# Greater Hartford Ryan White Part A Planning Council
# FY2021 – 22 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 2, 2020

| All Service Categories | 1. Provide services in a culturally and linguistically competent manner.<br>2. Address service gaps for all special populations reflected by the current Early Identification of Individuals with HIV/AIDS/HEPATITIS (EIIHAH) Plan.<br>3. Whenever possible, provide services during nontraditional hours, at locations that offer ease of access with COVID-19 safety precautions, and are optimal for client choice.<br>4. Give preference to providers who ensure that all program services are sensitive to the needs/issues specific to racial/ethnic, and LGBTQ communities; that are ethnically, culturally and linguistically appropriate; and delivered at a literacy level suitable for the targeted population(s) being served.<br>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.<br>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.<br>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. |
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| 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 providers in their proposed service plans and through the provision of current Memoranda of Understanding or Agreement.<br>8. Select providers 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, be PrEP (Pre-Exposure Prophylaxis), U=U, & HCV informed, and LGBTQ friendly.<br>9. Ensure services are proportionately available to rural areas to the extent possible.<br>10. Require service providers to conduct annual client satisfaction surveys, that evaluates HIV services.<br>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.<br>12. Require contracted providers to address the Connecticut Integrated HIV Prevention and Care Plan 2017 – 2021 as it is related to care and prevention services as needed.<br>Continue to collaborate with Housing Opportunities for Persons With AIDS (HOPWA) Providers where possible |
| Emergency Financial Assistance (EFA) | 1. One-time emergency rental assistance [back rent, 1st month rent, emergency (hotels)]<br>2. Essential utilities<br>3. Short term medication coverage<br>4. Provide reasonable flexibility to the Recipient to adjust existing caps to meet clients' needs.<br>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. |

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| Housing | 1. Give preference to providers able to provide a multiplicity of housing services in the most cost-effective manner.<br>2. Provide, if funds are available:<br>• Short-term rental assistance [$150 month],<br>• Supportive housing [scatter site with case management],<br>• Step-down housing [preference given to clients with a history of reunification with their families] with a case management component, and<br>• Housing related referral services, with an emphasis on persons with HIV who are homeless. |
| 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.<br>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 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.<br>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.<br>3. Give preference to providers, when available, who offer a co-location model of core clinical services such as mental health, substance abuse treatment and medical case management and support services designed to contribute to increased health outcomes for those in care.<br>4. Provide centralized and/or decentralized training, supervision, and education to all on site case managers |

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| Medical Case Management (incl Treatment Adherence) continued | (medical site and community based).<br>5. Provide treatment adherence support.<br>To ensure services are proportionately available to rural areas to the extent possible. Ensure services are available to reduce disparities and health inequities in Gay, Bisexual, men who have sex with men, Transgender individuals; Individuals Over 50 Years of Age; Black and Hispanic Heterosexual Individuals and individuals co infected Hepatitis. The Continuum of Care Committee also identified Caucasians as a Trending Population in response to the ongoing Opioid Epidemic.<br>6. All Ryan White-funded Case Managers are required to attend at least one joint monthly frontline Provider Care Coordination meeting.<br>7. 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 Use Disorders. |
| Outpatient/ Ambulatory Medical Care | 1. Ensure medical care is available to disproportionately infected minority populations including adolescent/ youth.<br>2. Provide women's and men's health services that is specific to the population seeking health services, to the extent possible.<br>3. Provide mid-level providers (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 and provide RN/LPN support as needed.<br>4. Ensure services are proportionately available to rural areas to the extent possible.<br>5. Ensure that a referral process is in place to link individuals in homeless shelter to clinic and support services. |

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| Outpatient/ Ambulatory Medical Care continued | 6. Give preference to providers, when available, who offer a co-location of core clinical services such as mental health, substance abuse treatment and medical case management and support services designed to contribute to increased health outcomes for those in care.<br>7. Where possible develop individualized special projects for viral load suppression in sub populations.<br>8. Providers are required to participate in statewide initiatives.<br>9. Provide treatment to individuals who are coinfected with Hepatitis C and reflex testing.<br>10. Provide PrEP Education, Resources and Referral services.<br>11. Develop quality improvement initiatives for individuals who are not virally suppressed. |
| Mental Health | 1. Provide co-location of mental health services in clinics and community settings.<br>2. Provide fee for service for Mental Health services.<br>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) | 1. Provide services that act as a bridge between 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.<br><br>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 providers, HIV counseling and testing sites, emergency rooms, substance abuse and mental health treatment programs, detoxifications centers, detention facilities, STD clinics, |

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| Early Intervention Services (EIS) continued | and homeless shelters. EIS providers 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.<br><br>2. Provide services to targeted populations in line with current demographics of PLWHA&H in the TGA.<br>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.<br>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.<br>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 engaged in care, or are at risk of falling out of the HIV care system.<br>6. EIS services to target those populations in neighborhoods throughout the TGA (Hartford, Middlesex & Tolland Counties) which are disproportionately affected with HIV/AIDS and STDs based on most recent epidemiological data to target late testers, individuals lost to care and those not virally suppressed.<br>7. Provide services during nontraditional hours and at locations that offer ease of access. These hours should include weekends and nights.<br>8. Ensure EIS services are linked to partner notification and aligned with the TGA's Early Identification of Individuals with HIV/AIDS and Persons Coinfected |

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| Early Intervention Services (EIS) continued | with Hepatitis (EIIHAH) model.<br>9. 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.<br>10. Where possible use PLWHA and those Persons Co-infected with Hepatitis Peer-to- Peer model to deliver services.<br>11. Identify and collaborate with other prevention providers and participate in community wide events.<br>12. EIS should support psychosocial services to link clients who are out of care and/or lost to care. |
| Substance Use Disorder- Outpatient | 1. Provide co-location of substance abuse services in clinic and community settings.<br>2. 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. |
| Medical Transportation Services | 1. Special consideration should be given to individuals in the rural area based on cost.<br>2. Special consideration should be given to nontraditional hours to offer ease of access to care during these hours.<br>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 providers and clients that facilitates the medical and psychosocial care of clients.<br>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.<br>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.<br>4. The PLWHA&H Peer works in a team setting as one component of the clients coordinated care. However, the |

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| Psychosocial Support Services continued | PLWHA&H Peer is an advocate for the client and maintains a culturally humility relationship with the client that fosters trust and understanding distinct from the provider role.<br>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.<br>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.<br>7. Peer workers must receive clinical support that includes psychosocial support from other peer workers that strengthens their resolve, honing their skill set to provide services in a healthy way.<br>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 service providers.<br>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. |

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| Food Bank/Home Delivered Meals | 1. Provide meals/foods at wellness centers for PLWHA&H<br>2. Recipient to determine caps based on funding availability.<br>3. Planning Council to fund food voucher/documentation process for ease of access.<br>4. Need language regarding funding food vouchers and the documentation process for ease of access.<br>Planning Council requested for Evaluation committee to address. |
| Oral Health | 1. For those who are 300 – 400% of poverty line and have no access to Case Management, funded sites should establish eligibility and provide services accordingly to include oral health Emergency Financial Assistance. |