot or too cold and 2% of those respondents reported having to be hospitalized from being sick because their home was too hot or cold
- Recipients of energy assistance are more likely to have vulnerable household members
- 90% of energy assistance recipients were found to have an elderly household member, a disabled household member, or a child in the home
- 60% of assistance recipients have annual incomes below $20,000

2008/2009/2010 Energy Assistance Summary[20]

In FFY 2011 (October 1, 2010 – September 30, 2011), there were 134,714 applications filed for energy assistance. Of those, 117,871 (87.5%) were approved leaving 16,843 (12.5%) applicants with denied applications. During FFY 2011, 26,086 applications for crisis assistance were approved, a 9.7% increase from the previous year.

In Connecticut, the home energy affordability gap for home energy is increasingly affecting even households that have traditionally been considered moderate income in both urban and rural areas.[21]

[20] Department of Social Services.
[21] The home energy affordability gap represents the dollar amount by which actual energy bills exceed affordable energy bills.

The average annual shortfall for homes with incomes under 185% of FPL is approximately $2,550 per household. Connecticut's statewide affordability gap is now near $585 million. While gaps vary by district according to poverty levels, even the smallest energy affordability gap in Connecticut is $105 million. The affordability gap affects households who are up to 185% of FPL, but they must be at or under 150% of FPL to be approved for assistance. While Connecticut's affordability gap has increased by nearly $385 million from 2002-2009, the LIHEAP allocation to Connecticut has only increased $61 million.

Housing

Housing continues to be one of the top needs for people with HIV/AIDS. During 2010, Connecticut AIDS housing providers turn away 91% of people with AIDS requesting housing simply because there is a lack of space. The National AIDS Housing Coalition has convened five AIDS and Housing Research Summits which have produced expansive research that clearly documents the correlation between good health outcomes and reduced HIV infection rates when people are safely housed. However, housing is not considered a core service under Ryan White services and is rarely, if ever, mentioned as a prevention strategy.

In Connecticut, the Fair Market Rent (FMR) for a two-bedroom apartment is $1,215. To afford this level of rent and utilities, without paying more than 30% of income on housing, a household must earn $4,052 monthly or $48,619 annually. Assuming a 40-hour work week, 52 weeks per year, this level of income translates into a Housing Wage of $23.37.[22] Additionally, Connecticut holds one of the highest tax burdens of any state, increasing the cost of living.[23]

In Connecticut, a minimum wage worker earns an hourly wage of $8.25. In order to afford the FMR for a two-bedroom apartment, a minimum wage earner must work 113 hours per week, 52 weeks per year. Or, a household must include 2.8 minimum wage earner(s) working 40 hours per week year-round in order to make the two-bedroom FMR affordable. In Connecticut, the estimated mean (average) wage for a renter is $15.10 an hour. In order to afford the FMR for a two-bedroom apartment at this wage, a renter must work 62 hours per week, 52 weeks per year.

Monthly Supplemental Security Income (SSI) payments for an individual are $674 in Connecticut. If SSI represents an individual's sole source of income, $202 in monthly rent is affordable, while the FMR for a one-bedroom is $1,002.

A unit is considered affordable if it costs no more than 30% of the renter's income. The FMR is the 40th percentile of gross rents for typical, non-substandard rental units occupied by recent movers in a local housing market.[24]

[22] *From the National Low Income Housing Coalition's "Out of Reach" 2010 report. www.nlihc.org*
[23] http://www.marketwatch.com/story/the-10-worst-states-for-retirees-2010-12-09.
[24] *HUD, Office of Policy Development and Research http://www.huduser.org/periodicals/ushmc/winter98/summary-2.html)*

Connecticut's lack of affordable housing supply has been exacerbated by a belief that towns creating housing will see school costs rise – and, in turn, cause a rise in property taxes to pay for them. The evidence of concern about property taxes can be seen in the rising number of municipal budgets adopted by referendum: votes are up 14% to 149 in 2009 from 128 in 2005.[25]

The lack of housing creation has already affected municipal budgets: towns are paying premiums to attract teachers, paraprofessionals, volunteer firefighters and other municipal workers. A lack of affordable housing options may deter young professionals and families from staying in or moving to Connecticut; realtors believe that this will ultimately have a dramatic effect on demand just as baby boomers are looking to sell their homes. With fewer offers from a smaller number of buyers, home values could drop, diminishing grand lists and requiring towns to make a tough decision - raise mil rates or cut services. That could affect the quality of life in Connecticut to a great degree.

Housing and Homelessness: Housing as Healthcare and Prevention

The Connecticut AIDS Resource Coalition (CARC) has been collecting statistics on the demand for and utilization of AIDS housing since 1992. In 2010, over 1,300 men, women and children were housed among the 25 supportive AIDS housing programs located across the state. During the same time period, 91% of those requesting housing were turned away due to a lack of available space. The vast majority (55%) of those newly admitted into the programs were homeless and living on the streets, living in shelters or were precariously housed with family or friends. In fact, over 100 newly admitted residents came directly from homeless shelters, a 50% increase from 2009.

In the Statewide Point in Time Homeless Count (PITC) in 2011, statewide, 5% of the people who were homeless self-reported as having HIV/AIDS. While in Hartford, the figure was twice that. Given that those surveyed were self-reporting as well as the degree of stigma people experience and perceive, we can reasonably expect that that number is actually much higher.

To highlight the overall state housing needs, in the summer of 2007, the state Section 8 program run by DSS, opened up the lists. There were 48,000 applicants for 1,000 vouchers 8,000 applications were put in the lottery for the 1,000 vouchers. 83% of original applicants were shut out of the lottery system and 40,000 people received letters that they did not even make the list.

Findings and Recommendations from the Office of National AIDS Policy Consultation on Housing and HIV Prevention and Care

Effectively addressing HIV risk and health care disparities in the United States will require attention to structural determinants— environmental or contextual factors that directly or indirectly affect an individual's ability to avoid exposure to HIV, or for HIV positive individuals the ability to avail of health promoting and risk reducing resources. A strong and consistent evidence base identifies housing status as a key structural factor influencing HIV vulnerability, risk, and health outcomes. Homelessness itself places persons at risk of HIV infection, and among persons already disproportionately impacted by HIV/AIDS (e.g., men who have sex with men, persons of color, homeless youth, IV drug users, and

[25] The Partnership for Strong Communities' "Housing in CT 2010" policy brief.

women), lack of stable housing greatly amplifies their vulnerability for HIV infection, poor health outcomes, and early death.

This substantial body of research also demonstrates that receipt of housing assistance has an independent, direct impact on receipt of HIV treatment, health status, and mortality among homeless/unstably-housed people living with HIV/AIDS (PLWHA). Further, housing has a prevention impact by reducing HIV transmission risk.

Housing is consistently cited as the greatest unmet need of Americans living with HIV

Compelling research findings presented at all five Summits demonstrate the critical significance of housing as an intervention to address both public and individual health priorities, showing strong correlations between improved housing status and reduced HIV risk, improved access to HIV medical care, and better health outcomes.

Food

Connecticut residents are increasingly requesting assistance for basic family needs such as food. The following gives a snapshot of Connecticut's SNAP program.

- SNAP/Food Stamp Program (FY 2010) Average Monthly Participation (Individuals) 336,034
- Change in Participation in last 5 Years 64.6%
- Average Monthly Benefit per Person $141.26
- Participation Rate of Eligible Persons (FY 2008) 66%
- Rank Among States 26 Participation Rate of Eligible Working Poor (FY 2006) 50%
- Federal Funding for CT SNAP/Food Stamps $569,684,382

According to the USDA report which presents data from December, 2010 (most recent), the number of Connecticut households on SNAP totaled 371,675 which represents a 10% increase in participation.

Not only was there an increase in application for the SNAP programs, the Connecticut Department of Social Services (DSS) saw increases in all other services. DSS had an 18% increase in their caseload in 2009. According to the End Hunger CT! website, these numbers have likely increased due to the economic downturn, which has affected every aspect of Connecticut resident's lives. Individuals continue to struggle trying to provide the basic needs for their family members, in part, due to the lack of jobs, unemployment and the high cost of living.

According to Foodshare, demand at local food pantries is up by 30% over the last two years. Food donations have been flat for two years in a row. Foodshare estimated that they served 1/3 to ½ of the real need before the huge increases due to the recession. Unfortunately, they have not been able to grow to keep up with the growing need.

Connecticut's Healthcare Workforce:

The public health workforce focuses on preventing disease and injury while protecting and promoting the health of *populations*. The health care workforce focuses on the health of *individuals.* The public health workforce is multidisciplinary, comprising nurses, physicians, occupational health and safety personnel, epidemiologists, environmental health professionals, public health laboratory personnel, health administrators, health economists, health planners and analysts, licensure inspection and regulatory specialists, community development workers, and health educators. An adequate and well-trained workforce is an essential element of public health efforts. According to the Health Resources and Services Administration (HRSA), the nation's health system faces a growing demand for health care, particularly primary care (e.g. primary care providers, primary care nurse practitioners and physician assistants), dental, mental health and pediatric health providers.

Connecticut's Primary Care Office (PCO), through a cooperative agreement with HRSA, works with health care providers and communities to improve access to care for the underserved, by recruiting and retaining providers to practice in federally designated shortage areas. The PCO ensures that Connecticut is able to recruit and retain high quality health professionals to serve as primary care providers in urban and rural areas. A number of efforts have been undertaken in Connecticut to address persistent healthcare workforce shortages. In 2009, the Connecticut General Assembly established the Sustinet Board of Directors. This board is charged with creating a plan that will improve the health of state residents, improve the quality of healthcare and access to healthcare, provide health insurance coverage to CT residents who would otherwise be uninsured, increase the range of health insurance coverage options, and slow the growth of per capita health care spending in both the short and long term. The Sustinet HealthCare Work Force Task Force, one of three task forces created, is charged with developing a comprehensive plan for preventing and remedying state-wide, regional and local shortage of necessary medical personnel, including physicians, nurses and allied health professionals.

The size and characteristics of CT's future healthcare workforce are and will be determined by the complex interactions of various environments and influences: the health care operating environment, economic factors, technology, regulatory and legislative actions, epidemiological factors, the health care education system and demographics.[26]

Some of the issues impacting the healthcare workforce in Connecticut include: (1) lack of or decreasing number of physicians specializing in HIV disease treatment; (2) starting wages for primary care physicians are considerably lower than for specialists; (3) primary care providers leaving the field because of long, erratic hours, administrative obligations (e.g. insurance companies), and malpractice liability forcing many internists and family doctors to reduce the number of high-risk patients served and services provided because of legal concerns; (4) pay scales and pay increases for non physician primary care providers tend to be lower and smaller, especially in facilities that serve a high proportion of Medicaid and uninsured patients; (5) lack of adequate state incentives to attract providers to underserved areas or family practice; (6) need for education and training opportunities to assist foreign-

[26] Sustinet Healthcare Workforce Task Force Briefing Paper, *Connecticut's Healthcare Workforce: Under Construction*, May 2010.

trained providers to become licensed (e.g. English proficiency) and assistance in helping individuals navigate the cumbersome licensing system in Connecticut; (7) difficulties in adequately staffing clinics and hospitals in underserved areas; (8) need for more minorities in the health care workforce to better address the concerns of CT's growing racially and ethnically diverse population; (9) current federal and state health care reforms are placing an emphasis on primary health care and prevention services, but current insurance reimbursement policies are at cross-purposes with this objective by providing higher reimbursement to specialists and encouraging more services to be provided through "fee for service" reimbursement policies; (10) on-going nursing shortage in CT despite recruitment efforts and scholarship/loan repayments incentives; (11) established long-time HIV (Infectious disease doctors) reaching retirement age with no or few replacements, and (12) aging CT population placing a greater demand on the health care system at the same time many health professionals will be retiring (e.g. between 2000 and 2030, the CT's population 65 years of age and over is expected to increase 69%).[27]

Connecticut has and is making strides to address the factors that act as barriers to increasing the size and quality of Connecticut's healthcare workforce: (a) development of online perioperative nursing courses for nurses interested in moving into this field; (b) promotion of student nurse summer internship programs with hospitals in underserved and rural areas; (c) working with colleges and universities to increase enrollment and retention of students in the allied health and nursing professions; (d) implementation of an on-line licensing renewal system for physicians, nurses, dentists and other licensed professionals, (e) establishment of Masters level Nursing degrees at state colleges and private universities to prepare baccalaureate nurses to serve as educators in nursing schools to address the shortage of nursing faculty, and (f) modification of the LPN curriculum so that LPNs are able to receive full credit for first year of an RN program offered at community colleges and fill second year RN slots where attrition rate is high.

Rural Issues in Connecticut

Background: The Connecticut Office of Rural Health (CT ORH) defines rural as all towns in a designated Metropolitan Statistical Area with a population of less than 15,000 and those towns in Metropolitan Statistical Areas with a population of less than this number 7,000.[28] The 2008 SCSN included findings from a rural data work group (of providers representing AIDS service agencies and the VNA) that developed a list of service related issues especially relevant to rural areas. Those issues include:

- *Oral health and Insurance:* Some dentists are unwilling to work with populations who are covered by Medicaid and/or living with HIV.
- *Oral health and Transportation:* Transportation for all rural towns is a problem. No public service exists, and in many instances there is no taxi service in many rural towns. In Windham County, although many clients go to Farmington for dental services, there are no resources to get dental patients to their appointments. Danielson and North Grosvenorsdale clients must ride to Farmington. The travel and appointment time may take an entire day, or they may be delayed because of the long travel time and miss the appointment. The New London area has dental services

[27] OLR Research Report, 2008-R-0679, *Recruiting and Retaining a Primary Healthcare workforce*, Saul Spigel, December 2008.
[28] CT-Office of Rural Health www.ruralhealthct.org/towns

but transportation becomes an impediment keeping them from accessing the services. Tolland has more severe transportation issues getting people to all health care providers and other health care.

- *Financial/Food Assistance:* Resources that are limited or unavailable in some communities are being accessed in neighboring towns, e.g., individuals in need from Lebanon are being sent to Willimantic for services, straining already tight resources.
- *Insurance:* Persons covered by Medicaid LIA and Medicaid have difficulty getting primary care.
- *Lack of clinics:* There is no facility that covers dental services and there are no medical clinics for the HIV/AIDS population in Tolland County. AIDS Project Hartford's (APH) satellite in Tolland County can access HIV testing and counseling as well as other prevention services through APH's prevention staff. The additional burden of no public transportation poses a critical barrier for individuals seeking primary care services elsewhere.
- *Medical Case Management:* Medical case management in Tolland County has reported a client wait list. Windham County medical case managers support active cases and report no wait list, and see many clients in their homes due to transportation issues and health-related concerns. New London County medical case managers reported average caseloads of 55-60 people until recently when additional funding was allocated for a full-time medical case manager in New London. As in other rural areas, medical case managers see many clients in their homes due to transportation and health issues. Waterbury Health Department, through its site in Torrington, provides medical case management in Litchfield County. Again as with other rural locations, Waterbury-Torrington case managers travel distances to see clients in their homes due to lack of adequate transportation.

Rural Health Report Corroborative Findings

The issues identified by the rural work group align with findings from the CT Office of Rural Health report.[29] For example:

- Public transportation in rural areas is extremely limited and nonexistent in most, and rural providers cite transportation as one of the top barriers to care. Healthcare providers identified transportation services as the most significant barriers to accessing healthcare for rural residents. Other factors identified by providers ranked in order from greatest to least include: (1) financial constraints or the lack of healthcare insurance coverage, (2) the time period to wait for a healthcare appointment, (3) lack of knowledge of services available, (4) lack of walk-in services, (5) language barriers, and (6) office hours.
- Transportation and physical access to care are some of the biggest issues for rural residents and a major factor distinguishing rural from urban health concerns. A survey of providers indicated transportation as the biggest barrier to care for their residents. As with the healthcare provider survey, transportation was identified among all interviewed providers as the leading barrier to accessing medical care in rural areas. In Danielson, there is no taxi service, and homebound residents must call an ambulance for the slightest health problem. Additionally, while there are

[29] http://www.ruralhealthct.org/report.htm.

public buses, they do not run at night, and cannot provide access to some of the larger regional health centers. The Putnam report noted similar issues but indicated progress working with the local bus service. There are no public transportation services in Tolland County other than the one town of Vernon.

- The rate of new HIV and AIDS cases reported in the state were far lower in the rural areas in recent years, but the challenge of providing services to lower income persons with HIV and AIDS is greater in the rural areas. Issues for isolated populations (e.g. gay, bisexual, transgender teens) may be more serious in rural areas. Prevention to ensure the continuation of this low rate and treatment for those with HIV/AIDS requires resources and access to care for the rural population. In 2008, an agency in Tolland County has been funded to provide prevention interventions in the area.
- Consumers have identified difficulties obtaining a primary care provider once they no longer have insurance or Medicaid coverage. Most providers request insurance information at the time appointments are made. As of 2005, there are 2,591 dentists in the state of Connecticut. Of these, only 385 accept Medicaid.
- Rural healthcare providers identified access to dental care as one of the top five services not currently being met in rural areas.

c.) Client Level Data

Beginning in 2010 Ryan White program grantees and respective service providers have used a new biannual data collection and reporting system to report information on their programs and the clients they serve to the HIV/AIDS Bureau (HAB). This report, the Ryan White HIV/AIDS Program Services Report (RSR), will consist of the Grantee Report, the Service Provider Report and the Client Report. The Client Report, to be completed by each service provider, will capture client level data such as client demographics (unique identifier, date of birth, race/ethnicity, gender, including recording of Transgender subgroup, Federal Poverty Level, housing status, HIV/AIDS status, risk factor, sources of medical insurance, etc) as well as HIV clinical information, and HIV Care medical and support services received. The most recent HRSA Performance Measurement outcomes have also been included in this Client Report.

Connecticut currently collects client level data through the CAREWare reporting system. In an outstanding example of collaboration, every Ryan White Grantee and Sub-grantee now has access to and enters data into a single central server housed by the City of Hartford. This system collects all of the client level data required by HRSA/HAB, including all the Performance Measures recommended by HRSA. This includes the following client level data: HIV Status, AIDS Status, Viral Load, CD4 Count, whether the client is on ARVs, and core medical and support services. Through the use of internal processes built into the software, providers are able to, with the client's permission, share information on the client's health and service status. This improves our ability to provide the best care possible to our clients.

Connecticut's Program Evaluation and Monitoring System (CPEMS) is a data reporting tool designed to strengthen monitoring and evaluation of HIV prevention programs. CPEMS is a secure internet browser-

based software program for data entry and reporting. To have access to CPEMS, all users need to be eAuthenticated at Level 3. The software was first released in 2004 and allows grantees to collect agency, community planning and program plan data as well as enter client-level data. Unique identifiers are used to protect client confidentiality.

CPEMS ensures that CDC receives standardized, accurate and thorough program data from health departments, and community-based organization grantees. The data help HIV prevention stakeholders examine program fidelity, monitor use of key program services and behavioral outcomes, and calculate and report the program performance indicators. Some of the data collected include agency information, program plan details, client demographics, referral outcomes, HIV test results, behavioral outcomes, community planning priority populations and interventions among others.

DPH contract agency CPEMS users have been trained and receive ongoing technical assistance from DPH staff serving as CPEMS Administrators on how to properly enter information into the system and maintain confidentiality of client-level data. There are currently two DPH staff persons, who monitor the use of CPEMS at contract agencies. These DPH CPEMS Administrators provide technical assistance to contract agency CPEMS Users and generate reports on service delivery for contract managers. They set up interventions, assign user roles, update site and worker information, and set up/reset logins. DPH CPEMS Administrators provide ongoing education to sites on the importance of keeping challenge phrases and login passwords private. Thus far, there have been no documented or reported breaches of confidentiality. DPH contractor who implement the Counseling, Testing and Referral (CTR) intervention use EvaluationWeb (XPEMS) as the HIV testing data reporting tool. XPEMS is an online data collection and reporting system specifically for HIV Prevention and HIV Counseling and Testing data. The XPEMS database system collects the same data required by the CDC's Program Evaluation Monitoring System (CPEMS). To have access to XPEMS, all users need to be eAuthenticated at Level 2.

Beginning in October 2012, client level and grantee level data collection and reporting will also be conducted through Connecticut's AIDS Drug Assistance Program (CADAP). The ADAP Data Report (ADR) will include client demographics such as gender, age, race/ethnicity, insurance type, homelessness and ADAP service utilization including formularies, medications, insurance participation and client billing services.

VII. Recommendations

The following recommendations were developed to inform the allocation and use of resources for service delivery in the State of Connecticut for PLWH/A and were revised by the SCSN Work Group identified by the Data and Assessment Committee during October – December 2011. Data reviewed to develop these recommendations were based on results from the 2010 Statewide Needs Assessment Survey and the Connecticut Epidemiological Profile of HIV/AIDS in Connecticut 2010.[30]

In developing the recommendations, the CHPC considered the National HIV/AIDS Strategy which has three primary goals: 1) reducing the number of people who become infected with HIV, 2) increasing access to care and optimizing health outcomes for people living with HIV, and 3) reducing HIV-related health disparities:

Process Recommendations

1. Promote innovative strategies, interventions, social marketing, and the use of technology to affect behavior change and address barriers to care.
2. Enhance and expand collaborations across and within State Agencies and service organizations to ensure PLWH/A get the services they need.

Service Improvement Recommendations

3. Ensure state funds are directed toward effective behavioral interventions targeting priority populations.
4. Develop strategies to ensure data collection measures are achieved and used for quality improvement.
5. Ensure compliance with protocols and standards for care and prevention services funded by the Department of Public Health.
6. Maximize training resources for service providers by collaborating with multiple partners.

Emerging Issues Recommendations

7. Implement the strategies of the Connecticut HIV/AIDS Identification and Referral Task Force (CHAIR) to identify, and refer the unaware population to HIV testing, education, care and prevention programs.

[30] Refer to pages 5 and 6 for a full list of participants and data sources.

CT's Current Efforts to Address the SCSN Recommendations

Connecticut Department of Public Health Care and Support Services and Prevention units are working in collaboration with the Ryan White Parts to link individuals to care who are unaware of their status. CT DPH remains committed to providing services that are culturally sensitive, geographically accessible and offer flexible hours. It works to strengthen the system of care linkages through co-location, cross training, referral strategies among substance abuse treatment, mental health treatment, counseling and testing, Comprehensive Risk Counseling Services, Partner Services, MCM, EIS and medical providers. CT DPH will continue to increase and expand efforts to engage and bring into care minority populations, MSM, undocumented individuals, individuals unaware of their status, and immigrants.

Part B funds two Early Intervention Services programs: one in the New Haven/Fairfield EMA and one in the Greater Hartford TGA and requires adherence to HRSA components for EIS, promotes linkages and referrals between HIV Counseling and Testing and Medical Case Management, and requires Partner Services Assessment and Referral as part of Medical Case Management and Medication Adherence Intake.

Connecticut HIV/AIDS Identification and Referral (CHAIR) Task Force

CHAIR was created from a recommendation made by the CHPC in 2010 to support the identification, linkage and referral of people living with HIV/AIDS but unaware of their status to care and prevention.

In 2010, the task force (supported and staffed by DPH) developed the following draft goals and objectives:

1. Develop and coordinate state and local strategies to identify people who are unaware of their HIV positive status and link them to care.
    a. To bolster referrals to DPH's highly successful, yet underutilized, HIV/AIDS Partner Services (PS) program.
    b. To improve the coordination of local strategies to identify people who are unaware of their HIV positive status and link them to care.
    c. To enhance the implementation of routine HIV testing currently at ERs, DMHAS, CHCs and STD clinics with enhanced PS/linkage to care and marketing to providers.
    d. To increase Routine HIV testing currently at non-DPH funded primary care, outpatient, and ER facilities.
    e. To decrease the barriers associated with identifying people who are unaware of their status and linked into care.
2. Foster collaboration between Ryan White A and B and Prevention in these efforts.
    a. Actively participate in the Statewide Coordinated Statement of Need and Connecticut's Comprehensive Plan

b. Work of the CHAIR should be incorporated into the work of the CHPC

c. To develop a protocol to foster collaboration between the different EIS programs and the Partner Services (PS) program, especially around patients with repeat co-infection of HIV and another STD.

3. Coordinate data collection, identify data needs, and evaluate approaches for identifying people who are unaware of their status and link them and their patient level data with community viral load.

    a. To identify data needs of prevention & care programs to align with the CSN/PEMS/CAREWare data collection systems.

    b. To improve Part As, Part B, and prevention collaboration regarding data needs for federal grant applications and reporting.

New Haven/Fairfield EMA

- FY 2012 all MAI funds will be used for EIS to identify people of color who are unaware of their status in connection with the National HIV Strategy and EIIHA.
- Top funding priorities for 2012 include: Outpatient/Ambulatory Medical Care, Medical Case Management Services, Substance Abuse Services and Mental Health Services.

Hartford TGA

- Prioritize EIS services and expand collaborations with HIV identification and engagement services, such as Partner Services and improved coordination with other HIV counseling and testing programs at key points of entry.
- Participate in an integrated strategy to identify individuals with HIV. The goals of the strategy will: increase the percentage of people with HIV in the TGA who know their serostatus; get people with HIV into care in the early stages of infection; improve health outcomes of individual with HIV and reduce disparities in access to care; reduce HIV incidence and educate the public about HIV and HIV testing.

SERVICE MATRIX: HIV CARE, PREVENTION and SUPPORT SERVICES by COUNTY June 2012)

The HIV Care, Prevention and Support Services included in this document include those organizations and agencies directly funded through the Connecticut Department of Public Health and Ryan White Parts A, B, C, D and F as well as other community and statewide organizations and agencies who provide similar or related HIV care, prevention, and support services for People Living with HIV/AIDS (PLWHA). The Department of Mental Health and Addiction Services (www.ct.gov/DMHAS) provide substance abuse treatment program for PLWHA, and the Department of Social Services (www.ct.gov/DSS) offers an expansive list of programs for PLWHA including Connecticut's AIDS Drug Assistance Program (CADAP), Connecticut Insurance Premium Assistance (CIPA) Program, Pre-Existing Insurance Plans, Medicaid and Medicare and other social service programs and entitlements.

Key: Core Medical Services: Outpatient/ambulatory (O/A), AIDS Pharmaceutical Assistance (APA), Oral Health (OH), Early Intervention Services (EIS), Health Insurance Premium (HIP), Mental Health (MH), Medical Nutrition Therapy (MNT), Medical Case Management (MCM), Substance Abuse-Outpatient (SAO) Support Services: Non-medical Case Management (NMCM), Emergency Financial Assistance (EFA), Food bank (FB), Health Education/Risk Reduction (HERR), Housing Services (H)S, Legal Services (LS), Linguistics and Translation (LT), Medical Transportation(MT), Outreach Services (OS), Minority AIDS Initiative (MAI), Psychosocial Support (PS), Medication Adherence Program (MAP),Substance Abuse –Residential, (SER); Counseling, Testing & Referral (CTR),Comprehensive Risk Counseling Services (CRCS), Drug Treatment Advocacy (DTA), Syringe Exchange Program (SEP), Prevention Interventions(DEBI/EBI) listed individually

HARTFORD COUNTY	
PROVIDER	**SERVICES**
AIDS Project Hartford Main Office Second site: Manchester 110 Bartholomew Avenue, Third Floor Hartford, CT 06106 Tel: 860-951-4833 **Funding Sources: Part A, B, Prevention, State**	**Prevention:** Counseling, Testing & Referral (CTR), Comprehensive Risk Counseling Services (CRCS),Drug Treatment Advocacy (DTA), Project RESPECT, SISTA, Street Smart **Part A:** Medical Case Management (MCM) including Treatment Adherence, Housing Services (HS), Food Bank (FB), Non-Medical Case Management (NMCM) for Connections Wellness Center **Part B:** MCM, NMCM (Project TLC), Medical Nutritional Therapy (MNT), Outpatient/Ambulatory (O/A), Emergency Financial Assistance (EFA), Food Bank (FB), Medication Adherence Program (MAP) **State:** Syringe Exchange Program
Burgdorf Clinic/ Bank of America Health Center 131 Coventry Street Hartford, CT 06112 Tel: 860-714-2813 **Sub-contractor through CAHEC (Part A and B)**	**Part A:** Outpatient Medical Services (APRN): funded provided through Central Area Health Education Center **Part B:** MCM (provided through Central CT Area Health Education Center)
Central CT Area Health Education Center (CAHEC) 20-28 Sargeant Street Hartford, CT 06105 Tel: 860-920-5149 **Funding Sources: Part A, Part B, Prevention**	**Prevention:** DTA, Healthy Relationships, **Part A:** O/A(APRN), Early Intervention Services (EIS), Substance Abuse-Outpatient(SAO), SAO-homeless shelter **Part B:** O/A, Oral Health (OH), Mental Health (MH), MCM, EFA, Medical Transportation (MT), Minority AIDS Initiative (MAI)
Charter Oak Health Center 21 Grand Street Hartford, CT 06106 Tel: 860-550-7500 **Funding Source: Part D**	Outpatient Medical Services. Dental Care, Mental Health and Substance Abuse Services, Women's Services (OB/Gyn), Outreach/ Counseling & Testing Pharmacy **Part D:** MCM, Nutritional Counseling, Primary Care, Counseling & Testing

HARTFORD COUNTY	
PROVIDER	**SERVICES**
Christian Activities Council/ Zezzo House 47 Vine Street Hartford, CT Tel: 860-548-1174 **Funding Sources:** HOPWA and State AIDS Housing Funds	Affordable housing for PLWHA, Case management and support services
Chrysalis Center 278 Farmington Avenue Hartford, CT 06105 Tel: 860-525-1261 **Funding Source: HOPWA, State AIDS Housing Funds**	Rehab and health care Mental health and substance abuse services Case management, Employment services, **HOPWA, State AIDS Housing:** Housing services and Programs targeting homelessness
Community Health Services 500 Albany Avenue Hartford, CT 06120 Tel: 860-808-8749 **Funding Sources: Part A, Part C, Part D, and State**	**Part A:** O/A **Part C:** Rapid HIV Testing, Early Intervention Services **Part D:** MCM, Nutritional Counseling, Primary Care, Counseling & Testing **State:** Medication Adherence Program (MAP) Hepatitis Services, Primary Care, Pharmacy, Mental Health and Substance abuse Services, OB/Gyn Services, Dental Care, Diabetes Care, Social Services
Community Partners in Action (CPA) 110 Bartholomew Avenue, Suite 3010 Hartford, CT 06106 Tel: 860-566-2030 **Funding Source: Prevention**	Beyond Fear (AIDS Education and Prevention in Jails) Alternate Incarceration Centers (AIC), Resettlement Programs, Transitional Housing, Case Management **Prevention:** RHAP (Riker's Health Advocacy Program)
Community Renewal Team(CRT) 555 Windsor Street Hartford, CT 06120 Tel: 860-560-5600 **Funding Sources: HOPWA, State AIDS Housing, Part A**	Mental Health and Substance Abuse Services (located at 1921 Park Street in Hartford, 860-247-1233 and Mt. Sinai Campus, 675 Tower Ave, Suite 302-303 in Hartford, 860-714-9200) Child Care Centers, Employment & Training, Supportive Housing & Shelters, Senior Housing and Senior Services, Re-Entry Services, Meals on Wheels **Part A:** Mental Health, Substance Abuse-Outpatient
Connecticut AIDS Resource Coalition (CARC) 110 Bartholomew Avenue, Suite 400 Hartford, CT 06106 Tel: 860-761-6699 **Funding Sources: Part A, State, HOPWA, DSS**	**Part A:** O/A (fee for service). MH (fee for service), OH, AIDS Pharmaceutical (local), Health Insurance Premium, MT, Housing (1x and rental subsidies), EFA, FB **State:** Housing (non TGA/EMA areas) **HOPWA and DSS:** Statewide Housing services (Rental subsidies, 1x assistance) Statewide Advocacy
Connecticut Children's Medical Center (CCMC)/UCONN 282 Washington Street Hartford, CT 06106 Tel: 860-545-9490 **Funding Sources: Part A, B, and D, Prevention**	**Part A:** O/A, MCM, MH **Part B:** Medical Case Management, Emergency Financial Assistance **Part D:** MCM, Primary Care, Counseling & Testing **Prevention:** Together Learning Choices (TLC),

HARTFORD COUNTY	
PROVIDER	**SERVICES**
ConnectiCOSH 683 North Mountain Road Newington, CT 06111 Tel: 860-953-2674 **Funding Source: Prevention**	Counseling, Testing and Referral (CTR): Migrant Farms Prevention interventions: Migrant farm population **Prevention:** Counseling & Testing, Safety Count, VOICES/VOCES
Greater Hartford Legal AIDS (AIDS Legal Network) 999 Asylum Avenue, 3rd floor Hartford, CT 06105 Tel: 860-541-5000 **Funding Sources: Part A**	**Part A:** Statewide Legal/advocacy services, legal representation, referral
Hands on Hartford/Peter's Retreat 330 Main Street, Hartford, CT Tel: 860-247-4140 **Funding Sources: HOPWA, State AIDS Housing Funds**	Supportive and transitional housing for PLWHA Case management, Meals, Financial assistance, Counseling Hospice Care
Hartford Dispensary 12-14 Weston Street Hartford, CT Tel: 860-525-2181 **Funding Source: Prevention**	Methadone maintenance Drug Treatment and Rehab Hepatitis C Program **Prevention:** Risk Avoidance Partnership **Medical Case Management (through Part B funding to CAHEC)**
Hartford Gay & Lesbian Health Collective 1841 Broad Street Hartford, CT 06114 Tel: 860-278-4163 **Funding sources: Part A, Part B, Prevention**	Counseling, Testing & Referral (CTR), Comprehensive Risk Counseling Services (CRCS), HIV Prevention Interventions **Part A:** Mental Health, EIS, OH, Food bank, Non-medical case management (Health Collective-East) **Part B:** Oral health **Prevention:** CRCS, Counseling & Testing, Healthy Relationships, MPowerment, Peer-non Peer Outreach to MSM, Services for Gay, Lesbian, Bisexual and Transgender
Hartford Health Department: Health and Human Services 131 Coventry Street Hartford, CT 06112 Tel: 860-543-8822 **Funding Source: Part A, Prevention**	**Ryan White Part A Program Administration** **Part A:** EIS **Prevention:** Counseling & Testing Counseling, Testing & Referral STD and Tuberculosis Clinic
Hartford Hospital (Brownstone) Washington Street Hartford, CT **Funding Source: Part A**	**Part A:** O/A, MCM
Hispanic Health Council 175 Main Street Hartford, CT 06106 Tel: 860-527-0856 **Funding Source: SAMHSA**	**SAMSHA: Project CONNECT**

HARTFORD COUNTY	
PROVIDER	**SERVICES**
Human Resources Agency Wellness Resource Center of New Britain 83 Whiting Street New Britain, CT 06051 Tel:860-826-4741 **Funding Sources: Part B, Prevention, HOPWA and State AIDS Housing Funds, AIDS Services Line (state)**	P**art B:** Medical Case Management, Medical Nutritional Therapy, Early Intervention Services, Medical Transportation, Emergency Financial Assistance, Food Bank and Hot Meals, HIV Medication Adherence Program **Prevention:** Counseling & Testing, Safety Counts, Scattered site Housing for PLWHA
Health Collective East 64 Church Street Manchester, CT 06040 Tel: 860-646-6260 **Funding Source: Part A**	Psychosocial support: support groups Food bank and meals **Part A:** Medical Case Management, Food, non-medical case management (Through HGLHC)
Immaculate Conception Shelter and Housing 560 Park Street Hartford, CT 06126 Tel: 860-586-7025 **Funding Sources: HOPWA, State AIDS Housing funds**	Scattered site and transitional/emergency housing Case management Food bank Street Outreach AIDS support services Substance abuse services
Latino Community Services 184 Wethersfield Avenue Hartford, CT 06114 Tel: 860-296-6400 **Funding Sources: Part A, Part B, Prevention, SAMSHA, CDC (direct funding), Office of Minority health (OMH)**	Counseling, Testing & Referral (CTR), HIV Prevention Interventions **Part A:** Medical Transportation, Linguistics **Part B:** Medical Case Management, Linguistic/Translation services **Prevention**: Counseling & Testing, Safety Counts, Spiritual Self Schema, VOICES/VOCES **SAMSHA:** Mental Health Services
McKinney Shelter 34 Huyshope Avenue Hartford, CT 06106 Tel: 860-772-6920	Overnight shelter and meals for homeless men, Day respite for medically compromised individuals Counseling Case Management
Mercy Housing and Shelter Corporation 211 Wethersfield Avenue Hartford, CT 06114 Tel: 860-808-2040 **Funding sources: Part A, HOPWA, State AIDS Housing Funds**	Housing services: transitional, emergency and supportive Rental assistance for multiple-diagnosed individuals Day shelter and meals **Part A:** Housing Services
New Britain Hospital (Hospital of Central Connecticut) Grant Street New Britain, CT 06053 **Funding Source: Part A**	**Part A:** O/A

HARTFORD COUNTY	
PROVIDER	**SERVICES**
St. Philip House 80 Broad Street Plainville, CT 06061 Tel: 860-793-2221 **Funding Sources: HOPWA, State AIDS Housing Funds**	Supportive housing and scattered site housing for PLWHA Case Management Support Groups and social services
Tabor House I And II) 67 Brownell Avenue Hartford, CT 06106 Tel: 860-244-3876 **Funding Sources: HOPWA, State AIDS Housing Funds**	Supportive and transitional housing and supportive services for PLWHA
University of Connecticut Health Center 263 Farmington Avenue Department of Medicine, Dowling North Farmington, CT 06030 Tel:860-679-3893 **Funding Sources: Part A, Part B,**	Primary medical care, Inpatient and outpatient medical services Medical case management **Part A:** O/A, MCM including Treatment Adherence **Part B:** MCM, HIV Medication Adherence Programs

Key: Core Medical Services: Outpatient/ambulatory (O/A), AIDS Pharmaceutical Assistance (APA), Oral Health (OH), Early Intervention Services (EIS), Health Insurance Premium (HIP), Mental Health (MH), Medical Nutrition Therapy (MNT), Medical Case Management (MCM), Substance Abuse-Outpatient (SAO) Support Services: Non-medical Case Management (NMCM), Emergency Financial Assistance (EFA), Food bank (FB), Health Education/Risk Reduction (HERR), Housing Services (H)S, Legal Services (LS), Linguistics and Translation (LT), Medical Transportation(MT), Outreach Services (OS), Minority AIDS Initiative (MAI), Psychosocial Support (PS), Substance Abuse –Residential, (SER); Counseling, Testing & Referral (CTR),Comprehensive Risk Counseling Services (CRCS), Drug Treatment Advocacy (DTA), Syringe Exchange Program (SEP), Prevention Interventions(DEBI/EBI) listed individually

NEW HAVEN COUNTY

PROVIDER	SERVICES
AIDS Project New Haven 1302 Chapel Street New Haven, CT 06511 Tel: 203-624-0947 **Funding sources: Part A, Part B, Prevention, HOPWA**	Ambulatory/outpatient, Mental Health, Substance abuse-outpatient, Early Intervention services, Medical Nutrition Therapy, Emergency Financial Assistance, Food Bank, Housing related services, Medical transportation, Psychosocial support **Part A:** MCM, SA/O, MH, Medical Transport, EFA, Food **Part B:** MCM, Medical Nutrition Therapy, Early Intervention Services (EIS),Food bank, EFA, Housing, Medical Transportation, Psychosocial Support, Medication Adherence Program (MAP) **Prevention:** SISTA, Street Smart,
Birmingham Group Health Services 435 East Main street #1 Ansonia, CT 06906 203-736-2601 **Funding Sources: HOPWA**	Mental Health, Substance Abuse – outpatient, Outreach, Housing, Support services
Clifford Beers Child Guidance 93 Edwards Street New Haven, CT 06511 Tel: 203-772-1270 **Funding Source: SAMHSA**	**SAMSHA:** Minority HIV Prevention –Minority Adolescents
Columbus House 586 Ella T. Grasso Blvd. New Haven, CT 06519 Tel:203-401-4400 **Funding Source: HOPWA, State AIDS Housing Funds**	Transitional housing program for adults living with HIV
CT Counseling Center, Inc. 4 Midland Road Waterbury, CT 06705 Tel: 203-755-8874 **Funding Source: Part A**	Substance abuse and mental health outpatient treatment, counseling, psychiatric services, methadone maintenance, HIV/TB and Hepatitis C prevention, testing, education and counseling **Part A:** MH, SA/O
Fair Haven Community Health Center 374 Grand avenue New Haven, CT 06513 Tel: 203-777-7411 **Funding Source: Part A, Part C, Part D**	Ambulatory/outpatient, Medical Case Management, emergency Financial assistance, Early Intervention services, Outreach, HIV Counseling, Testing and Referral (CTR), Behavioral health services, HIV nutrition counseling, Adherence services, nursing services **Part A:** O/A, MCM, EFA, Health Insurance Assistance **Part C:** EIS **Part D:** MCM, MH, Nutritional Counseling, Primary Care, Counseling & Testing

NEW HAVEN COUNTY	
PROVIDER	**SERVICES**
Haelen Center Hospital of Saint Raphael 1450 Chapel Street New Haven, CT 06511 203-789-4135 **Funding Source: Part A**	Specialized HIV Primary Care, Hep B and C Treatment, MH Evaluations, Nutritional Counseling, Tobacco Cessation Counseling, Social work services and case management, Medication management and adherence, Pharmacy services and medication review **Part A**: O/A, MCM
Cornell Scott Hill Health Center 400-428 Columbus Avenue New Haven, CT 06519 Tel: 203-503-3148 **Funding Sources: Part A, Part C, Part D, Prevention**	Ambulatory/outpatient, Drug Treatment Advocacy, HIV Counseling, Testing and Referral (CTR), Oral Health, Medical Case Management, Emergency Financial assistance, Early Intervention Services, Comprehensive Risk Counseling Services, Behavioral health, Medical adherence services, OB/GYN **Part A:** O/A, MCM, SA/O, OH, EFA, Health Insurance Assistance **Part C:** EIS **Part D:** MCM, Nutritional Counseling, Primary Care, Counseling & Testing **Prevention:** CRCS, Drug Treatment Advocacy,
Hispanos Unidos 116 Sherman Avenue, 1st Floor New Haven, CT 06511 Tel: 203-781-0226 Meriden Site: 203-630-6686 **Funding Sources: Part A, Part B, State**	Medical Case Management, Ambulatory/outpatient, Mental Health, Substance abuse-outpatient, Psychosocial support, Emergency Financial Assistance HIV Prevention Interventions **Part A:** MCM, SA/O, MH, EFA, Food, Housing, Medical Transport **Part B:** MCM, O/A (fee for service), Oral Health (fee for service), EFA **Prevention:** Latinas en Accion, Healthy Relationships, VOICES/VOCES **State:** Medication Adherence Program (MAP),
Independence Northwest, Inc. 1183 New Haven Road Naugatuck, CT 06776 Tel: 203-729-3299 **Funding Sources: Part A, HOPWA, State AIDS Housing Funds**	Transitional housing, Advocacy, Counseling, Peer Support
Leeway 40 Albert Street New Haven, CT 06511 Tel: 203-865-0068 **Funding Source: HOPWA, State AIDS Housing Funds**	Skilled nursing facility for PLWHA; short and long term care, transitional and palliative; complementary therapies, support groups, counseling, holistic wellness
Liberty Community Services 254 College Street, Suite 205 New Haven, CT 06510 Tel: 203-495-7600 **Funding Sources: Part A, Prevention, HOPWA, State AIDS Housing Fund**	Substance abuse treatment, transportation, supportive housing, outreach, Medical Case Management, Emergency Financial assistance, Drug Treatment advocacy **Part A:** MCM, Housing, EFA **Prevention:** Drug Treatment Advocacy,

NEW HAVEN COUNTY	
PROVIDER	**SERVICES**
Meriden Health Department 165 Miller Street Meriden, CT 06450 Tel: 203-630-4221 **Funding Source: Prevention**	**Prevention:** Counseling & Testing, Healthy Relationships, VOICES/VOCES
Nathan Smith Clinic Yale University 135 College Street New Haven, CT 06510 203-688-2685 **Funding Source: Part A**	**Part A:** O/A, MCM, SA/O, MH
New Haven Health Department 54 Meadow Street, 9th Floor New Haven, CT 06519 Tel: 203-946-6453 **Funding Source: Part A, Prevention, State**	**Part A:** Ryan White Part A Program Administration **Prevention:** Counseling & Testing, Safety Counts, VOICES/VOCE **State:** Syringe Exchange Program
New Haven Home Recovery 153 East street, 3rd Floor New Haven, CT 06511 Tel: 203-492-4866 **Funding Sources: Part A, HOPWA, State AIDS Housing Fund**	**Part A:** MCM, SA/O, Housing, EFA
New Opportunities, Inc. 232 North Elm Street Waterbury, CT 06702 Tel: 203-575-4337 **Funding Sources: Part A, HOPWA, State AIDS Housing Fund**	Medical Case management, Medical transport, Outreach, Housing, Food bank, Emergency Financial Assistance, Child Care, Elder Services, Energy assistance, Support Services **Part A:** MCM, EFA, Food, Medical Transport, Housing Assistance
Recovery Network of Programs 2 Trap Falls Road, Suite 405 Shelton, CT 06484 203-386-8802 **Funding Source: Part A**	**Part A:** SA/O and SA-Inpatient, Early Intervention
Staywell Health Center 1302 South Main Street Waterbury, CT 06702 Tel: 203-591-9044, ext 233 **Funding Source: Part A**	**Part A:** O/A, OH, MH, MCM, Food, Medical Transport

NEW HAVEN COUNTY	
PROVIDER	**SERVICES**
Waterbury Health Department, Waterbury & Torrington 95 Scoville Street Waterbury, CT 06706 Tel: 203-574-6883 **Funding Sources, Part A, Part B, Prevention**	Medical Case Management, Emergency Financial assistance, Housing Services, Medical Transportation, Outreach and Education, Psychosocial support groups **Part A (Waterbury):** EIS, Medical Transport **Part B:** MCM, O/A (fee for service), OH (fee for service), EFA **Prevention:** Counseling & Testing, Drug Treatment Advocacy, Healthy Relationships, MPowerment, SISTA, VOICES/VOCES
Waterbury Hospital Infectious Disease Clinic 64 Robbins Street Waterbury, CT 06708 Tel: 203-574-4187 **Funding Source: Part A and Part C**	Primary medical, ambulatory/outpatient, Medical Case Management, Mental Health, Substance abuse-outpatient, Local AIDS Pharmaceutical, Early Intervention services, Adherence services **Part A:** O/A, MCM, OH, SA/O, MH, Health Insurance Assistance, Housing Assistance, EFA, Medical Transport, Food, SA-Inpatient, EIS **Part C:** EIS
Yale Child Study Yale University 1230 South Frontage Road New Haven, CT 06520 Tel: 203-785-2513 **Funding Sources: Part A, Part D**	**Part A:** MH, Medical Transport, **Part D:** MCM, MH
Yale University 135 College Street New Haven, CT 06510 Tel: 203-688-2685 **Funding Source: Part A, SAMHSA**	**Part A:** O/A, MCM, SA/O, MH, OH, EIS, Housing, SA/Inpatient, Medical Transport, EFA, Food, Health Insurance Assistance SAMHSA: Project CHOICES
Yale University AIDS Program 333 Cedar street New Haven, CT 06510 **Funding Source: Prevention**	**Prevention:** CRCS

Key: Core Medical Services: Outpatient/ambulatory (O/A), AIDS Pharmaceutical Assistance (APA), Oral Health (OH), Early Intervention Services (EIS), Health Insurance Premium (HIP), Mental Health (MH), Medical Nutrition Therapy (MNT), Medical Case Management (MCM), Substance Abuse-Outpatient (SAO) Support Services: Non-medical Case Management (NMCM), Emergency Financial Assistance (EFA), Food bank (FB), Health Education/Risk Reduction (HERR), Housing Services (H)S, Legal Services (LS), Linguistics and Translation (LT), Medical Transportation(MT), Outreach Services (OS), Minority AIDS Initiative (MAI), Psychosocial Support (PS), Substance Abuse –Residential, (SER); Counseling, Testing & Referral (CTR),Comprehensive Risk Counseling Services (CRCS), Drug Treatment Advocacy (DTA), Syringe Exchange Program (SEP), Prevention Interventions(DEBI/EBI) listed individually

FAIRFIELD COUNTY

PROVIDER	SERVICES
AIDS Project Greater Danbury 30 West Street Danbury, CT 06810 Tel: 203-778-2437 **Funding Sources: Part A, Part B, Prevention, HOPWA, State AIDS Housing Fund, State**	HIV Counseling, Testing and Referral, Comprehensive Risk Counseling Services (CRCS), Drug Treatment advocacy Medical Case Management, Ambulatory/outpatient, Mental Health Services, Oral health, Emergency Financial Assistance, Housing services, Medical Transportation, Food bank, Local AIDS Pharmaceutical Assistance **Part A:** O/A, MCM, OH, SA/O, MH, Health Insurance, Housing, EFA, Medical Transport, Food, SA-Inpatient, EIS **Part B:** O/A (fee for service), MCM, Mental Health, EFA, MT, Housing **Prevention:** CRCS, Counseling & Testing, Drug Treatment Advocacy, **State:** Syringe Exchange Program
Bread & Roses St. Luke's Lifeworks 141 Franklin Street Stamford, CT 06901 Tel: 203-388-0100 **Funding Sources: HOPWA, State AIDS Housing Fund**	Transportation, alternative therapy, housing, nutritional counseling
Bridgeport Health Department 752 East Main street Bridgeport, CT 06608 Tel: 203-576-7679 **Funding Source: Prevention**	**Prevention:** Safety Counts **State:** Syringe Exchange Program
Bridgeport Hospital 267 Grant Street Bridgeport, CT 06610 Tel: 1-888-357-2396 **Funding Sources: Part A, Part D**	Primary care for HIV infected children, youth and families **Part A:** O/A **Part D:** Mental Health, Primary Care, Counseling and Testing
Catholic Charities Scattered Site Housing 238 Jewett Avenue Bridgeport, CT 06606 Tel: 203-372-4301 **Funding Sources: HOPWA, State AIDS Housing Fund**	Case management, housing subsidies for PLWHA

FAIRFIELD COUNTY	
PROVIDER	**SERVICES**
Danbury Hospital 71 Main Street Danbury, CT 06810 203-791-5042 **Funding Source: Part A**	**Part A:** O/A, OH
Family Centers, Inc. 60 Palmers Hill Road Stamford, CT Tel: 203-977-5108 **Funding Sources: Part A, Part B**	Ambulatory/outpatient, Local Pharmaceutical assistance, Emergency Financial assistance, Medical Case Management, Food bank, Mental Health, Oral Health, Medical Nutrition Therapy, Medical Transport, Outreach, Housing, **Part A:** O/A, MCM, OH, SA/O, MH, Health Insurance, Housing, EFA, Medical Transport, Food, SA-Inpatient, EIS **Part B:** O/A (fee for service), MCM, OH (fee for service), Medical Nutrition Therapy, Medication Adherence Program, EFA, Food, Medical Transportation, Psychosocial, Housing
Family Services Woodfield 475 Clinton Avenue Bridgeport, CT 06605 Tel: 203-368-4291 **Funding Sources: Part A, Part B**	Medical Case Management, Mental Health, Health Insurance Continuation, Emergency Financial Assistance, Medical Transportation, Psychosocial Support, Walk-in clinic, Transportation, Behavioral Health Services, Family and Youth Services **Part A:** MCM, Health Insurance, MH, Housing, EFA, Food **Part B:**O/A (fee for service), MCM, EFA, Food, Medical Transport
Greater Bridgeport Adolescent Pregnancy Prevention Program (GBAPPP) 200 Mill Hill Avenue Bridgeport, CT 06608 Tel: 203-384-3629 **Funding Sources: Part A, Prevention, SAMHSA**	Pregnancy Prevention Women's and Men's Health Programs, Teen Pregnancy Prevention, Faith –based linkages (NIA Alliance) **Part A:** O/A, MCM, OH, SA/O, MH, Health Insurance, Housing, EFA, Medical Transport, Food, SA-Inpatient, EIS **Prevention:** Counseling & Testing, SISTA **SAMHSA:** Capacity Building & Targeted Capacity-HIV - Odyssey Project, Bridgeport Partners for Teens
Helping Hand Center 1124 Iranistan Avenue Bridgeport, CT 06605 Tel: 203-336-4745 **Funding Source: State AIDS Housing Fund**	Rehab housing, group residence and scattered site housing; Substance Abuse Counseling; Housing for PLWHA
Interfaith AIDS Ministry of Greater Danbury 39 Rose Street Danbury, CT 06810 Tel: 203-748-4077 **Funding Sources: Prevention**	Food Pantry, food delivery, Financial assistance, Youth peer group (Youth Reacting To AIDS), Outreach, HIV Education **Prevention:** MPowerment
Liberation Programs 4 Elmcrest Terrace Norwalk, CT 06850 Tel: 203-851-2077 **Funding Sources: Part A**	Outpatient and inpatient substance abuse treatment programs, residential housing; Liberation House; Methadone maintenance; programs in Bridgeport and Stamford **Part A:** SA/O and SA-Inpatient

FAIRFIELD COUNTY	
PROVIDER	**SERVICES**
Mid-Fairfield AIDS Project, Inc. 16 River Street Norwalk, CT 06850 Tel: 203-855-9535 **Funding Sources: Part A, Part B, Prevention, HOPWA**	Ambulatory/outpatient; Medical Case Management; Oral Health; Emergency Financial Assistance; Medical Transport; Housing services; Medical Nutrition Therapy; Food bank **Part A:** MCM, OH, Housing, EIS, EFA, Medical Transport, Food, Health Insurance **Part B:** O/A (fee for service), OH (fee for service), MCM, Mental Health (fee for service), Medical Nutrition Therapy, EFA, Food, Medical Transport **Prevention:** Drug Treatment Advocacy
Norwalk Community Health Center 120 Connecticut Avenue Norwalk, CT 06854 203-899-1770 **Funding Sources: Part A, C**	**Part A:** O/A
Norwalk Health Department 137 East avenue Norwalk, CT 06850 Tel: 203-854-7776 **Funding Sources: Prevention**	**Prevention:** Counseling & Testing
Optimus Health Care (Centers in Stratford and Stamford) 982 East Main street Bridgeport, CT 06608 Tel: 203-696-3260 **Funding Sources: Part A, Part B, Part C, Part D, Prevention**	Integrated HIV Prevention services in Routine Medical Care (HIV Counseling, Testing and Referral) Outpatient early intervention services Medical case management, Outreach OB/Gyn services, Behavioral health, Dental, primary care **Part A:** O/A, MCM, OH **Part B:** MCM **Part C:** EIS **Part D:** MCM, Nutritional Counseling, Primary Care, Counseling & Testing
Regional Network 2 Trap Falls Road, Ste 405 Shelton, CT 06484 Tel: 203-929-1954 **Funding Sources: Part A,HOPWA, State AIDS Housing Fund**	In and outpatient Substance abuse treatment, outreach, drug and alcohol counseling, methadone maintenance, outpatient and residential services **Part A:** SA/O, SA-Inpatient, EIS
Shelter for the Homeless PO Box 1252 616 Atlantic Street Stamford, CT 06902 Tel: 203-406-0017 **Funding Source: Prevention**	Mental Health, Transitional Housing, Emergency shelter, Day and night programs, Case Management **Prevention:** Drug Treatment Advocacy

FAIRFIELD COUNTY	
PROVIDER	**SERVICES**
Southwest Community Health Center 561 Bird Street Bridgeport, CT 06605 Tel: 203-330-6000 **Funding Sources: Part A, Part C, Part D, Prevention**	HIV Counseling, Testing & Referral (CTR), Outpatient Early Intervention Services, Medical Case Management, Primary Medical Care, OB/GYN Services, Pediatrics, Mental Health, substance abuse treatment, Dental **Part A:** O/A, MCM **Part C:** EIS **Part D:** MCM, Nutritional Counseling, Primary Care, Counseling & Testing
Stamford Health Department 888 Washington Boulevard, 8th Floor Stamford, CT 06901 Tel: 203-977-4399 **Funding Sources: Prevention**	**Prevention:** CRCS, Counseling & Testing, Information and Enhanced AIDS Education, Street Smart
Stamford Hospital 166 West Broad Street Stamford, CT 06902 203-276-7000 **Funding Source: Part A**	**Part A:** O/A

Key: Core Medical Services: Outpatient/ambulatory (O/A), AIDS Pharmaceutical Assistance (APA), Oral Health (OH), Early Intervention Services (EIS), Health Insurance Premium (HIP), Mental Health (MH), Medical Nutrition Therapy (MNT), Medical Case Management (MCM), Substance Abuse-Outpatient (SAO) Support Services: Non-medical Case Management (NMCM), Emergency Financial Assistance (EFA), Food bank (FB), Health Education/Risk Reduction (HERR), Housing Services (H)S, Legal Services (LS), Linguistics and Translation (LT), Medical Transportation(MT), Outreach Services (OS), Minority AIDS Initiative (MAI), Psychosocial Support (PS), Substance Abuse –Residential, (SER); Counseling, Testing & Referral (CTR),Comprehensive Risk Counseling Services (CRCS), Drug Treatment Advocacy (DTA), Syringe Exchange Program (SEP), Prevention Interventions(DEBI/EBI) listed individually

MIDDLESEX COUNTY

PROVIDER	SERVICES
Community Health Center 635 Main Street Middletown, CT 06457 Tel: 860-347-6971 Operating the following: Oasis Wellness Center (Community Health Center) 33 Ferry Street Middletown, CT 06457 Tel: 860-344-0551 **Funding Sources: Part A, Part B, Part C, Prevention, State AIDS Housing Fund**	**Part A:** Mental Health, Food, Medical Transport, non-medical CM **Part B:** A/O (fee for service), OH (fee for service), MCM, EFA, Food, MT **Part C:** EIS **Prevention:** Counseling & Testing, VOICES/VOCES Dental, OB/Gyn; Domestic violence programs; Prescription drug program Sites in Clinton, Danbury, Groton, Enfield, Meriden, New Britain, New London, Norwalk, Old Saybrook and Stamford

Key: Core Medical Services: Outpatient/ambulatory (O/A), AIDS Pharmaceutical Assistance (APA), Oral Health (OH), Early Intervention Services (EIS), Health Insurance Premium (HIP), Mental Health (MH), Medical Nutrition Therapy (MNT), Medical Case Management (MCM), Substance Abuse-Outpatient (SAO) Support Services: Non-medical Case Management (NMCM), Emergency Financial Assistance (EFA), Food bank (FB), Health Education/Risk Reduction (HERR), Housing Services (H)S, Legal Services (LS), Linguistics and Translation (LT), Medical Transportation(MT), Outreach Services (OS), Minority AIDS Initiative (MAI), Psychosocial Support (PS), Substance Abuse –Residential, (SER); Counseling, Testing & Referral (CTR),Comprehensive Risk Counseling Services (CRCS), Drug Treatment Advocacy (DTA), Syringe Exchange Program (SEP), Prevention Interventions(DEBI/EBI) listed individually

TOLLAND and WINDHAM COUNTIES (TC and WC)

PROVIDER	SERVICES
AIDS Project Hartford-Manchester **Funding Source: Part B**	**Part B**: O/A (fee for service), MCM, Medical Nutrition Therapy, MAP, EFA
Generations Family Health Center (WC) 1315 Main Street Willimantic, CT 06226 Tel: 860-450-7471 **Funding Sources: Part C, Part D**	Outpatient early intervention services, Outreach, Medical and dental services, case management, health care for the homeless; mobile dental van **Part C:** EIS **Part D:** MCM, Nutritional Counseling, Primary Care, Counseling & Testing Sites in Danielson and Norwich
Hockanum Valley Community Council (TC) 155 West Main Street Vernon, CT 06066 Tel: 860-872-9825 **Funding Sources: Prevention**	Mental Health and Substance Abuse, Elder services, Food pantry, Dial-a ride **Prevention:** Counseling & Testing, Project Respect
Perception Programs (WC) 54 North Street Willimantic, CT 06226 Tel: 860-450-7122 **Funding Sources: Prevention, HOPWA**	Residential and outpatient services; OMEGA House for PLWHA; re-entry programs; Substance abuse treatment **Prevention:** Counseling & Testing, Drug Treatment Advocacy, Safety Counts
Rockville General Hospital (TC) 31 Union Street Vernon, CT Tel: 860-872-0501 **Funding Source: Part A**	**Part A:** O/A Primary care, in-patient and outpatient
Windham Regional Community Council 872 Main Street Willimantic, CT 06226 Tel: 860-423-4534 **Funding Source: Part B, State**	**Part B:** A/O (fee for service), OH(fee for service), MCM, EFA, Food **State:** Medication Adherence Program (MAP)

Key: Core Medical Services: Outpatient/ambulatory (O/A), AIDS Pharmaceutical Assistance (APA), Oral Health (OH), Early Intervention Services (EIS), Health Insurance Premium (HIP), Mental Health (MH), Medical Nutrition Therapy (MNT), Medical Case Management (MCM), Substance Abuse-Outpatient (SAO) Support Services: Non-medical Case Management (NMCM), Emergency Financial Assistance (EFA), Food bank (FB), Health Education/Risk Reduction (HERR), Housing Services (H)S, Legal Services (LS), Linguistics and Translation (LT), Medical Transportation(MT), Outreach Services (OS), Minority AIDS Initiative (MAI), Psychosocial Support (PS), Substance Abuse –Residential, (SER); Counseling, Testing & Referral (CTR),Comprehensive Risk Counseling Services (CRCS), Drug Treatment Advocacy (DTA), Syringe Exchange Program (SEP), Prevention Interventions(DEBI/EBI) listed individually

LITCHFIELD COUNTY

PROVIDER	SERVICES
Community Health and Wellness Center of Greater Torrington 459 Migeon Avenue Torrington, CT 06790 Tel: 860-489-0931 **Funding Sources: Part C, Part D**	Outpatient early intervention services Primary medical Case Management **Part C:** EIS **Part D:** MCM, Primary Care, Counseling and Testing
Waterbury Health Department-Torrington Satellite 339 Main Street Torrington, CT 06790 Tel: 860-201-3954 **Funding sources: Part B and Prevention**	**Prevention:** Counseling & Testing, Healthy Relationships **Part B:** O/A, OH, MCM

Key: Core Medical Services: Outpatient/ambulatory (O/A), AIDS Pharmaceutical Assistance (APA), Oral Health (OH), Early Intervention Services (EIS), Health Insurance Premium (HIP), Mental Health (MH), Medical Nutrition Therapy (MNT), Medical Case Management (MCM), Substance Abuse-Outpatient (SAO) Support Services: Non-medical Case Management (NMCM), Emergency Financial Assistance (EFA), Food bank (FB), Health Education/Risk Reduction (HERR), Housing Services (H)S, Legal Services (LS), Linguistics and Translation (LT), Medical Transportation(MT), Outreach Services (OS), Minority AIDS Initiative (MAI), Psychosocial Support (PS), Substance Abuse –Residential, (SER); Counseling, Testing & Referral (CTR),Comprehensive Risk Counseling Services (CRCS), Drug Treatment Advocacy (DTA), Syringe Exchange Program (SEP), Prevention Interventions(DEBI/EBI) listed individually

NEW LONDON COUNTY

PROVIDER	SERVICES
Alliance for Living 154 Broad Street New London, CT 06320 Tel: 860-447-0884 Site in Norwich: 107 Lafayette Street, Norwich Tel: 860-892-2752 **Funding sources: Part B, State AIDS Housing Funds**	**Part B:** O/A; OH; MH, MNT, MCM; EFA; Psychosocial support (PS); FB; MT; Housing Services, Medication adherence Program (MAP) **State AIDS Housing Funds:** Scattered site and supportive housing
Lawrence & Memorial Hospital 365 Montauk Avenue New London, CT 06320 Tel: 860-442-0711 **Funding Source: Prevention**	**Prevention:** CRCS Primary medical care Infectious disease Counseling & Testing
William W. Backus Hospital 326 Washington Street Norwich, CT 06360 Tel: 860-889-8331 **Funding Source: Prevention**	**Prevention:** HIV Counseling, Testing & Referral STD, HIV Education and testing

Part A New Haven Funding: $7,126,579
Part A Hartford Funding: $4,269,984
Part B: $14,595,600: (Includes $3,500,189 Base, CADAP $10,972,770, MAI $122,641)
Part B Supplemental: $119,410
State Medication Adherence (HCSS): $271,703
State Care Funding: $537,033
Part C (EIS): $3,866,318
Part D: $824,047
Part F (CAETC):$170,000
Part F (SPNS): $100,000 CADAP Health Information Technology (Part B Grantee)
SAMHSA: $2,887,858
HOPWA: $3,307,823
State AIDS Housing Funds: $4,148,632
CDC Prevention Funding (through 12/2012): $5,650,551
State Prevention Funding (through12/2012): $3,781,844
State Syringe Exchange Program (through 6/30/2013): $723,673

Term	Type	Definition
AIDS Drug Assistance Program (ADAP)	Care	Administered by states and authorized under Part B of the Modernization Act. Provides FDA-approved medications to low-income individuals with HIV disease who have limited or no coverage from private insurance or Medicaid.
AIDS Education and Training Center (AETC)	Care	Regional centers providing education and training for primary care professionals and other AIDS-related personnel. Authorized under Part F of the Modernization Act (formerly the CARE Act).
Application	Prevention	The health department's application to CDC for funding. Contains a proposed budget to support a specific set of prevention programs and interventions.
Antiretroviral	Care	A substance that fights against a retrovirus, such as HIV.
AIDS Service Organization (ASO)	Prevention/ Care	An organization that provides primary medical care and/or support services to populations infected with and affected by HIV disease. ASO's also provide prevention services to HIV+ individuals and populations at risk.
Capacity/Capacity Building	Care	Core competencies that substantially contribute to an organization's ability to deliver effective HIV/AIDS primary care and health-related support services. Capacity development activities should increase access to the HIV/AIDS service system. And reduce disparities in care among underserved PLWH/A in the EMA.
	Prevention	An activity that increases a community's ability to deliver effective HIV prevention programs.
CARE Act (Ryan White Comprehensive AIDS Resources Emergency Act) See also: Ryan White HIV/AIDS Treatment Modernization Act of 2006	Care	Federal legislation created to address the unmet health care and service needs of people living with HIV disease (PLWH) and their families. HRSA administers HIV/AIDS programs under Parts of the Act.
		Part A: HIV Emergency Relief Grant Program for Eligible Metropolitan Areas. Provides formula and supplementary grants to EMAs that are disproportionately affected by the HIV epidemic.
		Part B: HIV Care Grants to States. Provides formula grants to states, US territories, D.C. and Puerto Rico to provide health care and support services for PLWH/A. Grantees must also provide therapeutics to treat HIV/AIDS under ADAP.
		Part C: HIV Early Intervention Services. Supports outpatient HIV early intervention services for low-income, medically underserved people in existing primary care systems. Designed to prevent the further spread of HIV/AIDS, delay the onset of illness, facilitate access to services, and provide psychosocial support to PLWH/A.
		Part D: Coordinated HIV Services and Access to Research for Children, Youth, Women, and Families. A special grant program to coordinate HIV services and access to research for children, youth, women and families in a comprehensive, community-based, family-centered system of care.
		Part F: Special Projects of National Significance Program. To support the development of innovative models of HIV/AIDS care. These models are designed to address special care needs of PLWH/A in minority and hard-to-reach populations.
		Part F: AIDS Education and Training Centers. A national network of centers that conduct targeted, multidisciplinary education and training programs for health care providers.

Term	Type	Definition
		Part F: AIDS Dental Reimbursement Program. A grant program which assists accredited dental schools and post-doctoral dental programs with uncompensated costs incurred in providing oral health treatment to HIV+ patients.
CARE Act (Ryan White Comprehensive AIDS Resources Emergency Act) continued		Service categories for all CARE Act Parts: Ambulatory/outpatient medical care, Drug reimbursement programs, Health insurance, Home health care, Home- and community-based care, Oral health, Hospice services, In-patient personnel costs, Mental health services, Nutritional counseling, Rehabilitation services, Substance abuse services, Treatment adherence services, Child care services, Child welfare services, Buddy/companion services, Case management, Client advocacy, Day or respite care, Early intervention services, Emergency financial assistance, Food bank/home delivered meals/nutritional supplements, Health education/risk reduction, Housing assistance, Housing-related services, Legal services, Outreach services, Permanency planning, Psychosocial support services, Referral, Transportation, Other services (translation/interpretation), Program support, Grantee administrative costs, Quality management.
CARE Act Data Report (CADR)	Care	A provider-based report generating aggregate client, provider, and service data for all CARE Act programs. Reports information on all clients who receive at least one service during the reporting period.
Companion Awareness and Risk Reduction (CARE) Program	Prevention	State program that assists in the anonyomous or confidential notification for sex and needle sharing partners that they may be at risk. Notification is done by Disease Intervention Specialists from the State Health Department.
CD4 Cells, CD4+ Cells	Care	These cells are responsible for coordinating much of the immune response. HIV's preferred targets are CD4+ cells, which have a docking molecule on their surface. Destruction of CD4+ cells is the major cause of the immunodeficiency observed in AIDS, and decreasing CD4 levels appear to be the best indicator for developing opportunistic infections.
CD4 Cell Count	Care	The number of CD4 cells per one cubic millimeter of blood. As the CD4 cell count declines, the risk of developing opportunistic infections increases. Normal adult range for CD4 cell counts is 500-1500 per cubic millimeter. A CD4 count of 200 or less is an AIDS-defining condition.
Centers for Disease Control and Prevention (CDC)	Prevention	The federal agency responsible for monitoring diseases and conditions that endanger public health and for coordinating programs to prevent and control the spread of these diseases.
Centers for Medicare & Medicaid Services (CMS)	Care	Federal agency within HHS that administers the Medicaid, Medicare, State Child Health Insurance Program (SCHIP), and the Health Insurance Portability and Accountability Act (HIPAA).
Charter	CHPC	The CHPC Charter describes the CHPC's mission, structure, and operating guidelines.
Client-Centered Counseling	Prevention	Counseling conducted in an interactive manner responsive to individual client needs. The focus is on developing prevention objectives and strategies with the client.
Community-based Organization (CBO)	Prevention/ Care	A private or non-profit organization which is representative of a community or segment of a community and which provides services to individuals or groups.
Community Forum	Care	A small group method of collecting information from community members in which a community meeting is used to provide a directed but highly interactive discussion.

Term	Type	Definition
Community Health Centers	Care	Federally funded by HRSA to provide family-oriented primary and preventive health care services for people living in rural and urban medically underserved communities.
Community-level Interventions (CLI)	Prevention	Programs designed to reach a defined community and to increase community support of the behaviors known to reduce the risk for HIV infection and transmission. CLIs aim to reduce risky behaviors by changing attitudes, norms and practices through community mobilization and organization or structural interventions.
		Examples of CLIs in the DEBI Project: Community PROMISE, MPowerment, Popular Opinion Leader
Community Mobilization	Prevention	The process by which a community's citizens are motivated to take an active role in addressing issues in their community. Focuses on developing linkages and relationships within and beyond the community to expand the current scope and effectiveness of HIV/STD prevention.
Community Planning Group (CPG (now integrated with SWC forming the CHPC)	Prevention	The official HIV prevention planning body that follows the CDC Guidance to develop the comprehensive HIV prevention plan for the project area.
Community Services Assessment (CSA)	Prevention	A description of the prevention needs of people at risk for spreading and becoming infected with HIV, the prevention interventions/activities implemented to address these needs, and service gaps. Comprised of Resource Inventory, Needs Assessment, and Gap Analysis.
Co-morbidity	Care	A disease or condition, such as mental illness or substance abuse, co-existing with HIV disease.
Comprehensive HIV Care and Prevention Plan	Prevention/ Care	An overview of all HIV care and prevention priorities, programs and activities occurring in the jurisdiction.
Comprehensive Risk Counseling Services (CRCS)	Prevention	Client-centered HIV prevention activity with the goal of promoting the adoption of HIV risk reduction behaviors by clients with multiple, complex problems and risk reduction needs. A hybrid of HIV risk reduction counseling and traditional case management.
Concurrence	Prevention	Refers to the CPG's belief that the health department's application for HIV prevention funds reflects the CPG's target population and intervention priorities.
Connecticut HIV Planning Consortium	Prevention/ Care	The Statewide body existing to work collaboratively with and advise the State Department of Public Health and each Transitional Grant Area (TGA) on the provision of effective planning and the promotion, development, coordination, and administration of HIV/AIDS health care, prevention and support services.
Consensus Model	Prevention/ Care	A decision-making method in which a group holds discussions on an issue and arrives at a decision as a group. The group agrees without voting.
Consortium/HIV Care Consortium(now integrated with CPG forming the CHPC)	Care	A regional or statewide planning entity established under Part B of the Modernization Act, to plan and sometimes administer Part B services. An association of health care and support service agencies serving PLWH/A under Part B.
Continuous Quality Improvement	Care	An ongoing process that involves organization members I monitoring and evaluating programs to continuously improve service delivery.
		See also: Quality Improvement

Term	Type	Definition
Continuum of Care	Care	An approach that helps communities plan for and provide a full range of emergency and long-term service resources to address the various needs of PLWH/A.
Counseling Testing, and Referral, Services (CTRS)	Prevention	The voluntary process of client-centered, interactive information sharing in which an individual learns basic information about HIV/AIDS, testing procedures, how to prevent the transmission and acquisition of HIV infection, and takes a test. Appropriate referrals are made to the CARE Program or to medical, social or prevention services.
Cultural Competence	Prevention/Care	The knowledge, understanding and skills to work effectively with individuals from differing cultural backgrounds.
Diffusion of Effective Behavioral Interventions (DEBI)	Prevention	A national level strategy to provide training and ongoing technical assistance on selected evidence-based HIV/STD interventions to state and community HIV/STD program staff.
DEBI Project	Prevention	A set of 26 interventions listed by their primary population or risk group, that are packaged in user-friendly kits. Training and technical assistance is also provided. The interventions are:
		Clear (HIV+)
		Connect (Heterosexual Adults)
		D up: Defend Yourself! (MSM of Color)
		Focus on Youth + Impact (High Risk Youth)
		Healthy Relationships (HIV+)
		Holistic Health Recovery Program (HIV+ IDU)
		Many Men, Many Voices (MSM of color)
		MIP (Drug Users IDU)
		MPowerment (Young MSM)
		Nia (Hetrosexual Adult Men)
		Partnership for Health (HIV+)
		Popular Opinion Leader (MSM)
		Project START (All Released Prisoners)
		PROMISE (All)
		RAPP - Real AIDS Prevention Program (Heterosexual Women and their partners)
		RESPECT (Heterosexual Adults)
		Safe in the City (Heterosexual/MSM STD Clinic Patiients)
		Safety Counts (Drug Users)
		SHIELD (Drug Users)
		SISTA (Heterosexual Adult women)
		Sister to Sister (Heterosexual Adults in Primary Care)
		StreetSmart (High Risk Youth, runaway/homeless)
		Teens Linked to Care (HIV+ Youth)
		Voices/Voces (Herosexual Adults, African-American and Latino/a)

Term	Type	Definition
Demographics	Prevention	The statistical characteristics of human populations, such as age, race, ethnicity, and sex, that can provide insight into the development, culture, and sex-specific issues that the intervention will need to account for.
Division of Service Systems (DSS)	Care	The division within HRSA's HIV/AIDS Bureau that administers Part A and Part B of the Modernization Act.
Early Intervention Services (EIS)	Care	Activities designed to identify individuals who are HIV+ and get them into care as quickly as possible. Funded through Parts A and B, includes outreach, counseling and testing, information and referral services. Under Part C, also includes comprehensive primary medical care for PLWH/A.
Effective Behavioral Interventions (EBI)	Prevention	Evidence-based program models that were proven effective with a given population in a given venue through rigorous research studies. In order to be proven effective they had to produce positive behavior change among participants such as increased condom use, or produce positive health outcomes such as a reduction in the number of new infections.
Eligible Metropolitan Area (EMA)	Care	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.
Epidemic	Care	A disease that occurs clearly in excess of normal expectation and spreads rapidly through a demographic segment of the population. Epidemic diseased can be spread from person to person or from a contaminated source such as food or water.
	Prevention	The occurrence of cases of an illness, specific health-related behavior, or other health-related events in a community or region in excess of normal expectancy.
Epidemiological Profile (Epi Profile)	Care	A description of the current status, distribution, and impact of an infectious disease or other health-related condition in a specified geographic area.
	Prevention	A description of the current status, distribution, and impact of an infectious disease or other health-related condition in a specified geographic area.
Epidemiology	Care	The branch of medical science that studies the incidence, distribution, and control of disease in a population.
	Prevention	The study of factors associated with health and disease and their distribution in the population.
Exposure Category	Care	How an individual may have been exposed to HIV, such as injecting drug use, male-to-male sexual contact, and heterosexual contact.
		See also: Transmission Category, Risk Factor/Behavior
Family Centered Care	Care	A model in which systems of care under Part D are designed to address the needs of PLWH/A and affected family members as a unit, providing or arranging for a full range of services. Family structures may range from the traditional, biological family unit to non-traditional family units with partners, significant others, and unrelated caregivers.
Focus Group	Prevention	A method of information collecting involving a carefully planned discussion among a small group of individuals from the target population led by a trained moderator.
Formula Grant Application	Care	The application used by EMAs and states each year to request an amount of CARE Act (now Modernization Act) funding, which is determined by a formula based on the number of reported AIDS case in their location and other factors.

Term	Type	Definition
Gap Analysis	Prevention	A comparison of the needs of high-risk populations, as determined by the needs assessment, to existing prevention services as described in the resource inventory. It identifies the portion of prevention needs being met with CDC funds.
Grantee	Care	The recipient of CARE Act (now Modernization Act) funds responsible for administering the award.
Group-level Interventions (GLI)	Prevention	Health education and risk reduction programs that target groups of people with common characteristics (i.e. risk group, race/ethnicity, etc.) Aims to teach HiV information, improve attitudes toward prevention, increase supportive norms and teach behavioral skills..
GLI continued		Examples of GLIs in the DEBI Project: Healthy Relationships, Holistic Health Recovery Program, Many Men, Many Voices, SISTA, Teens Linked to Care, Voices/Voces
Guidance	Prevention	The CDC document that gives information and rules for receiving funds for HIV prevention programs and defines the process of HIV prevention community planning.
Health Education and Risk Reduction Interventions (HE/RR)	Prevention	Organized efforts to reach people at increased risk of becoming HIV-infected or, if already infected, of transmitting the virus to others. The goal is to reduce the risk of infection.
Highly Active Antiretroviral Therapy (HAART)	Care	HIV treatment using multiple antiretroviral drugs to reduce viral load to undetectable levels and maintain/increase CD4 levels.
HIV Disease	Care	Any signs, symptoms, or other adverse health effects due to the human immunodeficiency virus.
HIV Prevention Community Planning	Prevention	The cyclical, evidence-based planning process in which authority for identifying priorities for funding HIV prevention programs is vested in one or more planning groups in a state or local health department that receives HIV prevention funds from CDC.
HIV/AIDS Bureau (HAB)	Care	The bureau within HRSA of the US Department of Health and Human Service (HHS) that is responsible for administering the Ryan White CARE Act.
HIV/AIDS Dental Reimbursement Program	Care	The program within the HRSA HAB's Division of Community Based Programs that assists with uncompensated costs incurred in providing oral health treatment to PLWH/A.
Home and Community Based Care	Care	A category of eligible services that states may fund under Part B.
Housing Opportunities for People with AIDS (HOPWA)	Care	A program administered by the US Department of Housing and Urban Development (HUD) that provides funding to support housing for PLWH/A and their families.
Health Resources and Services Administration (HRSA)	Care	The agency of the US Department of Health & Human Services that administers various primary care programs for the medically underserved, including the Ryan White CARE Act (now the Modernization Act).
Housing and Urban Development (HUD)	Care	The federal agency responsible for administering community development, affordable housing, and other programs including HOPWA.
Incidence	Care	The number of new cases of a disease that occur during a specified time period.
	Prevention	The number of new cases of a disease diagnosed in a defined population in a specified period.
Incidence Rate	Care	The number of new cases of a disease that occur in a defined population during a specified time period, often expressed per 100,000 persons.

Term	Type	Definition
	Prevention	The number of diagnoses of new cases of a disease diagnosed in a defined population in a specified period, divided by that population. It is often expressed per 100,000 persons.
Individual-level Interventions	Prevention	One-to- one educational encounter with individuals from targeted at risk populations. Aim to teach HIV information, support positive attitudes and norms, and endorse protective behaviors. May also teach prevention skills (i.e. cleaning needles, using condoms)
Injection Drug Users (IDU)	Care	Injection drug user.
	Prevention	People who are at risk for HIV infection through the shared use of equipment used to inject drugs with an HIV-infected person.
Intervention	Prevention	An activity or set of related activities intended to bring about HIV risk reduction in a particular target population using a common strategy of delivering the prevention message. Has distinct objectives and a protocol outlining the steps for implementation.
Jurisdiction	Prevention	An area or region that is the responsibility of a particular governmental agency. Usually refers to an area where a state or local health department monitors HIV prevention activities.
Key Informant Interview	Prevention	An information collection method involving in-depth interviews with a few individuals carefully selected because of their personal experiences and/or knowledge.
Medicaid Spend-down	Care	A process whereby an individual who meets the Medicaid medical eligibility criteria but has income that exceeds the financial eligibility ceiling, may “spend down” to eligibility level. The individual does this by deducting accrued medically related expenses from countable income.
Medical Case Management	Care	A collaborative process that facilitates recommended treatment plans to assure the appropriate medical care is provided to disabled, ill or injured individuals.
Met Need	Prevention	A requirement for HIV prevention services within a specific target population that is currently being addressed through existing HIV prevention services. These are available to, appropriate for, and accessible to that population as determined through the resource inventory and assessment of prevention needs.
Migrant Health Centers	Care	Federally funded by HRSA’s Bureau of Primary Health Care, centers provide a broad array of culturally and linguistically competent medical and support services to migrant and seasonal farm workers and their families.
Minority AIDS Initiative (MAI)	Care	A national initiative that provides special resources to reduce the spread of HIV/AIDS and improve health outcomes for people living with HIV disease within communities of color. Enacted to address the disproportionate impact of the disease in such communities.
Modernization Act	Care	See: Ryan White HIV/AIDS Treatment Modernization Act of 2006
Multiply Diagnosed	Care	A person having multiple morbidities (e.g., substance abuse and HIV infection).
		See also: Co-morbidity
Needs Assessment	Care	A process of collecting information about the needs of PLWH/A (both those receiving care and those not in care), identifying current resources available to meet those needs, and determining what gaps in care exist.

Term	Type	Definition
	Prevention	The process of obtaining and analyzing findings to determine the type and extent of unmet needs in a particular population or community.
Nonconcurrence	Prevention	A CPG's disagreement with the program priorities identified in the health department's application for CDC funding. Nonconcurrence may also mean that the CPG thinks the health department has not fully collaborated in developing the plan.
Office of Management and Budget (OMB)	Care	The office within the executive branch of the federal government that prepares the President's annual budget, develops the federal fiscal program, oversees administration of the budget, and reviews government regulations.
Opportunistic Infection or Condition	Care	An infection or cancer that occurs in persons with weak immune systems due to HIV, cancer, or immunosuppressive drugs. Kaposi's Sarcoma, toxoplasmosis and pneumocystis pneumonia are examples.
Outcome Evaluation	Prevention	The assessment of the immediate or direct effects of a program on the program participants. Also assesses the extent to which a program attains its objectives related to intended short- and long-term change for a target population.
Outreach	Care	Principal purpose is to identify people with HIV disease, particularly those who know their HIV status, so that they may become aware of and enrolled in ongoing primary care and treatment.
	Prevention	HIV/AIDS educational interventions generally conducted by peer or paraprofessional educators face-to-face with high risk individuals in the clients' neighborhoods or other areas where clients congregate. Usually includes distribution of condoms, bleach, sexual responsibility kits, and educational materials.
Partner Counseling and Referral Services (PCRS) or Partner Notification	Prevention	A systematic approach to notifying sex and needle-sharing partners of HIV+ people of possible exposure to HIV so partners can avoid infection, or, if already infected, can prevent transmission to others. PCRS helps partners gain early access to individualized counseling, HIV testing, medical evaluation, treatment, and prevention services.
Patient Referral	Prevention	When the client (patient) notifies and refers his or her own partners for HIV testing.
Planning Council	Care	A planning body appointed or established by the Chief Elected Official of an EMA whose basic function is to assess needs, establish a plan for the delivery of HIV care in the EMA, and establish proprieties for the use of Part A of the Modernization Act funds. Planning Councils are not mandatory for TGAs unless the TGA was an EMA in FY 2006.
Planning Process	Care	Steps taken and methods used to collect information, analyze and interpret it, set priorities, and prepare a plan for rational decision making.
PLWH/A	Prevention/ Care	People living with HIV disease or AIDS.
Procedures and Operations Manual	CHPC	Document that describes and guides the CHPC's day-to-day functioning
Prevalence	Care	The total number of persons in a defined population living with a specific disease or condition at a given time.
	Prevention	
Prevalence Rate	Care	The proportion of a population living at a given time with a condition or disease.

Term	Type	Definition
	Prevention	The number of people living with a disease or condition in a defined population at a given time, divided by that population. Often expressed per 100,000 persons.
Prevention Need	Prevention	A documented necessity for HIV prevention services within a specific target population. The documentation is based on numbers, proportions, or other estimates of the impact of HIV or AIDS among this population from the epidemiologic profile. Also based on information showing that members of this population are engaging in behaviors that place them at high risk for HIV transmission.
Prevention Program	Prevention	A group of interventions designed to reduce disease or other negative results among individuals whose behavior, environment, and/or genetic history place them at high risk.
Prevention Services	Prevention	Interventions, strategies, programs and structures designed to change behavior that may lead to HIV infection or other disease.
Primary Prevention	Prevention	To reduce the transmission and acquisition of HIV infection through a variety of strategies, activities, interventions, and services.
Priorities	Prevention	In community planning, a rank-ordered set of target populations and recommended interventions for those populations.
Priority Setting	Prevention/Care	The process used to establish priorities among prevention and care service categories and priorities, to ensure consistency with locally identified needs, and to address how best to meet each priority.
Process Evaluation	Prevention	A descriptive assessment of a program's actual operation and the level of effort taken to reach desired results; that is, what was done, to whom, and how, when, and where.
Protease Inhibitor	Care	A drug that binds to and blocks HIV protease from working, thus preventing the production of new functional viral particles.
Provider Referral	Prevention	When health professionals, usually from the health department, notify the patient's partners of their exposure.
Public Health Surveillance	Prevention	An ongoing, systematic process of collecting, analyzing, and using data on specific health conditions and diseases in order to monitor these health problems to detect changes in trends or distribution.
Qualitative Data	Prevention	Data presented in narrative form, describing and interpreting the experience of individuals or groups.
Quality	Care	The degree to which a health or social service meets or exceeds established professional standards and user expectations.
Quality Assurance (QA)	Care	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.
Quality Improvement (QI)	Care	An ongoing process of monitoring and evaluating activities and outcomes in order to continuously improve service delivery.
Quantitative Data	Prevention	Data reported in numerical form.
Rank Order	Prevention	A list of priorities in order of importance.
Reflectiveness	Care	The extent to which the demographics of the planning body's membership look like the demographics of the epidemic in the service area.

Term	Type	Definition
Relevance	Prevention	The extent to which an intervention plan addresses the needs of affected populations in the jurisdiction and of other community stakeholders. Also the extent to which the population targeted in the intervention plan is consistent with the target population in the comprehensive HIV prevention plan.
Representative	Care	Term used to indicate that a sample is similar to the population from which it was drawn, and therefore can be used to make inferences about that population.
	Prevention	Term used to indicate that a sample is similar to the population from which it was drawn, and therefore can be used to make inferences about that population.
Resource Allocation	Care	The Part A planning council responsibility to assign now Modernization Act amounts or percentages to established priorities across specific service categories, geographic areas or populations.
Resource Inventory	Prevention	The existing community services for HIV prevention. Consists of the current HIV prevention and related resources and activities in your project area.
Risk Factor or Risk Behavior	Care	Behavior or other factor that places a person at risk for disease; for HIV/AIDS, this includes such factors as male-to-male sexual contact, injection drug use, and commercial sex work.
	Prevention	Factors or behaviors that place a person at risk for disease; for HIV/AIDS, this includes sharing injection drug use equipment, and/or unprotected sexual contact, with an infected person.
		See also: Exposure Category, Transmission Category
Routine HIV Testing	Prevention	Voluntary HIV testing conducted as a routine part of medical care.
Ryan White HIV/AIDS Treatment Modernization Act of 2006 (also known as the Modernization Act)	Care	The newly enacted Ryan White HIV/AIDS Treatment Modernization Act of 2006 provides the Federal HIV/AIDS programs in the Public Health Service Act to respond effectively to the changing epidemic. The new law changes how Ryan White funds can be used, with an emphasis on providing life-saving and life-extending services for people living with HIV/AIDS across this country.
		Part A: funds Eligible Metropolitan Areas and Transitional Grant Areas. 75% of funds must be spent on core services.
		Part B: funds States.75% of funds must be spent on core services.
		Part C: funds early intervention services. 75% of funds must be spent on core services.
		Part D: Grants for support services for women, infants, children and youth.
		Part F: comprises Special Projects of National Significance (SPNS), AIDS Education & Training Centers, Dental Programs, and Minority AIDS Initiative.
		Core Services: Outpatient and ambulatory health services, pharmaceutical assistance, substance abuse outpatient services, oral health, medical nutritional therapy, health insurance premium assistance, home health care, hospice services, mental health services, early intervention services, and medical case management including treatment adherence services.

Term	Type	Definition
		Support Services: Services needed by individuals with HIV/AIDS to achieve medical outcomes, which are those outcomes affecting the HIV-related clinical status of an individual with HIV/AIDS. Examples include: respite care, outreach, medical transportation, language services, referrals for health care and other support services.
Secondary Prevention	Prevention	To prevent a person living with HIV from becoming ill or dying as a result of HIV, opportunistic infections, or AIDS, through a variety of strategies, activities, interventions, and services.
Seroprevalence	Care	The number of persons in a defined population who test HIV+ based on HIV testing of blood specimens. Presented as a percent of total specimens or as a rate per 100,000 persons tested.
	Prevention	The number of people in a population who test HIV+ based on serology (blood serum) specimens. Often presented as a percent of total specimens or as a rate per 1000 persons tested.
Service Gaps	Care	All the service needs of all PLWH/A except for the need for primary health care for individuals who know their status but are not in care. For example, oral health care, mental health care, nutritional services, etc. (See Unmet Need for Health Services)
STD	Prevention/ Care	Sexually transmitted disease
Statewide Coordinated Statement of Need (SCSN)	Care	A written statement of need for the entire state developed through a process designed to collaboratively identify significant HIV issues and maximize CARE Act (now Modernization Act) program coordination.
Substance Abuse & Mental Health Services Administration (SAMHSA)	Care	Federal agency within HHS that administers programs in substance abuse and mental health.
Surveillance	Care	An ongoing, systematic proves of collecting, analyzing and using data on specific health conditions and diseases.
	Prevention	The ongoing and systematic collection, analysis, and interpretation of data about a disease or health condition.
Surveillance Report	Care	A report providing information on the number of reported cases of a disease such as AIDS, nationally and for specific sub-populations.
	Prevention	Documents on the number of reported cases of a disease, nationally and for specific locations and subpopulations.
Targeted Outreach	Prevention	Outreach to a particular population with the intent of getting them into specific prevention services or interventions.
Target Populations	Care	Populations to be reached through some action or intervention; may refer to groups with specific demographic or geographic characteristics.
	Prevention	Groups of people who are the focus of HIV prevention efforts because they have high rates of HIV infection and high levels of risky behavior.
Technical Assistance (TA)	Care	The delivery of practical program and technical support to the CARE Act community. TA is to assist grantees, planning bodies, and affected communities in designing, implementing and evaluating CARE Act-supported planning and primary care service delivery systems.
	Prevention	The provision of direct or indirect support to build capacity of individuals or groups to carry out programmatic and management responsibilities with respect to HIV prevention.

Term	Type	Definition
Transitional Grant Area (TGA)	Care	Under the Ryan White HIV/AIDS Treatment Modernization Act, cities that have between 1000 and 1999 cumulative AIDS cases during the most recent 5 years, and a population of 50,000 or more.
Transmission Category	Care	A grouping of disease exposure and infection routes; in relation to HIV disease, exposure groupings include men who have sex with men, injection drug use, heterosexual contact, and perinatal transmission.
	Prevention	In describing HIV/AIDS cases, the same as exposure categories (based) on how an individual may have been exposed to HIV.
		See also: Exposure Category, Risk Factor/Behavior
Unaware Population	Care	People who are HIV+ and are unaware of their status.
Unmet Need for Health Services	Care (HRSA Definition)	The need for HIV-related health services among individuals who know their HIV status but are not receiving regular primary health care. Regular HIV-related primary health care is defined as evidence of viral load testing, CD4 counts, or provision of antiretroviral medications in a given 12-month period. The term “unmet need” is used only to describe the unmet need for HIV-related primary health care, and is not considered a service gap. (See Service Gaps)
Unmet Need	Prevention (CDC Definition)	A requirement for HIV prevention services within a specific target population that is not currently being addressed through existing HIV prevention services and activities, either because no services are available or because available services are either inappropriate for or inaccessible to the target population.
Viral Load	Care	The quantity of HIV RNA in the blood. Viral load is used as a predictor of disease progression. Viral load test results are expressed as the number of copies per milliliter of blood plasma.
Weighting	Prevention	A method for determining the level of importance of two or more options relative to one another. Used to compare factors for populations and interventions.

Connecticut HIV Planning Consortium Member Diversity Chart – May 2012
Data-Driven Portion Based on CDC Guidance and Epidemiologic Profile

Categories	Current Membership	Goal[1]	Members Needed	% Short of Goal
Total	**28**	**35**[2]	**7**	**20**
Consumer/Provider[3]				
Consumer (HIV+)	11	18	7	39
Provider	21	18	0	--
Priority Populations[4]				
HIV+	11	18[5]	7	39
MSM	5	8	3	38
IDU	6	13	**7**	**54**
Heterosexual	18	13	0	--
Gender				
Female	11	12	1	8
Male	17	23	**6**	26
Race/Ethnicity[6]				
Black[7]	12	11	0	--
Hispanic or Latino	5	11	**6**	**55**
White	11	12	1	8
Age				
<29[8]	2	3	1	33
30-39	5	5	0	--
40-49	7	13	6	46
50+	14	15	1	7
County[9] [10]				
Fairfield	4	9	5	**55**
Hartford	9	11	2	18
Litchfield	1	1	0	--
Middlesex	1	1	0	--
New Haven	10	11	1	9
New London	2	2	0	--
Tolland	0	0	0	--
Windham	1	1	0	--
Department of Corrections[11]	6	3	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 is 35 to 42 members
[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] The goal for HIV+ members was set at 50% based on general agreement during planning for the creation of the CHPC
[6] Categories are not mutually exclusive, so total may be larger than # of members.
[7] Black includes African-American, African, Caribbean-American, West Indian, Haitian, etc.
[8] 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.
[9] Categories are not mutually exclusive, so total may be larger than # of members.
[10] Members who work in one region and live in another region are categorized according to their work region

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

Funding Source	# of Members
Part A	12
Part B	11
Part C	2
Part D	4
Part F Provider (Dental, SPNS, AETC)	0
Prevention Funds	13
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	0
Part D – Connecticut Primary Care Consortium	0
Part F – Dental Reimbursement Program	0
Part F – AIDS Education & Training Centers	0
CT Department of Social Services (CADAP)	0
CT Department of Mental Health and Addiction Services	1
CT Department of Correction	0
CHPC Youth Advisory Group Graduates (2)	2
Sexual Orientation	**# of Members**
Heterosexual	18
Gay Man	6
Lesbian	2
Bisexual	2
Occupation	**# of Members**
State health dept. HIV / AIDS staff	1
State health dept. hepatitis staff	1
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	0
Local education agency	2
Non-governmental STD agency	2
Non-governmental TB agency	0
Non-governmental substance abuse prevention & treatment	3
Non-governmental mental health services	2
Non-governmental homeless shelters	0
Non-governmental prisons/corrections	0
Non-governmental HIV care and social services	14
Non-governmental education agency	6
Medical doctor	0
Business community	1
Labor community	0
Faith community	2
Community member	28
Field of Expertise	**# of Members**
Health Planning	15
Behavioral Science	8
Social Science	6
Program Evaluation	11
Epidemiology	3

[11] The Department of Corrections is represented by former inmates.

The Connecticut HIV Planning Youth Advisory Group presents:

Our Voices – Information on HIV/AIDS for Youth by Youth

May 2011

WHAT YOU HAVE IS NOT WHO YOU ARE

by Arthur Harris

What you have, is not who you are
You are far beyond the aspects
Of a virus that divides
Under the essence of your eyes, your mind
To minimize what begins to find
The best of you
From your blood stream to your testicles
Combining the quality of who you are
What causes you of denial
Will devour who you are
You are far beyond who you are

FACT

Does HIV Look Like Me?

A person living with HIV/AIDS can look just like you or me. Young people living with the virus have many of the same goals and face many of the same challenges as other teens. They also cope with a serious illness. Check out the stories of young people living with HIV: www.doeshivlooklikeme.org

FACT

Young people in Connecticut are much more likely to contract STDs like Chlamydia and gonorrhea than adults. In 2009, 15-24 year-olds accounted for 70% of all reported cases of Chlamydia and 59% of all reported cases of gonorrhea.

Connecticut HIV Planning Youth Advisory Group

What is HIV?

HIV is a virus that can harm your body's ability to fight infection, and can lead to AIDS.

There is no cure for HIV or AIDS, but there are effective medications that can help people live with this serious illness.

HIV = Human Immunodeficiency Virus
AIDS = Acquired Immune Deficiency Syndrome

Myth: You can contract HIV by hugging or sharing a cup.

Fact: HIV is spread in two main ways:

1. By having sex with a person who has HIV
2. By sharing a needle or syringe with a person who has HIV

A 2006 national survey by the Kaiser Family Foundation found that 38% of young adults (18-29) incorrectly thought that HIV might be transmitted through kissing, sharing a drinking glass or touching a toilet seat.

Fact: More than 10,000 people in Connecticut are living with HIV/AIDS, including 352 people diagnosed in 2009.

Knowledge Is Protection.

1. Abstinence: Your safest choice is to not have vaginal, anal or oral sex.
2. If you do have sex, always use a latex condom.
3. Do not shoot drugs of any kind, and never share needles.
4. Get tested. Find a testing site near you at: www.hivtest.org

Fact: Most youth are not having sex. In the 2009 School Health Survey, only 40.5% of Connecticut high school students reported ever having sexual intercourse.

Fact: Most youth are protecting themselves. 59% of Connecticut high school students who were sexually active reported using a condom.

Fact: If a person has an STD like Chlamydia or gonorrhea, it is biologically easier to contract HIV.

Fact: Many youth are engaging in risky behaviors. More than 2 in 3 (67%) of Connecticut's high school seniors have had sex. Among sexually active high school students, 1 in 4 (25%) reported drinking alcohol or using drugs before they had sexual intercourse the last time, a major risk factor for unprotected sex.

Connecticut supports teaching youth the facts. The Connecticut State Department of Education's Healthy and Balanced Living Curriculum Framework supports students learning "medically accurate comprehensive sexuality education."

Connecticut HIV Planning Youth Advisory Group
For information on joining, contact the Connecticut Department of Public Health at (860) 509-7801. Find us on Facebook: www.facebook/CTyouthHIV

I learned about sex when I was about 6 years old and my older brother told me it was wrestling. I believed him of course, so when someone asked me to "wrestle" I told them "no" because it's for grown-ups. Rondell Batson

Let's NOT talk about sex?

My mother is infamous for spreading false information about sex. One day, amidst a fit of giggles, her younger sister told me what my mom had once told her: "Don't kiss boys, Khadijah. If you do, you will get pregnant!"

My mother looked at her smiling, neither denying the lie nor affirming the truth. I did not see why she was laughing because I naively believed this to be true. As I got older, my mother vaguely introduced me to the reality of it.

It is what gets you pregnant. It is what can give you diseases. Do not do it.

I did not know what it was until I was 15. This worked in ensuring that I abstained from the act until adulthood, but I wish I had learned the truth from my mother.

One notch up from clueless me were my friends, who learned about the topic through "Sex in the City". When we first got to talking, they had no clue about sex or its consequences. What our parents told us didn't seem as serious as it was. Instead, it seemed like fabrications to make us stray from sex, like the "Boogie Monster". Luckily, we learned that the "superstitions" our parents tried to instill in us had lots of truth to them. Though I am not sexually active, my friends who are have safe sex.

I think it is the parents' job to teach their children about sex. Although it's a difficult topic to discuss with an innocent ten year old, it has to be done. It would be lovely if all kids abstained from sex until marriage, but that is unrealistic. It is the parents' job to teach children about birth control, condoms, pregnancy, and sexually transmitted diseases. Times have changed and risks have gotten worse. The mindset of parents must evolve. Vague scare tactics soon lose their effect and kids will be curious; the facts must be passed on.

Khadijah Davis

Living Poz:

A Hartford Youth Shares His Story

By Sarah Ferris
(CT HIV Youth Advisory Group Member)

Wesley was five years old, lying on a hospital bed with his mother by his side. He was dying; the doctors told him he would not make it through the night. Wesley was born with AIDS. Since his first hour of life, Wesley experienced bouts of serious illnesses associated with AIDS. Hospital visits dotted his childhood, as did chronic side effects of medication. Now, at five years old, Wesley was six hours from death. But the next morning, Wesley awoke. His recovery may have been miraculous, but he had a difficult life ahead of him. Three years later, Wesley lost his mother to AIDS.

In January 2009, Wesley shared his story with the CT HIV Youth Advisory Group. "I'm lucky to be alive," Wesley said, recalling how his health has dramatically improved since treatment advances in the 1990s. Wesley explained that his viral load is now "undetectable" (meaning there is a very small amount of virus in his body).

While his health has improved, Wesley experiences other problems because of his positive status. "My status is just another thing to worry about in my relationships," said Wesley. "I never know how a girl will react." Eyes widened when Wesley told the group that an ex-girlfriend spread news of his status around school. "I can't imagine being on a date and trying to tell someone I have HIV," said Tyler Davenport, 16.

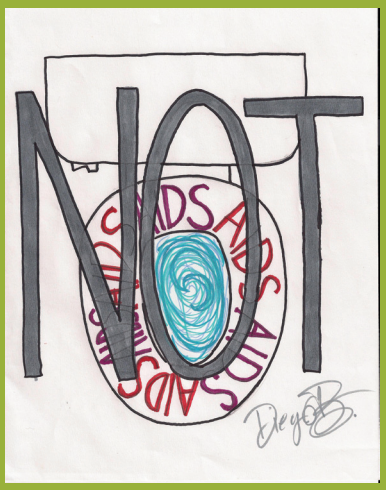
Who we are:
Connecticut's HIV Planning Youth Advisory Group

The Youth Advisory Group was formed in 2006 to give youth a voice in Connecticut's HIV planning efforts. Each year, approximately 20 teens from across Connecticut work together to educate their peers and to develop recommendations for improving HIV care and prevention for youth.

We are a diverse group: from different cities and towns, ethnic and racial backgrounds, and sexual orientations. Some of us have personal experiences with HIV through a family member or friend, and all of us share a common commitment to preventing the spread of HIV among youth.

We have 5 recommendations for improving HIV care and prevention for youth:

1. **Give Youth All the Facts.** All young people need to know how to protect themselves. Abstinence-only education is not enough.
2. **Teach Adults How to Engage Youth.** Adults – educators, parents, relatives – need to know the facts and how to engage young people. As an adult, encourage questions, learn with young people and be positive.
3. **Start Younger.** Young people need to learn about HIV prevention before they become sexually active.
4. **Make It Easy for Young People to Participate.** Programs need to bring education to young people or use technologies like texting and websites that make it easy to access information on demand.
5. **Involve Youth in Decision-Making.** Young people should have opportunities to share their insights and experiences with decision makers in their communities and at the state level.



Get more information

- www.teenwire.com
- www.amplifyyourvoice.org
- www.advocatesforyouth.org
- www.sexetc.org
- www.ourtruecolors.org
- www.doeshivlooklikeme.org
- www.hivtest.org

In This Issue

CHPC
CONNECTICUT HIV PLANNING CONSORTIUM

June 5, 2012

HIV/AIDS Planning News & Notes

AIDS Awareness Day 2012

Participants applaud at the AIDS Awareness Day Rally

The annual AIDS Awareness Day Rally took place on April 26 at the State Capitol. The Rally's theme was ***"Know Your Status".*** Hundreds of committed people from across the state told their stories and talked with their legislators about how HIV and AIDS continue to impact Connecticut's communities.

Several people shared their reasons for participating in AIDS Awareness Day and how the Rally impacted them:

"I attended the Rally because I wanted to make my presence known and to show support for the constant struggle for AIDS funding in Connecticut. I feel it is my obligation to go to the rally every year to get up, get out, get into it, and get over it! I am so grateful to still be here, playing the game of life." *(Rick Dumas, New Haven)*

"It was important for me to participate as a person who is positive because funding is withering away, and a 'voice of many' needs to be continually heard. I also wanted to attend because my brother passed away almost a year ago." *(George Lawson, Middletown)*

"HIV and AIDS are still present. Funding for programs related to them are just as vital now as ever before, so I will continue to be a "Voice of Many" in our blessed journey." *(Michael Hawkins, New Britain)*

"The most memorable thing was when Shawn Lang received an award and dedicated it to people living with HIV/AIDS." *(Carmen Cruz, Waterbury)*

"The most memorable part was listening to legislators speak about personal stories involving their own family members struggling with the disease and how it impacts everyone's life. It reminded me I am not alone and I have to stay vigilant and keep fighting this disease and realize that, through helping others, I help myself." *(Rick Dumas)*

"I was moved with gratitude to be able to recite a couple of my poems, "Time to Care" and "Voice of Many", which touched a lot of nerves. I was told not only by "Us", the people infected and affected, but also by the suits and ties and the state troopers that were watching and listening who came up to me and shook my hand thanking me." *(Michael Hawkins)*

Miranda Baldwin addresses the crowd

CT HIV Planning Consortium Update

CHPC members prep for a recent meeting

The CHPC completed two major pieces of work this spring:

1. In April, CHPC members voted to approve the 2012 ***Statewide Coordinated Statement of Need (SCSN)***. The SCSN identifies HIV/AIDS needs and services gaps across the state and makes recommendations to the State Department of Public Health (DPH) on how to increase the effectiveness of funding for HIV/AIDS care and prevention services.

2. In May, the CHPC approved its ***2012-2015 Action Plan***. The Action Plan includes goals, objectives, action steps, outcomes, implementation partners, and timelines to help the CHPC achieve its mission. The Action Plan responds to the information in the SCSN and aligns with the National HIV/AIDS Strategy. Action Plan goals relate to increasing statewide collaboration, promoting changes in the HIV/AIDS prevention and care service delivery system, and enhancing public awareness and education efforts.

In August, the CHPC will reconvene to review the 2012-2015 Comprehensive Plan for HIV Care and Prevention, and prepare for concurrence in September. Beginning in August, the Data and Assessment Committee work group will also begin preparing for the 2013 Needs Assessment Survey by reviewing prior assessments and discussing processes for implementation

In April, the CHPC elected ***George Lawson as a new CHPC Community Co-Chair***. George will begin his term as Co-Chair in January 2013.

Due to federal funding cuts and the completion of many of its major work products, the CHPC will not meet in June or July. The CHPC and its committees will remain busy during the summer and meet again in August. The Membership and Awareness Committee (MAC) will plan an HIV Community Forum to be held in Norwalk in the fall. MAC will also recruit new CHPC members from needed populations, including people living with HIV/AIDS, people from Fairfield County, and Latinos. To request an application, contact CHPC staff at 203.772.2050 x28.

Upcoming CHPC Meeting:
Held at Immanuel Baptist Church
1324 Chapel Street, New Haven
August 15
Call 866-972-2050 x18 for info

DPH Corner

Connecticut Department of Public Health

On June 3 and 4 the Health Care and Support Services Unit, in collaboration with HealthHIV, sponsored a Fiscal Health Sustainability Training for its Ryan White Part B providers (program and fiscal) at the Courtyard by Marriott in Cromwell.

The two-day training included presentations on the Affordable Care Act, HRSA Monitoring Standards and Third Party Reimbursement, Assessing Client Need for Ryan White Providers, Federal Grant Compliance and Organizational Sustainability and Financial Diversification. Guest presenters included Shar'ron Tendai, Education and Training manager with HealthHIV, Paul Calabrese, CPA and Senior Manager of Rubino and McGeehin; Ingrid Floyd, Executive Director of Iris House in Harlem; Dr. Julia Hildago, CEO of Positive Outcomes, Inc. and Research Professor at George Washington University School of Public Health, and Carolyn Thompson, former Deputy Chief of Prevention and Intervention Services Bureau of the HIV/AIDS, Hepatitis, STD and TB administration of the District of Columbia Department of Health.

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

Waterbury HIV/AIDS Walk

Call attention to HIV/AIDS and learn the facts about HIV by participating in the Waterbury HIV/AIDS Walk on Saturday, June 16 at 10 am. The Walk starts at Grace Baptist Church on 65 Kingsbury Street.

Community Corner

HIV/AIDS: 30 Years & the Battle Continues

By Nelly Marcin

Nothing was known about the strange invader who hijacked this nation without notice in the early 1980s. This mysterious invader was quickly referred to as GRID or, more informally, "gay cancer." Since this notorious killer respected no boundaries (male, female, gay, straight, young, old, rich, poor), it was later given the name AIDS. Graphic images of the slow, painful, and humiliating deaths of people from his ravages were displayed everywhere. People diagnosed with AIDS during the 80s and early 90s could expect to live only months. The only treatment available during this time had to be taken every four hours. This notorious invader was feared and quickly changed our views on disease and culture.

In 1995, with the introduction of anti-retroviral therapy (ART), the face of the AIDS epidemic changed from a death sentence into a chronic condition. Importantly, ART resulted in substantial reductions in morbidity and mortality worldwide. ART has simplified treatment with a single combination pill taken once a day. With improvements in ART, the life expectancy of certain HIV-infected patients now approaches that of uninfected individuals. ART also has proven effective in HIV prevention, reducing the risk of mother-to-child transmission and serving as post-exposure prophylaxis for individuals exposed to HIV.

Three decades into this battle, however, there is no cure in sight. Yes, treatment has proven to work, but there may be not enough money to treat all who need it. After 30 years of progress, I am appalled that stigma still exists. Now that HIV/AIDS is no longer in the headlines, there is misinformation on how it is passed on and what it is capable of doing without treatment, and too many people are nonchalant about it – as if ignoring it will make it go away. People are still afraid and mostly of the wrong things (like public toilet seats and hugging). No, HIV/AIDS is not over and the battle continues. Now is not the time to lose hope and give up the fight because the fact remains – there is no cure yet! As I wrote this article, I cried remembering friends and associates I've lost over the years. I hope their memories will one day be truly laid to rest with a cure. For those who are gone but not forgotten, I will continue to raise awareness and be connected to this Red Ribbon – a symbol of hope.

World Hepatitis Day

July 28, 2012

The theme for World Hepatitis Day 2012 is ***"It's Closer than you Think."*** This theme highlights the need for awareness, information, and testing. Do you know that one in 12 people worldwide is infected with either chronic hepatitis B or C? Many people infected with hepatitis B or C do not have symptoms and are unaware that they are infected. Could you be one of the infected people? Get the facts. Get tested. Know the risks and ways of getting infected. Find out how to protect yourself and those you care about.

Talk to your health care provider today or visit http://getstdtested.com/std-test-centers/connecticut-ct for a list of STD testing centers in Connecticut. Look out for a Connecticut Hepatitis Summit being planned for September.

The World Hepatitis Alliance coordinates World Hepatitis Day, and is proud to partner with a large number of groups in the viral hepatitis community and many other non-governmental organizations. For information about how to work with the World Hepatitis Alliance, email contact@worldhepatitisalliance.org.

2-1-1 HIV/AIDS Guide

The HIV/AIDS Prevention & Care Guide on the United Way of CT's 2-1-1 website has an inventory of CT HIV/AIDS services. To access the Guide, go to the 2-1-1 homepage at www.infoline.org, click "Find Help," and then "HIV/AIDS Prevention and Care Guide." The resources in the Guide can also be accessed by calling 211 within CT.

Youth Advisory Group "Gives the Facts"

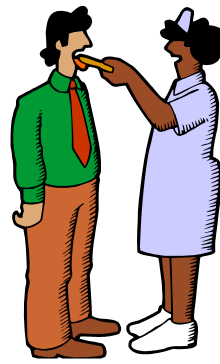
Nine CHPC Youth Advisory Group members presented at the True Colors Conference for sexual minority youth and their allies on March 16. The topic: ***What happens when young people don't get the facts about HIV and STDs?*** Advisory Group members explored this topic through activities, skits, a youth-produced video, group discussions, and a question and answer session. Skits focused on sexual relationships with partners and the challenges teens face getting the facts from adults.

- *Katie's Story* followed up with the lead character from the Advisory Group's 2010 public service announcement (www.youtube.com/watch?v=6yVgY1JddvM). What happens when young people don't get the facts? They may get misinformation from their peers which leads to unintended consequences (like teen pregnancy).
- *The Diary* explored a topic many of us would rather avoid. What would you do if you found out your friend was being sexually abused by a trusted adult?
- *Love Triangles* portrayed the love lives of a group of teens and could be summed up as: It's Complicated. Holly is cheating on JT, who cheats with Sammy, whose boyfriend Bobby has a relationship on the down-low with Alejandro.

Participants suggested how young people can get the facts and how they can help friends in need. The group also identified ways to protect themselves in a complicated world: don't have sex (abstinence); be faithful; use condoms.

The presentation was a success. More than 35 teens participated and contributed, and attendees gave high marks to the activities and skits. The Advisory Group's hard work preparing for the workshop – including two planning meetings and a dress rehearsal – really paid off! As a follow-up to True Colors, the Advisory Group posted facts from the presentation on its Facebook page (www.facebook.com\CTyouthHIV).

Rapid HIV Testing



Many people think they have to get blood drawn and wait a week or more to find out their HIV status, but that is no longer the case – rapid HIV antibody tests have been available for years. Rapid HIV testing differs from conventional HIV testing in that it may not require drawing blood, it provides test results in less than 30 minutes, and HIV testing, counseling, and referrals can be done in one visit.

One problem with conventional HIV testing is that many people who are tested do not return to learn their test results. The U.S. Centers for Disease Control and Prevention (CDC) estimate that in 2000, 31% of patients who tested HIV-positive at public-sector testing sites nationally did not return to receive their results. Rapid HIV tests can play an important role in HIV prevention activities and expand access to testing in clinical and nonclinical settings. They can help overcome some of the barriers to early diagnosis and improve linkage to care of infected people.

The CDC recommends that patients receive information about HIV testing, HIV infection, and the meaning of test results. Further testing is always required to confirm a reactive (preliminary positive) screening test result. For all clients with a reactive rapid HIV test result, it is essential to explain the meaning of the result in simple terms, emphasize the importance of confirmatory testing and schedule a return visit for the confirmatory test results, and underscore the importance of taking precautions to avoid the possibility of transmitting infection to others while awaiting results of confirmatory testing.

In Connecticut, everyone is entitled to a confidential HIV antibody test. Testing and counseling are offered at various health agencies, including city health departments and community health clinics. According to www.hivtest.org, 38 organizations in Connecticut currently offer rapid HIV testing. Visit www.hivtest.org and enter your zip code to find the rapid HIV testing site closest to you.

This article used information from www.cdc.gov.

Upcoming HIV/AIDS Prevention and Care Planning Meetings

To list a meeting in the October newsletter, contact nogelo@xsector.com or 203.772.2050 x28

See the next page for contact information for planning meetings

June

Mon	Tuesday	Wednesday	Thursday	Friday
4 • 12 New Haven HIV Care Contin.	5 • 10-11:30 Danbury Consortium	6 • 10-2:30 Hartford Planning Council • 9-10 Hartford PC Membership	7 • 9:30 Bridgeport Consortium	8
11	12 • Norwalk/ Stamford Consortium • 12 New Haven Mayor's Task Force on AIDS • 2:30 Hartford PC Evaluation Committ.	13 • 11:30 Hartford Positive Empowerment Committee (PEC)	14	15
18	19 • 9-11 Hartford PC Continuum of Care • 1 Hartford PC Needs Assessment/ Priority Committee • 2:30 Hartford PC Steering Committee	20	21 • 9 Southeast CT Ryan White Consortium • 10:30 African-American CARE Team • 2 Hartford Latino Caucus	22
25	26 • 12-2 AIDS LIFE Campaign	27 **National HIV Testing Day** • 9:30-12 Hartford Planning Council	28	29

July

Mon	Tuesday	Wednesday	Thursday	Friday
2	3 • 10-11:30 Danbury Consortium	4	5 • 9:30 Bridgeport Consortium	6
9 • 12-2 NH HIV Care Continu-um	10 • 12 NH Mayor's Task Force on AIDS (MTFA) • Norwalk/ Stamford Consortium • 2:30-4 Hartford PC Evaluation Committee	11 • 9:30-2:30 Hartford Planning Council • 9-9:30 Hartford Positive Empowerment Committee	12 • 12 New Haven/ Fairfield PC Membership/ Finance Committee • 2 NH/FF PC Strategic Planning and Assessment (SPA) Committee	13 • 12-2 NH/FF PC Quality Improvemnt (QI) Committee
16	17 • 9 Hartford PC Continuum of Care • 1 Hartford PC Needs Assessment /Priorities Committee • 2:30 Hartford PC Steering Committee	18	19 • 9 Southeast CT RW Consortium • 10:30 African-American CARE Team • 2 Hartford Latino Caucus	20 • 10:30 NH/FF PC Executive Committee 12 NH/FF Planning Council
23	24 • 12-2 AIDS LIFE Campaign	25 • 9:30 Hartford Planning Council • 1-2 Hartford PC Membership	26	27

August

Mon	Tuesday	Wednesday	Thursday	Friday
J 30	J 31	1	2 • 9:30 Bridgeport Consortium • 12-2 NH/FF PC Membership/Finance • 2-4 NH/FF PC SPA Committee	3 • 12-2 NH/FF PC QI Committee
6 • 12 NH HIV Care Continu um	7 • 10-11:30 Danbury Consortium	8	9	10 • 10:30 NH/FF PC Executive • 12 NH/ FF PC
13	14 • 12 NH MTFA • Nor/Stam Consortium • 9 Hartford PC Continuum of Care • 2:30 Hartford PC Evaluation Committee	15 **9 am-2 pm CT HIV Planning Consortium (CHPC) and committees**	16 • 10:30 Afro-Americ CARE Team • 2 Hartford Latino Caucus • 9:00 Southeast CT RW Consortium	17
20	21 • 1 Hartford PC NA/Priorities Committee • 2:30 Hartford PC Steering Committee	22	23	24
27	28 • 12-2 AIDS LIFE Campaign	29	30	31

Contact Information for Planning Meetings

Hartford Planning Council + Positive Empowerment	860-688-4858
New Haven/Fairfield Planning Council	877-336-5503
New Haven Task Force on AIDS	203-946-8351
Norwalk/Stamford Consortium	203-855-9535
Tolland County Collaborative	860-872-7727
AIDS LIFE Campaign	860-761-6699
Danbury Consortium	203-778-2437
Waterbury Consortium	203-575-4337
Bridgeport Consortium	203-576-9041
Windham Area Task Force	860-423-4534
African-American CARE Team	860-761-6699 x 304

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

Breakfast Anyone?

By Aurelio Lopez

Shawn Lang speaks at a legislative breakfast in Hartford

Legislators connect with community members at a breakfast in Hartford

The focus of the AIDS LIFE (Legislative Initiative and Funding Effort) Campaign (ALC) in 2012 has been to find a way to take HIV/AIDS off the "back burner," where it has been stuck for many years now. To accomplish this, the ALC encouraged communities to host "legislative breakfasts" to give Connecticut legislators an opportunity to hear from the HIV Community.

Breakfasts were hosted in communities across Connecticut by agencies such as the Windham Regional Community Council, AIDS Project New Haven, and the Bridgeport Health Department. ***All breakfasts*** were deemed 'successful' in their own unique way. After the legislative breakfast at the Connections Wellness Center in Hartford, Charles C. (West Hartford) commented on how well the speakers presented their unique stories to the legislators: "I believe the reps heard us loud and clear." Miranda B. (from AIDS Project Hartford (APH) Connections) said, "Speaking to the legislators helped me be more confident about telling my story, so it can help others."

Not all the messages from the legislative breakfasts were happy ones. Tim C. (St. Philips House) stated, "The future for HIV/AIDS agency funding from the state government is not going to get better. It is important that ***we*** take the initiative with additional local, community and corporate fundraising." Margaret Jones and Jacqueline Delgado from Alliance for Living tried to answer the ultimate question: "What's positive about being positive?" They explained that being positive has a grander meaning: being positive about life regardless of life's challenges; living longer, getting access to better medications, participating in advocacy events, and having hope.

It is important to end this article about these great events in our communities with a quote from Gilbert from St. Philips House: "I want to thank the legislators so much for attending the breakfast. I learned about how the *[appropriations]* process works. The legislators made me feel comfortable talking to them. Thank you so much for visiting us." This writer echoes Gilbert's sentiment: It takes a village to raise a child, but it takes all of us to ***re-raise awareness***.

En este número

CHPC
CONNECTICUT HIV PLANNING CONSORTIUM

5 de junio de 2012

Noticias de planificación del VIH/SIDA

Día de la Concientización sobre el SIDA 2012

Participantes en la concentración del Día de la Concientización sobre el SIDA

La celebración anual del Día de la Concientización sobre el SIDA tuvo lugar el 26 de abril en el Capitolio Estatal. El tema de la concentración fue "Conoce tu condición". Cientos de personas de todo el estado contaron sus historias y explicaron a los legisladores el impacto que el VIH y el SIDA sigue teniendo en las comunidades de Connecticut.

Muchas de ellas expresaron sus motivos para participar en la celebración y sus percepciones de la concentración:

"Asistí a la concentración para hacer sentir mi presencia y apoyar la lucha constante que hay en el estado por obtener recursos para el SIDA. Me siento obligado a ir a la concentración cada año para: ¡levantarme, salir, meterme de lleno y recuperarme! Agradezco estar aquí todavía, en el juego de la vida". *(Rick Dumas, New Haven)*

"Como portador de VIH, es importante para mí participar ya que los recursos han escaseado y muchos debemos alzar la voz constantemente. También quise asistir porque mi hermano falleció hace ya casi un año". *(George Lawson, Middletown)*

"El VIH y el SIDA aún están presentes. Los recursos para los programas siguen teniendo importancia, así que seguiré siendo la "voz de muchos" a lo largo de la jornada". *(Michael Hawkins, New Britain)*

"Lo más memorable fue cuando Shawn Lang recibió un premio y se lo dedicó a la gente que vive con el VIH/SIDA". *(Carmen Cruz, Waterbury)*

"Lo mejor fue escuchar a los legisladores hablar de sus parientes que batallan con la enfermedad y cómo eso afecta a todos los demás. Me recordó que no estoy solo y que tengo que estar alerta, seguir luchando y recordar que al ayudar a los demás me ayudo a mí mismo". *(Rick Dumas)*

"Me llené de gratitud al recitar dos de mis poemas, "Hora de hacer algo" y "La voz de muchos", que conmovieron a muchos. No solo "nosotros" los infectados y afectados, sino también funcionarios y agentes de policía que estaban presentes, se me acercaron para saludarme y darme las gracias". (Michael Hawkins)

Miranda Baldwin se dirige al público

Lo más reciente del Consorcio de Planificación del VIH de CT

Miembros del CHPC se preparan para una reunión reciente

En la primavera, el CHPC terminó dos proyectos importantes:

1. En abril, los miembros del CHPC votaron para aprobar la ***Declaración Coordinada de Necesidades del Estado (SCSN)*** de 2012. La SCSN señala los huecos que hay entre las necesidades y los servicios del VIH/SIDA del estado, y hace recomendaciones al Departamento de Salud Pública sobre la forma de aumentar la eficacia de los recursos destinados a la atención y prevención.

2. En mayo, el CHPC aprobó su ***Plan de Acción 2012-2015***. El Plan de Acción abarca metas, objetivos, medidas, resultados, socios de implementación y períodos de tiempo para ayudar al CHPC a cumplir su misión. El plan se basa en la información de la SCSN y se apega a la Estrategia Nacional del VIH/SIDA. Con el plan se pretende aumentar la colaboración en el estado, pugnar por cambios en el sistema de entrega de servicios de prevención y atención, crear más conciencia y realizar actividades de educación.

El CHPC volverá a reunirse en agosto a fin de revisar el Plan Integral 2012-2015 de Atención y Prevención del VIH y prepararse para la concurrencia de septiembre. A partir de agosto, el Comité de Información y Evaluación también comenzará a preparar la Encuesta de evaluación de necesidades 2013, para los cual revisará evaluaciones anteriores y analizará procesos de implementación.

En abril, el CHPC eligió a ***George Lawson como nuevo copresidente comunitario del CHPC***. George comenzará su gestión en enero de 2013.

Debido a los recortes de recursos federales y a la finalización de muchos de sus proyectos, el CHPC no se reunirá en junio ni en julio. El CHPC y sus comités se mantendrán ocupados durante el verano y se reunirán otra vez en agosto. El Comité de Membresía y Concientización (MAC) planificará un foro comunitario sobre el VIH a celebrarse en el otoño en Norwalk.

El comité también reclutará a nuevos miembros de comunidades importantes, incluso personas que tienen VIH/SIDA, del condado de Fairfield y latinos. Para pedir una solicitud, comuníquese con el CHPC al 203.772.2050 x28.

Próximas reuniones del CHPC:
En Immanuel Baptist Church 1324 Chapel Street, New Haven
15 de Agosto
Llame al 866-972-2050 x18 para pedir información

Esquina del DPH

DPH
Connecticut Department of Public Health

El 3 y 4 de junio la Unidad de Servicios de Atención y Apoyo a la Salud, en colaboración con HealthHIV, patrocinó una capacitación sobre sostenibilidad de la salud para proveedores del programa Ryan White Parte B en el hotel Courtyard by Marriot de Cromwell.

La capacitación incluyó presentaciones sobre: Ley de Atención Asequible, Normas de Monitorización de HRSA y Reembolso a Terceros, Evaluación de Necesidades para Proveedores del Programa Ryan White, Cumplimiento de Subvenciones Federales, Sostenibilidad de Organizaciones y Diversificación Financiera. Entre los presentadores estuvieron Shar'ron Tendai, encargada de educación y capacitación de HealthHIV, Paul Calabrese, contador y director de Rubino and McGeehin; Ingrid Floyd, directora de Iris House de Harlem; la Dra. Julia Hildago, presidenta de Positive Outcomes, Inc. y profesora de investigación de la facultad de salud pública de la Universidad George Washington, y Carolyn Thompson, ex subdirectora de la Agencia de servicios de prevención e intervención del VIH/SIDA, hepatitis, STD y administración de TB del Departamento de Salud del Distrito de Columbia.

Para presentar solicitudes de propuestas y obtener otra información, visite el sitio www.ct.gov/dph.

Caminata del VIH/SIDA de Waterbury

Hágase notar y aprenda sobre el VIH/SIDA al participar en la caminata de Waterbury el sábado 16 de junio a la 10 a.m. que comenzará en la iglesia Grace Baptist, en 62 Kingsbury Street.

Esquina de la comunidad

VIH/SIDA: 30 años y la batalla continúa

Por Nelly Marcin

A principios de los 80, nada se sabía sobre el extraño invasor que secuestró al país sin que nadie se diera cuenta. Al invasor se le dio rápidamente el nombre de GRID, o, de manera más informal, "cáncer gay". Como ese asesino no conocía límites (hombres, mujeres, gay, heterosexuales, jóvenes, mayores, ricos, pobres) más tarde recibió el nombre de SIDA. Por todos lados se mostraban imágenes gráficas de la muerte lenta, dolorosa y humillante de las víctimas de la enfermedad. Los que eran diagnosticados con SIDA en los 80 y los 90 solo esperaban vivir unos meses. El único tratamiento disponible entonces tenía que tomarse cada cuatro horas. El invasor era temido y pronto nos hizo cambiar la perspectiva sobre las enfermedades y la cultura.

Con la introducción de la terapia antirretroviral (ART) en 1995, el concepto del SIDA pasó a ser una condición crónica en vez de una sentencia de muerte. Lo mejor fue que la terapia redujo notablemente la morbosidad y la mortalidad a nivel mundial. Con ART, el tratamiento se ha simplificado a una simple pastilla que se toma una vez al día. Con las mejoras de ART, la esperanza de vida de los pacientes de VIH ahora es casi igual a la de las personas sanas. ART también ha comprobado su eficacia en la prevención del VIH, la reducción del riesgo de transmisión de madre a hijo y sirve de profilaxis de postexposición a personas expuestas al VIH.

No obstante, tras tres décadas de batalla aún no se vislumbra una cura. Si bien el tratamiento funciona, podría no haber recursos suficientes para atender a todos los afectados. Después de 30 años de avances, me consterna ver que el estigma aún existe. Ahora que el VIH/SIDA ya no es noticia, todavía se malinterpreta la forma en que se transmite y lo que puede producir si no se trata, y mucha gente actúa con indiferencia al respecto, como si al ignorarlo fuera a desaparecer. La gente aún tiene miedo y muchas veces de cosas que no son (como inodoros públicos y abrazarse). No, el VIH/SIDA no se ha ido y la batalla continúa. Ahora no es el momento de perder las esperanzas y rendirse porque el problema sigue, ¡todavía no hay cura! Al escribir este artículo lloré al recordar a amigos y compañeros que he perdido con los años. Espero que su memoria un día en realidad descanse en paz con una cura. Por los que viven en el recuerdo, seguiré creando conciencia y aferrándome a esta cinta roja, que es un símbolo de esperanza.

Día Mundial de la Hepatitis

28 de julio de 2012

El tema del Día Mundial de la Hepatitis 2012 es ***"Está más cerca de lo que crees"***. El tema resalta la necesidad de concientización, información y pruebas. ¿Sabía que una de cada 12 personas en el mundo tiene hepatitis crónica B o C? Mucha gente enferma de hepatitis B o C no tiene síntomas y no sabe que tiene la enfermedad. ¿Podría ser usted una de ellas? Averígüelo. Hágase una prueba. Conozca los riesgos y las formas de infectarse. Averigüe cómo protegerse a sí mismo y a sus seres queridos.

Hable con su proveedor de atención médica o visite http://getstdtested.com/std-test-centers/connecticut-ct para obtener una lista de centros de exámenes de enfermedades transmitidas por contacto sexual de Connecticut. Esté pendiente de una cumbre sobre la hepatitis a celebrarse en septiembre en Connecticut.

La Alianza Mundial contra la Hepatitis coordina el DMH y se enorgullece en asociarse con una gran cantidad de grupos de la comunidad de la hepatitis viral y muchas otras entidades no gubernamentales. Para obtener información sobre cómo colaborar con la Alianza, envíe un mensaje a contact@worldhepatitisalliance.org.

Guía del 2-1-1 para el HIV/AIDS

La Guía para la prevención y atención del VIH/SIDA de la página de Internet de 2-1-1 de United Way de CT cuenta con un inventario de los servicios para el VIH/SIDA que se ofrecen en Connecticut. Para el acceso a la Guía, visite la página principal de 2-1-1 en www.infoline.org, haga clic en "Find Help" y luego en "HIV/AIDS Prevention and Care Guide". También se puede obtener acceso a los recursos que se incluyen en la guía llamando al 211 dentro de CT.

El Grupo de Orientación para la Juventud dice la verdad

En la Conferencia True Colors para jóvenes de comunidades minoritarias y sus defensores celebrada el 16 de marzo, el grupo presentó el tema: ***¿Qué sucede si los jóvenes no saben la verdad sobre el VIH y las STD?*** Los miembros del grupo plantearon el tema mediante actividades, parodias, un video producido por jóvenes, análisis en grupo y una sesión de preguntas y respuestas. Las parodias eran sobre las relaciones sexuales y los retos que afrontan los adolescentes en la comunicación con los adultos.

- *La Historia de Katie* era sobre el personaje del anuncio de servicio público del Grupo de Orientación 2010 (www.youtube.com/watch?v=6yVgY1JddvM). ¿Qué sucede cuando los jóvenes no saben la verdad? Podrían recibir información errónea de sus amigos lo cual trae consecuencias desagradables (como el embarazo).

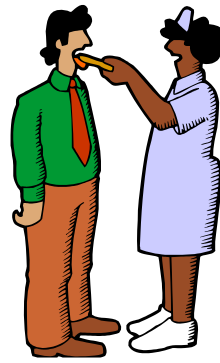
- *El Diario* trataba un tema que muchos preferirían evitar. ¿Qué harías si sabes que un amigo está siendo abusado sexualmente por un adulto de confianza?

- *Triángulos Amorosos* representó la vida amorosa de unos jóvenes y se podría resumir así: es complicado. Holly engaña a JT, quien le es infiel a Sammy, cuyo novio Bobby tiene una relación por debajo del agua con Alejandro.

Los participantes sugirieron cómo los jóvenes pueden enterarse de la verdad y ayudar a sus amigos. El grupo también determinó maneras de protegerse en un mundo complicado: abstenerse del sexo, ser fiel y usar condones.

La presentación fue todo un éxito. Más de 35 jóvenes participaron y colaboraron, y los asistentes elogiaron las actividades y las parodias. El arduo trabajo del grupo en preparación para el taller, incluso dos reuniones de planificación y un ensayo general, valió la pena. Como seguimiento de True Colors, el grupo publicó partes de la presentación en su página de Facebook (www.facebook.com\CTyouthHIV).

Pruebas rápidas del VIH



Muchas personas creen que se les tiene que sacar sangre y esperar una semana o más para saber su condición con el VIH, pero no es así, las pruebas rápidas de anticuerpos han existido por años. Las pruebas rápidas del VIH difieren de las convencionales en que podrían no requerir sacar sangre, los resultados se obtienen en menos de 30 minutos y la prueba y la orientación se hace en la misma visita.

Uno de los problemas con las pruebas convencionales es que muchas personas no regresan por los resultados. El Centro para el Control y la Prevención de Enfermedades (CDC) calcula que en 2000, el 31% de los pacientes que arrojaron positivo en pruebas del sector público no regresaron por los resultados. Las pruebas rápidas del VIH juegan un papel importante en las actividades de prevención del VIH y amplían el acceso a pruebas en entornos clínicos y no clínicos. Pueden servir para superar algunos obstáculos del diagnóstico a tiempo y mejorar la conexión a servicios de atención de personas enfermas.

El CDC recomienda que los pacientes reciban información sobre las pruebas y la infección del VIH, y el significado de los resultados. Siempre son necesarias más pruebas para confirmar resultados positivos (preliminares). Es esencial explicar a todos los pacientes con un resultado rápido positivo el significado de éste en términos sencillos, recalcar la importancia de las pruebas de confirmación, programar otra visita para los resultados, y subrayar la importancia de tomar precauciones para evitar la posibilidad de infectar a otras personas mientras se esperan los resultados de confirmación.

En Connecticut, todos tienen derecho a hacerse una prueba confidencial de anticuerpos del VIH. Las pruebas y la orientación se ofrecen en diversas agencias de salud, incluso departamentos de salud y clínicas comunitarias. Según www.hivtest.org, 38 organizaciones de Connecticut ofrecen actualmente pruebas rápidas del VIH. Visite www.hivtest.org e ingrese su código postal para buscar el centro de pruebas rápidas más cercano a usted.

En este artículo se utilizó información del sitio www.cdc.gov.

Próximas reuniones sobre la prevención y atención del VIH/SIDA

Para incluir una reunión en el boletín de octubre, escriba nogelo@xsector.com o 203-772-2050 x28
La página siguiente contiene información de contacto y el calendario de reuniones de planificación.

Junio

Lunes	Martes	Miercoles	Jueves	Viernes
4 • 12 New Haven HIV Care Contin.	5 • 10-11:30 Danbury Consortium	6 • 10-2:30 Hartford Planning Council • 9-10 Hartford PC Membership	7 • 9:30 Bridgeport Consortium	8
11	12 • Norwalk/ Stamford Consortium • 12 New Haven Mayor's Task Force on AIDS • 2:30 Hartford PC Evaluation Committ.	13 • 11:30 Hartford Positive Empowerment Committee (PEC)	14	15
18	19 • 9-11 Hartford PC Continuum of Care • 1 Hartford PC Needs Assessment/ Priority Committee • 2:30 Hartford PC Steering Committee	20	21 • 9 Southeast CT Ryan White Consortium • 10:30 African-American CARE Team • 2 Hartford Latino Caucus	22
25	26 • 12-2 AIDS LIFE Campaign	27 **National HIV Testing Day** • 9:30-12 Hartford Planning Council	28	29

Julio

Lunes	Martes	Miercoles	Jueves	Viernes
2	3 • 10-11:30 Danbury Consortium	4	5 • 9:30 Bridgeport Consortium	6
9 • 12-2 NH HIV Care Continu-um	10 • 12 NH Mayor's Task Force on AIDS (MTFA) • Norwalk/ Stamford Consortium • 2:30-4 Hartford PC Evaluation Committee	11 • 9:30-2:30 Hartford Planning Council • 9-9:30 Hartford Positive Empowerment Committee	12 • 12 New Haven/ Fairfield PC Membership/ Finance Committee • 2 NH/FF PC Strategic Planning and Assessment (SPA) Committee	13 • 12-2 NH/FF PC Quality Improvemnt (QI) Committee
16	17 • 9 Hartford PC Continuum of Care • 1 Hartford PC Needs Assessment /Priorities Committee • 2:30 Hartford PC Steering Committee	18	19 • 9 Southeast CT RW Consortium • 10:30 African-American CARE Team • 2 Hartford Latino Caucus	20 • 10:30 NH/FF PC Executive Committee 12 NH/FF Planning Council
23	24 • 12-2 AIDS LIFE Campaign	25 • 9:30 Hartford Planning Council • 1-2 Hartford PC Membership	26	27

Agosto

Lunes	Martes	Miercoles	Jueves	Viernes
J 30	J 31	1	2 • 9:30 Bridgeport Consortium • 12-2 NH/FF PC Membership/Finance • 2-4 NH/FF PC SPA Committee	3 • 12-2 NH/FF PC QI Committee
6 • 12 NH HIV Care Continu um	7 • 10-11:30 Danbury Consortium	8	9	10 • 10:30 NH/FF PC Executive • 12 NH/ FF PC
13	14 • 12 NH MTFA • Nor/Stam Consortium • 9 Hartford PC Continuum of Care • 2:30 Hartford PC Evaluation Committee	15 **9 am-2 pm CT HIV Planning Consortium (CHPC) and committees**	16 • 10:30 Afro-Americ CARE Team • 2 Hartford Latino Caucus • 9:00 Southeast CT RW Consortium	17
20	21 • 1 Hartford PC NA/Priorities Committee • 2:30 Hartford PC Steering Committee	22	23	24
27	28 • 12-2 AIDS LIFE Campaign	29	30	31

Información de contacto para las reuniones de planificación

Hartford Planning Council + Positive Empowerment	860-688-4858
New Haven/Fairfield Planning Council	877-336-5503
New Haven Task Force on AIDS	203-946-8351
Norwalk/Stamford Consortium	203-855-9535
Tolland County Collaborative	860-872-7727
AIDS LIFE Campaign	860-761-6699
Danbury Consortium	203-778-2437
Waterbury Consortium	203-575-4337
Bridgeport Consortium	203-576-9041
Windham Area Task Force	860-423-4534
African-American CARE Team	860-761-6699 x 304

Más información sobre reuniones - www.guardianhealth.org/calendar/calendar.htm

¿Alguien quiere desayunar?

Por Aurelio López

Shawn Lang habla en un desayuno legislativo en Hartford

Legisladores conviven con miembros de la comunidad en un desayuno en Hartford

La Campaña AIDS LIFE (ALC) (Iniciativa Legislativa y Labor de Financiamiento) de 2012 se centra en buscar la manera de sacar el VIH/SIDA del olvido, donde ya ha estado por muchos años. Para esto, la campaña ha alentado a las comunidades a ofrecer "desayunos legislativos" para que los legisladores de Connecticut escuchen a la comunidad del VIH.

Los desayunos fueron ofrecidos en comunidades de todo el estado por entidades como el Consejo comunitario regional de Windham, el Proyecto del SIDA de New Haven y el Departamento de Salud de Bridgeport. ***Todos los desayunos*** fueron considerados como un éxito a su manera. Después del desayuno legislativo efectuado en Connections Wellness Center de Hartford, Charles C. (West Hartford) comentó sobre lo bien que los discursantes presentaron sus casos a los legisladores: "Creo que los representantes nos entendieron". Miranda B. (de AIDS Project Hartford (APH) Connections) dijo, "el hecho de hablar con los legisladores me ayudó a sentirme con la confianza de hablar de mí y así puedo ayudar a los demás".

No todos los mensajes del desayuno fueron historias felices. Tim C. (de St. Philips House) afirmó que, "el futuro de las agencias del VIH/SIDA en cuanto a recursos estatales no va a mejorar. Es importante que ***tomemos*** la iniciativa de recaudar fondos entre la comunidad y las empresas locales". Margaret Jones y Jacqueline Delgado de Alliance for Living intentaron responder la pregunta: "¿Qué tiene de positivo dar positivo?" Explicaron que dar positivo tiene un significado más amplio: significa tener una actitud positiva a pesar de los problemas, vivir más tiempo, obtener acceso a mejores medicamentos, participar en eventos en favor de la causa y tener esperanza.

Es importante terminar este artículo con una cita de Gilbert de St. Philips House: "Agradezco mucho a los legisladores por asistir al desayuno. Aprendí cómo funciona el proceso de [asignación de presupuesto]. Los legisladores me hicieron sentir con la comodidad de hablarles. Gracias mil por acompañarnos". El redactor del artículo coincide con lo que dice Gilbert: Se requiere de toda una comunidad para criar a un niño, pero se requiere de todos para ***volver a crear conciencia***.

May 16, 2012 CHPC Meeting Dash Board

Meeting Participation **26 (of 28)** Members **39** Public Participants

Overall Satisfaction **95%** All participants **99%** CHPC members **88%** Public participants

Vote Outcomes 1) Approval of April 2012 meeting summary; 2) Approval of the 2012 – 2015 Action Plan

Feedback Summary Table
(comments on next page)

	Total (39)	*CHPC Members (24)*					*Public Participants (15)*				
Question	*Yes %*	*Yes*	*No*	*d/n*	*n/a*	*% Yes*	*Yes*	*No*	*d/n*	*n/a*	*% Yes*
2. Each task or agenda item was defined and kept in mind during the meeting.	**95%**	**24**	0	0	0	**100%**	**13**	2	0	0	**87%**
3. Understood all information and materials that were presented.	**97%**	**24**	0	0	0	**100%**	**14**	1	0	0	**93%**
4. Feel there is mutual respect for diverse cultures and opinions of the members.	**95%**	**23**	0	0	1	**100%**	**13**	2	0	0	**87%**
5. We accomplished all meeting tasks.	**95%**	**23**	0	0	1	**100%**	**13**	2	0	0	**87%**
6. Felt comfortable participating in the discussion and voice was heard.	**89%**	**23**	1	0	0	**96%**	**9**	3	0	3	**75%**
7. The Co-Chair Reflections presentation was clear, informative and relevant to the CHPC.	**95%**	**24**	0	0	1	**100%**	**13**	2	0	0	**87%**
8. The Introduction to Concurrence presentation was clear, informative and relevant to the CHPC.	**97%**	**23**	0	0	1	**100%**	**10**	1	0	4	**91%**
9. The Project REACH presentation was clear, informative and relevant to the CHPC.	**97%**	**23**	0	0	1	**100%**	**10**	1	0	4	**91%**
10. Understand the CHPC process for making decisions and accomplishing the work.	**97%**	**24**	0	0	0	**100%**	**13**	1	0	1	**93%**
11. Felt the meeting was well-run and organized.	**97%**	**22**	0	0	2	**100%**	**13**	1	0	1	**93%**

The comments below were written in on the front page of the feedback form.

- A few members participated in conversation, it was mostly providers.
- Yes comfortable, unsure voice was heard.
- Relevant to DPH agenda
- Some I am a new member.

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Overall comments about CHPC meeting

What I liked best about the May 16, 2012 CHPC meeting

CHPC members (responses denoted by numbers)	Public Participants (responses denoted by letters)
1. Breakfast is no good 2. DPH update 3. Being able to see all agencies working for the same cause a break from the everyday hectic office schedule 4. The co chairs take time to make sure you understand the information given. You feel comfortable enough to ask questions, you leave the meeting with an understanding of the process. 5. Connection and information 6. The interaction between members at the table and community how no one was over looked and their questions were answered and when there was no specific answer to give the question was placed in the parking lot to address later 7. The fluidity 8. Lots of topics covered in one meeting we are becoming much more efficient at what we do 9. The Information provide from members, activities, testing for help and other 10. Great discussion 11. Networking, meeting people, on a personal level, community building relationship , nice to see Chris DPH support, presence, collegial nature of group great to showcase our work in Connecticut 12. LCS presentation 13. The information and updates 14. Chris' update DPH 15. Lots of great new information discussed 16. Pizza was horrid 17. Good group 18. Everything was well run and clear 19. Information sharing and presentations 20. Networking, communication, discussions Latino Comm. Service presentation, excellent 21. Everything 22. That all steps were explained when a question is asked	a. Partner updates b. Angel's presentation c. Latino's presentation and concurrence presentation easier to follow with PowerPoint than just talking as Chris from DPH d. Gaining current state and national level information and education e. Information given f. Latinos presentation g. The presentation h. Updates and presentation from LCS i. DAC j. All well k. Well organized, respect l. Networking

CHPC
CONNECTICUT HIV PLANNING CONSORTIUM

Other comments about the CHPC meeting (May 16, 2012)

CHPC members (responses denoted by numbers)	Public Participants (responses denoted by letters)
1. I would like to become a community co chair 2. MAC is somewhat unclear 3. I will be coming more to meetings and speaking more 4. I heard from 2 individuals today that the meeting area was too cold, one was a member and stated this had been a reoccurring issue with her. 5. Have more time. 6. I wouldn't change a thing. 12. Information is still washing over me, lots to absorb, working on names, etc. sound in room are very difficult to hear, different microphone? Great try though, thank you for the great staff support handouts. Excellent group and work, thank you for salad for lunch. 14. Good use of time with questionnaire, need AA community, less side talk 15. Can you have protein option with salad? 18. Good meeting almost 100% CHPC members; new member of the public. 21. More diverse presentations 24. Always a well run meeting	a. Meeting is too long b. Keep up the good work c. Too much provide a list of acronyms don't take 10 minutes to explain, Leif wasn't too accepting of comments made, ran out of time in DAC meeting, didn't summarize what we did or didn't cover, sometimes It wasn't worth sharing I could tell it would be answered with exact same statement, Angel did a great job presenting and raising awareness of age doesn't matter, Barb made it clear and talked with passion about how important it is to take part, never enough time for DAC members, second time coming and we didn't cover everything again. Move the committee meetings to after lunch and presentations before lunch m. Thank you! n. Great job , great discussion o. Nothing at this time, very well organized p. Ran over, unable to stay for presentation, It would be great to move locations.

CHPC
CONNECTICUT HIV PLANNING CONSORTIUM

Overall Comments about CHPC Committee Meetings **(CHPC respondents by number; Public respondents by letter)**

Data and Assessment Committee (May 16, 2012)

What I liked best	What I would Change
1. New changes for prevention and care 2. You've given full understanding of all the material 3. Everyone was given the opportunity to share thoughts, feelings and have their questions answered 8 Our diversity 11. A lot of information, lots of discussion 12. Handouts respect, interest of members, DPH support, great co chairs, glad they are staying on , work great together, focus, direction, new measurements outcomes evaluation approach 14. The information shared and question asked by public and member and DPH involvement in the process. 15. Discussion 17. Looking at the process going forward 18. Discussion regarding performance measures, thank you. 19. Great discussion 21. Good information not sure how everyone in the room can add to the conversation 22. Discussion 23. That all people opinions and questions were answered 24. The explanation of the quality performance measures questions that were answered with the biological health outcome and service indicators. a. Discussion regarding indicators left out of DAC document b. Very well presentation on the proposed plan c. Participants felt comfortable to speak out a voice concerns safe space was definitely there e. Review of information g. Information given. h. Good data i. Everything j. Excellent overview of purpose of performance measures	8. Hot coffee 12. Perhaps more member participation, group work, perhaps less one way information exchange perhaps explore more data services to better build capacity with funding 15. Less people 21. Engage more people in the overall conversations 24. Give the group the opportunity to give their interpretation or understand of what they know on performance measures c. Facilitation be on same page and be able to respond to uncommon questions, facial expressions, if you don't know the answer that's fine, your human

Membership and Awareness (May 16, 2012)

What I liked best	What I would Change
1. Everyone was open with all suggestions 6. Discussing issues, working on how we connect to make progress 9. Great team, all worked, shared and contributed equally 10. The work shop, and well attending group, participation 13. Everyone participated 16. A meeting of the minds, everyone worked cooperatively with other 20. Group has shown maturity with the folks attending and all providing their feedback during process n. Well organized, everyone voice heard great ideas o. Great participation	2. I'll give it some thought 6. Have more time to make more progress on issues we are working on 16. People rambling

Member Supports (4 meetings through May 16, 2012)

Participation & Transportation Usage	1/18	3/21	4/18	5/16	Cumulative
Monthly member attendance	25/31 (81%)	25/31 (81%)	23/31 (74%)	26/28 (93%)	99/121 (82%)
Member attendance issues (e.g., warnings, dismissals)	n/a	6	8	3	17
Monthly public attendance	29	24	28	39	Average 30
# Members using ride service *	1	0	1	1	3
# Members using transportation plan	2	1	2	8	13
# Members receiving stipends	11	14	12	14	51
# Members using mileage reimbursement	9	9	10	10	38