Julie Hook: Good afternoon and welcome to this webinar on aligning local Getting to Zero and ending the epidemic initiative and integrated HIV prevention and care plans. My name is Julie Hook from the Integrated HIV/AIDS Planning Technical Assistance Center and I want to thank everyone for taking time to be on today's webinar. During today's webinar we'll talk about differences and similarities between Getting to Zero and ending the epidemic initiatives and the integrated HIV prevention and care plans, discuss the benefits of aligning the plans and then we'll also have some folks from the Santa Clara County Public Health Department that will talk about the steps that they have taken to align their plans and provide recommendations of activities and strategies for other recipients to adopt. I just wanted to let everyone know that the slides are available for download at our website, and they've just been chatted out.

Julie Hook: The Integrated HIV/AIDS Planning Technical Assistance Center, or the IHAPTAC, is a partnership between JSI, HealthHIV and NASTAD and is funded by the HRSA HIV/AIDS Bureau. As a reminder, we're a three year cooperative agreement that began in 2016 to support Ryan White HIV/AIDS Program Parts A and B recipients and CDC grantees and their respective planning bodies with overall integrated planning efforts and the implementation and monitoring of their integrated HIV prevention and care plans, and we provide both targeted and national technical assistance.

Julie Hook: We provide support in integrating HIV prevention and care at all levels, strategies for implementing integrated plan activities, publicizing and disseminating progress on implemented plan activities, identifying roles and responsibilities for implementation, monitoring and improving your integrated plan activities and collaborating across jurisdictions.

Julie Hook: We'll be answering questions at the end of the call. We'll answer as many as time permits. If you have any questions during the call, please chat them into the chat feature and I also just wanted to mention that after the webinar ends, an evaluation will pop up immediately and we hope that you'll fill this out as it helps us to improve and inform future trainings. So following the webinar we hope that you'll be able to describe the rationale and benefit of aligning integrated HIV prevention and care plans and local GTZETE initiatives, identify at least one way jurisdictions can operationalize integration efforts and describe at least one practical strategy to engage and involve new stakeholders in integrated planning efforts.

Julie Hook: But before we start today, I'd like to turn the call over to Steven Young, the Director of the Division of Metropolitan HIV/AIDS Program and the Acting Director of the Division of State HIV/AIDS Programs who'd like to say a few words.

Steven Young: Thank you Julie, and thanks everyone for joining us today. I look forward to hearing from the Santa Clara Health Department and the San Jose Part A Transitional Grant Area, as well as JSI staff about the interplay of integrated plans with Getting to Zero and/or ending the epidemic efforts. But first I just

wanted to briefly mention the fact that we are having an ending the HIV epidemic plenary at our upcoming National Ryan White Conference in December. I hope as many of you who are on the webinar today will be joining us in person for that conference.

Steven Young: The plenary on ending the epidemic is scheduled for Thursday morning, December 13th at 8:30 in the morning and this plenary will be focused on ending the HIV epidemic and we're going to include three geographic areas that have ending the HIV epidemic plans, initiatives and partnerships that drive their overall planning and resource allocation decisions. Each jurisdiction will be presenting in an interview format up on the dais.

Steven Young: We will have dyads with the following focal points. We're going to have a part a and part b health department perspective from Maricopa County, which is the Phoenix area and the state of Arizona. We will also have an HIV community and academia approach from Fulton County, which is the Atlanta area in Georgia. And then lastly, we're going to have a public/private partnership from Washington D.C.

Steven Young: Julie might actually be giving a quick reference or shout out to Arizona and Fulton County in an upcoming slide in a few minutes as well as some other jurisdictions and I think you'll also be hearing from JSI towards the end about some other exciting workshops that we have planned at the conference. So with that, again, welcome to everybody. Listen carefully and I'll turn it back to Julie.

Julie Hook: Great. Thanks so much Steve. Now I'd like to introduce our speakers. Mike Torres is a Health Planning Specialist for the County of Santa Clara Public Health Department. He works in the infectious disease and response branch for STD and HIV prevention and control. He's been with the Santa Clara County for almost eight years and has over 15 years of experience in public health covering the areas of tobacco prevention, obesity prevention, traffic safety and HIV/AIDS.

Julie Hook: We also have Molly Tasso who is from our IHAP TAC team and she is a technical assistance coordinator. She specializes in the Ryan White HIV/AIDS Program, healthcare reform in the ACA and community HIV planning efforts.

Julie Hook: So now that you know about us, we'd like to learn a little bit more about you and just do a couple quick audience polls. Have you ever been on an IHAP TAC webinar before? So it looks like it's pretty actually even least split. About just over half of you have been on IHAP TAC webinar before so welcome back and for those of you that are new, thanks for joining us.

Julie Hook: One other question that we are hoping to know is that does your jurisdiction have an integrated or joint prevention and care planning body? So yes, we currently have one in place, integration is currently in progress, we're currently thinking about it, no we don't or other. And I realize we probably should also have a not applicable as well since there maybe people on here that are not part

of a jurisdiction. All right, so just looking at the results about over 60% of you have an integrated planning body, and about 15% don't, and a handful of others are either in the currently in the process or thinking about it. So great, I'm glad you're all able to join us.

Julie Hook: So now I'd like to hand the slides over to Molly.

Molly Tasso: Great. Thanks so much Julie. So before we dive into discussing the ways that jurisdictions are aligning their integrated plans and they're Getting to Zero or ending the epidemic initiatives, it's important to first understand the similarities and differences between these types of plans and how each came to be valuable tools used to advance and promote care and prevention efforts within communities. So to provide a quick refresher, I'm just going to walk us through the basics of the integrated plan guidance and requirements that were set forth HRSA and CDC. And this will really help sort of make clear the contrast between these plans and the Getting to Zero plans that we are going to discuss a little bit later in the webinar.

Molly Tasso: So to start, I'm sure we are all familiar with the national HIV/AIDS strategy, although the focus is often placed on the first three goals and the development of the integrated HIV prevention and care plans is a tool that really supports the progress towards and eventually helps achieve the fourth goal, which is a more coordinated national response to the HIV epidemic. Specifically by way of increasing coordination of HIV programs across the federal government and between federal agencies and state, territorial, tribal and local governments.

Molly Tasso: So to this end, in 2015, the CDC and HRSA released joint guidance to support the submission of an integrated HIV prevention and care plan, including the statewide coordinated statement of need. The guidance built upon efforts to further reduce reporting burden and duplicated efforts, streamline the work of health department staff and HIV planning groups and promote collaboration and coordination in the use of data.

Molly Tasso: So as we know, integrated plans are considered living documents and serve as a roadmap to guide a jurisdiction's HIV prevention and care service planning throughout the year and also support jurisdictions to better leverage resources and improve efficiency in coordination of HIV prevention and care service delivery.

Molly Tasso: As required by HRSA and CDC, each HRSA, Ryan White Part A and B and CDC prevention funded jurisdictions were required to participate in the completion and submission of an integrated HIV prevention and care plan. Ultimately, health departments and HIV planning groups are really the responsible parties for developing these plans. To aid in the development of these plans, HRSA and CDC released guidance that detailed what content was required to be in a plan. So specifically, as I'm sure you are all aware, these plans were required to contain smart objectives, activities, strategies, a description of the responsible

parties for completing the activities, and also plans for ongoing monitoring and improvement of the plan.

Molly Tasso: Recognizing that a sort of one size fits all approach would not work for all jurisdictions, HRSA and CDC provided jurisdictions with the option to submit various types of plans. So as you can see on this chart here, jurisdictions did take advantage of this opportunity. As outlined in the charts about 37 plans, which represents about half of the 80 plans submitted were submitted on behalf of part B only, part B programs only. However, 29 of these were submitted in states without a part A program, so that part B only made sense.

Molly Tasso: On the other hand, 21 plans were submitted on behalf of a part A jurisdiction only and in total 22 integrated plans were submitted on behalf of a jurisdiction's part A program and part B program. So there was a pretty good mix in there of the different types of plans that were submitted.

Molly Tasso: So now that we've refreshed ourselves with the integrated plans, let's review the basics of Getting to Zero or ending the epidemic plans, which in many cases takes a much different form than an integrated plan. And just as a quick note, as I continue, I'm going to be referring to these just as Getting to Zero plans as they're often used sort of interchangeably.

Molly Tasso: So Getting to Zero plans are plans or initiatives that are developed in cities, counties and states that outline strategies or articulate a desire or a vision to addressing HIV in a specific area. So most often these are developed collaboratively with elected officials, local government entities, service providers, community based organizations and community activists. These plans are supported by multiple funding streams, including private foundations and national advocacy organizations as well as local government and community based organizations. Perhaps the biggest difference between integrated plans and Getting to Zero plans is that Getting to Zero plans are not mandated, reviewed or monitored by HRSA and CDC. They're entirely initiated, implemented and monitored by the state, county or local level.

Molly Tasso: So to get a better sense of what these plans look like and how they're advancing the goal of Getting to Zero, I'm going to introduce and describe to you a handful of these plans being implemented across the country. And just to be clear, there are many more initiatives like this happening that have been adopted, but what I'm discussing today represents only a snapshot of the work being done.

Molly Tasso: So first in the state of Arizona, the Arizona HIV Statewide Advisory Group and the Phoenix EMA Ryan white Part A Planning Council developed a wraparound initiative. I's not so much a standalone plan that's different than the integrated plan, but a campaign to promote the integrated plan and educate the community on the goals of the plan. The Victory Over HIV website contains links to the full integrated plan, a summary document of the integrated plan, links to the national HIV/AIDS strategy and other useful resources, and it's financially supported by the AIDS Healthcare Foundation and Phoenix Pride.

Molly Tasso: Next in Fulton County, Georgia. In 2014, the Taskforce on HIV/AIDS for Fulton County was established by the Board of Commissioners and tasked with providing input and recommendations in areas of public education, advocacy, treatment, prevention, housing, and related issues pertaining to HIV/AIDS in Fulton County. To this end, the taskforce set forth to develop a comprehensive evidence based strategy to end AIDS in Fulton County that would be implemented and monitored to track progress towards success.

Molly Tasso: The taskforce included various key stakeholders, including government officials, content experts, community members, and health department officials and since its inception has been transitioned to a permanent policy advisory committee. The strategy itself is rooted in a social justice and civil rights' framework that acknowledges and works to address and reduce the racial and economic disparities of the epidemic within the county. As such, the strategies they recommend such as adopting syringe exchange services in Fulton County, they support but don't precisely mirror the strategies of the state's integrated plan.

Molly Tasso: In Houston, the roadmap to ending the HIV epidemic in Houston was developed by Legacy Community Health in collaboration with Housing Works, the Harvard Center for Health, Law and Policy Innovation and various community leaders. The document puts forth a set of recommendations that can be adopted or implemented by service providers, community organizations and policymakers, and are centered around five broad areas including access to care, prevention, social determinants of health, criminal justice, and policy and research.

Molly Tasso: The recommendations found in the document include common goals and recommendations that are often found in integrated plans as well, such as increased HIV testing, increased access to mental health and substance use treatment, and improved health outcomes for people living with HIV with comorbidities. The roadmap though also contains recommendations that are unique to Houston's plan, such as a recommendation to collect more comprehensive data on the trans community and those recently released from incarceration and expanded access to condoms in the correctional system. One interesting thing to note is that a specific recommendation within this plan is to integrate their strategy with the Houston areas comprehensive HIV prevention and care services plan.

Molly Tasso: And lastly, let's take a look in Pittsburgh, excuse me, where community based organizations, government agencies and health care institutions collaborated to create a public health movement called AIDS Free Pittsburgh, which supports a website that contains information and resources for providers and consumers on HIV testing, PrEP, health insurance and case management services.

Molly Tasso: By employing strategies such as normalizing HIV testing, increasing access to PrEP, and improving linkage to care, AIDS Free Pittsburgh aims to achieve their goal of reducing new infections by 75% in the year 2020.

Molly Tasso: So having reviewed integrated plans and several specific Getting to Zero initiatives, the similarities, and differences between them are pretty clear as is though the opportunities for alignment and collaboration.

Molly Tasso: First, it's clear again that there is significant differences between integrated plans and local Getting to Zero initiatives. The plans often differ in terms of their structure, which is a major point. For example, all integrated plans are usually pretty lengthy written documents that includes epidemiological data and a resource inventory. Whereas the products of a Getting to Zero plan or the sort of final outcome of it can be anything from a website, a brief memo, informational or promotional graphics, social media, maybe toolkit or a combination of all those things.

Molly Tasso: Second, Getting to Zero initiatives receive funding from entities that do not fund the development or implementation of integrated plans such as private foundations or national advocacy groups.

Molly Tasso: Third, there's a varying level of political advocacy included in the plans as Getting to Zero initiatives are not operating with federal monies and as such are able to advocate for programs or policies that HRSA or CDC funded jurisdictions may not be able to for a number of reasons. Integrated plans and Getting to Zero plans may define what ending the epidemic means in different ways in their jurisdictions, which can make it difficult to align outcome measurements.

Molly Tasso: And lastly, of course the most obvious difference between the two is that Getting to Zero plans are not required, reviewed or monitored by HRSA or CDC. But despite differences, integrated plans and Getting to Zero plans often also share many similarities and most notably and obviously it's their overarching goal and the objectives of reducing new infections, increasing linkage and retention to care, promoting PrEP and increasing viral suppression.

Molly Tasso: Further, the development and implementation of these plans involve similar parties, such as health departments. service providers, community based organizations, and most importantly people living with HIV. Additionally, both types of plans focus on the ways the epidemic disproportionately impacts particular populations in their jurisdiction and puts forth strategies to eliminate those disparities.

Molly Tasso: So given their similarities, there are various opportunities to align the implementation work of integrated plans and Getting to Zero initiatives. First, there's an opportunity to align evaluation metrics and adopt data sharing agreements through teen health departments in those implementing the Getting to Zero initiative.

Molly Tasso: Second, planning groups responsible for implementing and monitoring progress towards the goals of the integrated plan and the Getting to Zero plan can consider integrated planning bodies or appointing individuals to serve on both

groups and act as liaisons. Also, formal or informal communication processes can be developed to support ongoing coordination between the implementation bodies. This can be in the form of a combined planning group, like I said, or even less formal measures such as just monthly check in calls or even just a simple meet and greet between individuals who are involved in this work.

Molly Tasso: These are just a handful of examples of opportunities for collaboration, but Mike is going to be talking a little bit more about what Santa Clara County is doing in a minute. As Michael will discuss also of course, efforts to align plans that are on such a large scale and longterm, that does not come without challenges. So issues of timing can be problematic as Getting to Zero initiatives were often created before the integrated plan and aligning these after the fact can be a bit tricky.

Molly Tasso: Second, there can be fundamental misalignment between the activities or goals set forth in the Getting to Zero initiatives and integrated plans. As I've described in some of the examples above or before, these are mostly centered around political or policy constraints that impact health departments less so than the implementation bodies of Getting to Zero plans. So of course, while there are challenges, alignment between plans certainly can be accomplished and to discuss in depth how Santa Clara County in California is doing this, I'm going to hand it over to Mike.

Mike Torres: Thank you. My name is Mike Torres and I'm a health planner with the County of Santa Clara Public Health Department. First off, before I get started, I just want to thank the IHAP TAC team for inviting us to present today. Next slide.

Mike Torres: Just an overview of what we'll be covering today. I'll just give you some demographics and the landscape of HIV in Santa Clara County. I'll give kind of the public health program structure, the integrated and our local Getting to Zero plan development, our challenges and successes, lessons learned and tangible tips.

Mike Torres: So just a quick overview of what our TGA looks like. We have a population of 1.9 million and as you can see, it breaks it out of who's living in our county. In the landscape of HIV in the county, in 2017 we had just over 3,000 people living with HIV infections and 51% of those people have received at least one Ryan White funded program. Then it breaks down, 86% are male, 13% female, 1% transgender. And in 2017 we had a 156 new cases. Next slide.

Mike Torres: The map kind of shows our county. The darker shaded areas are the prevalence of where people are living with HIV in our county. Next slide.

Mike Torres: This shows in our county where our care and prevention funding, our care funding is just over $3 million, $3.6 million and it breaks it down. We get Ryan white Part A, Part A MAI, Ryan White Part B, Part B MAI, and we also get some

county general fund. Our prevention funding is just over $900,000, we get that from the California Department of AIDS. Some money from Santa Clara County General Fund and STD Local Assistant Grant.

Mike Torres: So when I'm referring to Getting to Zero, both plans are called Getting to Zero. I'll be referring to our local Getting to Zero and then our integrated plan. So our local Getting to Zero, it's a collaboration between the county public health department, surrounding HIV service providers, healthcare organizations, advocacy groups and other community based organizations. And this was all brought about by one of our main champions, one of our county supervisors Ken Yeager and he's been a champion with a lot of public health initiatives over the year, and he's our champion for our local Getting to Zero.

Mike Torres: The local Getting to Zero Employees Collective Impact Model for implementation and this has five components, a common agenda, shared measurement systems, mutually reinforced activities, continuous communication, and a backbone organization. Our local Getting to Zero initiative focuses on four areas, PrEP and PEP access, stigma reduction, guideline base, STI screening and HIV testing and HIV linkage and retention to care.

Mike Torres: Now to talk about our integrated plan. We partnered with the state Office of AIDS. We are a coauthor with two other jurisdictions in California, Sacramento County and San Bernardino County. We have eight main objectives and five sub objectives addressing nine different priority populations and later on in the presentation, I'll go over the timeline of how we developed, implemented and now are reporting on our integrated plan.

Mike Torres: The goals of aligning the integrated plan and our local Getting to Zero initiative, and I'm sure you've heard this before, ensure consistency across goals, strategies, and performance measures. We wanted to align everything that we're doing locally with the state and with national goals so we're all on the same path. Decreased, duplicative work across two initiatives working towards the same goal.

Mike Torres: Increased collaborations between public health department officials, community members and stakeholders, and I think this is real important because you are getting, at our local level, we're getting some new partners at the table and now they're aware of the whole, the bigger plan, the integrated plan with the state. So it really informs everyone at the table working on these goals and that the initiative that we're all striving for, what our county is striving for, our goals, what our, like I said, the state is striving for and with the national goals. Next slide.

Mike Torres: So now I'm going to talk about operational of the alignment of both of them. In this timeline it kind of shows where we started. On the far left, the guidance came out I believe in June 2015 and that was right around when our supervisor, our champion supervisor Yaeger kind of a referred the board for the local Getting to Zero initiative. In September, he requests for the Getting to Zero

proposal. In October the state and the local jurisdictions created a work group. We talked biweekly, monthly, we were constantly emailing on how we were going to develop and plan the integrated plan and through January, through June this took place.

Mike Torres: We've got input from our planning council, service providers, consumers on input for our integrated plan and while this was going on, our local Getting to Zero initiative was being developed and constructed also. So in that February the Getting to Zero proposal is accepted, they were working on their priority strategies. So simultaneously these plans were being developed. In a perfect world, you would like the integrated plan to be developed and then as a blueprint for the local Getting to Zero you would like to have that. But unfortunately, they were being developed simultaneously.

Mike Torres: As we move down to the right in July, we were finalizing the plan, and it finally got submitted, the integrated plan in September. So moving forward, a lot of the same partners were at the table developing these plans, but kind of unaware of how they intersected. So on my side I was charged with the integrated plan. I started attending ... or met with the backbone agency, and the evaluator for our local Getting to Zero plan and just to let them know that we have this document, we could use this as a blueprint for moving forward with our local Getting to Zero. I started attending their monthly leadership team meetings. Their leadership team is made up of, like I said, service providers, and people in the community, advocacy groups that kind of lead the local Getting to Zero plan.

Mike Torres: In September, we were able to present with the state Office of AIDS the integrated plan at their leadership retreat and now moving forward, we have a standing agenda item for the integrated plan. We give updates monthly on where we are. For their second retreat that just happened in September, the state Office of AIDS and myself gave a report back on year one of where we are with the integrated plan in regards to our objectives. Next slide.

Mike Torres: So putting it all together, this kind of just gives you an idea of our integrated plan, and our local Getting to Zero. What the four areas, how they intersect with our integrated plan, and they intersect with more, but I just pulled these certain strategies out and we really want the people at our local Getting to Zero to be familiar with the integrated plan on how one thing affects the other and the intersection. We're all striving for the zero by 2021. Next slide.

Mike Torres: So I want to talk about successes. So this kind of gives you an idea of our local Getting to Zero activities and some of our successes. There'll be four areas, the priority areas that they're working on and then there's three other areas that the leadership team is striving for. So quickly I'll ... and each area of focus, they've created action teams and that's made up of key stakeholders, which include a representative from Gilead, the maker of the PrEP medication. We have our local PrEP navigator specialists. We have service providers. So they're all at the table.

Mike Torres: So for our PrEP, we were kind of ahead of the game, even in our integrated plan with PrEP. We had already started working on an assessment prior to developing the integrated plan, and our local Getting to Zero plan. We had an assessment of the landscape of PrEP with medical providers that was being done. We were creating a communication plan with providers and clients for PrEP. So when the inception of our local Getting to Zero initiative, we had hired a PrEP navigator and now our PrEP navigator is training the trainer on some for some of our service providers. So PrEP is moving along really well to improve HIV testing. Our focus has been on communication strategies with providers regarding guideline based STI and HIV testing.

Mike Torres: For improving linkage to care and retention they're focused identifying barriers to care across all access points, pharmacies, community agencies, hospitals, and clinics, and working with providers and consumers to find ways to address those barriers. They are conducting this through an assessment of a pharmacy tickler program and developing a model for how to have such a program in a pharmacy. Finding data, finding those barriers and trying to get feedback from the community.

Mike Torres: So around stigma, they're continuing to have messages with all the media they do in the local Getting to Zero, they all have a stigma message. And then to enhance community, collaboration and community involvement of the leadership team, like I said, they've invited certain stakeholders to be at the table at our leadership team meetings so they can provide input. Next slide.

Mike Torres: Then to further leverage existing resources, we are now focus our resources and funding for our local Getting to Zero ends in 2020. So currently the team is working on sustainability efforts. They're throwing ideas around on how to sustain if there is no more funding. So that is going on right now. They're brainstorming on how can we sustain efforts. Next slide.

Mike Torres: So some of our challenges and barriers, like I said, when I was going over the timeline both plans were developed simultaneously, but by different planning groups and there was a lot of the same stakeholders at these meetings, but kind of unaware of how these plans could intersect. Let me back up a little bit. Within the public health department, I believe it was about 10 years ago, the care and prevention, they were siloed. The care portion had a community planning group, and the care side, they were with our then planning council and the same thing. A lot of the same players were at the table, but it seemed like during the care meeting they were talking about prevention efforts and vice versa.

Mike Torres: So they were merged and that became our HIV Prevention and Care Planning Council. Now they are a planning body. So that was a great stride because now we're all housed at the same building. I could just yell across the room at prevention staff. So we're all on kind of the same page on what's going on and how we can help each other and how both plans can help each other. Communication is really vital, you've heard this before. With both of these plans

being developed simultaneously, it needed to be communicated that our integrated plan is a blueprint for what goes on locally and a lot of the stuff that was developed in our integrated plan directly would be influenced by what we were doing with our local Getting to Zero plan.

Mike Torres: Another challenge is the global Getting to Zero model, the collective impact that's gonna take time to see if it was a success. You need probably between six and eight years to see what the outcomes were and it ends in 2020, it was a four year initiative. So that's kind of still up in the air on how we can see if it was an effective model for the initiative. Not always the collective impact model will work in certain jurisdictions and then you have county bureaucracy. There's contract delays, everyone knows that working with the government and sometimes these contracts delays the work. So one thing impacts another. If there was a delay, then the work is being delayed and your services are not being provided.

Mike Torres: So our future direction, like I said, our local Getting to Zero funding ends in 2020. They're currently, the leadership team is, looking at sustainability planning. They are looking at just different ways of sustaining efforts and keeping the momentum going. Continued communication and collaboration between both the local Getting to Zero and our integrated plan, and this is being ongoing, like I said, at their monthly leadership team meetings. We have a standing agenda item with the integrated plan and they're constantly providing them information on what's going on, reporting back like we just did at their retreat on our goals and objectives for the integrated plan.

Mike Torres: Continued efforts to use data to inform adaptations to programs and strategies. The local Getting to Zero uses the evaluator JSI and we meet with them frequently to let them know what's going on with the integrated plan. Then the last bullet point, they're considering the adoption of a rapid air team action team in the Getting to Zero initiative and this is still in the planning stages, but they're looking at moving that forward also.

Mike Torres: So just tangible tips, like I said, communicate, I was able to initially get with the backbone agency, go over the integrated plan, kind of pick out what could be impacted from the local efforts, talk to the evaluators, talk to the leadership group, and all the stakeholders at the table.

Mike Torres: Utilizing available resources, like I said, a lot of stakeholders are similar at each table. So just getting them informed on what's out there, and what's available, and how to use it, understanding various funding streams. I believe Molly said our Part A Ryan White Program has a lot of requirements, that local Getting to Zero plan is funded through our county and can be a little more wiggle room on how we can use funding, featured planning.

Mike Torres: Moving forward, we hope to utilize the local leadership with our local Getting to Zero initiative on how their input on our next integrated plan. Probably one of the most important was having champions. Like I said, we had our county

supervisor Ken Yaeger move along our local Getting to Zero initiative. We also have Dr. Sarah Lewis who is our STD/HIV controller and she was hired right around the time that all this was going on and she's been a real champion on moving along the local Getting to Zero initiative also. I think that's really, really important to identify champions within your organization or in the community that could move these plans and initiatives along.

Mike Torres: So I am done. I'm going to hand it back off to Julie.

Julie Hook: Great. Thanks so much Mike and Molly. We do have some questions that have come in for you Mike. I just want to remind people if they have any additional questions for either Mike or Molly to please chat them into the chat box. Mike, the first question was just around, did the state or county initiate the alignment of the GTZ and integrated plan?

Mike Torres: Can you repeat it one more time please?

Julie Hook: Was there any direction or did the state or county initiate the alignment of the GTZ and the integrated plan?

Mike Torres: So like I said, the HRSA and the state, they all encouraged us to work with, if there is a local Getting to Zero plan, they all encouraged us to work with whoever's developing that plan. So I think that it was prompted from that and then just locally, like I said, we're housed together. I was not on the initial work group for the local Getting to Zero plan, but my colleague program manager for prevention Rosh Gill, she sat right across from me in her office and I would hear, "Oh, this, this. This is being planned." Then I would come to her and I'd go, "Well, we need to look at the integrated plan." So it was just kind of casual talk in the hallway and then it evolved from that where we sat down with our team and I had brought up that we need to be maybe at that table talking about the integrated plan. So they kind of have an idea of the bigger picture and how the local plan could feed into it.

Jimmy Pearson: And Molly, this is Jimmy Pearson from Santa Clara County. We had worked with the community and our HIV Commissioner Planning Council on the development of the integrated plan. Although the local Getting to Zero initiative developed slightly after that work had been almost completed, they didn't start out being aligned. But it became quite obvious early in the process of Getting to Zero, that there were a number of shared goals, shared interest areas that had already been addressed and incorporated in our integrated plan that made it really an obvious choice to work to have our Getting to Zero effort much more closely aligned and actually fully a part of our overall integrated plan efforts.

Julie Hook: Great. Thanks Mike and Jim. Another question was about if there was any information you could provide about the type of funding that you received, and amounts in the process to get funding commitments from the board of supervisors.

Mike Torres: So roughly speaking, we received about $500,000 per year over a four year period. It's fluctuated slightly over the years and this was an effort, at least for the Getting to Zero initiative again, we had an elected official who championed the effort and came to us with the request. "What do you think you would take to get this started," and our Getting to Zero effort was set up as a community collaborative approach with the intent that this be seed money and that as others joined, there would be funding from other sources and kind of a growing building approach to it. But that seed money that was provided is right around $500,000 per year and those funds are Santa Clara County General Funds.

Julie Hook: Thank you. Can you speak a little bit about, Mike and Jim, about any successes or challenges around engaging people living with and affected by HIV in terms of the GTZ plan? Are you able to get everyone around the same table?

Jimmy Pearson: Santa Clara County is a bit of a suburban ... It's really suburban in nature and so it's proved a challenge for us, not just with Getting to Zero but with many issues. Not just HIV related, but housing or other social justice issues, to develop a kind of strong community engagement. That has proved to be an ongoing challenge for us. However, those organizations and individuals who have joined with us are active and committed and are energetic. So I'm not sure if that fully answers the question, but getting people to participate and maintaining enthusiasm has been a challenge and is always one of those issues that we remain attentive to. To keep the energy going, keep the forward motion going, keep the public's attention and our community's attention, but not as easy as we would hope.

Mike Torres: And another thing that, like I said, our integrated plan, reporting and talking about it, we have a standing agenda item on the Getting to Zero leadership team and vice versa with our planning body, HIV planning care and prevention body. We also have a care committee that we talk about. They have a prevention committee that talks about all the Getting to Zero objectives and they're reporting back and there's consumers on each committee.

Julie Hook: Thanks Mike and Ken. Ken I apologize, I realized I called you Jim a couple times, so I apologize for that.

Jimmy Pearson: No. No, I am Jim. It is Jim.

Mike Torres: Jim is a member of the board of supervisors.

Julie Hook: Oh, got it. Sorry about that.

Jimmy Pearson: That's okay.

Julie Hook: Someone else wanted to send kudos for your prevalence maps that you showed, and just wanted to know, do you have the ability in your county health department to develop those census track HIV prevalence maps or do you have to request them from the state and the data from the state?

Jimmy Pearson: It's a little mix. So we have local data that we can use. Let me start again. We generate those maps locally and we have surveillance data that we can use. However, to ensure that we maintain alignment with state information, generally speaking we use the information that has been validated from the state in order to create those. So it's really a partnership. I mean there are a number of those prevalence maps that we can generate just based on the data that we develop in house through our HIV surveillance unit, however, we prefer to use the validated data from the state.

Julie Hook: Great. Someone had a couple sort of statistics questions. So if I'm putting you on the spot, if you don't know them off the top of your head, but there's a couple questions about what the median income was in the county and what percentage of those HIV infected individuals are minorities.

Jimmy Pearson: If you don't have that in a slide I can try and look that up. If you want to go to another question I'll pull that up.

Julie Hook: I had another, just there was someone that sort of mentioned whether sort of the language between the National HIV/AIDS strategy and academic strategy, and sort of the future of the NHAS. I'm gonna sort of turn it over to our IHAP TAC PI, Stewart Landers

Stewart Landers: Hi, thanks for this question. One of the great things about having GTZ/ETE plans in your jurisdiction is that they're not necessarily subject to some of the same concerns about types of language used. So I just wanted to say that that's, given the context of this webinar, that is one of the advantages where you don't have to worry so much about what you're referring to and whether it's okay with government officials because they're not necessarily signing off or reviewing the GTZ/ETE plans.

Stewart Landers: In terms of the language around national HIV strategy, generally speaking I would say that we've heard that too at times that there's some concern about using it. We've also seen it used in official situations. So we have not received any official guidance about using or not using that language.

Julie Hook: Thanks Stewart. So Jim and Mike, I don't know if you had found that data or maybe it's something we could collect from you afterwards and send out to the requester.

Mike Torres: So this is Mike. So the median income for Santa Clara County is a $93.

Jimmy Pearson: 854. $93,854.

Mike Torres: $93,854 and then the other question-

Jimmy Pearson: Mike has the other number.

Mike Torres: The minorities living with HIV. Was that the question?

Julie Hook: Yes. Yep.

Mike Torres: Jim is pulling that up right now.

Julie Hook: Great and while Jim's pulling that up I will say that as we noted the slides for this webinar are already up and within sometime next week the transcript and the video recording will be up so that if you have any colleagues that missed the webinar and you want to share with them, we'll send the link out to the participant list and that will be posted on our website sometime next week.

Stewart Landers: Jim, this is Stewart Landers. I don't know if this is totally okay, but I'm not sure of the point necessarily behind the question regarding median income. But having worked in Santa Clara County on HIV needs assessments, I think it's fair to say I was certainly surprised knowing there's a lot of affluence in the county to see how similar the HIV positive population was in terms of poverty, as you would see in other parts of the country.

Jimmy Pearson: Stewart, this is Jim. I would absolutely agree. There's a significant dichotomy that we are a very affluent community, however, if you look at our HIV population their levels of poverty are very much reflective of many, if not most other jurisdictions across the country. Of those living with HIV, 60% qualify for Ryan White services. For us, we use 500% of the federal poverty level as being eligible, however, the overwhelming majority, about 90% of those individuals live at or below 200% of the federal poverty level. So it is not unlike many, many other jurisdictions when you look specifically at those living with HIV.

Jimmy Pearson: Our population in general, those salary levels are a little distorted and you have to take into consideration housing costs that are quite startling. With regard to the question of our minority population, I mean I can get more specific numbers but it just generally breaks out that 67% of our population are minorities. So we are 33% white, 67% nonwhite minorities.

Julie Hook: All right, thank you for that. I think we are finished with the Q&A and I do want to thank Jim, and Mike, and Molly for their presentation and thoughtful answers to the questions. We want to encourage you to visit our website and check out our resources and our archived and upcoming webinars or to join our listeners. Including an online resource guide that we launched in the spring, which is intended to support the Ryan White HIV Program Parts A and B recipients and their perspective planning bodies with the implementation and monitoring of their integrated HIV prevention and care plans.

Julie Hook: We also want to invite you to join us at the 2018 National Ryan White Conference on HIV care and treatment in December. We will have four sessions. The first session is around HRSA and CDCs ongoing expectations for

implementing integrated HIV prevention and care plans and identify approaches in leveraging prevention and care resources and looking at research allocation.

Julie Hook: We'll also be hosting a listening session on Wednesday night. It's an auxiliary session. We're hoping to get feedback from folks on the guidance development in the feedback process of the 2017 and 2021 integrated HIV prevention and care plans. So having a listening session to gather thoughts from people to be able to provide feedback to HRSA, [inaudible 00:57:11] and CDC afterwards.

Julie Hook: Our third workshop, which is closely related to today's webinar, which is happening Thursday morning will explore how jurisdictions with either a Getting to Zero ending the epidemic plan, align or don't align with their integrated plans, and talk about sort of the activities as they've moved these two plans into the implementation phase.

Julie Hook: Then finally, we will be co-presenting with the recently formed Washington D.C. Regional Planning Commission on Health and HIV. They will discuss their rationale for their recent merging of their planning council, it's prevention and care planning councils and then we'll talk a little bit about promising practices and challenges from jurisdictions that have integrated their prevention and care programs within health departments.

Julie Hook: So we hope that you will come and join our sessions and stop by the JSI booth as well. So please contact us to obtain more information, request TA, share your experiences with integrated planning or to join our mailing list. And we thank you very much for listening today and just a reminder that an evaluation will pop up right after and we hope that you will fill that out. Thank you and have a great afternoon.