Connecticut HIV Planning Consortium

Ending the Syndemic Committee Meeting Summary

February 19, 2025

Date:	Wednesday, February 19, 2025	**Type:**	Virtual
Start Time:	10:20 a.m.	**End Time:**	11:45 a.m.
Leaders	Roberta Stewart (Chair)		
Participants:	17 (see last page for attendance)	**Next Meeting:**	March 19, 2025

WELCOME AND CHPC OVERVIEW

Ending the Syndemic (ETS) Committee support staff reviewed the committee charge, agenda, and suggested guidelines for virtual meeting etiquette. Roberta Stewart (ETS Chair) led a round of self-introductions in which participants shared their names and any organizational or town affiliations.

ADMINISTRATIVE MATTERS

Review of Prior Meeting Notes. The January 2024 draft ETS Committee notes were posted on the CHPC website (www.cthivplanning.org). Participants approved the meeting notes by consensus with no additions or corrections.

Leadership. CHPC Members can apply for open leadership positions for the CHPC Community Co-Chair as well as for leadership positions at the committee level. Applications are available on the CHPC website.

SYNDEMIC PARTNERS UPDATE

Syndemic Partner Group. The group will meet on February 25, 2025. Gina D'Angelo has been holding individual meetings with partners and distributed a syndemic-related resource published by the Centers for Disease Control and Prevention (CDC).

- Natalie DuMont explained how Regional Behavioral Action Organizations may be potential resources for more localized information to support access to substance misuse prevention and treatment services.
- Numerous individuals shared positive feedback with Venesha Heron for the Hepatitis C Elimination Plan presentation at the CHPC main meeting. The group briefly discussed the importance and urgency to increase awareness and knowledge of testing laws as well as the availability of a treatment and cure.

2025 ETS IMPLEMENTATION ACTIVITIES

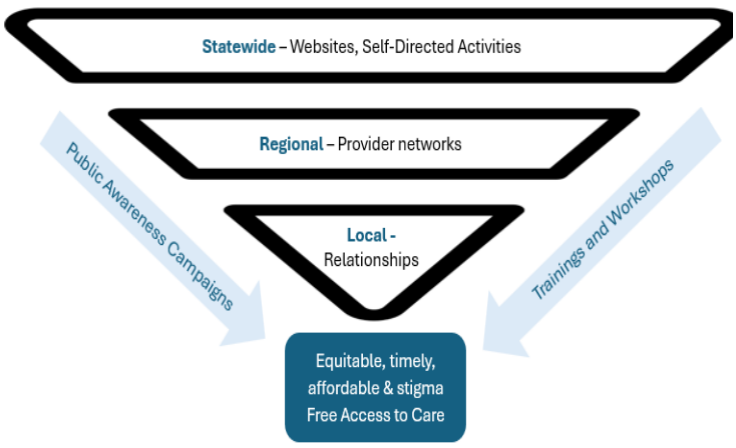
Regional Referral Process and Network. The Statewide Integrated HIV Prevention and Care Plan calls for strategies to improve the referral process to support increased testing (e.g., passage of routine HIV and HCV testing laws), to support a whole-person approach to care (i.e., syndemic areas of focus), and to expedite linkage to care and treatment. The ETS Committee has been working across three levels: statewide, regional, and local.

Statewide Level. At the statewide level, information exists to support *self-directed strategies* by providers and residents/patients. Examples of these resources include:

- www.endthesyndemicct.org
- www.positivepreventionct.org
- https://ryanwhitecarefinder.e2ct.org/
- https://uwc.211ct.org/

Other statewide organizations specific to the syndemic (e.g., Connecticut Harm Reduction Alliance) or to social determinants of health (e.g., Connecticut Coalition to End Homelessness) support websites.

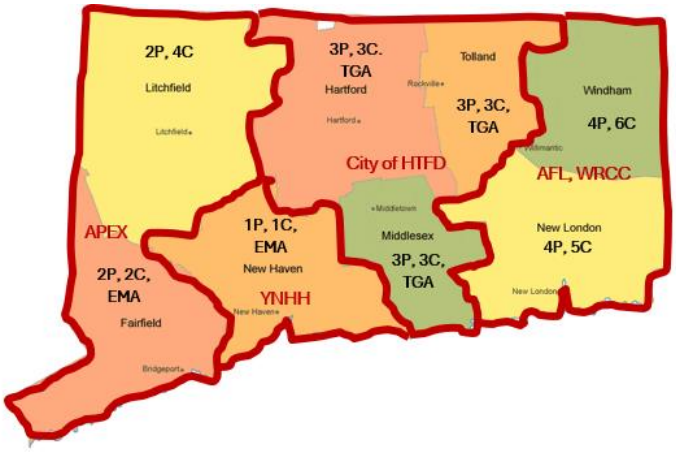
Statewide, Regional, and Local Efforts to Strengthen Access to Syndemic Services



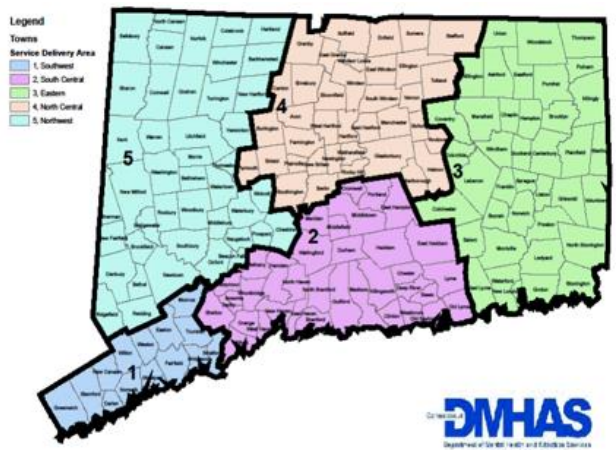
State agencies and their partners have been *supporting multiple public awareness campaigns* (e.g., routine HIV testing, Live Loud, Change the Script) intended to reach the public as well as targeted efforts to reach providers (e.g., CT DPH Commissioner letters to providers about changes in legislation and HIV and STD testing and care resources). Numerous entities *support professional development training initiatives* (e.g., CT DPH, AETC, CT DMHAS, CHCACT) and more regional and local partners support ongoing *professional development for staff and empowerment training for patients/residents*. This training varies appreciably across the state. The interactive poll at the February CHPC main meeting illustrated the impact: 50% of individuals answered correctly a question related to the existence of a cure for HCV. Participants recognized the value and importance of professional development and training workshops for providers and residents/patients on foundational knowledge as well as areas that address stigma reduction.

Regional Level. At the regional level, state agencies including CT DPH and CT DHMAS support integration and coordination of activities among and between their contractors operating within geographic regions. These geographic regions differ by state agency. The maps below show the geographic coverage areas for CT DPH's HIV prevention and treatment services and for CT DMHAS Regional Behavioral Health Action Organizations which facilitate access to behavioral health and substance misuse prevention and treatment services. Ryan White Part A Eligible Metropolitan Area (EMA) in New Haven and Fairfield Counties and the Hartford Transitional Grant Area (TGA) support coordination of services within their respective jurisdictions.

CT DPH HIV Prevention & Care Regions



Regional Behavioral Health Action Organizations



Roberta Stewart explained that the group had been *exploring options to identify and develop regional leads* that could serve as a primary point of contact to assist providers who want to link their patients to syndemic services in the region. Ideally, a single provider within a region could function as the single point of contact and/or facilitator of linkage to care. However, the lead entities within each region (for prevention and care) differ in terms of capacity and must also operate within the requirements of their funding sources. For example, an HIV Medical Case Manager funded solely by HIV Care Funds could not provide support to a patient who is not HIV+ (e.g., a patient interested in PrEP or treatment for SUD, HCV, or STDs). For this reason, and others, the CT DPH determined that it was not feasible to require its regional contract lead entities to serve as a single point of contact in a regional referral network.

Local Level. The ETS Committee spent most of its discussion time exploring options more relevant to interactions at the local level – where most problem solving occurs because (1) resident/patient is actively seeking access to a local service (with or without information from state or regional sources) and/or (2) a front-line worker such as a case manager may be supporting this very same individual or others in accessing local services. The following themes emerged from the discussion:

- *Community engagement and outreach work.*
    - Community health and wellness fairs occur less frequently since the COVID-19 pandemic.

- Several participants shared examples of local health and wellness fairs preceded by door-to-door outreach and filled with incentives such as lottery prizes for persons who visited a minimum number of booths/tables.
- Several participants explained how their organizations offer significant and intensive outreach services (e.g., Connecticut Harm Reduction Alliance, Syringe Services Programs, GBAPP). These programs attempt to maximize linkage to care and to educate the residents/patients about local resources and reinforce messages like "knowing your status is sexy."
- Staff members do form trusting relationships with residents/patients and these relationships prove valuable in encouraging and connecting residents/patients to other needed services.

- Technology may be part of the solution (e.g., access to information). However, *relationships often prove as or more valuable in solving problems at the local level* – especially when a front line worker can prepare and assist a patient in what comes next (e.g., need to show up at location X with documents 1, 2 and 3).
  - The turnover of frontline staff results in less knowledge of local resources within the organization and within the community.
- *Foundational knowledge about the shared risk factors and available treatments remains uneven at best* – including within the CHPC partners.
- *Normalizing testing and linkage to care across settings will help to reduce stigma* because a visit will address all issues such as blood pressure, cholesterol levels, weight, smoking, mental health, HIV, STDs, Hep C, and SUDS.
  - More must be done to educate providers on the syndemic approach and whole-person care as well as facilitating access to PrEP for individuals based on their risk factors and preferences.
  - More must be done to educate and to support consumers in knowing and advocating for their rights – including testing and screening requirements.
- Residents/Patients *need services beyond healthcare to address social determinants of health*.
  - Who better understands this dynamic than persons with lived experience (PWLE) who have been through the process? Yet, PWLE remain underutilized as staff members, peer supports, and as subject matter experts in designing and delivering strategies – including relationships building and training.
  - Historically, HIV case managers often functioned as the "answer grape" or the connection to helping clients solve a wide range of issues and challenges beyond healthcare. This problem solving leveraged relationships (vs. a suggestion to use an app or a website). An important part of the transaction is related to trust and the strength of relationships (i.e., connecting someone who needs help with someone who can help by a person trusted by each party).

The group identified several strategies specific to strengthening local relationships and networks that could be pilot tested with the support of the CHPC and the ETS Committee:

1. Develop a format and program to support local relationship building among front-line staff members and pilot this program once or twice in a geographic area that has a ready, willing, and able champion(s) to help coordinate the event.
   - Include PWLE as key contributors and/or facilitators to maintain the connection to client-centered care and reinforce the importance of understanding what the client needs and hearing how the clients access resources in the local area
   - Consider adding in an educational component (e.g., whole person care, stigma reduction) which allows for a connection to a pharmaceutical company that can pay for food. Mark Nickel offered to pay for food for the first pilot program.

- Focus on inviting front-line staff from multiple organizations within the local area – beyond HIV service providers. Expanding relationships among and between entities that address SDOH as well as healthcare will improve patient solutions and outcomes.

2. Increase intentional efforts for outreach and community engagement by CHPC partners at community and neighborhood health fairs.
    - Promote themed months and testing days and add in "door-to-door" outreach to increase participation.
    - Create plug and play resource kits for groups to attend community events – including incentives and prizes.
    - Identify sponsors willing to support these events or coordinate educational activities with pharmaceutical companies (e.g., hold an educational event + meal nearby a health fair).
3. Expand no- or low-cost access to giveaways (i.e., Distribution Center) that reinforce normalizing testing and promote healthy choices and access to resources and services (e.g., know your status, safe sex, PrEP, access to treatment for HIV, HCV, STDs and SUDs).
4. Collaborate with partners such as AETC and CHCACT to coordinate professional development training, connect providers to any local relationship building efforts, and emphasize and include PWLE in activities.
5. Connect the community outreach and engagement strategy to a broader approach informed by data (e.g., coordinate activities in communities experiencing hot spots or outbreaks).
6. Consider conducting a brief survey of front-line workers to identify services that clients are asking for and front-line workers cannot make the connection (e.g., no provider, no relationship with a provider).

Next Steps. The group decided to use the March meeting to design/develop a prototype local event format to build knowledge and strengthen relationships among local front line workers in a community that will lead to more effective and responsive referrals that connect clients to services they need. The discussion will address:

- Clarify the event purpose and how to measure success
    - Determine session length (anticipated to not exceed four hours including time for a meal)
    - Determine attendance (maximum number, # of partners)
    - Identify key objectives (and how to measure) such as:
        - Knowledge about shared risk factors across syndemic
        - Knowledge about testing laws
        - Knowledge about local resource partners
        - Knowledge of how PWLE accessed (or not) resources in local community
        - Strengthen person networks with front-line staff at other agencies
        - Other to be determined
- Clarify the role of the local partner / champion whose clients will benefit from strengthening the relationships. For example, the host will:
    - Help identify / secure a space (for about 30 people maximum)
    - Help identify and encourage participants (this will be release time / professional development for these workers)
    - Others to be determined
- Clarify the role of the ETS Committee:
    - (e.g., review of syndemic shared risk factors, build relationships between front-line staff in key resource partners)Provide the format, activities, and facilitators for the session

  - Coordinate any educational/professional development segments through partners (e.g., AETC, CHCACT, other subject matter experts)
  - Coordinate any giveaways
  - Coordinate support for CHPC Members who are PWLE and will play an active role in the session
  - Provide a meal for participants
  - Conduct feedback / satisfaction process
  - Develop a follow-up survey (e.g., what changed because of that event)
- Clarify how this strategy can be "scaled" (e.g., "how to" guide and resources)
  - To support replication for no or low costs across multiple communities
  - To enhance or tie into other statewide or regional training and professional development and networking event
- Clarify how this strategy fits into other CHPC committees and relates to other Statewide Integrated HIV Prevention and Care Plan objectives.

OTHER / NEW BUSINESS

Participants did not introduce any new or other business.

MEETING FEEDBACK

The table shows the results from the 13 participants who completed the interactive feedback poll at the end of the meeting.

Summary Table from Interactive Meeting Feedback Poll (n = 13)

Questions	Yes	No	Unsure
1. CHPC Member?	38%	54%	8%
2. I felt comfortable participating in the meeting	92%	8%	*
3. I felt the meeting was well organized and ran smoothly	100%	*	*
4. Liked the best: Interactive discussion, great ideas, a health fair, felt heard, informative, discussion, very informative, development of actionable items, opportunity to voice opinions, we heard from different people, community and relationships, sharing of great ideas, community			
5. Suggestions for improvement: have clear take away message and next steps, more community awareness, more people to participate, let's be slower to say, "why not?" and find solutions, it is well chaired and information sharing is great, more structure or agenda before hand			

ADOURN

Roberta Stewart adjourned the meeting at 11:45 a.m.

ATTENDANCE

The CHPC project support staff maintains attendance records. Participants at the meeting included: Roberta Stewart, Andre McGuire, Ben Grippo, Venesha Heron, Michel Daud, Angel Ruiz, Natalie DuMont, Zaidy, Evette Ellis, Michelle Beharry, Mary Tanner, Mike Judd, Jen Vargas, Vanessa Rosado, Jean Brown, Marianne Buchelli, Mark Nickel