Meeting Agenda

VIRTUAL:
Wednesday, January 27, 2021
2:30 p.m. – 4:30 p.m.

- Call to Order
- Welcome/Introductions
- Approval of Agenda
- Approval of Minutes *(October 28, 2020)*
- Report of Co-Chairs
- Report of Staff
- Discussion Items
    - DExIS
        - Breakout Discussion —*20 minutes*—
        - Regroup
    - Situational Analysis & Guiding Principles
- Old Business
- New Business
- Announcements
- Adjournment

Please contact the office at least 5 days in advance if you require special assistance.

The next Finance Committee meeting is
VIRTUAL: February 25, 2021 from **2:30 – 4:30 p.m.**
Office of HIV Planning, 340 N. 12TH Street, Suite 320, Philadelphia, PA 19107
(215) 574-6760 • FAX (215) 574-6761 • www.hivphilly.org

Prevention Committee

HIV Integrated Planning Council
Prevention Committee
Wednesday, October 28, 2020
2:30 PM – 4:30 PM
Office of HIV Planning 340 N. 12th Street, Suite 320, Philadelphia, PA 19107

Present: Keith Carter, David Gana, Gus Grannan, Lorett Matus (Co-Chair), Erica Rand, Clint Steib (Co-Chair)

Staff: Beth Celeste, Mari Ross-Russell, Nicole Johns, Sofia Moletteri

Call to Order: C. Steib called the meeting to order at 2:38 p.m.

Welcome/Introductions: All attendees introduced themselves with their name and area of representation.

Approval of Agenda:

C. Steib called for a motion to approve the October 28, 2020 Agenda. **Motion:** K. Carter motioned, D. Gana seconded to approve the October 2020 agenda. **Motion passed:** 80% in favor, 20% abstaining.

Approval of Minutes *(September 22, 2020):*

L. Matus called for a motion to approve the September 2020 meeting minutes. **Motion:** G. Grannan motioned, D. Gana seconded to approve the September 2020 minutes. **Motion passed:** 60% in favor, 40% abstaining.

Report of Co-Chairs:

No report.

Report of Staff:

M. Ross-Russell reported that the COVID-19 survey was live on the OHP website. She noted that on November 11, 2020, HIPC would be hosting another open house for interested members at 5:30 p.m. on Zoom.

N. Johns reported that HIPC was still accepting applications for Planning Council. M. Ross-Russell asked that anyone who interested in the Planning Council or those with questions contact the office. She also asked that current members reach out to those who would be a good fit for the council and put them in contact with the office to apply. C. Steib asked about the deadline for HIPC applications. N. Johns explained that there were no set deadlines as of now, but they would likely close applications within the next week or so.

N. Johns added that the COVID-19 survey was available in both Spanish and English. There is a steady amount of responses. She reminded the committee that the office has a social media packet on the website which allows people to help advertise the survey online. She asked that anyone in need of

paper copies let the office know so they can print and distribute them. N. Johns noted that there are also files online to print the surveys. In this case, contact the office, and they can arrange a way to return the completed surveys.

Public Comment:

None

EHE Update:

N. Johns reported that AACO is still collecting EHE feedback through the link on the EHE subdomain, hivphilly.ehe.org. There are two different surveys: the larger survey which dissects the plan strategy by strategy, and the Big Idea survey. She explained that AACO is running a campaign for the Big Idea survey.

M. Ross-Russell reported that on December 1st, AACO was planning on having EHE materials and feedback submitted and finalized. She noted that AACO also submitted EHE-related documents last week to the CDC.

Discussion Items:

—Committee Structure/Focus—

N. Johns reminded the committee that at their last meeting, they requested insight into other EMA's council structures. This request is part of a continuing conversation which will feed into deliberations/decisions for potential changes to committee structure.

M. Ross-Russell noted that EHE has been a guiding principal for Prevention Committee. There are two pillars from EHE, Prevent and Respond, which will likely be the categories of focus for Prevention Committee moving forward.

M. Ross-Russell said when looking at other jurisdictions' structures, Houston offered the most committee structure details. She explained that Washington and Houston had less than 50 council members. Overall, she was unable to find a jurisdiction that had 50 or more council members.

Lastly, M. Ross-Russell explained that the purpose of reviewing council structure is to more efficiently achieve the goals of Planning Council. The Council had a large number of tasks to address and review in the upcoming year. She explained that the consumer survey was coming up, and the council also had to revisit priority setting due to COVID-19 impact on community needs. The council will also be monitoring the results of the Integrated Plan.

Based on the current structure, she explained that most of the work listed falls to CPC. Other committees are capable of taking on the work, so this is why they are looking at structure. Another reason they are looking into this is because they have not reviewed their structure since 2002/2003, and work/culture has changed since 2002/2003. N. Johns said that the council has removed a couple of committees since then, but structure and work processes have remained the same.

N. Johns brought up a slide with Houston and Washington DC committees listed. Houston had the following committees: Affected Community Committee, Comprehensive HIV Planning Committee, Priority & Allocations Committee, Operations Committee, Quality Improvement Committee, Steering Committee, EIIH Working Group, and Project LEAP Advisory Board. Washington DC had the following committees: Executive Operations, Integrated Strategies, Research & Evaluation, Community Engagement & Education, and Comprehensive Planning.

M. Ross-Russell asked if there were any questions. K. Carter noted that they currently had six committees: Comprehensive Planning Committee, Prevention Committee, Positive Committee, Finance Committee, Executive Committee, and Nominations Committee. M. Ross-Russell noted that they also had ad-hoc working groups as necessary.

D. Gana asked if Positive Committee could be utilized as a resource for evaluating needs and identifying unmet needs. N. Johns noted that the intention of Positive Committee is to disseminate information to the community via the committee. However, N. Johns agreed that information can flow both ways. She agreed that the committee could be more intentional with their activities to achieve a two-way channel of information. The committee could become more heavily involved in reviewing proposals and other advisory activities.

M. Ross-Russell said that participation on the Council can be detail/information and process heavy. For community members who want to participate on the Council, the Positive Committee can also act as a mechanism to obtain information and assist with the learning curve. M. Ross-Russell recalled how in the past, needs assessments/priority setting were brought to Positive Committee for review and approval. It is possible, she explained, to have Positive Committee work more directly with the development of survey tools, assessments, etc.

C. Steib asked to make a list of each of the committees' current responsibilities as well as upcoming council tasks. This way, they could then separate each task out into applicable committees. M. Ross-Russell said Executive Committee could then review the list. C. Steib asked if OHP could create the list with different activities and future plans for Executive Committee to review and delegate the work as they see fit. N. Johns said they could do that and also include specific Planning Cycle activities and where they currently fall within the committees. Like Finance Committee, work can be rearranged. N. Johns said Finance Committee and priority setting may be a nice fit since there is significant overlap between data used for allocations and data used for priority setting. N. Johns said that rearranging workload by creating a list like C. Steib suggested, may even lead to a shuffle of membership. K. Carter agreed with C. Steib's idea.

M. Ross-Russell asked everyone to brainstorm the best ways to bring more members to the Council and how best to create ad-hoc committees to discuss involvement of specific populations/communities. She explained that such ad-hoc groups could encourage additional voices/input in HIPC processes and even increase membership.

K. Carter suggested coordinating with an outside organization to accomplish ad-hoc population-specific workgroups. M. Ross-Russell agreed that this may be a good idea. She noted that some members have connections with outside organizations/groups that may be helpful. For example, K. Carter and D. Gana are champions for the Elder Initiative. It may be beneficial to look to such organizations/groups that have an area of expertise. K. Carter said they could then bring people with areas of expertise to act as the building blocks of any population-specific workgroups.

M. Ross-Russell said that HIPC's meeting structure has be described as "dry" by some attendees. She asked the Council about any changes that would make the work and process more exciting.

C. Steib explained that a shift in committee structure may help with making the work more exciting by making the work more equitable and involved across all committees. He added that some committees could work jointly on some items to help with workload and create camaraderie.

L. Matus asked about the status and progression of the EHE plan and Integrated Plan. M. Ross-Russell responded that the release of the Integrated Plan guidance was postponed due to COVID-19. She added that the five-year Integrated Plan, itself, will be ending in 2021 in August or September. She explained that the new guidance for Integrated Plan would likely be a combination of the EHE plan guidance and past Integrated Plan guidance. M. Ross-Russell noted that the EHE pillars and Integrated Planning structure are very similar to the initial Integrated Plan guidance (which was based on National HIV/AIDS Strategy with four specific components). L. Matus said that they should look at the future duties for the Integrated Plan, keeping in mind that the guidance for the new plan would soon be released. They could review future duties by keeping EHE and the Integrated Plan in mind.

L. Matus asked what they should do since they have a tentative plan around committee structure. N. Johns responded that Executive Committee would still need to discuss structure. M. Ross-Russell said the Executive Committee would likely meet in December. L. Matus asked if the Prevention Committee typically meets in December, and N. Johns said no, but Finance Committee does.

L. Matus noted that there was a HIPC meeting on the December 10th. L. Matus asked about the Executive Committee meeting date. M. Ross-Russell said S. Moletteri would send out a Doodle poll to Executive members to help determine the best meeting date.

—Leadership/Workforce Development—

N. Johns shared the EHE Plan on the screen. She brought up Goal 5 under Pillar 4: Respond. The goal is as follows: Ensure that HIV workforce is appropriately trained. Supported, and capable of meeting the goals of the Philadelphia Ending the HIV Epidemic Plan. She said that there has been much discussion around workforce within the last year. This topic is within the EHE Plan and has been discussed in depth within HIPC, specifically Prevention Committee. She reminded the committee that in their meeting about prioritization of topics, the committee chose to prioritize the discussion of workforce. The Health Department has also prioritized this topic.

K. Carter suggested looking through each strategy of this goal, and L. Matus agreed. K. Carter ready Strategy 5.1—assess the capacity of the workforce needed to implement the EHE plan—and the corresponding activities. Please refer to the EHE plan, page 31 of version 3.5, for more information. L. Matus asked everyone to pause for feedback/comments when needed.

K. Carter read Strategy 5.2—develop the capacity of the prevention workforce to meet the goals of the Philadelphia EHE plan—and the corresponding activities. Please refer to the EHE plan, page 31 of version 3.5, for more information. K. Carter asked is this was regarding compensation for workers. L. Matus affirmed.

K. Carter asked which version/step of the EHE Plan they were currently reviewing. L. Matus responded that this was not yet the final plan. N. Johns explained that they were reviewing the plan to offer context of what is currently in the EHE Plan. They can review and discuss what is not included in the plan, so they can bring it forward for discussion, recommendation, etc. to AACO. She noted that AACO is prioritizing community feedback for implementation of the plan. The Council is of great help, because they have various areas of expertise.

M. Ross-Russell said that AACO is almost at the end of the EHE planning phase. The document is soon to be submitted and will be in its implementation phase as of January 1st.

K. Carter noted that Activity 5.2.2.—support expansion of the role of HIV testers to include responsibilities for active linkage to HIV medical care and PrEP through training and performance measures—especially stood out to him. He explained that this may be important for the committee to discuss since it is vital to ending the HIV epidemic.

K. Carter read Strategy 5.3—utilize programmatic and HIV public health data to develop the capacity of the HIV care workforce—and the accompanying activities. Please refer to the EHE plan, page 31 of version 3.5, for more information. K. Carter pointed out overlap between 5.2 and 5.3, and D. Gana agreed. He said that these activities corresponded, one being at the city-level and the other at agency-level. L. Matus said that for the last Activity of 5.3, she was curious to see how they are going to integrate these practices at the school district level.

K. Carter then read Strategy 5.4—develop capacity to implement services responsive to the changing landscape of healthcare in the wake of COVID-19 crisis and recovery—and the accompanying activities. Please refer to the EHE plan, page 31 of version 3.5, for more information.

K. Carter said that in the past, there has been pushback at the school district level, though he knows of new leadership. C. Steib said that new leadership may be more receptive. C. Steib said there has been a blockage of information getting into schools and general issues with testing and sexual education. K. Carter asked if AACO would personally visit schools to review the EHE plan. M. Ross-Russell was unsure.

D. Gana said talking to school districts would be important, but they should also consider including youth centers as a partnership. D. Gana suggested adding collaboration with youth centers as Activity 5.3.12. This would focus on meeting youth where they are at. Since the school district does not allow testing on site, youth centers may not have such regulations in place. C. Steib mentioned that some charter schools allow it on-site testing. K. Carter asked if charters are public or private, N. Johns responded that they are technically public, but the school district does not have full control over how they operate.

L. Matus said that adding youth centers to the list would enhance youth outreach, K. Carter said there is a new youth housing center with approximately 30 beds. They could get in touch with this new youth center as well.

C. Steib said that GSAs (gay/straight alliances) may also be helpful for dissemination of information within schools. K. Carter noted that when focusing on youth-centered outreach, they should look more into social media. M. Ross-Russell said that AACO is looking into more ways to enhance social media presence.

Old Business:

None.

New Business:

None.

Announcements:

L. Matus announced that Congreso is doing on-site HIV testing on Tuesdays and Wednesdays from 10:00 a.m. – 3:00 p.m. with the last test at 2/2:30 p.m. They are also assisting clients bilingually if people wanted to access at-home test kits. They can support this telephonically as well. She would forward the flyer to S. Moletteri to distribute to the rest of the Council. K. Carter asked if they have also been doing COVID-19 testing. L. Matus responded that Congreso Health Center does, and their next testing date was November 18th.

Adjournment: C. Steib called for a motion to adjourn. **Motion:** D. Gana motioned, K. Carter seconded to adjourn the October 28, 2020 Prevention Committee meeting. **Motion passed:** The meeting was adjourned by general consent at 3:55 p.m.

Respectfully Submitted,

Sofia M. Moletteri, staff

Handouts distributed at the meeting:

- October 2020 Prevention Committee Agenda
- September 2020 Prevention Committee Minutes

DExIS Feedback Worksheet
Prevention Committee
Wendesday, January 27, 2021

1. How do the DExIS findings compare to your experiences? What do these findings tell you about testing and linkage to care?

2. Which DExIS key theme speaks to you most and why? Key themes are as follows:
    a. *People with newly diagnosed HIV are engaged in healthcare. HIV testing is not always being offered at key junctures.*
    b. *Relationships with healthcare providers matter; people often experience being dismissed or judged in healthcare interactions.*
    c. *PrEP does not always feel relevant to people who may be able to benefit from its protection.*
    d. *We need to address HIV stigma in our EHE efforts.*

3. How can this key theme be used to enact positive change within the RWHAP system?

4. Stigma is a prominent theme within the Planning Council and DExIS findings. What can RWHAP do to combat stigma?

From the HIPC Meeting Minutes of
Thursday, December 10, 2020
TOPIC: DExIS Presentation from Akash Desai

—DExIS (Akash Desai)—

A. Desai introduced himself as the DExIS Project Coordinator with AACO. He said he would introduce the project and go over some of the findings they have learned so far. He explained that DExIS was an acronym for Demonstrated Expanded Interventional Surveillance. This is a demonstration project launched by the Philadelphia Public Health Department (PDPH) in early 2019. Philadelphia is 1 of 20 jurisdictions nationwide funded by the CDC to design and carry out the demonstration project.

He gave an overview of what he would be speaking about: (1) why DExIS is important, (2) what the project is trying to achieve, (3) who is contributing to the work, (4) how they are doing the work, (5) what the project has uncovered, (6) proposals made due to project findings, (7) how the program aligns with local and EHE efforts, (8) and how it responds to COVID-19.

A. Desai noted that, to end the HIV epidemic, the project needs to identify and close gaps within the HIV prevention system. They are centering the experiences of PLWH as a primary tool in addressing national and local EHE goals. Structured data collection that captures gaps within the local network of services can provide a compelling base for providers to reimagine service delivery. Moreover, the voices of individuals with lived experience need to be represented at the decision-making table to convey the nuances not visible in medical chart data alone.

A. Desai reiterated that DExIS is a CDC-funded, systems-level demonstration project within HIV prevention. It focuses on new HIV diagnoses among three populations: (1) Black and Hispanic/Latino gay, bisexual, and other men who have sex with men, (2) youth ages 18 to 24, and (3) transgender persons who have sex with men.

To explain DExIS's main goals, A. Desai listed the following main objectives. First, the project sought to engage individuals newly diagnosed with HIV to share their experience navigating systems that may not be responsive to their needs. Secondly, the project worked to mobilize medical providers citywide to participate in a robust de-identified review of new HIV diagnoses. Finally, the project identified patterns of missed opportunities and community needs through a monthly review. This information would is as a guide to inform actionable policy recommendations to enhance client-centered care.

Regarding who was contributing to DExIS work, A. Desai acknowledged that there was a large group of people throughout the city to participate in the project. The project engaged experts from six key sectors. The six sectors are (1) Prevention (frontline and management-level staff at HIV and STI testing sites), (2) Treatment (treatment providers and RW funded providers), (3) Legal, Regulatory, & Policy (including Health Department, AIDS Law Project, and PA State Health Department), (4) Social, Cultural (social and cultural serving institutions), (5) Support (mental health & behavioral health providers), and (6) Research (research institutions throughout the city). In all, there were upwards of 60 individuals participating in the project.

To explain how the project flows from team to team, A. Desai identified a flow chart which moved from DExIS staff → Case Review Team → Community Action Team → Policy Implementation Team. DExIS staff is responsible for identifying acute cases of HIV among the three priority populations, reviewing available medical charts reflecting two years care prior to HIV diagnoses, conducting in-depth semi-structured interviews, and writing de-identified case summary reports. He explained that the interviews were voluntary, but the project was fortunate enough to have enthused and engaged participants. The project ensured that they framed the interviews as different than primary services interviews. The interviews were unique in that the data collected would be used to enhance the system. Therefore, data collected did not focus on any identifying information such as dates, people, and places.

Using the de-identified case summary reports, the Case Review Team (CRT) reviews the reports. The CRT is internal to the PDPH to maintain confidentiality to the utmost level. This team consisted of those from AACO, the Division of Disease Control from the newly developed Substance Use Prevention Harm Reduction Division, the Viral Hepatitis Program, Youth Care Teams at the Maternal Child and Family Health Division, as well as the Chronic Disease Prevention Division. These individuals worked to identify patterns and emerging themes within the case summary reports. The team met monthly to review 4-6 cases to identify a couple themes at a time.

Next, themes and patterns from CRT are consolidated and presented to the Community Action Team (CAT). This group meets on a quarterly basis and is comprised of a variety of individuals. These team members may or may not be affiliated with organizations. This includes individuals who are intimately involved with the work, frontline staff, HIV and STI testing providers, disease intervention specialists, supervisors, researchers, clinicians closely involved with HIV prevention and treatment, and individuals from PA Health Department. CAT reviews the themes to identify missed opportunities and then reviews CRT's recommendations and proposes new ones.

Recommendations from CAT are then sent to the Policy Implementation Team (PIT). This team includes policy and healthcare leadership, executive-level leadership at agencies represented in CAT, clinicians, and other executive staff at other Philadelphia agencies. He clarified that, generally, this team is meant to be for individuals who hold executive or higher power and have more leverage regarding making actionable change. PIT develops concrete action plans to implement recommendations determined by CAT. PIT finds ways in which to propel the recommendations by looking at a number of factors. This team categorizes between long-term and short-term timelines, level of impact, involved effort, etc. PIT meets on a quarterly basis.

Overall, A. Desai explained that CRT has met nine times, CAT has met four times, and PIT has met three times. 42 cases have been reviewed with 15 of those having a completed interview. So far, DExIS has identified four consistent key themes. (1) People with newly diagnosed HIV are engaged in healthcare, meaning the majority of individuals have had some form of healthcare interaction in the past 12 months prior to HIV diagnosis. It was found that HIV testing is not always being offered at those key junctures. (2) Relationships with healthcare providers matter; people within the interviews often experienced being dismissed or judged in healthcare

interactions. Individuals who find providers they feel comfortable with have higher engagement with healthcare. (3) PrEP does not always feel relevant to people who may be able to benefit from its protection. People may determine risk in a different way that healthcare providers convey. There is a discrepancy between the way healthcare providers describe risk and patients perceive risk. (4) HIV stigma needs to be addressed throughout EHE efforts, including DExIS interview and chart extraction process.

Keeping the key themes in mind, A. Desai identified three proposals from DExIS thus far. First, DExIS has proposed "PrEP Follow-Up," meaning that providers must be issued guidance for routine follow-up with clients after PrEP initiation. Providers are to listen to clients and offer strategies to manage side effects. Throughout the interviews, they noted that individuals are eager to initiate PrEP but discontinue use due to side effects.

The second proposal involves "Advocacy to Extend Coverage." This involves drafting a sign-on letter to request the federal Ready, Set, PrEP program to extend coverage to young people on a parent's insurance, with the inclusion of medical visits and lab costs. He explained that for the HHS Ready, Set, PrEP program, the participant needs to have a negative HIV test, a prescription for PrEP, and cannot have comprehensive prescription drug coverage. This often leaves out youth who are not the primary policyholder on their insurance. Privacy concerns related to dissemination of EOB (Explanation of Benefits) and whether parents/guardians are able to see EOB often deter youth from initiating PrEP. This is why the letter of support from providers and community members would be helpful for extending federal coverage.

Lastly, DExIS has proposed to "Integrate HIV and STI Testing." This is to issue PDPH guidance to facilities on concurrent HIV-STI testing and same-day PrEP initiation.

A. Desai explained that DExIS aligns with local and national EHE efforts in two ways. DExIS fits into EHE Pillar 4: Respond. It aligns with the EHE goals of reducing new HIV infections, increasing access to care, and reducing HIV-related disparities and health inequities throughout the continuum. Secondly, all new cases of HIV should be viewed as public health emergencies. DExIS approaches new diagnoses through the framework of expanded interventional surveillance. The case reviews, emerging themes, and recommendations produced by DExIS are actionable and directly influencing AACO interventions.

COVID-19, as the council knows, has impacted healthcare greatly in regards to response. A. Desai explained that DExIS used COVID-19 as an opportunity to optimize DExIS to more immediately respond and capture the needs of individuals. DExIS did this is a number of ways. The project added interview questions on stigma, the pandemic's impact on accessing care, and individual resiliency. There was also an extended, optional interview segment added that will be entirely qualitative. All DExIS team meetings will be convened virtually via GoToMeeting. DExIS updated security and confidentiality agreements to continue protecting de-identified data. CRT and CAT will complete interactive activity in meetings to categorize recommendations according to anticipated effort and impact.

D. D'Alessandro explained that the Health Federation of Philadelphia in collaboration with AACO has a similar model to DExIS regarding mother to child HIV transmission, Fetal Infant

Mortality Review (FIMR). She noted that their challenge, even before COVID-19, involved engaging clients in the interview. She wanted to know how DExIS kept participants engaged in interview and how interview participation was impacted by COVID-19. A. Desai said that interviews started up again in early fall, because staff discontinued interviews during the summer of 2019. Even before the pandemic, they offered interview by phone. After COVID-19, interviews were still offered by phone, and they did not see much of a change in responses. DExIS was not hosting in-person interviews anymore, but phone interviews were especially beneficial for those who did not prefer face-to-face interaction. DExIS also had two versions of the survey: a 45-minute interview with quantitative data collection and a $50 incentive, and the 75-minute interview with a $100 incentive. He added that DExIS typically recruits participants with a phone call followed by a text, though they were not doing recruitment via mail due to remote work.

D. D'Alessandro asked how DExIS was getting participants incentives. A. Desai responded that DExIS staff would go to the office routinely to mail out gift cards with USPS. Moving forward, they were trying to secure digital, Amazon gift cards as well.

M. Cappuccilli noted that the project started in early 2019. He asked when A. Desai expected the project to finish. A. Desai said the project was intended to be throughout a 4-year grant period. The project was supposed to start in early 2018 and end before 2022. However, jurisdictions received funding in late 2018 and started onboarding staff early to mid 2019. The grant would still wrap up in 2021 and focus on evaluation within this final year. M. Cappuccilli asked if they were still continuing to do interviews and whether they would revisit with interviews to see how recommendations pan out. A. Desai said the goal was to integrate the DExIS model into the existing Core Surveillance program, including the addition of more outreach staff to the program. This way, in a sense, the work of DExIS would continue. DExIS was also looking to incorporate PWID and other populations into the interview process to collect more data.

G. Grannan asked if there were plans to report DExIS findings to those they interviewed. A. Desai said, as of now, there was no secured method for engaging past interviewees, and not many people wanted to have follow-up interactions with the CRT. However, they did offer linkage to Client Services Unit for MCM and other services. The teams are recently looking into how they can continue relationships with those interviewed and safely and confidentially disseminate information and findings.

S. Arrighy asked how they were tracking receipt of incentives. A. Desai said that typically, in person, participants sign a receipt. Over phone, they mail them and let participants know when the incentives are expected to arrive. The latter process, there was no way for participants to sign, and sometimes participants did not let them know if incentives were received. This is why, A. Desai noted, digital gift cards would be beneficial since participants could immediately let them know if the card's code was working. By mail, K. King noted that gift cards must be activated—therefore, they could find a way to ensure participants received incentive by tracking the activation status. A. Desai agreed that this was a good idea, and this would especially be easy to see with Amazon gift cards bought in bulk.

DExIS

Demonstrating Expanded Interventional Surveillance

Akash Desai

DExIS Project Coordinator, AIDS Activities Coordinating Office

Overview

1. Why is DExIS important?
2. What are we doing?
3. Who is contributing to this work?
4. How are we doing it?
5. What have we found?
6. What has been proposed?
7. How does this program align with local and national EHE efforts?
8. Responding to COVID-19

Why is DExIS important?

To end the HIV epidemic, we need to identify and close gaps within the HIV prevention system. Centering the experiences of people living with HIV (PLWH) must be harnessed as a primary tool in addressing national and local EHE goals.

Structured data collection that speaks to gaps within our local network of services can provide a compelling evidence base for providers to reimagine service delivery. The voices of individuals with lived experience need to be represented at the decision-making table to convey the nuances not visible in medical chart data alone.

What are we doing?

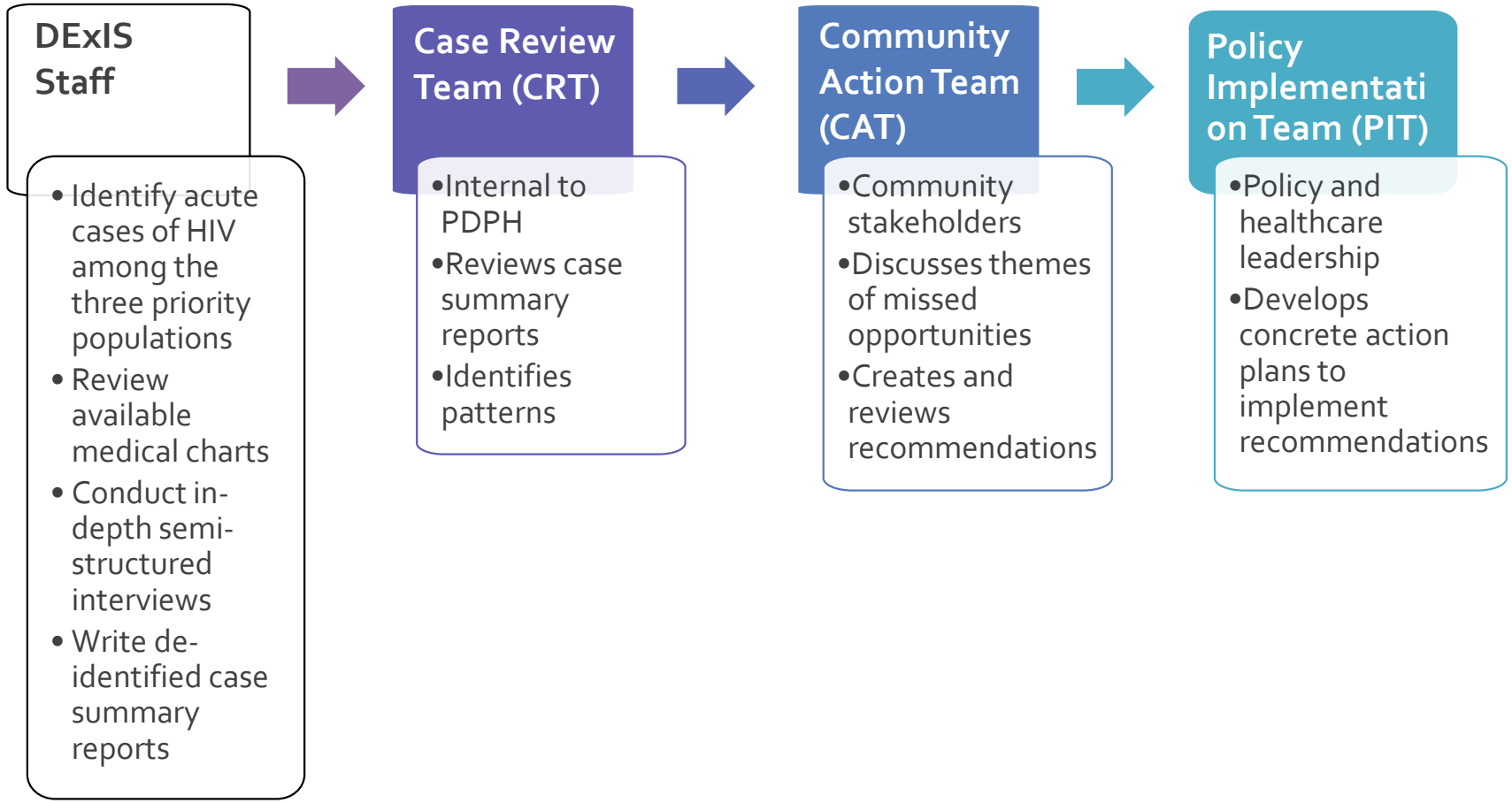
DExIS is a CDC-funded, systems-level demonstration project within HIV prevention. It focuses on new HIV diagnoses among three populations: Black and Hispanic/Latino gay, bisexual and other men who have sex with men, youth ages 18 to 24, and transgender persons who have sex with men.

The program has the following objectives:

- Engage individuals newly diagnosed with HIV to share their experiences navigating systems that may not be responsive to their needs.
- Mobilize medical providers citywide to participate in a robust de-identified review of new HIV diagnoses.
- Identify patterns of missed opportunities and community assets through a monthly review. This information guides the formation of actionable policy recommendations to enhance client-centered care.

Who is contributing to this work?

How are we doing it?



What have we found?

- Key themes:
  - People with newly diagnosed HIV are engaged in healthcare. HIV testing is not always being offered at key junctures.
  - Relationships with healthcare providers matter; people often experience being dismissed or judged in healthcare interactions.
  - PrEP does not always feel relevant to people who may be able to benefit from its protection.
  - We need to address HIV stigma in our EHE efforts.

What has been proposed?

PrEP Follow-Up

- Issue provider guidance for routine follow-up with clients after PrEP initiation. Listen to clients and the strategies they use to manage side effects.

Advocacy to Extend Coverage

- Draft a sign-on letter to request the federal Ready, Set, PrEP program to extend coverage to young people on a parent's insurance, with the inclusion of medical visits and lab costs.

Integrate HIV and STI Testing

- Issue PDPH guidance to facilities on concurrent HIV-STI testing and same-day PrEP initiation.

How does this program align with local and national EHE efforts?

- DExIS fits into EHE Pillar 4: Respond. It aligns with EHE goals of reducing new HIV infections, increasing access to care and reducing HIV-related disparities and health inequities.
- All new cases of HIV should be viewed as public health emergencies. DExIS approaches new diagnoses through the framework of expanded interventional surveillance. The case reviews, emerging themes and recommendations produced by DExIS are actionable and directly influence AACO interventions.

Responding to COVID-19

- Additional interview questions added on stigma, the pandemic's impact on accessing care, and individual resiliency
- An extended, optional interview segment will be entirely qualitative
- All DExIS team meetings will be convened virtually via GoToMeeting
- Updated security and confidentiality agreements to continue protecting de-identified data
- CAT and PIT will complete interactive activity in meetings to categorize recommendations according to anticipated effort and impact

For additional questions or suggestions—

Akash Desai

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