Connecticut Comprehensive HIV Care and Prevention Plan

2009-2012

Approved by the Connecticut HIV Planning Consortium
October 15, 2009

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Acknowledgements

Connecticut's 2009-2012 Comprehensive Statewide Plan for HIV Care and Prevention Plan is a product of collaborative planning meetings and writing efforts by various representatives of Ryan White Parts, the State of Connecticut Department of Public Health (DPH), the Connecticut HIV Planning Consortium (CHPC), provider agencies, consumers, and public participants from across the state who share a high level of dedication to ensuring that a comprehensive continuum of care and prevention exists for residents of Connecticut.

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CONNECTICUT COMPREHENSIVE STATEWIDE PLAN FOR HIV CARE AND PREVENTION

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. In 2004 Connecticut's Statewide HIV Care Consortium (SWC) issued a three year plan (2004-2007) designed to integrate care and prevention and continue and improve upon the public health services system. The Connecticut HIV Prevention Community Planning Group (CPG) issued a Comprehensive Prevention Plan for 2005-2008, and provided updates for 2007, which focused on the integration of care and prevention. With the imminent merger of Connecticut's two planning bodies into one unified planning body in October 2007, a Transition Plan for January – December 2008 was submitted to bridge the gap until a Statewide Comprehensive Plan for HIV Care and Prevention would be produced for 2009 - 2012. The 2008 Transition Plan outlined the accomplishments of the previous three years (2004-2007), defined gaps in the statewide continuum of care and prevention, addressed strategies to address those gaps, and outlined the process for the integration of the statewide planning bodies.

The DPH now convenes a Connecticut HIV Planning Consortium (CHPC) with a 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. CHPC is the statewide integrated care and prevention planning body that was officially introduced in October 2007. The DPH has charged the CHPC to develop this 2009-2012 statewide Comprehensive Plan for the delivery of HIV Care and Prevention services that informs the 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 proposed in the 2008 Statewide Coordinated Statement of Need (SCSN).

This combined 2009 Connecticut Comprehensive Plan for HIV Care and Prevention is a culmination of collaborative efforts which included active participation by Connecticut's two Ryan White Part A Transitional Grant Areas (TGA), prevention and care service providers, PLWH/A, as well as representatives from Ryan White Parts C, D and F (SPNS and Connecticut AIDS Education and Training Center) and other state department agencies.

IDENTIFYING GAPS AND ASSESSING NEED: WHERE ARE WE NOW?

Connecticut, New England's second smallest state, has a diverse population of approximately 3,500,000, a 4.6% 2007 unemployment rate (rate in June 2008 was 5.7%), a 2007 median household income of $65,967 and a statewide 2007 poverty rate of 7.9%.[1] . Despite its status as one of the wealthiest states in the nation, Connecticut is a picture of extremes between poor and rich. The six cities with critical levels of poverty, Bridgeport, New Haven, Hartford, New Britain, New London and Waterbury, report varying rates of poverty from 30.4% in Hartford to 15.8% in New London. Connecticut's 2006 poverty rate

[1] 2007 Economic Development Data & Information for Connecticut and Western Massachusetts, U.S. Census Bureau, Factfinder: 2007 American Community Survey, Connecticut

for children in families was 10.7%. The 2006 Office of Health Care Access (OCHA) Household survey reported approximately 6.4% of the population (222,600) as uninsured, of which 36% were Hispanic. Statewide population distribution is 84.5% white, 10.3% black or African American, 3.4% Asian, 0.4% American Indian/Alaskan Native, 0.1% Native Hawaiian/Pacific Islander, and 1.4% two or more races. 11.5 percent (%) of the people in Connecticut were Hispanic. The majority of whom are Puerto Rican, followed by Mexican, Cuban and others. In 2007, Fairfield County had the highest per capita income of $47,940 compared to Windham County at $26,470.[2]

Connecticut 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 and Hispanic populations, and approximately half of People Living with AIDS (PLWA) reside in these cities. Higher incidences of poverty, unemployment, crime, drug use, homelessness, violence, inadequate or insufficient housing, and co-morbidities impact heavily on PLWHA in larger cities. Inadequate transportation and fewer support services define Connecticut's rural towns and communities. As of December 31, 2007 forty-one percent (41%) of PLWH/A in Connecticut are associated with injection drug use (IDU), 20% with men who have sex with men (MSM), 22.% with heterosexual risk, 2% pediatric and 14% other/unknown risk.

AIDS: The number of AIDS cases reported from 1980 to December 31, 2007 is 15,325 and, of these, 7,872 (51.4%) have died. Of the 7,453 People Living with AIDS (PLWA) in 2007, 68% are male and 32% female; 35% white; 33% black and 31% Hispanic. IDU represents the highest risk at 45%, followed by MSM at 20%, heterosexual risk at 22% and 9% in other or unknown categories

HIV: HIV infection has only been reportable in adults (≥ 13 years of age) since January 2002. As of December 31, 2007, 3,278 Connecticut residents were reported living with HIV (not AIDS). Of these, 34% are white, 29% black and 36% Hispanic. IDU still drives the transmission mode, followed by MSM and Heterosexual sex.

People Living with HIV/AIDS (PLWH/A): As of December 31, 2007, 10,731 people are reported living with HIV or AIDS in Connecticut. Of these PLWH/A, 66% are male and 34% female; 35% are white, 32% black and 33% Hispanic. Transmission mode is 41% IDU, 20% MSM, 22% Heterosexual, 2% Pediatric and 14% other/unknown categories.

Total Reported Cases of HIV and AIDS: A total of 18,603 cases of HIV and AIDS have been reported in Connecticut as of December 31, 2007.

STD: High numbers of chlamydia and gonorrhea cases in older teens and younger adults, particularly in minority populations, have also 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 lead to increases in HIV infection. In Connecticut, IDU is the predominant risk group for both hepatitis C and HIV. Since 1992, more than 2,600 cases of dually diagnosed Hepatitis C and HIV have been reported in CT.

Needs: The care and prevention needs of PLWH/A corresponding with service and population priorities and targeted effective behavioral interventions (EBI) 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)

[2] U.S. Census Bureau: General Demographic Characteristics, Data Set: 2007 Population Estimates, Connecticut; U.S. Census Bureau: 2007 American Community Survey

counties. Service priorities are specified in the 2008 Statewide Coordinated Statement of Need (SCSN) and incorporate various needs assessments (in-care and out-of-care) used to establish the care and prevention priorities and prioritize populations and prevention interventions. This information will assist in addressing regional HIV /AIDS care and prevention service planning for FY2009-2012.

Gaps: The identified critical care and prevention service needs and gaps for PLWH/A as confirmed by the 2008 SCSN for the two TGA areas and the rest of Connecticut are: (1) core medical services: dental care, health insurance continuation, AIDS pharmaceutical assistance, substance abuse-outpatient and mental health; (2) support services: food bank, housing-related services, emergency financial assistance, and medical transportation, and (3) prevention related: prevention support services (e.g. prevention interventions), risk reduction services/information, and Comprehensive Risk Counseling Services (CRCS) for high risk HIV-negative and HIV-positive individuals.

Barriers: Barriers to accessing services include inability to pay, fear of revealing status, lack of transportation, housing and being unaware of services and benefits. For those individuals identified as out-of-care, the problems continue to be the same in 2008 as they were in 2006, 2004 and 2002: barriers of transportation, fear, distrust, lack of knowledge of services, homelessness, lack of insurance and substance abuse. Services that would facilitate individuals getting in to care include transportation, housing, case management, help finding a doctor and substance abuse treatment.

Ample room still exists for improving marketing and information dissemination efforts about service provision and availability throughout Connecticut. HIV prevention and care services must prepare to address the emerging needs associated with specific target populations as prioritized by the CPG in 2007 including the age group of 50+ years, Hispanic, transgender, migrant workers, populations of African descent (immigrant and undocumented), and continue to improve cross training among HIV/AIDS medical case managers, risk counseling and outreach workers, strengthen primary and secondary prevention efforts., and provide training regarding HIV, the medical case management model and HIV resources for medical providers.

Community Resources: Connecticut has a broad network of prevention and care services and social services that are available to state residents. In October 2006, through a collaboration between United Way, the SWC, CPG and Connecticut DPH, an HIV/AIDS Prevention & Care Guide was launched on the United Way of Connecticut's 2-1-1 website. The Guide, created to provide comprehensive information about specific HIV/AIDS services in CT, is accessible both online (www.infoline.org) and by dialing 2-1-1. This resource provides up-to-date HIV/AIDS care and prevention information, as well as information about other resources beyond the scope of HIV/AIDS.

In FY 2007-2008, the Connecticut AIDS Drug Assistance Program (CADAP) had more than 1,960 PLWH/A enrolled in the program, of which 1,612 received at least one paid prescription. More than 3,000 additional clients received services through Ryan White Part B statewide contractors (e.g. core medical and support services), transitional medical case management for individuals leaving Connecticut's correctional system and returning to communities (Project TLC), as well as education and referral services through the Minority AIDS Initiative (MAI). Through Connecticut's state-funded HIV Medication Adherence Programs (MAP), more than 600 people received adherence supportive services.

Effective Behavioral Interventions (EBI) are provided to various targeted high-risk and HIV-positive groups through statewide DPH funded prevention providers (e.g. Healthy Relationships, SISTA, Voices/Voces, Street Smart, etc.). From January 1, 2008 through June 30, 2008 more than 6,500 individuals participated in various EBIs. Targeted outreach

to high risk HIV-negative and HIV-positive individuals is implemented through Comprehensive Risk Counseling Services (CRCS), and through statewide counseling, testing and referrals (CTR) sites, routine HIV testing in medical settings, Drug Treatment Advocacy (DTA) programs and five Syringe Exchange Programs (SEP). Of the 24 funded CTR contractors, seven have proposed use of a social networks strategy as a means of identifying newly infected individuals. In 2009 the DPH will undertake the revision of the Early Linkage and Referral Initiative Protocol (ELRI), to ensure more timely and comprehensive HIV/AIDS secondary prevention and care services for clients. Funding will also be continued for routine HIV testing through Optimus Health Care, Inc. at its community health care centers in Bridgeport and Stamford. Through funding received in 2008 from the CDC for Expanded and Integrated HIV Testing for Populations Disproportionately Affected by HIV (primarily African Americans), routine testing in clinical settings will be expanded into three hospital emergency departments in Waterbury, New London and New Haven.

In 2009, DPH will continue to pursue revisions to the existing Connecticut legislation regarding counseling and testing, which currently requires separate informed consent and pre-test counseling prior to testing for HIV. DPH supports the elimination of this requirement in order to more fully implement CDC's 2006 Testing Guidelines for Adults, Adolescents and Pregnant Women in Health Care Settings.

DEVELOPING A PROCESS TO INTEGRATE CARE AND PREVENTION: WHERE DO WE NEED TO 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 (2003)* defines the CDC's expectations of health departments and HIV prevention community planning groups in implementing community planning. One of the responsibilities of DPH is to share the responsibility with representatives of affected communities and other technical experts in the development of a comprehensive HIV prevention 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 Statewide Plan for HIV Care and Prevention. A Comprehensive Plan Work Group of CHPC was assigned the responsibility to oversee the development of the plan. The resulting 2009-2012 Comprehensive Plan is a product of collaborative planning meetings and writing efforts by various representatives of Ryan White Parts, DPH, provider agencies, consumers and public participants from across the state. The Connecticut Department of Public Health (DPH) is in a new comprehensive planning stage (2009-2012) to ensure that resources are efficiently and effectively used to deliver necessary core medical, support services and prevention interventions in order to reduce the rate of HIV infection and ensure that those who are living with HIV/AIDS are connected to appropriate care and support services.

Convened by the DPH, the CHPC conducted statewide planning meetings in order to facilitate and share information across local, regional and statewide programs involved in HIV/AIDS service delivery to assist in the development of the 2009-2012 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 three major areas:

Collaborative Planning involves	*Integrating Services means*	*Service Delivery implies*
▪ assessing unmet need and service gaps ▪ aligning statewide planning processes to respond to service delivery issues ▪ keeping the system flexible to respond to changing and/or emerging needs and populations ▪ getting and maintaining clients in care, and bringing those out-of-care or those who have never been engaged into the care system ▪ reducing the rate of HIV, Hepatitis C and other sexually transmitted infections in the state of Connecticut through targeted prevention interventions, routine HIV testing, and comprehensive risk reduction services and counseling ▪ developing a systematic approach to maximize funding resources ▪ reviewing funding options and assessing duplication of effort ▪ coordinating planning across all HIV care and prevention related funded systems to maximize funding and resources	▪ instituting new statewide data collection / tracking systems – CAREWare and PEMS ▪ continued integration of care system service components (Ryan White Parts A and B) and co-location of services ▪ refinement and linkage of medical case management services (Ryan White Parts C and D) ▪ restructuring systems and identifying new resources to meet burgeoning demands and changing needs and addressing the impact of funding cuts in care and prevention ▪ working together between care providers through medical case management ▪ ensuring that Connecticut's system is client centered; creating a cadre of support systems/options for individuals with medication adherence issues ▪ incorporating into RFPs the process of linking care and prevention ▪ working with all systems to create a unified continuum of care ▪ collaborating with other Ryan White Parts and funding sources to create a state standard for Quality Assurance and Quality Improvement	▪ assisting entry and re-entry of PLWH/A into care and prevention services through collaborative outreach and a focus on hard to reach populations ▪ improving secondary prevention efforts to maintain an individual's HIV status ▪ providing HIV core medical and support services ▪ increasing the number of HIV Support groups (group sessions for those affected by or infected with HIV in order to reinforce prevention behaviors) ▪ exploring co-location of services ▪ providing equitable access to care regardless of geography (e.g., rural or lower incidence areas), race, gender, age, sexual orientation or risk factor and ensuring that these services are user-friendly, readily and easily accessible, and culturally and linguistically appropriate ▪ developing less burdensome reporting documentation for providers, clients and case managers ▪ maintaining access to HAART and a no-wait list for CADAP ▪ moving clients into care at first HIV+ diagnosis, fully assessing client needs when entering care, increasing client education and information (e.g., culturally, gender and age appropriate trainings safe sex workshops) ▪ maintaining medical case management and educator/counselor continuing education and pre-requisite training

A Summary of Connecticut's Action Plan for 2009 - 2012

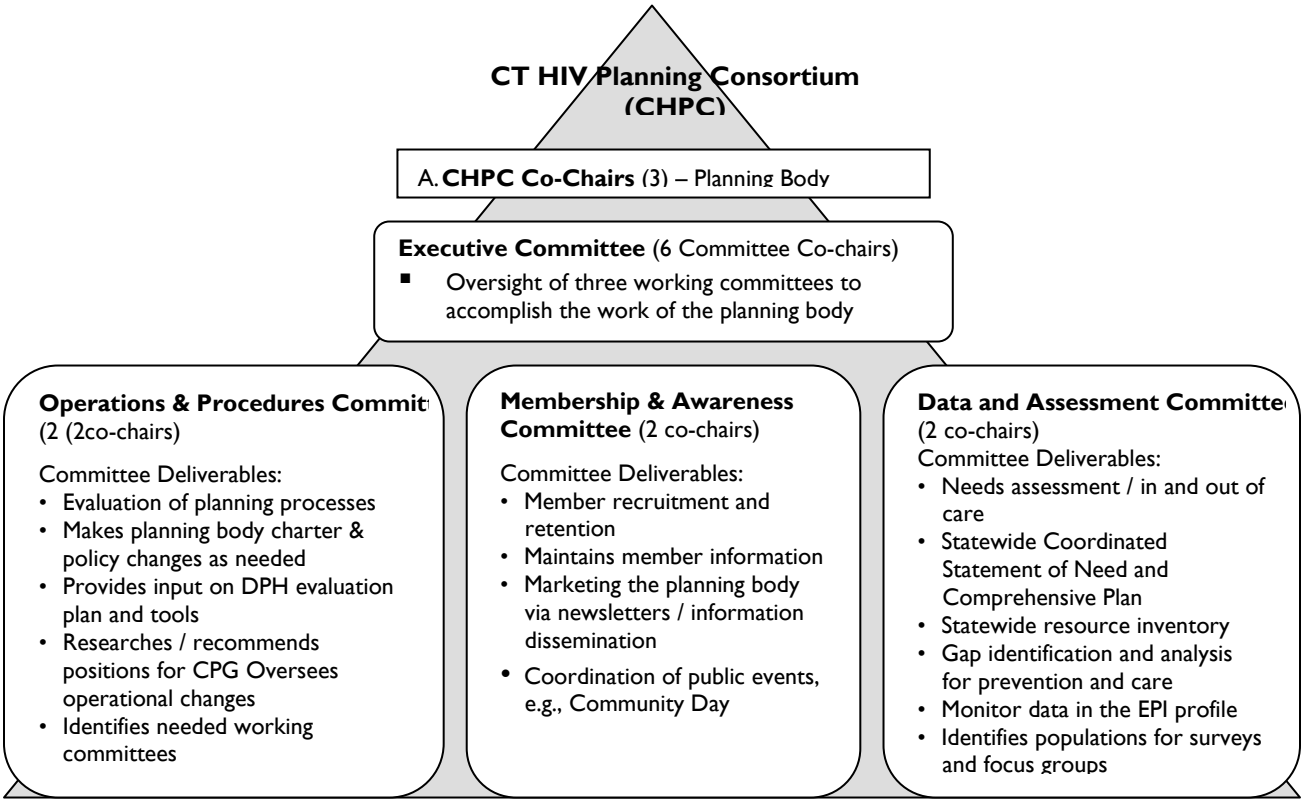
Collaboration Objectives	Anticipated Outcomes by 2012
1. Implement a fully collaborative statewide needs assessment for both in care and/or out-of-care in 2010 to allow for uniformity and strength of data, the CHPC, its members and partners (Ryan White Parts A, B, C, D, F/SPNS) and prevention. This will 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 completed with full engagement of all Ryan White Parts and Prevention, consumers, and other community partners ▪ Federal timelines for planning observed ▪ New survey methods employed
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 ▪ RFP processes reflect the Service Matrix

Service Capacity Objectives	Anticipated Outcomes by 2012
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 through both CAREWare and PEMS ▪ Provider survey conducted and data assessed ▪ Connecticut has the most accurate picture of HIV/AIDS for Care and Prevention
4. Explore methods to address barriers to services.	▪ New methods are identified to address barriers to care and prevention services.

Public Awareness and Training Objectives	Anticipated Outcomes by 2012
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.
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 and clinical practices, and available resources and services with the state.

THE CONNECTICUT HIV PLANNING CONSORTIUM (CHPC)

The Connecticut HIV Planning Consortium (CHPC) was officially launched in October 2007 as the state's integrated care and prevention planning body. Its first public meeting occurred in December 2007. CHPC is a hybrid organization consisting of members and participants from the Statewide HIV Care Consortium (SWC), the Connecticut HIV Prevention Community Planning Group (CPG), PLWH/A, community based AIDS service organizations (ASO) representing both care and prevention, 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.



CHPC Openness, Membership and Participatory Nature

The CHPC Charter allows for up to 42 members. Currently, there are 31 members who are representative of the cultural and geographic diversity of Connecticut's HIV epidemic, as well as both care and prevention arenas. Membership goal is 50% PLWH/A and 50% provider; presently that goal stands at 27% PLWH/A and 73% Providers. 53% of members are white, 13% Hispanic and 37% /African American. (See CDC Diversity Chart of CHPC membership in Appendix.)

Members are expected to actively participate in all CHPC meeting-related activities, as well as serve on one of the three committees (see above diagram). To encourage public participation in the planning process, monthly CHPC meetings are held on a rotating basis at

centrally located sites in the state - Hartford, Wallingford and New Haven. 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.

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 Membership and Awareness Committee 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 300 individuals and agencies.

CHPC Leadership and Committees: Effective and participatory leadership is key to 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. Current co-chairs bring expertise in Counseling and Testing, HIV Prevention Education, Care and Support services, and have each served on the CPG and SWC.

CHPC Co-chairs for 2007 - 2010

- Belinda Clark, Windham Regional Community Council, Willimantic
- Robert Houser, Southwest Community Health Center, Bridgeport
- Barbara Mase, Connecticut Department of Public Health, Hartford

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 three committees, meets regularly 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.

Executive Committee

- Belinda Clark, Windham Regional
- Erica Byrne, Latino Community Services, Hartford, Co-chair, Operations and Procedures Committee (OPC)
- Leah Datcher, Faith-based community representative, Co-chair, OPC
- Karen Frisbie, Community representative, Co-chair, Membership and Awareness Committee (MAC)
- Valerie Ingram, Central Area Health Education Center, Hartford, Co-chair, MAC
- Shawn Lang, Connecticut AIDS Resource Coalition, Hartford, Co-chair, Data and Assessment Committee (DAC)
- Roberta Stewart, AIDS Project Greater Danbury, Danbury, Co-chair, DAC

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 three standing committees, the Executive Committee, and specifically designated ad hoc committees and work groups. The three standing committees are Data and Assessment, Membership and Awareness, and Operations and Procedures. (See diagram for responsibilities). 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 Holt, Wexler and Farnam, as contractor.

CHPC Member Recruitment and Retention

CHPC Membership Goals
- Up to 42 members
- Reflective of epidemic
- Selection based on demographic profile and CHPC member needs

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 Membership and Awareness Committee (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 2008. 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. Nominee names are presented to the full CHPC at a monthly public meeting and are voted on by the members. No member may sit on the CHPC longer than two consecutive terms (four years), following which time the member must wait for a year before re-applying for member status. CHPC's attendance policy does not distinguish between excused (medical illness) and non-excused absences. Members may miss 3 meetings in a 12 month period.

All new CHPC members receive orientation training and are required to attend the annual CHPC member retreat. 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. In June 2008, the three CHPC co-chairs and two Operations and Procedures Committee co-chairs attended the HIV Prevention leadership Summit (HPLS) in Detroit, Michigan, where CHPC also presented on its integration process.

CHPC Meeting Structure: CHPC convenes a monthly public meeting in three sites throughout the state (Hartford, Wallingford and New Haven). Holt, Wexler and Farnam, a New Haven-based consulting firm and contractor for the CHPC, coordinates all meeting logistics. 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. Voting is generally by consensus, although ballot and/or hand votes are used 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 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.

SECTION I. WHERE ARE WE NOW?

In 2008, Connecticut submitted a one year transition plan to fully integrate care and prevention planning bodies and to write its Comprehensive HIV/AIDS Care and Prevention Plan for 2009-2012. Connecticut has achieved most of its overarching goals for 2007-2008 which were to effectively combine the statewide care and prevention planning bodies into one CT HIV Planning Consortium, plan and write a fully integrated care and prevention plan, and to provide education sessions across the state to consumer groups and providers. In October 2007, the two statewide bodies were successfully combined. During the 2008 planning year, the CHPC convened the Youth Advisory Group to address the care and prevention needs of youth, conducted a needs assessment, developed the 2008 Statewide Coordinated Statement of Need, and created this plan. The DPH conducted trainings and prevention education for medical case managers, prevention educators and counselors, and developed and completed a set of core standards for medical case management for Ryan White Parts A, B, C, and D, and rolled out routine HIV testing in medical settings.[3] The CHPC has begun planning for other educational sessions across the state through support groups and community organizations.

A. Geographic area of the CHPC

The geography of Connecticut, the location of the diverse client base and the services they need and are seeking, affect the way in which Connecticut's system of care is developed. This section briefly defines the geographic service area. Connecticut is New England's second smallest state (5,544 square miles), and is bordered by New York, Massachusetts and Rhode Island. It is still 60 percent forested and boasts more than 90 state parks and 250 miles of the Long Island Sound. Connecticut consists of eight counties, Hartford, Fairfield, Litchfield, Middlesex, New Haven, New London, Tolland and Windham, of which Hartford, New Haven and Fairfield contain 75% of the population. The three largest cities, Bridgeport, New Haven and Hartford, contain the highest percentage of and Hispanic populations, and approximately half of People Living with AIDS (PLWA) reside in these cities. Geographically, AIDS cases are concentrated in urban areas with the highest numbers in the three largest cities: Hartford, New Haven, and Bridgeport; but, 98% of Connecticut towns have at least one case.

Planning across the state has occurred in a collaborative manner among the two Ryan White Part A Transitional Grant Areas (TGA), consisting of New Haven/Fairfield County and Greate Hartford (Hartford, Middlesex and Tolland counties) other Ryan White Parts C and D, the DPH, care and prevention providers, and the CHPC. Ryan White Part B and CDC prevention funding is allocated to contractors based on a competitive bid process and prioritized needs as defined in the Statewide Coordinated Statement of Need (SCSN). Responding to federal expectations that care and prevention be integrated and to directives established by the State DPH AIDS and Chronic Diseases Section, this update reflects the collaborative efforts of all partners, and most current information available.

[3] In 2007, CT received technical assistance from HRSA to work with Ryan White Parts A, C, D planning bodies and providers to develop a set of standards for medical case management. The statewide standards were completed in late 2007 and revisited for final approval in early 2008. The group will be reconvening again in the fall to discuss the outcomes of first implementation efforts.

B. Epidemiological Profile

1. Connecticut's People

Connecticut has a diverse population, comprised of a rich blend of cultures and ethnic groups. Of the more than 3,500,000 residents in Connecticut, 75% reside in three of the eight counties, Fairfield, Hartford and New Haven. The three largest cities within these counties include the highest percentage of black (10.1-12.2%) and Hispanic (11.9-10.1%) residents, the highest percentage that speak a language other than English at home (27.1-18.3), and the highest percentage of foreign born (19.8-10.5%). Overall, the majority of residents are white (84.5%), 10.3 % black/African American, 3.4% Asian, 0.4% American Indian and less than 0.1% Native Hawaiian/Pacific Islander, and 1.4% two or more races (U.S. Census Bureau: 2007 American Community Survey estimates). 11.5% of the people in Connecticut are Hispanic[4], of which the majority are Puerto Rican (54.1%), followed by Mexican (10.6%), Cuban (1.6%) and others (33.7%).

Compared with national figures, Connecticut's residents are better educated; 88% or more hold a high school degree and median household income in 2007 was $65,967. Yet, nearly 8% of the state's residents live below the poverty line. Fairfield County has the highest per capita income ($47,940) and Windham County has the lowest ($26,470). These disparities translate into housing and healthcare access problems and growing needs for Connecticut's people living with HIV/AIDS. Table 1 highlights information about PLWH/A by county contrasted by the total number of people living with HIV/AIDS through December 31, 2007.

By Percent	Total PLWHA to 12/31/07	CT Population (FY2007 est)	White (2007)	or AA (2007)	AI& AN (2007	Asian (2007)	NH& OPI (2007)	Two or more races 2007	Hisp or Latino 2007	Foreign born 2007	Speak Other than English at home (2007)	High school of more 2007	Persons below poverty line 2007	Per capita income (2007)
Connecticut	**10,731**	3,502,309	81.2	10.5	0.8	3.8	0.1	2.0	11.5	12.8	19.4	88.0	7.9	$54,117
FAIRFIELD	**2,821**	895,015	79.1	10.2	0.1	4.3	<0.1	1.3	14.9	19.7	26.0	88.1	6.6	*$47,940
HARTFORD	**3,355**	876,824	76.0	12.5	0.2	3.5	<0.1	2.3	13.4	13.6	23.0	86.5	9.5	*$32,528
NEW HAVEN	**3,270**	845,494	78.5	12.3	0.2	3.5	0.1	2.1	12.8	11.5	18.4	87.1	9.7	*$30,848
NEW LONDON	**526**	267,376	86.2	5.6	0.8	3.5	<0.1	3.5	6.3	7.6	11.9	89.2	6.5	*$30,639
LITCHFIELD	**197**	188,273	96.1	1.1	0.2	1.5	<0.1	1.5	3.6	5.8	8.0	91.5	5.3	*$33,796
MIDDLESEX	**234**	164,150	91.5	4.3	0.3	2.3	<0.1	2.2	3.9	7.1	NA	91.7	4.8	*$36,134
TOLLAND	**112**	148,139	92.6	2.8	0.3	3.0	<0.1	1.7	3.6	6.0	10.0	93.6	6.7	*$31,411
WINDHAM	**206**	117,038	91.3	1.7	<0.1	0.9	<0.1	2.4	8.0	3.9	NA	84.5	7.6	*$26,470

[4] Ibid – races can be Hispanic or non-Hispanic

Sexually Transmitted Diseases and Viral Hepatitis

Information from the STD and viral hepatitis surveillance systems also provide insight into high-risk behavior that can potentially lead to HIV infection. High numbers of chlamydia and gonorrhea cases in older teens and younger adults have been reported in recent years suggesting the persistence of unsafe sexual activity. Similarly, the connection between MSM and both syphilis and hepatitis A in Connecticut, and nationally, suggests resurgence in high-risk behavior in MSM that could lead to increases in HIV infection. In 2007, 11,512 cases of Chlamydia were reported in Connecticut of which 23.9% were male, 76.1% female; 14.2% were white, 32.7 black and 17.3 % Hispanic. Of the reported female Chlamydia cases black and Hispanic females made up 40%. More than seventy percent (70%) of chlamydia cases were reported in the age category 15-24. A total of 234 primary and secondary syphilis cases have been reported in Connecticut from 2003-2007. Of these cases, 95.7% are male, 4.3% female; 47% are white, 33.8% black and 15% Hispanic.

2. HIV/AIDS Surveillance

The State of Connecticut has compiled data on AIDS cases since 1980.[5] In 2002, the state began compiling data on HIV. In 2005, the Centers for Disease Control and Prevention (CDC) recognized HIV data compiled by Connecticut as viable. Unmet need (PLWH/A that are out-of-care), a data set recently required by the Health Resources and Services Administration (HRSA), was first calculated based on a model established by a state with similar demographics to Connecticut in 2003. In 2005, Connecticut received technical assistance recommended by HRSA to develop an approved method for calculating statewide unmet need (See section on unmet need p. 35). This will change in subsequent reports since in 2006 all HIV viral load test results were made reportable by laboratories that conduct the tests. This step was taken to improve completeness of reporting of HIV and AIDS cases, allow monitoring of entry of newly diagnosed people into care, monitor consistency and effectiveness of care, and characterize those groups who may delay entry into care. Connecticut's most current data reflects reporting through June 30, 2008. The SCSN work group determined that the best approach for presenting the HIV/AIDS data for Connecticut would be through December 31, 2007, or the full calendar year. The data in the table below represents the cumulative data compiled for Connecticut in the most recent full calendar year.

AIDS National v. Connecticut: According to CDC surveillance, in 2006 the estimated number of cases of AIDS in the US and dependent areas was 37,852. Of the 37,852 cases, 29% were White, 47% were black, and 18% were Hispanic; 26% were female cases; 71% male; 38 were children less than 13 years of age. The modes of transmission nationally were MSM 42%; IDU 11.7%; MSM/IDU 5%; heterosexual 12%; other 0.6%.

Connecticut cases in 2006 according to the Connecticut Department of Health reported 543 cases of AIDS, 64% of whom were male and 36% female. The percentages by mode of transmission in Connecticut in 2006 were MSM 17%; IDU 33%; MSM/IDU 1%; heterosexual 18%; other risks not reported 29.5%. Connecticut's AIDS population differs from National figures (AIDS) in the following ways:

[5] The AIDS case definition consists of either HIV positive with a low CD4-positive cell count, or HIV positive and a diagnosis with one of several opportunistic infections or conditions. AIDS cases are reported to the Department of Public Health by diagnosing physicians and laboratories (low CD4 counts). The Department of Public Health maintains a computerized registry of AIDS cases. HIV has been reportable in children (< 13 years of age) since 1993 and in adults since 2002. HIV is reported when an individual is confirmed HIV positive by Western Blot or other confirmatory test. The number of HIV cases reported for a given year is the number of cases reported during that year minus those cases that were re-reported as AIDS cases during the year.

- Connecticut Female 36% v. 26% US
- Connecticut Mode of transmission IDU 33% v. US IDU 12%
- Connecticut black 25.8% v. US black 47%
- Connecticut Hispanic 41.4% v. US Hispanic 18%

AIDS Incidence

The table below shows the 2007 demographic breakdown of the reported HIV disease population in Connecticut, and the cumulative data since reporting began.[6]

HIV/AIDS Cases by Demographic Groups
Connecticut through December 31, 2007

1. Number represents all HIV and AIDS cases reported in 2007.
2. Number includes all cases reported from January 1, 1980 – December 31, 2007 living and deceased.
3. Number includes all people living with HIV/AIDS as of December 31, 2007.

Characteristics	2007 HIV/AIDS 1	Total AIDS 2	Total PLWH/A 3
	New reported through 12-31-07	Cumulative through 12-31-07	As of 12-31-07
Total Numbers	**1,300**	**15,325**	**10,731**
Gender	% of total	% of total	% of total
Male	67	72	66
Female	33	28	34
Race /Ethnicity			
White	35	37	35
Black	30	36	32
Hispanic	34	26	33
Other race/ethnicity	2	0	1
AGE			
0-12 years	0	1	0
13-19	2	0	1
20-29	11	13	5
30-39	22	42	17
40-49	36	30	41
50 and over	29	13	36
Transmission Mode			
IDU	25	48	41
MSM	23	22	20
MSM/IDU	1	3	2
Hetero	15	18	22
Pediatric	1	1	2
Other/risk not reported	35	7	14

Source: CT DPH AIDS Surveillance Data

[6] Note: Additional data can be obtained at www.ct.gov/dph/cwp/view.asp?a=3135&q=393044&dphPNavCtr=

HIV/AIDS Surveillance Highlights through December 31, 2007

AIDS cases reported in 2007

As of December 2007, 433 AIDS cases were reported with 70% male, 30% female; 32% white, 32% black, 35% Hispanic; 19.9% MSM; 30.3% IDU; 15.9% heterosexual, and 31.2% with other or unknown risk.

Cumulative AIDS cases

There have been 15,325 cases of AIDS reported in Connecticut since 1981. Of these, 7,872 (51.4%) have died.

AIDS has disproportionately affected specific demographic and behavioral groups including males (72% of cases), injection drug users (IDU) (48%), and people ages 30-39 (42%), people of color –total black and Hispanic (62%).

People living with AIDS (PLWA) in Connecticut

As of 2007, 7,453 people are living with AIDS in Connecticut (213 per 100,000 population). Of these, 68% are male, 32% female, 35% white; 33% black; 31% Hispanic; 3% are <30 years of age, 14% are 30-39, 43% are 40-49 and 40% are ≥50 years of age; 20% MSM, 45% IDU, and 22% heterosexual and 9% in other or unknown categories.

Total Reported Cases of HIV and AIDS

As of December 31, 2007 there were a total of 18,603 cases of HIV and AIDS reported in Connecticut. Of the 7,453 PLWA at the end of 2007, just over half live in the New Haven/ Fairfield TGA 56% (n=4,095) and (33%) live in the Hartford TGA (n=2,494).

People living with HIV (not AIDS)

During 2002-2007, 3,159 HIV cases were reported to DPH. Of the 3,278 people with HIV, 34.0% are white, 29% black, and 36% Hispanic.

People living with HIV/AIDS

10,731 people are reported living with HIV or AIDS.

Estimating the number of people with HIV/AIDS living in Connecticut

Using a method recommended by CDC, it is estimated that 18,293 to 20,863 (midpoint 19,578) HIV-infected people live in Connecticut (*Integrated Guidelines for Developing Epidemiologic Profiles*). This is based on the estimate that 1,039,000-1,185,000 HIV-infected people live in the United States and that of these 415,193 are PLWA (CDC, 2004). It is assumed that since Connecticut has 1.76% of PLWA (7,310/415,193) reported in the USA, it also has 1.76% of all HIV infections (1.76% of 1,039,000 = 18,293 and 1.76% of 1,185,000 = 20,863). CDC estimates that 24-27% of people infected with HIV are unaware of their infection.

HIV incidence

On August 3, 2008, the Centers for Disease Control and Prevention (CDC) released an estimate of the number of people newly infected with HIV in the United States during 2006. It was reported that 56,300 (22.8 per 100,000; 95% CI 19.5-26.1) people were newly infected with HIV in the USA during 2006. The estimate is based on information collected by health departments in 22 states, including Connecticut. An estimate for 2007 is expected in the spring of 2009.

Of the 56,300 estimated new infections in 2006, 73% were male, 35% white, 45% black, 17% Hispanic, 34% aged 13-29, 31% 30-39, 25% 40-49, 10% 50+, 53% MSM, 12% IDU, and 31% heterosexual. Back-calculations indicated that the overall number of cases each year has been steady since 1999 although the MSM subgroup has steadily increased in number over that time period. Decreases were observed among IDU and heterosexuals.

Estimates for Connecticut and other participating states were also released. It was estimated that 600 (20.5 per 100,000) people in Connecticut were newly infected with HIV in 2006. There is not a statistically significant difference between the US and Connecticut rates. The estimates and trends for demographic and behavioral subgroups should be interpreted cautiously with regard to implications for individual states.

HIV/AIDS Data Collection

Infections and other conditions of public health importance are monitored by DPH. The reportable disease list includes approximately 60 conditions that must be reported by physicians and/or laboratories. AIDS was first added to the reportable disease list in 1982 with additional HIV/AIDS related laboratory and physician reporting requirements added in subsequent years. HIV in children (<14 years of age) and in persons co-infected with TB was added in 1993 along with laboratory reporting of low CD4 results. CD4 (<200 or <14%) reporting is the primary method by which HIV cases are converted to AIDS cases. HIV exposure in infants was made physician reportable in 2001 and has facilitated follow-up of maternal-newborn HIV exposure cases. HIV infection in adults was made reportable in 2002 with a code-option and by name-only in 2005. HIV viral load became laboratory reportable in 2006 and has been responsible for reporting of prevalent HIV cases diagnosed when HIV was not reportable.

The DPH receives HIV/AIDS laboratory reports and follows-up with the diagnosing physician to complete the case report form. A variety of information is collected about each HIV/AIDS case including demographic, clinical, and behavioral information. Race, sex, age, date of HIV test or physician diagnosis, and probable source of infection are the most important data elements. These elements form the basis for most HIV/AIDS data analysis. Of these elements, the probable source of infection or 'risk' is the most problematic to collect. It is information that is never collected by laboratories and may not be immediately known by the diagnosing physician or noted in medical records. However, over the 2-3 years subsequent to diagnosis the percentage of cases for which risk is known steadily climbs. Currently, approximately 85% of PLWHA have a known risk.

In October 2007, the HIV/AIDS Surveillance registry, HARS, was retired and replaced with eHARS. This new registry is a browser-based, document-based system that allows for more complete information to be registered for each case and will result in the longitudinal analysis of HIV/AIDS surveillance information.

HIV Reporting and Maturity of HIV database: CDC analysis of HIV (not AIDS) surveillance information includes data from states that have used CDC-recommended methods for reporting HIV cases. Name-based HIV reporting systems were in operation in many states for many years but were slow to be implemented in a few states that opted for code-based reporting systems. In 2002 DPH implemented a code-option system in which the reporting physician had the option of reporting the HIV positive person by a DPH designed code. Although very few cases were reported by code, CDC did not incorporate Connecticut HIV cases in the national database until 2005 when the code option was removed and all cases were reported by name. CDC has been incorporating additional state HIV data into the national analysis as the individual reporting systems become 'mature.' CDC has informally defined a mature system as one that has been in operation for four or more years. By this criterion, the Connecticut system will become mature at the end of 2008. For several years, CDC has reported Connecticut AIDS and HIV case numbers to HRSA for use in allocation of Ryan White Act funding.

HIV viral load reporting: Reporting of HIV viral load test results (VL; detectable and undetectable) was implemented in 2006. Reporting was required to be electronic and until an electronic reporting system is fully developed, reports have been by CD, primarily, with some reports received by mail. The purpose of VL reporting was two-fold. First, it served a catch-up function to enable DPH to register HIV positive persons who were diagnosed when HIV was not reportable and had not met the case definition for AIDS. Second, it serves as a marker for entry into treatment as defined by HRSA. HIV-positive persons are recommended to receive VL tests routinely. The date of the first test after HIV diagnosis serves as the marker of entry into care and subsequent tests serve as markers of consistency of care. VL test results will be indicators of effectiveness of care.

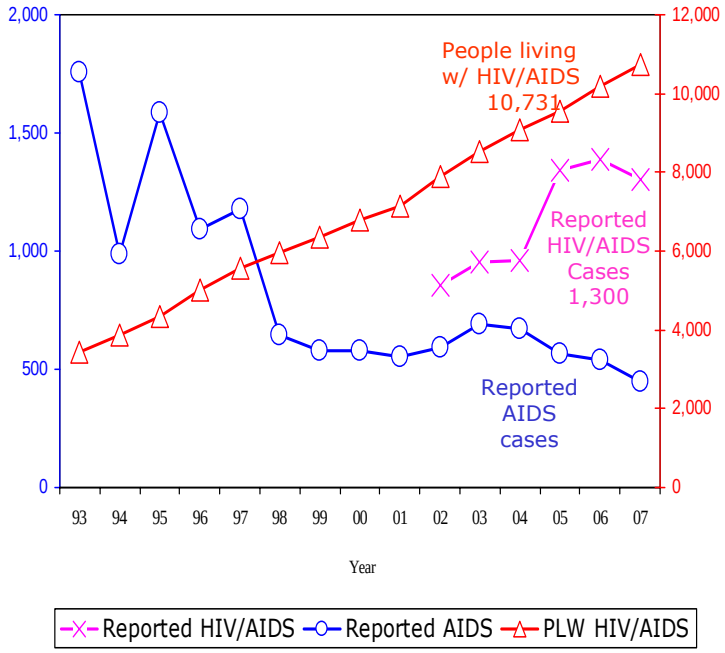
The DPH also obtains data through other methods such as client and agency surveys, evaluations, needs assessments, and specific studies all of which provide information that enables the state to update the SCSN. Data collection in FY 2007-08 involved out-of-care unmet needs assessments conducted by the two Part A TGAs and the State, as well as in-care needs assessments targeting the two Transitional Grant Areas (TGA) and the rest of the state as well as CADAP clients. The 2008 Statewide and Hartford TGA Needs Assessment also addressed both care and prevention needs. (Please see: 2008 SCSN in the Appendix).

3. Epidemiology Trends in HIV/AIDS, Connecticut, 1993-2007

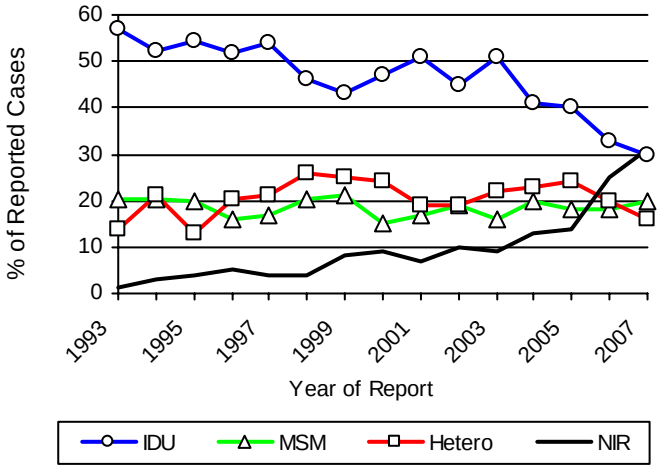
The three figures below and on the next page show the trend of new AIDS cases in Connecticut, which decreased from 1,585 in 1995 to 529 cases in 2006 and to 433 in 2007; the trend of cases by race/ethnicity from 1995-2008, and the mode of transmission for new AIDS cases from 1995-2006. (Source: CT DPH 2008)

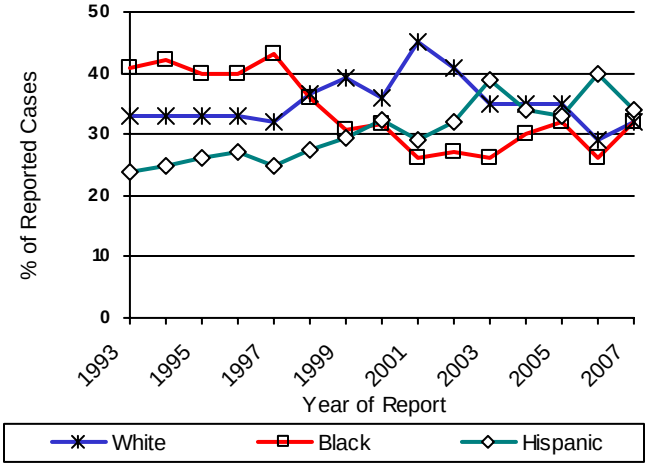
AIDS Trends over Time

AIDS Cases by Race/Ethnicity and Year of Report in Percent of Total -- Connecticut 1993-2007



AIDS Transmission Categories by Year of Report in Percent of Total with NIR -- Connecticut 1993-2007





4. Connecticut's Response

Responsiveness to needs and gaps in Connecticut's HIV Care and Prevention service delivery is guided by the DPH, CHPC, HRSA and CDC expectations and requirements. The integration of the state's Care and Prevention planning bodies in October 2007 has greatly increased HIV services planning for the State by having all key stakeholders at the same table. CHPC is responsible for assessing needs and gaps and services planning and making recommendations to the DPH on the best method to ensure equitable and effective distribution of care and prevention services and funding and helping to guide the State in the Medical Case Management model and Quality Management and Improvement. Most significantly, a shared vision has emerged as a result of the formal linkage of care and prevention services. Organizations, systems and providers throughout the state are recognizing the importance of collaboration to creatively respond to the needs of PLWH/A. 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 other states, Connecticut provides not only rich 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 both TGAs and the rest of the state. Connecticut also funds a broad array of CDC defined prevention services, which target the state's prioritized populations. These services include HIV Counseling, Testing and Referral (CTR) in both clinical and non-clinical settings, Comprehensive Risk Counseling Services (CRCS), Drug Treatment Advocacy (DTA) programs, as well as a cadre of Effective Behavioral Interventions (EBI). The EBIs are designed to specifically target certain affected populations (e.g. Heterosexual African American women, African, Latino and MSM, HIV+, etc). As of October 1, 2008, Connecticut's Drug Assistance Program (CADAP) supports 222 HIV and HIV-related

medications, boasts a responsive service system with seamless linkages to Medicaid/Medicare and other state/federally funded programs, and has no waiting lists or caps.

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 twenty-nine non-profit 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 2006, Connecticut hospitals provided

- more than $190 million in uncompensated care
- $52 million in charity care
- $138 million for patients unable to pay for health care

The Connecticut Hospital Association 2008 Annual Report

The state's 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 twelve 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, medical 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.

The Ryan White HIV/AIDS Treatment Modernization Act of 2006. On August 18, 1990, Congress enacted Public Law 101-381 known as the Ryan White Comprehensive AIDS Resources Emergency Act, or the CARE Act. This legislation was re-authorized in both 1996 and 2000, and was reauthorized in December 2006 as "Title XXVI of the PHS Act as amended by the Ryan White HIV/AIDS Treatment Modernization Act of 2006," or "Ryan White Act." The 2006 reauthorization not only brought changes to the way Connecticut provides care and supportive services, but also changed the make-up of the state's two former Eligible Metropolitan Areas (EMA) – New Haven/Fairfield County and the Greater Hartford EMA (including Hartford, Tolland and Middlesex Counties). HRSA Part A funds cities and communities as EMAs who report a cumulative total of more than 2,000 AIDS cases over the most recent five year period, and other localities as Transitional Grant Areas (TGA), who report 1,000-1,999 AIDS cases over the most recent five year period. As a result of the new legislation, Connecticut's two former EMAs were designated as TGAs and received an adjustment in funding. In addition, the reauthorization added the requirement that at least 75% of Ryan White Parts A through C funds had to be allocated to "core medical services" with the accompanying addition of Medical Case Management to the core service matrix. Connecticut's TGAs and Ryan White Part B had to reconfigure funding priorities based on

HRSA's new thirteen core medical services list, and reduce, cap or eliminate funding for support services such as transportation, housing, emergency financial assistance and food.

In response to the funding impact to Connecticut's two TGAs and resultant client services, the Connecticut State Legislature appropriated funding through 2009 (based on availability of funds) to fill part of the TGA funding gaps and restore dollars for vital core medical and support services (e.g. emergency financial assistance, food bank, housing, psychosocial support). Ryan White Part B also continues to fill in other service gaps (e.g. medical case management, mental health, emergency financial assistance, housing and psychosocial) through its funded statewide agencies.

For more than a year, beginning April 2007 and culminating in March 2008, the DPH, CHPC and representatives from Ryan White Parts A through D collaborated extensively to create a unified definition for Medical Case Management (MCM), Statewide Core Standards of Care for Medical Case Management and Outcome Measures. Each partner agreed that the core MCM standards and outcome measures were a basic set of standards that could be implemented by each Ryan White Part and modified where necessary to accommodate the differences in programs and demographics. (See training for MCMs p. 31)

DPH HIV/AIDS Program Structure: The Connecticut DPH AIDS & Chronic Diseases Section organizes its HIV/AIDS programs into three units: 1)The Health Care and Support Services Unit (HCSS) oversees care programs and services for people infected or affected by HIV, 2) The HIV Prevention Unit oversees prevention services and targeted interventions for people infected or at risk of HIV infection., and 3)The Surveillance Unit oversees the data that is collected 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.

The Health Care and Support Services Unit (HCSS) of the DPH AIDS and Chronic Diseases Section is responsible for the oversight of the Ryan White Part B grant, Connecticut AIDS Drug Assistance Program(CADAP), and Minority AIDS Initiative (MAI) funding. DPH currently funds 21 statewide agencies to provide such HRSA defined services as medical case management, ambulatory/outpatient, mental health, dental care, substance abuse services, medical nutrition therapy, housing services, transportation, emergency financial assistance, food bank, psychosocial support services, and education and referral to CADAP through the Minority AIDS Initiative. In FY 2007-2008, more than 3,000 clients received services through Ryan White Part B statewide contractors. Through state dollars, DPH also funds ten Medication Adherence Programs (MAP) that provide adherence and treatment support for People Living with HIV/AIDS in Connecticut. In FY 2007-08 more than 600 clients were the recipients of MAP services. Four state-funded programs for HIV-affected children and families further address the mental health needs of children and families living with and affected by HIV. Services include individual and group therapy and support groups.

HIV-positive ex-offenders re-entering Connecticut communities are offered transitional medical case management through Ryan White Part B's funded Project TLC (Transitional Linkage to the Community). Outreach, case management, and referral services are provided to inmates for 30-90 days pre-release and 30-45 days post-release. In 2007 more than 218 HIV-positive inmates, both male and female, were provided with services through Project TLC, including medical case management, referrals, emergency financial assistance and linkage with CADAP and Medication Adherence programs.

In addition, the HCSS and Prevention units share responsibilities in monitoring and evaluating their respective contracts through shared site visits and technical assistance. This

cooperative effort allows DPH staff to anticipate contractual or service delivery issues and recommend collaborative measures to assist agencies in improving care and prevention services for their clients.

In 2009, the Health Care and Support Services Unit will issue a Request for Proposal for the provision of mental health services for children and families affected by HIV/AIDS. Funded through state appropriations, this program provides individual and group mental health therapy and counseling to children, youth and families affected by HIV. Currently four agencies are funded to provide these services.

CADAP and CADAP Advisory Group*:* HCSS unit oversees the Connecticut AIDS Drug Assistance Program (CADAP) which is administered through the Department of Social Services via a Memorandum of Agreement. In FY 2007-2008, CADAP enrolled more than 1,960 PLWH/A into the program and 1,612 received at least one paid prescription. The CADAP Advisory Group is an integral part of the CADAP. The Advisory Group is designed to provide medical providers, consumers and members of the public with opportunities to recommend medications for Connecticut's CADAP formulary and offer feedback on service delivery. In order to be more inclusive of and responsive to providers, consumers and community representatives as well as continue to maintain a formulary that addresses the HIV treatment needs of PLWHA, the CADAP Advisory Group has recently made some important operational changes. In February 2008, the DPH rolled-out a more collaborative CADAP Advisory Group process including:

- Creation of a CADAP feedback email tool (CADAPfeedback.dph@ct.gov), which DPH, providers and consumers can utilize to exchange and receive CADAP and medication information
- CADAP updates are provided at monthly CT HIV Planning Consortium (CHPC) meetings
- Quarterly CADAP reports are published in the CHPC HIV News and Notes Newsletter
- Two annual CADAP Advisory Group Meetings are scheduled (March and September) in conjunction with the CHPC meeting and are open to the public
- The HCSS Nurse Consultant has been designated to oversee and monitor the CADAP Advisory Group and collaborate more closely with providers and the Department of Social services Pharmacy Unit, which administers the CADAP

As result of these recent changes, four medications (non-HIV) will be added (effective October 1, 2008) to Connecticut's CADAP formulary, bringing the number to 222 HIV- and HIV-related medications for all future medication recommendations as considerations for the CADAP formulary, the DPH Nurse Consultant. HCSS and DSS staff will review and research the medications for efficacy and effectiveness, perform a cost analysis, and then recommend the proposed medications to the DPH for further review and action.

Connecticut boasts a rich formulary, provides a seamless link through the Department of Social Services for eligible client enrollment into Medicaid via CADAP, has an eligibility of 400% FPL, and has no wait lists or caps.

Connecticut's Prioritized Populations, 2008*
1. HIV+
2. Hispanic IDU
3. White MSM
4. Black IDU
5. White IDU
6. Black Heterosexual
7. Hispanic Heterosexual
8. Hispanic MSM
9. White Heterosexual
10. Black MSM

** Effective July 1, 2008*

The HIV Prevention Unit*:* Connecticut's HIV Prevention Unit funds a broad array of CDC defined prevention services and interventions (See EBIs listed on p. 22 and detail in the Appendix) as well as state-funded programs, which target prioritized populations as listed in the figure. Because of the CDC's directive that prevention interventions must be evidence-based, proven effective and CDC-approved, DPH has responded proactively by providing comprehensive and individualized

training to its contractors on the EBIs funded on a statewide basis.

Effective Behavioral Interventions (EBI), funded through DPH's Prevention Unit, are offered to various targeted high-risk and HIV-positive groups through statewide funded prevention providers (e.g. Healthy Relationships, SISTA, Voices/Voces, Street Smart, etc.). Targeted outreach to high risk HIV-negative and HIV-positive individuals is implemented through Comprehensive Risk Counseling Services (CRCS).

New concepts for risk reduction HIV/hepatitis/STD prevention and intervention program will be developed with direct focus group input and will target the gay, lesbian, and transgender community. With state allocated dollars, Connecticut currently funds five Syringe Exchange Programs (SEP) targeting all priority populations, nine drug treatment advocacy programs, and three perinatal HIV transmission programs at three urban hospitals, which target pregnant women for HIV testing.[7] Through state dollars, DPH currently funds three urban hospitals to track and provide HIV counseling and testing to pregnant women in their OB/GYN clinics. Because of the success achieved through the 1999 legislation, DPH will discontinue funding of the three hospitals and will conduct an RFP process to redirect its efforts to women who are not receiving prenatal care. The goal of the new program is to identify and provide services to pregnant women who are not currently in care or at risk of falling out-of-care.

During 2009 DPH will maintain funding, through the cooperative agreement, of routine HIV testing through Optimus Health Care, Inc. at its community health care centers in Bridgeport and Stamford. In 2007 DPH received funding from the CDC to expand and integrate HIV testing to populations disproportionately affected by HIV, primarily African Americans. During the first year of the funding, DPH conducted a two part project – one that focused and continues to focus on integrating HIV testing into clinical settings, and a second and ongoing aspect that will use a social networks recruitment strategy in four organizations, currently funded for CTR, in order to enhance their ability to recruit African Americans who are unaware of their HIV status into counseling and testing services. In 2009, DPH will expand this routine testing in clinical settings into three hospital emergency departments in Waterbury, New Haven and New London, as well as to continue support for routine HIV testing in four community health centers, one health care van, nine drug treatment programs, and nine STD clinics.

-Expanded HIV Testing-

- To increase HIV testing for populations disproportionately affected by HIV – primarily African Americans who are unaware of their HIV status
- To standardize voluntary HIV/AIDS screening as part of routine clinical care in health care settings

DPH is currently working in collaboration with the National Alliance of State and Territorial AIDS Directors (NASTAD) to respond to the CDC's Heightened National Response to the HIV/AIDS Crisis among African Americans, particularly among women of African descent. A Primary Team has been created to develop a network of statewide contacts for the future roll-out of Town Hall meetings designed to provide health care information (including HIV/AIDS) to women of African descent (residents, immigrants and undocumented). The ultimate goal is the establishment of a proactive statewide Coalition of providers, consumers and key-stakeholders that will continue to champion prevention of HIV/AIDS among women of African descent in Connecticut.

[7] In 1999 CT passed legislation that requires testing of all newborns whose mothers were not tested prior to delivery. This law requires that pre-natal providers must offer HIV testing to all women within thirty days of their first pre-natal visit and a second time during the final trimester. As a result of this legislation, routine, universal HIV screening of all pregnant patients early in pregnancy has been facilitated and resulted in the decrease in perinatal HIV transmission in CT.

DPH will continue to provide funding through a Memorandum of Agreement (MOA) with the University of Connecticut Correctional Managed Care Program and the Department of Correction (DOC) to provide HIV prevention counseling and testing in all correctional facilities in the state. HIV education will continue to be offered during in-mate orientation, and HIV prevention materials and referral site information will be included in all discharge packets for prisoners reentering the community.

Expanded PCRS, 2009
- Hospital emergency departments (ED); will have a designated counselor for processing and delivery of results.
- Positive clients offered PCRS services
- Non returning will be locating by DIS
- Client will be offered appropriate services

DPH's Partner Counseling and Referral services (PCRS) continues to provide notification services for sex and needle sharing partners that are at high risk for HIV infection. Current referrals are received from counseling and testing sites, case managers, private doctors, and the HIV surveillance unit. Beginning in 2008, nine STD-funded clinics began participating in routine rapid HIV testing; all STD clinics provide HIV rapid testing as a standard test offered to clients. Disease Intervention Specialists (DIS) are assigned to area clinics to provide post-test counseling for those individuals that test HIV-positive.

Revised ERLI Protocol
- 2009 - improve overall outcomes for service referrals for those who test HIV-positive
- Updated logs to track & trend referrals
- Contractors required to document in PEMS
- Contractors trained on ERLI linkage forms, tracking, & PEMS database

The mission of the Early Referral and Linkage Initiative (ERLI) is to reduce the spread of HIV infection and to increase early access to treatment for infected individuals. The goal of the ERLI is for clients to obtain timely and comprehensive HIV/AIDS secondary prevention and care services, which match their needs. One way to accomplish this is to have HIV counselors and HIV medical case managers collaborate by providing culturally competent, psychologically and developmentally appropriate and linguistically specific client referrals.

HIV Surveillance Unit: All HIV/AIDS cases as well as cases of other infectious diseases are required to be reported to DPH. The HIV/AIDS Surveillance Unit oversees data that is collected on HIV/AIDS in the state and is responsible for producing the Epidemiological Profile and maintaining an HIV/AIDS surveillance registry containing the information collected through the reportable disease system. The Surveillance Unit also conducts several specifically-funded surveillance programs including: 1) core HIV/AIDS surveillance (e.g. case reporting, analysis and information dissemination), 2) HIV incidence, and 3) enhanced perinatal HIV surveillance.

Accomplishments FY 2007-2008: Connecticut has made major strides in planning and the provision of HIV care and prevention services over the years of CDC and Ryan White federal funding. Major care and prevention accomplishments in FY 2007 - 2008 include:

- Integration of the Statewide HIV Care Consortium (SWC) and the Connecticut HIV Prevention Community Planning Group (CPG) into one integrated combined care and prevention statewide planning body – CT HIV Planning Consortium (CHPC)
- Addition of new HIV antiretrovirals as well as other HIV-disease related medications to Connecticut's ADAP bringing the total formulary to 222 (10/1/2008), with a no-wait list or caps
- State funding of ten Medication Adherence Programs (MAP) in FY 2007-08
- Provision of regular updates on Viral Load Reporting and HIV surveillance via statewide distribution list and public meetings
- Utilization of VL data in the development of Connecticut's 2008 Unmet Need Tables
- Development of a 2008 Transition Plan for HIV Care and Prevention in Connecticut

- Continuation of cross-trainings for both Care and Prevention case managers on HIV 101, Labs and Metabolics, Hepatitis and HIV, and Fundamentals of Case Management
- Development of Medical Case Management Trainings and annual meetings for information dissemination, networking, and education
- Creation of a Service Matrix of Statewide Care and Prevention services and funding streams
- Development and distribution of four HIV/AIDS Planning News and Notes quarterly newsletter
- Creation and implementation of a 2008 Needs Assessment Survey surveying both care and prevention needs and gaps of in-care individuals
- Workshop presentation at the June 2008 national HIV Prevention Leadership Summit (HPLS) on Connecticut's integration process
- Creation of a unified definition of Medical Case Management across all Ryan White Parts, including development and roll-out of Standards of Care for Medical Case Management and Outcome Measures
- 11 monthly meetings (December – October) of CT HIV Planning Consortium (CHPC) and the development of membership application processes, operational policies and procedures, as well as the creation of the 2008 Statewide Coordinated Statement of Need (SCSN) and the 2009 Statewide Comprehensive Plan for HIV Care and Prevention
- Unanimous approval by the CHPC of the 2008 SCSN (September 2008)
- Receipt and distribution of CDC funds for the implementation of routine HIV testing in medical settings (January 2008)
- Development of a Continuing Education Series for statewide Care and Prevention service providers
- Creation of a DPH Primary Team in collaboration with NASTAD to address the CDC's Heightened National Response to the HIV/AIDS Crisis Among African Americans
- Creation of Report on the needs of Connecticut's Youth, by the Youth Advisory Group

HIV Service Delivery System: Connecticut provides health care assistance to people living with HIV or AIDS (PLWA) and their families through HIV/AIDS service organizations. Services include support for, but may not be limited to the following: medical case management, primary medical care, dental, mental health, medical nutritional therapy, substance abuse, specialty care prescriptions, transportation, housing, food/meals, and specific emergency financial assistance. PLWH/A can access medical and supportive services throughout Connecticut for assistance with the health care and supportive services they need at no cost. Statewide HIV/AIDS programs include AIDS Drug Assistance Program (ADAP), the Pediatric AIDS Program, Medication Adherence Programs, Transitional Linkage into the Community (TLC), and Connecticut Mental Health Services for Children Affected by HIV. Prevention services are also provided at no-cost on a local, regional and statewide basis to both HIV-positive and high-risk HIV-negative individuals through targeted population specific EBIs, community and clinical counseling and testing, and partner notification services through CTR sites, community health centers and STD clinics. High-risk individuals, both HIV+ and HIV-, are targeted for risk reduction and behavior modification through the intensive Comprehensive Risk Counseling Services (CRCS) programs located at nine community organizations including hospitals, health departments, and community-based organizations (CBO). In collaboration with the CT Department of Education, DPH developed a health education program for grades 9-12 that addresses HIV, STDs, Hepatitis and risk reduction.

C. Assessed Needs of the Affected Population

Process: Service priorities throughout the state are identified regionally, through Ryan White Part A partners in Hartford and New Haven/Fairfield counties, statewide through Ryan White Parts B and Part D and Part F in their targeted areas, and are specified in the 2008 SCSN. The SCSN incorporates HIV and AIDS surveillance data, data from the 2008 Needs Assessment process, and in care and out-of-care information provided by planning bodies and other 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 HIV+ in-care individuals across the state. The method involved statewide analysis by the three major geographic areas: the New Haven-Fairfield TGA, the Hartford TGA and a region consisting of Litchfield, Tolland, Windham and New London counties. Data on out-of-care HIV+ individuals was collected via a statewide out-of-care survey process similar in nature to the 2005 in-care survey process. The SCSN recommendations were used as a basis for the development of objectives and key outcomes to be measured by all entities in the State receiving Ryan White assistance.[8] 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 2007 with updates.
- **Needs of People Living with HIV (PLWH)** are assessed through survey results, information provided by planning partners such as focus groups, surveys, and key informant interviews, Youth Advisory Group interviews and focus groups, and supplementary data from both Ryan White TGAs, Parts, C, D and F/SPNS, and addressed through other mechanisms such as funding and quality assurance, among others.
- **Existing available services** – the CHPC collaborates with 211 Infoline to create a statewide resource inventory of public and private providers. In creating the inventory of resources, the partners considered the total Ryan White resources in the State, both in the amount of funds and the services being supported by these funds, and CDC prevention funds. This helped determine the types of services provided in each county.
- **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 Needs and Core Medical Service gaps.** In previous reports, the unmet needs information was obtained through an agreed upon method to estimate unmet need in the state of Connecticut. This year, Connecticut is providing the estimated unmet need based on viral load data. Electronic reporting of all viral load tests has been in place since 2006.
  - Service gaps were identified by the in-care needs assessment.
  - Out-of-care information is provided through various sources: Out-of-care surveys, identification of unmet need, viral load and needs assessments.

[8] 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…"

Care and Prevention Integration

Connecticut has successfully combined its care and prevention planning bodies to create a fully representative membership in the Connecticut HIV Planning Consortium (CHPC). This group fulfills the required participation of both HRSA and CDC for planning purposes. The comprehensive plan and the statement of need both acknowledge that effective prevention means full engagement of the care community. Incorporated within the Plan and 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. The SCSN represents a collaborative effort among Care and Prevention funded entities and clients to accomplish the goals set forth in the Comprehensive Plan.[9]

The 2008 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 both having a focus on the HIV+ population. The SCSN was presented and shared at a public meeting on July 16, 2008 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. All available data was considered in the development of the final SCSN report, which was approved by vote on September 17, 2008.

Needs Assessments

Unlike the approach taken in 2004, wherein the state conducted a collaborative statewide effort using one survey, the 2008 needs assessment process was conducted by different entities over a period of approximately one year. With reauthorization and the Ryan White HIV/AIDS Treatment Modernization Act of 2006, the two Part A Planning bodies decided to conduct their own needs assessments for their respective areas.

The Hartford TGA conducted a separate assessment during early 2008. The Hartford survey instrument was shared with the Connecticut DPH who then asked the new CHPC DAC committee to refine it to meet their data needs, and to conduct their needs assessment of the remaining counties in the state. Both Hartford and the state used similar prevention questions in their surveys.

In 2007, New Haven/Fairfield TGA conducted its assessment of the needs of those who had fallen out-of-care as defined by the Health Resources Services Administration (HRSA) to identify services vital to reaching persons living with HIV/AIDS need, and subsequently a 2007-2008 needs assessment on pathways to care using a different methodology and set of questions than those used by the CHPC. In 2007-2008 the DAC, recognizing the importance of obtaining prevention information from the entire state, recommended that the New Haven - Fairfield TGA be surveyed in some form for prevention data.

Limitations

The data are a compilation of formative research efforts conducted over a period of two or more years. Most 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.[10] These qualitative measures are incorporated in the assessment of HIV service gaps. The out-of-care surveys, although providing a picture of

[10] The surveys conducted in each of the three venues used a convenience surveying model. Each survey used a different set of questions from the 2005 Needs Assessment survey. The surveys, although looking for similar information, did not use similar tools. Conclusions drawn within this report are based on the disparate information sets and can be used only to suggest a "picture" of the needs of PLWH/A in Connecticut to assist in planning efforts.

the out-of-care population in Connecticut, are not statistically significant and should be viewed as "somewhat representative" of the out-of-care population. The CHPC acknowledges that the data from Ryan White Parts C and D is not as extensive as that from the other Parts and plans to include in depth analysis in future assessments of Ryan White Parts C, D and F as with Ryan White Parts A and B and prevention.

1. Data Sources

The information reported is based on separate needs assessments, and information from other sources. Each group has analyzed their data and shared the results with the CHPC for incorporation within this document. It should be understood, that because of the significant differences in questions asked, methods used, and intended use of the information, that conclusions drawn are at best the result of an agreed upon effort of the members of the DAC and the SCSN work group. Data from this report should be used with the understanding that there are significant limitations for statewide implications.

2008 State Implemented Survey: The state effort conducted through the CHPC survey provided care information for Windham, New London, and Litchfield counties in 2008;

- Prevention information is provided through the 2008 needs assessments from the CHPC covering Windham, New London, Litchfield, New Haven, and Fairfield counties and the Department of Mental Health and Addiction Services and conducted through a collaborative effort with the Department of Social Services (DSS) sent through the Connecticut AIDS Drug Assistance Program (CADAP) and CHPC.
- Out-of-care data are derived from the 2006 out-of-care surveys reported in the 2007 SCSN update on out-of-care population. The problems for the out-of-care population continue to be the same in 2008 as they were in 2006, 2004 and 2002, e.g., barriers of transportation, fear, distrust, lack of insurance and substance abuse, and services that would facilitate their getting in to care include transportation, case management, and substance abuse treatment.

Part A TGA Implemented Surveys: The New Haven/Fairfield Part A TGA implemented an out-of-care needs assessment conducted in 2007; and an in care needs assessment conducted in 2008. The Greater Hartford Part A TGA implemented a needs assessment of care and prevention services in 2008.

Part D Needs Assessment 2006-2008: The Children, Youth and Family AIDS Network of Connecticut (CYFAN) the Part D federal grantee in Connecticut, continued expanding and refining case finding and testing services for the statewide population under the age of 25 in calendar year 2007 in response to service trends and needs.

Special Projects of National Significance (SPNS) on Oral Health Care: The Community Health Center, Inc. (CHC), a federally qualified health center (FQHC), coordinates the "Norwalk Smiles" program Oral Health Care Program for People with HIV Project funded by SPNS (HRSA). Focus groups were conducted in the Norwalk community to identify barriers to care and needs of the HIV community.

2008 Youth Advisory Group Chapter - Report on Prevention and Care: The Youth Advisory Group (YAG) is a group of young individuals ages 18-24 recruited from across the state of Connecticut to work as a component of the Connecticut HIV Planning Consortium representing the interests of youth across the state. The YAG has been meeting for three years.

DPH Group Training Feedback: In April 2008, DPH conducted a two day "Connecting to Care" Training for representatives from both care and prevention (e.g. CRCS managers, medical case managers). During a break-out session, groups were asked to discuss barriers/needs their clients have faced in entering regular medical care and barriers/needs clients have faced in maintaining a consistent relationship with regular medical care.

2006-7 Updated/Revised Statewide Coordinated Statement of Need (SCSN)

2006 Out-of-care Surveys conducted statewide in New Haven / Fairfield TGA, Hartford TGA and the Windham, New London, and Litchfield counties.

2005 Needs Assessment: Through Needs Assessments conducted in collaboration with the Ryan White Part A partners in Hartford and New Haven/Fairfield counties, Ryan White Part B statewide and the CPG people living with HIV/AIDS were surveyed to confirm how services are being used, and to identify and document the primary unmet needs.

2. Gaps in HIV Care and Prevention

Care: With the 2006 Ryan White reauthorization and the status change to TGAs of Connecticut's two Eligible Metropolitan Areas (EMA) some core services were affected and support services were reduced, capped or eliminated completely. In response, the Connecticut State Legislature appropriated funding until 2009 (based on availability) to fill part of the TGA funding gaps. Ryan White Part B funding continued to fill in other service gaps (e.g., medical case management, mental health, emergency financial assistance, housing, and psychosocial). The following Care Service Gaps were identified by comparing the SCSN findings to the Care & Prevention Service Matrix:

- Dental services and health insurance continuation in Windham County
- Dental services, health insurance continuation, food bank and housing-related services in Litchfield County
- Dental services and health insurance continuation in New London County
- Dental services, Emergency Financial Assistance, and Housing-related services in Hartford County
- Middlesex and Tolland Counties fall under the Greater Hartford TGA jurisdiction, but for Tolland County recurring service gaps exist in medical transportation, dental care, and food bank
- AIDS Pharmaceutical Assistance, oral health, health insurance continuation, and additional mental health and housing-related services in New Haven-Fairfield TGA

Note: Ryan White Part C Community Health Centers, local hospitals, private practitioners and clinics sited in these counties address gaps noted on the service matrix (e.g. mental health and substance abuse services, ambulatory/outpatient and oral health)

Prevention: Connecticut funds CDC defined prevention services including Counseling, Testing & Referral (CTR), Comprehensive Risk Counseling Services (CRCS), Drug Treatment Advocacy (DTA), as well as a cadre of Effective Behavioral Interventions (EBIs). The following gaps (see table below) were identified through the examination of resources, service provision, provider capacity as discussed among DPH and the CHPC Data and Assessment Committee members. (See Service Matrix)

- Interventions targeting MSM in New London, Litchfield, Tolland, and Windham Counties
- Interventions targeting Latino and/or African American Heterosexual women in New London, Fairfield and Windham Counties

- Comprehensive Risk Counseling Services for high risk individuals in Windham, Middlesex and Litchfield Counties

State of Connecticut Service Gaps and Priorities

Note: service priorities varied by region, i.e., TGA and the rural areas or rest of the state, hence statewide services are listed as a best guess for priority based on 2005 and 2007 SCSN information, since data was compiled from various non comparable sources.

County Abbreviations: New London (NL), Litchfield (L), Tolland (T), Windham (W), Hartford (H), New Haven (NH), Fairfield (FF), Middlesex (M)

Prevention	Care Core Services	Care Support Services	Barriers
Prevention Support Services-prevention interventions NL, L, T, W, FF	Dental W, L, NL, H, T, NH, FF	Housing W, H, L, NH, FF	Inability to pay All
Risk Reduction Services/Information NL, L, T, W, FF, H	Mental Health Services NH, FF	Emergency Financial Assistance H, L, W, NL	Transportation All
Comprehensive Risk Counseling Services L, W, M	Insurance Assistance (for HIV services / medications) W, L, NH, FF, NL	Food H, L, T, NH, FF	Unaware of services All
	Substance Abuse-outpatient NH, FF	Transportation T, NH,FF	Fear of revealing status All

Information from the various data sources indicates that, *to engage as many people as possible (underserved and those yet to enter care) into both prevention services (primary and secondary) and care services; and to reengage individuals who have fallen out-of-care* , Connecticut must create strategies to reduce barriers through providing education/information on available services, meeting people's basic needs to ensure they can receive care, making certain that there are culturally appropriate services, providing transportation to medical services and making sure that costs are covered for medical care. These issues were considered in developing the six objectives outlined in the Action Plan for Connecticut – Section III. Goals and Objectives.

D. Inventory of Community Resources

1. Community Resources

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 listed on pages 34 and 35 of the SCSN.

Connecticut has a network of services that are catalogued and updated by Infoline, which was created in 1976 as a public/private partnership of United Way and the State of Connecticut. Infoline is a single source for information about community services, referrals to human services, and crisis intervention. It is an integrated system of help via the telephone. Accessed toll-free from anywhere in Connecticut by dialing 2-1-1, Infoline operates 24 hours a day, 365 days a year. Multilingual caseworkers and TDD access are also available. Infoline has developed the state's most comprehensive database of human service resources and can be accessed online at www.infoline.org.

Since October 2006, an HIV/AIDS Prevention & Care Guide has been on the United Way of Connecticut's 2-1-1 website. The Guide, which is accessible both online (www.infoline.org) and by dialing 2-1-1, provides up-to-date HIV/AIDS care and prevention information, as well as information about other resources and supportive services beyond the scope of HIV/AIDS. A detailed inventory (by county) of agencies that provide HIV/AIDS related service is located in the appendices. In 2007, 2-1-1 received more than 450,000 service requests for information, and of these the top five service requests, which are also reflective of needs and gaps in HIV/AIDS services, were: 1) housing/shelter, 2) utilities/heat, 3) information services, 4) outpatient mental health care, and, 5) substance abuse services. A detailed inventory (by county) of agencies that provide HIV/AIDS related service is located in the appendices.[11]

2. Planning and Funding Structures

The following groups are planning and funding structures (state and federal) across the state and with whom DPH planning efforts are coordinated.

Centers for Disease Control and Prevention (CDC), one of the 13 major operating components of the Department of Health and Human Services (HHS), is the nation's premiere health promotion, prevention and preparedness agency. The CDC funds state and local health and education agencies and community-based organizations to conduct proven effective behavioral HIV prevention intervention programs for both HIV-positive and at risk populations.

The Ryan White Program administered by the HIV/AIDS Bureau (HAB) of the Health Resources and Services Administration (HRSA) provides funding to develop, organize, coordinate, and operate more effective and cost-efficient systems for the delivery of essential core medical and support services to PLWH/A and their families. Connecticut provides services through the following:

- *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 TGAs are New Haven/Fairfield Counties and the Greater Hartford area (including Hartford, Middlesex and Tolland Counties).
- *Part B* provides funding through the 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.
- *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, testing and referral (CTR), 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 centers are the recipients of these Part C grant awards.

[11] These numbers reflect the sites where services are provided. The number of services may be duplicated across programs and counties.

- *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, and maintains an adolescent-focused website at www.ctyouthhiv.com

- *Part F includes:*

  Connecticut AIDS Education and Training Centers Program (CAETC) 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

  Dental Reimbursement and Dental Partnership Programs provide reimbursement to dental schools, postdoctoral dental education programs, and dental hygiene programs for oral health care of individuals living with HIV.

  Minority AIDS Initiative (MAI), created in 1998 in response to growing concern about the impact of HIV/AIDS on racial and ethnic minorities, provides funding across several Department of Health and Human Services (DHHS) agencies and programs, including the Ryan White Program. The Ryan White component of the MAI was codified in the recent HIV/AIDS Treatment Modernization Act of 2006. In Connecticut, both Ryan White TGAs and Part B are the recipients of MAI funding. Part B MAI dollars provide education and referral to link HIV-positive minority populations with CADAP as well as refer individuals for medical care and support services.

  Special Projects of National Significance (SPNS) funds research and development activities for assessing the effectiveness of care models, providing support for innovative models of HIV/AIDS service delivery, and for assisting the replication of effective models. In Connecticut, Community Health Center, Inc. (CHC), a federally qualified health center located in Middletown, Connecticut, is the recipient of a SPNS grant for its "Norwalk Smiles" program, which will provide comprehensive dental care to more than 700 HIV positive individuals at sites in Norwalk and Stamford .

- *HOPWA or Housing Opportunities for Persons with AIDS* funding is provided through the Department of Housing and Urban Development (HUD) and addresses the specific housing need and social service needs of low income persons diagnosed with HIV/AIDS and their families.

Prevention Programs: Through both CDC and state allocations, the DPH funds agencies to provide a cadre of prevention initiatives and interventions, with a specific focus on effective behavioral interventions, targeting Connecticut's prioritized populations. Full detail on all prevention programs can be found in the Appendix. With state-designated dollars, Connecticut funds syringe exchange programs (SEP), drug treatment advocacy programs (DTA), perinatal HIV transmission programs, as well as such effective behavioral interventions as Spiritual Self Schema, Latinas en Accion, Risk Avoidance Partnership and Peer/Non-Peer Outreach for MSM. In total Connecticut funds fourteen (14) EBIs through its network of providers, see figure below.

Effective Behavioral Interventions for Prevention funded by DPH

- Healthy Relationships: a group-level intervention based on social cognitive theory
- Information and Enhanced AIDS Education (Project Smart) is a 7-session intervention targeting the drug- and sex-related risk behaviors of in-treatment drug users
- Latinas en Accion (The Effects of HIV/AIDS Intervention Groups for High Risk Women)
- Intensive AIDS Education in Jail/Rikers Health Advocacy Program MPowerment: a community-level intervention for young men who have sex with men
- RESPECT: an individual-level intervention that utilizes a client-focused and interactive HIV risk-counseling model (being funded for the first time in 2008)
- Risk Avoidance Partnership (RAP): RAP is designed to train active drug user as Peer Health Advocates (PHAs)
- Safety Counts: an intervention targeting active injection and non-injection drug users to reduce risk for HIV and Viral Hepatitis
- SISTA: a group-level, gender- and culturally-specific intervention, designed to increase condom use with African-American women
- Spiritual Self-Schema (3-S): In 3-S Therapy, a Buddhist framework facilitates the convergence of spirituality and contemporary cognitive psychology
- Street Smart: a multi-session, skill-building program designed to help runaway and homeless youth practice safer sexual behaviors and reduce substance use
- Together Learning Choices (TLC): a group-level intervention based on cognitive-behavioral strategies to change the behavior of young people living with HIV (being funded fir the first time in 2009)
- Voices/Voces: a single-session video-based intervention designed to increase condom use among heterosexual African-American and Latino/a men and women who visit STD clinics

Public Information Programs: Most of the public information campaigns are funded with state money. The following are examples of what will be accomplished in 2009.

Public Information Programs for Prevention

- Expansion of the 'Tell Me What You See' (TMWYS) health education program for grades 9-12 into entire school systems in both New London and Stamford
- Development of the 'Tell Me what You See' (TMWYS) supplemental curriculum for children in grades 4 – 8. The art based design of this innovative program features age appropriate lessons and classroom activities on HIV/hepatitis/STDs
- Development of new artwork for use in TMWYS health education program with 14 - 18 juvenile offenders incarcerated at the Manson Youth and York Correctional Facilities.
- A creative art program for the American School for the Deaf (ASD) will enable deaf students to produce targeted HIV/hepatitis/STD materials for use in the TMWYS supplemental health education curriculum (targeted at deaf young adults)
- A community mural painting and related educational materials project will focus on the dangers of IV drug use and the growing health crisis of HIV/hepatitis co-infection

Other Collaborating Connecticut State Agencies and Programs

During 2009, DPH will collaborate with various agencies, institutions and health department units to deliver HIV prevention services to high risk populations. The following is a list of those efforts:

- Memorandum of agreement with the University of Connecticut Correctional Managed Care Program and the Department of Corrections to provide HIV Prevention Counseling and Testing in all correctional facilities in the state.
- HIV prevention unit staff members will continue to serve on the Department of Education's Coordinated (SDE) Health Education Cadre. This cadre provides training for school personnel and health educators on issues related to HIV and STDs.
- With the Hepatitis C Program, DPH helps to provide Hepatitis C screening to clients that have a history of intravenous drug use. This screening is currently at 14 HIV Counseling and testing sites and at STD clinics funded by DPH and drug treatment centers funded by the Department of Mental Health and Addiction Services (DMHAS).
- Continuation of HIV counseling and testing in DMHAS drug treatment centers throughout the state. DPH provides the resources, including rapid test kits, free laboratory services, and training to be able to continue to offer these services.
- In 2009 DPH will continue to collaborate with the STD and TB control units of DPH to offer routine HIV testing in nine STD clinics in the state and HIV testing in the TB clinics and in the field.
- The prevention unit will continue to work within the department with Health Care and Support Services Unit to integrate prevention and care training and promote cross referrals and collaboration between our funded programs on a local level.
- Collaboration will continue with clinical settings such as Community Health Centers and Hospital Emergency Departments to implement routine HIV testing in their practices.

State of Connecticut Department Social Services (DSS) provides supportive services to people living with HIV, including the CADAP. It offers a broad range of services for the elderly, persons with disabilities, families and individuals. It is also the state agency responsible for administering the Rehabilitation Act, the Food Stamp Act, the Older Americans Act and the Social Security Act. DSS administers housing assistance, emergency assistance, child care assistance, Temporary Assistance for Needy Families (TANF), State Administered General Assistance (SAGA), employment and training services, and Medicaid coverage, among others.

- *HUSKY Insurance Program* is the Connecticut health insurance that provides coverage for low-income eligible children and teenagers up to age 19 and their families/caregivers.

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 (for this population) 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.

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 DPH funds the University of Connecticut Correctional Managed Health Care to provide Counseling, Testing and Referral (CTR) and Community Partners Action (Beyond Fear) to provide Intensive AIDS Education in Jail (Rikers Health Advocacy Program)

State of Connecticut Department of Education (DOE) provides educational programs, leadership and curriculum development, planning, evaluation, assessment and data analyses to residents and organizations in Connecticut. The Department of Education and DPH 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.

E. Profile of Provider Capacity

In FY 2007-2008, the Ryan White Part B services provided care to more than 1,960 unduplicated clients through the Connecticut AIDS Drug Assistance Program (CADAP). More than 3,000 additional clients were served through the Part B-funded care providers (e.g. medical case management, ambulatory/outpatient, dental, mental health, emergency financial assistance, housing, transportation, food), Project TLC, which provides transitional medical case management to HIV-positive inmates transitioning into the community, and education and referral for HIV-positive minority clients to CADAP through the Minority AIDS Initiative (MAI). An additional 600 clients were provided medication and treatment adherence services through ten state-funded Medication Adherence Programs (MAP), and approximately 23 families, received mental health therapy through the state's four funded programs for HIV Affected Children and Families.

In December 2006, the Health Care and Support Services (HCSS) of the DPH issued a competitive Request for Proposals (RFP) for all Ryan White Part B funded services. An RFP for state-funded services for Medication Adherence Programs was also issued in 2006. The contracts awarded under the Ryan White Part B RFP commenced on July 1, 2007 and were for one year funding cycle, with renewal for two additional years (through 6/30/2010). Twenty-one (21) agencies are currently funded, through Part B, to provide core medical and support services. Ten statewide agencies are funded to provide Medication Adherence services.

HRSA requires that Part A and B service categories be divided into core medical and support services. Core Medical services must be funded at least at 75%. Connecticut's Ryan White Part A and B service allocations are indicated in Table 9.

Table 9: FFY Ryan White Parts A & B 2008 Service Allocations	Part B Totals[1]	Part A NH/FF[2] totals	Part A Hartford[3] totals	Totals
Core Medical Services Sub-total Footnote 5	$2,429,966	$3,718,664	$2,499,960	$8,648,590
a. Outpatient /Ambulatory Health Services	$189,662	$1,108,435	$709,029	$2,007,126
b. AIDS Drug Assistance Program (ADAP) Treatments				
c. AIDS Pharmaceutical Assistance (local)		$7,441	$60,333	$67,774
d. Oral Health Care	$110,391	$22,525	$145,482	$278,398
e. Early Intervention Services			$171,918	$171,918
f. Health Insurance Premium & Cost Sharing Assistance			$19,547	$19,547
g. Home Health Care			$14,381	$14,381
h. Home and Community-based Health Services				
i. Hospice Services				
j. Mental Health Services	$74,748	$476,411	$270,001	$821,160
k. Medical Nutrition Therapy	$8,100	$6,458		$14,558
l. Medical Case Management (+ Treatment Adherence)	$2,044,635	$1,280,554	$644,808	$3,969,997
m. Substance Abuse Services–outpatient	$2,430	$816,840	$464,461	$1,283,731
Support Services Sub-total	$353,510	$992,588	$832,987	$2,179,085
a. Case Management (non-Medical)				
b. Child Care Services	$34,209			$34,209
c. Emergency Financial Assistance	$164,090	$101,056	$16,489	$281,635
d. Food Bank/Home-Delivered Meals	$24,215	$144,282	$88,000	$256,497
e. Health Education/Risk Reduction				
f. Housing Services	$44,466	$258,057	$344,802	$647,325
g. Legal Services			$32,810	$32,810
h. Linguistics Services	$7,862			$7,862
i. Medical Transportation Services	$50,769	$100,559	$219,505	$370,833
j. Outreach Services		$200,747		$200,747
k. Psychosocial Support Services	$27,899	$9,323	$131,381	$168,603
l. Referral for Health Care/Supportive Services				
m. Rehabilitation Services				
n. Respite Care				
o. Substance Abuse Services - residential		$178,564		$178,564
p. Treatment Adherence Counseling				
Total Service Dollars	**$2,783,476**	**$4,711,252**	**$3,332,947**	**$10,827,675**

Includes all eight CT counties, with specific focus on non Part A funded counties (Litchfield, New London and Windham Counties)
Includes New Haven and Fairfield Counties
Includes Hartford, New Haven and Middlesex Counties

Ryan White Parts C and D also provide core medical and supportive services to people living with and affected by HIV/AIDS through a system of federally qualified Community Health Centers, clinics and hospitals. Ryan White Parts C and D applicable care funded services and funding amounts are indicated in Table 10.

TABLE 10: **Ryan White Parts C and D Allocations and Services**

PART C AGENCY (BY COUNTY)	SERVICES	FEDERAL FUNDING
HARTFORD		
Community Health Services	Outpatient EIS	$385, 125
NEW HAVEN		
Fair Haven Community Health Center	Outpatient EIS	$341,148
Hill Health Center	Outpatient EIS	$671,653
Waterbury Hospital	Outpatient EIS	$292,500
MIDDLESEX		
Community Health Center	Outpatient EIS	$419,970
TOLLAND AND WINDHAM		
Generations Health Center	Outpatient EIS	$321,750
LITCHFIELD		
Community Health and Wellness Center of Greater Torrington	Outpatient EIS	$243,750
FAIRFIELD		
Optimus Health	Outpatient EIS	$552,696
Southwest Community Health Center	Outpatient EIS	$521,233
New London (No program funded)	-0-	$0
TOTAL		**$3,749,825**
PART D AGENCY (BY COUNTY)	SERVICES	**FEDERAL FUNDING**
HARTFORD		
Charter Oak Health Center	Outreach/Counseling & Testing	$57,500
University of Connecticut (CCMC)	Medical case management, primary care & outreach	$170,500
NEW HAVEN		
Fair Haven Community Health Center	Outreach, Counseling & Testing	$47,465
Hill Health Center	Outreach, Counseling & Testing	$68,000
Yale Child Study	Medical case management, primary care & mental health	$245,735
MIDDLESEX (NO PROGRAM FUNDED)		
TOLLAND AND WINDHAM		
Generations Health Center	Outreach	$19,000
LITCHFIELD (NO PROGRAM FUNDED)		
FAIRFIELD		
Bridgeport Hospital	Primary Care	$29,700
Optimus Health	Medical case management, outreach, counseling & testing	$57,500
Southwest Community Health Center	Medical case management, outreach, counseling & testing	$65,500
TOTAL		**$760,900**

Note: Part C Outpatient EIS: Direct provision of medical care including primary care, lab, x-rays and other diagnostic tests, medical/dental equipment and supplies, medical case management, electronic medical records, patient education in conjunction with medical care, transportation for clinical care provider staff to provide care and other diagnostic services regarding HIV/AIDS and periodic evaluation of PLWH/A

Through CDC prevention funding, DPH's Prevention Unit provides resources to statewide agencies to target priority populations with proven effective behavioral interventions. Table 11 outlines prevention services and funding provided by statewide agencies by county. See Appendices for care and prevention service detail.

TABLE 11. COUNTY	HIV PREVENTION INTERVENTIONS/INITIATIVES	FUNDING (FEDERAL AND STATE*)
HARTFORD	CTR, CRCS, DTA*, SEP*, Healthy Relationships, Mpowerment, Peer/Non Peer MSM Outreach*, RESPECT, Risk Avoidance Partnership*, Safety Counts, SISTA, Spiritual Self Schema*, Street Smart, Together Learning Choices, Voices/Voces	Federal: $1,699,774 *State: $342,813
NEW HAVEN	CTR, CRCS, DTA*, SEP*, Children's Health Initiative – HIV Perinatal*, Healthy Relationships, Latinas en accion*, Mpowerment, Safety Counts, SISTA, Street Smart, Voices/Voces, Treatment Van Services (health van)	Federal: $1,406,574 *State: $ 340,261
MIDDLESEX	CTR, Healthy Relationships, Safety Counts	Federal: $135,500
TOLLAND AND WINDHAM	CTR, DTA*, RESPECT, Safety Counts	Federal: $282,000
LITCHFIELD	CTR, Healthy Relationships	Federal: $135,000
FAIRFIELD	CTR, CRCS, DTA*, SEP*, Children's Health Initiative – HIV Perinatal*, Information and Enhanced AIDSEducation (Project Smart), Integrated HIV Prevention Services (CTR) in Routine Medical Care*, MPowerment, Safety Counts, SISTA, Street Smart	Federal: $1,307,000 *State: $353,792
NEW LONDON	CTR, CRCS	Federal: $182,000
DEPT. OF CORRECTION	CTR	Federal: $520,509
STATEWIDE PROGRAMS	CTR, Intensive AIDS Education in Jail, Safety counts, Voices/Voces	Federal: $408,546
Totals		**Total Federal: $6,076,903**
Key: Counseling, Testing & Referral (CTR), Comprehensive Risk Counseling Services (CRCS), Drug Treatment Advocacy (DTA), Syringe Exchange Programs (SEP) *-State-funded interventions		**Total State: $1,036,866**

F. Infrastructure Development

Provider staff development and capacity are an integral part of yearly needs assessment and plan development activities. Since mid-2003, the state has used the Uniform Reporting System (URS) to collect Prevention and Care service data. Significant barriers to the accurate, timely recording of this data were noted, especially for the Prevention providers. In March of 2008 a decision was made to transition from URS to the data collection systems being offered free of charge by the CDC and HRSA, (PEMS and CAREWare respectively).

Prevention Infrastructure: Transition from URS to CPEMS for Prevention Activities

In recent months DPH decided to migrate from the URS data collection system to CPEMS, Connecticut's Program Evaluation and Monitoring System. The goal is to implement a more user friendly data collection system for all DPH funded programs as well as use it as tool for data reporting, quality control and assurance. PEMS is a program that captures information through secure Internet Explorer browser-based software for data entry and reporting. PEMS was designed as a confidential data collection tool geared toward evaluating and monitoring public health programs for and by Health Departments, Community-Based Organizations (CBOs) and CDC. PEMS contains a comprehensive and standardized set of variables for monitoring CDC-funded HIV prevention programs. These data variables are based on federal program guidance mandates (e.g. Program Performance Indicators) and are collected by Health Departments and directly funded CBOs. These standardized data variables facilitate improvement in data collection, reporting, analysis, interpretation, and program delivery.

PEMS will contribute to the goal of decreased HIV transmission by strengthening accountability and monitoring organizational capacity to monitor and evaluate HIV prevention programs. PEMS will provide secure, standardized, reliable and timely data for effective program monitoring and evaluation in collaboration with community, state and national partners. These data will allow more comprehensive reporting of HIV prevention activities, fiscal information, and community planning information. This information will help HIV prevention stakeholders examine program fidelity, monitor use of key program services and behavioral outcomes, and calculate and report the program performance indicators. PEMS will also help CDC monitor and evaluate critical areas of HIV prevention.

PEMS Data Variables

- Agency information
- Program plan details
- Client demographics
- Referral outcomes
- HIV test results
- Partner elicitation and notification
- Client use of services
- Community planning priority populations and interventions

PEMS Goals

- Reduce the number of new HIV infections
- Implement evidence-based programs
- Promote accountability
- Improve program monitoring

In the decision making process special consideration was given to data security and confidentiality. Client confidentiality, security and privacy are top priorities for DPH and are embedded into PEMS by:

- Security measures designed to prevent unauthorized release, accidental loss or damage of data.
- A variety of security measures are used including technical controls (user ID & passwords, digital certificates), management controls (documented security plan, Certification & Accreditation, Assurance of Confidentiality), and operational controls (Rules of Behavior (ROB) for end users, Memorandum of Understanding (MOU)).
- All personnel involved with PEMS have security related responsibilities – health department and CBO leadership and staff, individual end users of PEMS, and CDC.
- Security responsibilities differ according to the selected deployment model for PEMS.

Each PEMS user is required to have a digital certificate issued by CDC to identify specific users authorized to access the SDN website. Individuals requiring access to the SDN website must request and install a digital certificate on the user's workstation to access the SDN website.

PEMS Advantages:

- PEMS Program Monitoring: PEMS can help improve Program Monitoring by providing information to describe: a) what services are being provided, b) which agencies are delivering or funding services, c) to whom are services being provided, d) what resources are allocated to those services, and e) what behavioral and service utilization outcomes to report.
- PEMS Program Evaluation: PEMS can assist in improving Program Evaluation by providing data to describe: a) the extent to which the program is reaching the target population, b) the extent to which the intervention plan is delivered as intended, c) the degree to which performance indicator targets are being achieved, and d) the relationship between exposure to services and changes in behavioral outcomes.
- Data Analysis: PEMS can help support data analysis to: a) monitor client and service data, b) understand community needs, c) improve HIV/AIDS prevention programs, d) comply with federal funding requirements, and e) provide enhanced reporting capabilities.

PEMS can help:

- DPH Providers identify, develop and refine their interventions for maximum effectiveness and efficiency
- Identify local prevention practices as well as capacity building and technical assistance needs
- Increase motivation among prevention staff and volunteers by offering a concrete way of tracking success
- Ensure that HIV prevention resources are reaching priority populations
- Provide systematic information about the status of HIV prevention efforts throughout CT for ongoing planning

DPH began the transition to CPEMS in September 2007 with the CDC sponsored PEMS training of all statewide contractors involved in offering funded prevention interventions. The transition from URS to CPEMS is expected to be completed on or around January 1, 2009. With the transition to CPEMS, DPH will also introduce the new HIV testing form for data collection. Initially the data will be processed manually, but eventually the form will be linked to CPEMS. Training for all counselors on the use of the new form and its eventual linkage with CPEMS is scheduled for October 2008. Initially prevention data will be entered in both the URS and CPEMS systems until DPH can ascertain how well providers are managing data entry into PEMS.

Care Infrastructure: Transition from URS to CAREWare for Health Care and Support Services Activities

In March and April of 2008 the Greater Hartford and New Haven/Fairfield Ryan White Part A TGA programs began working to implement a new statewide, web-accessed CAREWare system. They contacted the Ryan White Part B, C and D grantees and received buy-in to have all Ryan White funded agencies participate in this project. A new server with sufficient data storage capacity was purchased and is housed at the Hartford Health Department, who ensures security and provides appropriate technical support.

Planning for the transition to CAREWare began in May 2008 and continues with weekly conference calls among Part A and Part B grantees. The Part A partners have contracted with Jprog (the software designers of CAREWare) to construct a data conversion tool that will allow much of the existing URS data to be electronically entered into the statewide

CAREWare data base to relieve the added burden on funded providers of re-entering all the client information. The design of this tool is expected to be completed by the end of September 2008, with the full transition completed by the end of 2008. The Ryan White Part A and B partners will collaborate on establishing standards for data entry and will structure CAREWare to facilitate data entry. The Ryan White Part C and D partners have federally mandated standards and will be responsible for their own CAREWare structure.

Prior to each funded agency's move to CAREWare, the conversion tool will be used to automatically load a local version of CAREWare with client and service information. Using a CAREWare utility called "Store and Forward" this data will then be downloaded into the main Hartford server. A brief orientation to the new CAREWare software will be provided and permissions to view and enter data on the main server will be issued. At that point each agency will become a member of the statewide system and will be able to record their data via the Web.

Since most of the client and service data will be migrated from URS to CAREWare, funded agencies and grantees will have access to their own historical data, at least to the extent that annual service reports may be reconstructed. The current statewide database housed at the Connecticut Department of Public Health will be maintained for the near future in order to fulfill ad hoc data requests from grantees and funded agencies.

CAREWare Advantages

- Fulfills new federal reporting requirements and recommendations by generating standardized reports for HRSA. HRSA contracts directly with JProg to implement any new HRSA mandated reporting requirements. State reporting requirements are met by generating custom reports for the DPH, the region, local agencies, OPM, and the Legislature.
- Data security is an integral part of the design of CAREWare. Access, permissions and data sharing are strictly controlled by technical experts at the central server level as well as providing local control features for the funded agencies.
- Since there is a single server, administered by Hartford, modifications and upgrades to the software are implemented by qualified staff directly from the HRSA website as soon as they are available and are uploaded to agencies automatically when they next access CAREWare via the Web, thus, eliminating the need for funded agencies to make these technical changes.
- Each funded agency can agree to have every site that provides services have its own access to data entry, thereby eliminating the need to transport data to the parent site for entry.
- Client personal data and medical records can be selectively shared (with appropriate permissions) within the CAREWare real time network for providers that service the same client, eliminating duplicative data entry.

Challenges

- Connecting and authorizing a large number of agencies/sites to the system in a short period of time.
- Training the funded agencies in the use of CAREWare. It is the grantee's responsibility for software training.
- Managing the authorized user lists and permissions over the long term.
- Resolving data discrepancies and assigning responsibility for updates to client records.

Quality Management Program

The goal of the Ryan White Part B Quality Management Program (QMP) is to sustain and improve the health and the quality of life for people living with HIV/AIDS (PLWH/A). The process for achieving this goal is a multifaceted approach of quality management activities that are performed on a continuous basis. Services are delivered to Ryan White Part B eligible PLWH/A and their families in accordance with: 1) the Ryan White Part B regulations; 2) the most current Public Health Service (PHS) Guidelines for PLWH/A; 3) standards developed by the Connecticut Department of Public Health; 4) other nationally accepted standards of care (e.g., National Association of Social Work Standards of Practice and Care), and 5) HRSA Core I and II Group Performance Measures.

Quality management activities have focused on the linkage of social support services to medical services, the retention in care for HIV positive individuals, and adherence to the new Statewide Core Standards for Medical Case Management, written in collaboration with Ryan White Parts A, C and D, and finalized in January 2008. Medical Case Manager (MCM) Training was provided in April 2008 for new and seasoned Medical Case Managers to educate them about the new standards and outcome measures. DOH Training staff will continue to offer MCM trainings as needed to ensure familiarity and compliance with the standards, as well as the HRSA Performance Measures, both current and others as released.

In Spring 2008, the Ryan White Part B client record was revised to reflect the change from case management to medical case management including a new client assessment form that documents the client's physical and emotional health including HIV medication adherence assessment, risk assessment, activities of daily living, referrals, and the outcomes of the referrals. This new record was piloted at the Human Resources Agency of New Britain, Inc. in July 2008 and received positive feedback. It was then introduced to the Medical Case Managers at their yearly annual meeting in August 2008. The training for their MCM Supervisors will be held in October 2008 regarding MCM Standards of Care, outcome measures and client forms. In addition, as routine site visits are being conducted by HCSS Staff, the revised client record is reviewed with the staff, questions answered, and feedback collected. Based on evaluation of the feedback regarding use of the form, the document will be revised as needed.

Since July 2007, Ryan White Part B funded MCM's have been required to collect CD4 and viral load 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 Core I Performance Measures. During the past year and a half, most site visits have included feedback to the funded agencies in the form of URS reports, which included clients that have no or old (> 6 months) lab tests, clients whose lab tests have been entered inaccurately (missing or inconsistent results), average number of lab tests per client, number of clients with and without primary care visits, and number of referrals for core services made, completed, verified, and pending. These reports were provided not only to ensure that relevant data was collected and entered into the database, but also to help funded agencies identify clients with missing or inconsistent data in order to rectify those reporting deficiencies. As result of these efforts and the diligent work of funded agencies, DPH has observed greatly improved levels of compliance with these data requirements. DPH anticipates equally as high compliance when the Core II and subsequent HRSA Performance Measures are released and adopted.

All Ryan White Part B funded Medical Case Management and state-funded Medication Adherence Programs receive three (3) site visits per year in 2009. The first visit is administrative and reviews program expectations. The second and third are audit visits

where client records are comprehensively reviewed for program and financial compliance, adherence to the medical case management standard, and documentation of the following Group 1 HAB HIV Core Clinical Performance Measures for Adult/Adolescent Clients:

- CD4 count in the last six (6) months
- Prescription of HAART
- Medical visit in the last six (6) months
- ARV for pregnant women
- PCP Prophylaxsis (to be collected when CAREWare is rolled-out)

Additional data elements enabling evaluation of the HRSA Core II Clinical Performance Measures will be added once the transition to CAREWare has been accomplished. Data reports will continue to be prepared in advance of the site visits indicated previously. The DPH official brings this "report card" on the visit and reviews it with the staff to help them identify deficiencies in reporting and/or care being delivered. This document has been a very effective tool in measuring the agency's adherence and documentation of that adherence to the MCM standards of care.

At this time, Ryan White Part B funded programs are in transition from the current reporting system, URS, to the CAREWare database program. Quality management activities will be adapted to accommodate the change in dataware systems and reporting requirements as necessary. If discrepancies or issues are identified, the DPH officials will provide TA and review the findings with the QMP and corresponding supervisory staff. Contractors may be requested to submit a corrective action plan. As noted above, DPH expects to be able to migrate all medical information from the URS to CAREWare when the transition is made. It is anticipated that using CAREWare will result in large savings in duplicative efforts to obtain this information since medical information in CAREWare is client-oriented rather than agency-oriented as in URS. DPH anticipates a 10-15% reduction in clients with missing lab data and equal increases in number and accuracy of current lab test results (based on studies of client records in the statewide URS database).

The Ryan White Part B contractor's quarterly internal audit forms will be revised in 2009 to reflect the changes in the MCM standards of care and include documentation of client level data to ensure adherence to the new standard. The DPH site visit forms for the MCM programs are also in the process of being revised to ensure that the appropriate data is being collected in the most efficient and effective manner possible. In May 2008, the site visit form for the Medication Adherence Program was revised to facilitate the review of the client clinical data in the client record in a more efficient manner.

In October 2008, DPH's trainer will provide training for the staff of HCSS on Quality Management to ensure that the staff is knowledgeable about the new processes, collection tools and QM strategies.

As of July 2008, the HCSS Health Program Supervisor; Health Program Associate and Nurse Consultant will participate in the HRSA HIV/AIDS Bureau (HAB)/National Quality Center's Quality Management Cross-Part Collaborative. This initiative is designed to improve the collaboration across the state by all Ryan White Parts (A, B, C, D, & F) in order to improve access to care for clients, maximize resources, align efforts, and avoid duplication of services. This twelve (12) to eighteen (18) month Quality Management project includes working with representatives from four other states: Texas, Pennsylvania, Virginia, and New Jersey.

Quality Assurance

The DPH assures quality through specific actions that involve strengthening the capacity of grantees/contractors to deliver interventions that are culturally sensitive, appropriate, and acceptable for the target populations served.

In 2009, there will be required Cultural Competency training for all new HIV care and prevention providers within the first six months of training. All new HIV care and prevention providers who attend the training will be tracked in the Department of Public Health (DPH) training database. Outcome: All new HIV care and prevention providers will attend the Pre-requisite training, which includes a half-day training on Cultural Competency within the first six-months of hire.

During the course of the contract year, DPH staff will perform programmatic site visits on a semi-annual basis to ensure that services are delivered in a culturally sensitive manner. The site visit will consist of an environmental assessment that will focus on access to services for the target population, culturally appropriate informational materials, review client satisfaction survey data, and the availability of staff that are bi-cultural and bi-lingual on site to meet the needs of the target population. In addition, DPH staff will conduct an informant interview with staff to address cultural issues that impact current HIV care and prevention services.

Improving Capacity through Training

The DPH training team continues to assure the highest standards for training by fostering linkages with academic and community-based organizations that provide direct care and prevention services. Since 2007, a variety of training workshops and conferences were conducted to meet the educational needs of funded HIV care and prevention providers. During the months of September 2007 through May 2008, the DPH's Health Care and Prevention Services Units instituted the first full year of Core and Continuing Education trainings. Core Trainings are offered by the State that focus on the following HIV Care and Prevention services: Pre-requisite training (includes: HIV 101, Substance Abuse, Domestic Violence, Sexual Assault, Hepatitis 101, Cultural Competency, and Entitlements and Resources), HIV Medical Case Management, HIV Prevention Counseling, Comprehensive Risk Counseling Services (CRCS), and HIV Education Training. In the last year, a total of eight (8) Core Trainings and thirty-four (34) Continuing Education workshops have occurred.

CORE Trainings Summary: To date, eight (8) trainings were conducted on the following Core Trainings:

- Pre-requisite Training: Medical and Legal Basics of HIV: For new HIV Care and Prevention Providers
- Fundamentals of HIV Prevention Counseling: For Prevention Counselors & Case Managers
- Fundamentals of HIV Medical Case Management: For Medical Case Managers
- Comprehensive Risk Counseling Services (CRCS) for CRCS providers

In an effort to adhere to HRSA's requirements for Medical Case Management (MCM), the DPH has been collaboratively working with MCM providers and Ryan White Parts A through D in the State to ensure that the trainings are in alignment with the newly approved Standards of Care for Medical Case Management.

Continuing Education Trainings Summary: FY 2007-2008 saw the first ever full implementation of Connecticut's Continuing Education Training Workshops. The Continuing

Education (CE) Workshops are geared towards those providers who currently hold Certificates of Training from the State of CT or who are contractually required to participate in CE workshops: Topics include Motivational Interviewing, Understanding Labs, Prevention for Positives, and Skill Enhancement for HIV Counselors, and strategies to recruit and move people into care, such as the Use of Social Networks: A recruitment strategy for Counseling, Testing, and Referral Services and the Strategies for Connecting People to Care: Addressing Unmet Need in HIV.

In August 2008, the DPH Training Coordinator implemented the 2009 Capacity Building Training Needs Assessment to identify the training and workshop needs of HIV Care and Prevention Providers. At this time over one hundred and five (105) providers have completed the assessment. Following are the Top Ten Training Workshops identified for the upcoming 2009 Continuing Education (CE) Year:

1. Skill Enhancement for HIV Medical Case Management
2. HIV Prevention Counseling (CDC 6 Steps)
3. Harm Reduction Strategies
4. HIV/Hepatitis C Co-infection
5. Medication Adherence & Medical Interpretation: In HIV Service Setting
6. Strategies for Connecting People to Care & Accessing Local and State HIV resources (housing, entitlements, DSS, and DMHAS)
7. Motivational Interviewing Skills Tied with HIV/Domestic Violence
8. Overdose Prevention Tied with HIV/Sexual Assault
9. Skill Enhancement for HIV Prevention Counselors & Prevention for Positives
10. Opportunistic Infections

In 2009, DPH will implement a more integrated training program for prevention and care staff employed at CDC and Part A -D funded agencies. These trainings will enable more Ryan White care providers to access training in prevention. DPH will also work with the New England AIDS Training Center based out of Yale and the Sylvie Ratelle STD/HIV Prevention Training Center out of Massachusetts to co-sponsor and promote training opportunities for health care providers that will strengthen their ability to incorporate HIV prevention into their practices.

G. Assessment of Service Gaps

Connecticut compiles a Service Matrix that includes Prevention and Care Ryan White Parts A, B, C, D, and F and State-funded Care and Prevention Programs.[12] (See appendix) This matrix provides a comprehensive picture of funded services in the state of Connecticut, which is used by the Data and Assessment Committee to determine where funds are distributed and what services are provided across the state. The DAC then examines the most current epidemiological data to assess where services are in relation to the HIV population. This information is then compared to the needs assessment data which involve the out-of-care population, unmet need, and identification of priorities to address the underserved.

[12] *RFP #901 Funding Cycle Memorandum of Agreement (MOA) 7/1/08-12/31/11 and ** RFP #902 Funding Cycle*** 7/1/08-6/30/11

Out-of-care Population

- Windham, Litchfield and New London Counties: Of the 227 surveys received by the CHPC for the W, L and NL counties, 4 out-of-care individuals were identified. The number was too low to allow for proper assessment.
- Greater Hartford identified 28 out-of-care individuals over 30 years of age. Services most needed by the out-of-care population include CADAP 14%. Services needed but not used in the last 12 months were Medical Care for HIV 57%, Dental Care 50%, Medical Case Management 39% and AIDS medication assistance 29%.
- Barriers to services for out-of-care respondents in Greater Hartford: For Emergency Financial Assistance respondents identified lack of knowledge of where to go to get the service. For accessing help to pay rent the barriers were not knowing the service was available, fear that others would find out about HIV status, and homelessness.
- New Haven/Fairfield TGA reported on 204 out-of-care individuals in 2007, ranking the identified service needs in order of priority. Of the 20 services listed, that were ranked 1-9 the following services in the highest ranking (1-5) are 1) housing, 2) medical care for HIV, 3) other primary medical care, 4) AIDS medication assistance (not CADAP), 4) Substance abuse treatment, 4) dental care, 4) transportation, and 5) mental health treatment. The highest ranking two barriers in New Haven-Fairfield TGA were lack of transportation and lack of housing. Reasons for not seeking care were worry over others finding out, fear of telling someone else, feeling healthy, other basic needs not met/health/job.

The SCSN 2007 update data on the out-of-care population supports the following methods to help individuals seek care/see a doctor: help with transportation followed by case management, and help finding an MD. It is interesting to note that almost one third of this group who answered no, stated that nothing would help them to seek treatment.

- Among those not wanting to see a doctor, almost 1/2 stated that they felt healthy or were recently diagnosed, and about 1/3 mentioned that they distrusted doctors.
- Among the respondents wanting to see a doctor, but not doing so, substance abuse; lack of insurance, lack of a stable home, and depression or mental illness were most given as answers to the question "What is preventing you from seeing a doctor?"

Unmet Need

Connecticut's 2008 unmet need estimate 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 eHARS data registry, although some continue to be reported on paper and are manually entered. 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 term "unmet need" is used only to describe the unmet need for HIV-related primary health care, and is not considered a service gap." Viral load is only one component of the measure. However, DPH estimates the unmet need largely using viral loads since the percentage of people on drug therapy getting CD4 counts and not a VL is small. Connecticut requires reporting of a CD4 result only if it is diagnostic of AIDS (<200 count or <14%). The available CD4 data is included in the estimate.

Unmet Need Estimate. The Unmet Need table below shows the current model for estimated unmet need for primary care services in the state of Connecticut. The total percent of HIV+/aware not receiving the specified HIV primary medical care (quantified estimate of unmet need) is thirty-eight percent (38%).

Unmet Need Framework Table

Population Sizes		Value		Data Source(s)
Row A.	Number of persons living with AIDS (PLWA), as of date December 31, 2007	7,453		eHARS
Row B.	Number of persons living with HIV (PLWH)/non-AIDS/aware, as of date December 31, 2007	3,278		eHARS
Row C.	Total number of HIV+/aware as of date December 31, 2007	10,731		eHARS
Care Patterns		**Value**		**Data Source(s)**
Row D.	Number of PLWA who received the specified HIV primary medical care during 2007	4,770		eHARS VL and CD4 data
Row E.	Number of PLWH/non-AIDS/aware who received the specified HIV primary medical care during 2007	1,901		eHARS VL and CD4 data
Row F.	Total number of HIV+/aware who received the specified HIV primary medical care during 2007	6,672		eHARS VL and CD4 data
Calculated Results		**Value**	**Percent**	**Calculation**
Row G.	Number of PLWA who did not receive the specified HIV primary medical care	2,683	36%	Value = A - D. Percent = G/A
Row H.	Number of PLWH/non-AIDS/aware who did not receive the specified HIV primary medical care	1,377	42%	Value: B - E. Percent: H/B
Row I.	Total HIV+/aware not receiving the specified HIV primary medical care (quantified estimate of unmet need)	4,060	38%	Value: G + H. Percent: I/C

In Care Population of PLWH/A based on Viral Load Reporting
Source: CT DPH Surveillance 2007

Based on VL reporting	PLWAIDS In care 64%	PLWHIV In care 58%	Total In care 62%
Male	62%	57%	61%
Female	67%	58%	65%
	63%	58%	62%
	65%	55%	63%
Hispanic	63%	60%	62%
Other	59%	55%	57%
IDU	65%	57%	63%
MSM	63%	60%	62%
MSM/IDU	64%	60%	63%
Hetero	63%	60%	62%
Pedi	71%	59%	66%
Other unknown	62%	53%	58%
0-12	80%	60%	65%
13-19	72%	73%	72%
20-29	64%	51%	55%
30-39	64%	55%	60%
40-39	64%	58%	63%
50+	64%	61%	63%
Hartford TGA	66%	57%	63%
New Haven/Fairfield TGA	64%	59%	62%
Non-TGA areas	59%	51%	57%

Priorities to ensure underserved populations are accessing care

Reaching underserved populations and assisting them to access care continues to be a challenge in Connecticut. According to our unmet need estimate from viral load reporting, 62% are in care and 38% are out-of-care. Based on the needs assessments, data indicates that the issues confronting both in care and out-of-care populations are similar. The one striking difference for those who may be in need of services but are not accessing them is 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 services (care and prevention) to get people into care and keep them there.

Connecticut identifies populations who are most likely to need prevention services by risk category. In April 2007 populations were prioritized (effective July 1, 2008): HIV-positive were the number one priority, followed by Hispanic IDU, MSM, IDU, IDU, Heterosexual, Hispanic Heterosexual, Hispanic MSM, Heterosexual and MSM. The HIV infection has been increasing in Hispanic populations across Connecticut (e.g. of People Living with HIV, 36% are Hispanic and of PLWH/A 33% are Hispanic). Infections among women of color have also been increasing in recent years, and, as a result CT funds DEBIs targeting African American/ females and Latinas (SISTA and Voices/VOCES). The CHPC continues to discuss the need for prevention services for everyone while acknowledging the need for interventions to target disproportionately impacted populations and to see a significant influx of funding to increase prevention efforts. For both care and prevention, the emphasis is on reducing barriers through education and information dissemination on available services; ensuring that a person's basic needs are met; providing culturally appropriate and sensitive services; assistance with transportation to medical services; and ensuring that costs for medical care are covered. The core medical gaps needing to be addressed are dental and mental health services, and assistance with paying for AIDS services and medications.

SECTION II. WHERE DO WE NEED TO GO, AND HOW WILL WE GET THERE?

A. Process to design ideal continuum of care

1. Assessing our Progress

	Accomplishments from Transition Plan 2007-2008	Status
	Structure	
	▪ Confirm operating structure, bylaws, membership roles and responsibilities, recruitment and retention processes of new planning body ▪ Confirm process to meet all federal requirements for the Human Resources Services Administration and the Centers for Disease Control and Prevention	▪ October 2007 and on-going ▪ October 2007
	Unified Plan & Needs Assessment	
	▪ Develop and write one unified and integrated care and prevention plan ▪ Conduct second statewide needs assessment & develop a Statewide Coordinated Statement of Need (SCSN) ▪ Coordinate focus groups, one-on-one and key informant interviews and surveys to identify care and prevention needs, barriers, and service gaps ▪ Coordinate with Youth Advisory Group (YAG) for needs, gaps, in prevention / care efforts targeting youth at risk ▪ Conduct public forums/ focus groups to assess the impact of Ryan White funding cuts in the TGAs and statewide ▪ Continue to consider emerging needs, the needs of those who are out-of-care or have unmet needs ▪ Continue to monitor the CADAP formulary through the Statewide CADAP Advisory Group, add HIV and other medications as recommended by the group, and maintain the "no-wait list" status ▪ Continue to review prevention outcomes relevant to funded DEBIs and Effective Behavioral Interventions (EBI) being implemented through statewide HIV prevention and care agencies	▪ October 2008 ▪ May 2008 and September 2008 ▪ February – May 2008 ▪ January – May 2008 and on-going ▪ 2008 ▪ Ongoing ▪ Ongoing ▪ Ongoing ▪ Ongoing
	Continued coordination and collaboration	
	▪ Coordinate and collaborate across Ryan White Parts A. C, D and F to assure services aren't duplicated and individuals/ families affected and infected by HIV/AIDS receive quality care and prevention services in a culturally appropriate and accessible environment ▪ Coordinate across all Ryan White Parts in the development of standards of care, performance measures and assessment tool reflecting the medical case management model	▪ Ongoing ▪ March 2008 and on-going
	Training / Information	
	▪ Continue to promote the on-going cross training of prevention and care staff, as well as supervisors and program managers through a series of continuing education workshops and seminars ▪ Implement informational sessions across the state to inform care, prevention and other relevant social service organizations on the integration of care & prevention and promote the work of the CHPC ▪ Develop / present an integration of care & prevention workshop at the 2008 HIV Prevention Leadership Summit	▪ September 2007 and ongoing ▪ December 2007 and ongoing ▪ June 2008

The Connecticut Department of Public Health (DPH) is in its 4th year of a comprehensive planning process to ensure that resources are efficiently used to deliver necessary medical and support services in an ideal care system.[13]

The CHPC convened by the DPH, continues its primary mission to 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. This multi-year 2009 to 2012 statewide Comprehensive Plan for the delivery of HIV/AIDS care and prevention services informs the policy and Part B and prevention funding decisions implemented by DPH, informs and aligns Ryan White Parts A, C, D, F and has a defining feature that align with HRSA and CDC expectations to integrate care and prevention while establishing an improved infrastructure for ascertaining priorities for the allocation of funds. Connecticut now offers the highest level of integrated planning, funding and policy-making that supports a robust continuum of prevention and care services responsive to the needs of persons living with HIV/AIDS.

This fully unified plan highlights the successful integration of prevention and care planning bodies, and sets forth an action plan based on analyzed data that considers identified priority gaps in the statewide continuum of care. The efforts outlined in this plan are a product of collaborative planning meetings and efforts by various representatives of Ryan White Parts, prevention, community and provider agencies, consumers and public participants from across the state with the same dedication to ensuring that a comprehensive continuum of care and prevention exists for residents of Connecticut.

In October 2007, the CHPC met for the first time as an established body. In approximately one year, the new planning body has: approved an operating Charter, developed and implemented a needs assessment, developed and approved a Statewide Coordinated Statement of Need, created and disseminated four HIV Newsletters, developed and approved the Action Plan outlined in this Comprehensive Plan for the delivery of HIV services in Connecticut, and recruited new members.

2. Reassessing Current Practices

The Connecticut HIV Planning Consortium (CHPC)

The DPH addresses disparities and gaps in HIV care, access, prevention and support services through an HIV Planning Consortium that involves Ryan White Part B programs, Prevention programs, State agencies, Ryan White Parts A-D providers, as well as state funded programs and initiatives. The Connecticut HIV Planning Consortium a) advises the State Department of Public Health and each TGA on the provision of effective care and prevention planning and the promotion, development, coordination, and administration of HIV/AIDS health care,

CHPC Members/Participants

- The Greater Hartford and New Haven/Fairfield County Part A TGA Planning Councils
- Regional Ryan White Part B Contractors
- Part C Community Health Centers
- Part D Contractor (CYFAN)
- SPNS Dental Contractor
- People Living with HIV/AIDS reflective of Connecticut's epidemic
- Statewide Organizations: CT AIDS Resource Coalition (CARC), , Project TLC (AIDS Project Hartford)
- Government agencies: Department of Mental Health and Addiction Services (DMHAS), UCONN Correctional Managed Health Care(DOC), Department of Social Services (CADAP
- DPH appointed Co-Chair
- Two elected Community Co-Chairs representing prevention and care

[13] Under the Ryan White CARE Act, the Comprehensive HIV Service Plan provides a common understanding of our current HIV/AIDS epidemic, and a framework to move Connecticut's system of care toward an ideal continuum of care.

prevention and support services; b) develops a statewide comprehensive plan for HIV care and prevention, and c) establishes a collaborative process to identify unmet need and out-of-care individuals, as well as prevention and care service needs and gaps.

RFP Process

The DPH conducts an open bidding process that is open and competitive. The process is also consistent with the state RFP as mandated by Connecticut Public Health Codes.

Applicant proposals and priorities for care and prevention funding are measured against the Statewide Coordinated Statement of Need included in the state's Comprehensive Plan. Agencies are required to establish measurable outcomes, including Ryan White Core Services, Core Group Measures I and II, CDC program indicators, evaluative measures and define service delivery plans that will ensure client accessibility to services, cultural competency, efficiency and effectiveness of services, and avoid duplication of efforts. Collaboration with other partners is strongly recommended for all applicants. Funding is allocated according to criteria established through evidence-based processes, needs assessments, prioritizations, and HIV/AIDS surveillance data.

B. Shared Vision: New Planning Body

CHPC Vision/Mission: A shared vision has emerged as a result of the move to link and integrate care and prevention services. Organizations, systems, and providers throughout the state are recognizing the importance of collaboration to creatively respond to the needs of the target population. The shared vision and expressed mission of the new Connecticut HIV Planning Consortium (CHPC) is to 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.

C. Statewide Coordinated Statement of Need

The SCSN is updated every three years. Data to update the SCSN in FY 2008 includes evaluative studies, the needs assessment, and supplemental information. The existing needs assessments providing care information for the report include the State effort, conducted by the Connecticut HIV Planning Consortium (CHPC) for Windham, New London, and Litchfield counties in 2008; the New Haven /Fairfield TGA Unmet Need needs assessment conducted in 2007; and the Greater Hartford TGA 2008 needs assessment. Prevention information is provided through the 2008 needs assessments from the CHPC covering Windham, New London, Litchfield, New Haven, and Fairfield counties and conducted through a collaborative effort with the Department of Social Services (DSS) and CHPC. Surveys for prevention information were sent through the Connecticut AIDS Drug Assistance Program (CADAP) and implemented through partner agencies in Windham, New London and Litchfield counties, and the Department of Mental Health and Addiction Services. The following are highlights of the SCSN. [For detail, please see the full report in the Appendix.]

For both care and prevention, the emphasis is on reducing barriers and addressing core medical gaps. Reducing identified barriers means a) providing education and information on available services; b) meeting a person's basic needs to help them get into care; c) providing services that are culturally appropriate, d) providing transportation to medical services, e) covering costs for medical care. Core medical gaps needing to be addressed

include dental, mental health and substance abuse services, and assistance paying for AIDS services/medications.

Recommendations were developed to inform the allocation and use of resources for service delivery in the State of Connecticut for PLWH/A and to guide the implementation activities of the Comprehensive Plan. Please see Objectives in Section III. Action Plan.

D. Coordination with other services

The Connecticut HIV Planning Consortium has fully linked Prevention with Care activities. For further information on coordination and integration activities, see p. 23. DPH continues to foster full collaboration across programs to advance the ideal continuum of care.

Areas of collaboration between care & prevention

- Needs Assessment – In care and out of care
- Quality Assurance & Management
- Information/data sharing
- Focus groups and key informant interviews
- Membership
- Gap analysis / prioritization
- Monitoring the epidemic – data collection method development for care and prevention
- Cross training / education and capacity building

E. Shared Values

Shared values are essential to the development of an ideal continuum of care and serve as the fundamental standards upon which a collaborative plan evolves. But, what is that ideal continuum when looking at an entire state, which includes various funding streams and both care and prevention services? The following definition was determined by the committee and approved by the CHPC. The statewide plan for an ideal continuum of care is a totally integrated care and prevention system that is:

- Comprehensive
- Culturally and developmentally appropriate
- Easily accessible and coordinated through multiple points of entry
- High quality and evidence based
- Cost effective
- Actively engaged in providing current and accurate information, services and support, appropriate referral mechanisms, skill building techniques for both clients and providers, decision making involving standards of care, and a coordinated system to assess individuals at various points of entry

SECTION III: THE COMPREHENSIVE PLAN

A. Process to Design Strategies

Strategic planning has been an integral part of the integration of care and prevention process. The Connecticut Care and Prevention Plan for 2004-2007 was the first step toward integrating both care and prevention data and planning into one comprehensive document. In October 2007 the new combined care and prevention planning body was formed: The Connecticut HIV Planning Consortium. A 2007-2008 transition plan was submitted that had specific goals to establish this new body, fulfill the federal requirements of CDC and HRSA, while ensuring a comprehensive continuum of care and prevention services for PLWH/A in Connecticut. The 2007-2008 Plan objectives and strategies are nearly accomplished, this combined Plan being one major part. The following pages outline the goals and objectives to achieve them in the new three year action plan.

B. Goals and Objectives

Plan Goals

- To create an ideal system of care and prevention that creatively responds to the needs of the target population with a focus on getting people into primary care and treatment
- To decrease the number of HIV infections
- To create appropriate links for a comprehensive continuum of care that increases efficiency and avoids duplication of effort
- To maximize resources through efficacy of planning and allocation, flexibility, and effective program fiscal management

Plan Objectives

A. Collaboration

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 would be developed in full cooperation with direct input from all Ryan White Parts and prevention.*

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.*

B. Service Capacity

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.*

4. *Explore methods to address barriers to services.*

C. Public Awareness and Training

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.*

6. *Provide ongoing training to medical case managers (MCMs) on the medical model and clinical practices, and available resources and services within the state.*

C. Action Plan

Year 1 - 2009-2010	*Year 2 – 2010-2011*	*Year 3 - 2011-2012*	*Outcome(s)*
A. Collaboration			
Objective 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 would 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 would be developed in full cooperation with direct input from all Ryan White Parts and prevention.			
▪ Engage all Ryan White Parts and DPH prevention to evaluate data needs and timelines ▪ Develop and pilot a uniform survey that considers data needs and timelines ▪ Engage consumers to assist with the development of survey questions making it time relevant, e.g., end of month, seasonal, winter v. summer ▪ Explore the feasibility of using electronic survey format for doctors and other providers	▪ Establish relationships with partners to assist in implementing a possible web based survey for consumers ▪ Implement surveys and analyze data for SCSN, Ryan White Parts, and prevention ▪ Identify Out-of-care persons who have tested positive but are not in care through VL data ▪ Use optimum method to implement survey	▪ Assess the needs based on new data ▪ Develop SCSN	**Outcomes:** ▪ Collaborative needs assessment process completed with full engagement of all Ryan White Parts and Prevention, consumers, and other community partners ▪ Federal timelines for planning observed ▪ New survey methods employed
Objective 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 would 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.			
▪ DPH, DMHAS, DSS & Yale work together to begin geo-coding maps of services, overlays of service use and epi (Hep C, STDs, poverty level) ▪ Work with DSS to get data on PLWH/A receiving Medicaid and Medicare ▪ Work with DMHAS to get data on PLWH/A and substance use ▪ Service matrix to include all Prevention and Care services and interventions	▪ Develop the service matrix ▪ Share the information developed within the service matrix with planning groups and public, and its possible applications	▪ Assess the effectiveness of the service matrix for planning purposes	**Outcomes:** ▪ Service Matrix model developed with input from all stakeholders ▪ RFP processes reflect the Service Matrix

Year 1 - 2009-2010	Year 2 – 2010-2011	Year 3 - 2011-2012	Outcome(s)
2. Service Capacity			
Objective 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.			
▪ PEMS training complete and converted by June 30, 2009 ▪ Identify current practitioners and other HIV providers e.g., MCM, involved in HIV specialty care ▪ Engage doctors and other providers to pilot an electronic survey format ▪ Assess the needs of formerly incarcerated HIV+ individuals who are returning to the community. ▪ Work with AIDS Life Campaign to conduct focus groups with formerly incarcerated individuals on HIV issues in the correctional system	▪ CAREWare data reviewed and assessed ▪ PEMS data reviewed and assessed ▪ Conduct a survey of HIV/AIDS providers to capture emerging populations, needs, trends and other service matrix issues ▪ Share the findings to inform DOC, DPH, and DSS on issues within the correctional system	▪ Assess progress of and quality of information from CAREWare and PEMS implementation ▪ Assess impact of provider survey to identify new information on emerging needs, needs and trends	**Outcomes**: ▪ Client level data is retrievable and de-duplicated through both CAREWare and PEMS ▪ Provider survey conducted and data assessed ▪ Connecticut has the most accurate picture of HIV/AIDS for Care and Prevention
Objective 4. Explore methods to address barriers to services.			
▪ Convene focus groups to assess barriers to care and prevention services in rural and/or non urban areas ▪ Identify and assess issues related to access ▪ Explore the feasibility of raising client eligibility for Ryan White A and B funding to 400% federal poverty level to ensure client access to Ryan White funded services ▪ Identify models of one stop shopping and the feasibility of co-location of services in the continuum of care	▪ Work with state agencies to explore options in order to enhance access to services ▪ Look at eligibility guidelines across Ryan White Parts ▪ Work with DPH to research numbers of persons who fall in the 400% category, and if resources can support this	▪ Determine feasibility of implementing options ▪ Align eligibility guidelines across Ryan White Parts to coincide with CAREWare implementation	**Outcome:** ▪ New methods are identified to address barriers to care and prevention services.

Year 1 - 2009-2010	*Year 2 – 2010-2011*	*Year 3 - 2011-2012*	*Outcome(s)*
3. Public Awareness Information and Training			
Objective 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.			
▪ With DPH and all Ryan White Parts develop a set of information on legislative changes to inform medical providers on routine testing and informed consent (within legal parameters) ▪ With DPH and all Ryan White Parts provide information on the care and prevention services available across the state ▪ Conduct social marketing campaigns on routine testing toward specific populations ▪ Work with New England AIDS Training Center to train providers on routine testing within legal parameters	▪ Use creative methods to inform providers (including internists and ob-gyn) on services and legislative changes, e.g., recent updates both electronically (flash drives) /hard copy ▪ Work with DPH and all Ryan White Parts to continue social marketing and updates on training and services	▪ Explore funding options for implementation of provider updates	**Outcome:** ▪ Medical practitioners are effectively informed and trained about HIV care and prevention services and applicable state services.
Objective 6. Provide ongoing training to medical case managers (MCMs) on the medical model and clinical practices, and available resources and services within the state.			
▪ Continue to work with DPH and all Ryan White Parts to train MCMs ▪ Bring MCM issues to CHPC for incorpration within data reports ▪ Cultural Competency training for all new HIV care and prevention providers within the first six months of training. ▪ Explore creative ways to inform and educate MCMs on an ongoing basis of available resources, services, and relevant issues (access to services for the target population, culturally appropriate informational materials, review client satisfaction survey data, and the availability of staff that are bi-cultural and bi-lingual on site to meet the needs of the target population)	▪ Continue to align medical case management core standards across Ryan White Parts ▪ Partner with "Train Connecticut" to explore use of web based training sessions ▪ Use creative methods to inform MCMs on services and legislative changes, e.g., recent updates both electronically (flash drives) /hard copy ▪ Coordinate training opportunities for all AIDS service providers and training bodies	▪ Continue to monitor legislative changes that may impact services and resources	**Outcome:** ▪ MCMs in Connecticut will receive ongoing training on the medical model and clinical practices, and available resources and services with the state.

SECTION IV: MONITORING AND EVALUATION

A. Assessing Connecticut's Progress

The DPH has instituted various new monitoring and evaluation programs and methods that will provide a more comprehensive picture of changes in the epidemic, care and prevention service needs, provider capacity, resources and legislative issues, including regulatory and treatment guidelines. These include the epidemiological profile, out-of-care surveys, needs assessment surveys, Part A Planning Council reports, contractor site visits, quality assurance audits, and contractor quarterly reports. Client satisfaction surveys will also be implemented to assess client perception of access to needed services and quality of care. Grantee and/or lead agency systems will be monitored through the data collection systems (CPEMS and CAREWare), quarterly reports, and site visits. Evaluation of program effectiveness and quality of care will be accomplished through quality assurance audits, client satisfaction surveys and data.

The new planning body will 1) serve as a forum for information dissemination and exchange, 2) advise the DPH on the provision of effective health care planning and the promotion, development, coordination, and administration of HIV/AIDS health care, prevention and support services, 3) develop an integrated care and prevention comprehensive plan, 4) establish a collaborative process to identify out-of-care populations and disproportionately affected populations to connect them with care, and 5) adjust its focus in response to needs of statewide members, evidence-based interventions and data (e.g., HIV trends), and policy issues. The CHPC will conduct self-evaluation according to its new by-laws.

1. Reviewing our plan: This Comprehensive Statewide Plan will be revised on a periodic basis per outcomes identified in the action plan, when new information is available, and when incidents occurring in the external environment cause elements of the plan to shift. All significant changes will be communicated to the public, providers, consumers, HRSA and CDC. As articulated throughout the plan, the DPH has effectively set in motion a method to evaluate and assess current and proposed programs, while retaining flexibility to address potential changes in provider capacity or funding environment. For example, readjusting the RFP process to ensure prevention services are in place across the state and ensuring that reduced funds for Ryan White Part B are allocated fairly and according to the identified needs. Plan will be reviewed through formative and summative process methods. The overall plan will be monitored by the DPH in consultation with the CHPC as outlined in the Action Plan, which specifies outcomes and indicators to be tracked to ensure that each objective outlined in the plan is effectively carried out. The following are the current and proposed activities that will be reviewed to assess the CHPC effectiveness in meeting the goals.

- Client level data through CAREWare and PEMS
- Emerging Trends data
- Electronic Surveys – ongoing data collection

2. Quality and Cost Effectiveness

CARE: The DPH is committed to assuring that the results of linking prevention and care will improve client-level, community-level, and state-level HIV prevention and care outcomes. Connecticut's Quality Management (QM) findings are used to provide a comprehensive mechanism to assess the degree to which Ryan White Part B funded programs meet their obligations ensuring that care is delivered effectively, in a time and cost efficient manner,

and is appropriate to the needs of the individual and the prevailing standards of care. It is the vision of the DPH that all PLWH/A will maintain or improve linkages to an array of comprehensive health care and prevention services that will foster self-efficacy, reduce risk behaviors, and promote optimal health outcomes. While the data for indicators of the quality of care and supportive services is collected at the client level, it is generally aggregated to make assessments at the provider, agency and program level. Connecticut uses its quality indicators and outcomes data in a variety of ways, for example, in the contract bidding process, quality data is considered in funding decisions as well as in prioritization of services. Gap analysis uses standardized client-level data and is compared with needs assessment data to help distinguish between consumers' perceived care needs and what services are actually utilized, thus informing funding decisions.

As a result of shifting to Medical Case Management model, DPH, going forward will increasingly emphasize Care Coordination, ensuring that Medical Case Managers act as a pivot point to help all providers involved in a patient's care (e.g. physicians, advocates, nutritionists, pharmacists, and counselors) and are all aware of what each is doing for the client. Care coordination can improve a client's health status and result in a more effective and efficient care delivery system.

Ryan White Part B funded-contractors are required to adhere to a minimum of administrative policies, procedures and standards of practice and care to assure that PLWH/A receive appropriate, accessible and timely core medical, medical case management, psychosocial and supportive services and referrals. Both Ryan White Part A TGAs and Part B use these minimum standards. Medical Case Management Standards of Care and Outcome Measures are also posted on the DPH website and are reviewed for updating by HCSS staff at quality management meetings.

During the fourth quarter (April – June 2008), the Medical Case Management Record was revised to reflect the new core Medical Case Management Standards adopted in March 2008. These revisions included the design of a new comprehensive Client Assessment Form that provides for improved screening and documentation of the client's physical health, emotional health, activities of daily living, HIV medication adherence, risk reduction needs, substance abuse, partner notification and referrals for services. The Client Care Plan has also been divided into two sections: 1) the Core Medical Plan to be updated every three months, and 2) the Support Service Plan to be updated every six months. The revised Client Record was rolled-out in August 2008 and a survey will be conducted in 2009 with Medical Case Managers to assess the forms and make revisions as necessary.

As a result of the 2005 HRSA/Mosaica site visit, DPH increased its vigilance to collect HIV Viral Load (VL) and CD4 tests from funded contractors. In 2006, all HIV viral load test results were made reportable by laboratories that conduct the tests. This step was taken to improve the completeness of reporting of HIV and AIDS cases, allow monitoring of entry of newly diagnosed people into care, monitor consistency and effectiveness of care, and characterize those groups who may delay entry into care. DPH funded Care Contractors are required to collect HIV VL and CD4 counts at a minimum of every six months and enter the results in the URS. This data establishes a baseline to measure not only contractor compliance with this requirement, but also assist with identifying the number of clients who are engaged in care. To further increase the capacity to collect these important biological markers, the Department of Social Services, that administers the CADAP application process, has also been directed to collect VL and CD4 test results.

Desired outcomes and indicators for the new *prevention and care* paradigm will be developed by a collaborative effort between the CHPC and DPH. The intent is still to include monitoring methods and time frames in the quality assurance plan. Prevention interventions will also include components of a *continuous quality improvement* model to support the success of the plan:

- Contract monitoring methods, e.g., joint site visits to be conducted for providers of both prevention and care
- Review /revise quality assurance standards to fit the model
- Assessment and implementation of training/education for providers and consumers, e.g., cross-training and continuing education
- Collection of data elements including Ryan White Core 1 and 2 Group Measures and prevention C-PEMS data.
- Evaluation and analysis of CAREWare data

As the integrated plan is implemented, provisions for evaluation of cost effectiveness and efficiencies will be developed and implemented on several levels. The evaluation process will be continually reviewed and refined. Because care and prevention are funded through different sources, efficacy studies will at best, be assessed through: 1) qualitative evaluation, that is, reviewed through client satisfaction surveys, 2) quantitative analysis involving contract monitoring (to ensure that new requirements for collaboration are being met), 3) and by enumerating the number of agencies submitting proposals that incorporate streamlined services through collaborative planning. The cost effectiveness of the plan will be evaluated by comparing the current cost of providing the services to the new proposed services.

Prevention

To ensure the quality of HIV prevention programs, a DPH staff member is assigned to each contractor to provide administrative oversight of their contract, which includes 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 or conducting process monitoring to ensure that they are being implemented with fidelity. Reports are written based on monitoring that includes observations and recommendations.

Prevention Unit staff conduct semi-annual site visits, one of which is in conjunction with a Health Care & Support Services staff, in order to monitor the progress of funded programs. Monitoring tools have been developed for each funded Effective Behavioral Intervention (EBI), Counseling, Testing and Referral (CTR), Comprehensive Risk Counseling Services (CRCS) and Drug Treatment Advocate (DTA) program to be used during visits to ensure the quality of programs provided by contractors.

In the 2007 Interim Progress Report to CDC, the HIV Prevention Unit identified three specific actions for 2008 to strengthen the capacity of grantees/contractors to deliver interventions that are appropriate, understandable, and acceptable for the target population served. DPH staff will ensure that all contractor staff conducting interventions from the Diffusion of Effective Behavioral Interventions (DEBI) Project receive training either locally or out of state.

The Prevention Unit will continue to offer the HIV prevention counselor and the HIV/AIDS educator certificate trainings for contractor staff. The trainings will ensure that HIV counselors and educators are familiar with CDC and state guidelines and protocols for conducting HIV prevention counseling and HIV prevention education and are prepared to provide these services in the community. DPH will monitor the progress by keeping track of those trained and determining that all new HIV prevention counselors and HIV/AIDS educators who are funded to conduct these interventions will have demonstrated the required skills to receive a certificate of training in the respective program. This includes ensuring that funded counselors and educators complete the necessary continuing education courses annually as required.

HIV Prevention staff will continue to provide technical assistance to all contractors on the interventions they are conducting and will request capacity building assistance through CDC's Capacity Request Information System (CRIS) as requested and as appropriate. DPH staff will document problems that contractors are having in implementing interventions and will document the request for capacity building made through the CRIS system. The outcome will be that DPH contractors will be more equipped to effectively implement and adapt their interventions to the target populations with whom they are working.

All prevention contractors are required to submit quarterly program reports as well as monthly reports and extracts through the Uniform Reporting System (URS). Over the next year, prevention contractors will be migrating over to the Program Evaluation and Monitoring System (PEMS), to collect and report data to DPH and CDC.

Table 10. Current and Future Outcomes and Indicators for the New Prevention and Care Paradigm

Outcomes	Indicators
Client Level	
Expedient referrals to prevention/care services (e.g. Comprehensive risk and counseling services, medical case management, core medical services, support services)	▪ All clients who need referrals for health care, prevention and support services complete referral process ▪ Clients are enrolled, retained in primary care, support services, prevention and other entitlements ▪ Clients' nutritional status is improved for weight gain and health maintenance, and improved HIV medication adherence ▪ Clients receive comprehensive risk counseling services and develop plan to change high risk behaviors ▪ Eligible clients receive appropriate levels of psychological/psychiatric treatment and counseling including, provided by Connecticut licensed mental health professionals
Services are culturally competent	▪ Number of staff knowledgeable about target population: health beliefs, culture, level of communication skills, literacy, etc. ▪ Number of staff who can communicate with client's in native language ▪ Staff receive annual mandatory training in cultural competence and diversity training
Clients referred for care, remain in care	▪ Number of clients who remain in care over time ▪ All clients who need referrals for health care, prevention and support services complete referral process ▪ Eligible clients with access to oral health services and treatment rendered by licensed dental professionals at a minimum of two times yearly ▪ Assure access for Ryan White eligible clients to formulary pharmaceuticals through CADAP ▪ Adequate transportation services available for clients to access primary medical care appointments and other supportive services to maintain in-care status in system of care ▪ Assist eligible clients with emergency needs to sustain health outcomes and maintain in-care status
Increased quality	▪ Measuring client satisfaction ▪ Clients enrolled, retained in primary care, support services, prevention and other entitlements ▪ Improvement to client biological markers (Viral Load, CD4) and improved health outcomes (e.g. weight gain, health maintenance, improved medication adherence) ▪ Clients receive food and/or nutritional supplements to maintain/increase weight to prevent wasting, counteract medication side effects and maintain medication adherence. ▪ Clients receive housing related services to enable them to obtain or maintain medical care through provision of stable housing environment ▪ Eligible clients receive assistance with health insurance continuation to maintain health outcomes and maintenance ▪ Client level data collected for the HAB Core 1 Group Measures for CD4/Viral Load; HAART; Medical Visits; PCP Prophylaxis; ARV therapy for pregnant women. ▪ Client-level data collected for the four of the nine HAB Core 2 Group Measures for Adherence Assessment and Counseling; Hepatitis B Vaccination; Hepatitis C Screening; TB Screening; HIV Risk Counseling; Oral Exams

Table 10. Current and Future Outcomes and Indicators for the New Prevention and Care Paradigm

Outcomes	Indicators
Community Level	
Decreased number of HIV infections by x%	▪ Number of HIV infections reported to DPH
Decreased number of AIDS cases by x%	▪ Number of AIDS cases reported to DPH
Decreased number of sexually transmitted diseases (e.g. Chlamydia, syphilis, gonorrhea) by x%	▪ Number of STD cases reported to DPH
Increased newly identified HIV + cases reported by CRT	▪ Number of HIV infections reported via CRT sites
Increased referrals and enrollment in CADAP	▪ Number of eligible clients enrolled in CADAP
Increased number of HIV tests for persons contacted after PCRS notification	▪ Number of persons receiving an HIV test after contact
Increased proportion of persons completing HERR sessions	▪ Number of persons completing the sessions for EBIs, DEBIs, CRCS
Increased number of HIV+ inmates who receive outreach, education and referral to health care , prevention, and entitlements both pre and post release	▪ Number Of HIV+ inmates who do not return to prison and /or relapse and are enrolled in CADAP
Increased accessible prevention /care services (Possible co-location of services)	▪ Number of clients who access services within a geographic area
Increased the number of clients who access prevention/care services	▪ Number of clients who are aware of and access services compared to estimated number of persons at risk for HIV and not in care and are not aware of services
State Level	
Increased cost effectiveness	▪ Cost of providing proposed services compared to current cost ▪ Proposals reflecting collaborative planning ▪ Review of data to avoid duplication of services ▪ Assure an up-to-date CADAP formulary that responds to community needs ▪ Improve quality assurance and quality management programs to assess compliance with standards of care and contractual agreements
Increased efficiency	▪ Staff ratio needed to provide proposed services compared to current staff ratio ▪ Number of completed prevention/care referrals ▪ Current client-level data collection systems now CAREWare and CPEMS ▪ Required medical case manager and prevention educator trainings regarding prevention and care relevant topics ▪ Care and Prevention Unit staff training, and educational updating and development

C. Anticipated revisions

The Plan is fashioned to hold a steady course, yet to be flexible enough to accommodate changes in data and in external circumstances. It is anticipated that revisions will be made to implementation activities and strategies as the planning years unfold, and will take into consideration federal changes in guidance (CDC is revising their guidance this year and HRSA is continuing to modify guidance in accordance with the revised core standards), and reauthorization due in 2009. The Comprehensive Plan will be assessed and revised on a periodic basis when new information is available, or when incidents occur in the external environment cause elements of the plan to shift. All significant changes will be responsibly communicated to the public, CDC and to HRSA.

APPENDIX I.

CHPC Member Diversity Grid as of October 1, 2008

Data-Driven Portion Based on CDC Guidance and Epidemiologic Profile

CATEGORIES	CURRENT MEMBERSHIP	GOAL[14]	MEMBERS NEEDED	% SHORT OF GOAL
Total	**30**	**40[15]**	**10**	**25**
PRIORITY POPULATIONS[16]				
HIV+	8	20[17]	**12**	60
MSM	4	9	5	56
IDU	4	17	**13**	**76**
Heterosexual	22	14	--	--
GENDER				
Female	19	14	--	--
Male	11	26	**15**	58
RACE / ETHNICITY[18]				
[19]	11	13	2	15
Hispanic or Latino	4	13	9	**69**
	16	14	--	--
AGE				
<29[20]	1	3	2	67
30-39	5	6	1	17
40-49	8	16	8	50
50+	**16**	14	--	--
A. COUNTY[21 22]				
Fairfield	6	11	5	45
Hartford	15	12	--	--
Litchfield	1	1	--	--
Middlesex	0	1	1	**100**
New Haven	5	12	7	58
New London	1	2	1	50
Tolland	1	0	--	**--**
Windham	1	1	--	--
Department of Corrections[23]	5	5	--	--

[14] Goals are based on the CT Department of Public Health Epidemiological Profile – data on people living with HIV or AIDS
[15] The target range is 35 to 42 members with a loose goal of 40
[16] Categories are not mutually exclusive, so total may be larger than # of members.
[17] The goal for HIV+ members was set at 50% based on general agreement during planning for the creation of the CHPC
[18] Categories are not mutually exclusive, so total may be larger than # of members.
[19] includes African-American, African, Caribbean-American, West Indian, Haitian, etc.
[20] The CPG Youth Advisory Group, which represents people age 24 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.
[21] Categories are not mutually exclusive, so total may be larger than # of members.
[22] Members who work in one region and live in another region are categorized according to their work region
[23] The Department of Corrections is represented by former inmates.

APPENDIX 2.

Prevention Interventions

DPH Prevention Programs: Through both CDC and state allocations, the DPH Prevention unit funds agencies to provide a cadre of prevention initiatives and interventions, with a specific focus on effective behavioral interventions, targeting Connecticut's prioritized populations. With state-designated dollars, Connecticut funds syringe exchange programs (SEP), drug treatment advocacy programs (DTA), perinatal HIV transmission programs, as well as such effective behavioral interventions as Spiritual Self Schema, Latinas en Accion, Risk Avoidance Partnership and Peer/Non-Peer Outreach for MSM. In total Connecticut funds fourteen (14) DEBIs and EBIs through its network of provider, see figure below.

- Healthy Relationships: a group-level intervention based on social cognitive theory; consists of five (5) group sessions for PLWH/A to build risk reduction and disclosure skills
- Information and Enhanced AIDS Education (Project Smart) is a 7-session intervention targeting the drug- and sex-related risk behaviors of in-treatment drug users. It consists of 6 group sessions, focusing on AIDS prevention education and skill-building, and 1 individual consultation with a health educator.
- Latinas en Accion (The Effects of HIV/AIDS Intervention Groups for High Risk Women): Risk reduction behavior change intervention targeting high-risk Latinas through five group sessions focusing on risk education, skills training in condom use, sexual assertiveness, problem solving, risk trigger self-management, and peer support for change efforts.
- Intensive AIDS Education in Jail/Rikers Health Advocacy Program: Intervention is based on a problem-solving therapy model; consists of four 60-minute sessions focusing on health education issues relevant to male adolescent drug users, with emphasis on HIV/AIDS; Sessions used interactive methods and a small group; topics included general health knowledge, HIV and AIDS knowledge, factors associated with initiation and continuance of drug abuse, types of sexual behavior and HIV risk, the relationship of drug use and sexual behavior, and strategies to access services and drug abuse treatment in the community.
- MPowerment: a community-level intervention for young men who have sex with men that uses a combination of formal and informal outreach, discussion groups, creation of safe spaces, social opportunities, and social marketing o reach a broad range of young gay men with HIV prevention, safer sex, and risk reduction messages
- RESPECT: an individual-level intervention that utilizes a client-focused and interactive HIV risk-counseling model; designed to support risk reduction by increasing perception of risk and emphasizing incremental risk reduction strategies; can be implemented with any population at risk but originally tested with heterosexuals, ages 14 and older accessing STD services (Being funded for the first time in 2009)
- Risk Avoidance Partnership (RAP): RAP is designed to train active drug user as Peer Health Advocates (PHAs) to disseminate HIV prevention intervention through drug networks to high risk drug-use sites.
- Safety Counts: an intervention targeting active injection and non-injection drug users to reduce risk for HIV and Viral Hepatitis; a seven(7) session intervention conducted over a four-month period that includes group and individual sessions; uses the Stages of Change Theory to help participants identify risk reduction goals

and steps; intervention strongly encourages HIV testing as a precursor to program enrollment; clients can be recruited from testing programs and sessions include a discussion of the importance of HIV testing to the client

- SISTA: a group-level, gender- and culturally-specific intervention, designed to increase condom use with African-American women; five (5) peer-led group session conducted focusing on ethnic and gender pride; provides HIV knowledge and skills training around sexual risk reduction behaviors and decision making; based on Social Learning Theory as well as the theory of Gender and Power
- Spiritual Self-Schema (3-S): In 3-S Therapy, a Buddhist framework facilitates the convergence of spirituality and contemporary cognitive psychology and is particularly appropriate in the development of a manual-guided intervention for individuals in treatment for addiction.
- Street Smart: a multi-session, skill-building program designed to help runaway and homeless youth practice safer sexual behaviors and reduce substance use; sessions address improving youth's social skills, assertiveness and coping through exercises on problem solving, identifying triggers and reducing harmful behaviors; includes individual counseling and trips to community health providers
- Together Learning Choices (TLC): a group-level intervention based on cognitive-behavioral strategies to change the behavior of young people living with HIV; program helps young people identify ways to improve the quality of their lives by setting new habits and daily social routines; goals are set regarding health, sexual relationships, drug use and daily peace; based on social Action Theory (Being funded for the first time in 2009)
- Voices/Voces: a single-session video-based intervention designed to increase condom use among heterosexual African-American and Latino/a men and women who visit STD clinics; participants are grouped by gender and ethnicity, view English or Spanish video on HIV risk behaviors and condom use and take part in a facilitated discussion.

Public Information Programs: Most of the public information campaigns are funded with state money. The following are examples of what will be accomplished in 2009.

- Expansion of the 'Tell Me What You See' (TMWYS) health education program for grades 9-12 into entire school systems in both New London and Stamford, CT targeting at risk young adults.
- Development of the 'Tell Me what You See' (TMWYS) supplemental curriculum for children in grades 4 – 8. The art based design of this innovative program featuring age appropriate lessons and classroom activities on HIV/hepatitis/STDs will be modeled on the common elements of pre and post student assessment and the art based, participatory classroom activities found in the grades 9 – 12 version noted above. A pilot version will be ready for the classroom by spring 2010.
- Development of a new artwork for use in TMWYS health education program with group of 14 - 18 juvenile offenders incarcerated at the Manson Youth and York Correctional Facilities. Mural artwork depicting real life situations and highlighting the benefits of informed decision making on HIV/hepatitis/STDs will be produced and integrated into existing supplemental curricula materials.
- A creative art program for the American School for the Deaf (ASD) will enable deaf students to produce targeted HIV/hepatitis/STD materials for use in the TMWYS supplemental health education curriculum. TMWYS pilot program evaluation, site visits, teacher and administration feedback have indicated a strong desire and need

for developing deaf and hard of hearing specific artwork to better connect curricula lessons to students. This program is designed to help prevent an increase of HIV/hepatitis/STDs in deaf at risk young adults as well as the broader deaf and hard of hearing community.

- A community mural painting and related educational materials project will focus on the dangers of IV drug use and the growing health crisis of HIV/hepatitis co-infection for use in community health centers, community based organizations, and on needle exchange vans. This program will target the large and cross-cultural intravenous drug using population in CT.

Other Collaborating Connecticut State Agencies and Programs

During 2009, DPH will collaborate with various agencies, institutions and health department units to deliver HIV prevention services to high risk populations. The following is a list of those efforts:

- Memorandum of agreement with the University of Connecticut Correctional Managed Care Program and the Department of Corrections to provide HIV Prevention Counseling and Testing in all correctional facilities in the state.
- HIV prevention unit staff members serve on the Department of Education's Coordinated (SDE) Health Education Cadre. This cadre provides training for school personnel and health educators on issues related to HIV and STDs.
- With the Hepatitis C Program, DPH helps to provide Hepatitis C screening to clients that have a history of intravenous drug use. This screening is currently at 14 HIV Counseling and testing sites and at STD clinics funded by DPH and drug treatment centers funded by the Department of Mental Health and Addiction Services (DMHAS).
- Continuation of HIV counseling and testing in DMHAS drug treatment centers throughout the state. DPH provides the resources, including rapid test kits, free laboratory services, and training to be able to continue to offer these services.
- In 2009 DPH will continue to collaborate with the STD and TB control units of DPH to offer routine HIV testing in nine STD clinics in the state and HIV testing in the TB clinics and in the field.
- The prevention unit continues to work within the department with Health Care and Support Services Unit to integrate prevention and care training and promote cross referrals and collaboration between our funded programs on a local level.
- Collaboration continues with clinical settings such as Community Health Centers and Hospital Emergency Departments to implement routine HIV testing in their practices.

Term	Care or Prevention	Definition
Accountability	Prevention	A framework for how a group and its members will be responsive and responsible to itself and the community as it carries out its mission.
AIDS Drug Assistance Program (ADAP)	Care	Administered by states and authorized under Title II of the CARE 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)	Care	An organization that provides primary medical care and/or support services to populations infected with and affected by HIV disease.
Behavioral Interventions	Prevention	Programs to change individual behaviors without an explicit or direct attempt to change the norms of the community or target population.
		See also: Intervention, Community-level Interventions, DEBIs, EBIs, Group-level Interventions
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 titles and Part F of the Act.
		Title I: HIV Emergency Relief Grant Program for Eligible Metropolitan Areas. Provides formula and supplementary grants to EMAs that are disproportionately affected by the HIV epidemic.
		Title II: 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.
		Title III: 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.
		Title IV: 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.
		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.

Note: The Ryan White Modernization Act was enacted in December 2006 and replaced the CARE Act.

		Service categories for all CARE Act Titles: 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.
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).
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)	Care	An organization that provides services to locally defined populations.
	Prevention	An organization offering services to a specific group of people in a defined area.
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.
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.
		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)	Prevention	The official HIV prevention planning body that follows the 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 Prevention Plan	Prevention	An overview of all HIV prevention programs and activities occurring in the jurisdiction.

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	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	Care	A regional or statewide planning entity established under Title II of the CARE Act (now Part B of the Modernization Act), to plan and sometimes administer Title II (Part B) services. An association of health care and support service agencies serving PLWH/A under Title II (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
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 and Testing	Prevention	The voluntary proves 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.
Counseling, Testing, Referral, and Partner Notification (CTRPN)	Prevention	Voluntary HIV/AIDS counseling and testing, referral to appropriate medical and social services, and anonymous or confidential notification of sex and needle-sharing partners by health department staff.
Cultural Competence	Care	The knowledge, understanding and skills to work effectively with individuals from differing cultural backgrounds.
	Prevention	
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 12 interventions listed by their primary population or risk group, which can target multiple populations and risk groups and are packaged in user-friendly kits. The interventions are:
		Community PROMISE (Community Level Intervention)
		Healthy Relationships (HIV+)
		Holistic Health Recovery Program (HIV+ IDU)
		Many Men, Many Voices (Gay men of color)
		Mpowerment (Young MSM)
		Popular Opinion Leader (MSM)
		Real AIDS Prevention Program (Sexually active women and male partners)
		Safety Counts (IDU and non-injecting drug users)
		SISTA (sexually active women)
		StreetSmart (runaway homeless teens)
		Teens Linked to Care (HIV+ youth)
		Voices/Voces (African-American and Latino/a heterosexuals)
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 Title I (now Part A) and Title II (now Part B) of the CARE Act (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 Titles I and II (now Parts A and B), includes outreach, counseling and testing, information and referral services. Under Title III (now 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 Title IV 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.
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 counseling that shifts the delivery of service from the individual to groups of varying sizes. These involve a wide range of skills, information, education and support.
		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 proprieties 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 Title II.
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.
	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	Health education and risk reduction counseling provided to one person at a time. These assist clients in making plans to change individual behavior and to appraise their own behavior. These also help clients obtain services.
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.
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

Note: The Ryan White Modernization Act was enacted in December 2006 and replaced the CARE Act.

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.
	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)	Prevention	A systematic approach to notifying sex and needle-sharing partners of HIV+ people of possible exposure to HIV to 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 Title I CARE Act (now 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	Care	People living with HIV disease or AIDS.
	Prevention	
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.
	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 Case Management (PCM)	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.
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	Care	The process used to establish priorities among service categories, 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.
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 Title I (now Part A) planning council responsibility to assign CARE Act (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	Whatever places a person at risk for disease; for HIV/AIDS, this includes such factors as sharing injection drug use equipment, unprotected male-to-male sexual contact, and commercial unprotected sex.
		See also: Exposure Category, Transmission Category

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 under Title XXVI 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 (formerly Title I): funds Eligible Metropolitan Areas and Transitional Grant Areas. 75% of funds must be spent on core services.
		Part B (formerly Title II): funds States.75% of funds must be spent on core services.
		Part C (formerly Title III): funds early intervention services. 75% of funds must be spent on core services.
		Part D (Formerly Title IV): 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.
		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	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.
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.

Note: The Ryan White Modernization Act was enacted in December 2006 and replaced the CARE Act.

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.
Transitional Grant Area	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. The categories are based on how an individual may have been exposed to HIV.
		See also: Exposure Category, Risk Factor/Behavior
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.

The Statewide Coordinated Statement of Need for Connecticut 2008

Produced by:
The Connecticut HIV Planning Consortium
for the Connecticut Department of Public Health
AIDS and Chronic Diseases Section

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Preface

The 2008 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 both having a focus on the HIV+ population. The SCSN was presented and shared at a public meeting on July 16, 2008 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.

In 2007, the new Connecticut Epidemiological Report was released, and the CHPC was formed through the merger of the Connecticut Statewide HIV Care Consortium and the Connecticut Statewide HIV Prevention Community Planning Group in October. One of the first tasks of the Data and Assessment committee of the CHPC was to conduct a new Needs Assessment for both prevention and care. The committee 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 new planning body operates with open participation from both members and the public, this survey was developed with full input from representation in all sectors. This SCSN is based on the 2008 Connecticut Needs Assessment, the 2007 Connecticut Epidemiological Profile (with updates), the 2008 Hartford Transitional Grant Area (TGA) Needs Assessment, the 2008 New Haven/Fairfield Needs Assessment, the 2006 and 2007 out of care surveys, and unmet need and includes a comprehensive resource inventory for the state of Connecticut. This document also references comparative national data.

The Needs Assessments

Unlike the approach taken in 2004, wherein the state conducted a collaborative statewide effort using one survey, the 2008 needs assessment process was conducted by different entities over a period of approximately one year. With reauthorization and the Ryan White HIV/AIDS Treatment Modernization Act of 2006, the two Part A Planning bodies decided to conduct their own needs assessments for their respective areas. They have shared their report and findings which are included in this document.

The Hartford TGA conducted a separate assessment during early 2008. The Hartford survey instrument was shared with the Connecticut DPH who then asked the new CHPC DAC committee to refine it to meet their data needs, and to conduct their needs assessment of the remaining counties in the state. Both Hartford and the state used similar prevention questions in their surveys.

In 2007, New Haven Fairfield TGA conducted its assessment of the needs of those who had fallen out of care as defined by the Health Resources Services Administration (HRSA) to identify services vital to reaching persons living with HIV/AIDS need, and subsequently a 2007-2008 needs assessment on pathways to care using a different methodology and set of questions than those used by the CHPC. In 2007-2008 the DAC, recognizing the importance of obtaining prevention information from the entire state, recommended that the New Haven - Fairfield TGA be surveyed in some form for prevention only.

Limitations

These data are a compilation of formative research efforts conducted over a period of two or more years. Most 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.[1] These qualitative measures are incorporated in our assessment of HIV service gaps. The out of care surveys, although providing a picture of the out of care population in Connecticut, are not statistically significant and should be viewed as "somewhat representative" of the out of care population. The CHPC acknowledges that the data from Parts C and D is not as extensive as that from the other Parts and plans to include in depth analysis in future assessments of Parts C, D and F as with Parts A and B and prevention.

This report is organized in the following order: The executive summary, which provides an overall summary of the report. The surveillance data (State Epidemiological Profile) sets the stage for the overall picture. This information includes demographics and HIV/AIDS data from the most current information used in the state epidemiological reports on the DPH website (as of June 2008). Next is the data from the Needs Assessment(s) and other existing sources, the SCSN findings based on the various sets of information, emerging issues that impact Connecticut, and finally identified recommendations and recommended approaches for the provision of services in Connecticut. These recommendations will be aligned with the 2009 Statewide Comprehensive Plan for HIV Care and Prevention.

Acknowledgement

Deep appreciation to the citizens of Connecticut living with HIV/AIDS, the Data and Assessment Committee (DAC), the Statewide Coordinated Statement of Need (SCS) work group and to all other people and service providers who gave their time and efforts to provide detailed, accurate data with reflective details to create a truly collaborative 2008 SCSN for Connecticut. The document reflects an underlying compassion while proposing valid strategies to propel Connecticut to excel in our HIV/AIDS service delivery.

Note: This report reflects the new guidance which has a greater emphasis on quality management, oversight and accountability consistent with the reauthorization principles used to strengthen Federal HIV treatment programs. They are: 1) focus on primary care and treatment; 2) efforts to increase flexibility to target resources; ensure accountability using sound fiscal management tools to evaluate program effectiveness.[2]

[1] The surveys conducted in each of the three venues used a convenience surveying model. Each survey used a different set of questions from the 2005 Needs Assessment survey. The surveys, although looking for similar information, did not use similar tools. Conclusions drawn within this report are based on the disparate information sets and can be used only to suggest a "picture" of the needs of PLWH/A in Connecticut to assist in planning efforts.

[2] See new guidance for Part B grantees on the development of the SCSN, dated June 12, 2008

I. EXECUTIVE SUMMARY

Background: The Statewide Coordinated Statement of Need (SCSN) enables Ryan White programs to identify key issues and enhance coordination of HIV/AIDS care. In accordance with HAB/DSS[3] expectations, which are to "enhance access to the continuum of services," the State of Connecticut's Care Consortium has merged with the HIV Prevention Community Planning Group to better integrate services and comply with the requirement as a Ryan White grantee to "build relationships with other Federal and State agencies."[4] The SCSN has been a requirement of the since the 1996 reauthorizations. The State Part B program is responsible for convening the SCSN for all grantees under Section 2617(b)(4)(F) and Section 2617(b)(5). Further, 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 participate in the development of the SCSN and demonstrate consistency with the SCSN in annual grant applications to HRSA. This report follows the updated guidance as issued by DHHS, HRSA, HIV/AIDS Bureau, dated June 12, 2008.

Purpose: The SCSN is a collaborative effort among Parts 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, and linkages across the Ryan White HIV/AIDS Program Parts and efficacy of funding for HIV/AIDS care and prevention services.

Participation: The SCSN development team was comprised of the DAC members and public participants of the CHPC. The membership of the CHPC includes representatives as fully engaged members from the Parts A Planning Councils of the Hartford and New Haven-Fairfield Transitional Grant Areas (TGA), Part B State Department of Public Health AIDS and Chronic Diseases Division, UCONN Correctional Managed Healthcare, Department of Social Services (DSS), Connecticut AIDS Drug Assistance Program (CADAP), Connecticut Department of Public Health Sexually Transmitted Disease (STD) Program, the Connecticut Department of Mental Health and Addiction Services (DMHAS), the Center for Interdisciplinary Research on AIDS (CIRA), Ryan White Parts C, Part D, Part F, Connecticut AIDS Education and Training Centers (CAETC), and consumers and providers from around the state. This report reflects the input of all Ryan White HIV/AIDS Program Parts.

Process: The SCSN incorporates HIV and AIDS surveillance data, data from the 2008 Needs Assessment process, and additional data[5] provided by planning bodies and other 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 HIV+ in-care individuals across the state. The method involved statewide analysis by the three major geographic areas: the New Haven-Fairfield TGA, the Hartford TGA and a region consisting of Litchfield, Tolland, Windham and New London counties. Data on out-of-care HIV+ individuals was collected via a statewide out-of-care survey process similar in nature to the 2005 in-care survey process. The report will be

[3] HIV AIDS Bureau / Division of Service Systems
[4] Ryan White CARE Act Title II Manual Section VII, p. 3.(Note: Title II Manual is still in use and used for Part B.)
[5] Additional data refers to: focus group information, surveys conducted, and individual interviews. These were provided by the CPG, community organizations, and Title I planning bodies.

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.[6] 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 People Living with HIV (PLWH)** are assessed through the needs assessment results, information provided by planning partners such as focus groups, surveys, and key informant interviews, Youth Advisory Group interviews and focus groups, and supplementary data from both TGAs, Parts, C, D and F/SPNS, and addressed through other mechanisms such as funding and quality assurance, among others.
- **Existing available services** – the CHPC collaborates with 211 Infoline to create a statewide resource inventory of public and private providers[7]. In creating the inventory of resources, the partners considered the total Ryan White resources in the State, both in the amount of funds and the services being supported by these funds, and CDC prevention funds. This helped determine the types of services provided in each county.
- **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 Needs and Core Medical Service gaps[8]**. In previous reports, the unmet needs information was obtained through an agreed upon methodology to estimate unmet need in the state of Connecticut. This year, Connecticut is providing the estimated unmet need based on viral load data. Electronic reporting of all viral load tests has been in place since 2006.
  - Service gaps were identified by the in-care needs assessment.
  - Out-of-care information is provided through various sources: Out of care surveys, identification of unmet need, viral load and needs assessments.

Care and Prevention Integration

Connecticut has successfully combined its care and prevention planning bodies to create a fully representative membership in the Connecticut HIV Planning Consortium (CHPC). This group fulfills the required participation of both HRSA and CDC for planning purposes. The comprehensive plan and this statement of need both acknowledge that effective prevention means full engagement of the care community. Incorporated within the Plan and 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 clients to accomplish the goals set forth in the Comprehensive Plan.

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[6] 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…"

[7] 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.

[8] See June 12, 2008 communication from HRSA notifying Part B to update SCSN with updated guidance according to the Modernization Act of 2006 and the president's reauthorization principles: The expectations include: "A list of priorities identified, including addressing Unmet need and gaps in Core Medical Services;…"

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, and non TGAs. 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. The recommendations consider this impact and the importance of integrating care and prevention services.

SCSN: The Development and Approval Process

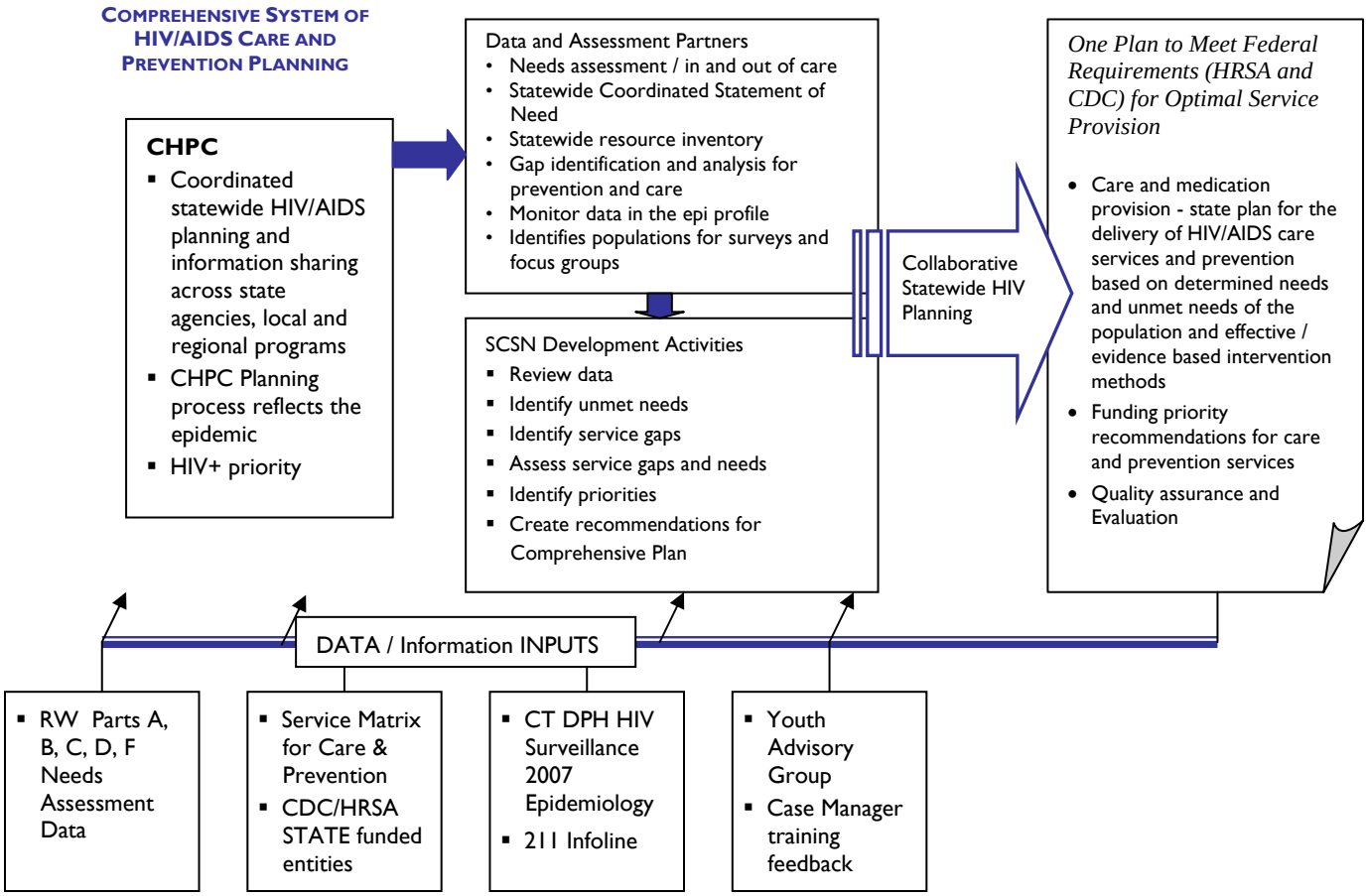
The SCSN was developed through the efforts of the Connecticut Department of Public Health AIDS and Chronic Diseases Section Part B, in partnership with the CHPC. The CHPC was charged with the creation of the report and the identification of critical gaps in life extending care needed by people living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

The Committee first determined their data needs by looking at existing available data. This included the State Epidemiological Report 2007 (with additional updates through June, 2008); the 2007-2008 Needs Assessment Report for Part A, Greater Hartford TGA; Out of Care reports from 2006 and 2007 conducted by Greater Hartford, the State, New Haven/Fairfield, and the new viral load reports. The DAC determined that they would need data from the remaining areas of the state not covered by the TGAs. Prevention questions were used in Hartford, Litchfield, New London, and Windham counties to assess the need for prevention services. New Haven-Fairfield did not include prevention questions therefore the DAC approved a process to gain a representative picture of New Haven-Fairfield on their prevention needs only.

2008 Survey process: On February 20th 2008 the DAC agreed to the following implementation process, with the understanding that this was a convenience survey, as were those implemented by the TGAs. For Care in the Non TGA areas, the group agreed to use both CADAP and agencies to implement the survey. For Prevention in the TGA areas where no prevention questions were asked, the group agreed to use CADAP to survey the New Haven/Fairfield area for prevention information. The 2008 survey process differed from the 2005 survey in the following ways:

1. 2005 – All planning bodies collaborated on the survey, questions, process and implementation and used the same survey. This survey was implemented across the state using the same process (random sampling) resulting in comparable information across the state.
2. 2008 – Hartford and New Haven-Fairfield TGAs decided to conduct their own survey processes. Connecticut needed to survey the rest of the state not covered by the counties in the two TGAs.

Using the agreed upon approach, the Department of Social Services provided the number of CADAP recipients by counties to be surveyed. (New Haven-Fairfield was surveyed for prevention content only.) Mailing labels were printed by DSS and separated by zip code. Surveys were apportioned by zip code to cover a representative number of the TGA (labels provided by DSS were unduplicated CADAP clients as of 3/19/08). Out of state or "in care of" labels were separated out as were "in care of" Case Managers. New Haven-Fairfield (1,095) labels were printed (1,000 used); for non TGA locations, all CADAP recipients were sent a survey. These locations were being surveyed for both care and prevention. The graphic on the next page depicts the input of information for the SCSN and Plan.



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 for development and approval of the SCSN.

1. Epidemiological Report issued in December 2007 (Note: the most current data available is through June 20, 2008)
2. CHPC Data and Assessment committee conducts the review and approval of SCSN data needs and process for input and approval - March 2008
3. The CHPC Needs Assessment is conducted in March and all Parts share data – June 2008
4. An SCSN purpose presentation is made to the public at the CHPC meeting - June 2008
5. DAC identifies gaps across care and prevention services May - July
6. DAC appoints work group to review the analyzed data, identify key issues in the state of Connecticut for PLWH/A – July 2008
7. SCSN work group reviews analyzed data, identifies key issues, makes proposed recommendations for comprehensive plan – July – August 2008
8. SCSN work group and DAC approve final review process and create a presentation for CHPC – July - August 2008
9. SCSN sent to members and public for input and review – August 2008
10. SCSN work group and DAC review input – August 2008
11. SCSN is voted upon by the CHPC at August 20, 2008 meeting

Limitations: This report is based on separate needs assessments, and information from other sources. Each group has analyzed their data and shared the results with the CHPC for incorporation within this document. It should be understood, that because of the significant differences in questions asked, methods used, and intended use of the information, that conclusions drawn are at best the result of an agreed upon effort of the members of the DAC and the SCSN work group. Data from this report should be used with the understanding that there are significant limitations for statewide implications.

Service gaps and priorities for the Connecticut:

Connecticut Service Gaps and Priorities

Note: service priorities varied by region, i.e., TGA and the rural areas or rest of the state, hence statewide services are listed in an a best guess for priority based on 2005 and 2007 SCSN information, since data was compiled from various non comparable sources.

County Abbreviations: New London (NL), Litchfield (L), Tolland (T), Windham (W), Hartford (H), New Haven (NH), Fairfield (FF), Middlesex (M)

Prevention	Care Core Services	Care Support Services	Barriers
1. Prevention Support Services-prevention interventions - NL, L, T, W, FF	1. Dental - W, L, NL, H, T, NH, FF	1. Housing - W, H, L, NH, FF	1. Inability to pay All
2. Risk Reduction Services/Information - NL, L, T, W, FF, H	2. Mental Health Services - NH, FF	2. Emergency Financial Assistance - H, L, W, NL	2. Transportation All
3. Comprehensive Risk Counseling Services - L, W, M	3. Insurance Assistance (for HIV services / medications) - W, L, NH, FF, NL	3. Food - H, L, T, NH, FF	3. Unaware of services All
	4. Substance Abuse-outpatient - NH, FF	4. Transportation - T, NH,FF	4. Fear of revealing status All

Information from the various data sources indicates that, *to engage as many people as possible (underserved and those yet to enter care) into both prevention services (primary and secondary) and care services; and to reengage individuals who have fallen out of care*, Connecticut must create strategies to reduce barriers through providing education/information on available services, meeting people's basic needs to ensure they can receive care, making certain that there are culturally appropriate services, providing transportation to medical services and making sure that costs are covered for medical care. These issues were considered in developing the following recommendations.

Recommendations: These 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 the months of July - September 2008.

Process Recommendations

1. *To allow for uniformity and strength of data, the CHPC, its members and partners (Parts A, B, C, D, F/SPNS) and prevention should implement a fully collaborative statewide needs assessment for both in care and/or out of care in 2010. This would 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 would be developed in full cooperation with direct input from all Ryan White Parts and prevention.*
2. *To further understand the HIV/AIDS prevention and care landscape, all stakeholders should collaborate to develop a model for a service matrix analysis process. This would include services, utilization, and epidemiology. The outcome of the service matrix analysis should drive the Part B and Prevention RFP process, and inform the Parts A, C, D, F in their planning processes. Assure that technical assistance is available to providers and contractors on applicable interventions to assist them in responding to RFP(s) issued by DPH.*
3. *Conduct a survey of HIV/AIDS providers to capture emerging populations, needs, trends and other service matrix issues. This might include medical case management, early intervention services, comprehensive risk counseling services; counseling, testing & referral; syringe exchange.*

Service Improvement Recommendations

4. *Encourage HIV service providers to link all individuals to appropriate HIV care and prevention services and applicable state services with an emphasis on co-location and one stop shopping.*
5. *Encourage DPH to create a procedure to collect, analyze, monitor and share with stakeholders client level data from intake and assessment forms to provide the most accurate picture of HIV/AIDS in Connecticut.*
6. *Provide training and continuing education for medical practitioners on risk assessment and risk reduction, secondary prevention and available HIV care and prevention services*
7. *Continue training medical case managers (MCMs) on the medical model and clinical practices, and explore creative ways to inform and educate MCMs on an ongoing basis of available resources, services, and relevant issues (e.g., Operation Fuel, energy assistance, alternate home care, housing opportunities, Medicaid, SAGA, Connecticut Action Agencies, among others).*
8. *Assess the needs of HIV+ individuals leaving the correctional system who are returning to the community.*
9. *Explore alternative methods to address barriers to services, for example telemedicine, to connect people in rural locations.*

Emerging Issues Recommendation

10. *Explore the feasibility of raising client eligibility for Ryan White A and B funding to 400% federal poverty level to ensure client access to Ryan White funded services.*

II. HIV/AIDS Surveillance

Background

The State of Connecticut has compiled data on AIDS cases since 1980[9]. In 2002, the state began compiling data on HIV. In 2005, the Centers for Disease Control and Prevention (CDC) recognized HIV data compiled by Connecticut as viable. Unmet need (PLWH/A that are out-of-care), a data set recently required by the Health Resources and Services Administration (HRSA), was first calculated based on a model established by a state with similar demographics in 2003. In 2005, Connecticut received technical assistance recommended by HRSA to develop an approved method for calculating statewide unmet need (See section on unmet need p. 29). This will change in subsequent reports since in 2006 all HIV viral load test results were made reportable by laboratories that conduct the tests. This step was taken to improve completeness of reporting of HIV and AIDS cases, allow monitoring of entry of newly diagnosed people into care, monitor consistency and effectiveness of care, and characterize those groups who may delay entry into care. Connecticut's most current data reflects reporting through June 30, 2008. The SCSN work group determined that the best approach for presenting the HIV/AIDS data for Connecticut would be through December 31, 2007, or the full calendar year. The data in the table below represents the cumulative Connecticut data compiled in the most recent full calendar year.

AIDS – National v. Connecticut

According to CDC surveillance, in 2006 the estimated number of AIDS cases in the US and dependent areas was 37,852. Of the 37,852 cases, 29% were White, 47% were Black, and 18% were Hispanic; 26% were female cases; 71% male; 38 were children less than 13 years of age. The modes of transmission nationally were MSM 42%; IDU 11.7%; MSM/IDU 5%; heterosexual 12%; other 0.6%.

According to the Connecticut Department of Health Surveillance in 2006 there were 543 reported cases of AIDS, 64% of whom were male and 36% female. The percentages by mode of transmission in Connecticut in 2006 were MSM 17%; IDU 33%; MSM/IDU 1%; heterosexual 18%; other risks not reported 29.5%.

Connecticut's AIDS population differs from National figures (AIDS) in the following ways:

- Connecticut Female 36% v. 26% US
- Connecticut Mode of transmission IDU 33% v. US IDU 12%
- Connecticut Black 25.8% v. US Black 47%
- Connecticut Hispanic 41.4% v. US Hispanic 18%

[9] The AIDS case definition consists of either HIV positive with a low CD4-positive cell count, or HIV positive and a diagnosis with one of several opportunistic infections or conditions. AIDS cases are reported to the Department of Public Health by diagnosing physicians and laboratories (low CD4 counts). The Department of Public Health maintains a computerized registry of AIDS cases. HIV has been reportable in children (< 13 years of age) since 1993 and in adults since 2002. HIV is reported when an individual is confirmed HIV positive by Western Blot or other confirmatory test. The number of HIV cases reported for a given year is the number of cases reported during that year minus those cases that were re-reported as AIDS cases during the year.

AIDS Incidence

The table below shows the 2007 demographic breakdown of the reported HIV disease population in Connecticut, and the cumulative data since reporting began.

HIV/AIDS Cases by Demographic Groups
Connecticut through December 31, 2007

1. Number represents all HIV and AIDS cases reported in 2007.
2. Number includes all cases reported from January 1, 1980 – December 31, 2007 living and deceased.
3. Number includes all people living with HIV/AIDS as of December 31, 2007.

Characteristics	2007 HIV/AIDS 1	Total AIDS 2	Total PLWH/A 3
	New reported through 12-31-07	Cumulative through 12-31-07	As of 12-31-07
Total Numbers	**1,300**	**15,325**	**10,731**
Gender	% of total	% of total	% of total
Male	67	72	66
Female	33	28	34
Race /Ethnicity			
White	35	37	35
Black	30	36	32
Hispanic	34	26	33
Other race/ethnicity	2	0	1
AGE			
0-12 years	0	1	0
13-19	2	0	1
20-29	11	13	5
30-39	22	42	17
40-49	36	30	41
50 and over	29	13	36
Transmission Mode			
IDU	25	48	41
MSM	23	22	20
MSM/IDU	1	3	2
Hetero	15	18	22
Pediatric	1	1	2
Other/risk not reported	35	7	14

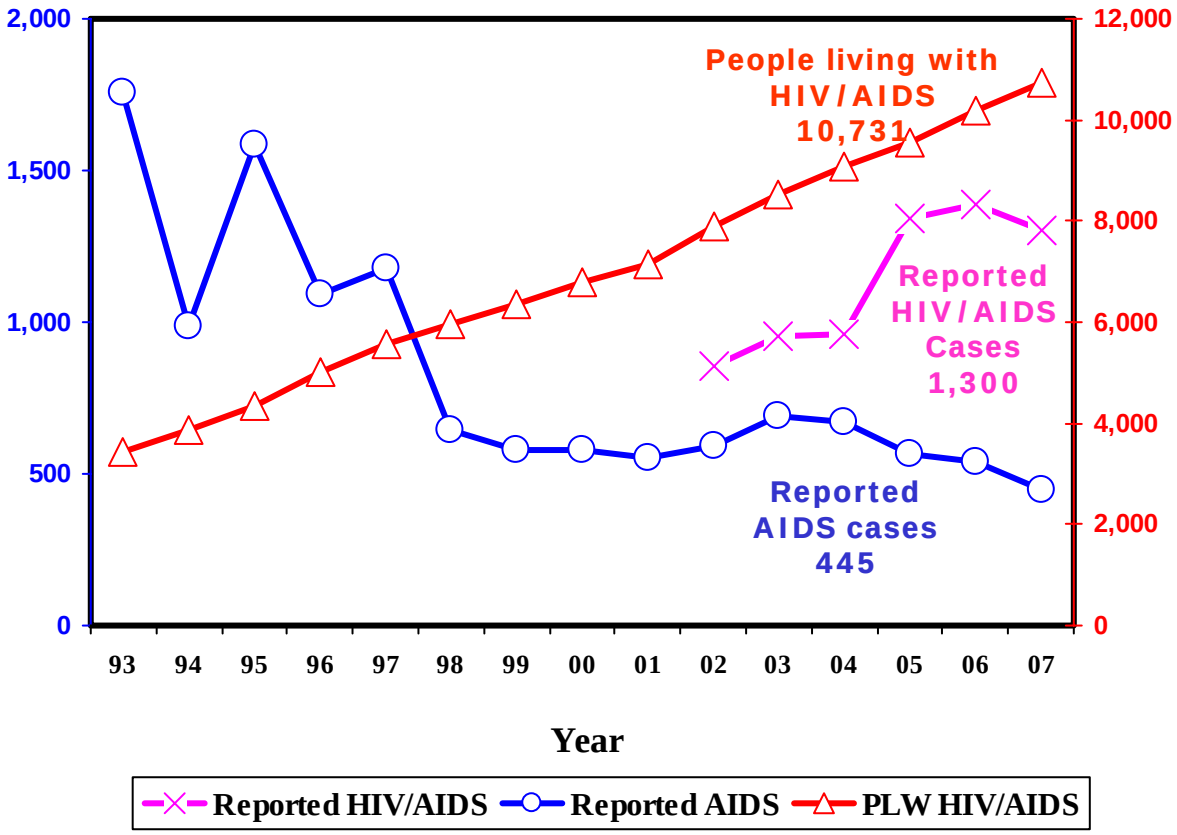
Source: CT DPH AIDS Surveillance Data

Note: Additional data can be obtained at
http://www.ct.gov/dph/cwp/view.asp?a=3135&q=393044&dphPNavCtr=|

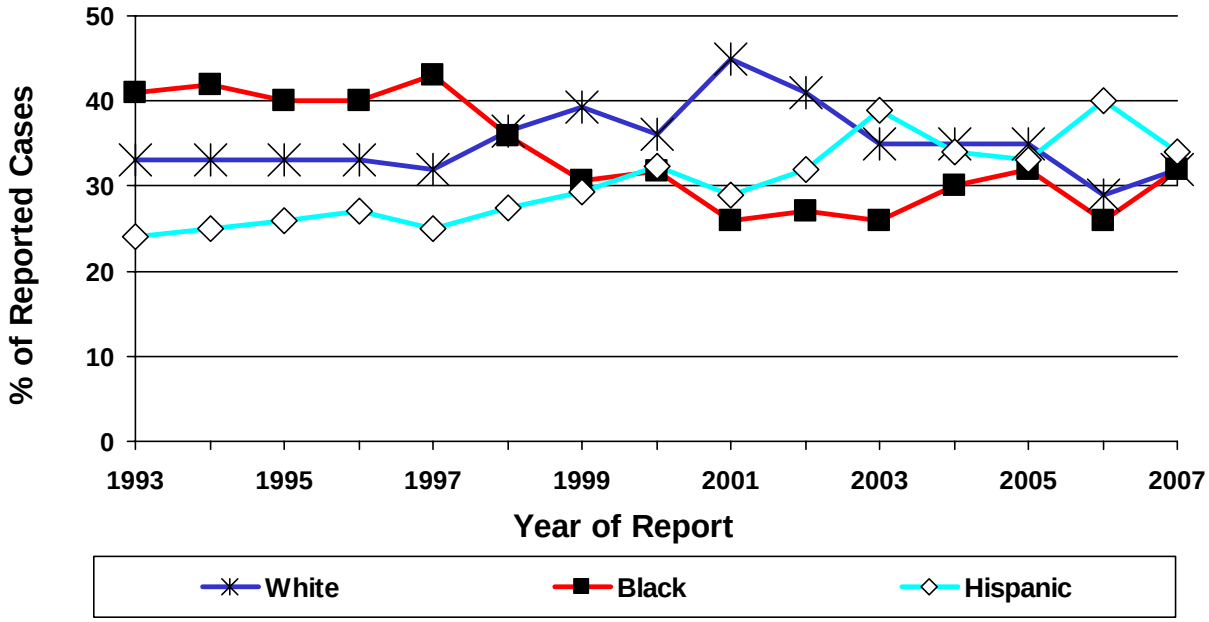
Trend in HIV/AIDS, Connecticut, 1993-2007

The three figures below and on the next page show the trend of new AIDS cases in Connecticut, which decreased from 1,521 in 1995 to 543 cases in 2006 and to 445 in 2007; the trend of cases by race/ethnicity from 1995-2008, and the mode of transmission for new AIDS cases from 1995-2006. (Source: CT DPH 2008)

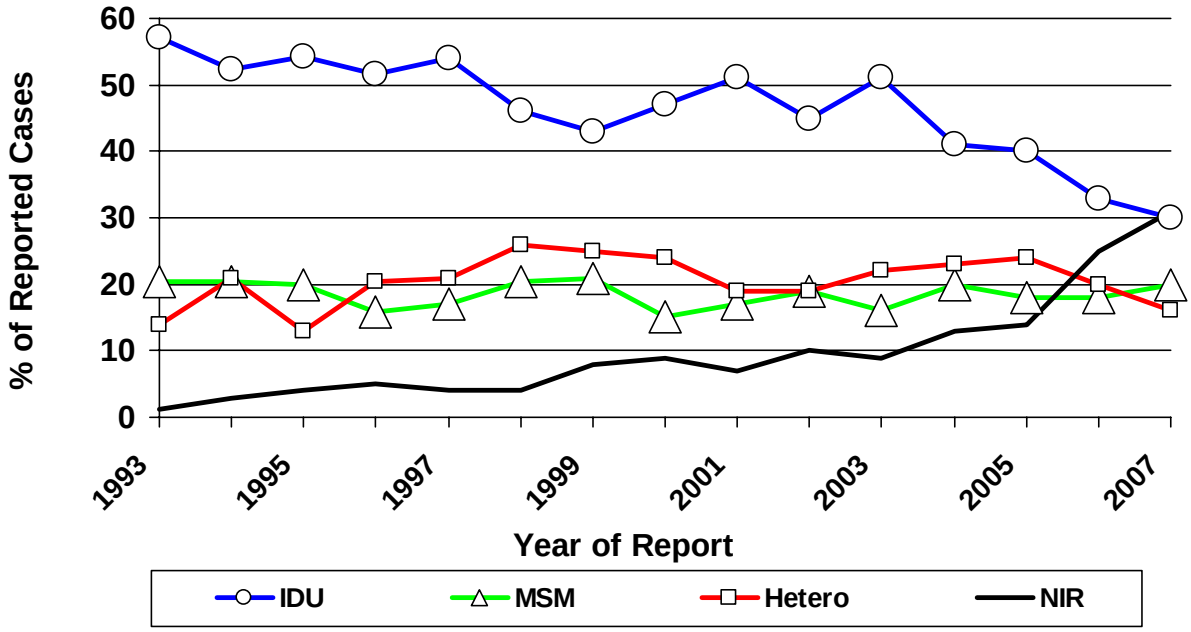
AIDS Trends over Time



AIDS Cases by Race/Ethnicity and Year of Report In Percent of Total -- Connecticut 1993-2007



AIDS Transmission Categories by Year of Report In Percent of Total with NIR -- Connecticut 1993-2007



HIV/AIDS Surveillance Highlights through December 31, 2007

AIDS cases reported in 2007

As of December 2007, 445 AIDS cases were reported with 70% male, 30% female; 31% white, 33% black, 35% Hispanic; 16.9% MSM; 29.7% IDU; 13.5% heterosexual, and 35.3% with other or unknown risk.

Cumulative AIDS cases

There have been 15,325 cases of AIDS reported in Connecticut since 1981. Of these, 7,982 (51.4%) have died.

AIDS has disproportionately affected specific demographic and behavioral groups including males (72% of cases), injection drug users (IDU) (48%), and people ages 30-39 (42%), people of color –total Black and Hispanic (62%).

People living with AIDS (PLWA) in Connecticut

As of 2007, 7,453 people are living with AIDS in Connecticut (213 per 100,000 population). Of these, 66% are male, 28.3% female, 36.7% white; 36.5% black; 34.8% Hispanic; 13% are <30 years of age, 35% are 30-39, 44% are 40-49 and 51% are ≥50 years of age; 20.0% MSM, 45% IDU, and 22% heterosexual and 9% in other or unknown categories.

Total Reported Cases of HIV and AIDS

As of December 31, 2007 there were a total of 18, 603 cases of HIV and AIDS reported in Connecticut. Of the 7,453 PLWA at the end of 2007, just over half live in the New Haven TGA 56% (n=4,095) and (33%) live in the Hartford TGA (n=2,494).

People living with HIV (not AIDS)

During 2002-2007, 3,278 HIV cases were reported to DPH. Of the 3,278 people with HIV, 34.0% are white, 29% black, and 36% Hispanic.

People living with HIV/AIDS

10,731 people are reported living with HIV or AIDS.

Estimating the number of people with HIV/AIDS living in Connecticut

Using a method recommended by CDC, it is estimated that 18,293 to 20,863 (midpoint 19,578) HIV-infected people live in Connecticut (*Integrated Guidelines for Developing Epidemiologic Profiles*). This is based on the estimate that 1,039,000-1,185,000 HIV-infected people live in the United States and that of these 415,193 are PLWA (CDC, 2004). It is assumed that since Connecticut has 1.76% of PLWA (7,310/415,193) reported in the USA, it also has 1.76% of all HIV infections (1.76% of 1,039,000 = 18,293 and 1.76% of 1,185,000 = 20,863). CDC estimates that 24-27% of people infected with HIV are unaware of their infection.

HIV incidence

On August 3, 2008, the Centers for Disease Control and Prevention (CDC) released an estimate of the number of people newly infected with HIV in the United States during 2006. It was reported that 56,300 (22.8 per 100,000; 95% CI 19.5-26.1) people were newly infected with HIV in the USA during 2006. The estimate is based on information collected by health departments in 22 states, including Connecticut. An estimate for 2007 is expected in the spring of 2009.

Of the 56,300 estimated new infections in 2006, 73% were male, 35% white, 45% black, 17% Hispanic, 34% aged 13-29, 31% 30-39, 25% 40-49, 10% 50+, 53% MSM, 12% IDU, and 31% heterosexual. Back-calculations indicated that the overall number of cases each year has been steady since 1999 although the MSM subgroup has steadily increased in number over that time period. Decreases were observed among IDU and heterosexuals.

Estimates for Connecticut and other participating states were also released. It was estimated that 600 (20.5 per 100,000) people in Connecticut were newly infected with HIV in 2006. There is not a statistically significant difference between the US and Connecticut rates. The estimates and trends for demographic and behavioral subgroups should be interpreted cautiously with regard to implications for individual states.

III. Needs Assessments and Other Data

The existing needs assessments providing care information for this report include the State effort, conducted by the Connecticut HIV Planning Consortium (CHPC) for Windham, New London, and Litchfield counties in 2008; the New Haven /Fairfield TGA Unmet Need needs assessment conducted in 2007; and the Greater Hartford TGA 2008 needs assessment. Prevention information is provided through the 2008 needs assessments from the CHPC covering Windham, New London, Litchfield, New Haven, and Fairfield counties and conducted through a collaborative effort with the Department of Social Services (DSS) and CHPC. Surveys for prevention information were sent through the Connecticut AIDS Drug Assistance Program (CADAP) and implemented through partner agencies in Windham, New London and Litchfield counties, and the Department of Mental Health and Addiction Services.

The CHPC survey addressed both care and prevention needs. The survey was only administered to individuals 18 years old or older. [See Appendix A for the needs assessment survey questions and page 5 for process.] Important elements of the 2008 Needs Assessment process included:

- 560 surveys were collected. 441 surveys were identified to be valid based on completeness and respondent eligibility.
- Care data was collected from 227 persons living with HIV/AIDS in Windham, New London, and Litchfield counties. This data is not representative of the entire state of Connecticut.
- 4 individuals were identified as out of Care in Windham, New London, Litchfield
- 59% of respondents in Windham, New London, Litchfield receive most services in their home town; 38 % do not
- Prevention data was collected from 441 persons in Windham, New London, Litchfield, New Haven and Fairfield counties.
- Respondents received an incentive valued at $10

Information is presented in three sections based on Needs Assessment source.

A. 2008 Statewide Needs Assessment Survey Part B and Prevention (DMHAS, Windham, New London, Litchfield, New Haven, and Fairfield Counties)

1. **Demographic Information of Persons Surveyed for Prevention and Care**

Gender	N	%	Age	%	Race/Ethnicity	%
Male	295	66.9%	20-29	1%	White	46%
Female	144	32.7%	30-39	15%	Black/African Amer.	27%
Transgender	1	0.2%	40-49	42%	Hispanic	24%
No answer	1	0.2%	50 and over	40%		
Sexual Orientation	**%**		**Risk Category**	**%**	**Source**	**N**
Heterosexual	61%		Heterosexual	42%	Litchfield	27
Gay	29%		MSM	30%	New London	113
Bisexual	6%		IDU	13%	Windham	87
Unsure/no answer	4%		Unknown	15%	New Haven/Fairfield	206
					DMHAS	16

2. Risk behaviors

Of those persons from Department of Mental Health and Addiction Services (DMHAS), Windham, New London, Litchfield, New Haven, and Fairfield who received a diagnosis of HIV within the past year, and were asked about having unprotected sex:

- 20% reported having had unprotected sex within the past year, 16% over one year.
- 14% reported having had unprotected sex with an anonymous partner (mostly over a year ago)
- 10% reported they had unprotected sex under the influence of alcohol or drugs
- 9% reported they had unprotected sex with an HIV- partner less than a year ago
- 5% reported they had unprotected sex for drugs or money

Within the past year:

- 25% stated that they did not disclose their status to their partner
- 19% reported having had a tattoo or piercing
- 11% reported they had sex with a partner who uses intravenous drugs
- 6% had a sex partner met on the internet

3. Prevention Service Needs (DMHAS, Windham, New London, Litchfield, New **Haven, and Fairfield)**

Most respondents, nearly 50% or more, indicate that they do not need prevention services.

Note: non answers account for discrepancies in row totals of approximately 2-5%

Prevention Service Needs	Use Service	Needs service	Needs but doesn't know about	Doesn't Need
Prevention Support Groups	32%	11%	6%	49%
Prevention programs (SISTA, Healthy Relationships, etc.)	12%	5%	8%	71%
Comprehensive Risk Counseling Services	21%	5%	4%	66%
Condom distribution/info.	32%	5%	4%	57%
Partner risk services	18%	5%	6%	66%
HIV prevention services, e.g., Syringe Exchange Services	12%	4%	3%	78%

4. CARE: Demographics for Windham, New London, Litchfield counties

- 227 persons responded: 27 Litchfield, 113 New London, 67 Windham

Gender	N	%	Sexual Orientation	%	Risk Category	%
Male	148	65.2%	Heterosexual	67%	Heterosexual	44%
Female	77	33.9%	Gay	22%	MSM	23%
Transgender	1	0.4%	Bisexual	6%	IDU	15%
No answer	1	0.4%	Unsure/no answer	4%	Unknown	19%

5. Core Medical Service Needs in Windham, New London, Litchfield counties

Core Medical Service Needs	Use Service	Needs service	Needs but doesn't know about	Doesn't need
Medical Care for HIV	90%	2%	1%	7%
Medical Case Management	67%	6%	2%	21%
CADAP	57%	4%	2%	33%
AIDS medication assistance (not CADAP)	18%	5%	8%	65%
Substance abuse treatment, outpatient	23%	6%	1%	67%
Mental health treatment	31%	9%	4%	52%
Dental care	60%	14%	10%	14%
Home health care	12%	5%	5%	75%
Early intervention services	16%	3%	4%	73%
Health insurance premium/co-pays	22%	11%	12%	54%
Home and community based health services	14%	4%	6%	74%
Medical nutrition therapy	23%	8%	8%	57%

6. Support Service Needs for Windham, New London, and Litchfield counties

Support Service Needs	Use Service	Needs service	Needs but doesn't know about	Doesn't Need
NON - Medical Case Management	50%	7%	9%	32%
Child Care services to attend medical appts.	3%	4%	2%	89%
Emergency Financial Assistance	27%	9%	14%	44%
Food Bank/Home delivered meals	27%	8%	5%	40%
Health Education Risk Reduction Services	29%	3%	3%	55%
Housing Services (finding and paying for)	29%	11%	13%	46%
Legal Assistance - eligibility	12%	8%	10%	70%
Translation Services	10%	3%	2%	82%
Medical Transportation	24%	7%	8%	59%
Outreach to connect to services	22%	9%	10%	57%
Support and Counseling non mental health	29%	9%	6%	54%

7. Barriers to Care for Windham, New London, and Litchfield counties

Barriers to Care Services	No problem	Minor Problem	Major Problem
Lack of Transportation	66%	18%	15%
Drug and/or Alcohol use	85%	5%	6%
Inability to pay	63%	15%	20%
Distrust of providers	77%	13%	7%
Fear of revealing status	63%	18%	17%
Not aware of services	74%	14%	9%
Language barrier	74%	5%	6%

8. Out of Care

Of the 441 valid surveys conducted in DMHAS, Windham, New London, Litchfield, New Haven, and Fairfield, 4 individuals who identified themselves as HIV+ indicated that they were not in care, that is they did not receive HIV medical treatment, had a CD4 count or viral load in the past 12 months.

This out-of-care data are derived from the 2006 out-of-care surveys reported in the 2007 SCSN update on out of care population. The problems for the out-of-care population continue to be the same in 2008 as they were in 2006, 2004 and 2002, e.g., barriers of transportation, fear, distrust, lack of insurance and substance abuse, and services that would facilitate their getting in to care include transportation, case management, and substance abuse treatment.

Don't want to see a doctor because they

- 47% feel healthy/were recently diagnosed
- 30% distrust doctors
- 24% said they would not seek treatment

Don't want to see a doctor but would if they had

- 35% help with transportation
- 29% case management/ support
- 24% help finding an MD

Want to see a doctor but don't because of

- 34% substance abuse
- 17% lack of insurance
- 15% lack of stable home/depression/mental illness

Want to see a doctor, but to get in and stay in care need help with

- 58% case management/support
- 21% substance abuse treatment
- 13% insurance, financial help, stable home

B. Greater Hartford Transitional Grant Area Needs Assessment 2008

1. Demographics of surveyed individuals in Greater Hartford

Gender	N (380)	%	Age	%	Race/Ethnicity	%
Male	248	65.3%	20-29	6	White	19
Female	126	33.2%	30-39	15	Black/African Amer.	37
Transgender	4	1.1%	40-49	45	Hispanic	39
No answer	2	0.5%	50 and over	33	Multi/Other	4

Sexual Orientation	%	Risk Category	%
Heterosexual	68	Having sex w/HIV+ male	43
Gay	18	Having sex w/HIV + female	17
Bisexual	6	Sharing needles or works	32
Lesbian	2	Blood Transfusion	3
Unsure/no answer	2	Mother to child	1

2. Risk behaviors

Of those persons from the Hartford TGA who received a diagnosis of HIV were asked about having unprotected sex:

- 39% reported they had unprotected sex with an HIV- partner after testing positive
- 38% reported having had unprotected sex after testing positive
- 22% reported having had unprotected sex with an anonymous partner
- 17% reported having had unprotected sex within the past 6 months
- 15% reported they had unprotected sex for drugs or money after testing positive
- 10% reported they had unprotected sex under the influence of alcohol or drugs

After testing positive,

- 43% stated that they did not disclose their status to their partner
- 19% reported they had sex with a partner who uses intravenous drugs
- 14% reported having had a tattoo or piercing
- 12 % shared needles over a year ago
- 5% had a sex partner met on the internet

3. Prevention Service Needs for Greater Hartford

Prevention Service Needs	Use Service	Doesn't get	Doesn't know about	Doesn't Need
Prevention Support Groups	60%	6%	6%	21%
Prevention programs (SISTA, Healthy relationships etc.)	--	--	--	--
Comprehensive Risk Counseling Services	35%	8%	12%	32%
Risk Reduction Services	22%	3%	16%	46%
Partner risk services	24%	7%	15%	40%
HIV prevention services, e.g., Syringe Exchange Services	30%	8%	16%	35%

4. Core Medical Service needs for Greater Hartford

Core Medical Service Needs	Use Service	Needs but not used in 12 mos.	Needs but can't get	Doesn't Need
Medical Care for HIV	91%	5%	3%	3%
Medical Case Management	86%	6%	5%	6%
Dental care	59%	25%	1%	9%
AIDS medication assistance /co-pays	47%	8%	1%	42%
Mental health treatment	46%	8%	7%	46%
CADAP	38%	8%	4%	49%
Substance abuse treatment, outpatient	35%	7%	1%	57%
Home health care	10%	4%	4%	83%

5. Support Service Needs for Greater Hartford

If participants checked any services that they needed but were unable to get, they were asked to indicate which ones, up to 3, were the most important to them. The 3 services most frequently identified as most important but were unable to get were: 1) emergency financial assistance (16.6%), 2) help paying rent (12.8%), and 3) help finding an apartment (10.6%)." (Hartford N/A Report, 2008 p. 23)

Support Service Needs	Use Service	Needs but not used in 12 mos.	Needs but can't get	Doesn't Need
Emergency Financial Assistance	26%	16%	17%	42%
Housing Services (paying for)	31%	18%	13%	39%
Housing Services (finding)	20%	21%	11%	49%
Food Bank/Home delivered meals	49%	15%	8%	28%
Transportation	39%	18%	7%	36%
Nutritional Counseling	27%	15%	6%	52%
Legal Assistance - eligibility	16%	11%	5%	68%
Translation Services	11%	4%	2%	84%
Medication Adherence Support	32%	8%	1%	58%
Child Care services to attend medical appts.	4%	2%	1%	94%
Drop-in centers	39%	10%	1%	59%

6. Barriers to Services for Greater Hartford

Barriers to services for the in-care population were reported on those areas identified as most needed, Emergency Financial Assistance, help paying rent, and help finding an apartment. They are:

Barriers to Care Services (% are listed at 30% or above)	EFA	Help on Rent	Help finding apt.
Did not know this service was available	60%	63%	71%
Did not know where to get this service	64%	65%	81%
No transportation	--	30%	34%
No openings/waiting list	--	35%	36%
Could not afford to pay for this service	36%	45%	47%
Fear of revealing status	--	--	34%
Have a prison record	--	33%	41%

7. Out of Care/Unmet need

Greater Hartford identified 28 out of care individuals who are all over 30 years of age.

- 22 are from Hartford County
- 12 are between the ages of 40-49
- 19 are male
- 12 are African American, 8 white and 4 Latino, 4 other
- 19 identified themselves as heterosexual

Core Medical Service Needs for out of care persons total N = 28	Used in last 12 mos.	Needs but not used in 12 mos.	Needs but can't get ~~N~~	Doesn't Need ~~N~~
Medical Care for HIV	3	16	1	7
Dental care	7	14	1	6
Medical Case Management	8	11	2	7
AIDS medication assistance /co-pays	3	8	1	15
CADAP	3	6	4	13
Mental health treatment	6	4	0	18
Substance abuse treatment, outpatient	6	7	1	14
Home health care	1	2	0	24

Support Service Needs for out of care persons total N = 28	Used in last 12 mos. ~~N~~	Needs but not used in 12 mos. ~~N~~	Needs but can't get ~~N~~	Doesn't Need ~~N~~
Transportation	2	14	3	9
Housing Services (paying for)	3	13	4	8
Emergency Financial Assistance	3	12	2	10
Food Bank/Home delivered meals	5	10	4	9
Nutritional Counseling	1	10	1	16
Housing Services (finding)	4	9	1	14
Drop-in centers	3	6	2	17
Legal Assistance - eligibility	1	3	1	23
Translation Services	1	2	1	24

Barriers to services for out of care respondents:

For Emergency Financial Assistance –

- Lack of knowledge of where to go to get the service

For accessing help to pay rent -

- Not knowing the service was available
- Fear that others would find out that the participant was HIV positive
- Homelessness

C. New Haven/Fairfield Transitional Grant Area Needs Assessment 2008

New Haven / Fairfield conducted an in care assessment of needs in early 2008 from approximately 327 individuals. 246 or 77% reported that they were living with HIV, 64 or 20% reported a diagnosis of AIDS and 3% or 8 said they did not know.

- Of 317 respondents, 38% stated that they have at some point stopped primary medical care and restarted it. The reasons given for stopping were jail 34%; drug use 21%; HIV medicine side effects 25%; and left the area 17%.
- Of 111 respondents, 34% stated they stopped care for 3-6 months before restarting; 31% (34) for 6-12 months; 23% (25) over a year and 13% or 14 more than 2 years.
- Reasons given for restarting treatment were became sick 35% (38); returned from jail 22%; 13% (14) returned to area; 28% (30) stated other reasons.

1. Demographics of in care population in the New Haven/Fairfield TGA

Gender	N	%		Risk Category	N	%		Race/Ethnicity	N	%
Male	193	61		MSM	69	21		White	57	18
Female	115	37		IDU	91	28		Black/African Amer.	147	47
Transgender	6	2		MSM/IDU	5	2		Hispanic	83	27
				Heterosexual	133	41		Multiracial/Other	25	8
				Other/Unknown	23	7				
				Perinatal	7	2				

2. Prevention service needs for New Haven/Fairfield

- Prevention service needs were not obtained by New Haven-Fairfield in 2007. See results in section I. 2008 survey conducted by CHPC.

3. Services used to get into primary care and services needed by in care individuals in New Haven/Fairfield TGA

- For New Haven-Fairfield TGA Primary Medical Care 138 (49%)
- The information in the table below was derived from survey questions that asked about pathways to care, or services used to help see an HIV doctor, and the services most needed by PLWH/A to see the doctor.

Services	Services Used	Needed Service
AIDS Drug Assistance	39 (18%)	72 (26%)
Medical Case Management	88 (40%)	43 (15%)
Emergency Financial Assistance	3 (1%)	27 (10%)
Food Bank	4 (1%)	65 (23%)
Housing Assistance	11 (5%)	116 (41%)
Medical Nutrition Therapy	--	6 (1%)
Mental Health counseling	34 (16%)	61 (22%)
Oral Health Care	3 (4%)	11 (4%)
Substance Abuse rehab out patient	14 (6%)	33 (12%)
Transportation to medical appt.	122 (56%)	54 (19%)

4. **Barriers to getting to see their HIV doctor were indicated by those services in care individuals in New Haven-Fairfield could not get**
   - Lack of Housing 34% (51) was identified as the #1 service needed but unable to get followed by lack of transportation 19% (28) , dental 13% (19) and food bank 11% (17)
   - Fifty-one individuals indicated that were unable to get housing

5. **Out of Care / Unmet need**

The following information is from the 2007 out of care report in New Haven Fairfield TGA

New Haven / Fairfield identified 204 out of care persons.

- 114 Male; 90 Female
- 30White; 96 Black, 78 Hispanic
- 102 IDU; 69 Heterosexual; 21 MSM; 12 MSM/IDU

Of the 204 respondents, 150 or 75% were referred into HIV primary medical care upon diagnosis, and 70% successfully entered care following initial diagnosis.

There were 130 or 65% evidence being 'technically' out of care over a period of greater than one to two years, and 40 report a never "in care" status (pg. 26 New Haven-Fairfield Unmet Needs Report)

Core Medical Service Needs 1=highest need	n		Support Service Needs 1=highest need	n
Medical Care for HIV	2		Housing Services (finding and paying for)	**1**
Other primary medical care	3		Transportation	4
Medical Case Management	-		*Employment*	6
CADAP	-		NON - Medical Case Management	7
AIDS medication assistance (not CADAP)	4		Emergency Financial Assistance	8
Substance abuse treatment, outpatient	4		Support and Counseling non mental health	8
Dental care	4		Translation /culturally relevant providers	8
Methadone maintenance	5		Food Bank/Home delivered meals	9
Mental health treatment	5		Outreach to connect to services	9
Other meds	7		*Treatment adherence support*	9
			Child Care services to attend medical appts.	9

The four most stated reasons identified why they are not in care:

1. Worried others will find out/privacy
2. Fear of telling someone else
3. Feel healthy
4. Other basic needs not met/health/job

The most important stated barriers to services for out of care population were Housing, Transportation, Timely mental health/psych services, Employment assistance, Help staying sober, Culturally relevant providers/sensitivity, Dental Care, Insurance and help paying for Lab work.

D. Parts C and D

This section discusses the needs and plans to address those needs identified by RW Part C and D. Part C covers HIV Early Intervention Services; specifically supporting outpatient HIV early intervention services for low-income, medically underserved people in existing primary care systems. The Part C program is 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 is a special grant program intended to coordinate HIV services and access to research for children, youth, women and families in a comprehensive, community-based, family-centered system of care.

In Connecticut, Part C programs are individually funded through HRSA. Part D is funded through the Community Health Center Association of Connecticut (CHCACT). The CHCACT works with community health centers, hospitals and other public health partner agencies to guarantee that primary care is effective and accessible. CHCACT represents organizations that provide health services in a wide range of settings receiving diverse funding throughout the Ryan White Treatment and Modernization Act. The Children, Youth and Family AIDS Network of Connecticut (CYFAN) receives Part D funding through CHCACT, with an exclusive focus on service to women, children, youth, and their families.

CYFAN offers HIV/AIDS primary care services, coordination of the Perinatal HIV Transmission Project, medical case management services include intensive child- and youth-centered medical case management, mental health services, and support groups for infected and affected children, youth and their families. In addition, the six community health centers that participate in CYFAN all administer comprehensive, culturally competent HIV/AIDS outreach services that are driven by case finding and appropriate linkages to care for youth between the ages of 13-24. (Please see section III for a list of Part C and D agencies)

Service Needs (as identified through Part D Needs Assessment 2006-2008)

The Children, Youth and Family AIDS Network of Connecticut (CYFAN) the Part D federal grantee in Connecticut, continued expanding and refining case finding and testing services for the statewide population under the age of 25 in calendar year 2007 in response to service trends and needs. This included:

- Incorporating education and case finding components within selected medical case management providers across Connecticut
- Encouraging other program partners to develop youth focused provider capacity in the area of HIV counseling and testing
- Encouraging community health center partners to make HIV testing a more routine part of primary care services
- Developed measurements of quality across a variety of care categories funded by Ryan White Part D, HRSA Office of Performance Review with an assigned trainer from the National HIV Quality Center.

Other Factors Influencing Strategic Planning

The number of enrolled clients in CYFAN has essentially leveled out over the period from 2005 -2007. In 2005, the overall number of enrolled clients was 304 (174 HIV infected/indeterminate and 130 affected), as of 1/1/07 the total number of overall clients dropped to 278 (177 HIV infected/indeterminate and 101 affected), although the number of

infected/indeterminate individuals rose. In the 2007 Ryan White Data Report filed in March, 2008 the overall number of clients rose to 322 totals including 186 HIV infected. These totals for the last three years are down from a three year average of approximately 415 total individuals receiving services from the period 2002-2004. Those totals included an average of 195 individuals HIV infected or indeterminate and 220 affected individuals.

- As the patient population of "infected" youth has aged into and through adolescence the population has required more attention from assigned case managers and therefore, some of the capacity available for "affected" family members to receive case management has been lost and the numbers of "affected" individuals has dropped in a corresponding fashion as noted above.
- A second patient population aging out of the service spectrum for CYFAN in the past six years has been the HIV+ female population over the age of 25. In 2000, for example CYFAN served 81 HIV+ females in this age category, in the 2003 Ryan White Data Report that number had dropped to 49 and the calendar year total for 2007 checks in at 32. This is indicative of a female population in our caseload that has moved beyond the existing care system due to child bearing considerations into other truly "adult-focused" care system providers across Connecticut.
- As a program CYFAN has become better in the recent past about closing cases that for a number of reasons probably should not have been kept open (particularly for affected family members) to make case management services more widely available in a comprehensive way to those individuals most in need of services. In addition, under section 6 Evaluation some basic information is presented on level of service intensity for CYFAN and this information reinforces the fact that as infected individuals are getting older they are in need of more time consuming, intense services.
- The final item to consider is that in 2007 across CYFAN statewide approximately 1 FTE of case management service time has been transitioned into either HIV testing services or primary care nursing support for clients already accounted for within CYFAN. This loss of service capacity has had an impact on the total number of medical case management client contacts this year in comparison to calendar years 2005 and 2006 when the additional FTE of medical case management service was available.

Strategic Planning Priorities for CYFAN

- Continue to track and manage increasing volume of individual outreach contacts across Connecticut as case finding and counseling and testing services have been reconfigured within RW Part D funding from 2000 to present.
- Develop a comprehensive data management and reporting system that supports continuous quality improvement.
- Work on a continual basis with providers in assisting youth infected from birth to transition into the "adult" service environment.
- Continue to work with enrolled clients (particularly infected and affected youth) on a number of life skills. In two program sites across Connecticut, staff complete a formalized life skills curriculum that includes topics such as money management, educational achievement and basic parenting among others.
- Continue to support a well-trained Community Advisory Board (CAB) that is linked to all aspects of care and administration to insure that consumer and community needs and concerns receive the utmost attention.

CYFAN, a Ryan White Part D funded program, is very closely linked to a number of the RW Part C grantees in Connecticut and currently works with a total of nine sub-contractual partner agencies throughout Connecticut within RW Part D. Five of the nine partner agencies also receive RW Part C funding. They include:

- Generations Family Health Center (Willimantic)
- Fair Haven CHC (New Haven)
- Hill Health (New Haven)
- Optimus/Bridgeport CHC (Bridgeport)
- Southwest CHC (Bridgeport)

All of the above agencies use RW Part C funding in either the medical case management or outreach categories to support the primary care objectives established within their individual RW Part C grants. A concrete goal for the five RW Part C agencies working within RW Part D is to continue to enhance overall capacity for counseling and testing (particularly as relates to the population at highest risk under the age of 25). HRSA expects those organizations to offer Counseling and Testing to a large number of people under the age of 25 throughout the year.

CYFAN also contracts with the following four agencies that are multiply funded with Ryan White Services and include:

- Charter Oak Health Center
- UCONN Health Center/ Connecticut Children's Medical Center
- Yale Child Study Center
- Bridgeport Hospital

E. Special Projects of National Significance (SPNS) on Oral Health Care

The Program

Community Health Center, Inc. (CHC) is a community federally qualified health center (FQHC) providing health care to more than 70,000 people annually through its offices in Connecticut. Medicine, dentistry, and mental health are the core clinical services, supported by a range of social and support services including a battered women's shelter, a family wellness Center, a drop-in center for people with HIV, and CHC's Healthcare for the Homeless Program. The organization has created primary care facilities in nine Connecticut towns and cities throughout the state: Middletown, Old Saybrook, Meriden, New London, Groton, New Britain, Clinton, Norwalk and Stamford. The "Norwalk Smiles" program Oral Health Care Program for People with HIV Project is funded by SPNS (HRSA) and opened June 1, 2007. The Program operates five days a week in both CHC's Norwalk and Stamford sites.

Barriers

Focus groups conducted in the Norwalk community revealed several barriers to PLWH/A receiving oral health care. The first was the availability of appointments with providers who accepted Title XIX or Medicaid. The second most commonly identified barrier was fear of disclosing HIV status or being discriminated against for HIV status. Other barriers included bad experiences with dentists in the past, embarrassment over lack of recent dental care, transportation, childcare, fear of pain.

Identified Needs

1. Access to appointments
2. Dental personnel trained in HIV care, management and cultural competency.
3. Transportation
4. Outreach and incentives for following through with dental care.

Funded Approach (5 year grant period)

Comprehensive dental care will be provided to 700 HIV+ people at each of two sites: 1) Norwalk Smiles, 49 Day Street in Norwalk, Connecticut, and 2) The Dental Center of Stamford, 141 Franklin Street in Stamford, Connecticut. Comprehensive care is provided five days a week at both sites with dentists, hygienists and dental assistants specifically trained in HIV management and stigma reduction. The Oral Health Care Project for People with HIV is embedded into CHC's full scale dental practices at each site. Transportation is also available. Each consumer is given an intake at the beginning of treatment. A care coordinator assesses needs other then dental and then makes appropriate referrals. The care coordinator also remains in contact with patients throughout all follow-up appointments and identifies barriers to care and gaps in service and assists with the resolutions. Each consumer meets with an Access to Care Worker who determines eligibility for any type of insurance. All staff is bi-lingual and trained in cultural competence. At intake, and again at six months and twelve months, each consumer is given an incentive to participate in a study evaluation of previous barriers to care, demographic information and habits that affect oral health care. This study will be used to evaluate oral health care in the HIV population and to assist HRSA in directing future funding in this area.

F. Youth Advisory Group

The Youth Advisory Group (YAG) is a group of young individuals ages 18-24 recruited from across the state of Connecticut to work as a component of the Connecticut HIV Planning Consortium representing the interests of youth across the state. The YAG has been meeting for three years. The following are a list of barriers and recommendations on how to work with youth:

Barriers identified by the Youth Advisory Group for prevention services:

- Traveling to programs. While there are resources available, many youth from suburban areas will not travel to the cities to access resources like HIV testing and counseling. For example, teenagers from Fairfield may not go to Bridgeport, even if most of the services and programs are located there.
- Limited reach of peer education programs. Many peer education programs meet once a week, so it can take a long time to train and prepare peer educators, and to develop the materials and outreach programs. As a result, these programs may not reach large numbers of youth beyond those directly involved in the program.
- School restrictions. Many high schools restrict access to information and access to condoms. Peer educators can get in trouble for giving out condoms at school.
- Bring education to youth on a regular basis. It is important to bring programs and HIV prevention directly to youth, and for programs to keep coming back to schools, rather than just having one-time events.

Care services/recommendations identified by the Youth Advisory Group are:

- Give youth all the facts. Provide youth with current information regarding STD/HIV prevention as well as a guide outlining care services for HIV+ youth. Also provide assistance to youth transitioning from youth to adult systems of care
- Caring, respectful staff. Providers should explain the process step by step, be personable and friendly and help youth to feel comfortable. Providers also need to learn how to tell a youth his/her HIV status.
- Flexible hours, help with transportation. Transportation to and from appointments is crucial. Youth need to meet with providers in a neutral/comfortable setting. Care services need to protect an individual's confidentiality and privacy.
- Start young. Tell HIV+ youth early on about their status – don't wait until they are older. Talk to HIV+ youth at a younger age about the body, viruses and why people need to take their medications
- Youth involvement. Involve HIV+ youth in decision making opportunities (e.g. designing trendy youth pill cases). Involve HIV+ youth on the impact of medication trials. Solicit feedback from HIV+ youth on the quality of their care.

G. DPH Group Training Feedback

In April 2008, DPH conducted a two day "Connecting to Care" Training for representatives from both care and prevention (e.g. CRCS managers, medical case managers). During a break-out session, groups were asked to discuss barriers/needs their clients have faced in entering regular medical care and barriers/needs clients have faced in maintaining a consistent relationship with regular medical care. Following is a synopsis of those answers:

Entering Care		***Maintaining Consistent Relationship***	
Barriers	**Needs**	**Barriers**	**Needs**
Insurance Location Finances/lack of income Housing Transportation Mental Health and Substance Abuse Culture, language, religion Confidentiality Stigma / disclosure Criminal history Undocumented, illegal, immigrant Lack of education	Adequate, available & affordable transportation Co-located services Bi-lingual &culturally competent staff Flexible hours Translators/interpreters Client education Financial advocacy Support systems Affordable housing Outreach	Income Language Medications Substance Abuse and Mental Health Location of services Relation with providers Insurance / can't pay co-pays Disclosure, discrimination & stigma Religion Immigration/ undocumented	Client Advocacy Bi-lingual staff and medical providers Adherence nurse (treatment team) Affordable and available transportation Culturally competent MH/SA providers Co-located services Provider education Support systems (families/groups) Client education

IV. SCSN General Findings

The information in this 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; and d. out of care/unmet need and gap priorities. Information is separated according to the Non TGA areas, and the New Haven-Fairfield and Hartford TGAs.

- Please note that information reported across the State is based on different data sets and targets. The following represents a best effort at assessing the different sets of information that can only suggest a picture of needs in Connecticut. When appropriate, suggested statements will be identified as supported by the 2005 Statewide Needs Assessment.

A. Care and Prevention Services Used

Prevention

From the information compiled through DMHAS, Windham, New London, Litchfield, New Haven, and Fairfield, 49% to 78 % of respondents indicate that they do not need prevention services. 20% reported having had unprotected sex within the past year. 25% stated that they did not disclose their status to a partner within the past year.

In the Hartford TGA, 21-46% of respondents report that they do not need prevention services. However, 39% reported they had unprotected sex with an HIV- partner after testing positive; 38% reported having had unprotected sex after testing positive; 22% reported having had unprotected sex with an anonymous partner and 43% stated that they did not disclose their status to their partner.

- **Prevention Services most used**: Prevention support groups 32%; Condom distribution 32%; Comprehensive Risk Counseling Services (CRCS) 21%
    - **2005 SCSN data** supports this information on service use, particularly for CRCS

Care

- **Core Medical Services most used:** Core Services most used in Windham, New London, and Litchfield Counties, Greater Hartford TGA and New Haven/Fairfield County are listed in order of priority in the table below.

Core Medical Service Most Used	W, NL, L	HTFD.	NH/FF	Statewide 2005
Medical Care for HIV	90%	91%	49%	88%
Medical Case Management	67%	86%	43%	68% *
Dental care	60%	59%	4%	57%
CADAP	57%	38%	--	68% *
* Definitions for these services have changed as a result of the 2006 Modernization Act Note: % for NH/FF should be understood as the % of persons using this service to help them see their HIV doctor. NH/FF did not distinguish between Case Management v. Medical Case Management.				

B. Care and Prevention Services Most Needed

- **Prevention Services most needed:** Of the individuals who responded to this question, 11 % indicated that they need Prevention support groups. In Greater Hartford, the most significant need was for education or information dissemination on prevention services as 6-16% indicated that they did not know about prevention services available to them.

  2005 SCSN data supports the need for Prevention support groups

Core Services most needed: For Windham, New London and Litchfield of those who responded, the core services most needed were: Dental services 14%; Insurance assistance / co-pays 11%. 12% need Insurance Assistance, but do not know this service was available.

- For Greater Hartford, the only core medical service that was significantly needed was Dental care where 25% of the respondents identified needing that service but had not used it within 12 months.
- For New Haven, the services most needed were Mental Health counseling 22% and Substance Abuse Outpatient Rehabilitation 12%, Assistance paying for AIDS Medications 26%.

  2005 SCSN data statewide information identified Dental Care 33%, Mental Health services 20%, Case Management 11%, and Assistance Paying for Medication 10% as the services needed most.

Support services most needed:

- For Windham, New London and Litchfield of those who responded, the support services most needed were Housing 11%, with 13% indicating that they needed this service but did not know about it. 14% indicated they needed Emergency Financial Assistance but did not know about it.
- Greater Hartford TGA respondents also indicated that Emergency Financial Assistance 17%, Help paying for Housing 13%, and Help finding housing 11% were the services most needed.
- New Haven Fairfield TGA respondents identified Housing Assistance 41%, Food Bank 23% and Transportation 19% as the most needed support services.

  2005 SCSN data supports the need for housing related services 30% and Emergency Financial Assistance 29%.

C. Barriers to Care and Prevention Services

- For Windham, New London and Litchfield of those who responded, the barriers posing the most problems for obtaining services are: inability to pay for services with 20% stating it as a major problem and 15% stating it is a minor problem; fear of revealing status is the next most identified problem at 17% stating it is a major problem and 20% stating it is a minor problem. Lack of transportation was identified by 15% as a major problem and 18% as a minor problem; 14% stated that being unaware of services was a minor problem.

- Barriers to services for the in-care population in Greater Hartford were reported on those areas identified as most needed, Emergency Financial Assistance, help paying rent, and help finding an apartment. The barriers included lack of knowledge of the service availability (60-70%), did lack of knowledge on where to get this service (64-81%), inability to pay for this service (36-47%).
- Barriers to service needs of in-care individuals in New Haven/Fairfield were reported on those areas most needed, and therefore keeping individuals from seeking primary medical care. Housing 34% (51) was identified as the #1 service needed but unable to get followed by transportation 19% (28), dental 13% (19) and food bank 11% (17); 51 individuals indicated that were unable to get housing.

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

D. Out-of-care; Unmet Need; Priority Needs For Underserved

1. Out of Care Population

- Windham, Litchfield and New London Counties: Of the 227 surveys received by the CHPC for the W, L and NL counties, 4 out of care individuals were identified. The number was too low to allow for proper assessment.
- Greater Hartford identified 28 out of care individuals who are all over 30 years of age. Services that were most needed by the out of care population in Greater Hartford include CADAP 14%. Services needed but not used in the 12 months were Medical Care for HIV 57%, Dental Care 50%, Medical Case Management 39% and AIDS medication assistance 29%.
- Barriers to services for out of care respondents in Greater Hartford: For Emergency Financial Assistance respondents identified lack of knowledge of where to go to get the service as the barrier. For accessing help to pay rent the barriers were not knowing the service was available, fear that others would find out that the participant was HIV positive, and homelessness.
- New Haven/Fairfield TGA reported on 204 out of care individuals in 2007, ranking the identified service needs in order of priority. Of the 20 services listed, that were ranked 1-9 the following services in the highest ranking (1-5) are 1 housing, 2 medical care for HIV, 3 other primary medical care, 4 AIDS medication assistance (not CADAP), 4 Substance abuse treatment, 4 dental care, 4 transportation, and 5 mental health treatment. The highest ranking two barriers in New Haven-Fairfield TGA were lack of transportation and lack of housing. Reasons given by the out of care respondents in New Haven-Fairfield TGA were worry over others finding out, fear of telling someone else, feeling healthy, other basic needs not met/health/job.

2007 SCSN Update data on the out of care population supports the following methods to help individuals seek care/see a doctor: help with transportation followed by case management, and help finding an MD. It is interesting to note that almost one third of this group who answered no, stated that nothing would help them to seek treatment.

- Among those not wanting to see a doctor, almost 1/2 stated that they felt healthy or were recently diagnosed, and about 1/3 mentioned that they distrusted doctors.
- Among the respondents wanting to see a doctor, but not doing so, substance abuse; lack of insurance, lack of a stable home, and depression or mental illness were most given as answers to the question "What is preventing you from seeing a doctor?"

2. Unmet Need

Connecticut's 2008 unmet need estimate 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 eHARS data registry, although some continue to be reported on paper and are manually entered. 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 term "unmet need" is used only to describe the unmet need for HIV-related primary health care, and is not considered a service gap." Viral load is only one component of the measure. However, we are estimating the unmet need largely using viral loads since the percentage of people on drug therapy getting CD4 counts and not a VL is small. Connecticut requires reporting of a CD4 result only if it is diagnostic of AIDS (<200 count or <14%). The available CD4 data is included in the estimate.

Unmet Need Estimate. The Unmet Need Table below shows the current model for estimated unmet need for primary care services in the state of Connecticut. The total percent of HIV+/aware not receiving the specified HIV primary medical care (quantified estimate of unmet need) is thirty-eight percent (38%).

Unmet Need Framework Table

Population Sizes		Value		Data Source(s)
Row A.	Number of persons living with AIDS (PLWA), as of date December 31, 2007	7,453		eHARS
Row B.	Number of persons living with HIV (PLWH)/non-AIDS/aware, as of date December 31, 2007	3,278		eHARS
Row C.	Total number of HIV+/aware as of date December 31, 2007	10,731		eHARS
Care Patterns		**Value**		**Data Source(s)**
Row D.	Number of PLWA who received the specified HIV primary medical care during 2007	4,770		eHARS VL and CD4 data
Row E.	Number of PLWH/non-AIDS/aware who received the specified HIV primary medical care during 2007	1,901		eHARS VL and CD4 data
Row F.	Total number of HIV+/aware who received the specified HIV primary medical care during 2007	6,672		eHARS VL and CD4 data
Calculated Results		**Value**	**Percent**	**Calculation**
Row G.	Number of PLWA who did not receive the specified HIV primary medical care	2,683	36%	Value = A - D. Percent = G/A
Row H.	Number of PLWH/non-AIDS/aware who did not receive the specified HIV primary medical care	1,377	42%	Value: B - E. Percent: H/B
Row I.	Total HIV+/aware not receiving the specified HIV primary medical care (quantified estimate of unmet need)	4,060	38%	Value: G + H. Percent: I/C

In Care Population of PLWH/A based on Viral Load Reporting Source: CT DPH Surveillance 2007			
Based on VL reporting	PLWAIDS In care 64%	PLWHIV In care 58%	Total In care 62%
Male	62%	57%	61%
Female	67%	58%	65%
White	63%	58%	62%
Black	65%	55%	63%
Hispanic	63%	60%	62%
Other	59%	55%	57%
IDU	65%	57%	63%
MSM	63%	60%	62%
MSM/IDU	64%	60%	63%
Hetero	63%	60%	62%
Pedi	71%	59%	66%
Other unknown	62%	53%	58%
0-12	80%	60%	65%
13-19	72%	73%	72%
20-29	64%	51%	55%
30-39	64%	55%	60%
40-39	64%	58%	63%
50+	64%	61%	63%
Hartford TGA	66%	57%	63%
New Haven/Fairfield TGA	64%	59%	62%
Non-TGA areas	59%	51%	57%

3. Priorities to ensure underserved populations are accessing care

Reaching underserved populations and assisting them to access care continues to be a challenge in Connecticut. According to our unmet need estimate from viral load reporting, 62% are in care and 38% are out of care. Based on the in care and out of care assessments, the issues confronting both populations are similar. The one striking difference for those who may be in need of services but are not accessing them is 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 services (care and prevention) to get people into care and keep them there.

Connecticut identifies populations who are most likely to need prevention services by risk category. In 2006, the those populations were identified in order of priority as HIV+, Hispanic IDU, White MSM, Black IDU, White IDU, Black Heterosexual, Hispanic Heterosexual, Hispanic MSM, White Heterosexual and Black MSM. In 2007, the new reported number of HIV/AIDS cases was 1,300. Of those, 35% were White, 30% were Black and 34% were Hispanic. Of the 1,300 newly reported cases, the transmission mode listed was 25% IDU, 23% MSM, 15% Heterosexual, and 1% MSM/IDU with 35% listed as other or risk not reported. The DAC continues to discuss prevention services for everyone while acknowledging the need for interventions to target disproportionately impacted populations and to see 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.

Reduction of barriers	Address core medical gaps by priority
• Education/information on available services • Basic needs met to help people get care • Culturally appropriate services • Transportation to medical services • Covered costs for medical care	• Dental • Mental Health Services • Assistance paying for AIDS services/medications

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 SPNS, and programs administered through state, regional and local entities: a. AIDS Service Organizations, b. State Agencies, c. Parts C and D, d. Special Projects of National Significance, e. 211 Resource Inventory of Services across the state, f. Identified service gaps and priorities.

A. Statewide AIDS Organizations

Connecticut provides core medical and supportive services to people living with HIV/AIDS (PLWH/A) and their families through various "HIV/AIDS service organizations (ASO)." 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 PLWH/A 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 income limit 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).
- **Charter Oak Health Plan** – State of Connecticut program offering health insurance coverage to the uninsured (Monthly premiums based on household size/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+ 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.
- **Connecticut's Mental Health Services for HIV Affected Children's Programs** – These mental health services are available to help children and their families deal with problems related to the stress of living with loved ones who have HIV/AIDS through individual or family therapy, group therapy, bereavement counseling or other therapeutic modalities.

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, URS and CAREWare)

HIV Prevention, Education and Interventions (e.g. DEBI's, EBI's, Comprehensive Risk Counseling Services, Social Network)

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)

Mental Health for HIV Affected Children and Families (State-funded)

Connecticut Department of Corrections (DOC):

HIV Counseling, Testing & Referral

HIV + Support Groups

Inmate Orientations (Health Communications/ Public Information)

Intensive AIDS Education in Jail (Rikers Health Advocacy Program)

Connecticut Department of Social Services (DSS): Note: DSS is currently reviewing the roll-out of a Connecticut Home and Community-based waiver for persons living with HIV/AIDS. This Medicaid program would allow the State to provide a broad array of services not otherwise covered by Medicaid and would function as an alternative to nursing home institutionalization. Initially the program would serve 100 HIV+ Medicaid eligible individuals.

CONNPace

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

Housing Opportunities for Persons With AIDS (HOPWA) Grant

AIDS Residence Programs

Medicaid Managed Care Services

Stated Assisted General Assistance (SAGA)

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 Grant

Mental Health Services for the Homeless Grant

General Assistance Demonstration Projects

Basic Needs Program

Connecticut Department of Children & Families (DCF):

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

Medically Fragile Children's Program

Child Guidance Clinics

Connecticut Department of Education (SDE):

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

2007 Connecticut School Health Survey (Youth Behavior Component)

SAMHSA (Directly funded by federal agency)

Connecticut Department of Mental Health & Addiction Services (DMHAS): various statewide sites

City of Hartford (MetroHartford Prevention Coalition)

Hispanic Health Council (ProjectConnect)

Latino Community Services (Latino Faith Partnership for Prevention and Treatment)

Hill Health Center (HIV substance abuse services for African-American women)

Greater Bridgeport Adolescent Pregnancy Program (Bridgeport Partners for Teens)

Chemical Abuse Services Agency, Inc.

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

Note: A complete listing of HIV/AIDS services and other supportive services can be found in the Connecticut Resource Inventory addendum.

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 HIV Planning Consortium (CHPC)

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: (2007-2008)

Statewide Collaborative Consumer Needs Assessment Out-of-care (2007)

Statewide Care and Prevention Needs Assessment Survey of non-TGA counties and CADAP clients (2008)

Statewide HIV/AIDS Technical Assistance regarding Medical Case Management standards and Outcome Measures (2007 and 2008)

Statewide Medical Case Manager training (2008)

Statewide Integration of HIV Care and Prevention Training Program and Continuing Education Programs

Participation of Ryan White Parts

Part A – HIV Emergency Relief Grant Program (Transitional Grant Areas)

New Haven/Fairfield Counties Planning Council(Administered by the City of New Haven)

AIDS Interfaith Network

AIDS Project Greater Danbury

AIDS Project New Haven

Birmingham Mental Health Center

Clifford Beers Guidance Clinic, Inc.

Connecticut Counseling Centers, Inc.

Fair Haven Community Health Center

Greater Bridgeport Adolescent Pregnancy Program

New Haven/ Fairfield County TGA (continued)

Health Care Connections

Hill Health Center

Hispanos Unidos, Inc.

Liberation Programs, Inc.

Liberty Community Services, Inc.

Macedonia AIDS Ministry, Inc.

Mid-Fairfield AIDS Project

New Haven Home Recovery

New Opportunities, Inc.

Regional Network

Staywell Health Care, Inc.

Waterbury Hospital

Yale University AIDS Program

Yale University Child Study Center

Hartford/Middlesex/Tolland Counties Planning Council (Administered by the City of Hartford)

AIDS Project Hartford

Central Area Health Education Center, Inc.

Charter Oak Health Center

Community Health Center, Inc.

Community Health Services, Inc.

Community Renewal Team

Connecticut AIDS Resource Coalition

Greater Hartford Legal Aid, Inc (AIDS Legal Network)

Hartford Gay & Lesbian Health Collective, Inc.

Human Resources Agency of New Britain

Immaculate Conception Shelter & Housing, Inc.

Latino Community Services, Inc.

Manchester Area Network on AIDS

Mercy Housing & Shelter Corporation

North Central Regional Mental Health Board

Rockville General Hospital

UCONN Health Center

UCONN Health Center /Connecticut Children's Medical Center

Part B – HIV Care Grants DPH administered

AIDS Interfaith Network

AIDS Project Greater Danbury

AIDS Project Hartford

AIDS Project New Haven

Alliance for Living

Birmingham Group

Central Area Health Education Center

City of Waterbury Health Department (Waterbury/Torrington sites)

Community Health Center (Middletown)

Family Services Woodfield

Hartford Gay & Lesbian Health Collective

Health Care Connections

Hispanos Unidos

Human Resources Agency of New Britain

Latino Community Services

Mid-Fairfield AIDS Project

New Opportunities, Inc.

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.
Fair Haven Community Health Center, Inc.
Generations Family Health Center, Inc.
Hill Health Center
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 (funds 9 programs)

Bridgeport Hospital
Charter Oak Health Center, Inc.
Fair Haven Community Health Center, Inc.
Generations Family Health Center, Inc
Hill Health Corporation
Optimus Health Care Inc.
Southwest Community Health Center
UCONN Health Center
Yale Child Study Center

Title V – Maternal and Child Health Program
Connecticut Department of Public Health

Part F SPNS

Community Health Center, Inc – Norwalk Smiles (Norwalk and Stamford, Connecticut)

United Way 211 Infoline

Information helpline on all public and private providers of HIV related services (see Resource Inventory in Appendix)

Connecticut HIV Care Consortium Representation (Funded by Part B & CDC)

Public Health Planning Bodies

New Haven-Fairfield Part A Planning Council
Hartford Part A Planning Council

Consumer Representation by County

Hartford	Fairfield
Litchfield	Middlesex (tbd)
New Haven	New London
Tolland	Windham

Part B Provider Agencies

(Programs funded by both care and prevention are marked with * and have only one representative on CHPC)
AIDS Project Greater Danbury*
Alliance for Living
Birmingham Group Health Services, Inc.
Central Area Health Education Center, Inc*
City of Waterbury Health Department*
Community Health Center, Inc.*
Hartford Gay and Lesbian Health Collective*
Hispanos Unidos*
Latino Community Services*
University of Connecticut Children's Medical Center (CCMC)*
Windham Regional Community Council

Part C: Provider Agencies

Hill Health Center
Waterbury Hospital Health Center

Part D: Provider Agencies

Community Health Center Association of Connecticut (CHCACT)

Government Agencies

Department of Public Health
Department of Social Services (CADAP)
Department of Correction: University of Connecticut Correctional Managed Health Care
Department of Mental Health and Addiction Services

Prevention Agencies

Programs funded by both Part B and prevention are marked with * and have only one representative on CHPC)
Hartford Health and Human Services Department
Optimus Health Care
Southwest Community Health Center

Part F: Provider Agency

Connecticut AIDS Education & Training Center (CAETC)
SPNS: Norwalk Smiles (Community Health Center, Inc.)

Statewide Programs
Project TLC (AIDS Project Hartford)
Connecticut AIDS Resource Coalition

C. Identified Service Gaps: Prevention and Care

Prevention: Connecticut funds a broad array of CDC defined prevention services including Counseling, Testing & Referral (CTR), Comprehensive Risk Counseling Services (CRCS), Drug Treatment Advocacy (DTA), as well as a cadre of Diffused Effective Behavioral Interventions (DEBI) and Effective Behavioral Interventions (EBIs). The DEBIs and EBIs are designed to specifically target certain affected populations (e.g. Heterosexual African American women, African American, Latino and White MSM, HIV+, etc). In November 2007 DPH released two Requests for Proposals (RFP) for HIV prevention services to fund statewide agencies to provide CTR, CRCS, DEBIs and EBIs. Funds were allocated for statewide programs and for each County based on HIV/AIDS rates. The second RFP was designed to support creative and more interventions targeting Men Who Have Sex with Men (MSM) and Intravenous Drug Users (IDU), including Drug Treatment Advocacy (DTA). A total of 41 agencies statewide were funded to provide HIV prevention services and interventions to Connecticut's prioritized populations. One outcome of the review process was that several long-standing agencies did not receive funding and new agencies were funded for the first time resulting in service gaps that have been addressed by the DPH.

The following gaps (see table on the next page) were identified through the examination of resources, service provision, provider capacity as discussed among DPH and the CHPC Data and Assessment Committee members. (See Service Matrix)

- Interventions targeting MSM in New London, Litchfield, Tolland, and Windham Counties
- Interventions targeting Latino and/or African American Heterosexual women in New London, Fairfield and Windham Counties
- Comprehensive Risk Counseling Services for high risk individuals in Windham, Middlesex and Litchfield Counties

Care: With the 2006 Ryan White reauthorization, and the status change of Connecticut's two Eligible Metropolitan Areas (EMA) to TGAs, some core services were impacted and support services were reduced, capped or eliminated completely. In response, the Connecticut State Legislature appropriated funding until 2009 (based on availability) to fill part of the TGA funding gaps. Part B funding continued to fill in other service gaps (e.g., medical case management, mental health, emergency financial assistance, housing, and psychosocial). The following Care Service Gaps were identified by comparing the SCSN findings to the Care & Prevention Service Matrix. (See Section 4 and the next page):

- Dental services and health insurance continuation in Windham County
- Dental services, health insurance continuation, food bank and housing-related services in Litchfield County
- Dental services and health insurance continuation in New London County
- Dental services, Emergency Financial Assistance, and Housing-related services in Hartford County
- Middlesex and Tolland Counties fall under the Greater Hartford TGA jurisdiction, but for Tolland County recurring service gaps exist in medical transportation, dental care, and food bank
- AIDS Pharmaceutical Assistance, oral health, health insurance continuation, and additional mental health and housing-related services in New Haven-Fairfield TGA

Note: Part C Community Health Centers, local hospitals, private practitioners and clinics sited in these counties address gaps noted on the service matrix (e.g. mental health and substance abuse services, ambulatory/outpatient and oral health)

The table below lists the service gaps and priorities for the State. As discussed on the preceding page, the services needed have been identified by County. For prevention, specific populations are targeted on page 37.

Connecticut Service Gaps and Priorities

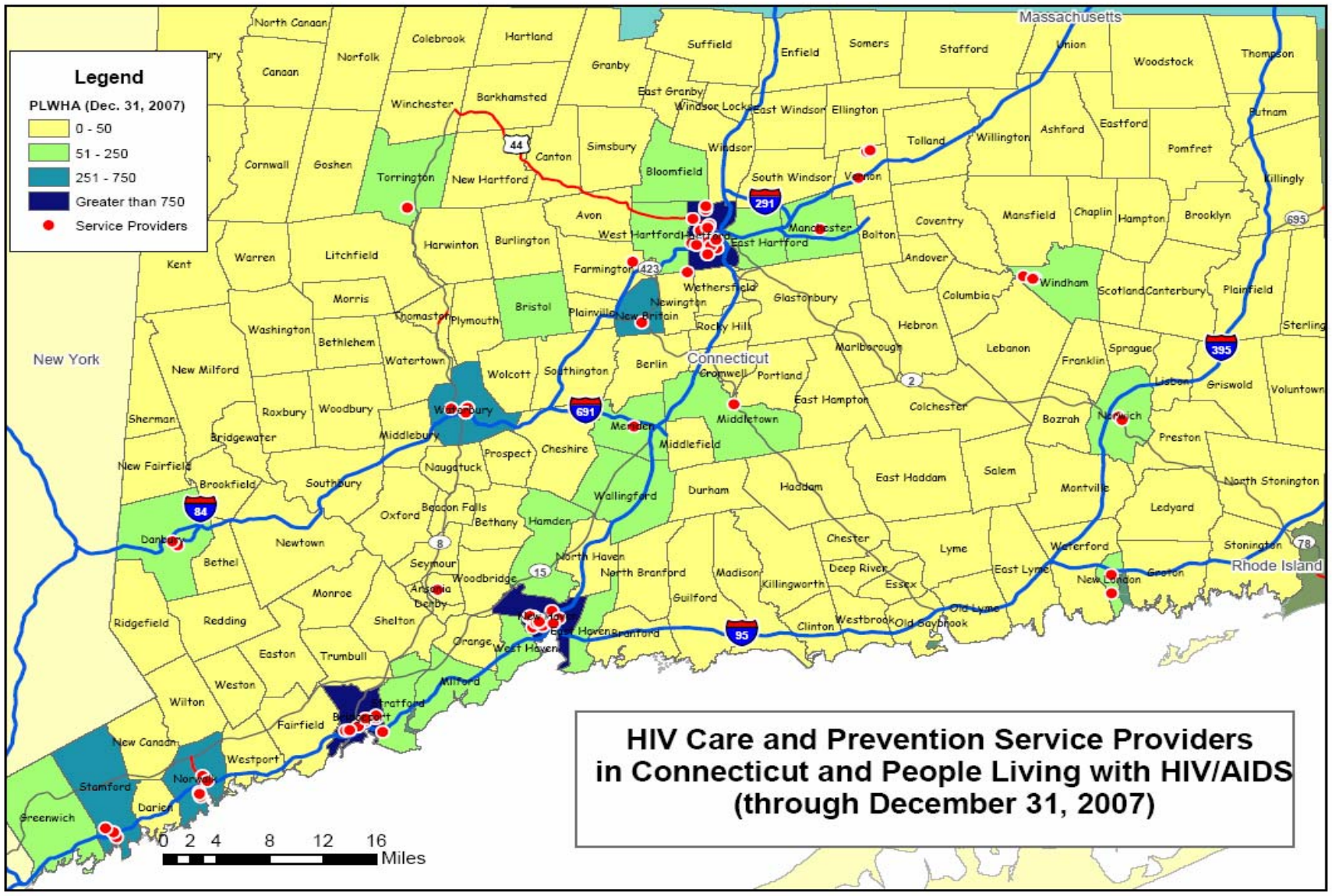
Note: service priorities varied by region, i.e., TGA and the rural areas or rest of the state, hence statewide services are listed in an a best guess for priority based on 2005 and 2007 SCSN information, since data was compiled from disparate sources

County Abbreviations: New London (NL) Litchfield (L), Tolland (T), Windham (W), Hartford (H), New Haven (NH), Fairfield (FF), Middlesex (M)

	Prevention		Care Core Services		Care Support Services		Barriers
1.	Prevention Support Services/prevention interventions NL, L, T, W, FFF	1.	Dental W, L, NL, H, T, NH, FF	1.	Housing W, H, L, NH, FF	1.	Inability to pay All
2.	Risk Reduction – services/Information NL, L, T, W, FF, H	2.	Mental Health Services NH, FF	2.	Emergency Financial Assistance H, L, W, NL	2.	Transportation All
3.	Comprehensive Risk Counseling Services L, W, M	3.	Insurance Assistance (for HIV services/medications) W, L, NH, FF, NL	3.	Food H, L, T, NH, FF	3.	Unaware of services All
		4.	Substance Abuse NH, FF	4.	Transportation T, NH, FF	4.	Fear of revealing status All

Information from the various data sources indicates that, *to engage as many people as possible (underserved and those yet to enter care) into both prevention services (primary and secondary) and care services; and to reengage individuals who have fallen out of car*e, Connecticut must create strategies to reduce barriers through providing education/information on available services, meeting people's basic needs to ensure people can receive care, making certain that there are culturally appropriate services, providing transportation to medical services and making sure that costs are covered for medical care.

The map of Connecticut on the next page, provides a picture of service providers funded through HRSA and CDC, as an overlay to population density of people living with HIV/AIDS in Connecticut as of December 31, 2007.



Prepared by Holt, Wexler & Farnam, LLP

6. Emerging Needs, Issues, Trends

This section discusses three major 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 a.) economic issues (housing, food, energy costs); b.) rural area issues; and the use of c.) client level data. As the CHPC enters its next three year cycle, these factors (reflected in the report recommendations) will be considered when implementing their 2009 Comprehensive Plan.

a.) Economic Issues in Connecticut

Connecticut is a rich and progressive state. It is also one of the most expensive states in which to live, yet there are many in Connecticut who fall well below the poverty level. Douglas Hall, Ph.D. & Shelley Geballe, J.D., M.P.H. report through Connecticut Voices for Children that the gaps in average real income between the rich and poor families in Connecticut and between the rich and middle income families is wider in Connecticut than other states in the nation. They emphasize that "Connecticut is the only state in which real income for the poorest fifth of families declined significantly since the late 1980s. On average, real income for low-income families in the U.S. increased by $1,814 (11%), but in Connecticut, real income for these families actually declined by $4,437 (-17%). The average income of the wealthiest fifth of Connecticut families now is 8 times greater than the income of the poorest fifth, compared to 4.6 times in the late 1980s. The wealthiest families now have income 2.7 times that of middle-income families, compared to 1.9 times in the late 1980s. Both of these increases in income inequality are the greatest among all states." [10]

What does this mean for Connecticut? The income gap between the poor and rich creates wide health disparities. According to a recent article in the Harvard Magazine, "Disparities in health tend to fall along income lines everywhere: the poor generally get sicker and die sooner than the rich. But in the United States, the gap between the rich and the poor is far wider than in most other developed democracies, and it is getting wider. That is true both before and after taxes: the United States also does less than most other rich democracies to redistribute income from the rich to the poor." [11]

What it Costs to Live in Connecticut (2007): 'Out of Reach", National Low Income Housing Coalition. www.nlihc.org

# of Bedrooms (BDR)	0 BR	1BR	2BR	3 BR	4 BR
State of CT Fair Market Value (FMR)*	$728	$876	$1.062	$1,299	$1,538
Minimum Income Needed to afford FMR	$29,131	35,034	$42,480	$51,960	$61,514
Percent of Family Area Median Income (AMI) Needed to Afford a rental unit at FMR**	35%	42%	51%	63%	74%
*In general, the Fair Market Rent (FMR) for an area is the amount that would be needed to pay the gross rent (shelter rent plus utilities) of privately owned, decent, and safe rental housing of a modest (non-luxury) nature with suitable amenities. (see 24 CFR 982.503). ** A unit is considered affordable if it costs no more than 30% of the renter's income					

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[10] Pulling Apart in Connecticut: Trends in Family Income, Late 1980s to Mid 2000s *Douglas Hall, Ph.D. & Shelley Geballe, J.D., M.P.H.* (April 2008)

[11] (**http://harvardmagazine.com/2008/07/unequal-america.html**) Unequal America, Causes and consequences of the wide—and growing—gap between rich and poor

The Fair Market Rent (FMR) for a two-bedroom apartment in CT is $1,062. In order to afford this level of rent and utilities, without paying more than 30% of income on housing, a household must earn $3,540 monthly or $42,480 annually. Assuming a 40-hour workweek, 52 weeks per year, this level of income translates into a Housing Wage of $20.42. In CT, a minimum wage worker earns an hourly wage of $7.40. In order to afford the FMR for a two-bedroom apartment, a minimum wage earner must work 110 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 bedrooms FMR affordable.

The estimated mean (average) wage for a renter in the state is $15.09 an hour. In order to afford the FMR for a two-bedroom apartment at this wage, a renter must work 54 hours per week, 52 weeks per year. Or, working 40 hours per week year-round, a household must include 1.4 worker(s) earning the mean renter wage in order to make the two-bedroom FMR affordable. PLWHA struggle with health issues that often makes working a 40 hour week impossible.

Persons living at or below 300% of the 2007 Federal Poverty Level

Socioeconomic status shapes social and individual factors that affect the care of PLWHA, the risk of HIV infection, and the high probability of relying on publicly funded health care services. Poverty is particularly associated with increased morbidity and premature mortality. Although it is the richest state in America, 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 6.8% of people living in CT live below the poverty line (US Census data).

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 $13,428. In Bridgeport, more than 62% of city residents are minorities, and the city-wide poverty rate is almost 25%. Bridgeport's unemployment rate at 9% 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 with 24.7 percent of residents living in poverty. Children under five years of age are experiencing the most poverty in Connecticut, with 11.3% living in poverty.

2007 Poverty Rate in Connecticut by County and People Living with HIV/AIDS

County	% of Population living in poverty	PLWH/A
New Haven	9.5	2,990
Hartford	9.3	3,060
Windham	8.5	185
Fairfield	6.9	2,657
New London	6.4	494
County	**% of Population living in poverty**	**PLWH/A**
Tolland	5.6	104
Middlesex	4.6	207
Litchfield	4.5	174

Supplemental Housing, Food and Energy Data

The 2008 Needs Assessments conducted by the Hartford TGA - which includes Hartford, Tolland and Middlesex counties; the balance of state covering Litchfield, Windham and New London counties; and New Haven-Fairfield capture a point in time "assessment" of the needs of people with HIV/AIDS, barriers to care and services and what is most important to them. By design, needs assessments can't capture the less tangible factors that will impact future demands for the array of available services offered by Ryan White providers. The following information is meant to assist in and round out actual and potential needs.

Housing[12]

The Connecticut AIDS Resource Coalition (CARC) has been collecting statistics on the demand for and utilization of AIDS housing since 1992. In 2007, over 1,200 men, women and children were housed among the 24 supportive AIDS housing programs located across the state. During the same time period, 93% of those requesting housing were turned away due to a lack of available space. The vast majority (58%) 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 the Statewide Point in Time Homeless Count in 2007, 15.6% of the people who were homeless self-reported as having HIV/AIDS. 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.

Since 2005, the National AIDS Housing Coalition organized three HIV/AIDS and Housing Research Summits which provided an unprecedented venue for the presentation of research of significance to HIV/AIDS housing policy, coupled with dialogue about the public policy implications of research findings. Compelling research findings presented at all three Summit meetings 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. Key findings from the recent Chicago Housing for Health Partnership (CHHP) and the HUD/CDC Housing and Health studies showed strong evidence of the scientific basis that housing is health care and prevention, that saves lives and money. Over time, housing status is among the strongest predictors of entry into HIV care, primary care visits; continuous care that meets clinical practice standards and receipt of housing assistance has an independent, direct impact on improved medical care. [13]

Food

According to Gloria McAdam, CEO and President of FoodShare, as of April 2008 (the latest data available), the demand at Connecticut's food pantries was up 10%. Food donations were up, too, but because they are generally only able to meet 25 – 33% of the need, the need continues to outstrip donations and availability.

[12] For more information about the AIDS and Housing Research Summits, visit http://nationalaidshousing.org/national-housing-and-hivaids-research-summit-series/

[13] Recently published findings on the relationship of housing status and HIV risk and health outcomes, Angela Aidala, Mailman School of Public Health, Columbia University.

The Connecticut Department of Social Services reported 8,000 more people on food stamps in 2008 than at the same time in 2007. However, with the hiring freeze imposed by eh Governor, DSS has not been able to hire additional staff to meet the demand. Expedited food stamps, which are generally issued in one week, now take up to 6 weeks.

Energy[14]

In 2007 – 2008, Operation Fuel assisted 40% more households than were assisted in 2006 – 2007. Home energy costs have increased significantly over the past few years as the chart below demonstrates.

Fuel	2006	2007	2008
Electricity (per kWh)	$.126	$.136	$.173 *
Fuel Oil (per gallon)	$ 2.386	$ 2.277	$ $3.96**
Natural Gas (per therm)	$ 1.687	$ 1.369	UA***
* CT Independent Petroleum Information, 2006 -2007 Outlook ** US Energy Administration 7/18/2008 *** Unable to find price per therm			
NOTE: Except where noted, facts are from Bureau of Labor Statistics: Consumer Energy Price Index			

Low income customers have little incentive, and even fewer choices to pursue constructive responses to their energy poverty. For example, agreeing to a deferred payment arrangement does not address affordability on a going forward basis. All too frequently, the customer is faced with an immediate need without a solution to meet that need.

The average energy shortfall for households at or below 185% FPL reaches over $1700 per household. (An increase from $880 since 2002.) The aggregate Home Energy Affordability Gap in Connecticut for 2007 reached nearly $405 million statewide. In anticipation of even higher fuel costs in 2008, one can reasonably expect that gap to widen exponentially. The Home Energy Affordability Gap is based on energy process given normal weather.

Connecticut's Low Income Home Energy Assistance Program (LIHEAP) is grossly inadequate to meet this need. While LIHEAP covered 32.6% of the heating/cooling Affordability Gap in 2003; it only covered 20.2% in 2006. The Home Energy Affordability Gap increased by more than $89 million in Connecticut from 2002 – 2006; Connecticut's LIHEAP allocation increased by only $5.9 million.

b.) Issues in Rural Connecticut

Background: 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 this number 7,000.[15] In a June 2006 report created for the CT ORH on Rural Community Health in Connecticut: Challenges and Opportunities, three areas or zones identified as the Northwest Region, the East Region, and the Connecticut River Valley were examined for demographics, healthcare services, and health status. During the update and revision of the Statewide Coordinated Statement of Need in 2007, members of the Statewide HIV Care Consortium Data Work

[14] (Unless otherwise noted information is from Operation Fuel's "Home Energy Affordability Gap: Connecticut (2007)" Report)
[15] CT-Office of Rural Health www.ruralhealthct.org/towns

Group raised concerns that the rural areas were still underrepresented in the report. The Work Group recommended that a subgroup be formed to identify key issues and formulate recommendations that would address those issues specific to rural and nonurban areas. The subgroup, composed of providers representing AIDS service agencies and the VNA, identified key issues that impact service delivery that are corroborated by the findings of a Rural Health Report prepared by the CT ORH. This section focuses on key issues, difficulties and needs particular to those areas identified by the subgroup.

Issues identified by the Rural Areas Subgroup

Work group participants developed a list of service related issues especially relevant to rural areas.

- *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 but transportation becomes an impediment keeping them from accessing the services. Tolland has more severe transportation issues getting people to dental services 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.
- *Lack of clinics:* There is no facility that covers dental for the HIV/AIDS population in Tolland County. The Visiting Nurse Association refers clients to other sources for HIV testing and services. Litchfield County experienced the loss of a large provider forcing 50 PLWH/A to seek alternative sources for primary care. The additional burden of no public transportation poses a critical barrier for individuals seeking primary care services elsewhere.
- *Insurance:* Persons covered by SAGA and Medicaid have difficulty getting primary care.
- *Medical Case Management:* Medical case management in Tolland County, until June 30, 2008, was provided by the VNA. In June, VNA discontinued its HIV/AIDS medical case management services, and, a Hartford County agency has been funded to provide those services through a site in Tolland County. Windham County case managers are part time and overburdened. New London County case managers have an average caseload of 55-60 people making connections to medical providers difficult. Providers report a need for continuing support for affected children whose parents have succumbed to AIDS. A state-funded program for HIV affected children is sited in Norwich, Connecticut (part of New London County). Litchfield County uses the Waterbury Health Department (sited in Torrington) to provide case management services – many of their new clients are minorities.

Public Health Insurance Programs

Since 2000 significant increases are noted in recipients of:

- SAGA
- HUSKY A (Medicaid)
- In 2004 four rural towns have more than 14% of their residents enrolled in public health programs in 2004, ranking among the highest in the state.

Rural Health Report Corroborative Findings[16]

The issues identified by the Rural Areas Subgroup align with findings from the CT ORH report. For example:

- Public transportation in rural areas is extremely limited, 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 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.
- 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.[17]
- As of 2005, there are 2,591 dentists in the state of Connecticut. Of these, only 385 accept Medicaid.[18]
- 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 2009 Ryan White program grantees and respective service providers will use a new biannual data collection and reporting system to report information on their programs and 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 such client level data as client demographics (Unique identifier, date of birth, race/ethnicity, gender, including recording of Transgender subgroup, Federal Poverty Level,

[16] CT Department of Public Health. Statewide Oral Health Plan
[17] Information provided by Patricia Beckenhaupt, Northeast Department District of Health.
[18] Connecticut Oral Health Initiative

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 Measure outcomes have also been included in this Client Report.

Connecticut currently collects client level data through its Uniform Reporting System (URS).Presently the State collects the following client level data: HIV Status, AIDS Status, Viral Load, CD4 Count, Primary Care Physician (PCP), date of last visit with PCP, whether the client is on ARV's (HAART, Dual Therapy, Monotherapy or None),and core medical service referrals and outcomes of those referrals. In 2008, both TGAs financially supported a project to convert existing URS data into CAREWare. This conversion will benefit all Ryan White providers in Connecticut. Connecticut's two Part A TGA's and DPH will be converting to CAREWare as of January 1, 2009 and when that conversion is completed, Connecticut will add the following to client level data collection (along with any other client level data and/or Performance Measures required by HRSA): HIV+ with <200 CD4 Count and on prophylaxis treatment and HIV+ with two or more medical visits per year (Note: Currently with the URS system Connecticut can only track date of last visit).

CPEMS, Connecticut's Program Evaluation and Monitoring System is a data reporting tool designed to strengthen monitoring and evaluation of HIV prevention programs. This program uses the Centers for Disease Control's software, and is slated for roll-out out in Connecticut to all prevention-funded providers between December 2008 and January 2009. Currently staff at DPH are receiving training on CPEMS; future trainings will be scheduled for agencies and system administrators.

PEMS is a secure internet browser-based software program for data entry and reporting. Client names will not be entered into PEMS, rather a unique client identifier will be employed. 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. CPEMS will help providers monitor and refine their prevention interventions for maximum effectiveness and efficiency and ensure that HIV prevention resources are reaching priority populations. PEMS will ensure that CDC receives standardized, accurate and thorough program data from health departments and community-based organization grantees. Data will 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 to be collected include agency information, program plan details, client demographics, referral outcomes, HIV test results, behavioral outcomes, community planning priority populations and interventions and others.

More information will be provided as these systems are implemented.

7. Recommendations

These 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 the months of July - September 2008.

Process Recommendations

1. *To allow for uniformity and strength of data, the CHPC, its members and partners (Parts A, B, C, D, F/SPNS) and prevention should implement a fully collaborative statewide needs assessment for both in care and/or out of care in 2010. This would 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 would be developed in full cooperation with direct input from all Ryan White Parts and prevention.*
2. *To further understand the HIV/AIDS prevention and care landscape, all stakeholders should collaborate to develop a model for a service matrix analysis process. This would include services, utilization, and epidemiology. The outcome of the service matrix analysis should drive the Part B and Prevention RFP process, and inform the Parts A, C, D, F in their planning processes. Assure that technical assistance is available to providers and contractors on applicable interventions to assist them in responding to RFP(s) issued by DPH.*
3. *Conduct a survey of HIV/AIDS providers to capture emerging populations, needs, trends and other service matrix issues. This might include medical case management, early intervention services, comprehensive risk counseling services; counseling, testing & referral; syringe exchange.*

Service Improvement Recommendations

4. *Encourage HIV service providers to link all individuals to appropriate HIV care and prevention services and applicable state services with an emphasis on co-location and one stop shopping.*
5. *Encourage DPH to create a procedure to collect, analyze, monitor and share with stakeholders client level data from intake and assessment forms to provide the most accurate picture of HIV/AIDS in Connecticut.*
6. *Provide training and continuing education for medical practitioners on risk assessment and risk reduction, secondary prevention and available HIV care and prevention services*
7. *Continue training medical case managers (MCMs) on the medical model and clinical practices, and explore creative ways to inform and educate MCMs on an ongoing basis of available resources, services, and relevant issues (e.g., Operation Fuel, energy assistance, alternate home care, housing opportunities, Medicaid, SAGA, Connecticut Action Agencies, among others).*
8. *Assess the needs of HIV+ individuals leaving the correctional system who are returning to the community.*
9. *Explore alternative methods to address barriers to services, for example telemedicine, to connect people in rural locations.*

Emerging Issues Recommendation

10. *Explore the feasibility of raising client eligibility for Ryan White A and B funding to 400% federal poverty level to ensure client access to Ryan White funded services.*

APPENDIX

To include:

- CHPC Survey Questions
- Resource Inventory
- Service Matrix

SERVICE MATRIX: Prevention and Care (Parts A, B, C, D, and F) and State-funded Care and Prevention Programs

*RFP #901 Funding Cycle 7/1/08-12/31/11 ** RFP #902 Funding Cycle 7/1/08-6/30/11 *** Memorandum of Agreement (MOA)

Key: HIV Positive (HIV+), African American (AA), White (W), Latino/a (L), Medical Case Management (MCM), Emergency Financial assistance (EFA), Men Who Have Sex With Men (MSM), Injection Drug Use (IDU), Counseling, Testing & Referral (CTR), Comprehensive Risk Counseling Services (CRCS), Drug Treatment Advocacy (DTA)

HARTFORD COUNTY

PROVIDER	DPH Contractor Status	SERVICES	TARGET POPULATION(s)	Prevention $
		Total dollars in Hartford County Care $ **A *(includes Fed. Consolidated, State approp. and MAI):* $4,203,590** **B: $792,281** **C: $385,125** **D: $228,000** **State funded (Care): $369,490** **HRSA New Access Point: $355,540**		
AIDS Project Hartford *[1] Note: AIDS Project Hartford will provide free confidential/anonymous HIV testing services in East Hartford (East of the River) at: East Hartford Community Health Center, Manchester Wellness and Recovery Center and Manchester Area Network on AIDS (MANA)* AIDS Project Hartford FUNDING: $1,600,493	Prevention $439,107 Care (Part A, MAI, State & Fed. Approp.): $931,449 State funded (Care): $49,937 State-funded (Prevention): $180,000	Counseling, Testing & Referral (CTR)*[1]	All Priority Populations	
		Comprehensive Risk Counseling Services (CRCS)*	AA, L and W MSM, AA, L and W IDU, AA Hetero	
		Drug Treatment Advocacy (DTA)**	HIV+, AA, L and W MSM and IDU	
		RESPECT*	All Priority Populations	
		SISTA*	Heterosexual AA Women	
		Street Smart*	AA, L and W Hetero (Youth)	
		MCM, Housing Services, Psychosocial Support , Food bank	HIV+	
		Medication Adherence		
		Syringe Exchange	All Priority Populations	
Central CT AHEC (CAHEC) CAHEC	Prevention $156,000	Drug Treatment Advocacy (DTA)**	AA, L and W IDU	
		Healthy Relationships*	AA and L Heterosexual	

HARTFORD COUNTY

PROVIDER	DPH Contractor Status	SERVICES	TARGET POPULATION(s)	Prevention $
FUNDING: $871,772	Care (Part B): $186,409 Care (Part A, MAI, State & Fed. Approp.) $529,363	Ambulatory/Outpatient, MCM, EFA, Medical Transportation Ambulatory/Outpatient including Health Van, Substance Abuse Services - Outpatient, Mental Health Services, Early Intervention Services	HIV+	
Charter Oak Health Center FUNDING: $350,946 (Part A, D) $355,540 (New Access Point) $706,486	Care (Part A, MAI, State & Fed. Approp.) $293,446 Care (Part D) $57,500 New Access Point Grant (HRSA): $355,540	Ambulatory/Outpatient, Substance Abuse-Outpatient, Mental Health, women's Services (Ob/Gyn) Outreach/ Counseling and Testing Primary care, pharmacy, preventive dental, mental health, prenatal, substance abuse	HIV+, Women of Color HIV infected and affected children, youth and families All populations	
Community Health Services FUNDING: $509,905	Care (Part A, MAI, State & Fed. Approp.) $124,780 Care (Part C): $385,125	Ambulatory/Outpatient, Women's Services (Ob/Gyn) Outpatient EIS	HIV+, Women of Color All Priority Populations	
Community Renewal Team (CRT) FUNDING:$687,106	Care (Part A, MAI, State & Fed. Approp.) $687,106	Mental Health, Substance Abuse - Outpatient	HIV+	
CT AIDS Resource Coalition (CARC) FUNDING: $411,736	Care (Part A, MAI, State & Fed. Approp.) $411,736	Ambulatory/Outpatient fee for services, Health Insurance Premium, Oral Health Fee for Service, Local AIDS Pharmaceutical, EFA, Food bank, Mental Health Fee for Services, Housing Services (Rental subsidies, 1x assistance)	HIV+	
Greater Hartford Legal AIDS (AIDS Legal Network) FUNDING: $32,810	Care (Part A, MAI, State & Fed. Approp.) $32,810	Legal and Advocacy Services	HIV+	

HARTFORD COUNTY

PROVIDER	DPH Contractor Status	SERVICES	TARGET POPULATION(s)	Prevention $
Hartford Dispensary FUNDING: $90,000	Prevention	Risk Avoidance Partnership**	HIV+, AA, L and W IDU	
Hartford Gay & Lesbian Health Collective FUNDING: $603,358	Prevention $370,393 Care (Part B): $81,243 Care (Part A, MAI, State & Fed. Approp.) $151,722	Counseling, Testing and Referral (CTR)*	AA, L and W MSM	
		Comprehensive Risk Counseling Services (CRCS)*	HIV+, AA, L and W MSM	
		Healthy Relationships*	HIV+, AA, L and W MSM	
		MPowerment*	HIV+, AA, L and W MSM	
		Peer/Non Peer MSM Outreach**	HIV+, AA, L and W MSM	
		Oral Health Oral Health, Substance Abuse Services-Outpatient	HIV+	
Hartford Health Department FUNDING: @$162,813	State-funded (Prevention) $162,813	Counseling, Testing and Referral (CTR)	All Priority Populations	
Human Resources Agency of New Britain, Inc. Human Resources Agency FUNDING: $419,753	Prevention $149,439 Care (Part B): $136,523 Care (Part A, MAI, State & Fed. Approp.) $82,610 State-funded (Care) $51,181	Counseling, Testing and Referral (CTR)*	High risk individuals	
		Safety Counts*	AA, L and W IDU	
		Medical Nutritional Counseling, Substance Abuse Services, MCM, Psychosocial, EFA, Food bank Psychosocial Support, Food bank Medication Adherence	HIV+	
Immaculate Conception Shelter FUNDING: $14,037	Care (Part A, MAI, State & Fed. Approp.)	Food bank	HIV+	
Latino Community Services FUNDING: $813,279	Prevention $324,565	Counseling, Testing and Referral (CTR) with Social Networks*	All Priority Populations	
		Safety Counts*	L Heterosexual and IDU	

HARTFORD COUNTY

PROVIDER	DPH Contractor Status	SERVICES	TARGET POPULATION(s)	Prevention $
Latino Community Services	Care (Part B) $169,057 Care (Part A, MAI, State & Fed. Approp.) $269,657 State-funded (Care) $50,000	Voices/Voces* Spiritual Self Schema* MCM, EFA, Linguistic Services Medical Transportation, Linguistic Services Medication Adherence	L Heterosexual L IDU HIV+	
Manchester Area Network on AIDS (MANA) FUNDING: $63,651	Care (Part A, MAI, State & Fed. Approp.)	Psychosocial Support, Food bank	HIV+	
Mercy Housing & Shelter FUNDING: $384,150	Care (Part A, MAI, State & Fed. Approp.)	Housing Services	HIV+	
University of Connecticut Health Center FUNDING:$366,418	Care (Part B) $136,418 Care (Part A, MAI, State & Fed. Approp.) $90,000 State-funded (Care): $140,000	MCM MCM Medication Adherence	HIV+	

HARTFORD COUNTY

PROVIDER	DPH Contractor Status	SERVICES	TARGET POPULATION(s)	Prevention $
University of Connecticut Health Center (CCMC) FUNDING: $455,501	Prevention $65,297 Care (Part B) $82,631 Care (Part A, MAI, State & Fed. Approp.) $137,073 Care (Part D) $170,500	Together Learning Choices* Ambulatory/Outpatient, MCM, EFA Ambulatory/Outpatient, MCM, Mental Health MCM, Primary Care and Outreach	AA, L and W MSM, AA and L Heterosexual HIV+ HIV infected and affected youth, children and families	
Village for Families and Children FUNDING: $78,372	State-funded (Care): $78,372	Mental Health Services Individual, Group, and Family Therapies	HIV/AIDS Affected Youth	
Yale University FUNDING: $104,973	Prevention $104,973	CRCS for Released Prisoners*	All Priority Populations	

NEW HAVEN COUNTY				
PROVIDER	**DPH Contractor Status**	**SERVICES**	**TARGET POPULATION(s)**	**Prevention $**
		Total dollars in NEW HAVEN COUNTY Care $ **A: $2,482,545** **B: $702,474** **B/MAI Funds:$91,778** **C: $1,305,301** **D:$361,200** **State-funded (Care): $253,231** **MAI (NH/FF Part A): $148,730** ***Special State CARE Allocation [SSCA-Part B] (ends 2009): $50,238***		**$1,406,574** **State-funded (Prevention): $340,261**
AIDS Interfaith Network FUNDING: $286,061	Care (Part B) $75,369 Care (Part A) $147,080 MAI(NH/FF Part A) $63,612	MCM, EFA, Food bank MCM, Mental Health, Substance Abuse-outpatient, EFA, Food bank, Housing, Outreach MCM, MH, SA	HIV+	
AIDS Project New Haven FUNDING: $716,745	Prevention $167,000 Care (Part B): $250,516 Care (Part A) $299,229	SISTA* Street Smart* Ambulatory/Outpatient, Mental Health, Medical Nutritional Counseling, MCM, Psychosocial Support, EFA, Food bank, Housing Services, Medical Transportation MCM, Medical Nutritional, Mental Health, Substance Abuse-outpatient, Medical Transport, EFA, Food bank, Psychosocial Support	HIV+, AA and L Heterosexual AA and L Heterosexual Youth HIV+	
Birmingham Mental Health Center FUNDING: $200,080	*SSCA (Part B): $50,238* Care (Part A) $141,792 MAI (NH/FF Part A) $8,050	MCM, EFA, Mental Health MCM, Mental Health, Substance Abuse-outpatient, EFA, Food bank, Outreach Mental Health, Substance Abuse	HIV +	

NEW HAVEN COUNTY

PROVIDER	DPH Contractor Status	SERVICES	TARGET POPULATION(s)	Prevention $
Clifford W. Beers Guidance Clinic FUNDING:$104,033	Care (Part A) $15,712 State-funded (Care): $88,321	Mental Health Mental Health Services Individual, Group and Family Therapies	HIV+ HIV/AIDS Affected Youth	
Fair Haven Community Health Center FUNDING: $626,446	Care (Part A) $223,192 MAI (NH/FF Part A) $14,641 Care (Part C): $341,148 Care (Part D) $47,465	Ambulatory/Outpatient, MCM, EFA Ambulatory/Outpatient Outpatient EIS Outreach, Counseling and Testing	HIV+ All Priority Populations, HIV+ HIV infected and affected children, youth and families	
Hill Health Center Hill Health Center FUNDING: $1,215,054	Prevention Prevention $244,000 Care (Part A) $218,343 MAI (NH/FF Part A) $13,058 Care (Part C): $671,653 Care (Part D) $68,000	Comprehensive Risk Counseling Services (CRCS)* Counseling, Testing and Referral (CTR)* Drug Treatment Advocacy (DTA)** Ambulatory/Outpatient, Oral Health, MCM, EFA Ambulatory/Outpatient, Oral Health Outpatient EIS Outreach, Counseling and Testing	All Priority Populations All Priority Populations All Priority Populations HIV+ All Priority Populations, HIV+ HIV infected and affected children, youth and families	
Hispanos Unidos Inc. FUNDING: $695,812	Prevention $184,000	Voices/Voces* The Effects of HIV/AIDS Intervention Groups for High Risk Women (Latinas en Accion)*	Latino Heterosexual Latina IDU and Heterosexual	

NEW HAVEN COUNTY

PROVIDER	DPH Contractor Status	SERVICES	TARGET POPULATION(s)	Prevention $
Hispanos Unidos	Care (Part B) $194,688 Care (Part A) $225,976 State-funded (Care) $91,148	Ambulatory/Outpatient, Mental Health, MCM, Psychosocial Support, EFA MCM, Mental Health, Substance Abuse-outpatient, EFA Medication Adherence	HIV+	
Hospital of St. Raphael FUNDING $62,189	State-funded (Prevention) $62,189	Children's Health Initiative – HIV Perinatal (July-December,2008)	Women, Infants	
Liberty Community Services FUNDING: $179,321	Prevention $60,000 Care (Part A) $119,321	Drug Treatment Advocacy (DTA)* MCM, Mental Health, Housing, EFA	AA, L and Heterosexual IDU HIV+	
Meriden Dept. of Health & Human Services FUNDING: $77,574	Prevention $77,574	Counseling, Testing and Referral (CTR)*	All Priority Populations	
		Healthy Relationships*	HIV+ AA, L and W Heterosexual and HIV+ AA, L and W MSM	
		Voices/Voces*	AA and L Heterosexual	
New Haven Health Department FUNDING: $305,000 New Haven Health Department	Prevention $155,000 Prevention State funded (Prevention) $150,000	Counseling, Testing and Referral (CTR) with Social Networks*	All Priority Populations	
		Safety Counts*	AA, L and W IDU, AA, L and W Heterosexual	
		Voices/Voces* Syringe Exchange	AA and L Heterosexual	
New Haven Home Recovery FUNDING: $130,173	Care (Part A) $130,173	MCM, Substance Abuse-outpatient, Housing, EFA	HIV+	
New Opportunities FUNDING: $207,200	Care (Part A) $181,255 MAI (NH/FF Part A) $25,945	MCM, Medical Transport, Outreach, Housing, Food bank, EFA MCM	HIV+	

NEW HAVEN COUNTY

PROVIDER	DPH Contractor Status	SERVICES	TARGET POPULATION(s)	Prevention $
Staywell Health Care, Inc. FUNDING: $99,268	Care (Part A) $83,238 MAI (NH/FF Part A) $16,030	Ambulatory/Outpatient, Mental Health, Oral Health, Substance Abuse-outpatient, Local AIDS Pharmaceutical Ambulatory/Outpatient, Oral Health	HIV+	
Waterbury Health Department FUNDING: $875,513 Waterbury Health Department	Prevention $400,000 Prevention State-funded (Prevention):$128,072 Care (Part B): $181,901 Part B: Minority AIDS Initiative:$91,778 State-funded (Care) $73,762	Counseling, Testing and Referral (CTR) with Social Networks *	All Priority Populations	
		Drug Treatment Advocacy (DTA)**	AA, and L Heterosexual IDU and MSM	
		Healthy Relationships*	HIV+ AA Heterosexual	
		MPowerment**	AA, L and W MSM	
		SISTA*	AA and L Heterosexual	
		Voices/Voces*	AA and L Heterosexual	
		Treatment Van Services (C/T, Treatment Adherence) MCM, Psychosocial Support, EFA, Housing Services, Medical Transportation Outreach and education Medication Adherence	All Priority Populations HIV+ HIV+ AA and L HIV+	
Waterbury Hospital FUNDING: $586,706	Care (Part A) $294,206 Care (Part C): $292,500	Ambulatory/Outpatient, MCM, Mental Health, Substance Abuse-outpatient, Local AIDS Pharmaceutical Outpatient EIS	HIV+ All Priority Populations	
Yale Child Study FUNDING: $281,035	Care (Part A) $35,300 Care (Part D) $245,735	Mental Health, Medical Transport MCM, Primary Care and Mental Health	HIV+ HIV infected and affected children, youth and families	
Yale New Haven Hospital FUNDING: $119,000	Prevention $119,000	Counseling, Testing and Referral (CTR)*	All Priority Populations	

NEW HAVEN COUNTY

PROVIDER	DPH Contractor Status	SERVICES	TARGET POPULATION(s)	Prevention $
Yale University AIDS Program Yale AIDS Van FUNDING: $375,122	Care (Part A) $367,728 MAI (NH/FF Part A) $7,394	Ambulatory/Outpatient, MCM, Medical Nutrition, Mental Health, Substance Abuse-Outpatient, Outreach, Medical Transport, Food bank Ambulatory/Outpatient	HIV+	

MIDDLESEX COUNTY

PROVIDER	DPH Contractor Status	SERVICES	TARGET POPULATION(s)	Prevention $
		Total dollars for MIDDLESEX COUNTY Care $ **Part A: $75,787** ***Part B: see SSCA*** **Part C: $419,970** **Part D: -0-** ***Special State CARE Allocation [SSCA] (ends 2009):$106,510***		**$135,500**
Community Health Center FUNDING: $688,068	Prevention $85,801 *SSCA (Part B) $106,510* Care (Part A, MAI, State & Fed. Approp.) $75,787 Care (Part C): $419,970	Counseling, Testing & Referral (CTR)* Voices/Voces* Ambulatory/Outpatient, MCM, EFA, Medical Transportation Psychosocial Support, Medical Transportation, Mental Health, Food bank Outpatient EIS	All Priority Populations AA and L Heterosexual HIV+	

MIDDLESEX COUNTY

PROVIDER	DPH Contractor Status	SERVICES	TARGET POPULATION(s)	Prevention $
		Total dollars for MIDDLESEX COUNTY Care $ **Part A: $75,787** ***Part B: see SSCA*** **Part C: $419,970** **Part D: -0-** ***Special State CARE Allocation [SSCA] (ends 2009):$106,510***		**$135,500**
Hartford Gay & Lesbian Health Collective FUNDING:$49,699	Prevention $49,699	Counseling, Testing & Referral (CTR)*	AA, W, L MSM	
		Healthy Relationships*	HIV + AA, L and W MSM	

TOLLAND and WINDHAM COUNTIES

PROVIDER	DPH Contractor Status	SERVICES	TARGET POPULATION(s)	Prevention $
		Total dollars for TOLLAND and WINDHAM COUNTIES Care $ **Part A:$87,821** **Part B: $299,284** **Part C: $321,750** **Part D: $19,000** **Special State CARE Allocation [SSCA] (ends 2009):$94,044** **State-funded (Care): $131,565**		**$282,000**

AIDS Project Hartford (formerly VNHSC) FUNDING: $170,825	*SSCA (Part B) $94,044* Care (Part A, MAI, State & Fed. Approp.): N/A: see Hartford County State-funded (Care): $76,781	MCM, Oral Health, EFA, Health Insurance, Ambulatory/Outpatient Outpatient/ambulatory Medication Adherence	HIV+
Generations Health Center FUNDING: $340,750	Care (Part C); $321,750 Care (Part D) $19,000	Outpatient EIS Outreach	All Priority Populations HIV infected and affected children, youth and families
Hockanum Valley Community Council, Inc. FUNDING: $82,000	Prevention $82,000	RESPECT* Counseling, Testing and Referral (CTR)*	All Priority Populations
Perception Programs FUNDING: $200,000	Prevention $200,000	Counseling, Testing and Referral (CTR)*	All Priority Populations
		Drug Treatment Advocacy (DTA)**	HIV+, AA, L and W IDU
		Safety Counts*	HIV+, AA, L and W IDU
Rockville General Hospital FUNDING: $87,821	Care (Part A, MAI, State & Fed. Approp.): $87,821	Ambulatory/Outpatient	HIV+
Windham Regional Community Council FUNDING: $354,068	Care (Part B) $299,284 State-funded (Care) $54,784	Ambulatory/Outpatient, Oral Health, Mental Health, MCM, Child Care, EFA, Food bank, Housing Services, Medical Transportation Medication Adherence	HIV+

LITCHFIELD COUNTY

PROVIDER	DPH Contractor Status	SERVICES	TARGET POPULATION(s)	Prevention $
		Total dollars for LITCHFIELD COUNTY Care $ **Part B: $149,380** **Part C: $243,750** **State-funded (Care): $50,000**		**$135,000**

LITCHFIELD COUNTY

PROVIDER	DPH Contractor Status	SERVICES	TARGET POPULATION(s)	Prevention $
		Total dollars for LITCHFIELD COUNTY Care $ **Part B: $149,380** **Part C: $243,750** **State-funded (Care): $50,000**		**$135,000**
Community Health and Wellness Center of Greater Torrington FUNDING: $243,750	Care (Part C) $243,750	Outpatient EIS	All Priority Populations	
New Opportunities, Inc.(Torrington) FUNDING: $74,690	Care (Part B) $74,690	MCM, Medical Transportation, EFA	HIV+	
Waterbury Health Department (Torrington)	Prevention $135,000	Counseling, Testing and Referral (CTR)*	All Priority Populations	
		Healthy Relationships*	HIV+	
Waterbury Health Department (Torrington) FUNDING:$259,690	Care (Part B) $74,690 State-funded (Care) $50,000	MCM, EFA, Medical Transportation Medication Adherence	HIV+	

FAIRFIELD COUNTY

PROVIDER	DPH Contractor Status	SERVICES	TARGET POPULATION(s)	
		Total dollars for the FAIRFIELD COUNTY Care $ **Part A: $2,228,705** **Part B: $593,075** **Part C: $1,073,929** **Part D:$152,700** **F: @$400,000** **State-funded (Care): $136,532** ***Special State CARE Allocation [SSCA] (ends 2009):$84,476*** **MAI (NH/FF Part A): $124,679**		**Prevention $ $1,307,000** **State-funded (Prevention) $353,792**
AIDS Project Greater Danbury FUNDING: $558,598 AIDS Project Greater Danbury	Prevention $175,000 State-funded (Prevention) $69,091 Care (Part B) $126,481 Care (Part A) $175,311 MAI (NH/FF Part A) $12,715	Comprehensive Risk Counseling Services (CRCS)*	All Priority Populations	
		Counseling, Testing & Referral (CTR)*	All Priority Populations	
		Drug Treatment Advocacy (DTA)**	All Priority Populations	
		Syringe Exchange Ambulatory/ outpatient, Mental Health Services, MCM, EFA, Housing services, Transportation Ambulatory/Outpatient, MCM, Mental Health, Oral Health, Local AIDS Pharmaceutical, Outreach, EFA, Housing, Food bank Ambulatory/Outpatient, MCM, Mental Health, Oral Health	All Priority Populations HIV+	
Bridgeport Health Dept FUNDING: $266,284	Prevention $109,273 State-funded (Prevention) $157,011	Safety Counts* Syringe Exchange Program	AA, L and W IDU All Priority Populations	
Bridgeport Hospital FUNDING: $52,719	Care (Part D) $29,700 State-funded (Prevention):$23,019	Primary Care Children's Health Initiative-HIV Perinatal (July-December,2008)	HIV infected and affected children, youth and families Women, Infants	

FAIRFIELD COUNTY

PROVIDER	DPH Contractor Status	SERVICES	TARGET POPULATION(s)
Child Guidance Center of Greater Bridgeport FUNDING: $58,749	State-funded (Care): $58,749	Mental Health Services Individual, Group and Family Therapies	HIV/AIDS Affected Youth
Community Health Center (Middletown) *Sited in Norwalk and serves surrounding communities: "Norwalk Smiles"* FUNDING: $400,000	Care (Part F-SPNS): $400,000	Oral/dental services and transportation	HIV+
CT Counseling Centers, Inc. FUNDING: $58,165	Care (Part A) $58,165	Mental Health, Substance Abuse-outpatient	HIV+
Family Services Woodfield FUNDING: $357,485	Care (Part B) $357,485	MCM, Mental Health, Health Insurance Continuation, Psychosocial Support, EFA, Medical Transportation	HIV+
Greater Bridgeport Adolescent Pregnancy Program (GBAPP) FUNDING:$1,060,191 GBAPP	Prevention $173,461 Care (Part A) $826,372 MAI(NH/FF Part A) $60,358	Counseling and Testing and Referral (CTR) with Social Networks SISTA	AA Heterosexual
		Ambulatory/Outpatient, MCM, Mental Health, Oral Health, Medical Transport, Housing, Food bank, EFA Ambulatory/Outpatient, MCM, Mental Health	HIV+
Health Care Connections, Inc. FUNDING: $598,394	Care (Part B): $109,109 Care (Part A) $411,502 State-funded (Care) $77,783	Ambulatory/Outpatient, Local Pharmacy, EFA, MCM, EFA, Food bank Ambulatory/Outpatient, MCM, Mental Health, Oral Health, Medical Transport, Outreach, Housing, Food bank, EFA Medication adherence	HIV+
Interfaith AIDS Ministry of Greater Danbury FUNDING: $75,000	Prevention $75,000	MPowerment	AA, L and W MSM

FAIRFIELD COUNTY

PROVIDER	DPH Contractor Status	SERVICES	TARGET POPULATION(s)
Liberation Programs, Inc FUNDING: $353,866	Care (Part A) $60,251 MAI (NH/FF Part A) $7,038	Outpatient and Inpatient substance Abuse Substance Abuse	HIV+
Macedonia AIDS Ministry, Inc. FUNDING: $71,685	Care (Part A) $27,117 MAI (NH/FF Part A) $44,568	Medical Transport, Outreach, Psychosocial Support, Housing, Food bank, EFA Medical Case Management	HIV+
Mid-Fairfield AIDS Project FUNDING: $262,441	Prevention $85,000 *SSCA (Part B)* *$84,476* Care (Part A) $92,965	Drug Treatment Advocacy (DTA) Ambulatory/Outpatient, MCM, Oral Health, EFA, Medical Transport MCM, Medical Nutritional, Oral Health, Medical Transport, Housing, Food bank, EFA	All Priority Populations HIV+
Norwalk Health Dept. FUNDING: $100,000	Prevention $100,000	Counseling, Testing & Referral (CTR)*	All Priority Populations
Optimus Health FUNDING: $730,196	Prevention $120,000 Care (Part C): $552,696 Care (Part D) $57,500	Integrated HIV Prevention Services (CTR) in Routine Medical Care Outpatient EIS MCM, Outreach, Counseling and Testing	All Priority Populations HIV infected and affected children, youth and families
Regional Network FUNDING: $228,917	Care (Part A) $228,917	In and Out patient Substance Abuse, Outreach	HIV+
Shelter for the Homeless FUNDING: $85,000	Prevention $85,000	Drug Treatment Advocacy (DTA)	AA, L and W IDU: AA, L and W Heterosexual
Southwest Community Health Center FUNDING: $685,416	Prevention $98,683 Care (Part C): $521,233 Care (Part D) $65,500	Counseling, Testing and Referral (CTR)* Outpatient EIS MCM, Outreach, Counseling and Testing	All Priority Populations All Priority Populations HIV infected and affected children, youth and families

NEW LONDON COUNTY

PROVIDER	DPH Contractor Status	SERVICES	TARGET POPULATION(s)	Care	Prevention
			Total Dollars for this region:	**Part B: $354,761 State funded(Care): $33,770**	**$182,000**
Alliance For Living FUNDING: $354,761	Care (Part B) $354,761	Ambulatory/Outpatient, Oral Health, Health Insurance, MCM, Psychosocial Support, EFA, Food bank, Medical Transportation, Housing Services	HIV+		
Lawrence and Memorial Hospital FUNDING: $107,000	Prevention $107,000	Counseling, Testing & Referral (CTR)* Comprehensive Risk Counseling Services (CRCS)*	All Priority Populations HIV+		
United Community and Family Services FUNDING: $33,770	State Funded (Care): $33,770	Mental Health Services	HIV/AIDS Affected Youth		
William W. Backus Hospital FUNDING: $75,000	Prevention $75,000	Counseling, Testing & Referral (CTR)*	AA, L and W IDU; AA, L and W Heterosexual		

FAIRFIELD COUNTY

PROVIDER	DPH Contractor Status	SERVICES	TARGET POPULATION(s)
Stamford Health Dept. FUNDING: $328,066	Prevention $285,583 State-funded (Prevention):$42,483	Counseling, Testing & Referral (CTR) with social Networks Comprehensive Risk Counseling Services* Information and Enhanced AIDS Education (Project Smart)* Street Smart* Syringe Exchange Program	All Priority Populations All Priority populations AA, L and W Heterosexual and IDU AA, L and W Heterosexual and MSM All Priority Populations
Stamford Hospital FUNDING $62,188	State-funded (Prevention) $62,188	Children's Health Initiative-HIV Perinatal (July-December,2008)	Women, Infants

DEPT OF CORRECTION	DPH Contractor Status	Services	Target Populations	Care $	Prevention $
			Total Dollars for this region		**$520,509**
UCONN Correctional Managed Health Care FUNDING: $520,509	Prevention $520,509	Counseling , Testing and Referral (CTR)* HIV+ Support Groups (GLI) Inmate Orientations (Health Communications/Public Info)	All Priority populations (incarcerated) HIV+		

STATEWIDE

PROVIDER	DPH Contractor Status	SERVICES	TARGET POPULATION(s)	Care	Prevention
			Total Dollars for this region:	**B: $525,874**	**$408,546**
AIDS Project Hartford (Transitional Linkage to the Community: Project TLC) FUNDING: $407,853	Care (Part B) $407,853	Transitional Medical Case Management, Medical Transport	HIV+ (Incarcerated and Newly Released)		
CT AIDS Resources Coalition (CARC) FUNDING: $118,021	Care (Part B) $118,021	Housing Services	HIV+		
Community Partners in Action FUNDING: $276,767	Prevention $276,767	Intensive AIDS Education in Jail /Rikers Health Advocacy Program (Beyond Fear)	All Priority Populations (incarcerated)		
ConnectiCOSH Health Technical Committee, Inc. FUNDING: $131,779	Prevention	Counseling, Testing & Referral (CTR)* Safety Counts* Voices/VOCES*	Latino Heterosexual, IDU and MSM Latino Heterosexual and IDU Latino Heterosexual		

@Prevention Statewide Funding: $6,076,903

@CADAP Funding: $11,471,742

@Part A Statewide Funding: $9,078,448 (Greater Htfd included MAI in its totals; NH/FF MAI is broken out separately)

@Mai (Part A: New Haven/Fairfield): $273,409

@Part B Statewide Funding: $3,417,139

@MAI Part B: $91,778

@Special State Care Allocation [Part B] (ends in 2009): $335,268.

@Part C Statewide Funding (Outpatient EIS): $3,749,825

Outpatient EIS: costs associated with direct provision of medical care including primary care, lab, x-ray and other diagnostic tests, medical/dental equipment and supplies, Medical Case Management, electronic medical records, patient education in conjunction with medical care, transportation for clinical care provider staff to provide care, and other diagnostic and clinical services regarding HIV/AIDS and periodic medical evaluations of PLWHA

@Part D Statewide Funding: $760,900

@Part F (SPNS) Funding (Norwalk smiles): $400,000

@HRSA New Access Point Grant (Charter Oak Health Center):$355,540

@State Funding (CARE): Includes Medication Adherence & Mental Health Programs for HIV Affected Kids: $974,588

@State Funding (Prevention): Includes Syringe Exchange, Mobile Health Van, Perinatal Initiatives: $1,036,866

HIV Care and Prevention Youth Chapter

Produced by the Connecticut HIV Planning Youth Advisory Group

"Adults can't change the sexual or social drives of youth. Promoting abstinence-only and shunning teens that don't agree only perpetuates the very cycle they are trying to stop. Youth need positive, understanding role models to listen and educate them, rather than trying to keep them in the dark."

Youth Advisory Group member

1. INTRODUCTION

The HIV care and prevention community planning process seeks input from a wide range of stakeholders, including populations at greatest risk for HIV infection; people living with HIV/AIDS; and representatives of varying races and ethnicities, genders, sexual orientations, ages, educational backgrounds, professions, and expertise. One of the key stakeholders is young people. In developing HIV care and prevention plans, it is important to hear what young people are saying about how best to prevent the spread of HIV/AIDS and to provide care for youth living with HIV/AIDS.

Staff engaged young people across the state through the following strategies:

1. **Youth Planning Meetings**. Meetings were held with young people to seek their feedback on HIV prevention and care efforts, working in collaboration with youth organizations that deliver HIV prevention programs and organizations that serve youth at higher risk for contracting HIV/AIDS.
2. **Statewide Youth Advisory Group**. From April 2006 through May 2008, young people participated on a statewide Youth Advisory Group. In 2006-07, more than 25 young people participated in Advisory Group meetings focused on HIV prevention. In 2007-08, 20 young people participated in meetings focused primarily on care.
3. **HIV Planning Youth Updates**. Updates inform interested youth and adults about the role of young people in the statewide HIV care and prevention planning process. Six updates were distributed from December 2005 through January 2007 to more than 130 youth and adults, and the 2007 Youth Chapter was distributed in July 2007.

2. ABOUT CONNECTICUT'S HIV PLANNING YOUTH ADVISORY GROUP

The Youth Advisory Group was formed in Spring 2006 as a sub-committee of the Connecticut HIV Prevention Community Planning Group (CPG) to give youth a voice in the HIV prevention planning process. In 2006-07, the Advisory Group: (1) developed a Youth Chapter for the state's HIV Prevention Plan; (2) presented and shared ideas about HIV prevention with the CPG; and (3) provided feedback to DPH on HIV prevention products and programs.

"HIV is one of the biggest problems facing my generation because even though it's 100% preventable, it infects millions of people every day. We as a generation have to take on the challenge of ending this epidemic."

Alexandra Clement

In 2007-08, the Youth Advisory Group expanded its focus to include care, in concert with the state's creation of the Connecticut HIV Planning Consortium (CHPC) as a unified statewide care and prevention planning body. The Advisory Group revised the 2007 Youth Chapter to integrate recommendations about care for young people living with HIV/AIDS. ***The 2008 Youth Chapter is the culmination of two years of work by young people across Connecticut***, and includes the voices of youth in sidebars throughout the Chapter.

Twenty-five (25) youth initially volunteered to serve on the Youth Advisory Group, and approximately 15 youth have attended as guests or joined the Advisory Group in 2006 and 2007. On average, 12 youth participated in statewide meetings, with 16 youth attending at least six statewide meetings. Overall, 37

young people have attended at least one meeting. It is important to note that some youth only participated for one of the two years, moving on to college, new jobs or other interests.

The young people participating on the Advisory Group[1] are a diverse group.

- **Gender**. 11 female and 16 male participants.
- **Racial/ethnic**. More than half are African-American and/or Latino youth.
- **Geographic**. Youth from urban (16), suburban (8) and rural (3) areas of Connecticut.
- **Age / School**. The Advisory Group included a mix of high school students (17), college students (2) and older, out-of-school youth (7).
- **GLBT and Allies**. Six (6) members of gay-straight alliance (GSA) or related groups.

While diverse in many ways, **all Advisory Group participants share a common commitment to preventing the spread of HIV/AIDS among youth in Connecticut**. Twenty-two (22) 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 full Youth Advisory Group met 14 times from April 2006 through May 2008, and presented at the July 19, 2006 CPG meeting. In addition, Advisory Group committees and ad hoc groups have met 13 times since March 2006 – to help plan statewide Youth Advisory Group meetings, prepare for the CPG presentation, and plan specific projects like an HIV prevention public service announcement (discussed below). Meetings included a mix of "work" and fun activities – including team building ice breaker activities, interactive HIV prevention exercises, outings like a trip to Ocean Beach State Park in New London, presentations by guest speakers on HIV care and prevention topics, and whole-group and small-group discussions. To create and revise this Youth Chapter, **members engaged in animated, intense debates** on the issues – and developed and refined the key recommendations. As one member stated, "This is serious business, and we're passionate about it."

Youth Advisory Group

- Hope Angell
- Erin Baier
- Rondell Batson
- William Braswell
- Reynaldo Caraballo
- Janeé Chapman
- Alexandra Clement
- Blaise Gilchrist
- Danny Huang
- Tempestt Latham
- Amanda Leslie
- Brian X. Lester
- Javon Meekins
- Wesley Moreno
- Alex Ocampo
- Dana Rogers
- Jonathan Simmons
- And 10+ more youth from across the state

Advisory Group members take an active role in planning meetings, and bring their skills as peer educators to the Group. Peer educators led HIV prevention exercises, youth facilitated and presented the key points from group discussions, and several youth co-facilitated youth planning meetings in the community. Many Advisory Group members belong to other youth groups (peer education, GSAs, etc), and shared information and prevention activities with these groups to raise HIV/AIDS awareness in their communities. Over the past two years, the Advisory Group created and shared the following products and activities:

- **A Poem about HIV/AIDS**. At the April 2006 meeting, an Advisory Group member shared a poem she wrote: *I Didn't Mean It*.
- **HIV Prevention Poster and Skits**. Advisory Group members created a poster and three skits with the theme: It Could Be You. The skits focused on three different scenarios: a skit featuring men on the "down low", a tattoo artist operating out of his house

"You can see at events like AIDS Walk NY that millions rally in support of AIDS awareness and prevention. We have to face challenges head-on. In the end, when lives are saved, we will be happy that we took a risk and promoted the kind of programs that we know will work, even if it means being controversial."
Youth Advisory Group member

[1] Youth attending at least three meetings.

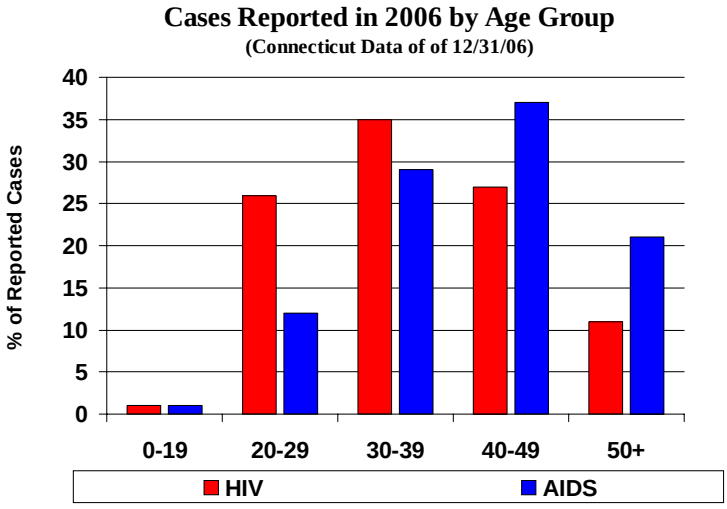
using unclean needles, and a straight couple where the man is forced to disclose his HIV status.

- **HIV Prevention Activities**. Youth facilitated a range of activities, drawing on their work as peer educators. These included exercises about 'going on a date' to explore the positive aspects and risks of dating, a Jeopardy-style game with questions on HIV/AIDS and related topics, and discussions of 'what you did on Saturday night.'
- **HIV Prevention Public Service Announcement (PSA)**. Youth worked with staff and Downtown Community Television (DCTV) to develop a successful grant application to the Cable Positive Tony Cox Community Fund, create a storyboard for the PSA, assemble the art and props needed for the PSA, and serve as actors and crew for the video shoot. Two youth traveled to DCTV in summer 2006 to plan the application, 10-12 youth were involved in developing the final script and storyboard, and 15 youth helped produce the PSA at a February 11, 2007 video shoot in Hamden. DCTV produced the 30-second PSA, which Comcast aired throughout Connecticut in June 2007. Youth Advisory Group members also helped disseminate the PSA through DVDs and the Internet.
- **Presentations to CPG**. Fifteen (15) members of the Youth Advisory Group presented at the July 2006 CPG meeting, including a PowerPoint presentation and two skits (noted above). An Advisory Group member and staff person co-presented an update on the Youth Chapter at the March 2007 CPG meeting.
- **Guest Speakers**. At the November 2007 meeting, Advisory Group members shared their personal experiences with HIV.
- **Youth Ambassadors**. Youth have attended CPG and CHPC meetings as Youth Advisory Group representatives, and provided updates on the work of the Advisory Group at these meetings.

Please see the attached Appendix for documents produced by and with the Youth Advisory Group.

3. DATA ON HIV/AIDS AND HIV PREVENTION AMONG YOUTH IN CONNECTICUT

At the November 2006 Youth Advisory Group meeting, Kenneth Carley, an epidemiologist with the Connecticut Department of Public Health (DPH), led a presentation and discussion on the use of data in HIV prevention planning. Below are key findings from the data and research, and youth perspectives on the data.



Few reported HIV/AIDS cases among teens. Connecticut data shows very few reported HIV cases among teens (see chart). The Advisory Group discussed the implications and limitations of this data. First, data on HIV cases by age does not tell you when people were infected with HIV. Young people may be getting infected but not learn their status until they are in their 20's. Second, the number of HIV cases increases dramatically in the 20-29 age group, suggesting the need to keep young people safe as they reach their late teens and early 20's. Finally, the data does not show the prevalence of risky behaviors among youth (see below).

Many Connecticut youth are engaging in risky behaviors. The 2007 Connecticut School Health Survey was completed by 2,072 high school students (grades 9-12) in 46 public schools. More than 4 in 10 (42%) of students reported that they have had sexual intercourse, including 68% of 12th graders.

Among sexually active teens, more than 1 in 4 (27%) reported drinking alcohol or using drugs before they had sexual intercourse the last time, a major risk factor for unprotected sex. More than 1 in 3 sexually active teens (34%) reported not using a condom the last time they had sex.

> "As a society, we place the burden and responsibility of choice on our youth. At an age when they are not allowed to buy cigarettes, drive or buy alcohol, we expect youth to just IGNORE the highest-risk activity, sex. Only with the best possible education can we expect young people to develop independence, but still keep themselves safe."
> *Danny Huang*

Most schools are not teaching "all the facts." The 2004 CDC School Health Profile surveyed approximately 500 principals and teachers in Connecticut. While 99% of CT schools report teaching HIV prevention, only 55% taught how to effectively use a condom, and only 44% taught all 10 HIV prevention topics listed in the CDC survey. A 2003 national survey found that 30% of schools taught abstinence-only, 47% taught "abstinence plus" (abstinence is best but also teach about condoms and contraception), and 20% taught that making responsible decisions about sex was more important than abstinence (NPR/Kaiser/Kennedy School Poll).

Youth Advisory Group members shared some negative experiences with HIV education. Many districts teach abstinence-only, or only teach HIV prevention once in high school, or teach directly from a textbook without any discussion and/or interactions. Youth comments from this discussion included the following:

- We didn't get to practice role-plays or practice putting on condoms. All we did was read a book.
- We began taking classes freshmen year. We had peer buddies who talked to us about how to practice safer sex, but it didn't work because they were not serious.
- I had six weeks of nothing.
- I had mis-education. We never talked about Sexually Transmitted Diseases (STDs).
- I just had a basic health class – we just focused on the human body and there was only one chapter on pregnancy.
- There weren't any classes before the prom, ring dances, or carnation balls. These are the events where there is a lot of buzz about having sex. We should be having classes around these events to remind us about abstinence, safer sex and pregnancy prevention.
- I noticed that sex education classes never get repeated as I went further on in high school. I think that we should be taking classes every year and they should progress in levels of knowledge that we learn.
- In my class, the teacher was the only one who demonstrated how to put on a condom properly. All of us were interested in practicing but she wouldn't let us because there were not resources for all of the students to practice with.

> "Teens are going to have sex. Instead of discouraging young adults, we need you to embrace us, make yourself accessible to help if asked, and accept our views and opinions."
> *Tempestt Latham*

It is important to note that the Connecticut State Department of Education's new Healthy and Balanced Living Curriculum Framework supports **students learning "all the facts."** The Framework includes expectations for what students should know at Kindergarten, Grade 4, Grade 8 and Grade 12. For example, Grade 8 expectations are that students will "describe puberty and human reproduction as it relates to medically accurate comprehensive sexuality education" (page 13).

> "Adults need to know how to help young adults by understanding the mindset of young adults, and take everything we say seriously."
> *Javon Meekins*

Most parents do NOT want abstinence-only education for their teens. The 2003 national survey found that only 15% of parents reported that they wanted schools to teach abstinence-only – 46% of parents believe that the most appropriate approach is abstinence-plus and 36% believe that schools should teach teens how to make responsible decision about sex.

4. HIV CARE AND PREVENTION RESOURCES AND PROGRAMS FOR YOUTH

In 2007, as part of the HIV planning process, staff assembled a database of community-based organizations offering HIV care and prevention services for youth. Of the 50 organizations identified, 30 are in the major cities: 12 in Hartford, 12 in New Haven and 6 in Bridgeport. Danbury, Meriden, New Britain, New London and Stamford also have two or more programs. At least 12 organizations offer multiple programs and services (e.g., counseling and testing, street outreach, education programs, case management). At least 9 organizations run peer education programs, and many offer HIV prevention education programs. Finally, a number of programs (9) work directly with HIV-positive or HIV-affected children and youth.

Youth Advisory Group members noted the following challenges related to HIV prevention resources:

- **Traveling to programs**. While there are resources available, many youth from suburban areas will not travel to the cities to access resources like HIV testing and counseling. For example, teenagers from Fairfield may not go to Bridgeport, even if most of the services and programs are located there.
- **Limited reach of peer education programs**. Many peer education programs meet once a week, so it can take a long time to train and prepare peer educators, and to develop the materials and outreach programs. As a result, these programs may not reach large numbers of youth beyond those directly involved in the program.
- **School restrictions**. Many high schools restrict access to information and access to condoms. Peer educators can get in trouble for giving out condoms at school.
- **Bring education to youth on a regular basis**. It is important to bring programs and HIV prevention directly to youth, and for programs to keep coming back to schools, rather than just having one-time events.

In 2007-08, the Youth Advisory Group met with professionals providing care for young people living with HIV, including social workers from Connecticut Children's Medical Center (CCMC) and Yale University. Some themes from these presentations and discussions include the following:

- A key issue for many youth born with HIV has been **finding out their status as adolescents**. Before there were effective treatments for HIV/AIDS many parents, supported by providers, chose not to tell their child of their HIV status. Parents wanted to protect their children from stigma, and at that time, children were not expected to live into adulthood. Disclosure of their status can change everything for a young person. The young person might question if anything and everything else they have been told is true (e.g., am I adopted, are members of my family HIV-positive), might mistrust their family and providers, might wonder what their mother did to get infected, and might wonder if there are more secrets.
- The importance of **having someone trustworthy to talk to**. Providers described the multiple roles a counselor can play – including as a person that young people can talk to without worrying about their relationship (which might be different than speaking with a friend or family member).
- Whether to **disclose your status** to others. Youth need support to help cope with the stress around disclosing their status. Do you tell at all? Who do you tell? When and how do you tell friends, family, partners, students in your school, and other acquaintances? Stigma is still an issue, especially in high school where rumors can fly.
- The importance of **addressing basic and immediate needs**, as well as health issues. Providers noted that youth who become infected as teens may also face other immediate challenges in their lives (e.g., housing, employment, lack of transportation).

- Meeting young people in a **comfortable setting**. Counseling and support services may be delivered in young people's homes or at a neutral public location. Some of the most important conversations can occur while driving youth to and from a meeting place.

"HIV is a world-wide epidemic that needs more attention to the youth today. It must be treated early before it's too late."
Alex Ocampo

5. WHAT WORKS IN HIV PREVENTION FOR YOUTH?

This section highlights what young people in Connecticut say works in HIV prevention. A diverse group of young people contributed their thoughts, including youth living with HIV/AIDS.

It is important to note that youth perspectives in many ways agree with and build on what the research says about effective HIV prevention. For example, at the September 2006 Youth Advisory Group meeting, youth learned about Effective Behavior Interventions (EBIs), HIV prevention programs that have been studied carefully over time and proven to work. In examining the CDC list of 10 common characteristics of effective prevention programs, youth noted many similarities with their own recommendations. Also, the CPG liaison to the Advisory Group suggests that networks and collaborations like the Youth Advisory Group itself are effective HIV prevention programs.

Currently, DPH funds two EBIs that directly target youth: (1) AIDS Project Hartford and Windham Regional Community Council are implementing *Street Smart* – an HIV prevention program for runaway and homeless youth; and (2) the City of Stamford Health Department is implementing *Intensive AIDS Education in Jail*. Approximately 448 young people have participated in these programs from July 2005 through March 2007. While youth were specifically targeted through the programs mentioned above, 5,898 youth were also reached inadvertently through other funded programs such as: Community PROMISE, Counseling and Testing, Drug Treatment Advocacy, MPowerment, Informational and Enhanced AIDS Education, Comprehensive Risk Counseling Services, Real AIDS Prevention Project, Rikers Health Advocacy Program, Safety Counts, SISTA and Voices/Voces. Beginning July 1, 2008, DPH will fund two EBIs specifically targeting youth: 1) AIDS Project Hartford, AIDS Project New Haven and City of Stamford Health Department will implement *Street Smart*; and 2) The University of Connecticut Health Center (CCMC) will implement *Together Learning Choices* (TLC) – an intervention for HIV positive young people ages 13-29. As with the previous funding cycle, youth will be reached inadvertently through other interventions as well.

"HIV is a life threatening disease and virus. Youth and adults need to get information now rather than later. Today's youth and adults don't have the right information to understand the meaning or the consequences of living with HIV/AIDS. Adults need to study more and more to improve their research in how to find better meds and try to find a cure. Youth need to stay in school and have support groups to keep them busy in positive ways. Prevention is so important today, with pregnancy at younger ages."
Wesley Moreno

Youth Participating in Planning Meetings
From December 2005 through February 2007, a total of 26 "youth planning meetings" were held with 266 young people. Meetings were held all across Connecticut, including seven meetings in New Haven, five in Hartford and three in Bridgeport. Youth Advisory Group members co-facilitated two such planning meetings. Meetings were held with a wide variety of groups – with emphasis on reaching peer educators and those populations at higher risk of infection (MSM, youth involved with juvenile justice, homeless youth and youth living in communities with high infection rates).

Young people noted a key challenge to HIV prevention efforts – that many young people do not worry about HIV/AIDS or cannot imagine becoming infected. In other words, HIV affects other people; ***"it can't happen to me."*** Staff at HIV prevention agencies cited lack of funding as a critical challenge – for salaries, staff training, and incentives for youth to participate in prevention programs (e.g., food, stipends).

At these meetings, youth suggested ways to make HIV/AIDS real and to get the attention of young people. Strategies included:

- Interactive and engaging education, including games, activities, performances, discussions, role-

plays, etc. Programs should use a range of strategies, rather than just reading about HIV/AIDS in a textbook.

- Using the media, celebrities, and rap stars to get the message out.
- HIV-positive guest speakers, especially speakers who "looked like" the youth. Many youth noted the importance of making HIV/AIDS real, and showing the consequences of risky behaviors.
- Encouraging youth to get tested, by noting that testing is free and confidential and through incentives like gift certificates.
- Easier access to condoms (e.g., free, available at school).
- Peer education and one-on-one conversations with young people.
- Starting education in middle school.
- Providing comprehensive sex education in schools.
- Educating parents as well as young people.

> "HIV prevention is so important because a lot of youth are getting infected. The number is too high – we need to reduce it."
> *Rondell Batson*

Youth Advisory Group Members
Advisory Group members discussed what works at many meetings. The main themes are presented below:

- **100% real information without any sugar coating**. Young people need to know all the facts about HIV/AIDS, and learn all the ways to protect themselves. Abstinence-only programs will not be effective, because many young people are already sexually active.
- **Use a range of strategies to reach youth**. There is no one approach that will work for everyone. Programs should include interactive exercises, role-plays, games, peer education, multimedia (visuals, videos, music), group discussions, guest speakers, written materials, etc. There should be opportunities to practice skills in a realistic environment – whether it's role playing how to talk to a partner or practicing how to use a condom.
- **Ongoing education starting in middle school**. One-time events or presentations are not enough. Young people need more consistent education in HIV/STD prevention. Students need to start learning at a young age, before they become sexually active.
- **Make it real**. One of the challenges is that many young people do not worry or think about HIV/AIDS. Programs need to make HIV/AIDS real – through guest speakers, discussions about what it is like to be infected or have a family member infected, activities that show what it is like to be HIV-positive, or education that shocks youth out of their complacency.
- **Speakers/teachers should have real experience of HIV/AIDS and come from the same background as students**. The best messengers are those who have personal experience with HIV/AIDS (affected or HIV-positive) and who "look like" the audience. Peer educators can be very effective if they are serious and know the material. Having youth and young adults telling their stories about STDs and HIV/AIDS can be powerful. This can make HIV/AIDS real for young people – and convey the message of what it is really like to live with HIV/AIDS (the medications, the hope that there is life after infection, etc).

> "What works for me is knowing that my life is going to be lived and that I am having a positive influence. That's why I participate on the Youth Advisory Group: to help those who need it and have no place to find that help."
> *Brian X. Lester*

- **Educate parents on how to talk to their children about HIV prevention**. Parents often do not want to think about their children engaging in risky behaviors, and may avoid conversations about HIV and safe sex. Parents need to know the facts about HIV/AIDS so they can talk about it with their children. The importance of parent-child communication is supported by research. The 2005 Connecticut School Health Survey found that students who report good communication with their parents are much less likely to engage in risky behaviors. These students report less

sexual intercourse (40% vs. 64%), less alcohol use (39% vs. 62%) and less marijuana use (18% vs. 38%) than their peers.

- **Written materials should show people who "look like us" and give all the facts**. Pamphlets and brochures should be 100% real and supply information on who to call if a person thinks they may be infected with HIV/AIDS or other STDs. Materials need to include eye-catching photos (using the latest fashions) and graphics – including pictures that really show the different stages of STDs. Youth noted that written materials should be used in combination with the other strategies discussed above.

The What Works sub-committee of the Advisory Group also developed two slogans for youth prevention: (1) Practice what you preach and (2) No slippies in '07 [no slip-ups in being safe].

6. RECOMMENDATIONS

At the May 2007 meeting, Youth Advisory Group members finalized the key recommendations for improving HIV prevention for youth. At the May 2008 meeting, Advisory Group members agreed on key recommendations for improving care for young people living with HIV. These HIV care and prevention recommendations are summarized below.

1. **Give Youth All the Facts**

   Prevention. 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. As one member noted, "I don't think of myself as a statistic." 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, as well as a guide that outlines care services for HIV-positive youth. The latter will empower and encourage youth to take more responsibility for their health care and related decisions. Provide information and assistance for youth transitioning to adult systems of care.

2. **Teach Adults How to Engage Youth**

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

   a) Learn 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).

   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 to help their friends and peers as well. As one Advisory Group member tells her peers, "Don't be scared to know too much – the knowledge you learn can help others."

   c) 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.)

   d) Learn with young people. If you do not know the facts or answer to a question, acknowledge this and find out the answer together with the youth.

   e) Continue the conversations. There need to be many conversations about these topics, not just one parent-child talk about "the birds and the bees."

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 and HIV and AIDS are, how to be healthy, and how to make healthy decisions. (Advisory Group members noted that there may be differences by gender, with many girls developing physically at a younger age than boys.)

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 (hours, transportation, location)**

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, whether at school, in the community or through conversations with their families at home.

Care. Programs need to provider 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**

> "Listen to us. We may know more than you think."
> *Amanda Leslie*

Prevention. There need to be more opportunities for young people to speak with policymakers, legislators, and groups like the Connecticut Board of Education. One member suggested, "There should be a Connecticut law that schools teach all the facts (no abstinence-only) and an HIV prevention training requirement for all school principals." We need to have these discussions with policymakers, so our voices are heard.

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.

7. EVALUATION

At the May 2007 and 2008 meetings, members provided feedback on the Youth Advisory Group itself. Why do you participate? Did the Advisory Group accomplish its goals this year? Were the meetings well-organized? What did you like best? How can the Advisory Group be improved?

Overall, members enjoyed participating on the Advisory Group, meeting other young people, creating the Youth Chapter and learning about HIV care and prevention. Major themes include:

- **Young people can be leaders**. Many members emphasized that young people can make a difference in ending HIV/AIDS, and that youth can be leaders in HIV prevention. "I strongly believe HIV/AIDS can be eliminated."
- **The Advisory Group is accomplishing its goals**. All agreed that the Advisory Group accomplished its goals, that meetings were well-organized, diverse cultures and opinions of members were respected, and that they enjoyed participating. Members enjoyed meeting young people from across the state who shared their dedication to HIV prevention, and the "friendly and goal-oriented atmosphere."
- **Maintain a diverse group of young people**. As current members move on to college and jobs, it is important to recruit new youth. Several noted the importance of maintaining a diverse group. As one member said, "The members are from all over and are NOT just like me. This helps us to learn from each other as well as get the most out of discussions."

Why Involve Youth in HIV Planning?

"It is one thing to have been young. It is another thing to be young."

Blaise Gilchrist

Youth Chapter Appendix

1. Youth Planning Meetings

2. Orientation to the Youth Advisory Group

3. Presentations to CPG

4. HIV Prevention Youth Updates

5. PSA Storyboard

6. Minutes from May 5, 2007 meeting (sample)

7. Adult-Youth Communication: Role Play Scripts

CT HIV Care and Prevention Resource Inventory 2008

Ansonia							
Birmingham Group Health Services - outpatient/clinic services	435 East Main St.	Ansonia	CT	06401	HIV Medical case management, Case Management, Mental Health, Substance Abuse-outpatient, Emergency Financial assistance, Food bank, Outreach	2037362601	M: 8:30am-7:30pm; W: 8:30am-7pm; T,Th, F: 8:30am-5pm
HILL HEALTH CENTER - COMMUNITY HEALTH CONNECTION	121 Waklee Ave.	Ansonia	CT	06401	HIV Counseling, Testing & Referral, HIV Risk counseling services, Drug Treatment Advocacy, Disease/Disability Information,	2035033570	M, W: 8:30am-6:30pm; T, Th: 8:30am-5pm; F: 8:30am-12:30pm
Bridgeport							
AMERICAN RED CROSS - MID-FAIRFIELD COUNTY CHAPTER	158 Brooklawn Ave.	Bridgeport	CT	066042012	Disease/Disability Information * AIDS/HIV	8003199935	M-F: 8:30am-4:30pm
BRIDGEPORT, CITY OF - ARCHIVES AND RECORDS DEPT	45 Lyon Terrace	Bridgeport	CT	066044062	Archives	2035768192	M-F: 8:30am-4:30pm Open to the public by appointment only
BRIDGEPORT, CITY OF - HEALTH AND SOCIAL SERVICES - HIV/AIDS PROGRAM	752 East Main St.	Bridgeport	CT	06608	HIV Prevention Intervention, Needle Exchange/Distribution Programs, HIV/AIDS Information, Outreach	2035767679	M-F: 8:30am-4pm
BRIDGEPORT HOSPITAL	267 Grant St.	Bridgeport	CT	06610	Primary Care, Children's Health Initiative-HIV Perinatal	2033813000	
CATHOLIC CHARITIES - BRIDGEPORT	238 Jewett Ave.	Bridgeport	CT	06606	Supported Living Services for Adults with Disabilities * AIDS/HIV	2033724301	M,W,F: 9am-5pm; T,Th: 9am-8pm
CHEMICAL ABUSE SERVICES AGENCY	690 Arctic St.	Bridgeport	CT	06608	Substance Abuse Counseling * AIDS/HIV, Case Management*AIDS/HIV	2033394112	M-F: 9am-5pm
CHILD GUIDANCE CENTER OF GREATER BRIDGEPORT	180 Fairfield Ave.	Bridgeport	CT	06604	Adolescent/Youth Counseling and Mental Health for Families affected by HIV/AIDS	2033946529	M: 8am-6pm; T,W,Th: 8am-8pm; F: 8am-5pm
FAMILY SERVICES WOODFIELD	475 Clinton Ave.	Bridgeport	CT	06605	HIV Medical case management, Case Management, Disease Disability Info., Mental Health, Housing related services, HIV Prescription expense assistance, Health Insurance Assistance, Emergency Financial Assistance, General Counseling, Psychosocial support, Medical	2033685602	M,Th,F: 8am-5pm; T-W: 8am-9pm
GREATER BRIDGEPORT ADOLESCENT PREGNANCY PROGRAM - 158 MILL HILL AVE.	158 Mill Hill Ave.	Bridgeport	CT	06610	HIV Counseling, Testing and Referral, HIV Prevention Interventions, Ambulatory/Outpatient, HIV Medical case management, Mental Health, Oral Health, Medical Transportation, Housing, Food bank, Emergency Financial Assistance, Outreach, Substance Abuse Counseling	2033668255	M-F: 10am-6pm
LIBERATION PROGRAMS - BRIDGEPORT OUTPATIENT SERVICES	399 Mill Hill Ave.	Bridgeport	CT	06610	Case management, Outpatient and Inpatient Substance Abuse Services, Individual advocacy	2033849301	M-F: 9am-5pm and by appointment
OPTIMUS HEALTH CARE	471 Barnum Ave.	Bridgeport	CT	06608	HIV Counseling, Testing and Referral, Outpatient EIS, HIV Medical case management, Outreach, HIV Medication Adherence, Disease/Disability Information, Specialized Treatment,	2033336864	M,W,Th,F: 8am-5pm; T: 8am-7:30pm; Sat: 9am-1pm
OPTIMUS HEALTH CARE - EAST MAIN ST. CLINIC	982-988 East Main St.	Bridgeport	CT	06608	HIV Specialized Treatment, HIV Counseling, Testing and Referral, Disease Disability Info., Outreach programs, HIV Medical case management	2036963260	M,T: 8am-7:30pm; W,Th,F: 8am-5pm; Sat: 9am-1pm

OPTIMUS HEALTH CARE - PARK CITY PRIMARY CARE CENTER	64 Black Rock Ave.	Bridgeport	CT	06605	HIV Specialized Treatment, HIV Counseling, Testing and Referral	2035795000	M,T,Th,F: 8:30am-5pm; W: 8:30am-7:30pm; Sat: 8:30am-12:30pm
PLANNED PARENTHOOD OF CONN. - BRIDGEPORT	211 State St., 2nd Fl.	Bridgeport	CT	06604	HIV Testing	2033660664	M: 9am-4:30pm: Tu: 8am-6:30pm; W: 10:30am-4:30pm; Th: 8am-6:30pm; F: 9am - 4:30pm; Sa: 9am - 12pm;
PROGRESSIVE TRAINING ASSOCIATES	965 Fairfield Ave.	Bridgeport	CT	06605	Disease/Disability Information, Job Training, Family and Youth Services	2039084200	M-F: 9am-5pm
SOUTHWEST COMMUNITY HEALTH CENTER	968 Fairfield Ave.	Bridgeport	CT	06605	HIV Medical case management, HIV Counseling, Testing and Referral, Dental Care, HIV Specialized Treatment, Outpatient EIS, Outreach, Programs for infected and affected children, youth and families	2033306000	M,W,Th, F: 8:30am-4:30pm; T: 8:30am-5:30pm; Sat: 9:30am-12:30pm
SOUTHWEST COMMUNITY HEALTH CENTER - BIRD STREET	361 Bird Street	Bridgeport	CT	06605	HIV Medical case management, Dental Care, HIV Counseling, Testing and Referral, HIV Specialized Treatment, Outpatient EIS, Programs for infected and affected children, youth and families	2033306000	M,W,Th, F: 8:30am-4:30pm; T: 8:30am-5:30pm; Sat: 9:30am-12:30pm
SOUTHWEST COMMUNITY HEALTH CENTER - MARINA VILLAGE	743 South Ave.	Bridgeport	CT	06604	HIV Medical case management, Dental Care, HIV Counseling, Testing and Referral, HIV Specialized Treatment, Outpatient EIS, Programs for infected and affected children, youth and families	2033306000	M-F: 8:30am-4:30pm
Bristol							
BRISTOL-BURLINGTON HEALTH DISTRICT	240 Stafford Ave.	Bristol	CT	060104617	HIV/AIDS Information; HIV Testing	8605847682	M-F: 8:30am-5pm

Danbury							
AIDS PROJECT GREATER DANBURY	30 West St.	Danbury	CT	06810	HIV Medical case management, Disease/disability information, Health related support groups, Families/Friends of PLWH/A, Outreach, HIV Counseling, Testing and Referral, HIV Risk counseling services, Drug Treatment Advocacy, Needle Exchange/Distribution Programs, Emergency financial assistance, Oral health, Mental health, Housing-related services, Food bank, Ambulatory/outpatient, Medical transportation, HIV Prescription expense assistance, HIV Medication adherence	2037782437	M-F: 9am-5pm; Answering machine after hours
DANBURY HOSPITAL - AIDS/HIV CENTER	70 Main St.	Danbury	CT	06810	HIV Specialized Treatment	2037915065	M-F: 8am-4pm
DANBURY VISITING NURSE ASSN.	4 Liberty St.	Danbury	CT	06810	Home Health Care * AIDS/HIV	2037924120	M-F: 8:30am-4:30pm; Answering service after hours
INTERFAITH AIDS MINISTRY OF GREATER DANBURY	39 Rose St.	Danbury	CT	06810	Disease/Disability Information * AIDS/HIV, Outreach Programs, Food pantry, Temporary Financial Assistance, HIV Prevention Interventions	2037484077	M-Th: 9am-4:30pm
PATIENT CARE - DANBURY OFFICE	11 Lake Avenue Ext., Suite 3W	Danbury	CT	06810	Medication Adherence Programs * AIDS/HIV	2035466712	M-F: 8am-5pm; Answering service after hours
PLANNED PARENTHOOD OF CONN. - DANBURY	44 Main St.	Danbury	CT	06810	HIV Counseling and Testing	2037432446	M: 12:00-7:30pm; Tu: 11am-6:30pm; W, F: 8:30am-4:00pm; Th: 9:30am-4pm; Sa: Call for availability; Answering service
Danielson							
PLANNED PARENTHOOD OF CONN. - DANIELSON	87 Westcott Rd.	Danielson	CT	06239	HIV Counseling and Testing	8607740533	M: 10:00am-6:00pm; Tu: 9:30am-4:30pm; W: 9am-5pm; Th: 11:30am-7:30pm; F: 8:30am-4:30pm; Sa: Call for availability; Closed Wednesday;
Derby							
AMERICAN RED CROSS - VALLEY CHAPTER	2A Francis St.	Derby	CT	06418	Disease/Disability Information * AIDS/HIV	2037359518	M-F: 9am-4pm

Enfield							
PLANNED PARENTHOOD OF CONN. - ENFIELD	76 Palomba Dr.	Enfield	CT	06082	HIV Counseling and Testing	8607412197	M: 11am-7pm; T, F: 8:30am-4:30pm; Th: 12-7pm; Call for Saturday hours; Closed Wed. & Sun.; Answering service: 24 hr/7
Fairfield							
STEWART B. MCKINNEY FOUNDATION	1216 Post Rd.	Fairfield	CT	06824	Supported Living Services for Adults with Disabilities * AIDS/HIV, Temporary Financial Assistance	2032557965	M-F: 9am-12noon
Farmington							
UNIVERSITY OF CONN. HEALTH CENTER - JOHN DEMPSEY HOSPITAL	263 Farmington Ave	Farmington	CT	06030	HIV Testing, HIV Medical case management, HIV Medication adherence, Specialized treatment	8606792000	Main switchboard: 24 hr/7 days
Greenwich							
AIDS ALLIANCE OF GREENWICH	101 Field Point Rd.	Greenwich	CT	06836	Disease/Disability Information * AIDS/HIV, 'Health Related Support Groups * Families/Friends of People with AIDS/HIV, 'Case management, 'Temporary Financial Assistance	2036226496	M-F: 8am- 4pm; Evening appointments; Answering machine after hours
AMERICAN RED CROSS - GREENWICH CHAPTER	99 Indian Field Rd.	Greenwich	CT	06830	Disease/Disability Information * AIDS/HIV	2038698444	M-F: 9am-5pm. Emergency response 24 hr/7 days
CHILD GUIDANCE CENTER OF SOUTHERN CONN. - GREENWICH COMMUNITY OFFICE	23 Benedict Pl.	Greenwich	CT	06830	Adolescent/Youth Counseling * Families/Friends of People with AIDS/HIV	2039835294	By appointment, weekday and evening
GREENWICH, TOWN OF - HEALTH DEPT.	101 Field Point Rd.	Greenwich	CT	06830	HIV Testing	2036226496	M-F: 8am-4pm
Hartford							
AIDS LEGAL NETWORK FOR CONN, c/o Greater Hartford Legal Aid	999 Asylum Ave.,	Hartford	CT	061052465	Legal Representation * AIDS/HIV, Benefits Assistance, Discrimination Assistance, Individual Advocacy	8605415000	M-F: 8:30am-4:30pm
CHARTER OAK HEALTH CENTER	21 Grand St.	Hartford	CT	06106	HIV Counseling and Testing, Early Intervention services, Case Management, Ambulatory/outpatient, Substance abuse-outpatient, Mental Health, Women's Services, Bereavement Counseling *AIDS/HIV, Disease/Disability Information*AIDS/HIV, Outreach, Pharmacy	8605507500	Office: M-F: 8:30am-5pm; Medical Center: M,T,W,Th: 8:30am-7:30pm; F: 9:30am-6:30pm; Sat: 8:30am-5pm; Dental clinic: M-Th: 8:30am-5pm; F: 9:30am-5pm; Sat: 8:30am-5pm
CHRYSALIS CENTER	278 Farmington Ave	Hartford	CT	061053301	Case Management * AIDS/HIV, Housing services	8605251261	M-F: 8:30am-4:30pm
COMMUNITY DISTRIBUTION CENTER	3580 Main St., Suite 115	Hartford	CT	061201121	Disease/Disability Information * AIDS/HIV, HIV Information, HIV Risk Prevention Materials	8003223222	Walk-in hours M-Th: 9:30am-3:30pm; Call first to verify
COMMUNITY HEALTH SERVICES - ADULT MEDICINE AND INFECTIOUS DISEASES	500 Albany Ave.	Hartford	CT	06120	General Counseling Services * AIDS/HIV, Out patient EIS, Ambulatory/outpatient, Women's Services, Case management, Dental Care	8608088740	M-Th: 8am-7pm; F: 12noon-5:30pm
COMMUNITY HEALTH SERVICES - BEHAVIORAL HEALTH DEPT	500 Albany Ave.	Hartford	CT	06120	Substance Abuse Counseling * AIDS/HIV	8608088780	M-Th: 8am-6pm; F: 12noon-5:30pm
COMMUNITY PARTNERS IN ACTION - BEYOND FEAR PROGRAM	110 Bartholomew Ave., 4th Fl.	Hartford	CT	06106	HIV Information, Intensive AIDS Education in Jail Prevention Intervention	8602933985	M-F: 8:30am-4pm

COMMUNITY RENEWAL TEAM, BEHAVIORAL HEALTH	1921 Park St.	Hartford	CT	06106	Psychiatric Disorder Counseling * AIDS/HIV, Mental Health, Substance Abuse-Outpatient Counseling	8609518770	M-F: 9am-5pm; Evening appointments available
COMMUNITY RENEWAL TEAM, STEWART MCKINNEY SHELTER	34 Huyshope Ave.	Hartford	CT	06106	Homeless Drop In Centers * AIDS/HIV, Congregate Meals, Homeless shelter, Case Management	8607226921	Intake: M-Sun: 5pm-7am Donations accepted M-Sun: 6am-4pm
CONN. AIDS RESOURCE COALITION	20-28 Sargeant St.	Hartford	CT	06105	Planning/Coordinating/Advisory Groups * AIDS/HIV, Rent Payment Assistance, Housing services, Organizational Consultation/Technical Assistance, Employment Training, System advocacy, Supported Living Services for Adults with Disabilities*AIDS/HIV, Food Vouchers, Temporary Financial assistance, Utility Assistance, HIV Prescription expense assistance, Health insurance assistance, Emergency Financial Assistance, Rental subsidies, Ambulatory/outpatient fee for service, Oral health fee for service, mental health fee for service	8607616699	M-F: 8am-4pm
CONN. CHILDREN'S MEDICAL CENTER - HIV/AIDS PEER EDUCATION TRAINING	282 Washington St.	Hartford	CT	06106	Disease/Disability Information * AIDS/HIV, Outreach, General Counseling, HIV Medical case management, HIV Prevention Interventions, Ambulatory/Outpatient, Emergency Financial assistance, Mental Health	8605457479	M-F: 3:30-5:30pm
CT AREA HEALTH EDUCATION CENTER PROGRAM - CENTRAL AHEC	2 Holcomb Street	Hartford	CT	06112	Drug Treatment advocacy, HIV Prevention interventions, Ambulatory/outpatient, HIV Medical case management, Emergency Financial assistance, Medical Transportation, Health Van, Substance Abuse-outpatient, Mental Health, Early Intervention services, Outreach	8605438865	M-F: 8:30am-4:30pm
FAMILY MEDICINE CENTER AT ASYLUM HILL	99 Woodland St.	Hartford	CT	06105	HIV Testing, Specialized Treatment	8607144212	Office: M-F: 9am-5pm; Services: M,T,Th,F: 8:30am-5pm; Wed: 1-8pm; Appointments: M,T,Th,F: 8:30am-5pm; Wed: 1-8pm
HARTFORD DISPENSARY	345 Main St.	Hartford	CT	06106	HIV Medical case management , Case Management, Risk Avoidance HIV Prevention intervention, Methadone Maintenance	8605252181	M-F: 6am-6pm; Sat,Sun,Holidays: 7:30-10am
HARTFORD GAY AND LESBIAN HEALTH COLLECTIVE	1841 Broad St.	Hartford	CT	06114	Dental Care, HIV Counseling, Testing and Referral, HIV Risk counseling services, HIV Prevention Interventions, Outreach, Substance Abuse-outpatient, Acupuncture	8602784163	Office open M,T,W,F: 9am-5pm; Th: 9am-9pm; STD clinic open Th: 6:30-8pm
HARTFORD, CITY OF - HEALTH AND HUMAN SERVICES DEPT., AIDS/HIV PROGRAM	131 Coventry St.	Hartford	CT	06112	HIV Counseling, Testing and Referral, Disease/Disability Information*AIDS/HIV, Outreach, Health Van	8605438822	M,T,TH,F: 8:30am-4:30pm; W: 8:30am-6:30pm
HISPANIC HEALTH COUNCIL	175 Main St.	Hartford	CT	06106	Disease/Disability Information * AIDS/HIV, Outreach Programs	8605270856	M-F: 8:30am-4:30pm
IMMACULATE CONCEPTION SHELTER AND HOUSING CORPORATION - SHELTER AND HOUSING SERVICES	560 Park St.	Hartford	CT	06106	Congregate Meals/Nutrition Sites * AIDS/HIV, Rent Payment Assistance, Transitional Housing/shelter, Food bank/meals	8607244823	Shelter hours: M-Sun: 4pm-8am

LATINO COMMUNITY SERVICES	184 Wethersfield Ave.	Hartford	CT	06114	Organizational Consultation/Technical Assistance * AIDS/HIV, Disease/Disability Information*AIDS/HIV, HIV Counseling, Testing and Referral, HIV Prevention Interventions, HIV Medical case management, Emergency Financial Assistance, Linguistic Services, Medical Transportation, HIV Medication Adherence, Substance Abuse Counseling, General Counseling,	8602966400	M-F: 8am-4pm
LOAVES AND FISHES MINISTRIES	360 Farmington Ave	Hartford	CT	06105	Food Pantries * AIDS/HIV, Job Skills	8605241730	M-F: 9am-5pm
MERCY HOUSING AND SHELTER CORPORATION - SUPPORTIVE HOUSING SERVICES	211 Wethersfield Ave.	Hartford	CT	06114	Transitional Housing/Shelter * AIDS/HIV	8605607904	M-F: 8:30am-4:30pm
PLANNED PARENTHOOD OF CONN. - HARTFORD - NORTH END	1229 Albany Ave., 4th Fl.	Hartford	CT	06112	HIV Testing, HIV Information	8607280203	M, Th: 11am-6:30pm; T: 8:30am-4pm; W: 9am-4:30pm; F: 9:30am-4pm; Saturday: Call for availability
PUBLIC HEALTH, CONN. STATE DEPT. OF - AIDS AND CHRONIC DISEASES SECTION	410 Capitol Ave.	Hartford	CT	061340308	HIV Prevention; Organizational Consultation/Technical assistance, Disease/Disability Information, Communicable Disease Control, HIV/AIDS Surveillance, Specialized Information and Referral, Planning/Coordinating/advisory Groups, Health Care and Support services, Counseling and Testing, STD and Hepatitis Surveillance; Cancer Control and Prevention, Diabetes Control and Prevention, Heart Disease and Stroke Prevention	8605097801	M-F: 8:30am-4:30pm
RYAN WHITE PART A GREATER HARTFORD TGA PLANNING COUNCIL - HARTFORD, MIDDLESEX AND TOLLAND COUNTIES	131 Coventry St.	Hartford	CT	06112	HIV Care Planning/Coordinating/Advisory Groups	8606676207	M-F: 8:30am-4:30pm
SOCIAL SERVICES, CONN. - CONN. AIDS DRUG ASSISTANCE PROGRAM (CADAP)	25 Sigourney St.	Hartford	CT	06106	HIV Prescription expense assistance * AIDS/HIV	8002332503	M-F: 8:30am-4:30pm
ST. FRANCIS HOSPITAL/UNIVERSITY OF CONN. PRIMARY CARE CENTER HIV/AIDS PROGRAM	131 Coventry St., 2nd Fl.	Hartford	CT	06112	HIV Medical case management, Substance Abuse Counseling, HIV Specialized Treatment	8607142813	M-F: 8am-4:30pm
SUBSTANCE ABUSE AND MENTAL HEALTH RYAN WHITE PART A PROJECT	1921 Park St.	Hartford	CT	06106	General Counseling Services * AIDS/HIV, Substance Abuse Counseling, Case Management	8609518770	By appointment
SUBSTANCE ABUSE TREATMENT ENHANCEMENT PROJECT	500 Blue Hills Ave.	Hartford	CT	06112	Case Management * Substance Abuse Counseling * AIDS/HIV	8607143701	24 hr/7 days
TRINITY HILL CARE CENTER	151 Hillside Ave.	Hartford	CT	06106	Hospice Care * AIDS/HIV, Adult Respite Care, Skilled Nursing Facility	8609511060	24 hr/7 days

THE VILLAGE FOR FAMILIES AND CHILDREN	1680 Albany Ave.	Hartford	CT	06105	Health Related Support Groups * AIDS/HIV, adolescent/Youth Counseling, Health related support groups, Bereavement Support Groups, Mental Health Services, Individual, Group and Family Therapies	8605274224	M-Th: 8am-7pm; F: 8am-5pm
AIDS PROJECT HARTFORD	110 Bartholomew Ave., Suite 3050	Hartford	CT	061062229	Speakers/Speakers Bureaus * AIDS/HIV, Disease/Disability Info, Needle Exchange/Distribution programs, HIV Counseling, Testing and Referral, Helplines/Warmlines, 'Gay/Lesbian/Bisexual/Transgender Support Groups * AIDS/HIV, Health related support groups, Housing related-services, HIV Medical case management, HIV Medication Adherence , HIV Risk counseling services, Drug treatment Advocacy, Prevention programs for HIV+, HIV Prevention Interventions, Food bank, Transitional Living to Community (Project TLC)	8609514883	M-F: 9am-5pm; Hotline answered as follows: 8am-5pm by agency staff; 5pm-8am by Centers for Disease Control
AIDS PROJECT HARTFORD - CONNECTIONS WELLNESS CENTER	360 Main St.	Hartford	CT	06106	Alternative Medicine * AIDS/HIV, HIV Medical case management, Health Related Support Groups*HIV/AIDS, Substance Abuse Counseling, Psychosocial support, Food bank/meals, Drug and alcohol dependency support groups, HIV Medication Adherence	8605471771	M-F: 8:30am-4pm
Manchester							
MANCHESTER AREA NETWORK ON AIDS	64 Church St.	Manchester	CT	06040	HIV Medical case management, Disease/Disability Information, Educational Programs, Food bank/ meals, AID-a Pet, Psychosocial Support, Support Groups, Thanksgiving Meals and Baskets	8606466260	M-F: 8:30am-4:30pm; Evening hours by appointment only
PLANNED PARENTHOOD OF CONN. - MANCHESTER	419 West Middle Tpke.	Manchester	CT	06040	HIV Testing, HIV Information	8606431607	M: 9am-7:30pm; T: 10am-5pm; W: 9am - 4:30pm; Th: 12:00-7:30pm; F: 9am-5pm; Sa: Call for availability; Answering Service: 24 hr/7 days
Mashantucket							
MASHANTUCKET PEQUOT TRIBAL HEALTH DEPT.	75 Rt. 2	Mashantucket	CT	06338	HIV Testing, Hive Information, Disease/Disability Information.	8603128000	M-F: 8am-4:30pm
Meriden							
COMMUNITY HEALTH CENTER - MERIDEN	134 State St.	Meriden	CT	06450	HIV Counseling and Testing, Specialized Treatment*AIDS/HIV	2032372229	M,F: 8:30am-5pm; T,W,Th: 8:30am-7:30pm; Sa: 9am-12noon OB-GYN Clinic M-F: 8:30am-5pm
MERIDEN DEPT. OF HEALTH & HUMAN SERVICES	165 Miller St.	Meriden	CT	06450	HIV Counseling, Testing and Referral, HIV Prevention Interventions	2036304221	
PLANNED PARENTHOOD OF CONN. - MERIDEN	26 Women's Way	Meriden	CT	06451	HIV Testing	2032380542	M: 8:30am-7:00pm; T, Th, F: 8:30am-4:30pm; W: 12:00noon-7:00pm; Sa: Call for availability; Answering service 24 hr/7 days
Middletown							
AMERICAN RED CROSS - MIDDLESEX CENTRAL CONN. CHAPTER	97 Broad St.	Middletown	CT	06457	Disease/Disability Information * AIDS/HIV	8603472577	M-F: 8:30am-4:30pm; Answering service after hours

COMMUNITY HEALTH CENTER - OASIS WELLNESS CENTER	33 Ferry St.	Middletown	CT	06457	Wellness Programs * AIDS/HIV, Health Related Support Groups, Psychosocial support, Food bank/meals, Mental Health, Medical Transportation, HIV Medical case management, Emergency Financial assistance, Ambulatory/outpatient, Outpatient EIS, Hispanic/Latino Support Groups*AIDS/HIV	8603476971	M,T,F: 9am-5pm; W: 11:30am-7:30pm; Th: 10am-6pm
HARTFORD GAY & LESBIAN HEALTH COLLECTIVE	1841 Broad Street	Hartford	CT	06114	HIV Counseling, Testing and Referral (MSM), HIV Prevention Interventions (MSM)	860-2784163	tba
POSITIVE SOLUTIONS	9 Rapallo Ave.	Middletown	CT	06457	Disability Related Center Based Employment * AIDS/HIV, Computer Classes, Parenting Education	8607048067	M-F: 9am-4:30pm
New Britain							
COMMUNITY HEALTH CENTER - NEW BRITAIN	One Washington Sq.	New Britain	CT	06051	HIV Counseling and Testing, Specialized Treatment*AIDS/HIV	8602243642	M-F: 8am-4:30pm
HUMAN RESOURCES AGENCY OF NEW BRITAIN - HIV PREVENTION	336 Arch St.	New Britain	CT	06051	Speakers/Speakers Bureaus * AIDS/HIV, HIV Counseling, Testing and Referral, HIV Prevention Interventions, Disease/Disability Information*AIDS/HIV	8608264482	M-F: 8:30am-4:30pm
HUMAN RESOURCES AGENCY OF NEW BRITAIN - WELLNESS RESOURCES CENTER	12 Rockwell Ave.	New Britain	CT	06051	HIV Medical case management, Disease/Disability Information*AIDS/HIV, Medical Nutritional Counseling, Substance abuse-outpatient, Psychosocial support, Emergency Financial Assistance, Food bank/meals, HIV Medication adherence, Health Related Support Groups, Wellness Programs, Social Clubs/Events*AIDS/HIV	8608264741	M,T,Th: 8:30am-4:30pm; W: 8:30am-7:30pm; F: 8:30am-1:30pm
NEW BRITAIN, CITY OF - HEALTH DEPT.	56 Hawkins St.	New Britain	CT	06052	HIV Testing, HIV Information	8608263473	M-F: 8am-4pm
PLANNED PARENTHOOD OF CONN. - NEW BRITAIN	100 Grand Street	New Britain	CT	06050	HIV Testing	2032388096	T,Th: 4:30-7:30pm; Sa: call for availability; Closed M, W, F
REPAIRING THE BREACHES FAMILY SERVICES MINISTRY	323 West Main St., 2nd Fl.	New Britain	CT	06050	HIV Testing, Prevention Information	8773554496	M-F: 10am-5pm
New Canaan							
AMERICAN RED CROSS - NEW CANAAN CHAPTER	51 Main St.	New Canaan	CT	06840	Disease/Disability Information * AIDS/HIV	2039661663	M-F: 9am-4pm; Summer F: close at noon
New Haven							
AIDS INTERFAITH NETWORK	1303 Chapel St.	New Haven	CT	06511	Substance Abuse-outpatient,' General Counseling Services, 'Food bank/meals, Outreach, 'Disease/Disability Information * AIDS/HIV, ' HIV Medical case management, Individual Advocacy, Youth Issues, Mental Health, Housing Services, Outreach, Medical Transportation, General Counseling, In home Assistance, Speakers Bureau, Alcohol/Drug Dependency Support Groups (women), Prevention Counseling, Health screening/diagnosis, Emergency financial assistance	2036244350	M,W,Th, F: 8:30am-4:30pm; T: 8:30am-7:30pm

AIDS PROJECT NEW HAVEN	1302 Chapel St.	New Haven	CT	06511	Outreach Programs * AIDS/HIV, Disease/Disability Information*AIDS/HIV, Individual advocacy, Buddy programs, Food bank/meals, HIV Medical case management, Alternative therapies and medications, Ambulatory/outpatient, Outreach programs, Health related support groups, Speaker's bureau, Alcohol and drug dependency support groups, General HIV Counseling, HIV Prevention Interventions, Mental health, Medical Nutritional Therapy, Psychosocial support, Housing services, Medical transportation, Substance abuse-outpatient, Emergency Financial assistance	2036240947	M-F: 8:30am-5pm; 3rd Sat: 10am-4pm
AMERICAN RED CROSS - SOUTH CENTRAL CONN. CHAPTER	703 Whitney Ave.	New Haven	CT	06511	Disease/Disability Information * AIDS/HIV	2037876721	M-F: 8:30am-4:30pm
CHEMICAL ABUSE SERVICES AGENCY - MULTICULTURAL AMBULATORY ABUSE SERVICES	426 East St.	New Haven	CT	06511	Substance Abuse Counseling * AIDS/HIV	2034957710	M-F: 9am-5pm
CLIFFORD W. BEERS GUIDANCE CLINIC	93 Edwards St.	New Haven	CT	06511	Outreach Programs * AIDS/HIV, Case Management, Mental Health Services for HIV Affected Children, Adolescent/Youth, Counseling, *Families/Friends of people with AIDS/HIV	2037721270	M,W,F: 8am-6:30pm; T,TH: 8am-8pm
FAIR HAVEN COMMUNITY HEALTH CENTER	374 Grand Ave.	New Haven	CT	06513	HIV Counseling and Testing, Ambulatory/Outpatient, Outreach, General Counseling*AIDS/HIV, HIV Medical case management, Emergency Financial Assistance, Outpatient EIS, Specialized Services,	2037777411	M-Th: 8:45am-9pm; F: 1-5pm
FAIR HAVEN COMMUNITY HEALTH CENTER - MEDICAL GROUP AT BELLA VISTA	321 Eastern Ave.	New Haven	CT	06513	Outreach Programs * AIDS/HIV	2034695331	M-F: 9am-4:30pm
FREE FOREVER PRISON MINISTRY	149 Rosette St.	New Haven	CT	06519	Food Pantries * AIDS/HIV	203773-9974	M-F: 9am-5pm
HAVEN FREE CLINIC	374 Grand Ave.	New Haven	CT	06513	HIV Testing	2033149305	Sa: 9am-12noon
HILL HEALTH CENTER - DIXWELL SATELLITE	226 Dixwell Ave.	New Haven	CT	06511	HIV Counseling and Testing, HIV Risk Counseling Services,Drug Treatment Advocacy, ambulatory/outpatient, Oral Health, HIV Medical case management, Emergency Financial assistance, Outpatient Early intervention services, Outreach, Disease/Disability information*AIDS/HIV, Specialized Treatment, Substance Abuse Counseling, Outreach	2035033420	General clinic hours: M:10:30am-6:30pm; T-F: 8:30am-5:30pm Pediatric clinic hours: M: 8:30am-5pm; T,W: 1:30-5pm; Th: 9:30am-6pm Closed daily for lunch 12:30-1:30pm; call Main clinic for help during lunch break

HILL HEALTH CENTER - MAIN HEALTH CLINIC	428 Columbus Ave.	New Haven	CT	06519	HIV Counseling, Testing and Referral, HIV Risk counseling services, Drug Treatment Advocacy, Ambulatory/outpatient, Oral Health, HIV Medical case management, Emergency Financial assistance, Outpatient EIS, Outreach, Disease/Disability information*AIDS/HIV, Specialized Treatment, Substance Abuse Counseling	2035033000	M,W,F: 8:30am-5pm; T,Th: 8:30am-8pm; Sat: 8:30am-12noon; Eye Clinic by appointment, M-Th
HILL HEALTH CENTER - STATE STREET HEALTH SERVICES	911 State St.	New Haven	CT	06511	HIV Counseling, Testing and Referral	2035033530	M-F: 9am-5pm
HISPANOS UNIDOS	116 Sherman Ave., 1st Fl.	New Haven	CT	06511	Disease/Disability Information * AIDS/HIV, Individual Advocacy, General Counseling, Health Related Support Groups, Outreach, HIV Prevention Interventions, Ambulatory/outpatient, Mental Health, HIV Medical case management, Psychosocial support, Emergency Financial assistance, Substance abuse-outpatient,	2037810226	M, Th, F: 8:30am-4:30pm; T, W: 8:30am-7:30pm
HOSPITAL OF SAINT RAPHAEL - HAELEN CENTER FOR INFECTIOUS DISEASES	1450 Chapel St.	New Haven	CT	06511	HIV Testing, Specialized Treatment, Smoking Cessation, Children's Health Initiative (Perinatal)	2037894135	M-F: 8:30am-4:30pm
LIBERTY COMMUNITY SERVICES	254 College St., 2nd Fl.	New Haven	CT	06510	Drug Treatment Advocacy, HIV Medical case management, Mental Health, Housing Services, Emergency Financial Assistance, Supported Services for Adults with Disabilities	2034957600	M-F: 9am-5pm; Staff on call 24 hr/7 days
NEW HAVEN GAY AND LESBIAN COMMUNITY CENTER	50 Fitch St.	New Haven	CT	06515	HIV Information, Special clubs and social events	2033872252	M,W,Th,F: 6-8:30pm; Answering machine after hours; Call for program schedules
NEW HAVEN HOME RECOVERY	153 East St., 3rd Fl.	New Haven	CT	06511	Health Related Support Groups * AIDS/HIV, HIV Medical case management, Substance Abuse-outpatient, Housing, Emergency Financial assistance	2034924866	M-F: 8:30am-4:30pm
NEW HAVEN, CITY OF - HEALTH DEPT. - AIDS COUNSELING/TESTING Svcs/ HEPATITIS C TESTING/EDUCATIONAL PROGRAMS and AIDS DIVISION	54 Meadow St., 1st Fl.	New Haven	CT	06519	HIV Counseling, Testing and Referral, HIV Prevention Interventions, Needle Exchange/Distribution, Disease/Disability Information, Outreach, Planning/Coordinating/Advisory Groups,	2039466453	By appointment
PATIENT CARE	One Church St., 2nd Fl.	New Haven	CT	06510	Medication Adherence Programs * AIDS/HIV	2037878660	M-F: 8am-5:30pm
PLANNED PARENTHOOD OF CONN. - NEW HAVEN - GRISWOLD-BUXTON CENTER	345 Whitney Ave.	New Haven	CT	06511	HIV Testing	2035030450	M, T: 8:30am - 8pm; W: 8:15am-5:30pm; Th:10am-6pm; F: 8am-5pm; Sa: 8:00am-2:00pm By Appointment; Answering service after hours
RYAN WHITE PART A PLANNING COUNCIL - NEW HAVEN AND FAIRFIELD COUNTIES	54 Meadow St., 9th Fl.	New Haven	CT	06519	HIV Care Planning/Coordinating/Advisory Groups	2039467388	M-F: 9am-5pm

YALE CHILD STUDY CENTER	230 South Frontage Rd.	New Haven	CT	06519	HIV Medical case management, Mental Health, Medical Transport, Primary Care	2037856862	M,W,Th,F: 8am-5pm; T: 8am-8pm
YALE UNIVERSITY COMMUNITY HEALTH CARE VAN	135 College St., Suite 323	New Haven	CT	065102483	HIV Counseling & Testing, HIV Prevention Kits, HIV Information, Ambulatory/outpatient	2037374047	Call for daily schedule
YALE-NEW HAVEN HOSPITAL - ADOLESCENT CLINIC	800 Howard Ave.	New Haven	CT	06519	HIV Testing	2036889335	M,T,Th: 1-4pm
YALE-NEW HAVEN HOSPITAL - HIV COUNSELING, TESTING, AND REFERRAL SERVICES	135 College St.	New Haven	CT	06510	HIV Counseling & Testing, Outreach, Disease/disability information	2036883184	M-F: 8:30am-5pm
YALE-NEW HAVEN HOSPITAL - NATHAN SMITH CLINIC	60 Davenport Ave.	New Haven	CT	06510	Specialized Treatment * AIDS/HIV, HIV Medical case management, Medical Nutritional Therapy, Mental Health, Substance Abuse-outpatient, Outreach, Medical Transport, Food bank	2036885303	M-F: 8am-4:30pm

New London							
ALLIANCE FOR LIVING	154 Broad St.	New London	CT	06320	Disease/Disability Information * AIDS/HIV, Ambulatory/Outpatient, Oral Health, Mental Health, Health Insurance assistance, HIV Medical case management, Psychosocial support, Emergency Financial assistance, Food bank/meals, Medical transportation, Housing related services	8604470884	M,T,F: 8:30am-4:30pm; W-Th: 8:30am-7pm
LAWRENCE AND MEMORIAL HOSPITAL	365 Montauk Ave.	New London	CT	06320	HIV Counseling, Testing and Referral, HIV Risk counseling services	8604420711	
NEW LONDON COMMUNITY MEAL CENTER, THE	12 Montauk Ave.	New London	CT	06320	HIV Testing	8604447745	Manager/Cook: M-F: 8am-4pm; Assistant Manager: M-F: 11:30am-1:30pm, 3:30-6:30pm; Sun: 3:30-6:30pm
OPPORTUNITIES INDUSTRIALIZATION CENTER OF NEW LONDON COUNTY	106 Truman St.	New London	CT	06320	Disease/Disability Information * AIDS/HIV	8604471731	M-F: 8:30am-4:30pm
PLANNED PARENTHOOD OF CONN. - NEW LONDON	45 Franklin St.	New London	CT	06320	HIV Testing, HIV Information	8604435820	M: 8:30am-7pm; T: 8:30am-7:30pm;W: 8:30am-4:30pm; Th: 8:30-11:30am, 12:30-7pm; F: 8:30am-4pm; Sa: Call for availability; Answering Service:
Newington							
CONNECTICOSH HEALTH TECHNICAL COMMITTEE, INC	683 North Mountain Rd.	Newington	CT	06111	HIV Counseling, Testing and Referral, HIV Prevention Interventions, HIV Information	8609532674	
Newtown							
NEWTOWN YOUTH AND FAMILY SERVICES	17 Church Hill Rd.	Newtown	CT	06470	Disease/Disability Information * AIDS/HIV	2032704335	M-F: 9am-5pm; Evenings by appointment only
Norwalk							
AMERICAN RED CROSS - MID-FAIRFIELD COUNTY CHAPTER - NORWALK SITE	596 Westport Ave.	Norwalk	CT	06851	Disease/Disability Information * AIDS/HIV	8003199935	M-F: 8:30am-4:30pm
COMMUNITY HEALTH CENTER-NORWALK SMILES	49 Day St.	Norwalk	CT	06854	Oral Health *AIDS/HIV	203854-9292	
CONN. COUNSELING CENTERS - NORWALK SITE	20 North Main St., 3rd Fl	Norwalk	CT	06854	General Counseling Services * AIDS/HIV, Case Management, Substance abuse counseling, Mental Health	2038386508	M-F: 6am-2pm
FAMILY AND CHILDREN'S AGENCY	9 Mott Ave.	Norwalk	CT	06850	General Counseling Services * AIDS/HIV	2038558765	M-Th: 8:30am-9pm; F: 8:30am-4:30pm
MACEDONIA AIDS MINISTRY	70 South Main St.	Norwalk	CT	06856	Health Related Support Groups, Support Groups for Families and Friends*AIDS/HIV, Medical Transportation, Outreach, Psychosocial Support, Housing Related services, Food bank, Emergency Financial assistance, HIV Medical case management	2038537811	Call for hours

MID-FAIRFIELD AIDS PROJECT	16 River St.	Norwalk	CT	06850	HIV HIV HIV Medical case management * AIDS/HIV, Drug Treatment advocacy, Ambulatory/Outpatient, Oral Health, Emergency Financial Assistance, Medical Transportation, Medical Nutritional Therapy, Housing related services, Food Bank, Health related support groups, Substance Education/Prevention, HIV Prevention Education/Counseling	2038559535	M-F: 9am-5pm
NORWALK ECONOMIC OPPORTUNITY NOW	98 South Main St.	Norwalk	CT	06854	Disease/Disability Information * AIDS/HIV, Specialized Information and Referral	2038992483	M-F: 9am-5pm
NORWALK, CITY OF - HEALTH DEPT.	137 East Ave.	Norwalk	CT	06851	HIV Counseling and Testing, Disease/Disability Information, Outreach	2038547979	M,T,Th,F: 8:30am-5pm; W: 8:30am-7pm
PATIENT CARE - NORWALK OFFICE	444 Westport Ave., 1st Fl.	Norwalk	CT	06851	Medication Adherence Programs * AIDS/HIV	2038408312	M-F: 8am-5pm; Answering service after hours
Norwich							
PLANNED PARENTHOOD OF CONN. - NORWICH	12 Case St.	Norwich	CT	06360	HIV Testing	8608895211	M: 8am-8pm; T: 8am-8pm; W: 9:30am- 4:30pm; Th: 8:30am-7:30pm; F: 9am-5pm; Sa: 8am-1pm; Answering service 24 hr/7
UNITED COMMUNITY AND FAMILY SERVICES	47 Town St.	Norwich	CT	06306	Mental Health Services for Affected Children and families	8608927042	
WILLIAM W. BACKUS HOSPITAL . - CLINICS AT 107 LAFAYETTE ST.	107 Lafayette St.	Norwich	CT	06360	HIV Counseling, Testing and Referral, Disease/Disability information*AIDS/HIV, Specialized treatment	8608236343	STD clinic is open M,W: 5:30-7:30pm. No appointment is needed. No new registration accepted after 7pm. HIV Education and Testing Site is open M,W: 5-8pm and T: 9am-
Old Saybrook							
PLANNED PARENTHOOD OF CONN. - OLD SAYBROOK	263 Main St.	Old Saybrook	CT	06475	HIV Testing	8603884459	M: 9am-5pm; T, Th: 12-8pm; F: 10am-5pm; Sa: Call for availability; Closed Wednesday; Answering service after hours
Plainville							
ST. PHILIP HOUSE	80 Broad St.	Plainville	CT	06062	Health Related Support Groups * AIDS/HIV, Supported Living Services for Adults with Disabilities*AIDS/HIV	8607932221	M-F: 8:30am-4:30pm; Answering machine after hours

Redding							
ST. LUKE'S LIFEWORKS - BREAD AND ROSES: GEORGETOWN		Redding	CT	06896	Supported Living Services for Adults with Disabilities * AIDS/HIV	2033880152	24 hr/7 days
Shelton							
PLANNED PARENTHOOD OF CONN. - SHELTON	415 Howe Ave.	Shelton	CT	06484	HIV Testing	2039247756	M: 8am-5:30pm; W: 8:30am-4pm; Th: 9:30am-7:30pm; F: 8:30am-3pm; Sa: 9am-12:30pm; Closed Tuesday;
Stamford							
CHILD GUIDANCE CENTER OF SOUTHERN CONN.	196 Greyrock Place	Stamford	CT	06901	Adolescent/Youth Counseling * Families/Friends of People with AIDS/HIV	2033246127	M: 8:30am-6pm; T-TH: 8:30am-8pm; F: 8:30am-5pm
CTE	34 Woodland Ave.	Stamford	CT	06902	Disease/Disability Information * AIDS/HIV	2033273260	M-F: 9am-5pm
FAMILY CENTERS - STAMFORD SITE	60 Palmer's Hill Rd.	Stamford	CT	06902	General Counseling Services * AIDS/HIV, Health Related Support Groups *AIDS/HIV	2033243167	M,F: 9am-5pm; T,W,Th: 9am-9pm
HEALTH CARE CONNECTIONS	888 Washington St.	Stamford	CT	06901	Ambulatory/outpatient, HIV Prescription expense assistance, Emergency Financial assistance, HIV Medical case management, Food bank, Mental Health, Oral Health, Medical Transportation, Outreach, Housing-related services, HIV Medication Adherence	2039775096	
OPTIMUS HEALTH CARE - STAMFORD COMMUNITY HEALTH CENTER	137 Henry St.	Stamford	CT	06902	HIV Counseling, Testing and Referral, Outpatient EIS, HIV Medical case management, Outreach, Ambulatory/outpatient	2033275111	M,Th,F: 8am-5pm; T,W: 8am-8pm; Sat: 9am-1pm
PLANNED PARENTHOOD OF CONN. - STAMFORD	1039 East Main St.	Stamford	CT	06902	HIV Testing	2033272722	M: 8:30am-7:30pm; T: 10am-5:30pm; W: 7am-2:30pm; Th: 9:30am-4pm; F: 8am-3pm; Sa: Call for availability; Answering
SHELTER FOR THE HOMELESS	PO Box 1252	Stamford	CT	06902	Drug Treatment Advocacy	2033482792	
ST. LUKE'S LIFEWORKS - BREAD AND ROSES	141 Franklin St.	Stamford	CT	06901	Temporary Financial Assistance * AIDS/HIV, Supported Living Services for Adults with Disabilities	2033880189	24 hr/7 days
STAMFORD, CITY OF - HEALTH DEPT.	888 Washington Blvd.	Stamford	CT	06901	HIV Counseling, Testing and Referral, HIV Risk Counseling services, HIV Prevention Interventions and Education, Disease/Disability Information, Needle Exchange Program/Distribution, Case Management, Outreach	2039774399	M-F: 8:30am-4:30pm
STAMFORD HOSPITAL	30 Shelburne Rd.	Stamford	CT	06904	Children's Healthy Initiative (HIV Perinatal), HIV Specialized treatment	2032761000	

Stratford							
OPTIMUS HEALTH CARE - STRATFORD COMMUNITY HEALTH CENTER	727 Honeyspot Rd.	Stratford	CT	06497	HIV Testing, Specialized Treatment,	2033757242	M,T,W,F: 8:30am-5pm; Th: 9am-7pm; Sat: 9am-1pm
REGIONAL NETWORK	2 Research Dr.	Stratford	CT	06615	Inpatient and Outpatient Substance abuse Treatment, Outreach	2039136439	
Torrington							
COMMUNITY HEALTH AND WELLNESS CENTER OF GREATER TORRINGTON	157 Litchfield St.	Torrington	CT	06790	HIV Testing, Case Management, Specialized Treatment, Outreach, ambulatory/outpatient	8604890931	M-F: 8:30am-4:30pm
NEW OPPORTUNITIES - TORRINGTON	232 North Elm St.	Waterbury	CT	06702	HIV Medical case management, Medical Transportation, Emergency Financial assistance	2035754337	TBA
NORTHWESTERN CONN. AIDS PROJECT	100 Migeon Ave.	Torrington	CT	06790	HIV Counseling and Testing, Buddy Programs, Disease/Disability Information, Outreach, Health Related Support Groups	8003812437	M-F: 9am-4pm
PLANNED PARENTHOOD OF CONN. - TORRINGTON	249 Winsted Rd.	Torrington	CT	06790	HIV Testing	8604895500	M: 11am-7pm; T: 9:30am-4pm; Th:11am-7pm; F: 8:30am-4:30pm; Sa: Call for availability; Closed Wednesday; Answering service 24 hr/7 days
VISITING NURSE SERVICES OF CONN. - TORRINGTON OFFICE	62 Commercial Blvd	Torrington	CT	06790	Core Medical, Hospice and Specialty Medical Services	8604826419	M-F: 8am-4:30pm; Services: 24 hr/7 days
WATERBURY HEALTH DEPARTMENT-TORRINGTON	95 Scovill St., Suite 100	Waterbury	CT	06706	HIV Counseling, Testing and Referral, HIV Prevention Interventions, HIV Medical case management, Medical Transportation, HIV Medication Adherence, Emergency Financial assistance	2035736000	
Vernon							
AIDS Project Hartford		Vernon	CT	06066	HIV Medical case management, Oral health, Health insurance assistance, Emergency financial assistance, Ambulatory/outpatient, HIV Medication adherence	8609514883	call for info
HOCKANUM VALLEY COMMUNITY COUNCIL, INC	155 West Main St.	Vernon	CT	06066	HIV Counseling, Testing and Referral, HIV Prevention Intervention, Elder Services, Mental Health, Transportation, Basic Needs, Substance abuse, Clothing, Food, Emergency assistance,	8608729825	M-Th: 9:00 a.m.-8:30 p.m.; F: 9:00 a.m. -1:00 p.m.
ROCKVILLE GENERAL HOSPITAL	31 Union St.	Vernon	CT	06066	Ambulatory/outpatient	8608720501	
VISITING NURSE AND HEALTH SERVICES OF CONN.	8 Keynote Dr.	Vernon	CT	06066	Core Medical, Hospice and Specialty Medical Services, Skilled Nursing	8608729163	Office hours: M-F: 8am-4:30pm; Services: 24 hr/7 days
Wallingford							

AMERICAN RED CROSS - SOUTH CENTRAL CONN. CHAPTER - WALLINGFORD/MERIDEN BRANCH	144 South Main St.	Wallingford	CT	06492	Disease/Disability Information * AIDS/HIV	2032656721	M-F: 8:30am-4:30pm
PARENTS AND KIDS FOUNDATION	101 North Plains Industrial Rd	Wallingford	CT	06492	Health Related Support Groups * Families/Friends of People with AIDS/HIV, Mental Health	2032848299	M-F: 9am-5pm

Waterbury							
CONN. COUNSELING CENTERS - WATERBURY SITE	4 Midland Rd.	Waterbury	CT	06705	Case Management * AIDS/HIV, Substance Abuse Counseling, General Counseling,	2037558874	M-F: 6am-7pm; Sat: 7-11am
NEW OPPORTUNITIES - AIDS/HIV ASSISTANCE PROGRAM	232 North Elm St.	Waterbury	CT	067021594	Individual Advocacy * AIDS/HIV, HIV Medical case management, Medical Transportation, Outreach, Housing, Food bank, Emergency Financial assistance, Support Groups	2035754337	M-F: 9am-5pm
PATIENT CARE - WATERBURY OFFICE	2457 East Main St., Unit 1	Waterbury	CT	06705	Medication Adherence Programs * AIDS/HIV	2035730866	M-F: 8am-5pm; Answering service after hours
PLANNED PARENTHOOD OF CONN. - WATERBURY	969 West Main St.	Waterbury	CT	06708	HIV Testing	2037532119	M: 11am-6:30pm; T: 12pm-6:30pm; W, Th, F: 8:30am-4pm; Sa: Call for availability; Answering service 24 hr/7 days
STAYWELL HEALTH CENTER	80 Phoenix Ave.	Waterbury	CT	06702	Ambulatory/outpatient, Mental Health, Oral Health, Substance Abuse-outpatient, HIV Prescription expense assistance,' General Counseling Services * AIDS/HIV, Specialized Treatment, Dental Care, General Counseling, HIV Testing	2037568021	M-F: 8am-4pm; 2 Saturdays/month: 8am-12noon Healthy Start site hours: M-F: 8am-4:30pm. 2 Saturdays/month and by appointment as needed
STAYWELL HEALTH CENTER - SOUTH	1302 South Main St.	Waterbury	CT	06706	Dental Care * AIDS/HIV, General Counseling, Specialized Treatment, HIV Testing	2035979044	Medical: By appointment, M,T,Th,F: 8am-4pm; W: 11am-7pm; Open one Saturday a month, 8am-12pm Dental: By appointment only, walk-in for emergencies only; Dental office hours: M,T,W,Th: 8am-7pm; F: 8am-4pm Mental health: M-Th: 8am-7pm;
WATERBURY, CITY OF - PUBLIC HEALTH DEPT.	95 Scovill St., Suite 100	Waterbury	CT	06706	HIV Counseling, Testing and Referral , Drug Treatment Advocacy, HIV Prevention Interventions, Treatment Van, HIV Medical case management, Psychosocial support, Emergency Financial Assistance, Housing-related services, Medical Transportation, Outreach and Education, HIV Medication Adherence, Health related support groups, Speakers Bureau, Disease/disability information	2035746780	Sexually Transmitted Disease Clinic is offered T: 8:30am and Th: 12:30pm.
WATERBURY HOSPITAL	64 Robbins St	Waterbury	CT	06708	Ambulatory/outpatient, HIV Medical case management, Mental Health, Substance abuse-outpatient, HIV Prescription expense assistance, Outpatient EIS, Outreach, HIV testing	2035736000	
VISITING NURSE ASSN. OF SOUTHEASTERN CONN.	403 North Frontage Rd.	Waterford	CT	06385	Skilled Nursing	8604441111	M-F: 8am-5pm; Answering service after hours

West Hartford							
PLANNED PARENTHOOD OF CONN. - WEST HARTFORD - HILDA STANDISH CLINIC	1030 New Britain Ave.	West Hartford	CT	06110	HIV Testing	8609536201	M: 8:30am-7pm; T: 8:30am-4:30pm; W: 8:30am-12pm, 1-7pm; Th: 8:30am-7pm F: 8am-4:30pm; Sa: 9am-1pm
West Haven							
HILL HEALTH CENTER - WEST HAVEN HEALTH CENTER	285 Main St.	West Haven	CT	06516	HIV Counseling, Testing and Referral, HIV Risk counseling services, Drug Treatment Advocacy, Ambulatory/outpatient, Oral Health, HIV Medical case management, Emergency Financial assistance, Outpatient EIS, Outreach, Disease/Disability information*AIDS/HIV, Specialized Treatment, Substance Abuse Counseling,	2035033400	M-F: 8:30am-5pm; Closed daily 12:30-1:30pm for lunch
Westport							
WESTPORT WESTON HEALTH DISTRICT	180 Bayberry Ln.	Westport	CT	068802855	HIV Testing	2032279571	M-F: 8:30am-4:30pm; Call for an appointment.
Wethersfield							
PATIENT CARE - WETHERSFIELD OFFICE	1290 Silas Deane Highway	Wethersfield	CT	06109	Medication Adherence Programs	8602571887	M-F: 8am-5pm; Answering service after hours
Willimantic							
GENERATIONS HEALTH CENTER	1315 Main St.	Willimantic	CT	06226	Outpatient EIS, Ambulatory/outpatient, Outreach, Dental, Case Management, Emergency assistance,		
PERCEPTION PROGRAMS - AIDS SERVICES		Willimantic	CT	06226	HIV Counseling, Testing and Referral, Outreach, Disease/Disability Information, HIV Prevention Interventions, Drug Treatment Advocacy, Supported Living services for adults with disabilities, Case management,	8604507248	M-F: 8am-5pm
PLANNED PARENTHOOD OF CONN. - WILLIMANTIC	1548 West Main St.	Willimantic	CT	06226	HIV Testing	8604238426	M: 8:30am-5pm; T: 10:30am-7:30pm; W: 10am-4:30pm; Th: 12:30-7:30pm; F: 8:30am-4:30pm; Sa: Call for availability; Answering service: 24 hr/7 days
WINDHAM REGIONAL COMMUNITY COUNCIL - WINDHAM AIDS PROGRAM	872 Main St.	Willimantic	CT	06226	Disease/Disability Information * AIDS/HIV, Buddy programs, Speakers Bureau, HIV Medication Adherence, Health related support groups, Support for families, Ambulatory/outpatient, Oral health, Mental health, Child care, Emergency financial assistance, Food bank, Housing-related services, Medical transportation, HIV Medical case management	8604234534	M-F: 8:30am-4:30pm

KEY OF TERMS

HIV Medical Case Management: Range of client-centered services linking clients with health care, psychosocial and other supportive services. Coordination and follow-up of medical treatments is a core component of medical case management. This is a clinical oriented form of case management rather than a social service model.

HIV Medication Adherence: Programs provided through an LPN or RN to assist People Living with HIV maintain consistency and regularity with their HIV medication treatments.

HIV Prescription Expense Assistance (RW: AIDS PharmaceuticalAssistance): Provides a temporary assistance with payment for HIV medications until CT AIDS Drug Assistance enrollment is completed (usually funded through RW Parts A and B).
Outpatient/ambulatory: Provision of professional HIV diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist or nurse practitioner in an outpatient setting (e.g. clinics, medical offices and mobile vans) where clients do not stay overnight.. Does not include emergency room services.
HIV Risk Counseling Services CDC: Comprehensive Risk Counseling Services): intensive 1:1 risk counseling and behavior change services for individuals at high risk of HIV infection (HIV-) and high risk HIV+ individuals practicing high risk behaviors.
EIS: Early Intervention Services (EIS) include services designed to move HIV+ individuals into care; includes testing (to confirm status, diagnose extent of immune deficiency, and to provide information on therapeutic measures) counseling with respect to HIV/AIDS referrals, clinical and diagnostic services, periodic medical evaluations and medical care.
Health Insurance Assistance (RW: Health Insurance Premium): Provision of financial assistance for eligible HIV+ individuals to maintain a continuity of health insurance or receive benefits under a health insurance program (includes premium payments, risk pools, co-payments and deductibles)
Medical nutritional therapy: Nutritional counseling provided by a licensed registered dietitian outside of a primary care visit and includes provision of nutritional supplements.
Substance abuse-outpatient: Provision of medical or other treatment and/or counseling to address substance abuse problems (e.g. alcohol and/or legal and illegal drugs) in an outpatient setting, rendered by a physician or under the supervision of a physician or other qualified personnel.
Case management (non-Medical): Non-medical provision of advice and assistance in obtaining medical, social, community, legal, financial and other needed support services. Does not involve coordination and follow-up of client's medical treatments.
Child care: Provision of care for children of clients who are HIV+ while client attends medical or other appointments. Does not include child care while a client is at work.
Emergency financial assistance: Provision of short-term payments to agencies or establishment of voucher programs to assist HIV+ clients with emergency expenses related to essential utilities, housing, food (including groceries, food vouchers and food stamps) and medications when other resources are not available.
Food bank/home-delivered meals: Provision of actual food or meals, but does not include finances to purchase food or meals. Essential household supplies such as hygiene items and household cleaning supplies included. Also includes vouchers to purchase food.
Housing services: Provision of short-term assistance to support emergency, temporary or transitional housing to enable an individual or family to gain or maintain medical care. Housing-related services include assessment, search, placement, advocacy and fees associated with them.
Linguistic services: Includes provision of interpretation and translation services.
Medical transportation: Include conveyance services provided, directly or through voucher, to a client in order that he/she may access health care services.
Outreach: Programs which have as their principal purpose identification of people with unknown HIV disease or those who know their status so that they may become aware of, and be enrolled in care and treatment services.
Psychosocial support: Provision of support and counseling activities, child abuse and neglect counseling, HIV support groups, pastoral care, caregiver support and bereavement counseling. Includes nutrition counseling provided by a non-registered dietitian but excludes provision of nutritional supplements.