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# Community Planning for HIV/AIDS Health Services System Transformation

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## ABSTRACT

*HIV is a public health concern. Duval County schools Youth Risk Behavior Surveillance data on middle and high school students for 2013 reveal high-risk sexual activity; yet, one in five received no formal instructions about HIV/AIDS. Knowing one's HIV status is pivotal for HIV prevention and treatment. HIV positive youth who seek treatment, and achieve viral suppression have optimal health outcomes and are less infectious. Northeast Florida joins the national initiative to reduce HIV infection. The City of Jacksonville, Ryan White Part-A Program, Florida Department of Health-Duval, and local HIV/AIDS organizations convened a Youth Summit. Conversations focused on how HIV prevention and treatment may integrate for seamless access and transition of youth into services. Six open-ended questions guided the summit. Three eight-member, moderated focus groups explored answers to two questions during one hour. From a healthcare access barriers perspective, structural and cognitive opportunities exist for health system integration. Almost twice as many solution strategies emerged for barriers to care and prevention-and-treatment attrition factors, compared to gaps in prevention, treatment, and health education. The Youth Summit is a first step in the journey toward a seamlessly integrated youth and adult HIV prevention, treatment, and health education system.*
*Florida Public Health Review, 2017; 14, 13-21.*

## BACKGROUND

The Jacksonville Chapter of the Florida Department of Health, Integrated HIV Prevention, and Care Plan 2017-2021 states that the health of youth and young adults is a local priority (unpublished). However, health disparities related to race, gender, sexual orientation, and age exist in the populations most impacted by the HIV epidemic in Duval County – namely, African-American men and women. The National HIV/AIDS Strategy 2020 identifies youth, ages 13 – 24 as a key population, noting the particularly high burden of HIV among young black gay and bisexual men (https://www.aids.gov/federal-resources/national-hiv-aids-strategy/nhas-update.pdf). The Jacksonville system of HIV prevention and care has many agencies, medical clinics, and community-based organizations in place to provide HIV prevention and care services, but few specialize in services for youth. Youth experience multiple challenges that affect their ability to access and retain in HIV prevention, support services, and medical care. The Jacksonville adult-oriented, HIV care system requires adaptations to support optimal linkage, care engagement, and retention of youth in HIV prevention and HIV Continuum of Care activities (Reisner et al., 2009) to support the health of HIV infected youth and young adults.

### Purpose

In Florida, HIV affects a significant number of today's youth. Data on the prevalence of HIV and AIDS among adolescents (ages 13-19) and young adults (20-24 years) tell a compelling story. According to Florida Department of Health, in 2014, persons under the age of 25 years accounted for 16% of all newly reported cases of HIV infections (http://www.floridahealth.gov/diseases-and-conditions/aids/surveillance/_documents/fact-sheet/2014/2014-adolescents-and-young-adults-fact-sheet.pdf). In Florida Partnership 4, a title for Baker, Clay, Duval, Nassau, and St John's counties, the year 2014 data showed that youth and young adults comprised 16% of the general population; 6% of all AIDS cases, but 16.5% of all HIV cases (http://www.floridahealth.gov/diseases-and-conditions/aids/surveillance/epi-profiles/2014/part-04-1314b.pdf). The knowledge of youth perceived invulnerability, risk-taking, peer influence, and experimentation during their developmental trajectory, makes it hard for public health and health services professionals to dismiss these prevalence

rates as a way of life when they indicate the need for community-wide, public health action.

Youth comprise an important segment of the public. Therefore, Partnership 4 health and social community leaders recognize the need to engage youth in dialog about how the system of HIV prevention and treatment should be modeled to make it inclusive of and responsive to the needs of at-risk and infected youth. Consequently, the University of Florida Center for HIV/AIDS Research, Education, and Services approached the City of Jacksonville Social Services Division, Ryan White HIV/AIDS Part A Program Manager to mobilize community partners such as Florida Department of Health in Duval County, and other community stakeholders for hosting an all-day Youth Summit. On July 19, 2016, the City of Jacksonville hosted its first community-wide Youth Summit to convene program and services providers to focus on the health and wellness of youth as it relates to HIV and STIs including education, prevention, early intervention, and treatment services. The Summit focused on three important areas: (1) the needs of HIV positive youth; (2) youth at-risk of HIV infection; and (3) limitations of the current, adult-oriented HIV system of care. Participants reviewed year 2014 Area 4 HIV Epidemiology of Youth and year 2015 Youth Risk Behavior Survey Data, followed by a presentation of best practices currently in place in the area for reaching and providing culturally responsive, youth-centric HIV prevention, linkage and integrated services. Summit participants heard perspectives on the impact of HIV from a panel of four youth, and then were asked to address six, formative questions. Each question had a stem that read – as it relates to HIV and STIs, including education, prevention, early intervention, and treatment services for youth:

- What are the barriers that keep youth from accessing prevention and treatment services?
- What can we do to eliminate or reduce barriers, if they exist?
- What causes youth to fall out of prevention and treatment services?
- What can we do to keep youth in care, after enrollment?
- What are the gaps in education, prevention, and treatment services?
- What can we do to close gaps, if they exist?

The questions guiding the Youth Summit owe their existence to the "…people centered, Ground/Bottom Up model. This model is about solving problems in communities by focusing on where the basic needs of the people are paramount. It... directly consults with the people in the communities" (http://groundbottomupmodeltt.com/index.html). However, unlike the natural sciences, where a logical positivist approach seeks causal explanations, the aim here is comprehension of phenomena. Local experience and programmatic data suggest that the questions posed are relevant for improving the system of HIV/AIDS care in Partnership 4. To illustrate the hypothesized value of the summit's questions, Figure 1 provides a framework that links the summit's formative questions to two salient, health care phenomena: dropping out of care and poor linkage to prevention and treatment services.

Figure 1 has two antecedent conditions: barriers to youth engagement in HIV prevention and treatment services, and existing gaps in Partnership 4 HIV prevention and treatment services. Local prevention and treatment network professionals assume that together, the antecedent conditions contribute to prevention and treatment avoidance and attrition factors. When this triadic state exists, there are missed opportunities for HIV testing, poor linkages to education, prevention, and treatment services, and attrition of clients formerly linked to HIV care. Hence, the local community wants to understand the issues as the first step toward system change.

**METHODS**

Community representatives met and planned the Partnership 4 Youth Summit. Participants included City of Jacksonville Social Services Division, University of Florida Center for HIV/AIDS Research, Education, and Services (UF CARES), Florida Department of Health (FDOH) in Duval County, Northeast Florida AIDS Network (NFAN), and Jacksonville Area Sexual Minority Youth Network (JASMYN). In a series of seven meetings, participants reviewed pertinent sections of the National HIV/AIDS Strategy Goals, the area's emerging Integrated HIV Prevention and Care Plan—2017-2021, City of Jacksonville Early Identification of Individuals with HIV/AIDS (EIIHA) goals and objectives, and a review of the literature on youth-focused HIV-care. These inputs set the stage for agenda development, which sequenced content and time limits so that the progression of events might set the stage for focus group discussions. There were seven assigned tasks. Core assignments included: (1) identification of individuals to be invited, with a focus on identifying youth services providers who provide HIV/STD or pregnancy prevention programs or testing / clinic services; (2) contacting and confirming guest speakers; (3) setting the agenda; (4) selecting questions to be asked in the breakout sessions; and (5) reserving a venue. Auxiliary assignments included: (1) inviting and confirming stakeholders; (2) arranging for meals, parking, and event security; (3) collating the power point presentations into one seamless presentation; (4) duplicating copies of event materials; and (5)

## Figure 1: Two Healthcare Systems Phenomena

Barriers to Youth Engagement in Prevention & Treatment Services

Existing Gaps in Jacksonville, FL HIV Prevention & Treatment Services

Prevention & Treatment Avoidance & Attrition Factors

Lost-to-Care (Dropping Out of Care)

Poor Linkage to Prevention & Treatment

## Figure 2: Frieda Saraga's Cognitive Wellness Model

Programmatic Emphasis on Self-Respect

Cyclical & Interactive Process

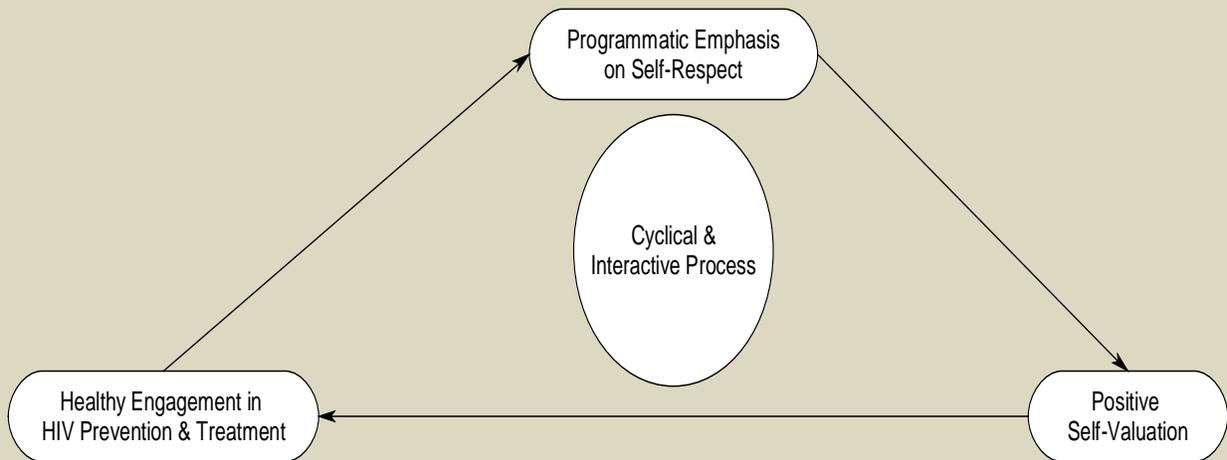Healthy Engagement in HIV Prevention & Treatment

Positive Self-Valuation

**Table 1**
**Themes Extracted from Group A Focus Group Discussion**

| Prevention & Treatment Barriers | Ideas to Eliminate/Reduce Barriers |
|---|---|
| Lack of transportation | -- |
| Negative health care experience | Educating the workforce |
| No interests | Youth input and engagement |
| Stigma | Adopt ideas from different cultures |
| Gaps in sexual health education | Begin education early & dispel myths |
| Fear of the unknown | Self-empowerment |
| Uncomfortable initiating sexual health dialog | Parents reinforce conversations at home |
| Unclear about where to access services | -- |
| Other life's priorities | Tap into youth social media skills |
| Bad judgments about medicine side effects | -- |
| Un-appealing prevention messages | Marketing prevention by youth promoters |
| Limited service hours | Create adolescent friendly environments |

**Table 2**
**Themes Extracted from Group B Focus Group Discussion**

| Prevention & Treatment Attrition Factors | Ideas to Eliminate/Reduce Attrition Factors |
|---|---|
| Don't want to face it [it refers to diagnosis] | Integrate education into [outreach] events |
| Fear of repercussions | -- |
| Fear of exposure | -- |
| Fear of rejection | Provide safe space, not just special environment |
| AIDS is no big deal [Low perceived severity] | Catchy marketing [about risks of non-treatment] |
| Not afraid of STDs [Low perceived severity] | Catchy marketing [about risk of non-treatment] |
| STDs pervasiveness seen as part of life | -- |
| Staff turnover at youth serving agencies | -- |
| Need to better connect youth with risk | No one-size fits all |
| -- | Transportation help |
| -- | Birds and the bees [talk][§] |

[§] **Refers to the time in children's lives when parents explain sexual relationships**

preparing a support team to assist with the summit's events. The event support team hosted a walk-through during the week preceding the summit and set up the venue on the day before the summit. The support team was on station early on the day of the summit to greet, register, and accommodate participants; and to ensure a smooth transition from one event to the next.

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**Table 3**
**Themes Extracted from Group C Focus Group Discussion**

| Prevention, Treatment, & Education Gaps | Ideas to Eliminate/Reduce Gaps |
|---|---|
| [Staff] communication methods | -- |
| Information presentation | -- |
| Talking to, not with | -- |
| Not listening | -- |
| Stigma | -- |
| Confidentiality | -- |
| [Duration of] visit not enough | -- |
| Insufficient youth-centric HIV testing | Provide innovative testing sites |
| [No] expanded or [after] hours or weekend testing | -- |
| Coordination between stationary & mobile services | Integrate HIV & STIs testing |
| [No assessment of] readiness for services | -- |
| [School curriculum limitations] | -- |
| Youth [unaware] they can test without parental consent | Raise awareness about testing without parental consent |
| Public school teachers not engaged | -- |
| Linkage and retention | Holistic approach to patient care |
| Lack of follow-up capacity | [More] Case Management follow-ups |
| -- | Agency partnerships |
| -- | More money |

## RESULTS

### Youth Summit Attendance

The Youth Summit invited 51 stakeholders. Attendees came from the City of Jacksonville Social Services Division, HIV/AIDS medical providers, HIV prevention agencies, including agencies serving youth; social services agencies, the public school system, and youth volunteers from social services agencies. The new, state of the art public library, located downtown Jacksonville, provided the hosting venue, with fully equipped audio-visual and computer technology services.

### Framing the Day

One of Jacksonville's lifelong health advocates (Frieda Saraga), gave the introductory remarks at the July 19, 2016, Northeast Florida, first Youth Summit in Duval County, Florida. Figure 2 summarizes the gist of the speech that framed the day of events. An emphasis on cognitive well-being (Hatfield & Hatfield, 1992) is an integral part of public and community health programs and services. Need exists to enhance youth sense of self-respect for influencing

positive self-valuation. Where these necessary, but necessarily sufficient antecedents exist, youth receive motivation for healthy engagement in HIV prevention and treatment activities. Although the one-sided arrows imply directionality, it is entirely conceivable that the cyclical process is bidirectional. Hence, any point on the cognitive wellness triangle may emerge as an antecedent to the others for support and maintenance of the whole person. After the introductory remarks, three half-hour sessions followed. The first session presented *Area 4 HIV Epidemiology of Youth*. The presentation revealed that in 2014 there were 349 persons ages 13-24 in Area 4 who were living with HIV, of which 80% were African-American youth and 60% were MSM. The second session presented *Youth Risk Behavior Survey Data*, which showed that lesbian, gay, and bisexual (LGB) students report rates of sexual and other risk behaviors at twice and sometimes three times the rate of their heterosexual peers. The third session presented *Best Practices in Northeast Florida*, which included three features. The first display presented APEL Health Services peer counseling program call Project Youth Link. The

second display presented the comprehensive HIV prevention, linkage to care, and STD clinic services for LGBT and YMSM youth at JASMYN's one-stop youth center. The third display presented the Teen Health Clinics, which provide STD/HIV Testing in local high schools as part of the Duval County Public Schools/FDOH-D collaboration under the CDC DASH 1308 grant. These presentations, along with the interactions that followed provided the context for the youth panel and subsequent focus group discussions, which occurred after lunch.

**Focus Group Discussions**

The Youth Summit hosted three focus groups, defined here as groups A, B, and C. Each group had 8 to 10 participants, which included an experienced discussion moderator, a note taker, and a timekeeper. Discussions lasted one hour. Group-A responded to two questions: "What are the barriers that keep youth from accessing prevention and treatment services" and "How can we work together to eliminate these barriers?" Table 1 presents themes extracted from group-A's discussions.

Group-B had two questions: "What causes youth to fall out of prevention and treatment services?" and "What can we do to keep youth in care?" Table 2 presents themes extracted from group-B's discussions.

Group-C had two questions: "For youth, what are the gaps in education, prevention, and treatment services?" and "What can we do to close [identified] gaps?" Table 3 presents themes extracted from group-C's discussions.

The final act of the Youth Summit gave participants the opportunity to complete a satisfaction survey. The results are presented below.

**Satisfaction Survey**

The Youth Summit participants completed a nine-item, open-ended survey as the day's proceedings folded. For all practical purposes, the survey assessed participant's satisfaction with planned events. Two items asked respondents about the usefulness of data (epidemiological and Youth Risk Behavior Surveillance), and helpfulness of the youth panel for understanding issues germane to youth. All (N = 25) participants self-reported that the HIV epidemiological data and Youth Risk Behavioral Surveillance data were useful. In contrast, 96% of respondents said the four-member, African-American youth panel was helpful. Another item asked respondents, "How well did we do with time"? No respondent had a negative comment, and a half (50%) said "great." Other comments repeated by multiple responders used adjectives such as "very well" (21%), "good" (8%), and "very good" (8%). In contrast, comments that did not repeat included adjectives such as "perfect, fine, and excellent." The

survey also asked, "How well did the presenter do"? No respondent had a negative comment, and 28% said "great." Other comments repeated by multiple responders used adjectives such as "well [or] very well" (28%), "great job" (8%), and "excellent" (16%). These responses accounted for 80% of respondents. In contrast, comments that did not repeat included adjectives such as "fine, fantastic, and no response."

The questionnaire asked, "What key factors did you take away from this event"? Respondents replied with the following comments: "Our youth need our [attention]. There are ways of participating with youth and affected youth, [such as] social media and snap chat. Youth have interesting ideas on how to promote collaboration on [community] events. Get youth involved, listen to youth, [and] meet youth where they are. Youth learn from peers! Map youth services and resources. More is going on [in Northeast Florida] than is thought. [This suggests that] much work has been done, yet much more remains to be accomplished, [such as] expanding parental education [to bring it] in alignment with [Duval County Public School] student programs, [and providing] comfort and security to HIV-infected people, especially youth." This common thread accounted for 64% (16 of 25) of respondents freestyle comments. In contrast, comments that were not repeated included take-home messages such as "enhanced awareness [of youth issues, need to] support all agencies, [and] statistics [describing the HIV] epidemiology."

The questionnaire asked, "What did you like most about the event"? Respondents replied with the following comments: "Youth panel and agency collaborations." This common thread accounted for 44% (11 of 25) of respondents repeated, freestyle comments. In contrast, comments that did not repeat included likes such as "Group discussion, audience diversity, interactive sharing, networking, attendees' passion, and the relaxed attitude of presenters."

The questionnaire asked, "What would you like to see at future event"? Respondents replied with the following comments: "More youth involvement, more youth, more community participation, and expand [the] youth panel." This common thread accounted for 60% (15 of 25) of respondents' repeated, freestyle comments. In contrast, comments that did not repeat included wishes such as "more youth speakers, more discussion with youth, [and] convene a small group to develop a draft plan to address the NHAS goals for youth locally."

The questionnaire asked, "What single thing did you learn or take away from this event"? This item yielded the most heterogeneous reply. Only 8% (2 of 25) of respondents' comments, suggests that youth should be involved in prevention and care planning. The two comments read thus, "The youth in the

community would like to get involved in their health care," and "Youth input on how agencies should approach treatment and prevention services and youth in general." The diversity of non-repeat responses included descriptors such as "Engage youth, keep working, service branding, increase collaborations, use social media, listen to youth, publish existing resources, and educate parents.

The final survey item asked, "Would you like to join future events like this one"? Respondents replied by providing their names, organizational affiliation, email address, and phone number. Almost two-thirds (64%, 16 of 25) provided contact information for possible inclusion in future events.

## DISCUSSION

The Jacksonville Transitional Grant Area Youth Summit drew a purposive sample of youth program and service providers as stakeholders. At this first local healthcare summit on youth, the majority of attendees were adults, largely from the field of allied health and education. Five youth also attended as informants to the discussion. The summit provided opportunities to collect adult professionals' comprehension of the HIV prevention and care systems strengths and weaknesses regarding youth-centric care. The one-hour long, four-member youth panel, with representatives from APEL Health Services and JASMYN, may not typify the perspectives on the Summits questions of all high-risk youth throughout the greater Jacksonville area. Therefore, the feedback from the focus groups, which largely came from the adult professionals in the room, may or may not accurately reflect youth-centric solutions for modifying the system of HIV care to make it more inclusive of youth and young adults. Some support for this interpretation comes from the single digit percentage (8%) of survey respondents who called for inclusion of youth in prevention and care planning. Nevertheless, the Youth Summit served as an important starting point for the community's journey toward a perfect union – a complete and seamlessly integrated youth and adult HIV prevention, treatment, and health education system.

What did the Jacksonville community learn from the youth summit? The community learned about more challenges (N = 37) than solution focused ideas to address acknowledged challenges (N = 23). That is, Tables 1-3 list 37 challenges, but only propose 23 solution strategies, a mere 63% of the way out of a health services dilemma. As is often the case, aggregate data mask subgroup differences. For example, of 12 identified barriers to prevention and treatment services, nine solution strategies emerged, which amounts to 75%. Of nine prevention and treatment service attrition factors, seven solution strategies emerged, which amount to almost 78%.

However, for gaps in prevention, treatment, and health education services, there were 16 gaps, but only seven proposed solution strategies, which amount to almost 44%. Clearly, the dearth of solution strategies to address extant gaps in the local, HIV/ADIS health services system is motivation to work collectively and collaboratively for change.

What help do the summit's findings suggest that Partnership 4 HIV/AIDS health and social care systems need? For that answer, Carrillo et al., (2011) Health Care Access Barriers, (HCAB), Model provide insights. This model proposes that financial, cognitive, and structural barriers underlie late presentation to care, decreased prevention, and decreased care. Hence, health outcome disparities persist. When the items populated in tables one to three come under the lens of the HCAB model, the cognitive domain, which focuses on knowledge and communication factors, and the structural domain, which focuses on institutional and organizational factors, illuminates. Translated, this means structural and cognitive solution focused strategies must emerge to address the plethora of themes from the youth summit.

A two-pronged approach appears warranted to understand how to transform the Partnership 4 HIV/AIDS system of care into the integrated, inclusive vision that stakeholders' want. Specifically, structural solution focused strategies must emerge in the months and years ahead to address a myriad of issues. These issues range from limited service hours to unappealing prevention services messages. They also include the culture of the health care setting, public unaware of service availabilities, and staff turnover at youth serving agencies. Weak connection with youth, ineffective staff communication methods; insufficient duration of healthcare visits, and no expanded, after hours, or weekend testing also emerged. However, this would not be enough. Cognitive solution focused strategies must also emerge in the months and years ahead. These would have to address issues such as stigma and negative health care experiences. They must also address intrapersonal issues such as fear of the unknown, fear of exposure, fear of rejection, the perception of sexually transmitted diseases (STDs) as a way of life, no fear of AIDS, gaps in sexual health knowledge, discomfort initiating sexual health conversations, and utilizing free HIV testing services.

## Conclusions

The HIV health care system integrative work has just begun. In this infancy stage of development, which largely relied on the adult professionals with limited input from youth, investigating the determinants of the status quo needs to go many steps further. One Ryan White Medical Case Management Supervisor identified a next logical step in that

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progression. The next Youth Summit should be planned and facilitated, largely by youth, centered on the same questions, but with significant youth involvement, and adult professionals as observers or inquirers. By doing so, the local, HIV health services community can evaluate next steps from the perspectives of shared understanding among affected youth and the health care service providers. This plausible next step does not freeze the community from any other potential system changing activities. For example, the Youth Summit identified the need for increased coordination between stationary and mobile service providers. Intra-and-inter-agency, health services planning and implementation can begin to brainstorm strategies for closing gaps in expedited linkage to HIV care, after diagnosis. Nevertheless, this local, HIV health-system integration journey has just begun. The months and years ahead will require tenacious commitments of time and other resources to reach a shared understanding of what needs to happen, and how to do it, to make the HIV/AIDS health care system work for youth, young adults, mature adults, and the elderly.

The findings reported here are local and largely relied on the experiences of allied health services professionals. Nevertheless, they have merit because they align well with research funded by a premier national agency. The Health Resources and Services Administration (HRSA) funded ten models of teenage HIV care demonstration projects in the United States. This work and the associated project evaluations sought to advance the body of knowledge about youth and young adults' engagement in care. Essential findings, available online at http://www.sciencedirect.com/science/article/pii/S1054139X98000524, appear below!

Effective service models for this population may include such elements as:

- peer-youth information and dissemination;
- peer-youth advisory groups;
- peer youth outreach and support;
- professional, tightly linked medical social support networks; and
- active case management and advocacy, for individual clients as well as the programs themselves, to [connect] the various components together.

One of the most important factors in a service model's success is that youth and professionals share an equal partnership in all stages of program design, planning, and implementation.

Service delivery models and the structure of care require attention. However, service models are only a starting point for thinking about HIV/AIDS health system reform for clients under 25 years old.

Assuming robust implementation of a service model, the Health Resources and Services Administration, (HRSA) HIV/AIDS Bureau (HAB) September 2015 online publication titled, *Youth and Young Adults and the Ryan White HIV/AIDS Program*, (http://hab.hrsa.gov/sites/default/files/hab/data/datareports/youthdatareport2015.pdf), outlines 17 characteristics of a service system that define successful HIV/AIDS prevention, care and services for youth and young adults. These characteristics follow in no specific order of importance:

- An LGBTQ-friendly environment,
- One-stop shops with health, hormone therapy, and social support services in one location (if not feasible, active referrals to youth-friendly social support settings),
- Employment of youth-dedicated, youth-friendly staff,
- Accessible location with walk-in appointments and flexible scheduling,
- Uses informal modes of communication, like texting and social media,
- Creates a warm, welcoming environment with social interaction and entertainment [while] waiting for [services],
- Active communication with youth,
- Opportunity for youth to give feedback and have opinions heard,
- Creation of leadership opportunities for youth,
- Access to youth peer support groups,
- Incentives, where possible, such as bus tokens to alleviate the financial burden of transportation,
- Navigators to help youth understand the health care system and enroll them in Affordable Care Act coverage (if applicable),
- Development of individualized transition plans,
- Early transition planning for adult care,
- Health education,
- Goal setting (for health, school, career), and
- Connection to youth-friendly activities and conferences to support social networking and skills building.

Taken together, these 17 points or any combination of them can serve as a benchmark (point of reference) for measuring the evolution of Partnership 4 Continuum of Care, guiding the way forward where the region wants to be in the next five years.

This study contributes to the HIV/AIDS public health and health services literature in a specific way. Namely, the focus on identifying where the service structure is and where it needs to be is the outgrowth of a sense of mission, vision, and values that pursue the goal of Healthy People in Healthy Communities.

Hence, the search for consensus on how individual community-based organizations can work collaboratively and seamlessly has begun. The direction of this collective search process is the integration of HIV prevention, treatment, and education services, which take direct aim at improving the quality, the utilization, the accessibility, the financing, the organization, the delivery, and the outcomes of prevention, treatment, and education services.

## Implications for Public and Community Health Practice

The system of HIV prevention and treatment must continually adapt to address the evolving epidemic. Why is that necessary? Younger populations, at risk of HIV infection, are living at a moment in time of unprecedented advances in HIV care, which have not allowed them to observe the severity of untreated HIV. Today people living with HIV, if enrolled and retained in life-saving antiretroviral therapy (ART) can lead healthy lives while engaged in clinical care, and can reach viral suppression, further reducing their risk for HIV transmission. Young people may sense that HIV is a manageable condition, and hold a false sense of security in the post-1996 ART era. Not being tested, not knowing one's HIV status, delayed entry into care, suboptimal involvement in care, if linked to treatment, are real threats to personal health and well-being. Therefore, concerned individuals, health advocates, community leaders, HIV health services management professionals, and other stakeholders in Northeast Florida cannot rely on historical prevention and treatment successes and make no further efforts for achieving the National HIV/AIDS Strategy for the United States. Hence, a growing sense of responsibility and urgency has come over Northeast Florida and given new impetus for engaging in "Participatory Impact Pathways Analysis (PIPA). PIPA is planning, monitoring, and evaluation tool to help the people involved in a project, program, or organization make explicit… how they see themselves achieving their goals and having an impact" (http://steps-centre.org/methods/pathways-methods/vignettes/pipa/). The consensus is still pending on all the details regarding how the local, HIV/AIDS system of care will change; but there is currently widespread agreement among local service providers and health leaders that the current, adult-oriented HIV/AIDS system of care must become increasingly youth-centric. That common goal resonates with two-thirds of the Youth Summit participants, who have committed to planning together for structural and cognitive changes in pursuit of excellence in the delivery of HIV prevention and treatment services. To that end, clinical and social services providers appear to recognize the need to transition from a paternalistic to an empowerment model of service delivery particularly important to meeting the needs of young people (Villa-Torres & Svanemyr, 2015).

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