



ENGAGING YOUTH IN CARE

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Ryan White HIV/AIDS Program Grantee Meeting
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**Grady Health System
Infectious Disease Program
Atlanta, GA**

- 4,711 total clients served in 2007
- Ryan White Parts A, B and D



275 HIV+ Youth (13-24 y.o.)

- Race/Ethnicity:
 - 237 (86.2%) Black/African American (not Hispanic)
 - 13 (4.7%) White (not Hispanic)
 - 12 (4.4%) Hispanic
 - 2 (7%) Asian
 - 1 (3.5%) American Indian/Alaskan Native
 - 10 (3.6%) More than one race/unreported

275 HIV+ Youth (13-24 y.o.)

- Gender
 - Male: 148 (53.8%)
 - Female: 127 (46.2%)
- Exposure Category
 - Perinatal: 118 (43%)
 - MSM: 67 (24.5%)
 - Heterosexual: 58 (21.1%)
 - IDU: 1 (0.36%)
 - MSM & IDU: 1 (0.36%)
 - Transfusion: 1 (0.36%)
 - Other/unknown 29 (10.5%)

IDP Services

- Ambulatory/Outpatient Care
 - Family Clinic (Women, Infants, Children, Youth)
 - Adult Men's Clinic
- Radiology
- Laboratory
- Pharmacy
- Subspecialty care (oncology, neurology, dermatology, etc.)
- Direct admissions from clinic to hospital ward

IDP Services (cont.)

- Mental Health/Substance Abuse Services
- Oral Health Services
- Nutrition
 - Adult
 - Pediatric (including WIC)
- Medical Social Workers/Case Managers
- Partner agencies on-site:
 - Project Open Hand Food Pantry
 - AIDS Legal Project Counseling
 - Living Room - Housing placement

“Teen Team”

- MDs, Nurse Practitioners, Nurse Educator, Charge Nurse
- Child Psychologist
- Medical Social Workers
- Nutritionist
- Peer Counselors



Typical Perinatally-Infected Youth

- Care starts at childhood diagnosis or late discovery of perinatal exposure
- Adherence decreases during adolescence
- Family support until mid teens and then noticeably reduced
- Takes advantage of social support system within clinic (camps, etc.)

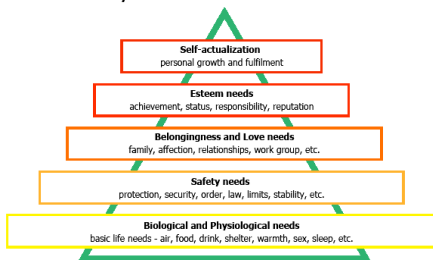
Typical Perinatally-Infected Youth (cont.)

- More open to mental health services (individual, family and group counseling)
- Periodically falls out of care in late teens; less likely to call to “check in” with SW
- Medical complications from long-term HAART (i.e. renal and/or GI complications); more specialty referrals

Typical Non-Perinatally-Infected Youth

- Delays/resists entry to initial care upon diagnosis (stigma and coping issues)
- Less parent/family involvement/support at beginning
- Resistant to mental health services
- Periodically falls out of care but keeps in touch with SW
- Medical complications related to untreated HIV (more OIs)

Maslow's Hierarchy of Needs



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Strategies to Engage Youth in Care

A. Intensive Case Management for all older teens

- One assigned Medical Social Worker
 - Centralized case management model in Atlanta discourages duplication of services and eliminates confusion
 - Located on-site in clinic; collaborates with medical providers
 - Has routine, regular contact with client to address holistic needs regardless of current level of "need"

Strategies to Engage Youth in Care (cont.)

B. Appointment reminder calls

C. Support group/individual mental health services provided on the same day as medical appointments

D. Trained Peer Counselors available on Teen Clinic days

Strategies to Engage Youth in Care (cont.)

F. Extensive Education Plan in 11 Areas:

1. Continuing your education
2. Employment/career planning
3. Housing resources/options
4. Financial literacy
5. Alternative transportation options
6. Ryan White/ADAP/insurance programs

Strategies to Engage Youth in Care (cont.)


- 7. Legal resources
- 8. State/federal resource programs
- 9. Community resources (financial assistance, etc.)
- 10. Mental health resources (including developmental assessments, individual and group counseling)
- 11. Comprehensive medical resources (reinforce adherence, medical compliance, oral hygiene, etc.)

Disease Self-Management Concepts and Strategies

- Upon completion of the 11 educational components, case is reviewed through case staffing to determine if client is ready to take over his/her own care with reduced/minimal intervention from Case Manager
- Case Manager remains in touch and available to "self-managed" clients to address intermediate needs or changes requiring more intervention


Disease Self-Management Concepts and Strategies (cont.)

- On-going teen support group participation is encouraged
- Participation in Family Clinic's Community Advisory Board is encouraged
- Extensive services available on-site are convenient and serve as incentives



Transitioning to Adult Care

- At 21, clients transitioned to adult care (children's hospital age limit is 21)
- Specific adult providers identified for male and female clients
 - Females remain in Family Clinic under care of adult providers
 - Males referred downstairs to Adult Clinic
- Case Managers remain with client until age 24 (Part D adolescent age limit) to facilitate transition; then reassigned to AID Atlanta CM



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