35.

PROJECT POSSE: HEALTH PROMOTION, RECRUITMENT AND ENGAGEMENT OF THE HOUSE/BALL AND KIKI COMMUNITIES FOR HIV PREVENTION
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Purpose: Black young men who have sex with men (BYMSM) are at high risk for contracting and transmitting HIV, representing a priority population for developing effective interventions. Within the Kiki Scene and House Ball community (HBC), a subculture of the LGBTQI community, HIV is highly stigmatized. This stigma, coupled with high HIV prevalence rates and elevated levels of undiagnosed/untreated HIV infection, places these BYMSM at risk for HIV infection. Understanding the social norms of the community along with knowledge of culturally-responsive interventions is crucial to implementing HIV prevention with the Kiki and HBC in order to make a broader impact among BYMSM. Project POSSE is a study examining the effectiveness and implementation of a community-level HIV prevention intervention based on popular opinion leader (POL) models across two cities with similar HBCs, Chicago and Philadelphia. At the midway point of the project, effective strategies for engagement and mobilization of the community have emerged and will be presented.

Methods: The CDC effective community-level interventions, Popular Opinion Leader (POL) and Defend Yourself (d-up!), rely on the enrollment of key members of a community who are trained to deliver health messages to the community and engage other members in safer sex conversations. Through social network mapping, 50-75 POLs in both cities are identified and trained. POLs then meet monthly to hone their communication skills, report on their POSSE conversations, and seek additional training. To ensure the effectiveness of this HBC-tailored adaptation of the opinion leader model, additional activities include enhanced community engagement through the POSSE Community Advisory Boards (whose members also serve as POLs), content consultants, and event planners; systematic collection of feedback from POLs for topics needed for capacity building; using data from key informant interviews every 6 months; and holding monthly health events called lounges, organized and lead by CAB members and serve as a safe space for HBC and Kiki youth to receive information, practice for balls, interface with study staff and socialize.

Results: Project POSSE meets its enrollment goals and contributes in meaningful ways to the HBC and Kiki communities. Community leaders consider the project and the study team as a resource and community partners, not just an HIV study. Attendance at lounges and other activities have increased from an average of 50 to 100 youth each month. Supporting data will show responses from key informants and enrollments. Presenters will share the diverse list of community partners and venues that have become accessible to this community through the project, expanding the reach of HIV prevention to other logically linked health promotion resources and activities.

Conclusions: Community-level interventions, particularly those that require community leaders to become interventionists, require strategic engagement of community members. HIV prevention interventions for communities at risk, such as the HBC and Kiki scene, should cover a broad range of health needs, addressing the myriad of other issues that impact HIV acquisition among these youth. The most successful activities provide safe spaces for youth and events designed by the community where they can be themselves and hear the messages we d
PRIMARY CARE PHYSICIAN ATTITUDES TOWARD INCORPORATING TOPICAL MICROBICIDES AND ORAL PRE-EXPOSURE PROPHYLAXIS (PrEP) INTO PRACTICE FOR HIV PREVENTION IN YOUTH

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Purpose: Topical microbicides and oral pre-exposure prophylaxis (PrEP) for human immunodeficiency (HIV) prevention could significantly reduce new infections. However, little is known about physicians’ attitudes toward incorporating these agents into their practices for use in adolescents. We examined these attitudes among primary care physicians (PCPs), a group likely to provide HIV prevention to at-risk youth.

Methods: Thirty-eight individual, in-depth, semi-structured interviews were conducted with U.S. PCPs caring for adolescents in one metropolitan area. Specialties included general pediatrics, internal medicine/internal medicine-pediatrics, obstetrics/gynecology, family practice, and adolescent medicine. The theory-driven interview assessed demographics and constructs from Diffusion of Innovations theory as related to providing microbicides and PrEP to adolescents: perceived advantages of microbicides and PrEP over condoms (relative advantage), desired outcomes of prescribing microbicides and PrEP to adolescents (observability), and perceived fit and ease of incorporating microbicides and PrEP for adolescents into practice (compatibility, complexity). Transcripts were analyzed using framework analysis. The study was IRB reviewed and deemed exempt.

Results: Mean age was 44.6 years (SD 10.9). Most physicians were female (n=27) and white (n=32). Mean number of adolescents cared for per week was 20.7 (SD 13.6). Perceived advantages of microbicides over condoms included: being user-controlled/not partner dependent (n=8), providing added protection in conjunction with condoms (n=7), potential for greater effectiveness because condoms break (n=7), and providing protection in the event of condom non-use (n=7). In contrast, 6 physicians reported that microbicides had no advantages over condoms, and 9 physicians reported that condoms had advantages over microbicides. Perceived advantages of PrEP over condoms included potential for greater adherence because PrEP is not linked to sex (n=16), greater convenience (n=10), being user-controlled (n=6), and lack of impact on the sexual experience (n=5). In contrast, 10 physicians reported that condoms had advantages over PrEP. Desired outcomes of prescribing microbicides and PrEP to adolescents were similar, including patient acceptability, patient adherence, few side effects, decreased rates of HIV infection in the community, and patients remaining HIV-uninfected. Overall, more physicians reported that microbicides vs. PrEP would fit into their current practice (n=31 vs. n=11); 26 physicians reported that PrEP would fit less well into their practice than a microbicide, and 6 reported that PrEP did not fit into their practice. Similarly, more physicians reported that microbicides vs. PrEP would be easier to incorporate than microbicides, and the same number reported that PrEP would be more difficult to incorporate than microbicides.
Conclusions: This is the first study to examine the attitudes of PCPs toward incorporating microbicides and PrEP for adolescents into practice. Although many PCPs recognized the value of these agents, endorsement was variable and microbicides were viewed as more compatible with current practice than PrEP. In order to optimize adolescent access to PrEP, educational interventions about the advantages of PrEP as well as strategies to improve the fit and ease of incorporation of PrEP for youth into practice need to be developed and disseminated.

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37.

MISSED OPPORTUNITIES FOR HIV SCREENING PRIOR TO DIAGNOSIS AMONG A COHORT OF YOUTH LIVING WITH HIV
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Purpose: Routine HIV screening reduces the risk of HIV progression and secondary transmission in adolescents and young adults, a group at disproportionate HIV risk. Our aims were to: 1) Determine prevalence and correlates of missed opportunities for prior HIV screening among a cohort of youth living with HIV (YLWH) and 2) describe the prevalence of seroconversion symptoms.

Methods: Retrospective chart review of YLWH aged 14-26 years initiating care from 2009-2015 at the Children’s Hospital of Philadelphia (CHOP) adolescent HIV clinic. Of subjects seen at CHOP primary or acute care sites prior to HIV diagnosis, we compared clinical and demographic characteristics of those with and without completed HIV screening in the one and three years prior to diagnosis using chi-squared, fisher’s exact and two-sample t-test if data were normally distributed and Wilcoxon rank-sum testing if not. Variables with a p value <0.1 in bivariate analysis were entered into univariate logistic regression models to identify factors associated with prior HIV testing. Variables remaining significant in univariate analyses were included in multivariable logistic regression models adjusted for insurance status, race and gender.

Results: The majority of subjects (n=301) were male (88%), African-American (87%), acquired HIV through male-male sexual transmission (84%). At diagnosis, the median age at HIV diagnosis was 19 (IQR 17- 21), CD4 count was 472 cells/µL (IQR 329-614), and HIV-1 viral load 19,745 (IQR 5,732.5-69,940). Symptoms of possible seroconversion were reported by 132/301 (44.2%) at the first HIV clinic visit. There were 79 subjects (26%) seen in the 36 months prior to their HIV diagnosis who contributed 325 visits to the analysis. HIV testing was performed in 31 (39%) of subjects in the three years prior to diagnosis. In the bivariate analysis examining the probability of completed HIV testing in the year prior to diagnosis among patients seen in the healthcare system during that time period, subjects with younger age at HIV diagnosis (p=0.004) and presenting with symptoms compatible with acute HIV infection (p=0.008), were less likely to be tested for HIV in the year prior to diagnosis. In the bivariate analysis of those seen in the three years prior to diagnosis, lack of a documented sexual history (p<0.001) was associated with not having received HIV testing. In the multivariate logistic regression model examining HIV screening in the year prior to diagnosis, adjusting for insurance, race and gender,
younger age at diagnosis was associated with decreased odds of HIV screening (aOR 0.7, 95% CI (0.5 - 0.9). In the multivariable model examining receipt of HIV testing within three years prior to diagnosis, absence of a documented sexual history was significantly associated (aOR 0.1, 95% CI (0.04-0.4) with lack of screening.

**Conclusions:** In this cohort of YLWH, we identified missed opportunities for HIV testing in one and three years prior to HIV diagnosis. Lack of a documented sexual history and younger age were associated with not receiving HIV testing, underscoring the need for comprehensive sexual health screening and HIV testing in younger adolescents.

**Sources of Support:** National Institute of Mental Health: F32 MH111341(PI: Wood); K23 MH102128 (PI: Dowshen)

38.

**HIGH PREVALENCE OF DEPRESSIVE SYMPTOMS AMONG ADOLESCENTS LIVING WITH HIV/AIDS IN UGANDA**

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**Purpose:** With the scaling up of HIV care in Uganda and the Early Infant Diagnosis (EID) program, many children who vertically acquired HIV are surviving into adolescence and adulthood. Depression has significant adverse outcomes among people living with HIV including disease progression and death. Routine screening for depressive symptoms in HIV is not routinely done in Uganda. This study established the prevalence of depressive symptoms and the associated factors among adolescents living with HIV in Uganda.

**Methods:** A cross sectional survey of adolescents(10-19 years) living with HIV and attending urban and rural clinics in Mbarara, SW Uganda was done in March-May 2017. Pretested questionnaires were administered by trained research assistants. Information on socio demographic characteristics, HIV associated factors was collected. The Centre for Epidemiological Studies Depression Scale for children was used to assess depressive symptoms. A cut off of 15 was used to evaluate presence of depressive symptoms. Logistic regression was done to assess factors associated with higher prevalence of depressive symptoms.

**Results:** A total of 336 adolescents were interviewed, the median age was 13 years (IQR 11, 16). A total 209 (62.2%) were female; only 52 (15.4%) were total orphans with 197(58.8%) residing in rural areas. Regarding HIV treatment factors, 123 (36.7%) adolescents had disclosed their status. Adherence to ART was high with 276 (88.9%) having good adherence >95% and 273 (84%) were in WHO clinical stage 1 with 212 (63.1%) having undetectable viral load. A total of 154 (45.8%) had a CES DC score of 15 and more, of which 25 (7%) having scores 30 and above. Among the sociodemographic and HIV/AIDS treatment factors in the final model, the only factor that was independently associated with higher depressive symptoms score was increasing age AOR 1.27 (95% CI: 1.09-1.47), P=0.002.
Conclusions: Prevalence of depressive symptoms among adolescents living with HIV was high with increasing age. Routine screening and prompt treatment of depression needed in care settings for adolescents with HIV infection.

Sources of Support: Mbarara University Research Training Initiative, research fellowship program (NIH capacity building grant)

39.

REDDUCING HIV/STD RATES AND BIRTHS TO TEENS: A COLLABORATIVE AND ONGOING PROGRAM
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Purpose: Adolescent risky sexual behaviors and their associated health concerns are well documented. This program, “Promoting Adolescent Health Through School-Based HIV/STD Prevention,” addresses such behaviors and the potential negative health outcomes. The overall goal of the program is to reduce HIV/STD rates and births to teens. This collaborative initiative aims to provide equal and ongoing access to evidence-based health education and health services by identifying and addressing health disparities.

Methods: In 2013, the Florida Department of Education was one of 19 state education agencies selected to receive a 5-year grant from the CDC to improve adolescent health. Twelve counties across the state, referred to as “partner districts,” were identified based on need and willingness to participate in the program. The steps to reaching the program goal in these partner districts include: 1) the adoption of comprehensive sexual health education policies, 2) implementation of evidence-based, medically accurate sexual health curricula, 3) building the confidence levels of instructors through high-quality professional development, and 4) providing technical assistance to district administrators to identify the value of a referral process for students to receive needed sexual health services. This initiative focuses on building school district capacity to develop, implement and sustain these efforts. The program mirrors national efforts, such as The Future of Sex Education (FoSE) striving to standardize and improve the quality of sex education and the CDC’s “16 Recommended Topics” for sexual health education.

Results: Initial results of this program include: 1) the development of a state-wide committee to provide guidance to the program, 2) data collected in seven of the 12 partner districts showing strong support for comprehensive sexual health education, 3) development or revision of health education policy to include quality sexual health education in three districts, 4) professional development offered to over 1,200 teachers in the 12 districts, 5) improvements in sexual health curricula in six districts, 6) development or improvements in delivering health services in five districts, and 7) improvements in addressing the sexual health needs of homeless youth in three districts.

Conclusions: Overall, the majority of partner districts have implemented changes which can have a positive impact on the long-term goal of reducing HIV/STD and teen birth rates. Lessons learned document that many teachers did not know their district policy, most were very supportive to teach this topic and want more professional development in this area, and most community members support youth learning about this topic. Many districts are interested in offering health services on site, and several have begun to do so successfully.
UNDERSTANDING THE FAMILY PLANNING AND HIV PREVENTION NEEDS OF SOUTH AFRICAN ADOLESCENT GIRLS: A CULTURAL CONSENSUS MODELING APPROACH

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**Purpose:** Globally, South African (SA) adolescent girls experience some of the highest rates of both unintended pregnancies and STI/HIV. One-third of SA adolescent girls will be pregnant by age 20 and SA accounts for one-third of all new HIV infections among young women worldwide. Culturally tailored, reproductive health counseling strategies to promote dual protection (use of methods to prevent both pregnancy and STI/HIV) among SA adolescent girls are urgently needed. Cultural consensus modeling (CCM) is a methodology to determine shared cultural beliefs or norms to arrive at a culturally sensitive understanding of a given topic. To inform the development of culturally-sensitive measures and interventions, CCM was used to examine Black, Sesotho-speaking, SA adolescent girls’ (ages 14 to 17 years) contraceptive and HIV prevention practices across three study phases.

**Methods:** In Phase 1, participants (N=50; M age=15.7) responded to free-listing survey questions about culture rather than individual behaviors, allowing participants to draw upon a shared cultural knowledge (e.g., “What do other adolescent girls in your community think are good ways to prevent pregnancy?”). Free responses were condensed to a single master list with frequencies generated. Utilizing these identified group beliefs, Phase 2 asked a different set of participants (N=100; M age=15.6) to rate the extent to which factors identified in Phase 1 are valued (e.g., “Among adolescent girls in your community, how acceptable are condoms to prevent pregnancy?”). Phase 2 utilized cultural consensus analysis (akin to an exploratory factor analysis using participants rather than items) to identify clusters of similar responses termed consensus models. Phase 3 conducted qualitative interviews with key informants from Phase 2 (N=25) who were highly consistent with the identified cultural consensus model to gather in-depth information regarding the identified determinants of contraceptive and HIV prevention strategies. Thematic coding was utilized to identify key themes.

**Results:** Free listing from Phase 1 identified 41 unique acceptable pregnancy prevention strategies (e.g., contraceptive pills, abortion), 16 important contraceptive method characteristics (e.g., cost, side effects), and 29 acceptable HIV prevention strategies (e.g., abstinence, condom use). Phase 2’s cultural consensus analysis identified a single cultural consensus model. Findings from Phase 2 highlight the importance of social motivators including affiliation with positive peer groups for pregnancy and HIV prevention (e.g., avoiding peers who use substances), abstaining from sex or having faithful relationships, and access to free public reproductive health clinic services. Phase 3 findings contextualized and confirmed findings from Phase 2.

**Conclusions:** Results point to the importance of cultural context in assessing factors associated with pregnancy and HIV prevention strategies among SA adolescent girls. In line with prevalent SA HIV prevention messaging (Abstinence, Be Faithful, and Condom Use: ABC), ABC prevention themes
emerged in the CCM combined with an important role of peers and free clinic service access. The use of emergency contraception with less emphasis placed on hormonal contraception and dual protection strategies emerged from the data. Implications for culturally-sensitive dual protection intervention strategies will be discussed.

**Sources of Support:** This study was funded by the Bill & Melinda Gates Foundation (OPP1161907; Brown: PI).

41.

**IMPLEMENTING HIV PRE-EXPOSURE PROPHYLAXIS EDUCATION AND MANAGEMENT STRATEGIES FOR PROVIDERS IN AN STI/HIV SCREENING PROGRAM WITHIN AN ADOLESCENT/YOUNG ADULT PRACTICE**

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**Purpose:** In the U.S., adolescents and young adults (AYA) account for over 20% of all new HIV infections. Young men who have sex with men (YMSM), and particularly YMSM of color, are disproportionally impacted. In 2014, MSM accounted for 83% (29,418) of the estimated new HIV diagnoses among males aged 13 and older. Pre-exposure Prophylaxis (PrEP), an FDA-approved medication regimen, provides a 92-99% reduction in HIV risk. Current research indicates awareness and utilization of PrEP is low among primary care providers. This study aimed to improve access and utilization of PrEP for AYA within a large academic AYA medical practice through an educational intervention and implementation of an evidence-based guideline (EBG).

**Methods:** As part of a publicly funded STI/HIV Screening Program within an AYA academic practice, we developed a provider training to assess eligibility and increase PrEP uptake. We completed a retrospective chart review of screening data for patients seen from July 2015-July 2016 (ages 18-30) to provide a baseline estimate of appropriate candidates for PrEP per Centers for Disease Control and Prevention (CDC) guidelines. Three 1-hour trainings were held to educate Adolescent Medicine providers how to screen for PrEP eligibility and utilize an EBG to manage PrEP. Likert scale questions were developed to assess baseline and follow-up medical providers’ knowledge, comfort, and utilization of PrEP among their AYA patients (pre-, post-, 3- and 6-month follow-up). In this AYA practice, 14 of 24 total AYA providers participated in the training (12 MDs, 2 NPs). Survey data were analyzed using non-parametric Mann-Whitney U test.

**Results:** Among the 549 patients seen in the STI/HIV Screening Program, 111 patients reported PrEP risk factors; patient factors were: MSM (50), injection drug use (7), sex with HIV positive partner (14), transactional sex (4), and concurrent positive STI [gonorrhea (4), syphilis (6), and chlamydia (27)]. Forty-one of these 111 individuals were primary care patients in the AYA practice. Of those 41 patients, 39 received a follow-up visit, 8 had PrEP prescribed with 6 continuing to stay active on PrEP. Pre-test of AYA providers (13 completed surveys) revealed that comfort with and knowledge of PrEP ranged dramatically among providers. While 100% reported awareness of PrEP prescribing guidelines and over 92% reported seeing patients with PrEP indicated risk factors, only 38% reported ever prescribing PrEP. Pre and post-survey comparison revealed statistically significant improvements in self-rated knowledge
of PrEP (p=0.005), PrEP assessment abilities (p=0.013), comfort in prescribing PrEP (p=0.004), and comfort in medical management of PrEP (p=0.001). Longer term follow-up of AYA providers are scheduled for August 2017 and November 2017, to allow assessment of the impact on practice.

Conclusions: In this study, AYA providers were uncommonly prescribing PrEP despite identifying eligible patients. A structured education program resulted in increased knowledge and attitudes, and may be able to improve provider utilization of PrEP among their at-risk patients. These results suggest that even among AYA providers, significant education is necessary to effect change in PrEP prescribing.

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42.

DOES PARENTAL INSURANCE IMPACT WILLINGNESS TO TAKE PREP IN ADOLESCENTS & YOUNG ADULTS?
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Purpose: Globally, adolescents and young adults (AYA) aged 13 to 25 years disproportionately account for new HIV infections (25%-75% in certain regions). Pre-exposure prophylaxis (PrEP) can reduce the risk of contracting HIV by 99%. Yet, in 2015, AYA accounted for only 8% of PrEP-related prescriptions. Existing literature suggests that dependence upon parental insurance is a potential barrier to the health services AYA seek; however, very little is known about whether it is a barrier to PrEP use. The specific aims are to: 1) determine whether parental insurance coverage negatively impacts willingness to take PrEP; 2) determine if confidentiality is associated with parental insurance and willingness to take PrEP; and 3) determine whether such factors confound the relationship between parental insurance coverage and willingness.

Methods: Participants consisted of 156 AYA aged 18-25 years (Mean = 22.1, SD = 2.2) in an urban adult Emergency Department who completed a 15-minute survey about sexual health and willingness to use PrEP. To evaluate confidentiality, AYA were asked the following questions: 1) whether they would want their parents to know that they are taking PrEP; 2) likelihood of using PrEP if discussion about side effects with parents were required; and 3) likelihood of using PrEP if discussion about sexual activity with parents were required. Simple logistic regression examined associations between: 1) parental insurance coverage and willingness to take PrEP; 2) confidential factors and parental insurance coverage; and 3) confidential factors and willingness. Multivariable logistic regression examined associations between parental insurance coverage, confidential factors, selected covariates (at p-value<0.10) and willingness to take PrEP.

Results: Most (91%, n=143) described having health insurance, with nearly half (46%, n=71) reported being on parent’s insurance policy. Most (59%, n=92) AYA identified as female, 87% (n=135) heterosexual and Black/African-American (69%, n=80). Dependence upon parental insurance was not significantly associated with willingness to take PrEP (p=0.147). Individuals who indicated that they would not want their parents to know that they are taking PrEP and individuals who were unlikely to use
PrEP if discussion about side effects or sexual activity were required were positively associated with being on their parent’s insurance [Unadjusted OR = 2.47, 95% CI (1.36, 4.47); OR = 2.90, 95% CI (1.50, 5.61); OR = 5.31, 95% CI (2.37, 11.91) respectively]. In the final model, individuals who indicated that they would not want their parents to know that they are taking PrEP had a 59% lower odds of using PrEP than those who would, after adjusting for covariates [95% CI (0.18, 0.85)].

**Conclusions:** Concerns about parent-patient confidentiality were associated with lower willingness to start PrEP, suggesting a potential barrier to PrEP uptake. These concerns were also associated with being on a parent’s insurance policy. Parental insurance was not a direct barrier to PrEP use, but may be associated with concerns related to disclosure of side effects and sexual activity to parents. More work is needed to understand how disclosure and being on parents’ insurance may create a barrier to preventive services.

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