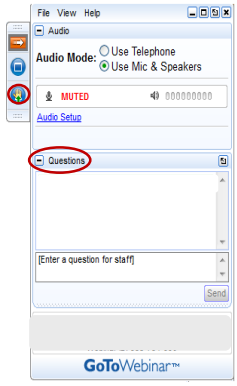
Good afternoon, thank you for joining we will begin the webinar shortly.

Thank you for joining the HRSA HAB Building Futures: Supporting Youth living with HIV webinar series. This series focuses on Improving Services to Youth Living with HIV and is a four part webinar series designed to share findings from the Building Futures: Supporting Youth Living with HIV Project a project funded by the Health Resources & Services Administration, HIV/AIDS Bureau (HRSA HAB).

The webinar will include an overview of the technical assistance toolkit developed at the culmination of this project. Each of the webinars will cover one of the 4 major themes of the toolkit and will include presentation from the project team and providers who have tested some aspects of the toolkit and who will share real world application and implementation strategies to help improve services for youth living with HIV.

Housekeeping

- This webinar is being recorded
- Methods for asking questions
  - Submit a question through the Chat feature
  - Raise your virtual hand to ask your question verbally
    - Input your audio pin, so we can unmute your line



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During this webinar we will have a Q and A section at the end please use the raise hand function found on the webinar control panel screen or you can type in your question using the chat function also found on your webinar control panel.

If you are asking a question verbally please enter your audio pin and we will un mute your line so that you can ask your question.

Logistics

- Please answer the evaluation questions at the end of the webinar!
- Certificates of completion will be sent via email to attendees
- The webinar recording and slides will be posted on the TARGET Center after the webinar
- The Toolkit is under final review: look out for an email announcing its release
- https://targethiv.org/news/building-futures

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At the conclusion of this webinar there will also be a survey, please take the time to complete this brief survey

You will receive a certificate of completion for this webinar. This certificate will be sent to the e-mail provided during registration.

The toolkit that we will be discussing throughout this webinar is under final review. Please look out for an e-mail announcement regarding it's release. When it is release it will be posted on the Target center website located at the URL on your screen. This will also be the same web-address that will host the webinars once they have been archived.

Objectives

At the end of this webinar, participants will be able to:

» Discuss the HRSA HAB Building Futures: Supporting Youth Living with HIV project's background and goal

» Describe the strategies and resources associated with the technical assistance toolkit

» Explain the lessons learned and implementation strategies from the youth-serving providers utilizing the toolkit

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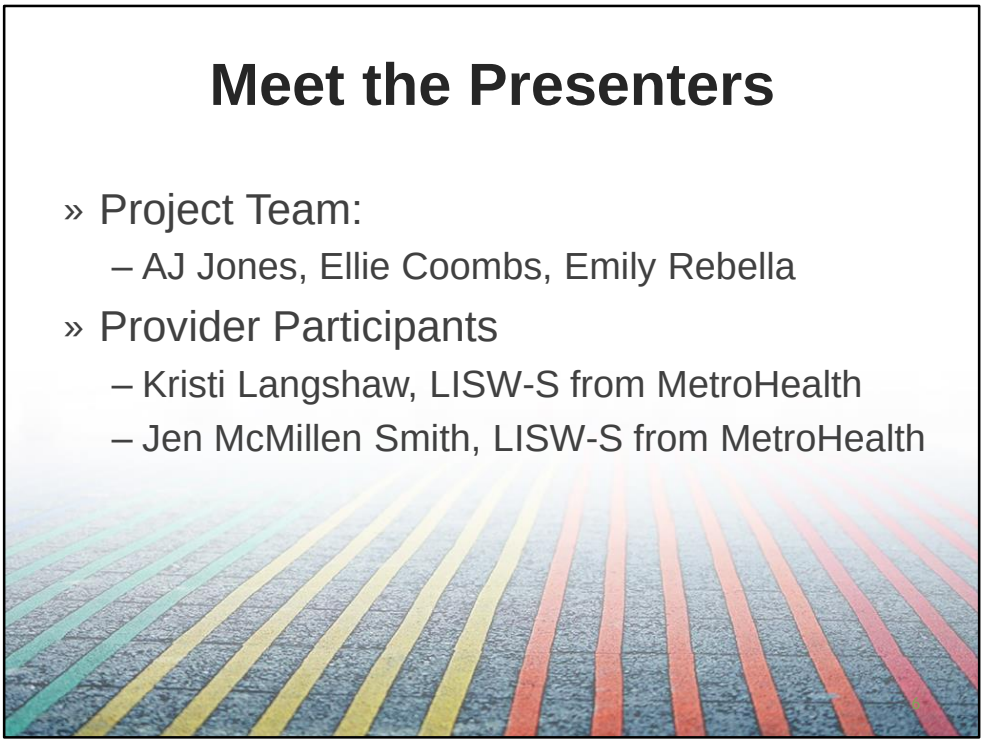
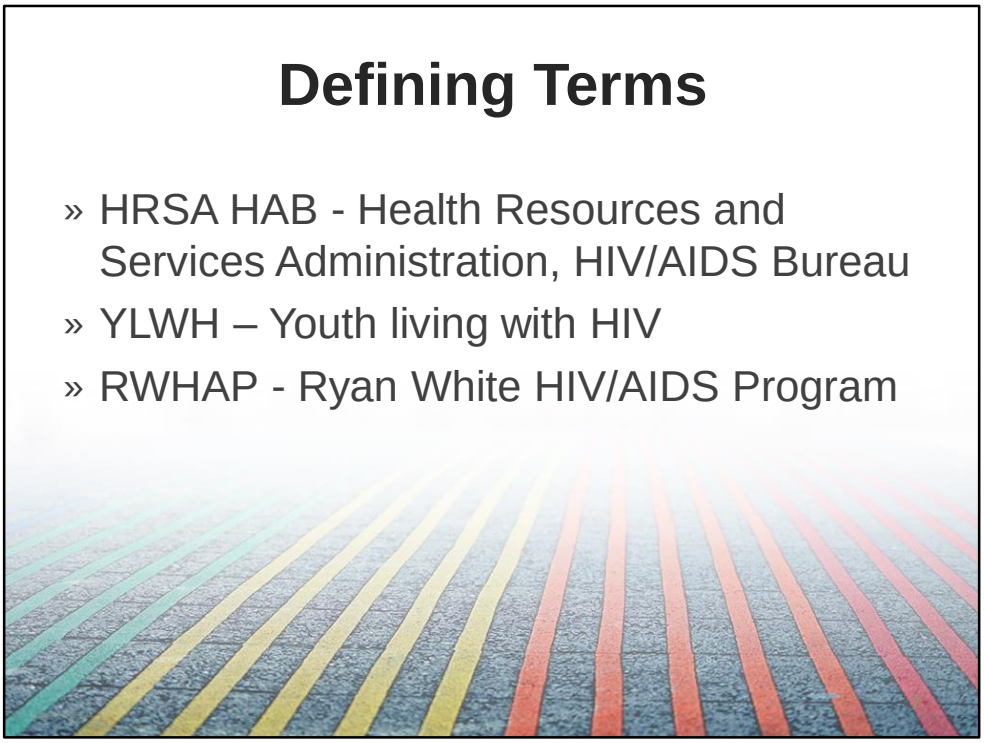


Today's webinar will include presentations from the Project team including youth consultant AJ Jones, Ellie Coombs and Emily Rebella. As well as representatives from MetroHeath in Cleveland, OH. Team members, provider participants will all be available to answer your questions at the end of the webinar.



To get started we would like to first define terms we will be using through out the webinar:
HRSA HAB - Health Resources and Services Administration, HIV/AIDS Bureau
YLWH – Youth living with HIV
RWHAP - Ryan White HIV/AIDS Program

We want to provide you some project background so that you are able to understand how the toolkit was developed and the source of the recommendations we will be sharing.

Project Team

- **Project Team**:
  - DSFederal, Inc., Mission Analytics, CAI, Positive Outcomes, Inc., and Debbie Isenberg
- **HRSA HAB**:
  - Antigone Dempsey, CAPT Tracy Matthews, CDR Holly Berilla, R. Chris Redwood, Jhetari Carney
- **Subject Matter Experts**:
  - Jeffrey Birnbaum and Adam Thompson
- **Youth Consultants**:
  - D. D'Ontace Keyes, Jontraye Davis, Kahlib Barton, DaShawn Usher, Antoine Crosby, AJ Jones

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The team included staff from DSFederal, Inc., Mission Analytics, CAI, Positive Outcomes, Inc., and consultant Debbie Isenberg

Staff from HRSA HAB:

Antigone Dempsey, Tracy Matthews, Holly Berilla, Chris Redwood, JT Carney

Subject Matter Experts:

Jeffrey Birnbaum and Adam Thompson

And ,Youth Consultants:

D'Ontace Keyes, Jontraye Davis, Kahlib Barton, DaShawn Usher, Antoine Crosby, AJ jones

We would like extend a special thanks to all the staff and consultants to contributed tot his project

Understanding the Need

» 551,567 clients received services from RWHAP-funded providers in 2016
  – 23,144 RWHAP clients living with HIV were youth aged 13-24
  – Retention in care (76.6%) was lower than the national RWHAP average (81.7%)
  – Viral suppression (71.1%) was much lower than the average (84.9%)

Source: Health Resources and Services Administration. Ryan White HIV/AIDS Program Annual Client-Level Data Report 2016. http://hab.hrsa.gov/data/data-reports. Published November 2017.

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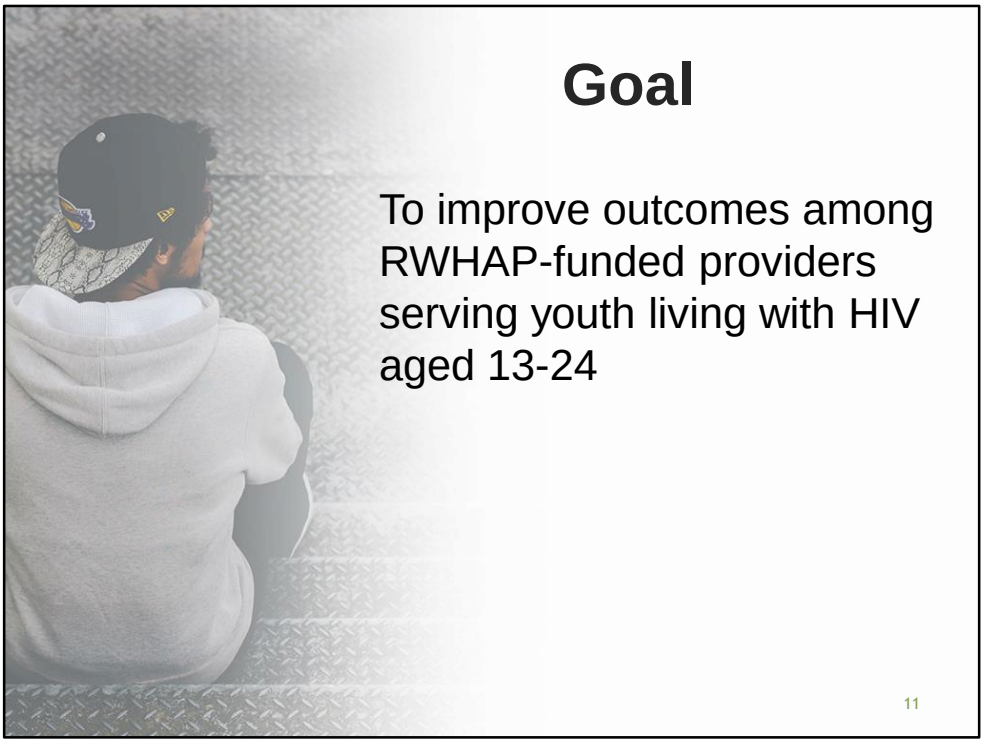
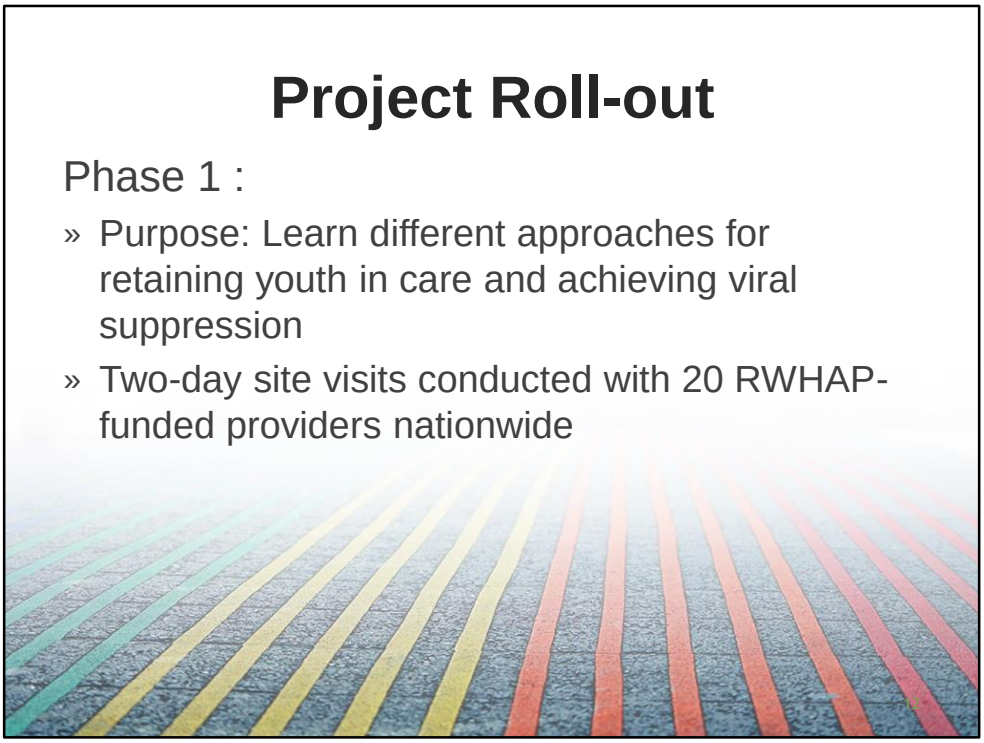
There are 23,144 Youth living with HIV aged 13-24 in the Ryan White HIV/AIDS Program. While improvements in both retention and viral load suppression have been made, disparities still exist:

- Retention in care for these youth is about 76.6% which was lower than the national Ryan white program average of 81.7% and
- Viral suppression for this population is at 71.1% which was was much lower than the national average of 84.9%.



So the Building Futures: Supporting Youth Living with HIV project was working to improve outcomes among Ryan White Program funded providers with the goal of improve outcomes along the HIV care continuum in both retention and viral load suppression. The project was divided into two phases. Phase 1 was the collecting of information and phase two was the translating those findings into an actionable toolkit. The resulting Technical Assistance Toolkit presents many experiences and lessons from Ryan white providers like you to help improve outcomes with youth clients

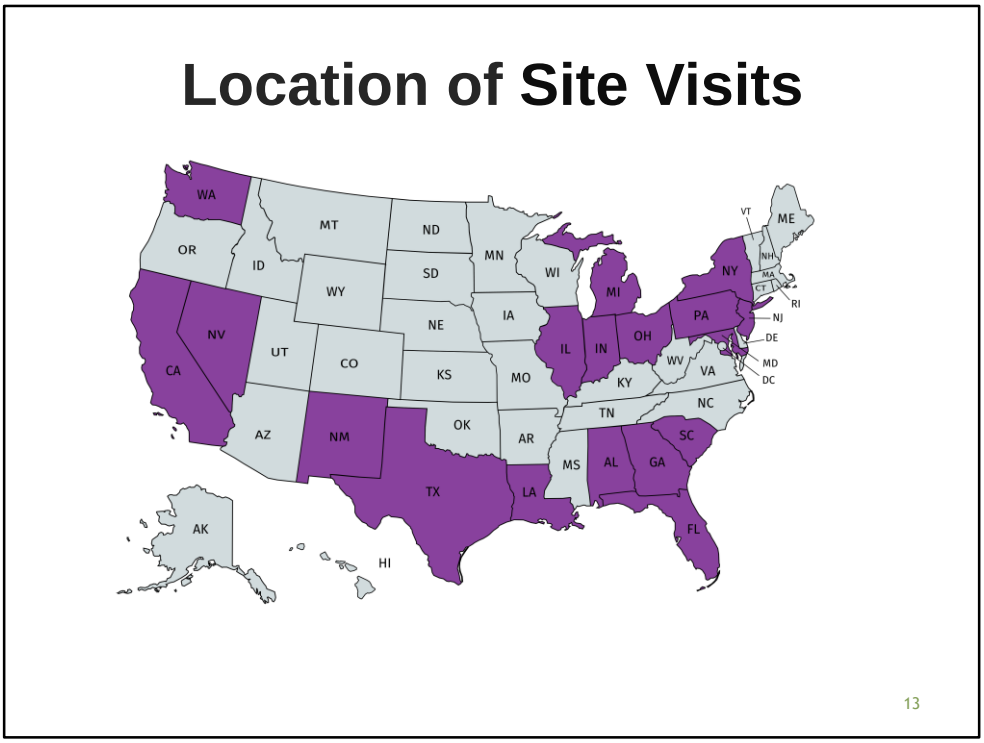


The purpose of phase 1 of the project was to learn different approaches for retaining youth in care and achieving viral suppression

The project team wanted to understand what challenges and successes agencies face when working with youth clients. In order to do this the project team conducted 2-day site visits. During those site visits the project team heard what works with youth and what does not work so well. We will present many of these findings during this webinar series and they can be found in the technical assistance toolkit.

The site visit included interview with staff and youth clients as well as walk throughs of the clinic and pre-site visit survey.

Each site visit was conducted by a three-person team that included a project team lead, a clinical expert, and a youth consultant.



Using 2014 and 2015 RSR data, a sample of providers was selected from Ryan white funded programs. A number of criteria were used when selecting the sites including the number of youth served client population demographics, geographic location, and provider type.

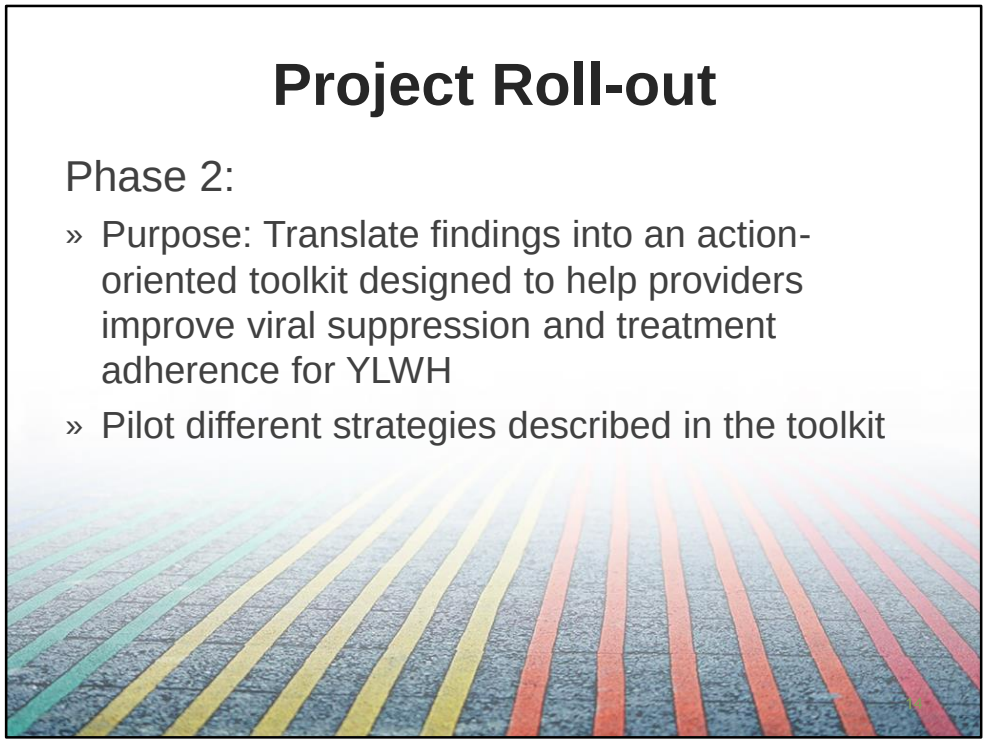
Provider type included:

- Health department
- Hospital/university based clinics
- Community health centers and community-based service organizations

This variety was very important to the project because it allowed the project team to consider applicability in different contexts for example e.g. engagement strategies in rural vs. urban context, or among different client populations

Participation in this project was voluntary.

The map shows the location of the providers by state.



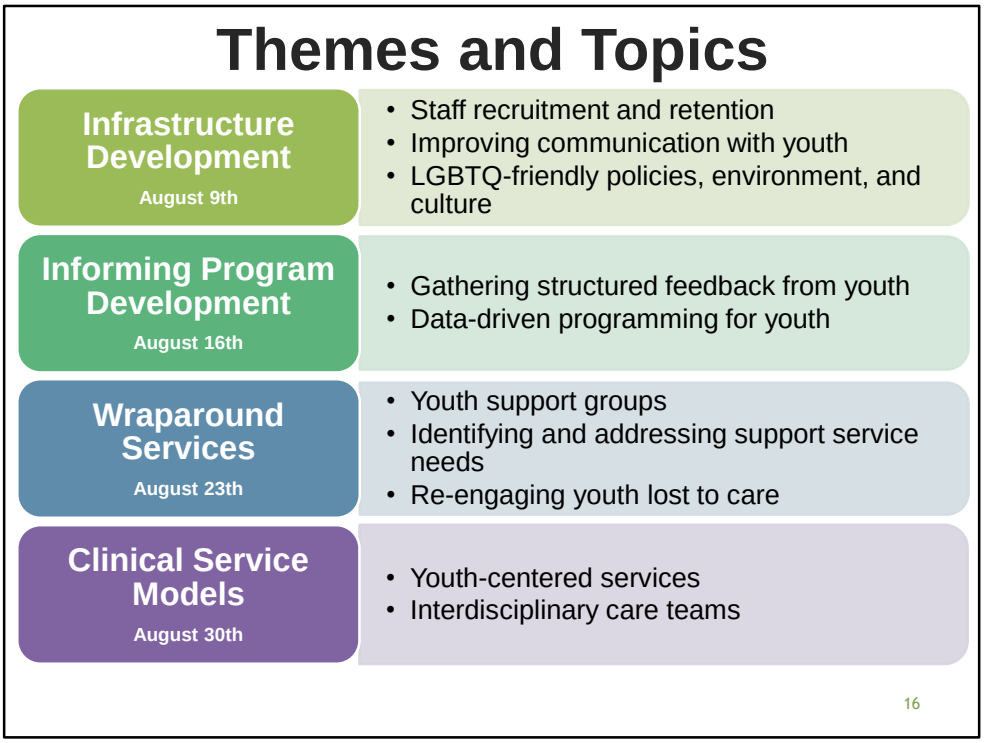
The result of phase one activities was the development of the technical assistance toolkit which integrates the feedback and lessons learned from the 20 sites that were visited. The toolkit focuses on best practices for improving outcomes for youth living with HIV.

After the development of the toolkit each of the original 20 agencies were contacted and asked if they would like to pilot some aspect of the toolkit that might be useful for their clinic. The agencies who piloted elements of the toolkit participated in 4 check-in webinars and 1 –in-person site visit. Their feedback was incorporated into the tool kit.

These providers are also participating in this webinar series so you will be able to hear what they found during this process and some of the strategies they implemented.

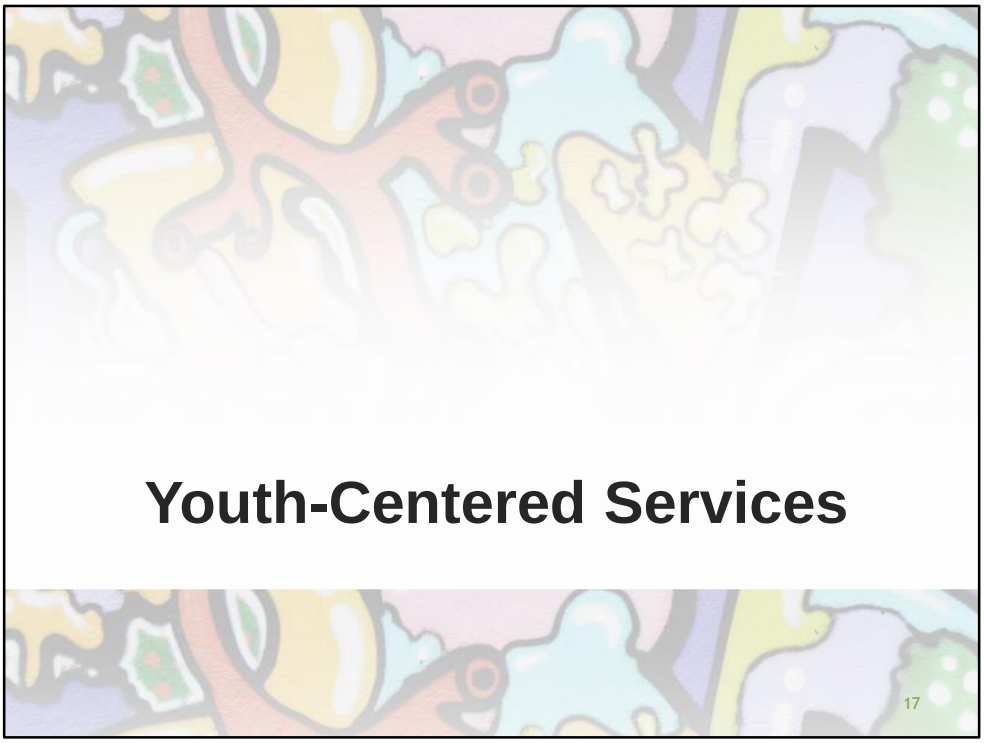
This Toolkit is a unique resource as it captures the lessons and experiences of providers working with youth clients. The resource is designed as an actionable tool and has been tested in field.

This toolkit contains 10 topic areas divided into 4 themes. Each of the 10 topics includes strategies to address the specific topic, with resources provided to support the implementation. Providers can use some or all information in the toolkit to enhance their programs to better meet the needs of YLWH.



The 10 topics within each theme are hyperlinked, so users can move easily from one topic area to the next. While topic areas predominantly summarize information gathered through the Building Futures project, they also contain links to other relevant resources on the TARGET Center site

You can see a list of topics found under each theme.



The first topic will be Youth-Centered Services.

Let's start by talking about strategies for making your clinic and clinical services more youth focused.

Background

- Providers have developed services specifically targeted at YLWH
- Approaches vary based on size of the youth population and operational context/need
- Three strategies are highlighted in the toolkit

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Providers are using various strategies based on their resource level and number of YLWH. We highlight three main strategies in the Toolkit.

Youth-Centered Services

Strategy	Relevance for…
» Youth clinic	Providers with large youth populations and resources to expand programming
» Youth-focused hours, staff, and physical space	Providers with smaller youth populations and varying availability of resources to expand programming
» Referrals to more youth-focused providers	Providers with small youth populations and no resources to expand programming

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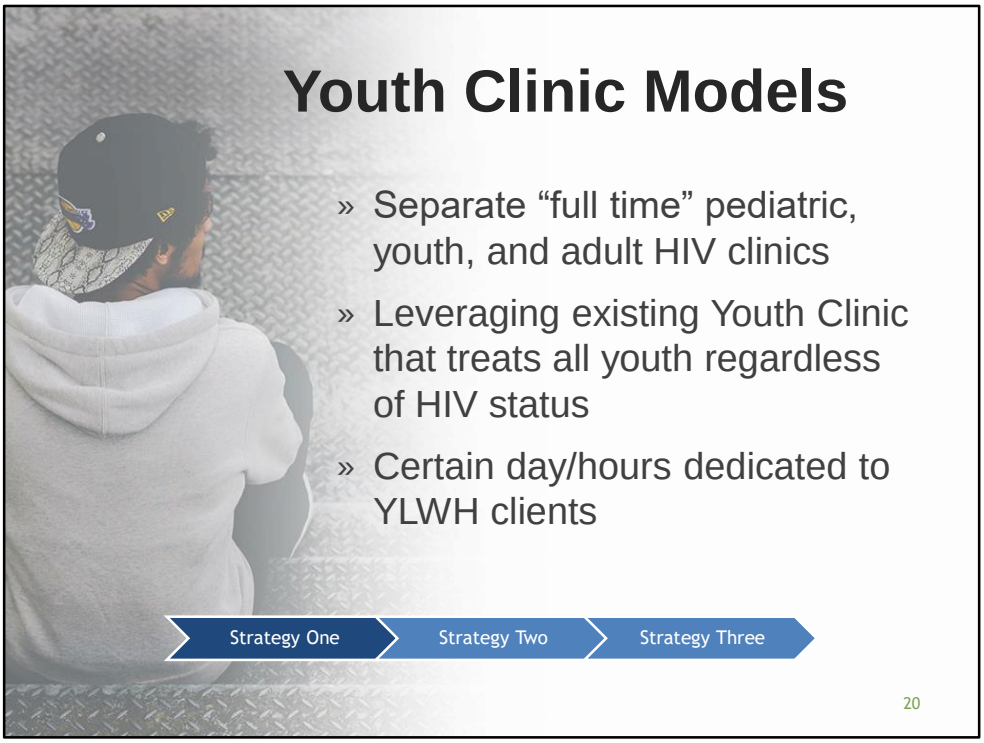
The first and most resource-intensive strategy is to establish a separate Youth Clinic. This option really only makes sense for those providers with a pretty substantial share or absolute number of youth clients.

The second and less intensive strategy is to modify your hours and physical space to make them more youth-focused, and hire or train specific staff, so they can better target and serve youth clients.

And, the final strategy is for those providers that have a small number of youth that feel they don't really have the capacity to expand or modify services, so they are more youth focused. These providers would instead refer youth clients to another provider with that capacity.

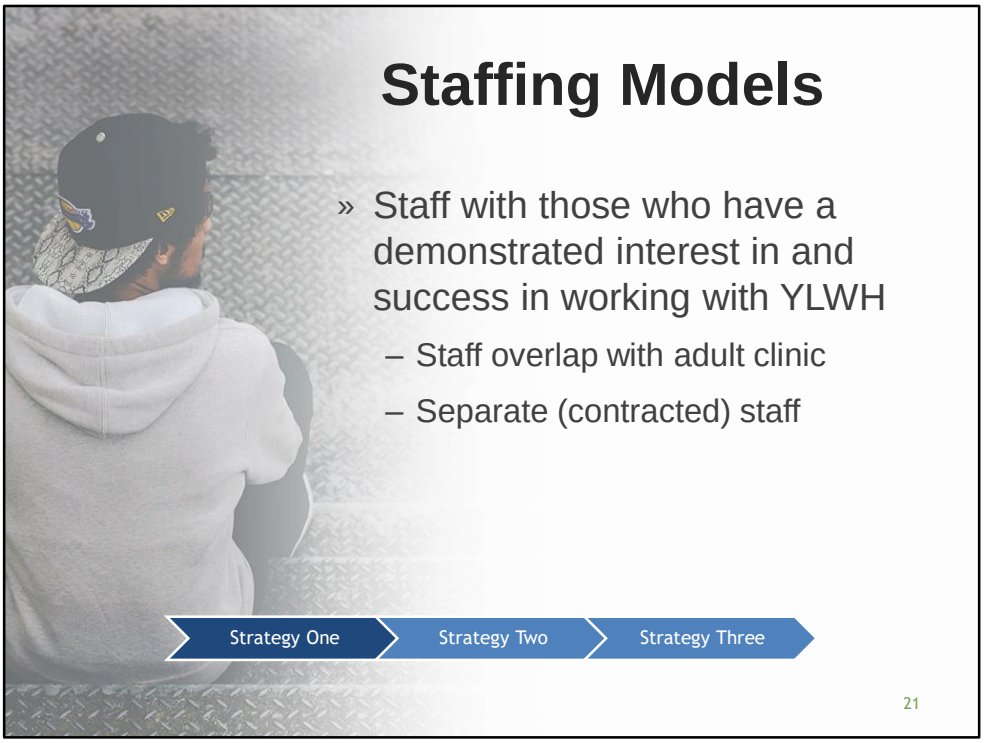
Let's talk about each of these strategies in more detail.



Several of the sites that we spoke with have separate Youth Clinics, with slightly different models. One large university-based healthcare system has a pediatric clinic, youth clinic and an adult clinic, each with their own clinic space and staff – although there is some staff overlap and the clinics coordinate pretty intensely as clients transition from one to another.

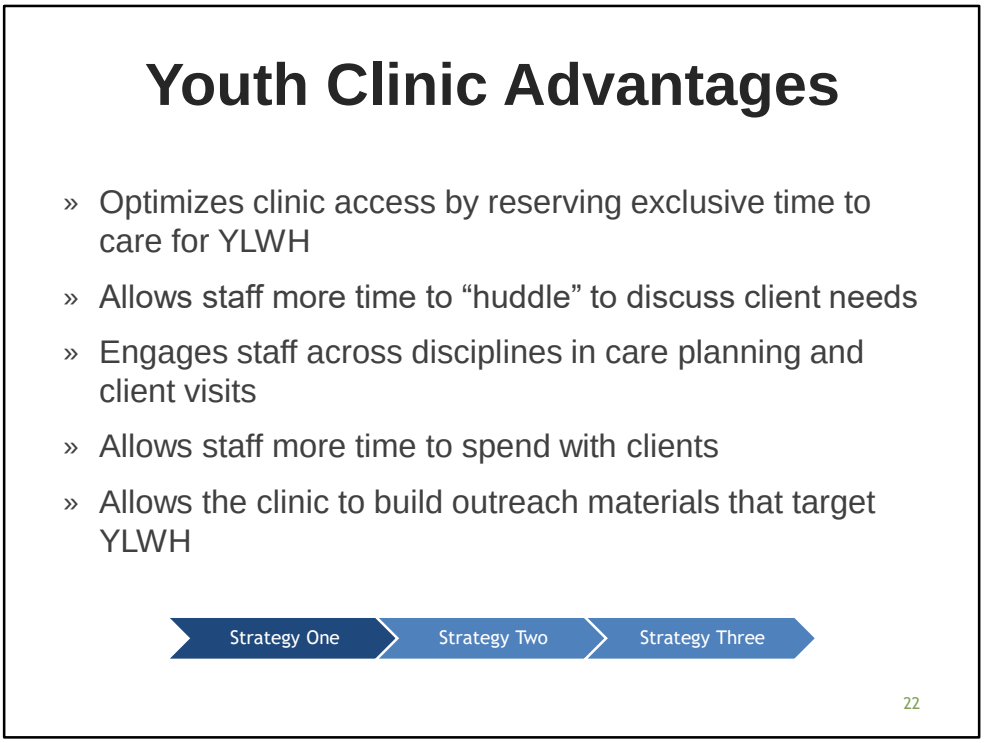
Providers also brought up a model that would be implemented in an FQHC-type setting that serves a broad population. This health center could start or leverage an existing Youth Clinic that serves all youth regardless of HIV status to target and provide more tailored supports to youth living with HIV.

Most commonly, an HIV clinic would set aside a specific day and time to only serve youth clients. This is the model that Metro Health recently launched and will present on today.



People who staff the Youth Clinic should have demonstrated interest and success in working with youth. In a couple of the sites we visited, these staff people overlapped with the overall clinic, which providers felt was an advantage. They reported it helped youth eventually transition out of the clinic because they were already familiar with the staff.

Another provider contacted with a clinician with expertise in youth. This clinician actually worked in multiple provider sites throughout the city, serving predominately youth clients.

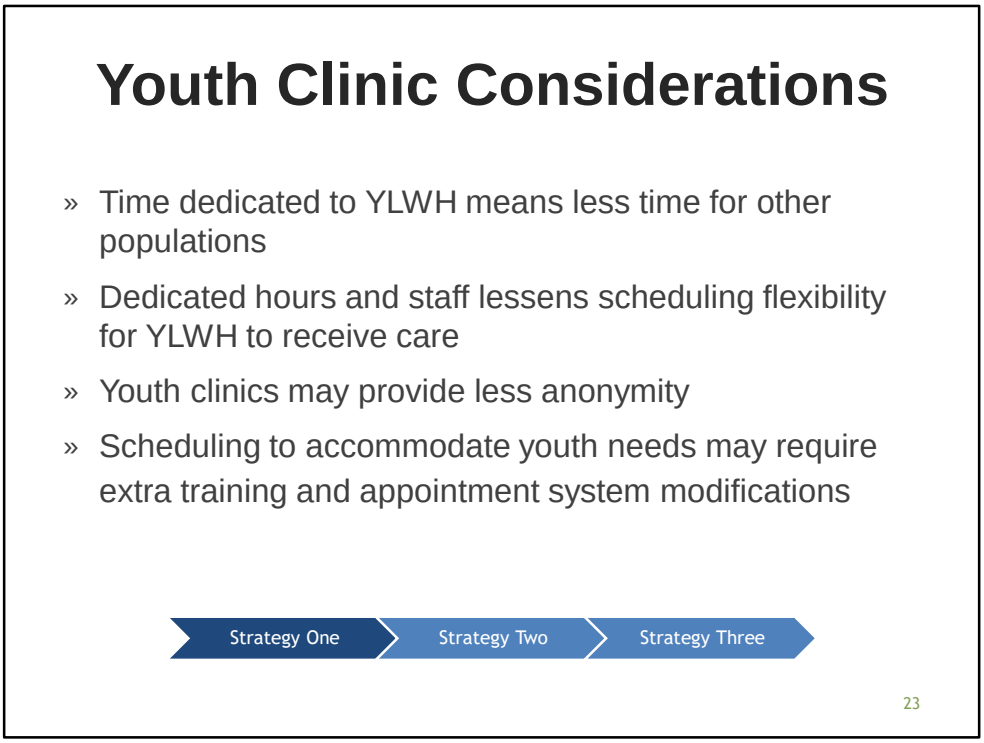


Now, let’s talk about some of the advantages of starting a Youth Clinic. For one, clients might feel more connected to the clinic because they are setting aside exclusive time just for them.

In addition, staff could huddle prior to the start of each Youth Clinic day to discuss each client’s progress and potential needs to be addressed during the visit. This huddle could be composed of an interdisciplinary care team, as AJ will discuss next.

And, depending on how you set up the client case load, you could set aside more time for clinicians, case managers, and social workers to spend with the clients than you typically would for your adult population.

Finally, it provides a outreach opportunity for the clinic to design and disseminate youth-centered marketing materials.

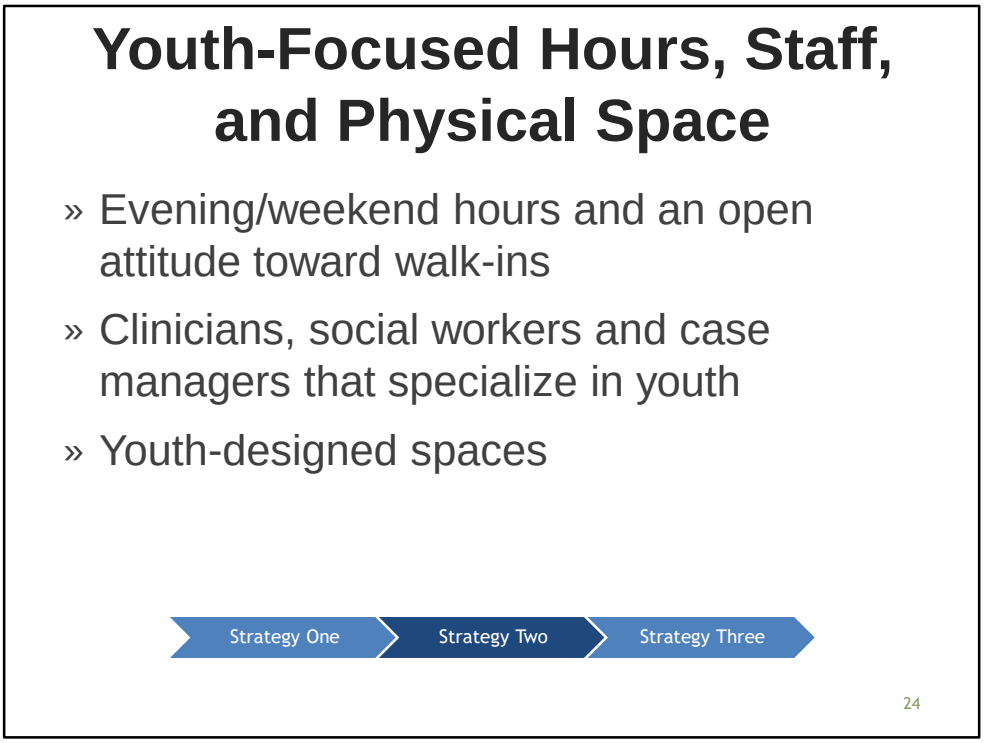


There are some drawbacks to this approach, which providers need to take into consideration. For one, a lighter case load during your Youth Clinic means a heavier case load during your adult time. You might be able to justify this, though, if your adult population is relatively more stable than the youth.

Also, youth may dislike having their appointments restricted to a certain day and time. Therefore, you'll definitely want to consult with youth to see what time works best for them – one provider set up the youth clinic on the day the high school had a half day. This provider also allows youth to come in during regular clinic hours, but they don't get the same intensive supports as during the Youth Clinic.

Youth Clinics also provide less anonymity, which may be a challenge if your YLWH population is small. One provider described the importance of taking interpersonal relationships into consideration when scheduling.

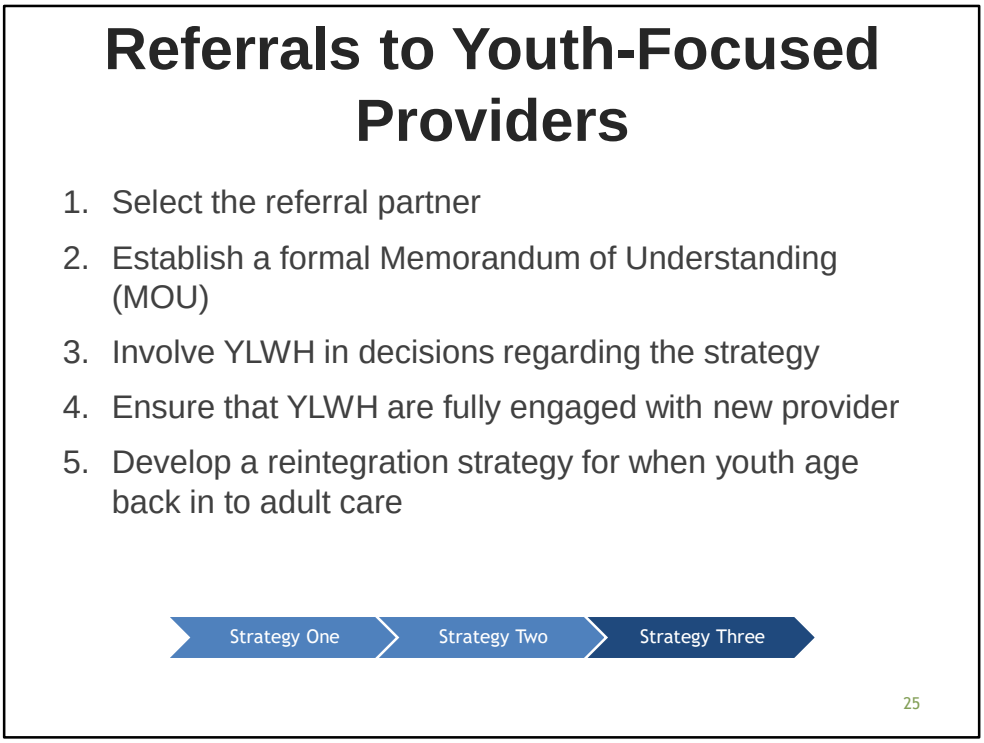
And, finally, don't underestimate the logistics involved with setting up appointment scheduling systems.



Ok, let's move onto the second strategy. These are some things you can do to support youth that don't involve a restricting of your clinic operations. For one, you may want to have some evening or weekend hours that fit better with youth schedules. An open, non-judgmental attitude toward walk-ins can also encourage youth to come in appointments more frequently.

Also, you could have one clinician, social worker or case manager that is assigned to all your youth clients. As I mentioned before, these staff people should have a particular interest in and ability to engage with youth.

And, finally, take a look at your physical space and see if you can make it more youth friendly. Some providers even have separate entrances and waiting rooms for youth and families. Others hang art created by youth clients, maybe at a youth group session, on the walls or get local artists to donate art or design ideas.



Our final strategy is for those sites that want to serve youth better, but just don't think they have the resources. If this sounds like you, you may want to check what other Ryan White providers that operate in your area. Maybe they receive Part D funding or have developed special programs for youth. If you feel that this provider might serve youth better than your clinic, reach out and establish a memorandum of understanding that clearly describes the referral process. Of course, you'll want to give youth a choice in the move, and have a process to ensure that they are engaged fully with the new provider by tracking kept appointments. If the plan is to have them eventually integrate back into your clinic once they age out, you'll also want to create a process for that.

Poll

Which do you think is the best fit for your site?

a. Youth clinic with specific hours for YLWH
b. No youth clinic, but flexible hours and qualified staff
c. Referrals to a more youth-focused clinic
d. Do not know
e. None of the above

Interdisciplinary Care Teams

Background

- Continuity of care and comprehensive services are important, especially for YLWH
- Interdisciplinary care teams bring together a range of professionals
- Teams can help reduce fragmentation in care

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Continuity of care and the availability of comprehensive, wrap-around services are essential for good outcomes for all PLWH, and are particularly important for youth. We heard from you all on the site visits that minor changes such as staffing changes can have a large impact on youth, and youth may be more likely than older clients not to follow up on referrals or make it to all parts of their appointments.

Many of you are probably familiar with interdisciplinary care teams, which bring together a wide range of professionals involved in care delivery and coordination to reduce fragmentation in care and ensure all clients' needs are being met by their care plan.

Poll

Do you currently use an interdisciplinary care team approach?

a. Yes, we have interdisciplinary care teams for all of our clients
b. Yes, we have interdisciplinary care teams only for high-need clients
c. No, but we have considered adopting this approach
d. No, and we have not considered this approach
e. Do not know

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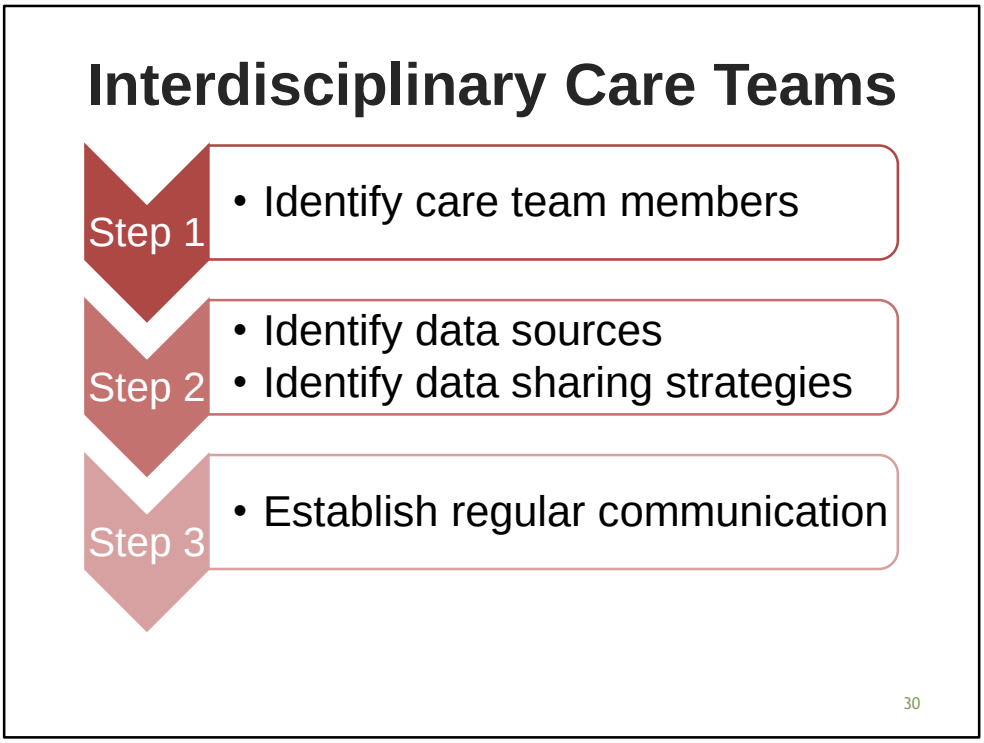
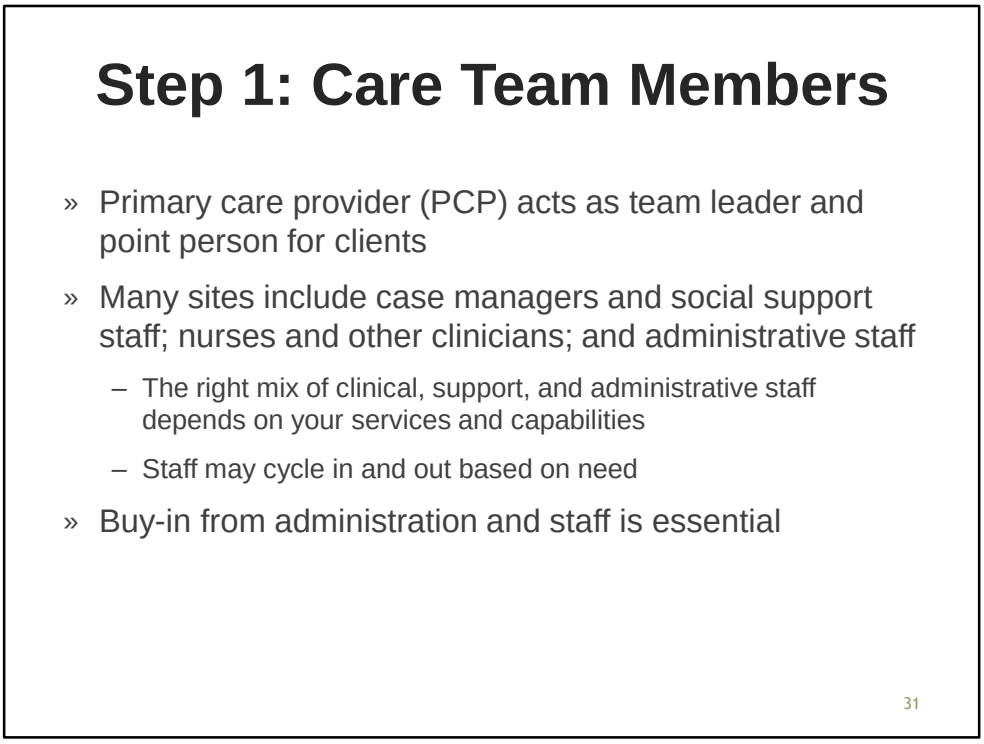
Before getting into our presentation today, we wanted to get a sense of how many of you are already using or are familiar with the interdisciplinary care team approach.



Today we're going to talk through three steps in establishing an interdisciplinary care team approach at your agency.

The first step is identifying who will be participating in your care team. Next, you'll need to work through how these care team members maintain and share data about the care they're delivering to clients. Finally, we'll talk through some strategies to establish regular communication across members of your team.



As I mentioned, the first step in establishing a care team approach is to identify who will be participating. The exact composition of your team will be dependent on the services that your site delivers – for example, if many of your YLWH clients are receiving counseling services for substance use disorders, you may want to bring counselors and other mental health staff in to your care team.

Regardless of composition, all the sites we visited that had implemented this approach had a primary care provider such as physician, nurse practitioner, or PA to lead the care team, bring members up to speed on how clients are doing clinically, and to act as the point person for clients.

Many sites brought case managers and social support staff in to the care team. Clients may be more comfortable discussing some personal problems or issues with these staff rather than clinicians, so these staff can help fill in the team on client barriers and needs. Sites also commonly included nurses and other clinicians such as infectious disease specialists in their care team. Finally, administrative staff who can help inform policies and procedures can also be valuable team members.

The right mix of these staff members will vary, and may change over time. For example, you may find that having administrative staff more heavily involved in early stages is helpful in getting your interdisciplinary care teams off the ground, but they may scale back their participation as the team becomes more established. You may also want to cycle staff in and out of care team meetings based on need – one provider that we visited had care team meetings before each of their youth clinic days, so they had a list of all YLWH who were coming in to the clinic for the day and could bring in any staff people who would be meeting with those clients.

Getting buy-in from administrative staff and these members that you've identified is essential for success in implementing and interdisciplinary care team approach.

Poll

Who is on your interdisciplinary care team? (select all that apply)

a. PCPs (e.g., physicians, physician assistants, nurse practitioners)
b. Other clinicians (e.g., infectious disease doctors, dentists)
c. Nursing staff (e.g., registered nurses)
d. Mental health staff (e.g., psychologists, licensed social workers, counselors)
e. Case managers or other support staff (e.g., treatment adherence specialists, outreach/linkage workers, medical assistants)

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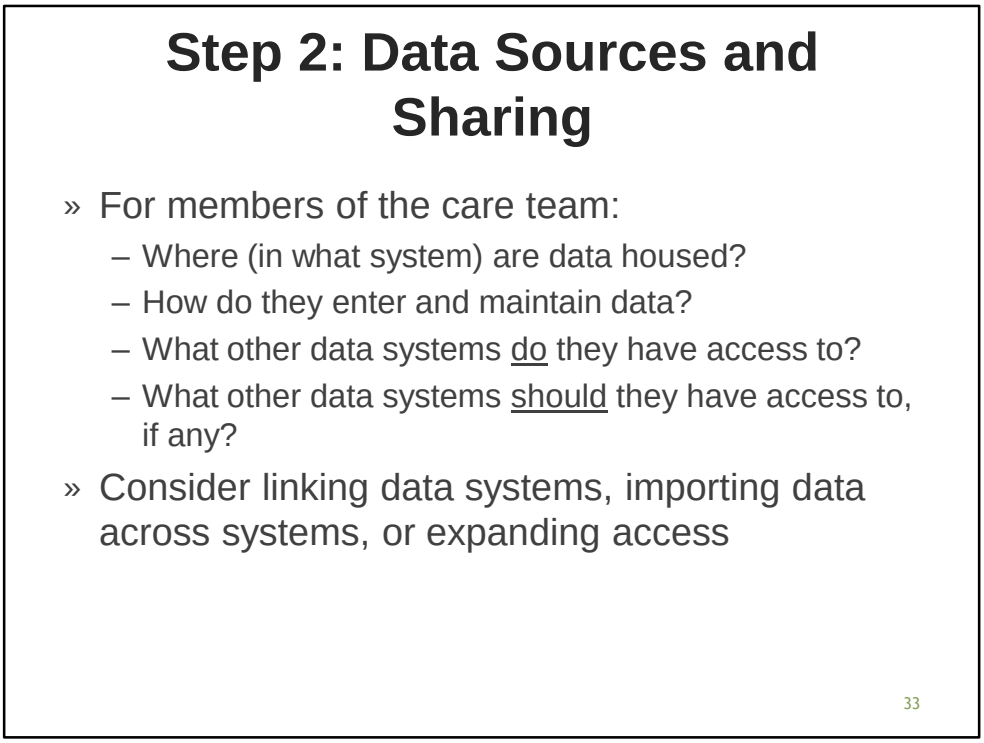
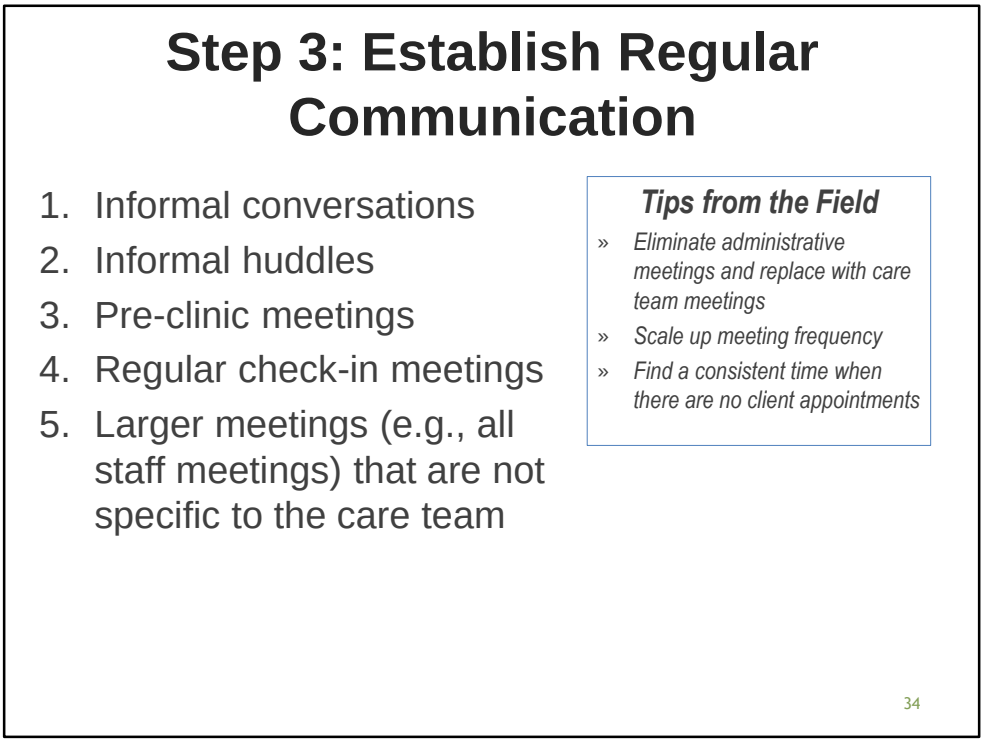
For those of you who have already implemented interdisciplinary care teams, we'd like to get a sense of who is included in your team.



The next step after you've identified the members of your team is to figure out how data are maintained and shared. Sites often have complex system that don't necessarily talk to one another. For example, one site that we visited had an electronic health record (EHR) for clinical data, CAREWare for RWHAP-specific data elements, and a separate social work system used by the case managers that was not specific to the clinic's RWHAP clients. Unless you take the time to understand where all these data are housed, information relevant to client care and care planning can be siloed.

With that in mind, you'll need to determine for each member of the care team what system(s) they are using to maintain data and what other systems they have access to. You might not want all members of the care team to have access to all data: for example, you may want the team to know when a client has seen a counselor, but not the case notes from the counseling session. From there you can determine what other data and/or systems members of the care team should have access to.

Depending on how what systems you're using and your capacity, you may want to consider linking systems together so that data are automatically shared. While interoperable systems are ideal for sharing data in real time, they may be prohibitively expensive or challenging to implement. You may prefer to import relevant data in to one location that all care team members are able to access, or you may want to keep your current systems and give access to care team members as appropriate.



Once you've worked out how to share data across the team, the step we'll discuss today is to establish regular communication across members of your care team.

Sites we visited reported that informal conversations and huddles were common strategies for keeping in touch and communicating quickly about clients. These brief interactions can be effective in communicating high-level information, but be sure to be careful not to discuss specific details where they may be overheard by other clients. Additionally, you may want to consider chat programs like skype that facilitate quick, real-time electronic communication across members of the team.

If you have a youth-specific clinic or hours as Ellie discussed earlier (or are considering implementing one of these approaches), you may also want to consider having pre-clinic meetings to discuss clients that are coming in to clinic for the day. As I mentioned previously, one site we visited who had a weekly youth clinic took this approach – a medical assistant would prepare a client list each morning, and the care team would discuss each of the YLWH coming in to identify who the client would be meeting with and map out flow for the day.

In addition to these client-specific meetings, you may want to establish regular check-in meetings for members of the care team to discuss successes, challenges and barriers that may inform updates to policies and procedures. Finally, you may want to carve out time for the care team to meet from larger meetings such as staff meetings.

The sites we visited shared several tips for establishing regular communication. Given how busy staff already are and how many meetings they have to attend, sites recommended trying to eliminate an administrative meeting to replace with a care team meeting. You can scale up the frequency of these meetings over time as the care team becomes more familiar and comfortable working with each other, until you find the right regularity for your team. Finally, it's crucial to find a consistent time when clients aren't coming in for appointment to limit the likelihood of

distractions during team meetings.

Lessons from the Field

MetroHealth

Kristi Langshaw, LISW-S
Jen McMillen Smith, LISW-S

MetroHealth

- Located in Cleveland, OH
- County “safety-net” hospital
- Infectious disease clinic provides HIV care for about 1,600 people living with HIV
- About 140 patients are 13-24 years old

Our approach to the toolkit

- Reviewed the entire document
- Chose topics and parts of topics we felt would be:
  - ***most beneficial*** for our patients
  - conducive to ***streamlined implementation***
  - Achievable without added staffing or much expense

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We chose topics and parts of topics that are most beneficial to our clients while can be achieved without much additional staffing and expenses.

Why We Chose Youth-Centered Services

YLWH-Friendly Hours, Staff and Physical Space

- Youth-centric staffing (MD and SW) were available and interested in implementing an evening clinic
- Logistics were in place: another physician was in clinic during same evening time period
- Youth were interested in more flexible clinic schedules, specifically evening

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We already have a doctor and social worker available Tuesday evening so we decided to turn that evening into a youth clinic.

Youth Centered Services **Plus** Youth Support Groups

- Daytime youth support group was already in place and meeting each month
- Youth were requesting evening groups/support
- Experienced group facilitator was willing to run an evening group

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Jen is already running a daytime support group. Our youth asked for an evening clinic. They worked to reach out to their peers, including perinatal infected youth, and they also came up with a name for the support group.

Activities

Evening Clinic

- Developed new evening clinic for youth <30 years of age
- Evening clinic does not allow overbooking, so physician has ample time to spend with young patients
- Evening clinic also allows for walk-ins as needed
- Social worker and RN are in clinic with physician as part of team approach to better serve youth

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We decided the clinic is open for walk-in. They could have an urgent care or they have been out of care and came back. We don't over-book so we can take walk-ins and our doctors can spend a little bit more time with the clients. We also do labs in evening clinic. It is very good for the clients as our labs get busy during the day.

Activities

Group

- Combined group with evening clinic. Same physical space, same time, flexibility to go from group to clinic and vice versa
- Added a co-facilitator to assist with smooth transitions in and out of the group space
- Laid-back vibe that eases slowly into talking about support group issues

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The group is right next door to the clinic to make it convenient. The co-facilitator helped me transit youth from the clinic to the group space and vice versa. The group went really well. They usually start with an ice breaker to get everyone laugh and relax, and then move into the support group topics. It is a great way to link to peers from each other. Some perinatal clients also come, which is very good as they are the most challenging group.

Activities

Re-Engaging Youth

- Met with Information Services to discuss using a kiosk or iPad for checking into clinic and collecting non-traditional contact information, such as social media usernames so they can be used to contact youth.
- The above occurred in addition to calls, letters, e-mails and outreach visits, which sometimes all fail as youth change phone numbers and addresses, but not Instagram usernames.

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As suggested in the tool kit, we started to sign clients in using a kiosk, where they can update their Instagram, Facebook or twitter account names. Phone number can change but they rarely change their Facebook or Instagram names. These information will help us reach out to youth if we can't find them via other means.

Activities

Other

» Met with Director of Arts in Medicine to discuss changing clinic art work to include patient-created pieces and/or artwork that is reflective of and appealing to our diverse client community

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This is also suggested in the tool kit. It is a little difficult at the beginning but eventually we were able to let youth clients create art work for the clinic.

Results

» Successes

- Six evening clinics held since March 20th, 2018
- Fantastic low no-show rate: 18% (without double booking)
- 25 youth participated in evening clinic visits – including one walk-in
- Group attendance average: 10 youth
- Greatly helped perinatally-infected youth engage in care and attend support groups, which has been very difficult in the past

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We started the clinic in March and had 6 since then. The no-show rate was great compared to day booking and we did not have double booking.

Results

- Barriers
  - *Clinic:* Initial scheduling issues – could not designate it as youth-only in the electronic health record; thus, schedule included all-age ID clinic patients
  - *Group:* Started off in a small, cramped room and moved to larger space next month, which led to challenges of interruptions by cleaning staff coming through the space and making youth feel exposed

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With these barriers, we can share our lessons learned. In electronic heath system, there is no way to indicate that this is a youth specific group, especially the central scheduling module. So we had to do some tweaking to the system to make this happen.

They showed us two spaces – one is more private but small, which gets very hot. Then we moved to a larger space, but the cleaning staff come during the support group. It can get strange that cleaning staff walk by when people are talking about living with HIV. We had to make special arrangements with cleaning crew for them to come after 7:30.

Results

» Barriers (continued)

– Logistics can be challenging, but manageable with good co-facilitation (request tables be put in space, carrying heavy materials, managing group attendance/privacy, etc.)

– Transportation concerns-Metro Van is not available in the evening.

– Still determining whether kiosk/iPad check-in and changing artwork is feasible

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We never had a support group in a lobby, so we had to get tables and chairs, as well as caterings. Logistics are a bit challenging.

The metro van is not available in evening otherwise they can schedule a free ride. However we offered parking validation and bus fare.

We are still determining how to create the youth-centered feel including the kiosk and new art work.

Next Steps

- Create a catchy name and marketing materials for the evening group and clinic combo. Currently the group is being called “Taco Tuesday” by attendees
- Obtain new artwork
- Get an iPad or kiosk so that social media contact info can be collected
- Train outreach staff to comply with HIPAA when using social media to conduct outreach to patients

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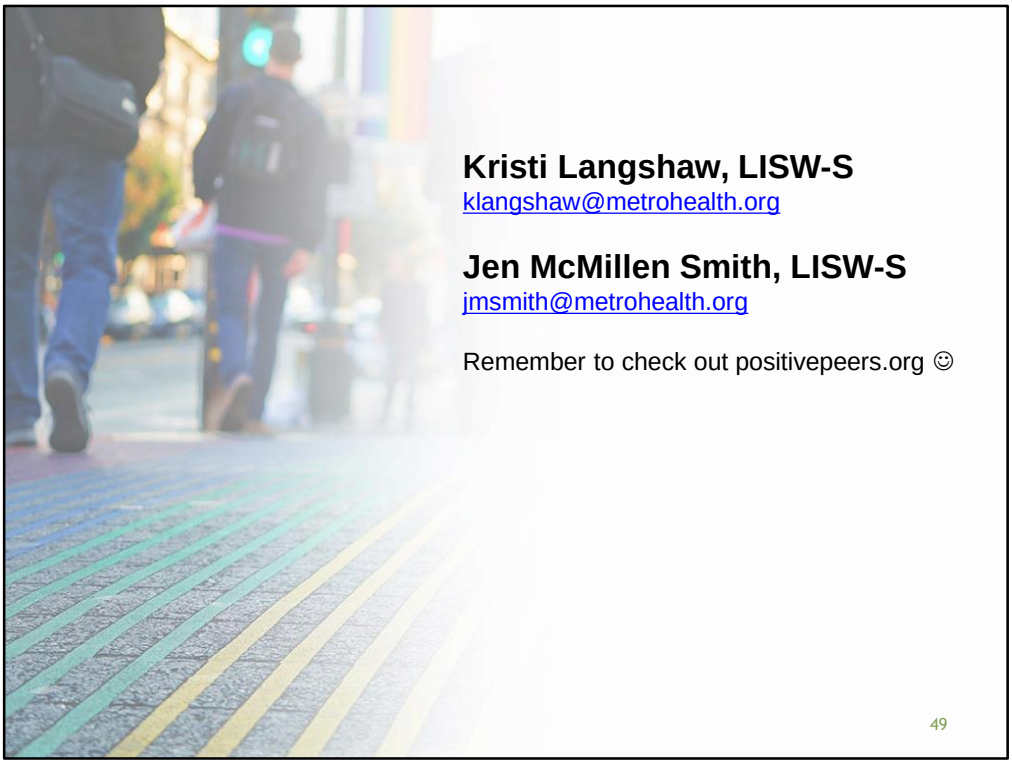
It seems we can’t go with the Taco Tuesday name now as the evening group and clinic are a combo. So we are still working on it. Using social media to reach out to clients is relatively new to us so our staff need to be trained with HIPPA regulations.



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Remember to check out positivepeers.org ☺

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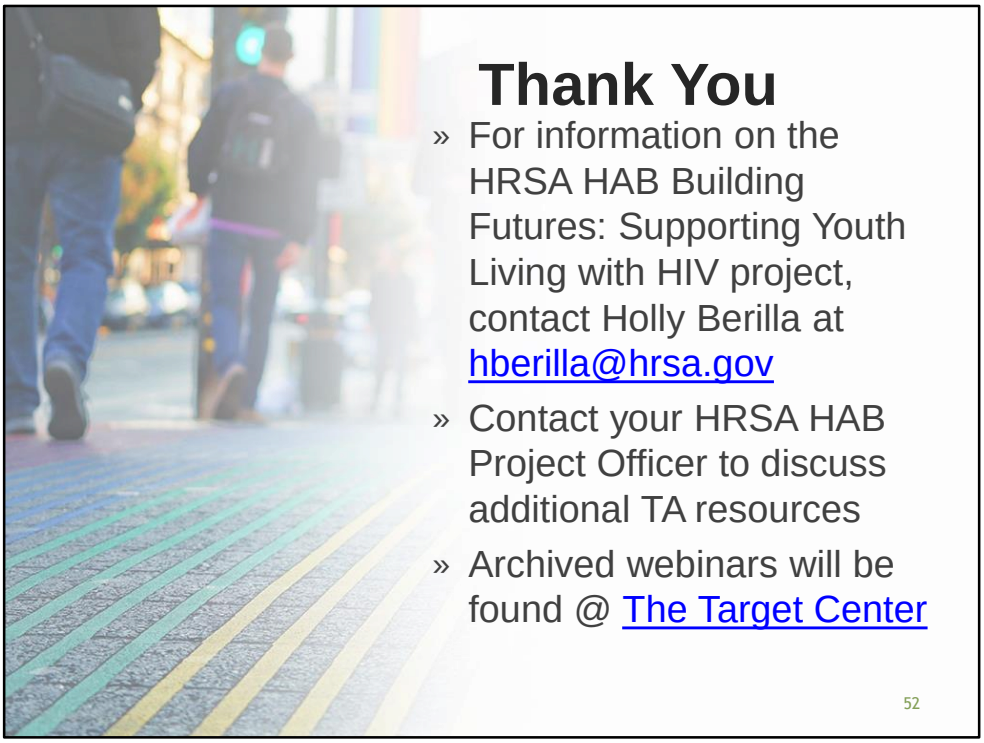
We will now be taking questions from participants. Remember you can raise your hand and we will unmute your line so that you can ask your question verbally. In order to do so however you need to have put in your audio pin. You can also type your question into the chat box in your webinar control panel.

Thank you for those questions we would just like to end presentation with a few final question to our providers:

- Are there specific resources that you found helpful?
- What suggestions do you have for other providers who will be using the toolkit?



If you have any questions about the toolkit or the building futures project please contact Holly Berilla. If you would like additional TA resources please contact your HRSA HAB project officer.

Remember at the completion of this webinar there will be a survey which opens automatically, it is important that you complete the survey.
Thank you.

This webinar as well as the other three in the series will be archived and posted on the target center website. And remember the technical assistance toolkit will be available soon and will be found at the same location on Target.