HRSA
Health Resources & Services Administration

# Serving Youth Populations

## Ryan White HIV/AIDS Program (RWHAP) Part D WICY Training

***September 7, 2023***

**Lillian S. Bell, Branch Chief, Central Branch**
**Division of Community HIV/AIDS Programs**
**HIV/AIDS Bureau (HAB)**

Vision: Healthy Communities, Healthy People

# HIV/AIDS Bureau Vision and Mission

## Vision

Optimal HIV care and treatment for all to end the HIV epidemic in the U.S.

## Mission

Provide leadership and resources to advance HIV care and treatment to improve health outcomes and reduce health disparities for people with HIV and affected communities.

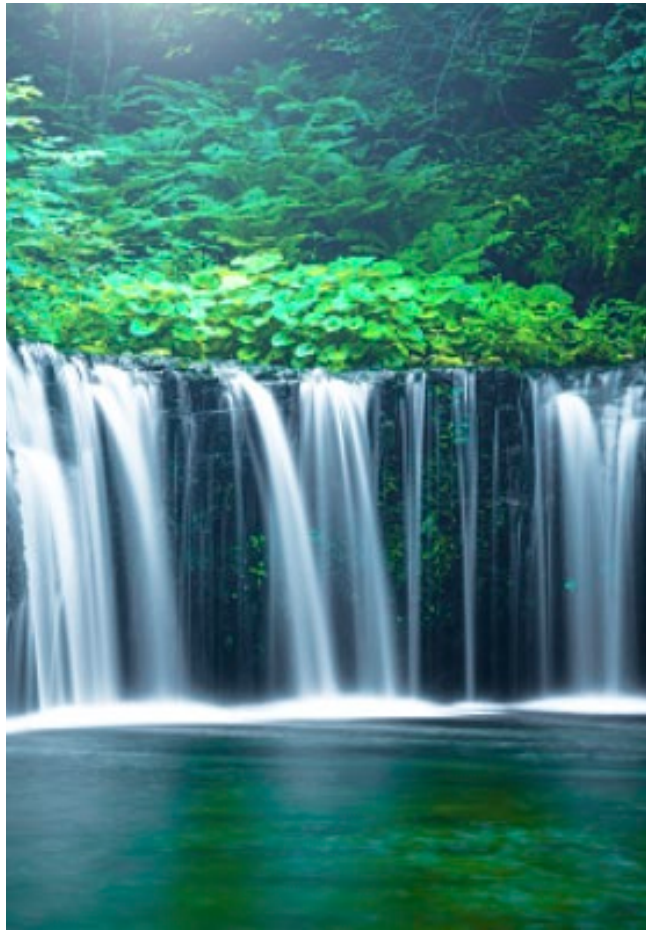
# Session Objectives

1. Discuss the RWHAP Part D program requirements related to serving youth with HIV.
2. Describe various strategies used by RWHAP Part D recipients to provide youth-specific services.
3. Identify common challenges and potential solutions.
4. Explore youth-specific resources available to RWHAP Part D recipients.

# Introductions

- **HRSA Division of Community HIV/AIDS Programs**
- **Facilitators**
  - Lori DeLorenzo
  - Cheryl Nesbitt
- **Recipients**
  - Southeast Mississippi Rural Health Initiative
  - University of California, San Diego

# Chatter-fall



What are your greatest challenges recruiting & engaging youth in care?

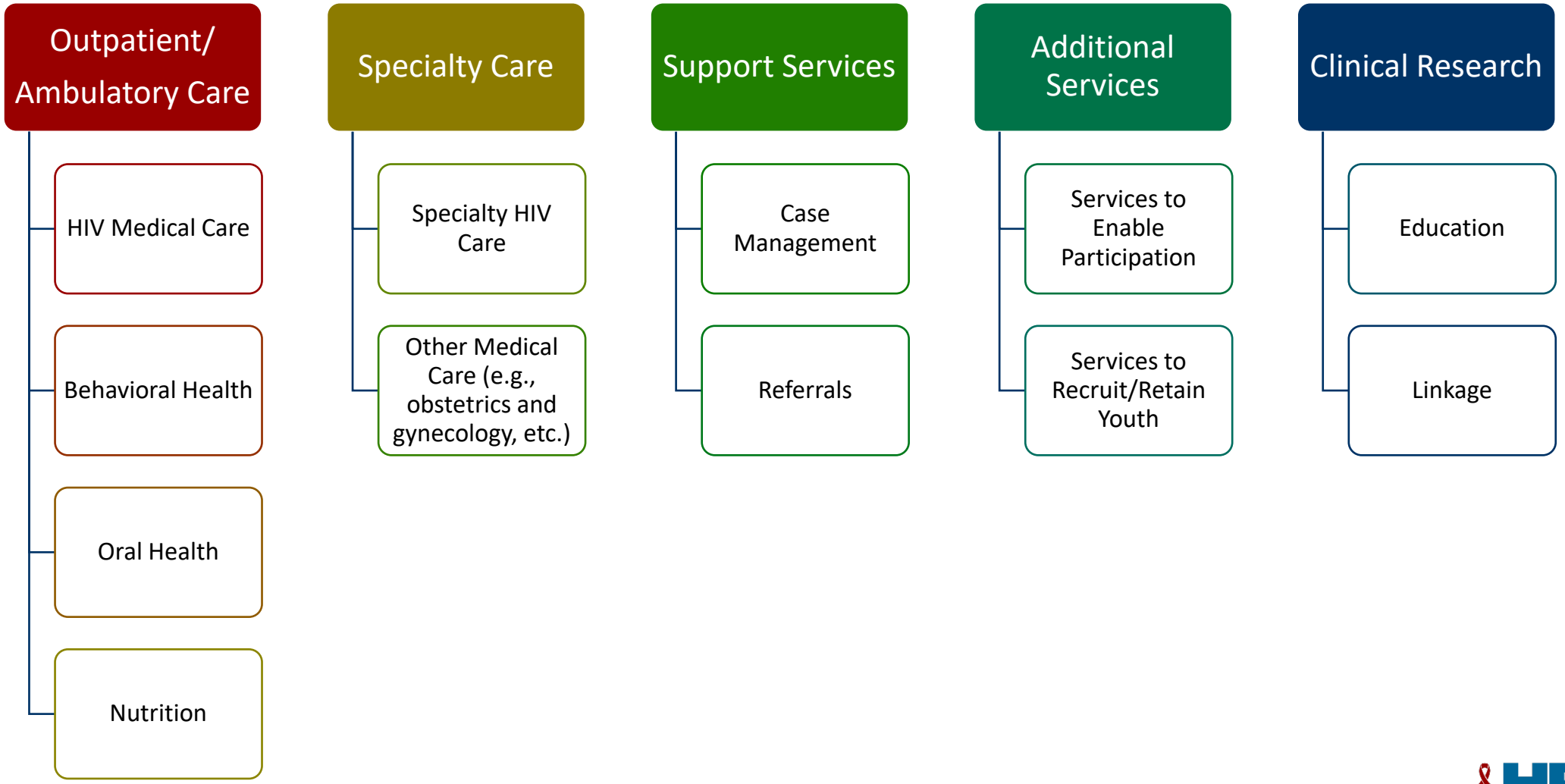
Drop the response into the chat room but **don't post just yet**

On the count of "3" everyone will post at the same time

# RWHAP Part D Requirements and Expectations

- Comprehensive coordinated system of family-centered care
- All priority populations must be served
  - ✓ low-income women (25 years and older with HIV)
  - ✓ infants (up to two years of age exposed to or with HIV)
  - ✓ children (ages two to 12 with HIV), and
  - ✓ **youth ages 13-24 with HIV**
- The entire service area must be covered

# Services Provided via Family-Centered Care



# RWHAP Part D Requirements and Expectations

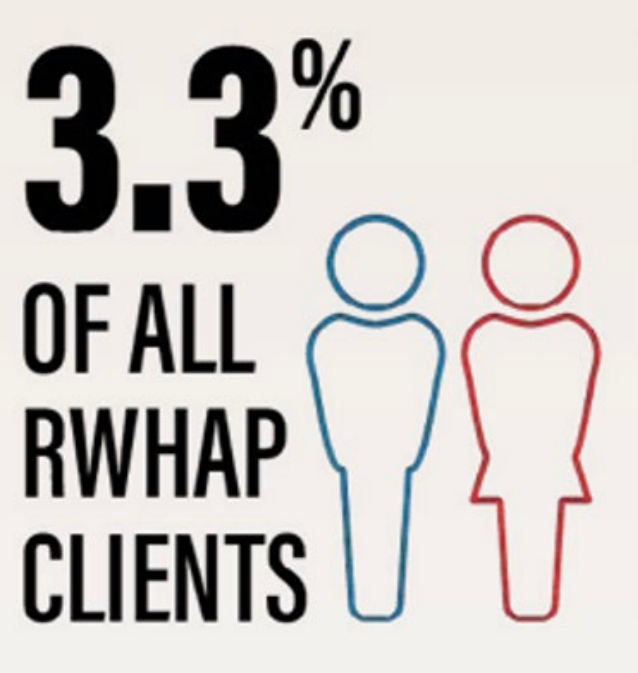
- **Culturally** and **linguistically** competent care
- Implement evidence-based interventions with disproportionately affected populations
- Services provided **directly, through contract or memoranda of understanding** (MOU)
- Consumer involvement

# Transition to Adult Care

- Services for youth can be provided until age 24.
- Females (inclusive of transgender women, assigned female at birth, and gender non-conforming persons) ages 25 and beyond can continue as RWHAP Part D clients, **BUT** are no longer considered youth.
- Males ages 25 and beyond can continue to receive care, however, are **no longer eligible** for RWHAP Part D services.
- Must assist youth to move into adult medical care at age 25.

# Youth Clients Served by RWHAP

# Fast Facts: Youth (13-24 years of age)

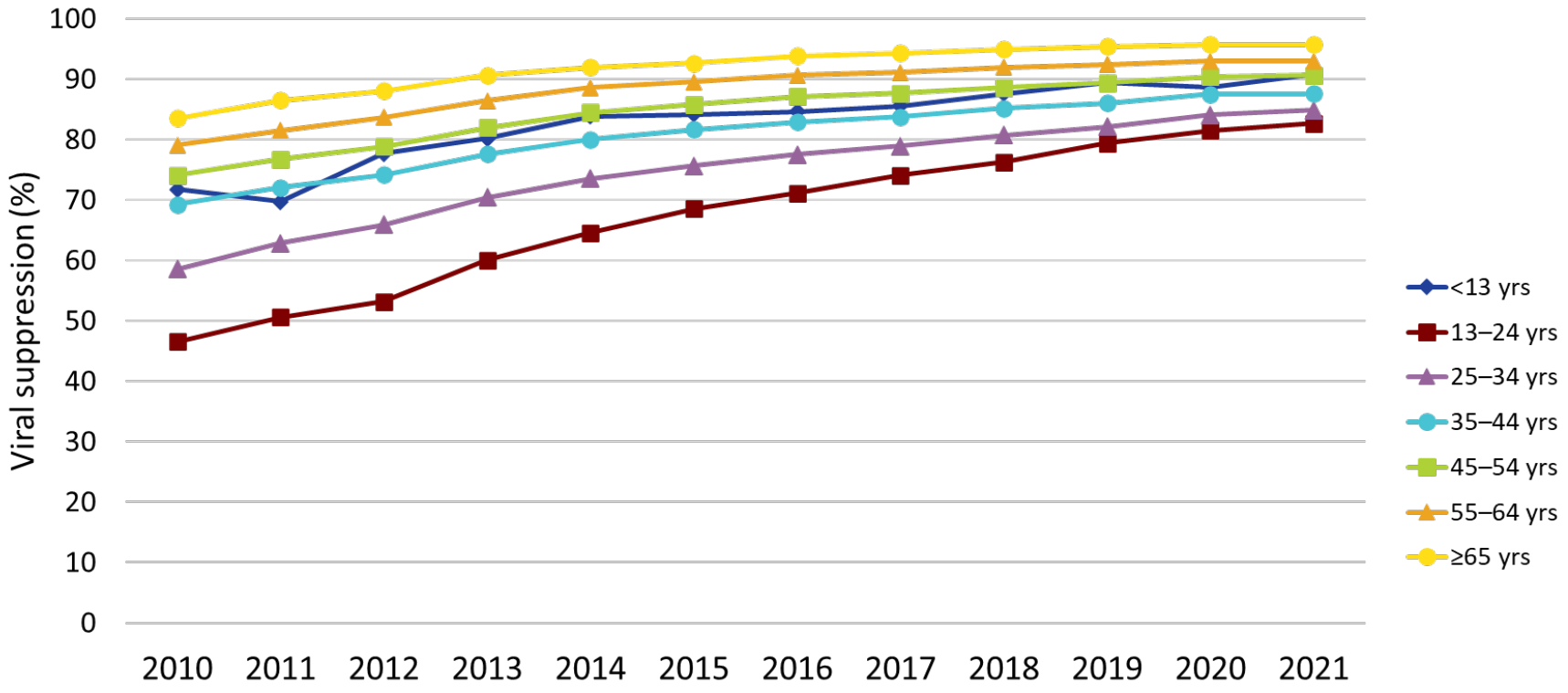


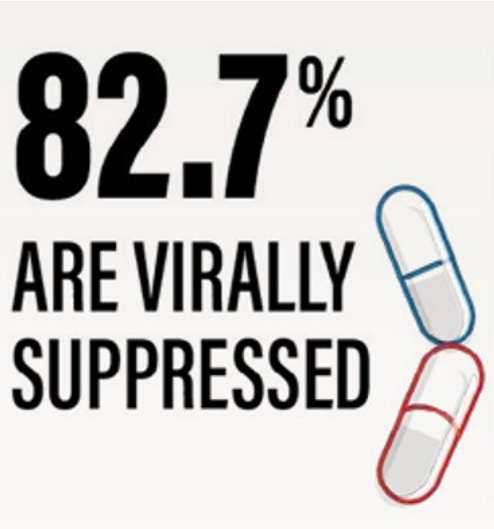



Source: Youth and Young Adult Clients: HRSA's Ryan White HIV/AIDS Program, 2021, Population Fact Sheet

HRSA Ryan White HIV/AIDS Program

# Fast Facts: Youth (13-24 years of age)



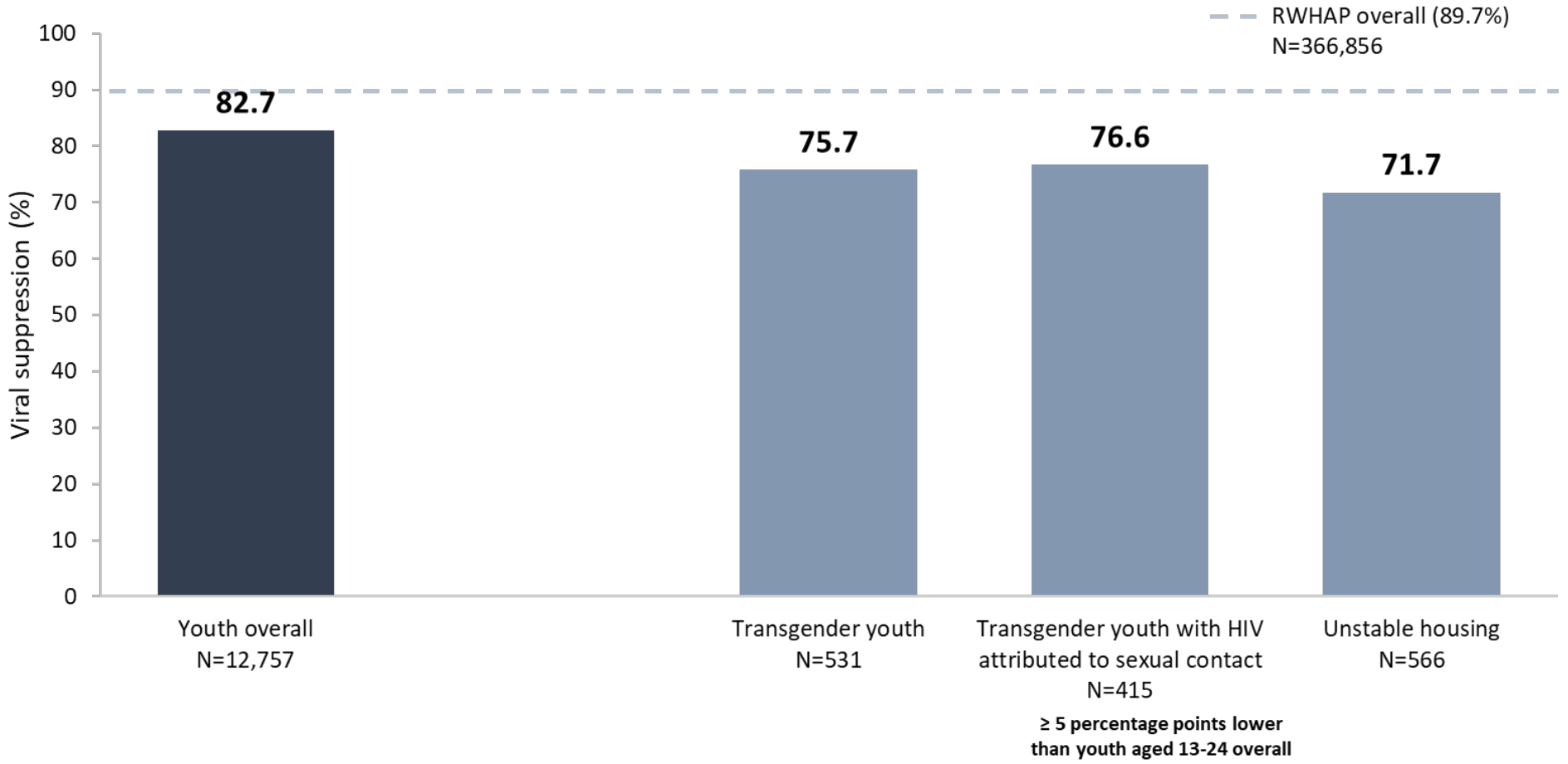

**89.7%**

National Average

Source: Clients Service by the Ryan White HIV/AIDS Program, 2021. Available at: https://ryanwhite.hrsa.gov/data/reports

HRSA Ryan White HIV/AIDS Program

# Viral Suppression among Youth Aged 13–24 Years Served by the Ryan White HIV/AIDS Program, 2021—United States and 3 Territories[a]




N represents the total number of clients in the specific population.
*Viral suppression:* ≥1 OAHS visit during the calendar year and ≥1 viral load reported, with the last viral load result <200 copies/mL. [a] Guam, Puerto Rico, and the U.S. Virgin Islands.

Source: Clients Service by the Ryan White HIV/AIDS Program, 2021. Available at: https://ryanwhite.hrsa.gov/data/reports

HRSA Ryan White HIV/AIDS Program

# Youth Receiving RWHAP Part D Services

# Demographics of Youth with HIV Served by RWHAP

| Client Characteristics | 2021 | 2020 | 2019 |
|---|---|---|---|
| # of WICY[a] served amongst Part D funded recipients | 70,319 | 68,765 | 73,772 |
| % of WICY[a] Virally suppressed amongst Part D funded recipients | 88.4% | 88.0% | 86.4% |
| # of infants and children served amongst Part D funded recipients | 2,881 | 2,826 | 2,908 |
| % of infants and children served amongst Part D funded recipients who are virally suppressed | 90.4% | 87.6% | 88.9% |
| # of **youth aged 13-18** served by amongst Part D funded recipients | **1,313** | **1,401** | **1,605** |
| % of **youth aged 13-18** served by amongst Part D funded recipients who are virally suppressed | **84.5%** | **85.2%** | **85.6%** |
| # of **youth aged 19-24** served amongst Part D Funded Recipients | **7,463** | **7,651** | **8,815** |
| % of **youth aged 19-24** served amongst Part D Funded Recipients who are virally suppressed | **82.0%** | **81.7%** | **79.2%** |

[a]WICY includes both women and transgender women (male to female)

Source: 2019-2021 RSR, HRSA HAB DPD

HRSA Ryan White HIV/AIDS Program

# Questions

## How does your program provide services to youth ages 13-24? (select all that apply)


A. Directly
B. MOU with CBO/ASO
C. Contract with Children's Hospital/Clinic
D. We do not serve youth 13-24
E. Other (specify in chat)

SEMRHI

Tonya Green


AJ Johnson

Joe Mora


Tonya Green, MPH, ACRN

Southeast Mississippi Rural Health Initiative, Inc. (SEMRHI)

Hattiesburg, Mississippi

# Agency Overview

Federally Qualified Health Center (FQHC)

Recognition as a Patient Centered Medical Home (PCMH)

15 medical clinics, 1 behavioral health clinic, 1 dental clinic and 1 mobile unit

Provides services in 47 schools in 5 Mississippi counties

Numerous partnerships: MSDH, local hospitals, private physicians' practice, schools, CBOs and other support service organizations

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# Medical and Support Services at SeMRHI

- Primary medical care
- HIV care for adolescents and adults
- OB/GYN
- Outpatient Behavioral Health/ Psychiatric services
- Comprehensive oral health services
- Vision care/eyeglasses voucher
- 340B Pharmacy
- Medication Assistance Program
- Minor care: acute care 7 days a week
- Ryan White Program
- Outreach and Education
- Interpretation Services
- School-based health services
- Mobile clinic-newest addition

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# Newest Addition: Mobile Clinic “Lady SeMRHI”


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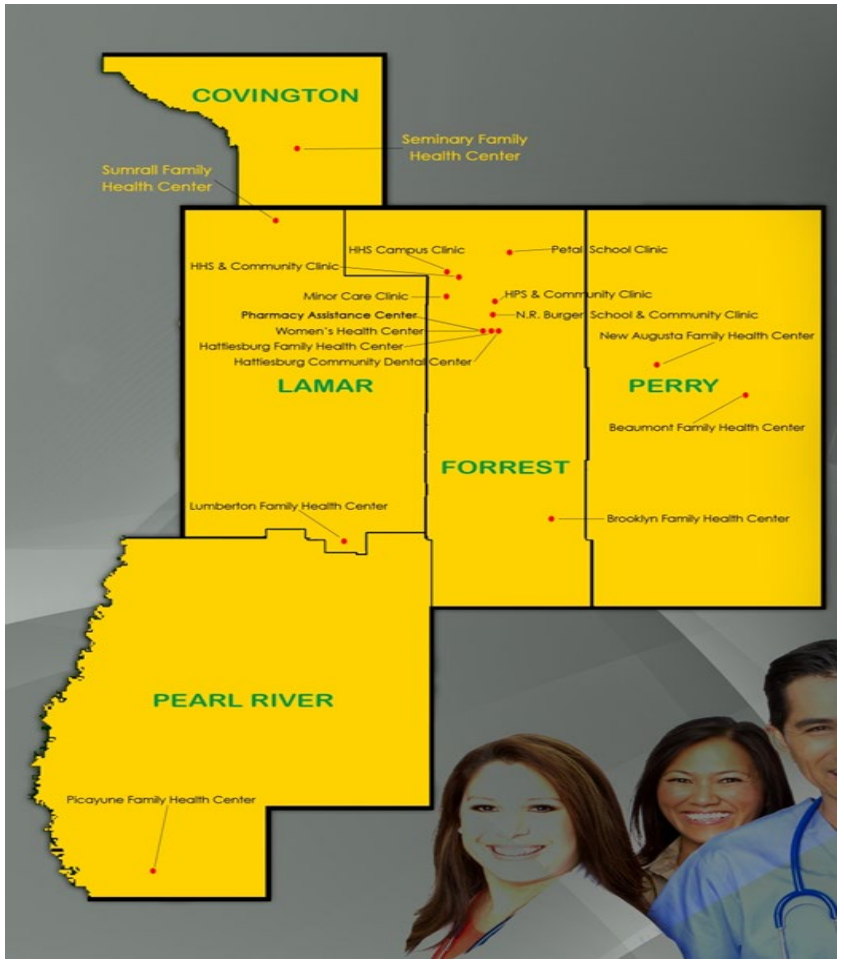
# Map of SEMRHI's Service Area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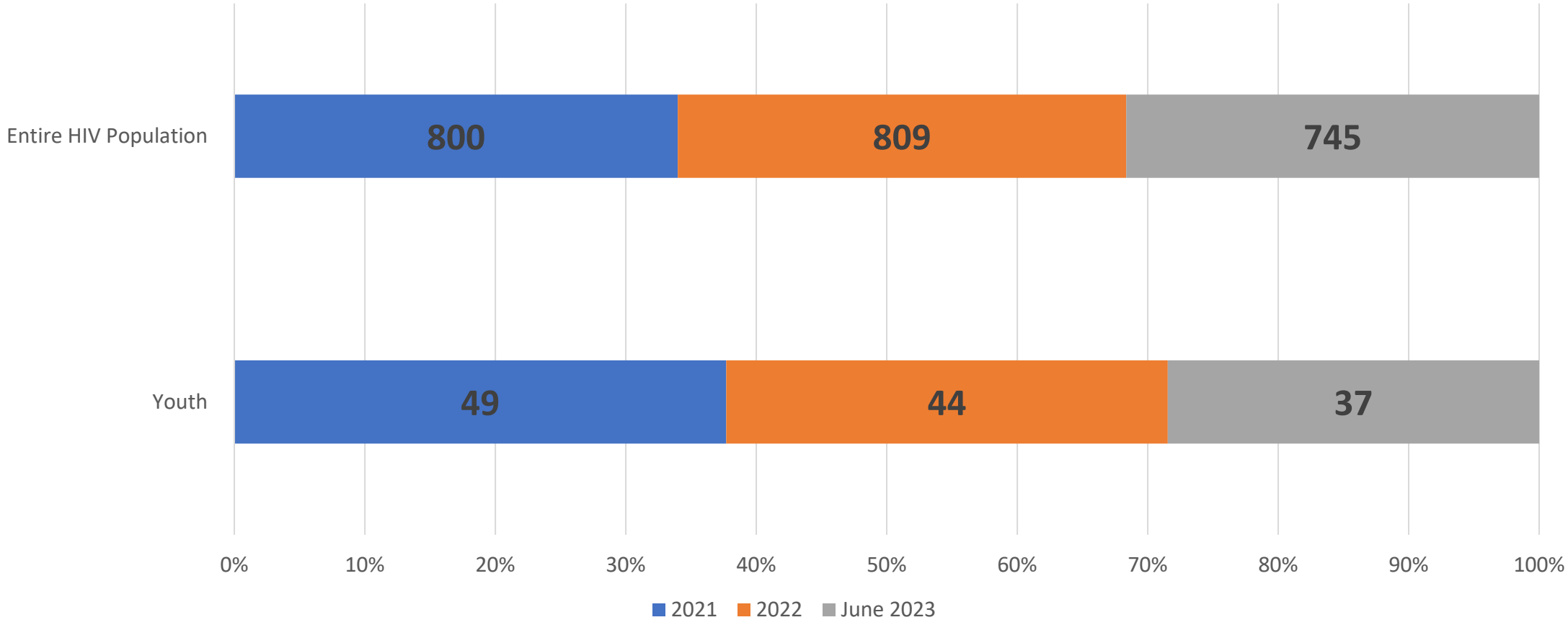
# Youth With HIV Served at SEMRHI

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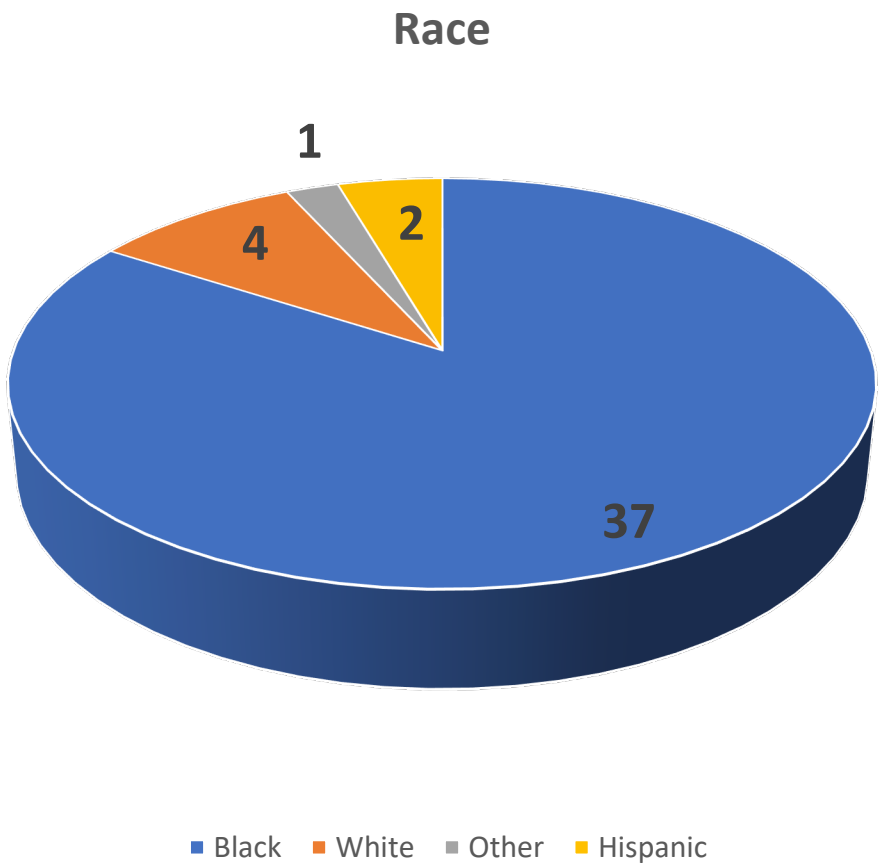
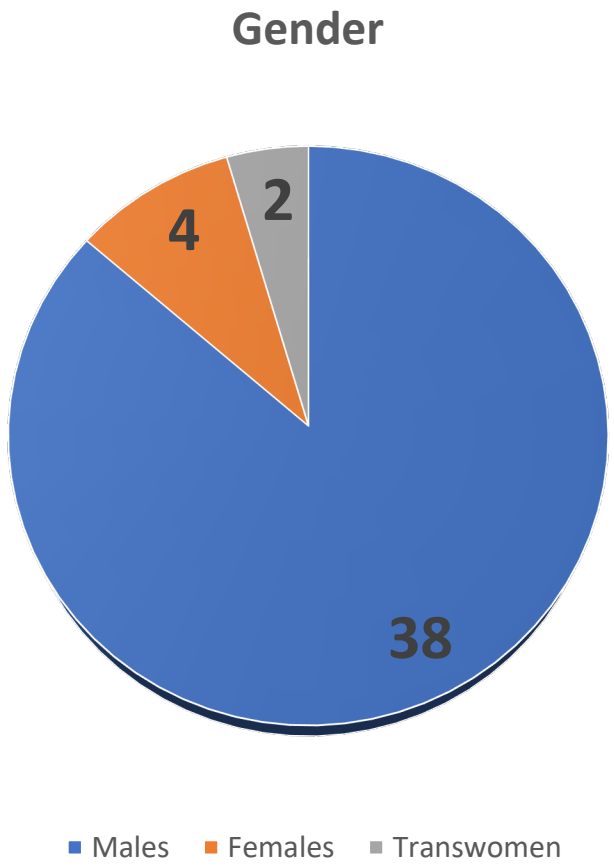
# Demographics of Youth with HIV

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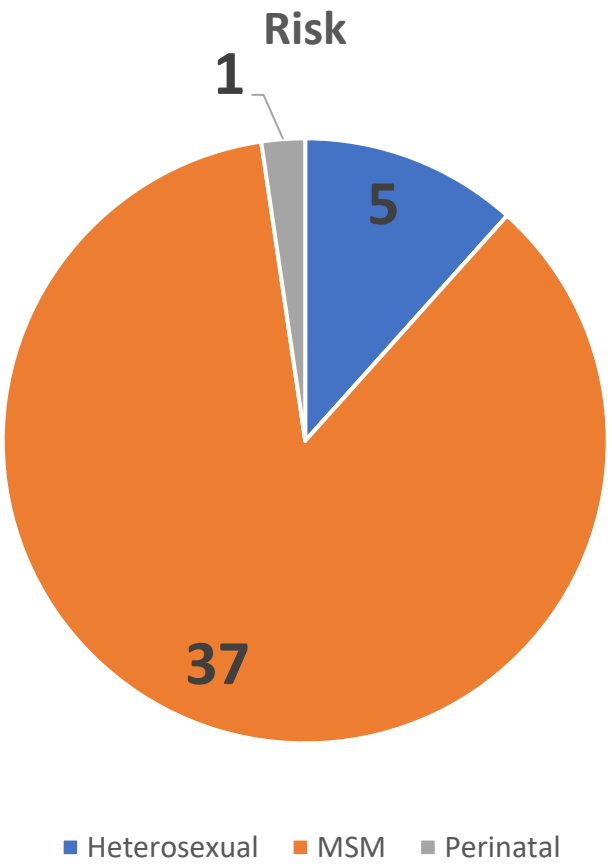
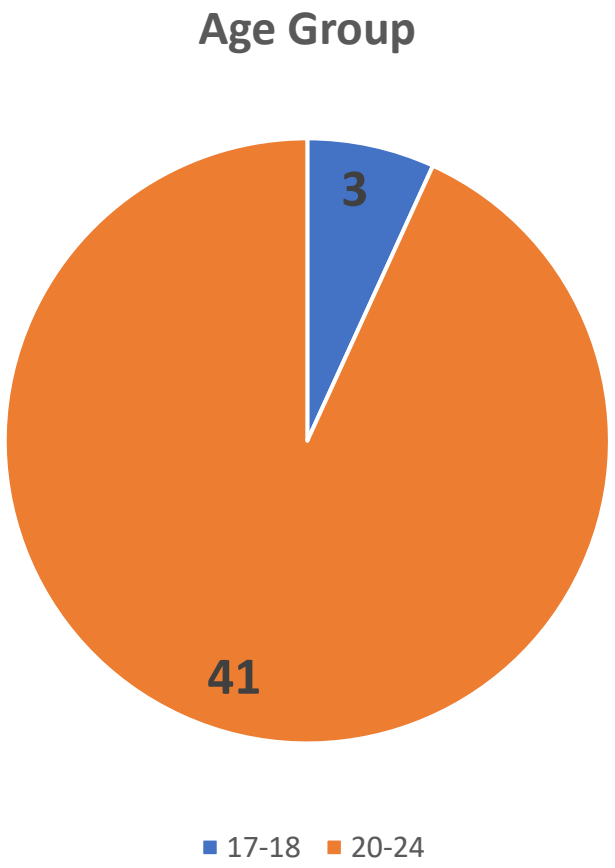
# Demographics of Youth with HIV, continue

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# Overview of Youth Services

- Wrap-around services
  - Integrated primary, HIV and behavioral health care and services
  - OB/GYN
  - Oral health care
  - Optometry with eyeglasses vouchers
  - 340B on-site pharmacy
  - On-site laboratory
- Transportation services: gas cards, rideshare, transit and bus passes
- Food bank services: grocery cards and nutritional supplements
- Emergency financial assistance: prescriptions, rental and utilities arrears, personal hygiene items, household cleaning supplies

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UC San Diego Health

# UCSD Mother Child Adolescent HIV Program




AJ Johnson, Intensive Case Manager

Joe Mora, Medical Case Manager

# UCSD Mother Child Adolescent HIV Program

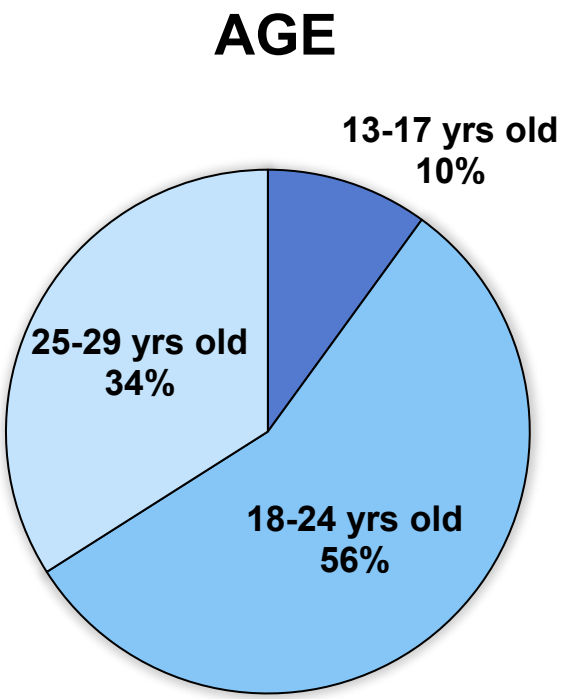
- Provide comprehensive integrated care and support services for pregnant people, women, infants, children, and youth living with and affected by HIV/AIDS.
- Established in 1989
- Serve San Diego County
- 2nd Most populous county in California
- San Diego-Tijuana transborder metropolitan area
- Large binational, refugee, and asylee population.

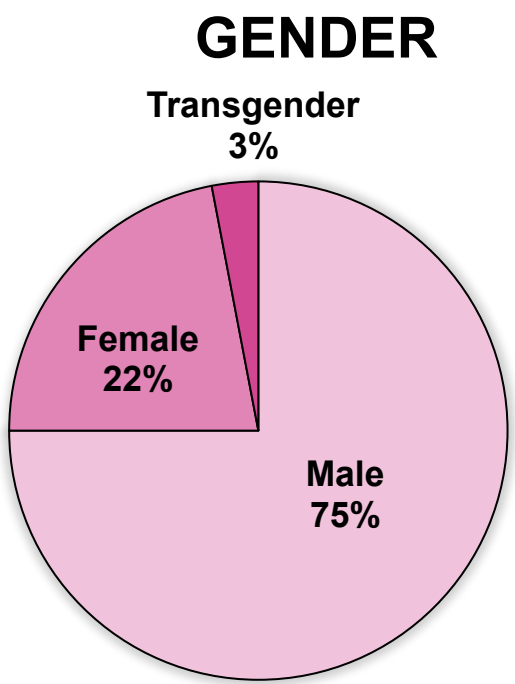


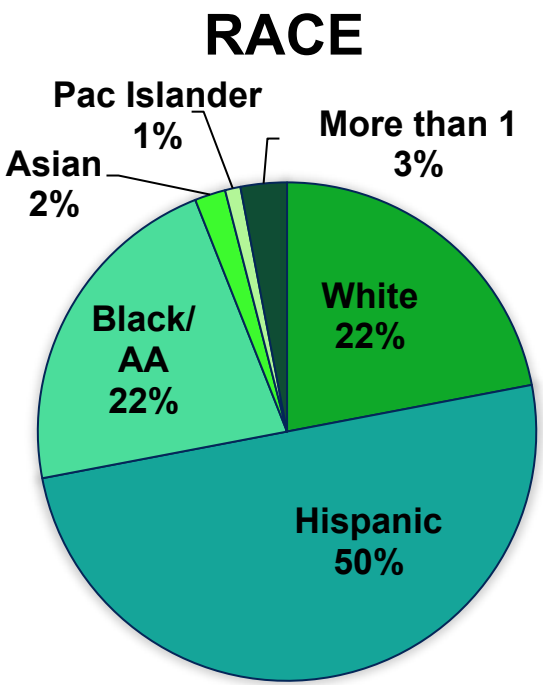

UC San Diego Health

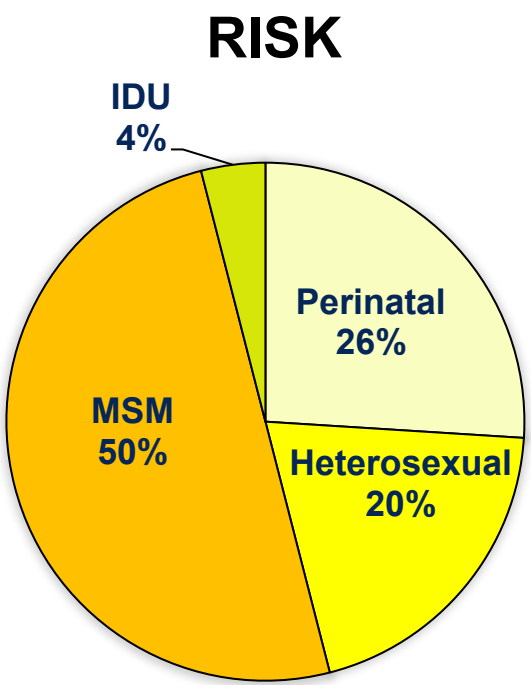
# Demographics

111 Clients served (January 2022 to present)



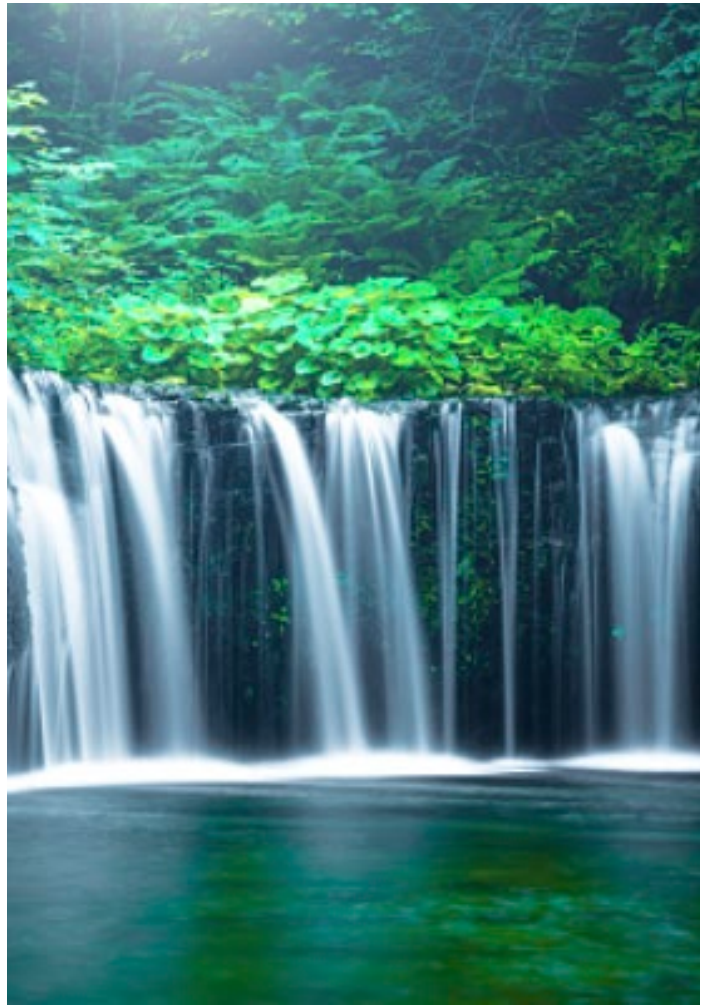



# Youth Program Services

- HIV primary care (physicians and nurse practitioner), including gender care services
- Specialty care coordination
- LGBTQIA+ affirming, gender responsive & trauma informed care
- Injectables - Medication assisted treatment (MAT) for substance use, HRT, CAB
- Rapid ART, Partner Services (Testing and PrEP linkage)
- Intensive case management (bilingual)
- Peer support
- Integrated substance use services
- Integrated psychiatry
- Bilingual Therapy, support groups, events
- Nutritionist
- Sexual health care & support
- Research opportunities

# Service Provision, Retention in Care & Reaching Viral Suppression

# Chatter-fall



What strategies have been most effective in retaining youth and achieving VLS?

Drop the response into the chat room but **don't post just yet**

On the count of "3" everyone will post at the same time

# Youth With HIV: Service Provision, Retention in Care and Viral Suppression

Tonya Green, MPH, ACRN

Southeast Mississippi Rural Health Initiative, Inc. (SEMRHI)

Hattiesburg, Mississippi

# Overview of Youth Services

- Wrap-around services
  - Integrated primary, HIV and behavioral health care and services
  - OB/GYN
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- Food bank services: grocery cards and nutritional supplements
- Emergency financial assistance: prescriptions, rental and utilities arrears, personal hygiene items, household cleaning supplies

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# Partners for Youth

- University of Mississippi: exposed infants and pediatric HIV care
- Mississippi State Department of Health (MSDH), Adolescent Health Program
  - Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services
- Family Planning
- First Steps (Early Intervention)
- STD/HIV Prevention
  - Rapid HIV testing in partnership with MSDH
  - SEMRHI is a PrEP/PEP provider

- Local and state-wide community-based organizations and resources:

1. HOPWA:
   - Long-term and short-term rental assistance
   - Non-medical case management services
2. Advocacy Services Coalition (ASC):
   - food pantry
   - transitional housing
   - ID cards
   - support groups
3. Youth Improvement Services for LGBTQ+ youth:
   - housing assistance
   - life skills training
   - career readiness

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# Provision of Youth Services

- Identify youth who are not virally suppressed and not retained in care on the daily huddle sheet
- Preconception counseling and sexual health addressed by providers and case managers on intake and during medical visits
- Identify social determinants of health and address them during face-to-face contact or phone contact with case managers (patient checklist)
- Health Literacy tools:
  - Bead Adherence tool
  - Teach Back tool
- Referrals to appropriate resources to address barriers, such as Behavioral Health and HOPWA
- Increase in staffing to render intensive medical case management and additional availability of medical appointments:
  - Hired an additional RN Case Manager and Linkage to Care Social Worker
  - Two contract ID physicians for rotating weekly clinic
  - Third contract ID physician started August 2023

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# Efforts for Retaining Youth in Care

- Utilization of daily huddle to identify youth who are not retained in care
- Intensive Case Management
- Immediate follow up with call or text message on date of missed appointment
- Identify and address social determinants of health (SDoH)
  - Housing referrals
  - Transportation assistance: use of rideshare (Lyft)
  - Grocery cards & food banks
- Behavioral Health referrals

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# Efforts to Reach and Support Viral Suppression

- Utilization of daily huddle to identify youth who are not virally suppressed
- Rapid ART Start
- Health Literacy Tools: Teach Back and Bead Adherence tools
- Identify and address social determinants of health (SDoH)
  - Housing referrals
  - Transportation assistance: use of rideshare (Lyft)
  - Grocery cards & food banks
- Intensive Case Management: patient checklist
- Behavioral Health referrals

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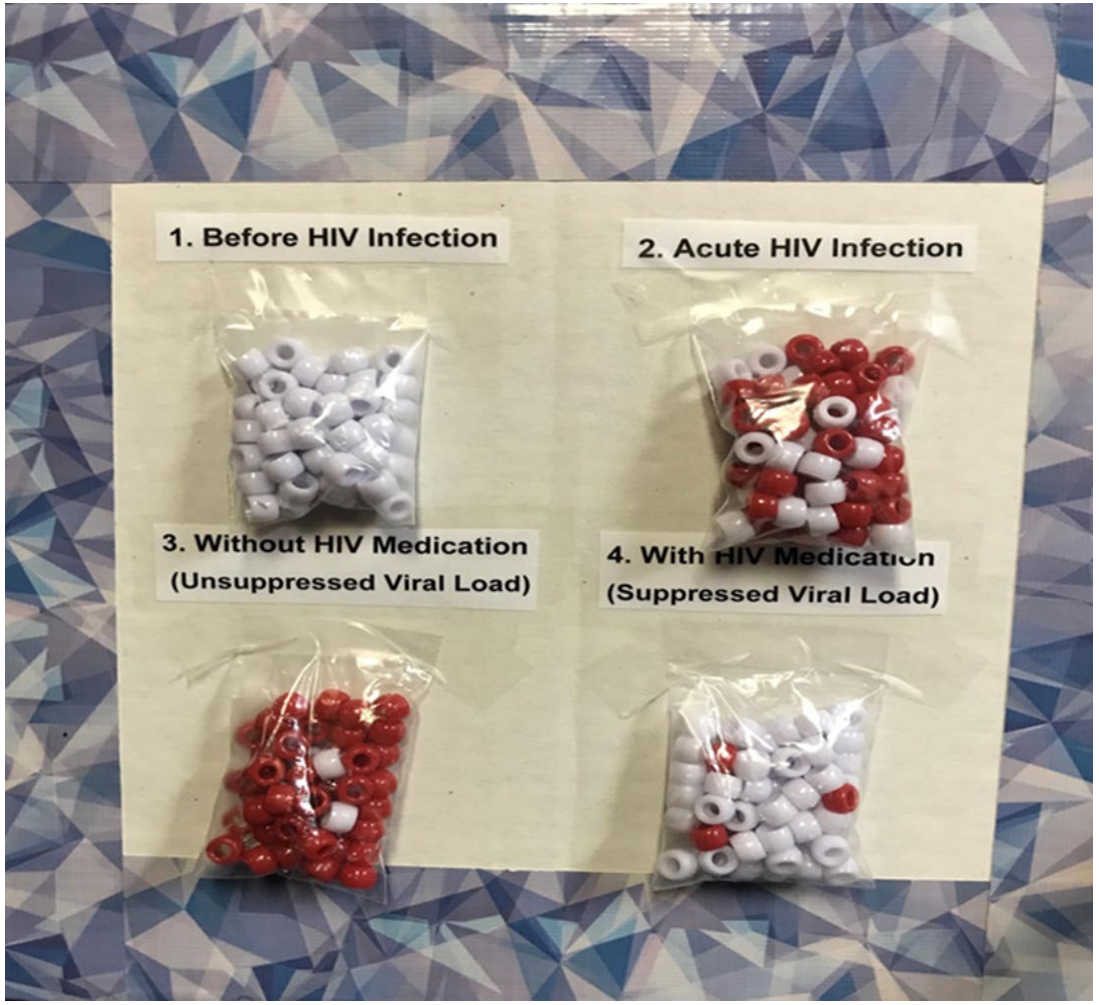
# Award-Winning Bead Adherence Tool




- Recipient of the National Quality Award: Center for Quality Improvement and Innovation (CQII) 2021 Award for Measurable Improvements in HIV Care to Mitigate HIV Disparities for improving the viral suppression rate for Youth with HIV
- Recognized as a Best Practice: https://targethiv.org/intervention/reaching-viral-suppression-youth-hiv?utm_source=bpURL

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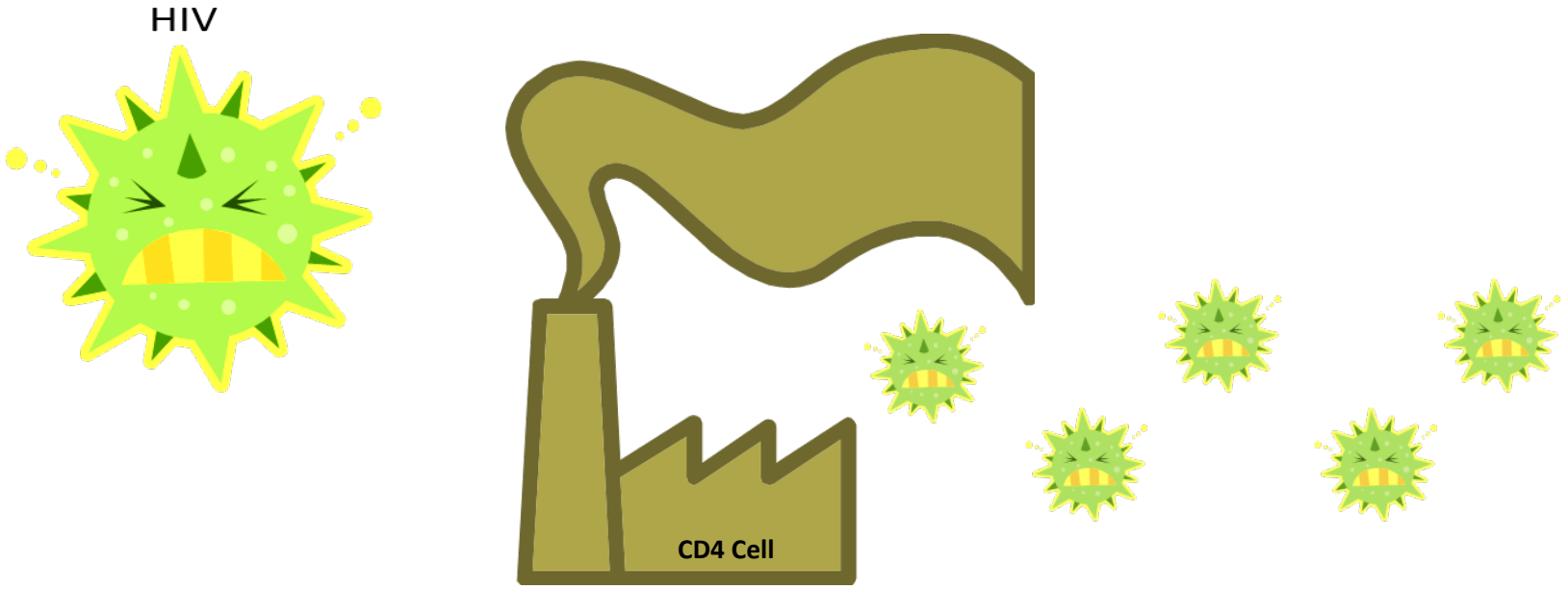
# Example of Health Literacy Tools: Teach Back Tool

Take **Your** HIV Medicine
On Time and Every Day

# The CD4 T cells in your body are your friends.

They are like a factory, making things that protect you from infection.

# Your HIV medicines stop that HIV factory!




It hijacks your good CD4 T  cells and turns them into an HIV factory.

Then you get a lot of HIV (a big Viral Load).

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# Patient Checklist

DATE: _____

NAME _____CASEMANAGER _____ MR# _____

DOB _____ AGE __ PROVIDER _____

BASELINE VIRAL LOAD _____ DATE _____

MOST RECENT VIRAL LOAD _____ DATE _____

ACUITY LEVEL: _____BASIC _____ INTENSIVE ____MODERATE _____PRN

CONTACT FREQUENCY _____ NEXT APPT _____

# OF MISSED APPTS IN PAST 12 MONTHS_____

ART REGIMEN: _____

DATE OF LAST CONTACT _____PHONE _____FACE-TO-FACE _____ OTHER_____

BARRIERS TO CARE _____

BARRIERS TO ART ADHERENCE _____

ART DOSAGE REMINDERS: ____ PILL BOX ____PHONE REMINDER ____OTHER _____

INTERVENTIONS USED:

- ____ BEAD ADHERENCE TEACH BACK TOOL
- ____ MOTIVATIONAL INTERVIEWING
- ____ MONTHLY CONTACT WITH PATIENT
- ____TEACHBACK TOOL (BOOK)
- ____OTHER _____

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# Helpful Tips

- **Meet the patients where they are**
- Offering wrap-around services to reduce barriers
- Multidisciplinary approach to engaging youth in care, leading to suppressed viral load
- Warm handoff to behavioral health staff
- Intensive case management
- Bead adherence tool (visual tool/maturity level)
- Referrals that are youth friendly and culturally competent for the LGBTQ+ youth population
- Utilize preferred method of communication: text messaging, patient portal, etc.
- Applaud small wins

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# Questions

# Youth Resources – Service Provision and Viral Suppression

**Reaching Viral Suppression in Youth with HIV-** Southeast Mississippi Rural Health Initiative, Inc., a network of community health centers serving Southern Mississippi, uses **data-driven quality improvement techniques** to identify youth who are not virally suppressed or have missed appointments. Medical case managers use a client checklist to identify and address barriers to antiretroviral therapy (ART) and medical care adherence. They also use a health literacy visual illustration tool to help youth understand the effects of ART on viral suppression. The intervention strategy was successful in improving viral suppression rates for youth. *Resource from the RWHAP Best Practices Compilation updated on 04/10/2023.*

**U=U Educational Initiative for Youth –** University of North Carolina implemented U = U **educational initiative** with young clients 18-24, both new and existing, via education during clinic visits, educational materials, and social media. Viral suppression steadily increased from 80% (40/50) in June 2018 to 84.8% (39/46) in June 2019. *Resource updated 05/06/2022*

# Youth Resources – Service Provision and Viral Suppression

**Positive Peers Mobile App -** MetroHealth System developed the Positive Peers **mobile app** in collaboration with a youth community advisory group. It **motivates youth** and young adults with HIV to stay engaged in HIV care through self-management tools and virtual support. Although specific outcomes vary by age group, individuals who used the app were more likely to attend their medical appointments, receive labs, and reach viral suppression. *Resource from the RWHAP Best Practices Compilation updated on 07/12/20*

**Positively Connected for Health (PC4H) -** The PC4H initiative employs a **mobile app** and a **digital literacy workshop** to improve engagement, retention in care, and medication adherence for young people with HIV. These strategies aim to reach young people who are disproportionately affected by HIV, including young men who have sex with men, young transgender women, and youth of color, with a focus on serving people who know their status but are inconsistently engaged in care. Developed by Children's Hospital of Philadelphia and Philadelphia FIGHT, PC4H was evaluated through the RWHAP Part F SPNS Social Media Initiative. The evaluation found that PC4H had positive impacts on retention in care and viral suppression. *Resource from the RWHAP Best Practices Compilation updated on 05/10/2023*

# Youth Resources – Service Provision and Viral Suppression

**Text Messaging Intervention to Improve Antiretroviral Adherence among HIV-Positive Youth: E2i -** The **Text Messaging Intervention** to Improve Antiretroviral Adherence among HIV-Positive Youth (TXTXT) is designed to keep young people, particularly young, Black, gay, bisexual, same-gender loving, and other men who have sex with men, engaged in HIV medical care, by delivering **personalized, daily, interactive text messages** that remind them to take their antiretroviral therapy as prescribed. Two sites implemented TXTXT as part of E2i, an initiative funded by the RWHAP Part F SPNS program from 2017–2021. The intervention resulted in a statistically significant improvement in engagement in HIV care. *Resource from the RWHAP Best Practices Compilation updated on 05/04/2023.*

**Positive Affirmations for Youth: App Messages to Support Adherence –** Boston Medical Center offers **personalized positive affirmations** to support adherence sent to youth (13-24 years), via the Care+ app. *Resource updated 07/27/2020.*

# Additional Resources on Serving Youth

**Building Futures: Supporting Youth Living with HIV Technical Assistance Toolkit -** This resource serves as a toolkit focused on activities agencies can undertake to enhance delivery of HIV care to youth living with HIV. *Resource updated 05/18/2021*

**Project ACCEPT -** is designed to improve engagement and retention in medical care for youth **ages 13 to 24** years with newly diagnosed HIV. The educational and skill-building intervention was deployed at four demonstration sites (*Chicago, Detroit, Memphis, and Miami)* and increased rates of medication use and appointment adherence in comparison to a control group. An Implementation Guide is available. *December 2021*

# Transitioning Youth to Adult Care


**Q1. At what age do most of your youth clients transition to adult care?**

**Q2. If your youth clients do transition, do they go to a youth program then to adult program or directly to an adult program?**

UC San Diego Health

# UCSD Mother Child Adolescent HIV Program

## TRANSITION TO ADULT CARE

September 7, 2023

AJ Johnson, Intensive Case Manager

Joe Mora, Medical Case Manager

# Youth Program Services

- HIV primary care (physicians and nurse practitioner), including gender care services
- Specialty care coordination
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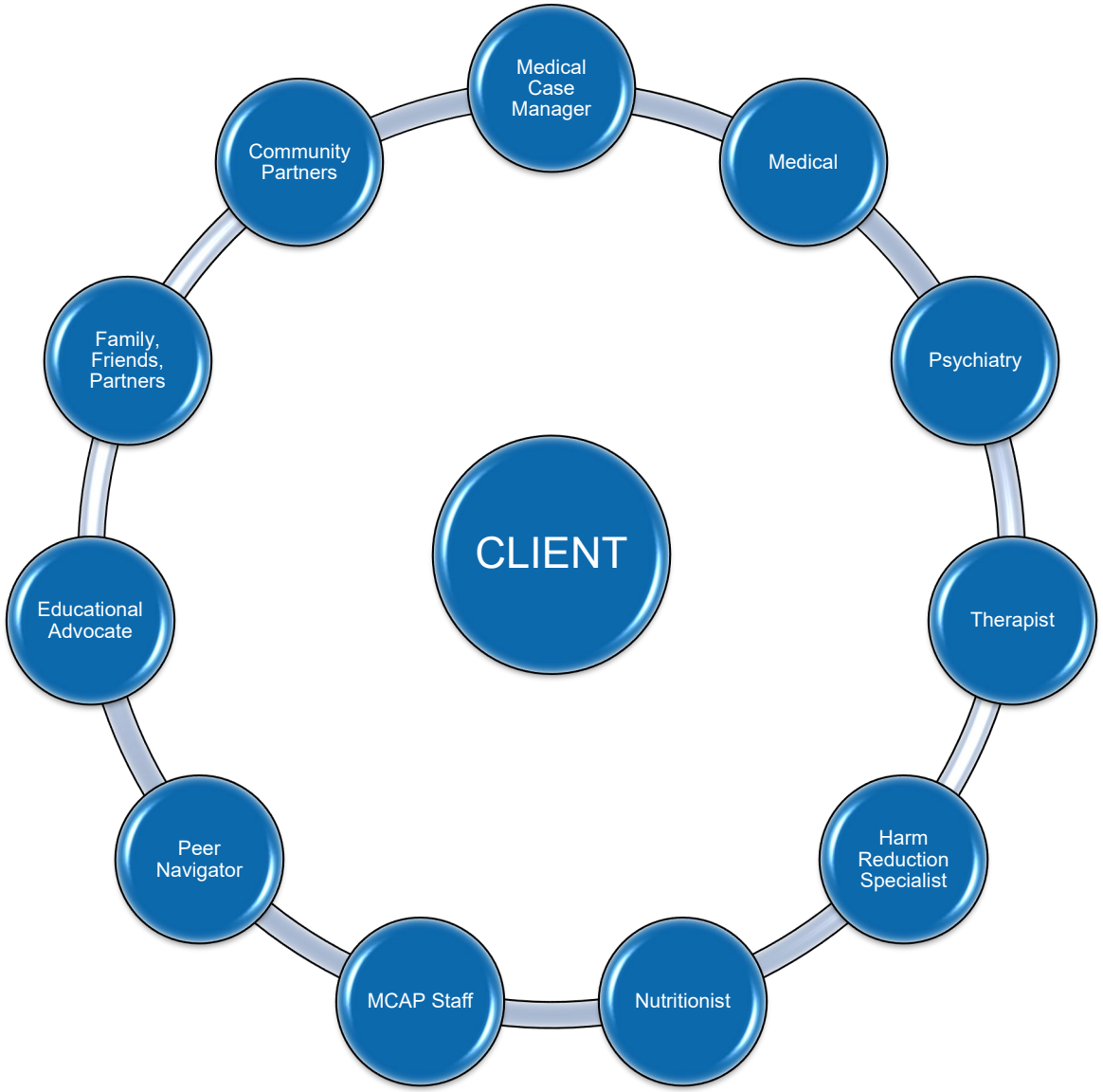
- Injectables - Medication assisted treatment (MAT) for substance use, HRT, CAB
- Rapid ART, Partner Services (Testing and PrEP linkage)
- Intensive case management (bilingual)
- Peer support
- Integrated substance use services
- Integrated psychiatry
- Bilingual Therapy, support groups, events
- Nutritionist
- Sexual health care & support
- Research opportunities

# Network Structure






UC San Diego Health

## Community Partners

- Community Health Clinics and case management agencies *(VCC, FHCSD, SYHC)*
- University Student Health Clinics *(UCSD, SDSU, Community Colleges)*
- Inpatient/Outpatient recovery programs *(Stepping Stone, Choices in Recovery)*
- Housing (Townspeople, Section 8, HOPWA, Affordable Housing, Transitional, Shelters)
- Employment & Vocational programs *(Employment Solutions, JobCorps, Dept of Rehab)*
- Legal/Criminal Justice *(Courts, Immigration, Public Defenders, Probation/Parole Officers)*
- Education (Universities, Community Colleges, Adult Ed, High Schools, IEP, SDSS)

# Opportunities for Collaboration

- Leverage diverse skills and experience.
- Develop a common language.
- Gain higher level insight.
- Challenge, discover, and innovate.

# Transition Planning

- Transition planning/education begins upon entry into care/youth program.
- Youth play a central role in transition planning.
- Discussion and planning of transferring care begins 6-12 months prior to turning 25 and/or when developmentally indicated.
- Review Transition Checklist.
- Selection of transition clinic/provider.
- Selection of case management site (*if needed*).
- Transition plan is integrated into case management Care Plan.

# Transition Checklist

**UCSD MCAP Transition Checklist**

**Name:** **DOB:** **MRN:**

**Date of Diagnosis:** **Projected Transition Date:**

**Completed by:** **Date:**

| TRANSITION | Discussed | Achieved | Date of Review |
|---|---|---|---|
| Is able to explain transition process, options & timeline & list steps to a successful transition. | | | |
| Able to identify the aspects of health care most important to them, evaluate care & self-advocate. | | | |
| Able to articulate concerns about transition. | | | |
| Linked to peer navigation. | | | |
| Has identified an adult care provider/clinic. | | | |
| Has visited adult clinic(s). | | | |
| Transferred records to new provider. | | | |
| Is able to access & use MyChart. | | | |
| Is provided discharge summary at each visit & is able to understand it. | | | |
| Set up intake appointment at adult clinic. | | | |
| Has current health care & prescription coverage to avoid gaps in service upon transition. | | | |
| Has identified agencies to obtain supportive services previously obtained at MCAP. | | | |
| Can identify resources for assistance with medical coverage & ADAP. | | | |
| Has been linked with an adult case manager if needed & eligible. | | | |
| Attended first appt with adult provider. | | | |
| **Comments:** | | | |

# Transition Plan

Patient Transition Plan
UCSD Mother Child Adolescent Program

Completed by: _____ on ___ / ___ / ___

**[Name]** _____

**[Projected Transition Date]** ___ / ___ / ___ **[Medical Visits Remaining]** ___ **[Case Mgmt Remaining]** _____

**[Provider]** ☐ Lisa Stangl, NP ☐ Jennifer Blanchard, MD ☐ Jill Blumenthal, MD

**[Case Manager]** ☐ AJ ☐ Joe ☐ Maria ☐ Nicole

Reason for transfer: _____

HOUSING:

EDUCATION & EMPLOYMENT:

SUBSTANCE USE:

MENTAL HEALTH:

SUPPORT SYSTEM:

CLIENT STRENGTHS & BARRIERS:

FUNDING: ☐ Ryan White ☐ ADAP ☐ Medi-Cal ☐ Medicare ☐ Private/Group ☐ SSI/SSDI ☐ State Disability ☐ Food stamps
☐ Rental Assistance: _____ ☐ Other: _____

TRANSITION PLAN:
☐ Discussed transition with client (including plan, options, timeline, process, concerns, etc.)
☐ Provided information about transition options; discussed what's important to client in choosing a provider
☐ Completed transition checklist
☐ Visit new clinic with client or attend first appt. with client

Medical records provided to: ☐ patient ___ / ___ / ___ ☐ provider ___ / ___ / ___
Health Maintenance Record provided to: ☐ patient ___ / ___ / ___ ☐ provider ___ / ___ / ___

Client plans to transition to:
☐ UCSD Owen ☐ Vista Community Clinic ☐ Neighborhood Health Care ☐ Other: _____
☐ FHCSD ☐ NCHS San Marcos Health Center ☐ Alpine / Mountain Health
☐ CASA SYHC ☐ NCHS Oceanside Health Center ☐ Our Place (Euclid) SYHC
New Provider Name & Contact: _____ Release ☐ Yes ☐ No
First Appt: ___ / ___ / ___ @ ___:___ AM/PM Attended? ☐ Yes ☐ No

Client needs the following supportive services:
☐ Housing ☐ Mental Health ☐ Case Management ☐ Substance Use ☐ Support Groups ☐ Transportation ☐ Employment
☐ Entitlements (e.g. ADAP, Ryan White, Medi-Cal, SSI, etc.) ☐ Other: _____
Referred to: _____

New Case Manager Name & Contact: _____ ☐ N/A; Release ☐ Yes ☐ No

Case Closed: ___ / ___ / ___ Completed Evaluation: ☐ 3 MO ☐ 6 MO ☐ 12 MO

# Transfer of Care

- Youth are informed and involved in the transfer of care and medical information.
- Walk Through of Clinic or Clinic Visit
- Review of medical information with patient (*Health Maintenance Record*).
- Communication and coordination between youth and adult providers.
- Last Clinic Visit - Introduction to Peer Navigator
- Attend First Clinic Visit with Client (if requested)

# Health Maintenance Record Example

**Health Maintenance Record**
UCSD Mother Child Adolescent HIV Program
4076 3rd Avenue #301, San Diego, CA 92103
(619) 543-8089 phone / (619) 298-2698 fax

**Patient: John Smith**
**DOB: 7/29/1998 SSN: 123-45-6789 MRN: 2111111-0**
Contact: (619) 555-5555 cell
123 Ocean Street #10, San Diego 92103

**Case Manager**: Joe Mora, MS / (858) 534-9255, UCSD MCAP
**Nurse Practitioner**: Lisa Stangl / (619) 543-8089 UCSD MCAP
**Physician**: Dr. Jennifer Blanchard, UCSD MCAP
**Psychiatrist**: Dr. David Grelotti, UCSD MCAP

**Date of Diagnosis**: 1/1/20 Risk: ☒ MSM **Last MCAP Primary Care Visit**: 6/8/23

**LABS**

| | Date | CD4 | VL |
|---|---|---|---|
| 1st labs | 3/31/20 | 423 (26%) | 2216 |
| **Lowest CD4** | 5/6/21 | 251 (23%) | 1621 |
| **Highest VL** | 3/31/20 | 423 (26%) | 2216 |
| Recent | 6/8/23 | 455 (45%) | <40 |
| Recent | 3/4/23 | 495 (38%) | <40 |
| Recent | 12/13/22 | 451 (41%) | <40 |
| Geno/Pheno | 1/2020 | Notes: pan sensitive | |

**IMMUNIZATIONS**

| Type | Date |
|---|---|
| Flu | 10/27/22 |
| Pneumovax | 4/8/20 |
| Twinrix | 7/15/20, 10/14/20, 1/27/21 |
| Tdap | 4/8/20 |
| Hep A IgG | 4/21/20 POSITIVE |
| Hep B anti-HBs | 4/10/20 POSITIVE |

**STIs & Hepatitis:**

| Type | Date | Result |
|---|---|---|
| HSV | 3/31/23 | NEG |
| Gonorrhea | 6/8/23 (3 SITE) | NEG |
| Syphilis | 6/8/23 | NR |
| Chlamydia | 6/8/23 (3 SITE) | NEG |
| HCV | 7/28/22 | NEG |

Last Pap: 7/28/10 ASCUS
Last PPD: 3/4/23 NEG

**MEDICATION :** Wellbutrin (1/1/20); Biktarvy (4/15/21); Atripla (d/c April 2021 due to CNS side effects) Allergies: ☒ NKA

**Other Medical Issues**: Panic/anxiety, h/o depression, high blood pressure
**Medical Summary**: ARV adherent, medically stable

**PSYCHOSOCIAL:** H/o substance use currently in remission. Receiving mental health services at The Center. H/o complex trauma. Currently taking Wellbutrin for panic, anxiety & mood, med managed by Dr. Grelotti. Lives with friend, but would like to establish own housing. Townspeople intake submitted 4/18/23 for housing assistance. Last dental visit 2 yrs ago, referred to Hillcrest Dental. Ryan White active through 2/2024. ADAP active through 2/1/24. Medi-Cal application pending. SSI app pending with Disability Help Center.

**Completed 6/14/23 by Joe Mora, MS & Lisa Stangl, NP**

# Transition Completion

- Confirming transition completion.
- Providing consultation (as needed).
- Assessing transition experience.
- Check-In with client at 3 month, 6 month, 12 months (beyond that on a case-by-case basis).

# Lessons Learned

- Developmental based transition appropriate for some clients.
- Providing education and consultation to community partners on working with youth.
- Regular assessment of transition process.
- Providing care in a youth affirming adult care setting has been helpful.

# Questions

# Youth Resources - Transitioning to Adult Care

**Transition HIV+ Youth from Adolescent to Adult Services: Adolescent Provider Toolkit - Toolkit** for implementing a program to support HIV-positive youth transitioning from adolescent to adult HIV care. Targethiv.org *resource updated 07/15/2022*

**Moving on Positively: A Guide for Youth, Caregivers and Providers –** Next Step and Mass CARE created a guidebook for multiple audiences that **outlines steps for transitioning youth** from pediatric care to adult services. *Resource updated 04/06/2022*

# Questions

# Youth Resources - Outreach

**Project CONNECT: E2i -** Uses linkage coordinators to effectively engage people in HIV medical care. It focuses on people with newly diagnosed HIV or people with HIV who are transferring their care or have been out of care. AIDS Taskforce of Greater Cleveland implemented Project CONNECT to support **young adults ages 18-29 years** and Black MSM and bisexual men as part of E2i, an initiative funded by the RWHAP Part F SPNS program from 2017–2021. Project CONNECT was successful in increasing the number of clients retained in HIV care and who reached viral suppression. *Resource from the RWHAP Best Practices Compilation updated on 05/04/2023.*

**Peer Engagement to Improve Linkage to Care and Retention in Care for Women and Youth -** University Health (TX) uses peers and patient navigators to provide support, reduce barriers, and improve linkage and retention to care for women and **youth with HIV**. Two peers with lived experience were hired as Outreach Specialists to spearhead the program, encourage medication adherence and use of services, and provide mentoring. The intervention was successful in moderately improving the numbers of clients linked to care, retained in care, and virally suppressed. *Resource from the RWHAP Best Practices Compilation updated on 03/15/2023*

# Outreach to youth with HIV not in care

**SPNS Social Media Initiative Demonstration Site Resources** - Various apps were developed by demonstration sites funded under the Use of Social Media to Improve Engagement, Retention, and Health Outcomes along the HIV Care Continuum project. The initiative focused on use of social and digital media methods to engage youth with HIV in primary care and supportive services.

*Several of these social media tools have been catalogued in the Best Practices Compilation of evidence-based HIV interventions. See also the full collection of the SPNS Social Media Initiative Demonstration Site Resources, with monographs, intervention manuals, and summaries on apps (and text messaging methods).*

# RWHAP Part D WICY Basic Training Program

# Next WICY Training

**When:** Winter 2023

**What:** Quality Management

# Feedback


1. How was the length of the session?
2. How useful was the information presented?
3. What additional topics would you like addressed as part of the WICY Training series?

# Contact Us

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# See you in the next session!

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