Ryan White Greater Hartford TGA
Early Identification of Individuals with HIV/AIDS/Hepatitis C (EIIHAH)
Plan 2022-2024

POPULATIONS OF FOCUS

I. Black/African American Individuals Who Are Unaware of Their HIV+ Status or Who Are Out of Care

II. Hispanic Individuals Who Are Unaware of Their HIV+ Status or Who Are Out of Care

III. Black/African American Men Who Have Sex with Men Who Are Unaware of Their HIV+ Status or Who Are Out of Care

EIIHAH GOALS

- Increase the percentage of persons with HIV/HCV in the TGA who know their serostatus
- Get persons with HIV/HCV into care in the early stages of infection
- Improve health outcomes of individuals with HIV/HCV and reduce disparities in access to care
- Reduce HIV/HCV incidence, and
- Educate the public about HIV/HCV and HIV/HCV testing

STRATEGIES/ACTIVITIES/OUTCOMES

Population: I. Black/African American Individuals Who Are Unaware of Their HIV+ Status or Who Are Out of Care II. Hispanic Individuals Who Are Unaware of Their HIV+ Status or Who Are Out of Care		
STRATEGIES	ACTIVITIES	OUTCOMES
1. Use alternative ways to deliver information, (such as social networks and on-line resource guides) and develop messaging for specific venues and populations	1. Identify social trends and conduct outreach through social media, such as Facebook, Twitter, and Instagram.	# of Black/African American Individual with HIV identified: # of Hispanic Individual with HIV identified: # of Black/African American individuals re-engage with
	2. Develop and publish messaging appropriate to Dating Apps, such as BeNaughty or BlackPeopleMeet	
	3. Use Texting to contact and maintain relationships with clients	

	4. Create and publish off-beat, eye-catching, compelling TikTok videos aimed at target populations	care # of Hispanic individuals re-engage with care:
	5. Use agency websites to deliver messages such as U=U	
	6. Develop non-judgmental messaging for art and culture settings and events, such as art exhibits, poetry readings, and music performances	
	7. Develop HIV messages and education targeted toward youth	
	8. Develop list of persons with lived experience of HIV who will "tell their story" at community events or other public forums	# of Blacks/African Americans and Hispanic with lived experiences who sign on to participate.
	9. ***Reframe Messaging*** [Note: This has many components, including (a) providing alternatives to sexualized messaging; (b) developing messaging and outreach that down-plays HIV and focuses on wellness (*Luis: If you emphasize HIV, you lose your audience because of the stigma behind it*.); (c) involving community leaders and gatekeepers by letting them decide what to say about HIV and how to say it; (d) developing teachable moments messages; (e) using people deeply embedded in the community to spread information about HIV; and (f) remembering that in some communities women can be effective partners in promulgating information about HIV and HIV resources.]	# of individuals who access HIV testing or PrEP services or who are re-engaged to care as result of new HIV messaging
2. Engage individuals who need services where they are likely to be found	1. Use Zip Codes to map areas with high concentrations of persons diagnosed with HIV and persons with HIV who are out of care	# of individuals who are re-engaged
	2. Track clients through street hangouts, IDU networks, homeless shelters and sex work areas	
	3. Publicize services at locations where potential clients access basic	# of locations

	needs, such as food pantries or soup kitchens	
	4. Provide HIV information, education, and confidential access to HIV and Hepatitis C testing at city parks, especially at events such as the Hartford Jazz Festival and ethnic fairs and other celebrations.	# of individuals screened for HIV and HCV/STIs
	5. Maintain a presence at the West Indian Parade to provide information and education about HIV and access to confidential testing	
	6. Maintain a presence at amateur sporting events such as Double Dutch competitions to provide information and education about HIV and access to confidential testing	
	7. Coordinate minority HIV health events for National Black HIV/AIDS/HCV Awareness Day and National Latino HIV/AIDS Awareness Day; National Hepatics Awareness Month and National HCV Awareness Day	
	8. Provide services at non-traditional hours, including late evenings	
	9. Post messages and information about HIV/HCV testing, available services, the importance of care, and how to contact numbers and email addresses at Mom and Pop shops, Bodegas, Beauty and Nail Salons, Barber Shops, Liquor stores,	
	10. Post messages and stock brochures with information about HIV/HCV testing, HIV/HCV services, and the importance of care with contact numbers and email addresses at locations where condoms are distributed.	
	11. Explore opportunities to raise HIV/HCV awareness on college and university campuses	
	12. Provide in-home services for clients with special needs	

	13. Promote HIV/ HCV education and testing in health and wellness programs in workplaces	
3. Overcome barriers and challenges for reaching target population (Barriers: language Stigma, Fear, Lack of Knowledge, Miss Information, Pride/Arrogance, COVID, Unstable Housing, Violence, Drug Use	1. Conduct an assessment of client characteristics and associated obstacles and barriers to care	
	2. Provide assurances regarding confidentiality	
	3. Develop and maintain long-term relationship built on trust and respect with IDU's and others at high risk for HIV	
	4. Build trust between EIIHA team and client	
	5. Identify or create *safe spaces* to talk to people about HIV/ HCV	
	6. Remain non-judgmental at all times	
	7. Distribute information about HIV/ HCV, including testing options, the importance of care, how to access services, and the connection between care and prevention	# of individuals who receive the distributed information?
4. Partner with Connecticut Department of Public Health (DPH)	1. Make full and relevant use of DPH HIV and HCV test kits, state lab services, Disease Intervention Services (DIS), Syringe Services Program, and the array of Community Health Workers serving the community	Develop a MOU with DPH
	2. Use HIV surveillance data, such as ZIP Codes of persons out of care, to target EIIHA services	# of individuals targeted for services
	3. Work with DPH to implement Data to Care Initiative in order to exchange out-of-care information and to implement local HIV reporting	Develop a consent to share information
	4. When possible participate in Funders Group, CHPC, joint trainings, etc.	# of meetings attended

	5. Work with DPH to develop a PrEp institute for women of color	
	6. Work with DPH PrEP program to ensure campaign messaging are generalized to reach health disparity sub-populations and primary care medical providers	# of TGA participants in campaign development
5. Coordinate EIIHA services with other entities and providers offering services to Populations of Focus	1. Coordinate activities with key points of entry, including public health departments, emergency rooms, substance misuse and mental health treatment programs, detoxification centers, detention facilities, STI clinics, homeless shelters, HIV/AIDS/ HCV counseling and testing sites, health care points of entry specified by the jurisdiction, and federally qualified health centers	# of referrals from points of entry
	2. Develop partnerships with institutions, community organizations and agencies that have connections with and serve the target populations	
	3. Coordinate services with Drug Treatment Advocate program	# of individuals who access long term drug treatment program
	4. Engage potential partners in conversations about how they might help in disseminating information about HIV and support HIV testing and engagement in care	# of information materials and titles of material developed for targeted populations
	5. Enlist help of community leaders to promote HIV/HCV testing	# of community leaders and organizations
	6. Raise HIV awareness by meaningfully engaging faith-based organizations	# of faith-based organizations
6. Ensure that newly diagnosed individuals and person lost to care are linked to care and support services	1. Educate clients about HIV/HCV disease, the importance of medical care, orient and familiarize clients with the system of care and support services, and accompany clients to their first appointments to ensure successfully completed referrals	

	2. Help clients understand their care issues and how to deal with obstacles and barriers to care	
	3. Build trust and maintain engagement with client until client is fully engaged in care and there are indications that the client will not drop out of care	
	5. Discuss the benefits of early medical care for HIV	
	6. Use OraQuick or other rapid test and provide test results on site	# of individual with preliminary positive HIV test results
	7. Schedule HIV positive confirmation test, remain engaged with client until result of confirmation testing is received and client is engaged with care and support services	
	8. Provide practical information about availability and use of treatment options	
	9. Schedule medical care and medical case management appointments for persons testing positive	
	10. Refer clients to appropriate support services, including Peer Support Counseling	
	11. Assist clients to navigate the Ryan White and HOPWA continuum of care	
	12. Ensure clients are followed up and tracked to medical care and medical case management appointments	
	13. Create directory of agencies, medical providers, and other organizations with immediate service openings and same day access to antiretroviral therapy and PrEP	
	14. Add “test and treat” recommendation to Directives	
	15. Discuss and encourage risk reduction behavior	
	16. Link individuals to Partner Services and other prevention programs	

	17. Work with AETC to educate providers	
7. Ensure that services are culturally, linguistically, and interpersonally sensitive	1. Provide annual training regarding cultural and interpersonal sensitivity	Recipient Office only.
	2. Ensure that staff reflects the communities being served	
	3. Employ bi-lingual personnel	
8. Follow a *syndemic* approach (covers HIV, Hepatitis C, and STI's) to provide services	1. Include Hepatitis education in EIIHA services	
	2. Explore possibility of adding STI testing to EIS services	# of STI tests competed
Population III. Black/African American Men Who Have Sex with Men Who Are Unaware of Their HIV+ Status or Who Are Out of Care		
STRATEGIES	ACTIVITIES	OUTCOMES
1. Use alternative ways to deliver information, (such as social networks and on-line resource guides)	***1. All relevant activities from Populations I and II, plus***:	# of Black/African American Men Who Have Sex with Men identified: # of Black/African American Men Who Have Sex with Men re-engaged with care:
	2. Implement Social Network Strategies to have MSM's testing positive help identity others in their social networks	
2. Engage individuals who need services where they are likely to be found	***1. All relevant activities from Populations I and II, plus***:	
	2. Develop and distribute information regarding HIV/HCV testing at gay community events, such as the Gay and Lesbian Film festival and the annual Gay Pride Parade, and in gay bars	
	3. Educate and encourage medical providers to discuss Partner Notification, obtain names of partners, and refer patients to Partner Notification program	
3. Overcome barriers and challenges for reaching target	***1. All relevant activities from Populations I and II, plus***:	

population (Barriers: Stigma, Fear, Lack of Knowledge, Miss Information, Pride/Arrogance, COVID, Unstable Housing, Violence, Drug Use		
	2. Focus more attention on bisexual men or men who identify as straight but also have sex with other men	
	3. Build trust with transgender persons	
4. Partner with Connecticut Department of Public Health and other organization and institutions	***1. All relevant activities from Populations I and II***	
5. Coordinate EIIHA services with other entities and providers offering services to Populations of Focus	***1. All relevant activities from Populations I and II, plus***:	
	2. Partner with agencies and individuals who can effectively engage and communicate with MSM's, bisexuals, and transgendered, such as PFLAG	
6. Ensure that newly diagnosed individuals are to linked to care	***1. All relevant activities from Populations I and II***	
7. Ensure that services are culturally, linguistically, and interpersonally sensitive	***1. All relevant activities from Populations I and II***	
8. Follow *syndemic* approach (covers HIV, Hepatitis C, and STI's	***1. All relevant activities from Populations I and II, plus***	
	2. Encourage all clients to send their partners for HIV/ HCV testing	
	3. For clients testing negative, educate clients about the benefits of PrEP, provide insurance and access information about PrEP, and facilitate immediate access to PrEP	