Greater Hartford Ryan White Part A Planning Council
FY2022 – 23 Directives to the Recipient for Part A & MAI Services

(Specific directions provided to the Recipient's Office for each service category as noted below)

Approved by Planning Council on September 1, 2021

All Service Categories	1. Provide services in a culturally and linguistically competent manner. 2. Address service gaps for all special populations reflected by the current Early Identification of Individuals with HIV/AIDS/Hepatitis (EIIHAH) Plan. 3. Whenever possible, provide services during non-traditional hours, at locations that offer ease of access with COVID-19 safety precautions, and are optimal for client choice. 4. Give preference to sub-recipients who ensure that all program services are sensitive to the needs/issues specific to racial/ethnic, and LGBTQ communities; that are ethnically, culturally sensitive, and linguistically appropriate; and delivered at a literacy level suitable for the targeted population(s) being served. 5. The ability to successfully integrate People Living With HIV/AIDS and those Persons Co-infected with Hepatitis (PLWHA&H) within their program models as staff and in consideration for all positions (i.e., Medical Case Manager, Nurse… PLWHA&H Peer to Peer staff), reflective of the demographics of the population served and culturally competent. Diverse staff with diverse leadership should offer education and training. Communication should be effective in languages easily understood – written, spoken, signs, etc. Systems that use strategic planning, epidemiological profiles and needs assessment data, as well as community and consumer involvement will be given preference. 6. Points on the Request for Proposal shall be added to bidders who show successful PLWHA&H Peer-to- Peer staff and are reflective of the demographics of the population served.

All Service Categories continued	7. To address unmet needs and fill service gaps of those in care, agencies must demonstrate the ability to collaborate with both Ryan White and non-Ryan White funded sub-recipients in their proposed service plans and through the provision of current Memoranda of Understanding or Agreement. 8. Select sub-recipients and provide services in such manner as to foster and sustain the Transitional Grant Area's (TGA) HIV Wellness Centers to promote anti stigma language, PrEP (Pre-Exposure Prophylaxis), U=U, & HCV informed, and LGBTQ friendly. 9. Ensure services are proportionately available to rural areas to the extent possible. 10. Require sub-recipients to conduct annual client satisfaction surveys, that evaluates HIV services. 11. Mandate contracted sub-recipients to designate a staff member to join the Planning Council and to secure membership applications from their consumers to join the Planning Council as Members and to participate in committee meetings. 12. Require contract sub-recipients to address the Connecticut Integrated HIV Prevention and Care Plan 2017 – 2021 (2022-2026 when it becomes available) as it is related to care and prevention services as needed. Continue to collaborate with Housing Opportunities for Persons with AIDS (HOPWA)sub-recipients where possible 13. All sub-recipients must have an emergency plan in place to address natural disasters, to ensure that service delivery continues. 14. CORE sub-recipients should deploy a status neutral approach to its service delivery model. **15.** Provide centralized and/or decentralized support/core services optimizing client preference in medical and/or community-based settings. Funded entities must make their application process clear and accessible to the public

	so that all eligible PLWHAH in the TGA can equally access the funds.
Emergency Financial Assistance (EFA)	1. One-time emergency rental assistance [back rent, 1st month rent, emergency (hotels)] 2. Essential utilities 3. Short term medication coverage 4. Provide reasonable flexibility to the Recipient to adjust existing caps to meet clients' needs. 5. Provide decentralized access to EFA funds to deliver quick and seamless accessibility to services and to ensure equal access to all clients. Funded sub-recipients to ensure equal access to all clients in the Care Continuum.
Housing	1. Funded sub-recipients must demonstrate cost effectiveness of programs and ability to leverage other funding sources. 2. Provide, if funds are available: • Short-term rental assistance [$150 month], • Supportive housing [scatter site with case management], • Step-down housing [preference given to clients with a history of reunification with their families] with a case management component, and • Housing related referral services, with an emphasis on persons with HIV who are homeless. **3.** Work collaboratively with the HIV/AIDS Housing community to bridge gaps between Ryan White and Housing Continuums of Care
Medical Case Management (incl Treatment Adherence)	1. Provide centralized and/or decentralized medical case management services that increase the number of case managers in medical settings and, where appropriate, the number of case managers employed directly by medical sites, while recognizing the continued need under appropriate circumstances for community-based case management services. In either model (centralized or decentralized) whether such as the availability of office space for confidential meetings, inclusion of the medical case manager in client

Medical Case Management (incl Treatment Adherence) continued	case conferences, or other methods to ensure that the medical case managers can work to help keep clients in care) of the incorporation of the medical case manager into the clinical care team. 2. Develop and expand the triage model within the Transitional Grant Area wherein individuals can receive assistance in obtaining medical, dental, social, community, legal, financial, and other needed services as needed. 3. Provide centralized and/or decentralized training, supervision, and education to all on site case managers (medical site and community based). 4. Provide treatment adherence support. To ensure services are proportionately available to rural areas to the extent possible. Ensure services are available to reduce disparities and health inequities in Black/African American Individulas; Hispnaic Individuals; Black/African American Men Who Have Sex with Men who are unaware of their HIV+ Status or who are Out of Care. 5. All Ryan White-funded Case Managers are required to attend at least one joint monthly frontline Provider Care Coordination meeting. 6. The Federal poverty level increased to 400% for those who do not have access to Medical Case Management Services. Medical Case Management should give preference to those who are out of care, to those who are not virally suppressed, and for individuals who have a history of Mental Health concerns and Substance Misuse Disorders.

Outpatient/ Ambulatory Medical Care Outpatient/ Ambulatory Medical Care continued	1. Ensure medical care is available to disproportionately infected minority populations including adolescent/ youth. 2. Encourage test and treat, same day ART initiation services, and seamless linkages to appropriate core and support services. 3. Provide women's and men's health services that is specific to the population seeking health services, to the extent possible. 4. Fund mid-level medical personnel (APRN, NP, PA, with HIV specialty) to make available more HIV care and to free up Infectious Disease physicians' time to work on more complex cases. Provide RN/LPN support as needed. 5. Ensure services are proportionately available to rural areas to the extent possible. 6. Ensure that a referral process is in place to link individuals in homeless shelter to clinic and support services. 7. Where possible develop quality improvement initiatives for individualized special projects to address detectable viral load in all sub populations. 8. Sub-recipients are required to participate in statewide initiatives. 9. Provide treatment to individuals who are coinfected with Hepatitis C and reflex testing. 10. Provide PrEP/PEP Education, Resources and Referral services. Encourage sub-recipients to initiate rapid initiation treatment model for PrEP/PEP.
Mental Health	1. Provide co-location of mental health services in clinics and community settings. 2. Provide fee for service for Mental Health services. 3. Providers should implement a trauma-informed care approach, where both staff and clients work together in a framework of wellness that produces improved outcomes for PLWHA.

Early Intervention Services (EIS) Early Intervention Services (EIS) continued	1. Provide services that act as a bridge between targeted testing and care by steering individuals from testing and linking them to primary medical care and medical case management, mental health and substance abuse treatment and support services. EIS services should be designed to work closely with key points of entry (i.e. Urgent Care Centers) thus facilitating easy access to the HIV/HCV care system once an individual learns of their status. Key points of entry are places where HIV/HCV testing occurs. For the Hartford TGA these include but are not limited to public health departments, private sub-recipients, HIV counseling and testing sites, emergency rooms, substance abuse and mental health treatment programs, detoxifications centers, detention facilities, STD clinics, and homeless shelters. EIS sub-recipients must have referral/linkage agreements with key points of entry that should be monitored by the Recipient to ensure effective linkage mechanisms are in place and active. 2. Provide services to targeted populations in line with current demographics of PLWHA&H in the TGA. 3. EIS services must serve to identify persons with HIV who are unaware of their status; make them aware of their HIV infection; educate them about HIV, the importance of care and the Ryan White system; and link them to primary medical care and case management. 4. EIS should document concerted attempts at face-to-face contact with client within 7-10 days from receiving Referral. Provide intensive support over a course of several months (3-6months) to build trust, orient clients to the system of HIV care, increase their knowledge about living with HIV, educate them regarding the importance of routine medical care, increase their health literacy and begin the process of developing the foundation for disease self-management. 5. Provide co-location of services, where possible at Outpatient Ambulatory sites that reengage individuals with HIV who have fallen out of care, are erratically

Early Intervention Services (EIS) continued	engaged in care, or are at risk of falling out of the HIV care system. 6. Provide PrEP/PEP Education, Resources and Referral services. PrEP/PEP referral priority should be given to those health organizations with emergency same day PrEP/PEP initiation. 7. Particular efforts must be made to provide targeted HIV testing in areas and populations as identified by the Early Identification of Individuals with HIV/AIDS/HEP-C Plan. 8. Work with Department of Public Health surveillance unit to gain access to individuals within the Transitional Grant Area who are out of care to link them back to care. The EIS teams must work with the Continuum of Care, Positive Empowerment Committee, and community members with lived experience to review the zip code of Out of Care and Non virally suppressed data. Refer to the EIIHAH Plan for priority populations. 9. Provide services during nontraditional hours and at locations that offer ease of access. These hours should include weekends and nights. 10. Ensure EIS services are linked to HIV Partner Services and aligned with the TGA's Early Identification of Individuals with HIV/AIDS and Persons Coinfected with Hepatitis (EIIHAH) model. 11. Where there is co-location of EIS with other HIV testing services, EIS should become a referral-based linkage program without creating a barrier to services. 12. Where possible use PLWHA and those Persons Co-infected with Hepatitis Peer-to- Peer model to deliver services. 13. Identify and collaborate with other prevention sub-recipients and participate in community wide events. 14. EIS should support psychosocial services to link clients who are out of care and/or lost to care. 15. Collaborate and coordinate in a meaningful way with Faith base churches to provide HIV testing, Re-engagement and targeted educational outreach events.

	16. EIS Services to include assessment, screening, and linkage for STIs and/or other health concerns.
Substance Use Disorder- Outpatient	1. Provide co-location of substance abuse services in clinic and community settings. 2. Sub-recipients should implement a trauma-informed care approach, where both staff and clients work together in a framework of wellness that produces improved outcomes for PLWHA.
Medical Transportation Services	1. Special consideration should be given to individuals in the rural area based on cost. 2. Special consideration should be given to nontraditional hours to offer ease of access to care during these hours. 3. Special consideration for use of alternative and cost-effective forms of transportation.
Psychosocial Support Services	1. The PLWHA&H Peer is to provide a bridge between sub-recipients and clients that facilitates the medical and psychosocial care of clients. 2. The PLWHA&H Peer is to be an integral part of the treatment adherence program as he/she provides specialized services in a professional environment according to the agency. 3. The PLWHA&H Peer works to encourage engagement into care and support adherence to HIV treatment by providing client centered individual and group level skill building sessions to achieve client goals. 4. The Peer Provider works in a team setting as one component of the clients coordinated care. The Peer Provider is an advocate for the client who maintains a relationship with the client that fosters trust and understanding. The Peer Provider must use a client centered approach. This advocacy may be in opposition to the direction of the agency. 5. The PLWHA&H Peer is expected to serve as a model who provides reliable information, assist in the coordination of appropriate referrals with the client care team, and emotional support to clients who are infected with HIV or AIDS and Hepatitis.

Psychosocial Support Services continued	6. Peer Navigators also help clients access services (medical, dental, emotional, economic, and legal) and when possible, accompany clients to appointments or arrange for transportation as needed. 7. Peer Provider must receive guided support that can include psychosocial support from other Peer sub-recipients that strengthens their commitment to serve and enhance their skill set to provide services that produce effective outcomes. 8. Programs must have a framework to describe how peers are integrated into their program models to address how peers will be recruited, trained, supervised, retained and reimbursed. Peer staff will be connected with established Peer Navigator to meet monthly to develop, educate and standardize peer service delivery including group facilitation across all psychosocial sub-recipients. 9. Peers should when possible, document concerted attempts at face-to-face contact with client within 7-10 days from receiving Referral. Provide intensive support over a course of several months (3-6months) to build trust, orient clients to the system of HIV care, increase their knowledge about living with HIV and HCV, educate them regarding the importance of routine medical care, increase their health literacy and begin the process of developing the foundation for disease self-management.
Food Bank/Home Delivered Meals	1. Provide meals/foods at wellness centers for PLWHA&H 2. Recipient to determine caps based on funding availability. 3. Sub-recipient agencies providing food vouchers for urgent nutritional/hygienic needs will work with the Recipient's Office to design a process that ensures clients are able to access assistance expeditiously while adhering to HRSA standards for this service category..
Oral Health	1. For those who are 300 – 400% of poverty level and have no access to Case Management, funded sites should establish eligibility and provide services accordingly. 2. Provide oral health fee for services where possibe.