Hartford Transitional Grant Areas 2025- 2027 EIIHAH Plan

POPULATIONS OF FOCUS

Individuals Aged 55 and older
Black Males (note: this does not include Hispanic males that identify as Black)
White Males (note: this does not include Hispanic males that identify as White)

EIIHAH supporting the National HIV AIDS Strategies

Reducing the number of people who become infected with HIV
Increasing access to care and optimizing health outcomes for people living with HIV
Reducing HIV-related health disparities

EIIHA Objectives
To increase the number of individuals who are aware of their HIV status
To increase the number of HIV and positive into care

Activities	**Outcomes**	**Partners**
Strategy One: Use alternative ways to deliver information (such as social networks and online resource guides) and develop messaging for specific venues and populations. **Required HRSA EIIHA Component i, iii, iv.**		
1. Identify social trends and conduct outreach through social media, such as Facebook, X, and Instagram.	# of social media events that reach individual 55+ # of Black Males (note: this does not include Hispanic males that identify as Black) identified # of White Males (note: this does not include Hispanic males that identify as White) identified # Individuals Aged 55 and older individuals re-engage with care	EIS, Health Collective (HC), Planning Council (PC)
2. Develop and publish messaging appropriate to Dating Apps, such as BeNaughty or BlackPeopleMeet		Positive Empowerment Committee, (PEC) & Continuum of Care Committee, CCC)
3. Use texting/SMS to contact and maintain relationships with clients		Providers
4. Create and publish off-beat, eye-catching, compelling TikTok videos aimed at target populations		PEC, CDPH and CCC
5. Use agency websites to deliver messages such as U=U		Providers and PC
6. Develop HIV messages and education targeted toward youth	# of youth in all sub-populations identified and re-engaged with care	Connecticut Children's Specialty Group (CCSG) & PEC
7. Develop a list of persons with lived experience of HIV who are willing to share their story at community events or other public forums	# of all sub-populations with lived experiences who sign on to participate	All Providers & PC

8. Reframe messaging, including: (a) providing alternatives to sexualized messaging; (b) developing messaging and outreach that focuses on wellness rather than disease; (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) leveraging women to promulgate 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	Key stakeholders, Providers, PEC, PC & CDPH
Strategy Two: Engage individuals who need services where they are likely to be found. **Required HRSA EIIHA Component i, ii, iii, iv.**		
1. Use zip codes to map areas with high concentrations of diagnosed PWH and out of care PWLH	# of individuals who are re-engaged	DPH & PNA
2. Track clients through street hangouts, IDU networks, homeless shelters, and sex work areas		EIS
3. Publicize services at locations where potential clients access basic needs, such as food pantries or soup kitchens	# of locations	MCMs & EIS
4. Provide HIV information, education, and confidential access to HIV and HCV testing at city parks, such as the Hartford Jazz Festival ethnic fairs, and other celebrations	# of individuals screened for HIV and HCV/STIs	EIS
5. Maintain a presence at the West Indian Parade to provide information and education about HIV and access to confidential testing	# of Outreach and # of individuals served	PEC & EIS
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	# of Outreach and # of individuals served	PEC & EIS
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	# of coordinated events	COH, DPH, PEC & CCC
8. Provide services at non-traditional hours, including late evenings	# of agencies with non-traditional hours	Providers
9. Post messages and information about HIV/HCV testing, available services, the importance of care, and contact numbers/email addresses at local shops, bodegas, beauty/nail salons, barber shops, liquor stores, etc.	# of businesses participated in posting HCV/HIV information	PEC, COH & EIS

10. Post messages and stock brochures with information about HIV/HCV testing, services, and the importance of care with contact information at locations where condoms are distributed	# of participating locations	PC, Providers & EIS
11. Explore opportunities to raise HIV/HCV awareness on college and university campuses	# of college/university engaged over the fiscal year	EIS
12. Provide in-home services for clients with special needs	# of "At Home" HIV/HCV tests conducted	EIS & DPH
13. Promote HIV/ HCV education and testing in health and wellness programs	# of HIV/HCV educational events conducted	EIS & Psychological Support Services, PN
Strategy Three: Overcome barriers and challenges for reaching the target population (Barriers: Language Stigma, Fear, Lack of Knowledge, Misinformation, Pride/Arrogance, COVID, Unstable Housing, Violence, Drug Use **Required HRSA EIIHA Component i, iii, iv.**		
1. Address barriers/obstacles hindering access to the focus populations (including language stigma, fear, misinformation, pride/arrogance, unstable housing, violence, and drug use)	# of events to address stigma, fear, misinformation, etc.	PC & Providers
2. Conduct an assessment to understand client characteristics and the hurdles they face in accessing care	# of individuals who participate in survey/focus group	PC, Connecticut HIV Planning Consortium & CDPH
3. Cultivate enduring relationships based on trust and respect with PWID and others at high risk for HIV	# PWH co-occurring with Substance Use Disorder fully engaged in care	Providers, City of Hartford (COH)
4. Foster trust between the EIS/DIS team and clients	# of clients that return to care as a result of DIS/EIS	EIS & DIS
5. Disseminate information about HIV/HCV, encompassing testing options, the significance of care, accessing services, and the link between care and prevention	# of individuals who receive the distributed information	EIS
Strategy Four: Partner with the Connecticut Department of Public Health (DPH). **Required HRSA EIIHA Component i, ii, iii.**		
1. Collaborate with CDPH to maximize the utilization of their HIV and HCV test kits, state lab services, DIS, Syringe Services Program, and the network of Community Health Workers catering to the community	Develop and sign MOU	CDPH
2. Utilize HIV surveillance data, including the zip codes of individuals not engaged in care, to strategically target EIIHAH services	# of individuals targeted for services	DPH, PC & EIS
3. Engage with DPH to implement the Data to Care Initiative, facilitating the exchange of information on individuals not engaged in care and enabling the implementation of localized HIV reporting	Develop consent mechanism to share information	COH & DPH

4. Actively participate in relevant gatherings such as the Funders Group, Community Health Planning Council (CHPC), and joint training sessions whenever feasible	# of meetings attended	Providers & COH
5. Collaborate with CDPH to establish a PrEP institute specifically tailored for women of color	# of women of color who access PrEP	Community Renewal Team (CRT), CCSG, Community Health Services (CHS), CDPH, VIIV & Gilead
6. Partner with the CDPH PrEP program to ensure that campaign messages are effectively reaching health disparity sub-populations and primary care medical providers	# of TGA participants in campaign development	CDPH, CHPC &PC
Strategy Five: Coordinate EIIHA services with other entities and providers offering services to Populations of Focus. **Required HRSA EIIHA Component iii, iv.**		
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 FQHCs	# of referrals from points of entry	Providers, COH & PC
2. Develop partnerships with institutions, community organizations, and agencies that have connections with and serve the target populations	# of partnerships developed	EIS, PEC & PNA
3. Coordinate services with the Drug Treatment Advocate program	# of individuals who access long-term drug treatment program	Providers, Reg. 3 Prevention & Evaluation Subcommittee
4. Engage potential partners in conversations about how they might help in disseminating information about HIV, support HIV testing and engagement in care	# of information materials and titles of material developed for targeted populations	Key stack holders & EIS
5. Enlist the help of community leaders to promote HIV/HCV testing	# of community leaders and organizations	Key stack holders & EIS
6. Raise HIV awareness by meaningfully engaging faith-based organizations	# of faith-based organizations	PEC, PNA & EIS
Strategy Six: Ensure that newly diagnosed individuals and persons lost to care are linked to care and support services **Required EIIHA Component ii, iii, iv.**		
1. Educate clients about HIV/HCV disease, and the importance of medical care, orient and familiarize clients with the system of care and support services, and accompany clients to	# of individuals participating in education and accessing care	EIS, COH & PEC

their first appointments to ensure completed referrals		
2. Help clients understand their care issues and how to deal with obstacles and barriers to care	# of clients trained	Medical Providers, MSMs & Peer Navigators
3. Build trust and maintain engagement with the client until the client is fully engaged in care and there are indications that the client will not drop out of care	# of clients engaged in care	EIS & MCMs
4. Discuss the benefits of early medical care for HIV	# of clients accessing care as a result of this education	Medical Providers
5. Use OraQuick or other rapid test and provide test results on-site	# of individuals with preliminary positive HIV test results	EIS & Medical Providers
6. Schedule HIV-positive confirmation test, and remain engaged with the client until the result of confirmation testing is received and the client is engaged with care and support services	# of clients with a confirmatory test	EIS & DIS
7. Provide practical information about the availability and use of treatment options	# of individuals who receive information on treatment options	MCMs
8. Schedule medical care and medical case management appointments for persons testing positive	# of medical and medical case management appointments scheduled for newly diagnosed clients	EIS and Peer Navigators
9. Refer clients to appropriate support services, including Peer Support Counseling	# of referred support services and name of service	MCMs, MH & SUD providers
10. Assist clients to navigate the Ryan White and HOPWA continuum of care	# of clients served within each sub-population	MCMs and HSS
11. Ensure clients are followed up and tracked to medical care and medical case management appointments	# of clients engaged in care	MCM, Peer Nav.
12. Create a directory of agencies, medical providers, and other organizations with immediate service openings and same-day access to antiretroviral therapy and PrEP	# of providers who offer same-day HAART and PrEP	PNA & DPH
13. Discuss and encourage risk reduction behavior	# educated on risk reduction	Providers
14. Link individuals to partner services and other prevention programs	# referred	EIS, MCMs & Medical Providers
15. Work with AETC to educate providers	# of trainings accessed.	All funded providers, AETC & COH
Strategy Seven: Ensure that services are culturally, linguistically, and interpersonally sensitive. **Required HRSA EIIHA Component iii, iv.**		
1. Provide annual training regarding cultural and interpersonal sensitivity	# of individuals who attended training	COH & PC

2. Ensure that staff reflects the communities being served	A comparison of Planning Council reflectiveness chart and agency EEO schedules	All funded providers & PC
3. Employ bilingual personnel	# of bilingual personnel working on RWHAP	All funded providers & COH
Strategy Eight: Follow a syndemic approach (covers HIV, Hepatitis C, and STIs) to provide services. **Required HRSA EIIHA Component iii, iv.**		
1. Include Hepatitis education in EIIHAH services	# hepatitis education sessions held by EIS workers	EIS & Evaluation Subcommittee
2. Explore the possibility of adding STI testing to EIS services	# of STI tests competed	PNA, EIS and STI providers