HIV Continuum of Care
Connecticut, 2015

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TB, HIV, STD & Viral Hepatitis Section | Public Health Initiatives
State of Connecticut Department of Public Health
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Based on persons receiving HIV care in 2015 among persons ≥13 years old at diagnosis, resided in Connecticut (based on most recent residence) and diagnosed with HIV infection through 2014 and living with HIV on 12/31/2015. A visit is defined as a CD4, viral load, or genotype test result during the evaluation period. The overall HIV population is overestimated because cases are only followed up for 11 months after 12/31/2015. CDC suggests cases should be followed up at least 18 months to collect death certificate information.

Source: HIV surveillance data through December 2016.

Based on the number of persons ≥13 years old, diagnosed with HIV in 2015, who resided in Connecticut (based on residence of HIV diagnosis) and were linked to care within 1,3,6,12 months after HIV diagnosis.

Source: HIV surveillance data through December 2016.
Based on persons receiving HIV care in 2015 among persons ≥13 years old at diagnosis, resided in Connecticut (based on most recent residence) and diagnosed with HIV infection 2010 - 2014 and living with HIV on 12/31/2015. A visit is defined as a CD4, viral load, or genotype test result during the evaluation period. The overall HIV population is overestimated because cases are only followed up for 5 months after 12/31/2015. CDC suggests cases should be followed up at least 18 months to collect death certificate information. **Source:** preliminary HIV surveillance data through June 2016.
Based on persons receiving HIV care in 2015 among persons ≥13 years old at diagnosis, resided in Connecticut (based on most recent residence) and diagnosed with HIV infection 2010-2014 and living with HIV on 12/31/2015. A visit is defined as a CD4, viral load, or genotype test result during the evaluation period. The overall HIV population is overestimated because cases are only followed up for 5 months after 12/31/2015. CDC suggests cases should be followed up at least 18 months to collect death certificate information. **Source:** preliminary HIV surveillance data through June 2016.
By Selected Cities, 2015

Based on persons receiving HIV care in 2015 among persons ≥13 years old at diagnosis, resided in the designated city (based on most recent residence) and diagnosed with HIV infection through 2014 and living with HIV on 12/31/2015. A visit is defined as a CD4, viral load, or genotype test result during the evaluation period. The overall HIV population is overestimated because cases are only followed up for 11 months after 12/31/2015. CDC suggests cases should be followed up at least 18 months to collect death certificate information. Source: preliminary HIV surveillance data through December 2016.
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<table>
<thead>
<tr>
<th></th>
<th>No.</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chlamydia</td>
<td>13,911</td>
<td>(+5%)</td>
</tr>
<tr>
<td>Gonorrhea</td>
<td>2,723</td>
<td>(+30%)</td>
</tr>
<tr>
<td>P&amp;S Syphilis</td>
<td>110</td>
<td>(-2%)</td>
</tr>
<tr>
<td>EL Syphilis</td>
<td>84</td>
<td>(27%)</td>
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</tbody>
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Getting To Zero Commission

- Representation from the 5 cities with the highest number of cases reported
- Focus on MSM of color, Black females, transgender females
- Local health departments, HIV service organizations, community members
- Also faith based, research, drug user health, DPH, DOC, Planned Parenthood, etc.
CT GtZ Commission

- Commission selected by DPH Commissioner
- Facilitator to work with selected Commission for one year
- Role of the Commission is to develop a G2Z template for CT
- G2Z plan will be provided to the 5 cities to implement
- Local G2Z plans will be shared with other cities for their own development
- Goal is to allow cities to plan their own G2Z initiative to meet local needs
Research

- How can we address stigma in HIV care and prevention?
- How can we engage community partners in the G2Z process?
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