# STATE OF MICHIGAN
# HIV/AIDS COMPREHENSIVE PLAN
## 2009

**Division of Health, Wellness and Disease Control**
**HIV/AIDS Prevention and Intervention Section**

**December, 2008**

# Michigan HIV/AIDS Council

October 16, 2008

Ghelahan Cole
Project Officer
Division of Service Systems
HIV/AIDS Bureau, HRSA
5600 Fishers Lane, Room 7A-55
Rockville, MD 20857

Dear Mr. Cole:

The Michigan HIV/AIDS Council's Comprehensive Plan Committee reviewed the state's proposed 2009 HIV/AIDS Care Comprehensive Plan and found it fully responsive to the priorities identified by the most recent Michigan needs assessment data as well as address HRSA core services. Those who participated on the review of the document are listed on the following "Acknowledgement" page.

The committee's recommendation for concurrence was without reservation, and was presented to the Michigan HIV/AIDS Council's Executive Committee (MHAC). The MHAC Executive Committee voted, on behalf of the full body of the Council, to concur with the committees' recommendation.

The chair and two community co-chairs of MHAC are designated as signatories to the letter of concurrence.

Sincerely,

Debra L. Szwejda, Chair  Paula Sirls, Co-Chair  Holly Joseph, Co-Chair

# ACKNOWLEDGEMENTS

The Comprehensive Plan is the culmination of many hours of work on the part of people dedicated to the improvement of the service system for persons living with HIV/AIDS (PLWH/A).

Michigan is very fortunate to have an outstanding group of skilled and dedicated individuals who have worked diligently to produce this document and the documents leading up to this plan. The Needs Assessment Committee of the Michigan HIV/AIDS Council (MHAC) was instrumental in developing a sound foundation upon which this document is based.

Special acknowledgements need to be made to the Comprehensive Plan Committee of the MHAC who was responsible for developing a plan which will serve as Michigan's Part B Continuum of Care roadmap for the next three years, as well as Continuum of Care staff.

**Comprehensive Plan Committee Members:**

Tim Neal, Chair
Laura Zeitlin, Co-Chair
John Joseph
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# Introduction

## PURPOSE

This Comprehensive Plan presents a detailed outline of Michigan's Part B Continuum of Care (COC) program. (Part B COC program refers to the Continuum of Care program in its entirety, which includes state and federal funding.) The process of developing this plan is intended to facilitate the creation of innovative ideas that address emergent and/or persistent issues. The Health Resources and Services Administration (HRSA) has also recognized the importance of creating such a plan and made the development of such a plan a requirement of the Ryan White HIV/AIDS Treatment Modernization Act of 2006 which provides federal funding for HIV/AIDS-related care services in Michigan.

The comprehensive plan is designed to cover a three-year span of time so its scope reaches beyond the annual implementation plan process and provides a road map for developing a system of care over time which includes:

- Addressing disparities in HIV care, access, and services among affected subpopulations and historically underserved communities
- Establishing and supporting a comprehensive HIV care continuum
- Coordinating resources among other Federal and local programs
- Addressing the needs of those who know their HIV status and are not in care as well as the needs of those who are currently in the care system
- Ensuring the availability and quality of core medical services throughout the state

## PROCESS

The Comprehensive Plan process, convened by the Michigan Department of Community Health, Division of Health, Wellness and Disease Control, HIV/AIDS Intervention and Prevention Section (MDCH/DHWDC/HAPIS) [i.e., Michigan's Ryan White HIV/AIDS Treatment Modernization Act of 2006 Part B grantee], was guided by the Michigan HIV/AIDS Council's (MHAC) Comprehensive Plan Committee (CPC). Established in January 2000, MHAC is a joint prevention/care planning body with forty active members and twenty-six expert and at-large advisors. Prior to the formation of the MHAC, community planning, in the form of two separate statewide care and prevention planning bodies, existed since 1995.

This document identifies a vision that is compatible and consistent with the a) goals and objectives put forth in the 2006 Statewide Coordinated Statement of Need (SCSN); b) Michigan's FY2008 Implementation Plan; c) HRSA guidance and, d) the findings of the Part B 2006 HIV/AIDS Care Needs Assessment. These sources fit together much like a puzzle with overlapping parts. The needs assessment process is designed to help the State understand what unmet needs exist and what barriers to care PLWH/A are

experiencing. The information collected through this process is then used to create an SCSN, which outlines the needs of PLWH/A and system-level needs such as education, training and collaboration issues. This document, the *Comprehensive Plan*, contains specific goals based on the findings of the needs assessment and the issues outlined in the SCSN, but also have a more broad scope in that it must contain specific components related to HRSA guidance. Finally, the Implementation Plan outlines specific activities and strategies developed to reach the goals put forth in this document along with other measurable program goals as they relate to core services. See Appendix D for information about how to access these documents in the public domain.

Although this document does not include all of the goals and objectives in the aforementioned sources, it does present a realistic scope of what can be accomplished in this plan's three-year planning cycle through 2012.

## OVERVIEW

Section 1 of this document provides an overview of the current system, which is designed to help the reader understand the contextual environment. Section 2 contains a brief statement of our values, which have guided not only the development of this document but also guided us toward the development of the SCSN. Section 3 contains the roadmap, whereby the goals are presented. Section 4 describes how we will monitor our progress.

The appendix of this document contains important information about the level of resources allocated to care services (Appendix A); Part B/MHI funded services available in the outstate and the agencies which provide these services (Appendix B); a glossary of the various Ryan White Program Service Definitions (Appendix C); a list of key documents and how to access these documents (Appendix D); FY2008 Implementation Plan (Appendix E); and the Division of Health, Wellness and Disease Control/Continuum of Care Strategic Plan (Appendix F).

# Section 1: Where Are We Now: What is Our Current System of Care?

## DESCRIPTION OF MICHIGAN'S PART B CONTINUUM OF CARE

The focus of Michigan's Part B COC is to improve and expand the continuum of care services available to persons living with HIV/AIDS (PLWH/A) in the state, with the goal of providing 100% access to care and 0% disparity in health outcomes. More specifically, the purpose of the Part B COC is to 1) meet the service needs of PLWH/A who reside in Michigan, 2) assure universal access to quality services, 3) extend the capacity of the care system through effective coordination with other service programs and resources, and 4) promote quality care through ongoing evaluation activities. Ryan White Part B funds have been the primary resource available to sustain and build a comprehensive care service system for PLWH/A in Michigan.

Although the Part B COC provides resources to support the broad range of services available to PLWH/A in the Detroit Eligible Metropolitan Area (DEMA), services are also available across the 77 counties which comprise the 'outstate' area. The outstate area is diverse both in terms of the distribution of the epidemic and the demographic profile.

### THE CURRENT CONTINUUM OF CARE

The Division of Health, Wellness and Disease Control receives federal funding in the form of Part B AIDS Drug Assistance Program (ADAP) earmarked funds and Part B base funds as well as a small allocation of Minority AIDS Initiative – Congressional Black Caucus (MAI – CBC) funds. Part B ADAP earmarked funds are used to support the ADAP, the Insurance Assistance Program-Plus, laboratory testing (CD4, viral load and genotype testing) and Monogram Biosciences for assay tests to determine the appropriateness for use of Maraviroc. Part B base resources, supplemented by Michigan Health Initiative (MHI)[1] funds, are used to support primary care, mental health services, case management, provider education and statewide direct service programs, including dental care and service linkages for individuals leaving the correctional system and re-entering the community. Part B resources, in amounts not to exceed administrative cost caps, are used for planning, evaluation, quality management and administrative activities to assure that persons living with HIV disease in Michigan have access to quality health care and support services to sustain their health and quality of life.

[1] MHI resources are allocated to MDCH by the Michigan legislature and are used to supplement RW Part B funds for care, and to support HIV/AIDS prevention services. MHI resources are generated through computer software sales taxes.

For a synopsis of the level of resources allocated to continuum of care services, see Appendix A.

Prior to October 1, 2002, MDCH provided services through eight regional care consortia/fiduciaries. Since October 2002, MDCH has funded service providers directly for Part B services in an effort to reduce administrative costs and improve the effectiveness of service provision through more direct relationships with providers. For approximately one year, MDCH funded agencies previously supported by consortia. While most agencies received an increase in resources, all others received, at a minimum, continuation funding. In FY 2007, MDCH issued a Request for Proposal (RFP) for care services in the outstate area. MDCH also allocates resources for care services to the DEMA, which are provided to the City of Detroit Department of Health and Wellness Promotion (Part A Grantee).

The RFP was based on the results of the 2006 Care Comprehensive Plan, the statewide needs assessment, the SCSN and other priorities identified by the grantee (MDCH) and MHAC. Successful applicants received annual awards through written agreements for the State fiscal year which begin October 1 and ends September 30 of each year. Contractors are awarded funds for a three year period, contingent upon performance, the availability of funds and emerging priorities.

For a detailed listing of the current Part B/MHI-funded providers and the services they are funded to provide, see Appendix B.

All Part B/MHI-funded providers are required to participate in the client-level Uniform Reporting System (URS), which tracks services provided. The data collected are then used to evaluate the performance of the HIV/AIDS care system in Michigan. The URS data include demographic information about clients served by funded providers, and the type and quantity of services delivered to each person. Through the use of the Unique Record Number (URN), an encrypted client identifier generated in the same way at each provider site, the URS permits client records to be unduplicated across multiple providers, while retaining the service utilization detail and protecting client confidentiality.

## EPIDEMIOLOGICAL PROFILE

According to the 2006 Census estimates, the population size of Michigan is 10, 095,643, with forty four percent residing in the Detroit Metro area, which consists of Oakland, Monroe, Lapeer, Macomb, St. Clair and Wayne Counties. The remaining counties comprise the out-state area. The Michigan Department of Community Health estimates that there are 18,000 persons currently living with HIV/AIDS in Michigan, the majority of whom (66%) reside in the DEMA. Most of the remaining 29% live in or around other urban areas of the state (i.e., Lansing, Grand Rapids, Kalamazoo, Flint, Saginaw, Traverse City, and Ann Arbor), although PLWH/A may be found in each of Michigan's 83 counties, as well as 5% in Michigan prisons. As of July 2008, 7,259 persons living with HIV are currently reported to have an AIDS diagnosis.

Overall, per the Annual Review of HIV Trends in Michigan, dated May 2008, the rate of new HIV diagnoses increased by an average of 4% per year, from 7.8 per 100,000 in 2002 to 9.0 per 100,000 in 2006 (779 cases to 908 cases, average 890 cases), after peaking at 9.5 per 100,000 in 2005. The increasing trend and peak in 2005 are most likely due to the implementation of mandatory laboratory reporting in 2005. Prior to this, the HIV Surveillance program in Michigan relied on a few laboratories who voluntarily reported positive HIV-related tests and health care providers, who are required by law to report positive cases. The addition of mandatory laboratory reporting has increased the case reports received, and appear to be driving the upward trend described here.

Between 2002 and 2006, the rate of new diagnoses increased among young adults 13-24 years of age and among persons 40-49 years. Rates in all other age groups were stable. This is the third consecutive year we have seen increases in 13-24 year olds. While the trends we are seeing may partially be attributed to heightened HIV testing efforts aimed at young persons, public testing data suggest that additional testing is not the sole explanation for the increases seen among teens and young adults. In fact, there appears to be a true increase in this group. Alarmingly, of all teens and young adults diagnosed in the last five years, 76% are black compared to 59% of persons diagnosed at older ages. Furthermore, young adults are much more likely to be black MSM compared to adults 25 years and older (48% vs. 19%). This continues to underscore a need for prevention campaigns tailored to these groups, as the differences we are now seeing in this young group will likely widen the already large racial gap among persons living with HIV.

The rate of new diagnoses increased among all males (average 4% per year), among all black persons (average 3% per year), and among black males (average 4% per year) between 2002 and 2006. The rates among black males and females are troubling, given that they are several times higher than other race/sex groups.

Between 2002 and 2006, the number of new diagnoses among men who have sex with men (MSM) increased by an average of 4% per year, whereas the number of new diagnoses among injecting drug users (IDU) decreased by an average of 7% per year. Decreases among IDU have been noted for three consecutive years, evidence of the success of programs like needle exchange. The increase among MSM, on the other hand, correspond to other data presented in this report that show increases in new HIV diagnosis rates in black men and young adults.

## ASSESSMENT OF NEED

During 2006, MDCH/DHWDC/HAPIS collaborated with the MHAC Needs Assessment Committee (NAC) to develop and implement a comprehensive needs assessment plan for HIV/AIDS care services in the State of Michigan.

The data collection included the distribution of a PLWH/A survey, of which 485 were completed and returned, and seven PLWH/A open forums conducted throughout the outstate area (non-metro Detroit area). The outstate is defined as all geographic areas in

Michigan *excluding* the Detroit Eligible Metropolitan Area (DEMA). The DEMA, the only designated EMA in the state of Michigan, consists of the City of Detroit and the Counties of Wayne, Oakland, Macomb, Monroe, Lapeer, and St. Clair. The planning body associated with the DEMA, the Southeastern Michigan HIV/AIDS Council (SEMHAC), conducted their own needs assessment earlier in the year and it was agreed by MHAC that any attempt to do a *statewide* needs assessment would be a duplication of efforts and costs.

The results of the needs assessment were used to help develop the 2007 RFP and will continue to be relied upon to help guide future HIV/AIDS care service planning. The next planned assessment of need period will begin in 2009, to drive the next RFP process effective October 1, 2010 to September 30, 2013.

The following is a brief overview of the findings of the needs assessment process. A full account of the needs assessment results can be reviewed in the document entitled "2006 Part B HIV/AIDS Care Needs Assessment".

- Across the outstate, the most commonly utilized services were: medical care, case management and ADAP.
- Across the outstate the services least needed were: harm reduction services, hospice services and child care services.
- Across the outstate service gaps most noted were: oral health and emergency financial assistance.

## SERVICE GAPS BY SERVICE AREA:

- For the Mid-South service area the most commonly cited service gap was help paying for rent/mortgage.
- For the Southwest Michigan service area the most commonly cited service gap was oral health.
- For the Central Michigan service area the most commonly cited service gap was oral health.
- For the Western Michigan service area the most commonly cited service gap was oral health.
- For the Mid-Thumb service area the most commonly cited service gap was emergency financial assistance.
- For the Northern Michigan service area the most commonly cited service gap was emergency financial assistance.
- For the Upper Peninsula service area the most commonly cited service gap was support groups.

Addressing these service gaps is a multi-staged process. The needs assessment results will be instrumental in establishing strategies to reduce and eliminate the identified service gaps. For example, oral health is a service provided by the Part B COC program through the Michigan Dental Program (MDP). According to the findings of the needs assessment, three of the seven service areas cited oral health as one of the top three most

pervasive service gaps. According to the results, many individuals in need of oral health do not know where to go for assistance and/or have been unable to find a dentist willing to participate in the MDP. Section 3 of this Plan addresses this and other service gaps.

## DETROIT EMA

The Southeastern Michigan HIV/AIDS Council (SEMHAC), in collaboration with the Detroit Department of Health and Wellness Promotion (DHWP), administered a needs assessment survey in 2005. There were a total of 554 people who completed the survey; of whom, 438 (or 79%) were HIV positive. The results of this survey showed that 175 (or 40.2%) cited financial help as the top service gap, followed by housing (35.2%), and oral health (34.9%). Transportation, judgment from others/stigma and lack of information were also cited as barriers to accessing services. Results also showed that of those surveyed, 90.9% were in care. Those not in care (have not received a CD4 count; viral load test; and anti-retrovial therapy/HAART in the past 12 months) stated it was because they could not afford it, had no transportation to obtain the care services or were too depressed to seek care. When these survey participants were asked whether they were not in medical care by personal choice, 23% responded "yes", while 77% responded "no".

At the time of the survey, most of the survey participants resided in Wayne County (348 or 81%). The greatest number of HIV positive cases could be found in the zip codes 48213 (29) and 48201 (28). Of those who had housing, a majority (217 or 51%) rent their place of residence. For those without housing, 93 (22%) of respondents reported that they had been homeless sometime in the past 12 months.

## SERVICE NEEDS FROM THE 2006 STATEWIDE COORDINATED STATEMENT OF NEED (SCSN)

### Access to Medical Care and Maintenance in Care

The SCSN identified several important issues relating to medical care, including substance abuse and mental health barriers, the need for coordination between medical professionals, lack of payment mechanisms (e.g., health insurance), and need for alternative medical sites.

The 2006 SCSN cites, as a factor in maintaining medical care, the need for mechanisms to pay for health care, including the ADAP and assistance with health insurance. In grant year FY07, Michigan allocated more than $11,000,000 in a combination of ADAP and Base resources to support the ADAP, including the cost of medications, laboratory testing and ADAP staff support. In addition, $660,000 is allocated to support health insurance continuation through the "Insurance Assistance Program-Plus" program, in collaboration with the Michigan Department of Human Services. Another $24,000 is budgeted to pay for Medicare Part D premiums.

**Need for Modified Case Management Services**

Michigan's 2006 SCSN suggests the need for greater focus on "modified" case management services, which includes tailoring services for high and low need clients, providing community–based, multi-disciplinary care teams, and improving and streamlining the referral, access and linkage to care system in Michigan.

As one strategy to address the need as stated in Michigan's SCSN, the Michigan Department of Community Health, DHWDC released its Request for Proposals (RFP) for $4 million for core and supportive services for individuals living with HIV. This funding is for the State fiscal year and began on October 1, 2007, six months after the start of the federal Ryan White Part B year. Funding is for a three-year period and is contingent upon available resources, contract compliance, changes in the HIV epidemic, performance in meeting goals and objectives, etc. (In grant year FY2007, MDCH allocated approximately $1,700,000 for case management.)

The RFP specifically addresses many needs raised in the SCSN, as did the RFP released in 2003. It puts greater focus and priority on improving access to care, providing culturally and linguistically appropriate services, addressing the unmet needs of people not in care, expanding the referral system, and creating formal linkages to all other critical services, such as medication adherence, partner counseling and referral services, primary and secondary prevention, substance abuse treatment, mental health treatment, hepatitis programs, sexually transmitted disease clinics, etc.

Another strategy to address the needs identified in the SCSN is to continue to revise the *Standards of Service for HIV/AIDS Case Management in Michigan.* This document was revised in late 2005 and again in 2007 to address the need for providing medical case management and non-medical case management according to the new HRSA service definitions. Medical case management focuses on client needs, medical monitoring and follow-up, adherence counseling, and improved medical outcomes. It is more intensive case management. Non-medical case management is less intensive and does not include medical monitoring and follow-up or adherence counseling. An acuity scale is included in the *Standards of Service* document, which is required to be used by case managers to assist them in determining the level of service required. Based on these changes, the MDCH developed a new HIV/AIDS Case Management Certification, which includes two, two-day sessions and one three-day session on adherence. Session 1 focuses on the new Standards of Service for HIV/AIDS Case Management (medical and non-medical) the new Universal Standards required by all funded agencies, the new Culturally and Linguistically Appropriate Standards (CLAS), biopsycosocial assessments, care plan development, reassessments, acuity scales, quality indicators, and information on access and linkages to primary care and other services. Session 2 focuses on Benefits and Entitlements, multi-cultural competency, data collection, ADAP, the Michigan Dental Program, the integration of STD/HIV prevention and care, and Partner Counseling and Referral Services.

Part B funds have also been allocated for the annual Case Management Conference, a training opportunity specifically designed to meet the training needs of HIV/AIDS case managers throughout the State. In addition, $80,000 in Michigan Health Initiative funds is used to support provider training through Wayne State University's AIDS Research and Education Center. MDCH and the Centers for Disease Control and Prevention (CDC) funds support the annual STD and HIV Conference, a broader learning two day opportunity for approximately 400 professionals.

The November 2007 STD and HIV Conference, for example, focused on STD, HIV and promoting healthy lifestyles to communities of color and was an educational update and training for those involved with STD, HIV, health disparities, hepatitis and substance abuse. During this conference participants had an opportunity to share information across all disciplines and learn about best practices. Workshop topics included: clinic-based prevention for positives; stories from people living with HIV; understanding health disparities and their health effects on HIV, and syringe access as HIV prevention.

### Outreach to the Unconnected

Michigan allocates more than $120,000 to outreach services to connect HIV positive individuals into care services. This includes our Minority AIDS Initiative funding and additional Part B Base resources, which are directed at high risk populations, e.g., recently incarcerated minority individuals, minority individuals from economically vulnerable communities, and those who know their HIV status, but are not in care.

## SERVICE GAPS

The 2006 SCSN also identified service gaps, including: dental care; housing assistance; emergency financial assistance; and, support groups/buddy companion services.

### Dental Care

Dental care has been identified as a service gap; however, Part B funding has greatly improved access to this service. Michigan has allocated more than $500,000 to oral health care, and delivers the service primarily through the MDCH Michigan Dental Program (MDP). At the time of this document's draft, 1,553 people are enrolled in the MDP. In addition, some case management providers reimburse dentists directly for their clients' dental care, in certain limited circumstances. Due to limited resources, the MDP is currently closed to new enrollment. As resources become available, enrollment may resume. Services are currently limited to existing clients.

### Housing Assistance

In recent years, Michigan has allocated few resources to housing assistance, and then only as a payer of last resort when Housing Opportunities for Persons with AIDS (HOPWA) funds were not available. Due to limitations in Michigan's HOPWA funding,

Part B case management providers have responded to meet the need by allocating funding to housing assistance.

### Emergency Financial Assistance

Case management providers have allocated a total of approximately $29,242 to this service category for grant year FY2008. This amount is less than prior grant years; however, it is likely that providers have identified trends in use of emergency financial assistance (EFA) dollars, and have allocated those dollars directly to high need service categories where the EFA funds are likely to be expended, i.e., reimbursements for medical visits, food vouchers, utilities and transportation. A decrease in allocations to EFA may also reflect continuing pressure to fund core services in an environment of level or reduced funding.

### Support Groups or Buddy/Companion Services

Although the SCSN states that lack of support groups is a gap, it is not a core service and has not been identified as a high priority need. We continue to emphasize core services to the greatest extent possible. However, Part B funding is provided to one contractor in Flint (Wellness AIDS Services, Inc.) for a pilot program entitled "Treatment Education Adherence Program," which is designed to promote treatment education counseling and adherence for PLWH/A. It serves as a venue to improve the level of adherence and as an adherence support group.

Even though not funded via MDCH-DHWDC, all Michigan agencies offer some type of support group to address the PLWH/A need for support groups. A complete resource directory for PLWH/A can be found at Michigan Go Local (MGL) which lists current health services in Michigan: www.medlineplus/gov/mi. Information on DEMA area resources can be found at: www.lib.wayne.edu/dcal.

## UNMET NEED ESTIMATE

***Population Estimates***

The Unmet Need Framework shows that for the time period (October 1, 2005 – September 30, 2006) there are an estimated 5,741 persons living with HIV and 6,883 persons living with AIDS for a total of 12,624. This is lower than the data shown in the Epidemiological profile due to different HIV diagnosis date restrictions, as described below. Although the Framework requests the number of persons who are aware of their status, HIV surveillance is not able to capture HIV status awareness. Thus, the estimates in the Framework include all persons reported to surveillance, whether aware of their status or not.

***Estimates of People with Met Need***

The Unmet Need Framework shows 7,351 people estimated have met need.

***Estimates of Unmet Need***

The Unmet Need Framework shows 5,273 people estimated to have unmet need.

(Note: May be in care, and not seen frequently, i.e., at least every 12 months.)

***Data Sources and Estimation Methods Used***
The following methodology was used in order to estimate unmet need for HIV-related primary care in Michigan.

First, two existing databases were selected:
- *The e-HIV/AIDS Reporting System* (eHARS). eHARS is the surveillance database that contains information on all reported cases of HIV/AIDS in Michigan, and is the database that replaced HARS. eHARS contains the population-based data needed to determine the population size of HIV-infected persons. Both HIV and AIDS are notifiable conditions in Michigan, so both are included in eHARS.

- *Laboratory Database*. Mandatory laboratory reporting in Michigan was implemented on April 1, 2005 for positive diagnostic HIV tests and July 1, 2005 for all HIV viral load and CD4 tests. These laboratory results are contained in an ACCESS database maintained by the HIV Surveillance program.

Second, "care" was defined as having a laboratory result for a CD4 count and/or percent or a viral load measure during a 12 month time period (October 1, 2005 through September 30, 2006) among patients in eHARS. Use of anti-retroviral therapy was not included in the definition of care because HIV Surveillance does not collect this information. However, it is believed that the vast majority of patients on medication regularly have CD4 and viral load tests run, and that there are few, if any, patients in care who are missed using laboratory data only.

Third, laboratory data were used to determine each patient's most recent CD4 count, CD4 percent, and/or viral load test date. These laboratory results were then joined to surveillance data in eHARS. Persons diagnosed after September 30, 2005 were excluded from analysis to eliminate the possibility of including those who were very recently diagnosed and had not yet obtained care. Unmet need was then calculated by determining the number of persons in eHARS who were diagnosed prior to October 1, 2005 and had not received a viral load or CD4 test between October 1, 2005 and September 30, 2006. While the combination of laboratory and surveillance data offers an ideal way to measure unmet need, there are some limitations to the data that should be noted. As mentioned above, mandatory laboratory reporting is new in Michigan. Thus, some laboratory results may not have been captured by the laboratory database as laboratories were rolled into the new reporting requirements. However, all of the major labs that were rolled into the new requirements at a date later than anticipated did provide historical lab data, so this is not likely to be a major source of discrepancy. In addition, persons who move out of state will automatically be counted as unmet need cases if Michigan's HIV Surveillance Program is not notified of the changes in residency. Michigan's HIV Surveillance Program does participate in Routine Interstate Duplicate Review (RIDR), in which Michigan collaborates with other states under the guidance of the Centers for Disease Control and Prevention to assess and resolve potential case matches between the states. This effort limits the possibility of residency affecting unmet need, although not all states

participate in a timely way. Similarly, if a person died and Surveillance was not notified, that person would be counted as an unmet need case. Michigan's HIV Surveillance Program also conducts a death match annually to minimize this undercount. Finally, there inevitably is room for error in the laboratory reporting system. For example, cases can potentially be falsely matched or non-matched to the surveillance database. Overall, however, the laboratory reporting system is strong and checks are in place to ensure the quality of those data.

## Assessment of Unmet Need: Analysis of Those Not in Care

***- Demographic data***

Of the 5,273 persons with unmet need, 77% are male and 23% are female. This distribution of sex is the same among persons with met need. Persons with unmet need are more likely than persons with met need to be IDU (16% versus 11%), and less likely to be MSM (43% versus 50%). Persons with unmet need are very similar to persons with met need according to age at HIV diagnosis and current age. The median age at HIV diagnosis is 34 years and the median current age of all cases is 42 years. The majority of persons with HIV, whether met or unmet need, are black, non-Hispanic (57%) or white, non-Hispanic (37%). Persons with unmet need are more likely to live in out-state Michigan (40%) than those with met need (33%).

The percentage of unmet need is highest among persons with IDU (51%), MSM/IDU (48%), or No Identified Risk (56%) mode of HIV transmission. In addition, persons who are adolescent or young adult at HIV diagnosis have higher proportions of unmet need than other age groups (46% among 13 – 19 year olds and 48% among 20 – 24 year olds). Hispanic persons living with HIV have the highest proportion of unmet need (50%) according to race/ethnicity. Asian/Pacific Islanders also have a high percentage of unmet need (49%), but the number of persons in this group is too small to allow us to draw definitive conclusions about the level of unmet need in Asian/Pacific Islanders in Michigan. In terms of geography, those living in out-state Michigan have a higher percentage of unmet need (47%) compared to those living in Southeast Michigan (39%). In particular, the Lansing—East Lansing (70%) Metropolitan Statistical Area (MSA) and Jackson MSA (58%) have high proportions of unmet need. Based on the analysis of unmet need estimated for various sub-populations in Michigan, the State will place increased emphasis on outreach to people living with HIV not AIDS, IDU or MSM/IDU, adolescents and youth, and people living in the outstate areas, particularly in the Lansing and Jackson MSAs. More analysis will be done to identify barriers to care for these groups. Surveillance has been requested to provide more demographic analysis of the geographic areas with the highest levels of unmet need so that outreach and services can be targeted more effectively.

The unmet need estimate and assessment were completed too late to be included in the Part B Care Needs Assessment of 2006, (the next analysis of data will begin in October 2008) but will be incorporated as part of the needs assessment process beginning in 2009, since it is based on reliable and comprehensive data and produces useful information.

The 2009 needs assessment will be used to begin to assess the barriers and service gaps of the populations identified as having high levels of unmet need.

## PREVENTION NEEDS AND STRATEGIES

The 2006-2009 Statewide Prevention Comprehensive Plan cited efficient and timely access to medical, prevention and support services as a key strategy to prevent HIV transmission for all risk populations.

Linkages between primary HIV prevention and Ryan White (Parts A – F) programs continue. Counseling, testing and referral and partner counseling and referral services will continue to serve as a primary link between primary HIV prevention services and programs supported under the Ryan White services. Early knowledge of serostatus and entry into appropriate care and treatment are essential to preventing and delaying the onset of HIV-related illness in individuals with HIV infection. Through the process of referral, HIV-infected individuals are linked to appropriate services, including medical care, case management, and mental health services.

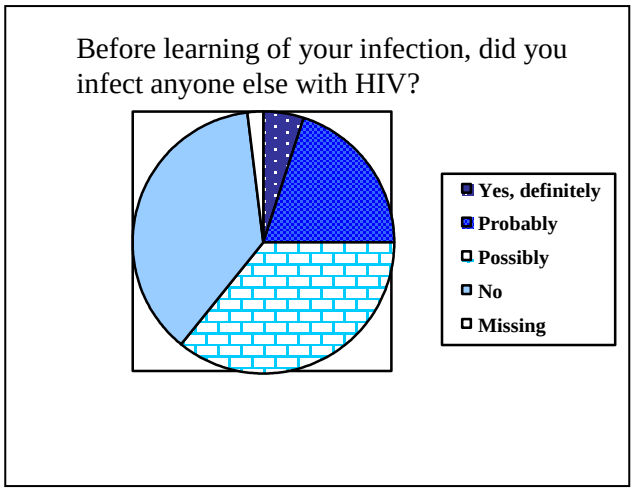
Integration of risk assessment, risk reduction counseling and referral into primary care has been identified as a priority prevention strategy for HIV-infected individuals. Primary care services are supported under Ryan White Parts A, B, C and D. Activities designed to enhance provider skills in this area should continue to be a priority.

The following prevention needs and strategies from the 2006-2009 Statewide Comprehensive Plan are broken down by populations:

### HIV+ Individuals: Prevention Needs and Strategies

Findings from Michigan's Persons Living with HIV/AIDS Needs Assessment 2006 reveal that HIV+ individuals have needs that fall into each of the five need categories.

About 50% of respondents struggle with practicing safer sex, feelings of hopelessness about intimate relationships and telling friends/family about their HIV status. HIV+ respondents also indicated that services that provided information about safer sex and safer injecting practices would be helpful to them. Almost 70% stated that counseling/support to help practice safer sex would be useful and an overwhelming 96% responded that opportunities to socialize with other HIV+ people would be useful.



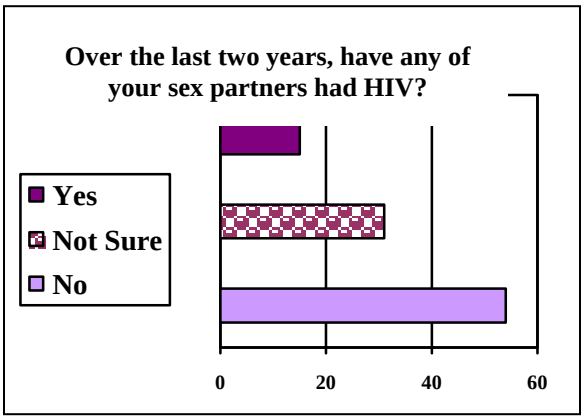

Respondents were asked if, before learning of their infection, they believed they had infected someone. Five percent said that they definitely infected someone, 19.9%

thought it was probable, and 35.6% responded that they possibly could have infected someone. Thirty seven percent of respondents believed that they had not infected someone.

Five prevention interventions were determined to best fit the needs of Michigan's HIV+ population. These included Individual Level Prevention Counseling, Prevention Case Management, Skills Building Workshops, Outreach and Partner Counseling and Referral Services.

**Men who have Sex with Men: Prevention Needs and Strategies**

Men who have sex with men are estimated to make up 1.5% of Michigan's population and account for over 8,240 reported cases of people living with HIV/AIDS. Prevention needs for MSM fall into four categories (knowledge, persuasion, supportive norms and skills). Data from the HIV-Related Attitudes and Behaviors Among MSM 2004 survey shows that Michigan's MSM population does not believe they are at risk for HIV infection, even though they are engaging in unprotected sex. Twenty-five percent have never been tested for HIV and 43% do not discuss/disclose their status to partners. Fifty-four percent had not used a condom during their last sexual encounter, 76% never use condoms for oral sex, and 30% never used condoms for anal sex. As the table below show, many MSM are not asking their partners about their HIV status.



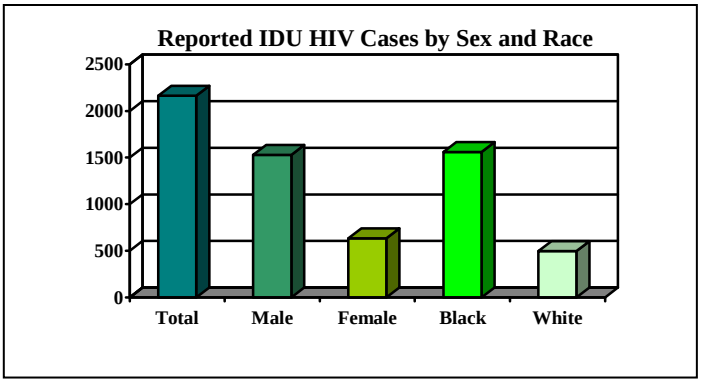

To address these prevention needs six strategies were identified. These include: Counseling, Testing and Referral Services, Skills Building Workshops, Structural Interventions, Health Communications, Outreach and Community Building.

**Injection Drug Users: Prevention Needs and Strategies**

According to the HIV/AIDS and Health Related Needs Among IDU in Michigan Report 30% of IDU used a "dirty needle" within the last year. At last injection, 25% had not used a new/clean needle, and over 60% did not use clean works. Almost none of those that reported cleaning needles, reported using the correct technique, as defined by the CDC.

Condom use with primary sexual partners was low (about 4% among female IDU) and only 22% of male IDU used condoms with non-primary partners all of the time. Forty-two percent of respondents indicated that they had at one time exchanged sex for money or drugs.

These risk behaviors reveal that IDU are placing themselves at risk through both sexual and drug using practices. Less than one third of those interviewed listed HIV as a primary health concern, and many stated that they believe they will not get HIV. When asked about routes of transmission most respondents were knowledgeable, but this did not translate into strategies that successfully reduced their risk.




IDU also face difficulties in acquiring clean works and needles, particularly from pharmacies. Needle Exchange Programs (NEP) were noted as essential to helping IDU reduce their HIV risk, but were not readily available in most areas of the state.

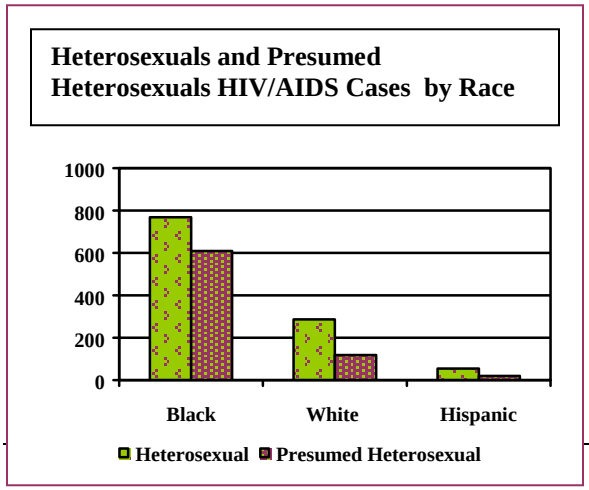
The above factors support the conclusions that IDU have prevention needs that fall into all five categories. The five following intervention models respond to those needs:

Counseling, Testing and Referral Services, Individual Level Prevention Counseling, Skills Building Workshops, Outreach and Structural Interventions.

## High Risk Heterosexuals: Prevention Needs and Strategies

For the purposes of HIV prevention service provision, a high-risk heterosexual (HRH) is an individual who is at increased risk for HIV by virtue of opposite-gender sexual contact and include: female sex partners of MSM, sex partners of IDU, sex partners of HIV+, individuals with a sexually transmitted disease, commercial sex workers (CSW), and those who provide sex for money or drugs.

According to the HIV Testing Survey and the needs assessment of CSW, most HRH do not use condoms with their primary partners. Thirty percent of female STD clients never use condoms for vaginal sex and 50% never use condoms for anal sex.




Data are limited for this population because many HRH do not know the sexual and drug use habits of their partners, nor their serostatus. A 'presumed heterosexual' is someone who had sex with someone of the opposite-gender as their only risk, but their partner's risk is unknown. Seventeen percent of reported HIV cases are presumed heterosexual, and 13% of AIDS cases fall into this category.

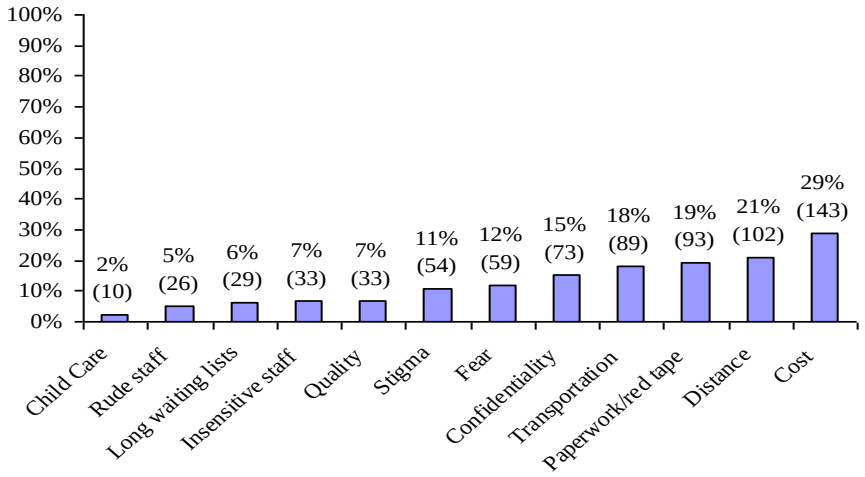
Overwhelmingly the prevention needs of HRH are those of persuasion, skills, and supportive community norms. The five intervention models that were matched to these needs are: Individual Level Prevention Counseling, Counseling, Testing and Referral Services, Health Communications, Skills Building Workshops, and Structural Interventions.

## BARRIERS TO ACCESSING HIV/AIDS CARE

A barrier is defined as any personal or system-related circumstance that inhibits or restricts access to one or more needed services. Twelve barriers were identified in the 2006 Needs Assessment. While all of the respondents were receiving medical care for their HIV at the time of this survey, they commented about what made access to medical care in the outstate a challenge. The following table shows the most commonly cited barrier (29%) to medical care was the **cost** involved in accessing care. Less than one-fourth (21%) also reported **distance** was a barrier to care.

The order in which these barriers are mentioned does not suggest their level of importance, although much of the information provided in reports and interviews indicates that cost of HIV-related medical care, and the distance traveled to obtain it, relative to the other barriers identified, plays the most profound role in accessing and receiving services.

**Figure 124: Barriers to HIV-related Medical Care**




Interviews conducted with case managers from the COC 2003 needs assessment offered similar results.

The most common barriers to accessing care cited from providers were client confidentiality concerns, transportation, lack of communication with client (due to

confidentiality concerns, client moving/homeless, no phone), denial, potential deportation and cost of medications.

The same case managers cited constraints in their own agencies, and most believed more staff was needed to manage their growing list of clients. Case managers also mentioned the time spent dealing with clients who are multiply-diagnosed, whose needs are more intense; assisting them with mental health, substance abuse and vision care, while at the same time managing their client's risk reduction and health education. Other agencies who have heavy African National or Hispanic caseloads stated that staff needed to be proficient in immigration laws and their client's ethnic/racial culture in order to better serve them. Many cited that the system of accessing care services could be improved greatly with quicker assistance from the Department of Human Services (formerly the FIA), HMOs and Medicaid/Medicare, and knowledge by local pharmacies of Michigan ADAP.

## MEDICAID/MEDICARE PART D

Currently Part B resources are being used to cover Medicare Part D out-of-pocket costs in two ways: 1) provision of treatments (out-of-pocket cost of medications, including deductibles, co-payments and full cost of medications when client is in the "donut hole" coverage gap); and 2) health insurance continuation (through payment of Part D premiums). In both cases ADAP Earmark resources are the only source of funds at this time. Clients who are already enrolled in Michigan's ADAP are eligible for this support if they are determined eligible for Medicare Part D, and do not qualify for full Low Income Subsidy. Clients who are eligible for partial Low Income Subsidy are still eligible for deductibles, co-payments and the full cost of medications when client is in the "donut hole" coverage gap. Medications are distributed through Michigan's ADAP Pharmacy Benefit Manager (PBM) RxAmerica under our usual administrative cost agreement, which includes a dispensing fee of $2 per prescription.

# Section 2: Where Do We Need to Go: What Is Our Vision of an Ideal System?

The purpose of this Comprehensive Plan is described on page 1 and is consistent with the Continuum of Care (COC) vision. The COC unit continually strives for the highest quality of services and to ensure the efficient and effective delivery of comprehensive care to all eligible PLWH/A in Michigan. Furthermore, this is consistent with the mission of MDCH, which is to strive for a healthier Michigan by promoting access to the broadest possible range of quality services and supports; taking steps to prevent disease, promote wellness, and improve quality of life; and striving for the delivery of those services and supports in a fiscally prudent manner.

The current "Guiding Principles" of COC are to address the growing impact of the HIV/AIDS epidemic among underserved people of color and hard to reach populations; ensure access to existing and emerging HIV/AIDS therapies consistent with the U.S. Public Health Service (PHS) treatment guidelines; reduce the level of unmet need, adapt to ongoing changes in the epidemic and the HIV/AIDS funding environment; and document and evaluate outcomes from the investment of CARE Act resources. These principles include the shared values for implementing system changes, such as focusing on allocating a greater proportion of HIV/AIDS care resources to the thirteen core services defined by HRSA, and updating the SCSN in relation to PLWH/A needs.

COC has crafted, with assistance from the MHAC Comprehensive Plan Committee, a plan consisting of three critical issues, goals related to each issue, and specific management strategies to advance each objective. The 2006 Comprehensive Plan described COC's conceptual framework, which focused on collaboration with public and private partners, reduction of barriers to care, development of standards of service (Medical Case Management, Non-medical Case Management, Universal, and CLAS), and ongoing efforts to monitor and evaluate the service delivery system and funded agencies. These efforts will continue throughout the three-year planning cycle and will guide in decision-making.

In addition, COC will continue to address unmet need, as it is currently doing in Ingham and Jackson counties, where unmet need is shown to be the highest. Based on the analysis of unmet need estimated for various sub-populations in Michigan, the MDCH continues to place an increased emphasis on outreach to people living with HIV/not AIDS, IDU or MSM/IDU, adolescents and youth, and people living in the outstate areas, particularly in the Lansing and Jackson Metropolitan Statistical Areas (MSAs). Additional analysis has been done to identify the barriers to care for these groups. The HIV Surveillance Section of MDCH has conducted demographic analysis of the two geographic areas with the highest levels of unmet need so that outreach and services can be targeted most effectively. The 2006 Needs Assessment provided data which was critical when assessing the barriers and service gaps of the populations identified as having high levels of unmet need.

COC's plan for high quality services is addressed in detail in Section 3. It is believed the three critical issues cited, and their related goals, capture the expectations for continuous quality improvement in the COC system expressed by PLWH/A via the 2006 Statewide Needs Assessment, and by MHAC members via their approval of the 2006 Comprehensive Plan, as well as the 2006 SCSN. The SCSN will present a detailed thematic analysis of the most current knowledge and insight about epidemiological trends and needs of PLWH/A in Michigan. It is intended to serve as a framework for programmatic action that will strengthen Michigan's collective response to PLWH/A over a three-year planning cycle and includes PLWH/A response to quality of care services. With these guiding principles, COC will continue to focus on care services, specifically those thirteen core medical services defined by HRSA, as it moves forward to realize the objectives and goals in the Plan. Those core medical services include: outpatient/ambulatory health services; ADAP treatments (the Michigan ADAP); AIDS pharmaceutical assistance (local pharmacy assistance programs); oral health care; early intervention services; health insurance premiums and cost sharing assistance; home health care; home and community-based health services; hospice services; mental health services; medical nutrition therapy; medical case management (including treatment adherence); and substance abuse services – outpatient. COC will also focus on support services including: case management (non-medical); child care services; emergency financial assistance; food bank/home-delivered meals; health education/risk reduction; housing services; legal services; linguistic services; medical transportation services; outreach services; psychosocial support services; referral for health care/supportive services; rehabilitation services; respite care; and treatment adherence counseling..

Surveillance, laboratory and client level CAREWare data have been used to target programs and resources in certain parts of the state, and will continue to be used in order to address gaps in core medical and support services.

# Section 3: How Will We Get There: How Does Our System Need to Change To Assure Availability and Accessibility To Core Services?

Three critical issues have been identified for the three-year planning cycle through 2012, and under each critical issue are a set of goals. These goals have been selected based on the findings of the 2006 Needs Assessment process, the goals set forth in the SCSN and HRSA's Guiding Principles.

This document is meant to include long and short-term goals and time lines. The following table lists joint activities with all Ryan White HIV/IDS Treatment Modernization Act Grantees. The strategies identified under each goal are either on-going strategies, or have specific time lines associated with each. The goals and strategies will be implemented and evaluated over the three-year cycle of the Comprehensive Plan. Annual, service related objectives and time frames are included in Michigan's 2008 Implementation Plan (the FY2008 Implementation Plan is attached as Appendix E.)

| All Parts Collaboration | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Joint Activity** | **Part A** | **Part B** | **Part C** | **Part D** | **AETC** | **SPNS** | **Dental School** |
| **Michigan HIV/AIDS Council** | x | x | x | x | | x | |
| **Statewide Coordinated Statement of need** | x | x | x | x | x | x | x |
| **Michigan Cross Parts Collaboration Quality Mgmt** | x | x | x | x | | | |
| **Part A Community Case Conferences** | x | x | | x | x | | x |
| **Case Management Trainings and Certification** | x | x | x | x | x | | |
| **First Line Entity for Part B** | x | x ADAP dental | x | | x | | x |
| **Part A Planning Council** | x | x | x | x | | | x |
| **Client Level data CAREWare** | x as of Sept. 1,2008 | x | x | x | n/a | x | x |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Quarterly Contractor Review process** | | x | | x | | | |
| **Case Mgmt Conference** | x Part A First Line entities | x | x | x | x | | |
| **Statewide Comprehensive Plan** | x | x | x | x | x | x | x |

## CRITICAL ISSUE A:
## Collaborate with other health care delivery services to maximize resources

**<u>GOAL 1:</u> Strengthen coordination with other Ryan White HIV/AIDS Treatment Modernization Act Grantees on an on-going basis.**

- **1:** DHWDC-HAPIS will continue to collaborate with the Part A Grantee. Currently, Part B resources are provided directly to the City of Detroit Department of Health and Wellness Promotion (Part A Grantee) to support medical services on a mobile van. Part A and Part B collaborate on the following activities: the MHAC, SCSN, SEMHAC (Part A Planning Council), monthly case conferences with the DEMA case managers and Part A grantee staff, and client-level data collection activities. Michigan's All Parts Quality Collaborative and other joint quality improvement activities are also on-going. Additionally, the Detroit Health and Wellness Promotion require Part A-funded case managers to receive training and certification through the MDCH HIV Medical and Non-medical Case Management Certification and Training.

- **2:** DHWDC-HAPIS will continue to collaborate with the four Part C Grantees. All four of the Part C Grantees participate on Michigan's All Parts Quality Collaborative and one Part C Grantee participates on the DAP Formulary Committee. Three of the four Part C Grantees hold seats on MHAC. Additional collaborations include: joint participation in the Comprehensive Plan, the SCSN, and client level data collection efforts.

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- **3:** The administration of Michigan's Part D program was shifted from another MDCH Division to HAPIS in 2006. The COC Unit is one of three units within the section. COC will continue to collaborate with the Part D programs in the following activities: the Comprehensive Plan, the SCSN, the All Parts Quality Collaboration, the implementation and monitoring of quality indicators, client-level data collection activities, and joint contractor review meetings.

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- **4:** DHWDC-HAPIS will continue to allocate Part B/MHI funds to Wayne State University (which is a sub-recipient of the Midwest AETC) to support HIV/AIDS care-related training to medical and support service professionals. MDCH provides resources to the Wayne State University, AIDS Education and Research Project, for provider education.

- **5:** DHWDC-HAPIS will continue to support MHAC, whose members, at-large and expert advisors, include representatives from other Ryan White Grantees, rural and urban public health representatives, AIDS Service Organizations, Non-Governmental Organizations, Community Based Organizations representatives, PLWH/A, and community members who represent the current profile of the epidemic in Michigan.

**GOAL 2: Strengthen coordination with Federal and State Non-CARE Act Programs on an ongoing basis.**

- **1:** DHWDC-HAPIS will take steps toward further collaboration with the Michigan Primary Care Association to develop effective methods of coordination of services with Federally Qualified Health Centers throughout Michigan. This collaboration will expand the availability of medical care in areas of high need, and increase the awareness that providers have about local HIV related services for both care and prevention. This will be helpful in placing emphasis on counseling and testing for those who don't know their status, and making counseling, testing and referral (CTR) a routine part of medical care to expand medical care in high need areas. A Michigan Primary Care Association representative sits on MHAC as an at-large advisor.

- **2:** DHWDC-HAPIS will continue to collaborate closely with the Michigan Office of Drug Control Policy (ODCP) to explore and support issues related to HIV. Current collaboration activities include an annual memorandum of understanding. The ODCP-DHWDC collaborative initiatives for substance abusers also include the formulation of HIV and communicable disease requirements and recommendations within substance abuse agencies and for staff. Specifically, the ODCP Communicable Disease Policy mandates all funded substance abuse treatment providers receive HIV and communicable disease straining. The policy further mandates screening of all clients entering the system for HIV, Hepatitis and other communicable diseases, as well as referral for testing when appropriate and Health Education/ Risk Reduction at the substance abuse treatment program for those identified as high risk. These mandates are in place despite the fact Michigan has not been a Designated State for HIV Early Intervention Services since 1998. Staff from the ODCP participate on MHAC and work directly with HAPIS staff to provide technical assistance and training for case managers and other health professionals.

- **3**: DHWDC-HAPIS will continue to support the Michigan's Department of Human Services (DHS) Insurance Assistance Program-Plus (IAP-P), which pays insurance premiums for eligible PLWH/A whose income exceeds the criteria for the IAP program. Because of this "plus" program, individuals eligible for the program are able to continue private health insurance coverage. DHS staff work directly with HAPIS to provide a portion of the HIV/AIDS Case Management Certification Training. DHS has conducted workshops at the Annual Case Management Conference and DWHDC-HAPIS will continue to build and strengthen this relationship.

- **4:** DHWDC-HAPIS will continue its collaboration with Michigan's Housing Opportunities for Persons with AIDS (HOPWA) program and housing related

supportive services. HOPWA representatives in the past have participated on MHAC and its SCSN and Needs Assessment Committee. HOPWA representatives also present annually at the Care Case Management Conference.

- **5:** DHWDC-HAPIS will seek to strengthen a collaborative relationship with the Bureau of Mental Health and Substance Abuse Administration of MDCH, particularly in the area of mental health. DHWDC-HAPIS recognizes the importance of mental health with respect to individuals with HIV in an effort to provide a continuum of care to all PLWH/A throughout the state of Michigan. Efforts will be made to coordinate needs assessment and planning activities through joint participation on MHAC and its SCSN Committee.

- **6:** DHWDC-HAPIS will continue its collaboration with the Michigan Department of Corrections (MDOC) to identify PLWH/A being released from facilities and insure that they are linked to medical care and ADAP. Data will continue to be monitored, which will guide further program developments.

**GOAL 3: Strengthen the integration and coordination of HIV prevention services into continuum of care services to reflect the expectation that care providers assess an individual's need for HIV prevention services as appropriate on an on-going basis.**

- **1**: DHWDC-HAPIS will continue to ensure quality prevention and continuum of care services.

- **2:** DHWDC-HAPIS will strengthen contract language related to Part B HIV care to include specific expectations for providing HIV prevention services.

- **3:** DHWDC-HAPIS will assess compliance of the "Principles of Standards of Service for HIV Case Management in Michigan" which include the delivery of HIV prevention information, knowledge of Michigan law regarding informing past and current partners of the need for testing, and an awareness of Partner Counseling and Referral Services. These are conducted at intake and at intervals throughout the case management process.

- **4:** DHWDC-HAPIS will continue training and linkage opportunities for Part B and CDC-funded providers through the annual HIV/AIDS-STD conference and through various specialized trainings. There are three sections within the DHWDC. To assure effective communication and facilitate information dissemination, the DHWDC holds bi-annual day-long staff meetings with staff from all three sections and publishes quarterly newsletters for division staff.

- **5:** DHWDC-HAPIS will continue to expand opportunities for supporting additional HIV primary medical care services and expand the number of direct contractual relationships DHWDC-HAPIS has with medical care providers including Federally Qualified Health Centers. Specific prevention goals and objectives will be included in contracts with each medical care provider.

- **6:** DHWDC-HAPIS will continue to develop methodologies to respond to the CDC's *"Incorporating HIV Prevention into the Medical Care of Persons Living with HIV"* initiative. Currently, HIV Prevention activities are required to be defined in each primary care contractor's service delivery model. Several prevention-related activities are required by the Standards of Service of HIV/AIDS Case Management in Michigan. Activities are monitored annually.

- **7:** DHWDC-HAPIS will provide funding and monitor quarterly the Treatment Education and Adherence Pilot Program with Wellness AIDS Services, Inc., which includes a HIV 101 workshop to increase participants' knowledge about HIV/AIDS as well as explains how HIV works in the body. This program provides a total of seven weeks of multi-level two hour workshops that also encompass disclosure and empowerment; physician relationship; understanding the importance of adherence; understanding how to read CD4 and viral loads; resources and how to utilize them; and planning for the future.

- **8:** DHWDC-HAPIS will provide funding and monitor quarterly the Youth Link Project, which will provide increased access for disproportionately impacted youth and young adult minority individuals to HIV/AIDS treatment and medications available through the Part B AIDS Drug Assistance Program and, as appropriate, other prescription drug coverage programs. This program will provide intensive one-to-one outreach services to 25 HIV-positive African American youth and young adults to link them to ADAP or other appropriate programs that provide prescription drug coverage.

**GOAL 4: Use the data collected in HIV Counseling, Testing and Referral, Health Education Risk Reduction, and the HIV Event System to link with and compare to data collected through surveillance and the Uniform Reporting System (URS) on an on-going basis.**

- **1:** DHWDC-HAPIS will annually compare HIV/AIDS Reporting System (HARS) data with URS data to identify gaps in care, including primary medical care.

- **2:** DHWDC-HAPIS will analyze data collected from care and prevention programs to better understand the extent to which prevention services are also being utilized by individuals receiving care services.

## CRITICAL ISSUE B:
## Reduce and/or eliminate barriers to care

**GOAL 1: Develop and implement methods to improve service access for people experiencing barriers to care on an on-going basis.**

- **1:** DHWDC-HAPIS will continue to provide resources to two Federally Qualified Health Centers (Ingham County Health Department and Health Delivery Inc.) and several other ambulatory health care centers in underserved geographical areas where there is a lack of medical care for PLWH/A.

- **2:** DHWDC-HAPIS will recruit additional dentists to participate in the Michigan Dental Program (MDP).

- **3:** DHWDC-HAPIS will continue to market and monitor the MDP.

**GOAL 2: Identify individuals who know they are positive but are not receiving regular primary medical care on an on-going basis.**

- **1:** DHWDC-HAPIS will collaborate with the Bureau of Epidemiology to annually calculate unmet need. This requires determining the approximate number of individuals with HIV in a service area that know they are HIV+ but are not receiving primary care services.

- **2:** DHWDC-HAPIS will assess barriers that create unmet need by determining the service gaps, barriers and needs of individuals who are not in care.

- **3:** DHWDC-HAPIS will develop additional strategies to help 'out of care' individual's transition into care.

- **4:** DHWDC-HAPIS will disseminate information about available HIV/AIDS services to a wide range of audiences. Strategies include the development and dissemination of a statewide web-based resource directory listing hospitals, clinics, AIDS community-based organizations, local health departments, posting services on the MDCH website, and continued sponsorship of the annual PWA conference.

- **5**: DHWDC will facilitate the referral of HIV/AIDS-infected individuals who test confidentially through funded HIV Counseling and Test Referral sites into the appropriate care services for evaluation, care and treatment via the Counselor Assisted Referral Form (CARF).

- **6:** DHWDC-HAPIS will collaborate with the Michigan Department of Corrections (MDOC) to insure that PLWH/A being released from its facilities are successfully linked to medical care and ADAP.

- **7:** Strategies developed by local and statewide services to identify individuals who know their status, but are not in care, will be shared among HIV/AIDS service providers.

## Critical Issue C:
## Monitor standards and evaluate the impact of services on individuals

**GOAL 1: Monitor Contractor's ability to adhere to the Standards of Service for HIV/AIDS Case Management in Michigan, the Universal Standards and the CLAS Standards.**

- **1:** Conduct contract annual compliance site visits to all COC-funded sites.

- **2:** Conduct chart reviews at all funded sites that provide case management services to assure compliance with the standards during annual review.
- 3: Conduct monthly technical assistance conference calls and case management training for RW Part A, B and D funded case managers.

**<u>GOAL 2:</u> Conduct general monitoring of services provided by funded agencies.**

- **1:** Monitor data that is directly related to health outcomes, such as monitoring CD4 and Viral Load data; hospitalization and emergency room visit data; and access to/participation in primary medical care on an on-going basis.

- **2:** DHWDC-HAPIS will conduct a statewide care needs assessment every three years.

- **3:** DHWDC-HAPIS will conduct annual site visits to all funded providers for program and fiscal monitoring.

**<u>GOAL 3:</u> Evaluate and monitor projects administered through DHWDC-HAPIS**

- **1:** DHWDC-HAPIS will conduct an evaluation of consumer satisfaction with ADAP every two years.

- **2:** DHWDC-HAPIS will conduct an evaluation of consumer satisfaction with MDP every two years.

**<u>GOAL 4:</u> Evaluate, monitor and modify projects which have been newly created on an on-going basis.**

- **1:** Evaluate and monitor the recently funded programs in Jackson and Ingham Counties that identify people who know they have HIV, but are not receiving primary care and other supportive services.
- **2:** Evaluate and monitor Counselor-Assisted Referral program.
- **3:** Evaluate and monitor the Correctional Community Re-Entry Project.

**<u>GOAL 5:</u> Evaluate indicators to measure quality in medical and case management settings**. **Indicators include:**

- Collection of CD4 counts and viral loads at least every six months.
- One PAP smear annually for HIV+ women.
- Medication Adherence Counseling at least every six months.
- Medical visit with a HIV specialist at least every six months.
- Case management and care plan documented at least every six months.

# Section 4: How Will We Monitor Our Progress: How Will We Evaluate Our Progress In Meeting Our Short and Long-Term Goals?

COC will continue to use a variety of tools to monitor and evaluate performance of short and long-term goals. These tools have grown out of a need to ensure COC addresses PLWH/A needs, internal goals and objectives, state and federal-level policies, and gain community stakeholder input. These monitoring tools have given COC an increasingly comprehensive view of its performance as well as move toward their vision to ensure efficient delivery of comprehensive, quality care services to all eligible persons living with HIV/AIDS in Michigan. In order to evaluate short-term goals, COC has implemented a Quality Management Plan (QMP), the guiding principles of the plan include addressing the growing impact of the HIV/AIDS epidemic among underserved minority and hard-to-reach populations, ensuring access to existing and emerging HIV/AIDS therapies consistent with Public Health Services (PHS) treatment guidelines, adapting to ongoing changes in the epidemic and the HIV/AIDS funding environment; and documenting and evaluating outcomes for the investment of COC resources. The goals of the COC-Quality Management Plan are to:

1) Improve client outcomes by using a systematic process to determine the success and the quality of the service delivery system;

2) Assure that services adhere to the PHS guidelines, established clinical practice standards, and standards of service developed in Michigan;

3) Assure that clients are linked to medical care, counseling and testing programs, partner counseling and referral services, and other prevention and adherence programs, and that clients remain in care if they so choose; and

4) Improve the service delivery system based on results of needs assessment information, the SCSN, surveillance data, and client-level CAREWare data.

These goals have been and will continue to be accomplished through the following:

- Review and revise as necessary the COC-QMP and ensure that there are adequate staff to implement and monitor the activities and that adequate resources are budgeted for the program;

- Review and revise as necessary measures, indicators, and data collection methodologies for continuous quality improvement and quality assurance activities and facilitate regular collection, analysis and reporting of quality management and client level data;

- Issue directives, guidance, standards, and recommendations to staff and funded providers;

- Conduct quality management, quality assurance, and continuous quality improvement trainings, including the four day case management certification training;

- Review the COC-QMP plan and the annual QM report;

- Convene and facilitate an ad hoc standards of care committee, which is responsible for developing and revising standards of care and reviewing standardized forms for intake, assessment, care plan development, reassessment, monitoring, discharge, effective referrals and partner counseling and referral services. COC will guide this process.

- Conduct annual site visits to provider agencies and assess contract compliance and adherence to the standards of care at the provider level;

- Develop with the provider a corrective action plan, when warranted;

- Provide and facilitate technical assistance to providers and various quality management committees and the ad hoc work group;

- Provide service utilization data and various data analyses to providers, funders, and other partners; and

- Facilitate All Parts meetings for the purpose of sharing information on COC Part B and Part D QMP activities and to learn about Part A, Part C and Part F QM activities. The COC Unit held two All Parts (Grantees) meeting in 2008 and will hold a minimum of two All Parts meetings in 2009.

Besides this program, COC also uses as a monitoring tool the FY2008 Implementation Plan. This document identifies the direct services funded April 2008 – March 2009, and the objectives of each funded service. These services were directed by the results of the PLWH/A 2006 statewide needs assessment. Core services are included in this plan. Substance abuse is funded via collaboration with the Office of Drug Control Policy (ODCP). The *Memorandum of Understanding between the Michigan Department of Community Health and the Office of Drug Control Policy* documents how ODCP and DHWDC will work together to coordinate resources, assure effective program services among their respective providers, and conduct policy development, technical assistance, and consultation as well as training regarding HIV/AIDS, tuberculosis (TB), sexually transmitted diseases (STDs) and hepatitis in the substance abuse network. This project is known as the ODCP Communicable Disease Plan, with each division internally budgeting dollars to support these collaborative efforts.

Although this funding cannot fully meet the need for substance abuse services, there are other needed core services (such as ADAP, HIV case management and primary/specialty care) where no source of funding exists other than the Ryan White Part B resources.

MDCH-ODCP awards substance abuse resources to sixteen sub-state regional fiduciaries called Coordinating Agencies (CAs). Through their Action Plan Guidance on Communicable Disease, the ODCP identifies a portion of the Coordinating Agency's (CA's) allocation to be used for communicable disease efforts as outlined in the Communicable Disease Policy, which includes assuring staff training and capability in meeting the needs of those living with HIV/AIDS. In addition, CAs are required to describe mechanisms in place for assuring access to service for PLWH/A and/or Hepatitis C in their provider network. At local, regional and state levels, collaborative relationships are in place to ensure coordination of care for persons dually-diagnosed with HIV and substance abuse.

The Implementation Plan is reviewed and updated bi-annually. This plan can be found attached as Appendix E.

The monitoring tool used for long-term goals is the *The Division of Health, Wellness and Disease Control Strategic Plan.* Annually there is an in-depth review of the Division's Strategic Plan by departmental staff. COC reviews their portion of the plan by goal area. The content and emphasis of the Care program is evaluated to achieve long and short-range goals. The COC's portion of the Division's Strategic Plan can be found attached hereto as Appendix F.

COC will continue to address the needs of the PLWH/A community by involving this community in consumer feedback. Planned projects include surveying ADAP and dental clients on accessing current services and on-going needs in 2009. Community forums throughout the state will also be held in 2009 to assess PLWH/A needs. A PLWH/A survey will also be conducted statewide. Both of these activities will help inform DHWDC/HAPIS, as well as organizations, of local service needs in preparation to apply for Ryan White Part B funding. Case managers will continue to be updated on care services via the annual Case Management Conference as well as through their own list-serve, where information is communicated daily.

## IMPROVING CLIENT LEVEL DATA

MDCH-DHWDC has begun to implement the statewide deployment of CAREWare, version 4.1. A central server is being used to house data from all Part B and State-funded providers. Given the "real time" nature of the new system, MDCH-DHWDC now has the capability to use more rapid monitoring of specific indicators (e.g. number of clients without medical insurance), instead of waiting for several months until the provider is required to submit reports to MDCH-DHWDC.

MDCH-DHWDC makes more use of client level data with the implementation of CAREWare 4.1 since each agency data reflects their funded contract services. CAREWare allows the sharing of information between agencies, thereby improving referral times, the tracking of clients as well as tracking quality indicators. CAREWare can also track the Counselor-Assisted Referral Form and allow for the easy running of reports. Hands on training will be conducted in order that all agencies are consistent in inputting data and the sharing of information is universally understandable to all users in order that reporting is accurate.

## USING DATA FOR EVALUATION

Data and information have been used to target programs and resources in certain parts of the state. For example, client level data was evaluated prior to the allocation of Part B Minority AIDS Initiative resources to southwest Michigan and southeast Michigan. Additional resources are targeted toward minority and hard-to-reach populations for the purpose of improving access to, and retention in, medical care and supportive services.

Michigan participated in the Part B Quality Collaborative (QC) that was initiated by HRSA in summer of 2005. The QC Team consisted of seven members, including surveillance (epidemiology) and data management staff. The team completed the third learning session in November 2007 and was a full participant throughout the entire project. A positive part of this collaborative was the ability to include some existing efforts, such as the deployment of CAREWare 4.0, Medicare Part D, and the implementation of the first standardized form to assess payer of last resort into the learning objectives for this effort.

## MEASURING CLINICAL OUTCOMES

Contract monitoring is one of the most effective ways to assess the quality of services and is also a critical component of quality management.

The use of the three specific contract monitoring tools will continue. In addition to site visits, a staff team with expertise in case management, contract management, and data management meet once each quarter to review provider progress reports, fiscal trends, client utilization data, site visit results and any issues of concerns. Appropriate follow-up, if necessary, is discussed and assigned to the appropriate COC staff for follow-up action.

Some activities that have been implemented to improve the service delivery system:

- Development of service standards for case management and client advocacy, and development of a tool to assess financial eligibility;
- Development of provider/contractor work plans that focus on outcomes;
- Development of contract requirements that require compliance with standards, and stipulate reporting of quality assurance activities;
- Collection and analysis of contractor data, including fiscal reports, utilization data, and narrative progress reports;

- Conducting training on program and administrative issues, and an ongoing training and certification for HIV/AIDS case managers;

- Ongoing communication with providers, technical assistance, face-to-face meetings, and telephone and electronic communication, including the use of a Case Manager listserv and a listserv for executive directors and program managers.

Additionally, the COC Unit will continue to work with providers to refine, as needed, a standardized acuity scale, which is required of all HIV/AIDS case management agencies funded with Part B and state resources. This tool is used to assess the degree to which medical and non-medical services, such as case management, will improve health and retention in medical care for those receiving services.

Since the development of the original HIV/AIDS case management standards, MDCH-DHWDC has conducted case management reviews to assess compliance with the standards of service for case management. In the past, some of the requirements were related more to record keeping and timeliness of intake, assessment, service plan development, monitoring, reassessment and discharge, rather than the "quality" of case management or the effectiveness of the case management referral system. Through the use of an acuity scale to assess the level of need, Michigan's HIV/AIDS care network has begun to move in a new direction, toward outcome measurement. Outcome indicators are now linked to the acuity scales, as measured on intake/assessment and during reassessment, to document health outcomes of clients receiving case management and/or client advocacy services.

At this time MDCH-DHWDC is monitoring the following indicators: 1) the number of persons receiving a CD4 and viral load test in the past six months; 2) the number of persons receiving case management services with a completed financial assessment in the past six months; and 3) the number of persons receiving case management services with a completed HIV transmission risk assessment in the past year.

As part of COC's vision to ensure efficiency and to evaluate our own progress, this completed plan and the SCSN will be distributed to all HIV/AIDS providers in order that they are knowledgeable of the COC program. In keeping with the added emphasis on quality management and accountability, it is imperative all stakeholders involved in HIV/AIDS care services are aware of the principles used to strengthen the Ryan White HIV/AIDS Treatment Modernization Act in order to move forward in creating a healthier Michigan.

# APPENDICES (A-F)

## Appendix A FY 2008 Part B & MAI Allocations Report

Detailed instructions for completing and submitting this report can be found in the Electronic Handbooks and download from the web: https://grants.hrsa.gov/webexternal/Login.asp

| *Section A: Identifying Information* |
|---|
| Michigan Department of Community Health |
| Brenda Behm |
| 517.241.5913 |
| behmb@michigan.gov |

| *Section B: FY 2008 Award Information* | |
|---|---|
| 1. Part B Base Award | $5,122,836 |
| 2. Part B ADAP Earmark Award | $11,681,534 |
| 3. Part B Supplemental Award | $0 |
| **4. Total Part B ADAP + Supplemental Award** | **$11,681,534** |
| 5. Part B Emerging Communities Award | $0 |
| **6. Total Part B Award** | **$16,804,370** |
| 7. Part B MAI Award | $148,954 |
| **8. Total Part B + MAI Award** | **$16,953,324** |

| *Section C: Part B Allocations by Program Component* | 1. Base Award | | 2. ADAP Earmark + Supplemental Award | | 3. Emerging Communities Award | | 4. Total | |
|---|---|---|---|---|---|---|---|---|
| | Amount | Percentage | Amount | Percentage | Amount | Percentage | Amount | Percentage |
| **1. Part B AIDS Drug Assistance Program Subtotal** | **$50,000** | **0.98%** | **$11,196,773** | **95.85%** | **$0** | **- -** | **$11,246,773** | **66.93%** |
| a. ADAP Services | | 0.00% | $10,211,773 | 87.42% | | - - | $10,211,773 | 60.77% |
| b. Health Insurance to Provide Medications | | 0.00% | $910,000 | 7.79% | | - - | $910,000 | 5.42% |
| c. ADAP Access/Adherence/Monitoring Services | $50,000 | 0.98% | $75,000 | 0.64% | | - - | $125,000 | 0.74% |
| **2. Part B Health Insurance Premium & Cost Sharing Assistance** | | **0.00%** | | | | **- -** | **$0** | **0.00%** |
| **3. Part B Home and Community-based Health Services** | | **0.00%** | | | | **- -** | **$0** | **0.00%** |
| **4. Part B HIV Care Consortia Services** (Provide detail in Section D, Column 1) [1] | **$0** | **0.00%** | | | | **- -** | **$0** | **0.00%** |
| **5. Part B State Direct Services** (Provide detail in Section D, Column 2)[1] | **$4,450,409** | **86.87%** | | | | **- -** | **$4,450,409** | **26.48%** |
| **6. Part B Clinical Quality Management[2]** | **$119,811** | **2.34%** | **$113,305** | **0.97%** | | **- -** | **$233,116** | **1.39%** |
| **7. Part B Grantee Planning & Evaluation Activities[3]** | **$60,371** | **1.18%** | **$62,197** | **0.53%** | | **- -** | **$122,568** | **0.73%** |
| **8. Grantee Administration [3]** | **$442,245** | **8.63%** | **$309,259** | **2.65%** | | **- -** | **$751,504** | **4.47%** |
| **9. Column Totals** | **$5,122,836** | **100.00%** | **$11,681,534** | **100.00%** | **$0** | **- -** | **$16,804,370** | **100.00%** |
| **10.Total Part B Allocations[4]** | **$16,804,370** | | | | | | | |

| Section D: Breakdown for Consortia, State Direct Services and Emerging Communities | 1. Consortia[5] | | 2. Direct Services | | 3. Emerging Communities [6] | | 4. Total | |
|---|---|---|---|---|---|---|---|---|
| | Amount | Percentage | Amount | Percentage | Amount | Percentage | Amount | Percentage |
| **1. Core Medical Services Sub-total[7]** | **$0** | **- -** | **$3,698,597** | **83.11%** | **$0** | **- -** | **$3,698,597** | **83.11%** |
| a. Outpatient /Ambulatory Health Services | | - - | $448,326 | 10.07% | | - - | $448,326 | 10.07% |
| b. AIDS Drug Assistance Program (ADAP) Treatments | | - - | $325,842 | 7.32% | | - - | $325,842 | 7.32% |
| c. AIDS Pharmaceutical Assistance (local) | | - - | | 0.00% | | - - | $0 | 0.00% |
| d. Oral Health Care | | - - | $785,975 | 17.66% | | - - | $785,975 | 17.66% |
| e. Early Intervention Services | | - - | $130,000 | 2.92% | | - - | $130,000 | 2.92% |
| f. Health Insurance Premium & Cost Sharing Assistance | | - - | | 0.00% | | - - | $0 | 0.00% |
| g. Home Health Care | | - - | | 0.00% | | - - | $0 | 0.00% |
| h. Home and Community-based Health Services | | - - | | 0.00% | | - - | $0 | 0.00% |
| i. Hospice Services | | - - | | 0.00% | | - - | $0 | 0.00% |
| j. Mental Health Services | | - - | $130,206 | 2.93% | | - - | $130,206 | 2.93% |
| k. Medical Nutrition Therapy | | - - | $8,315 | 0.19% | | - - | $8,315 | 0.19% |
| l. Medical Case Management (including Treatment Adherence) | | - - | $1,862,628 | 41.85% | | - - | $1,862,628 | 41.85% |
| m. Substance Abuse Services–outpatient | | - - | $7,305 | 0.16% | | - - | $7,305 | 0.16% |
| **2. Support Services Sub-total** | **$0** | **- -** | **$751,812** | **16.89%** | **$0** | **- -** | **$751,812** | **16.89%** |
| a. Case Management (non-Medical) | | - - | $475,034 | 10.67% | | - - | $475,034 | 10.67% |
| b. Child Care Services | | - - | | 0.00% | | - - | $0 | 0.00% |
| c. Emergency Financial Assistance | | - - | $29,242 | 0.66% | | - - | $29,242 | 0.66% |
| d. Food Bank/Home-Delivered Meals | | - - | $64,176 | 1.44% | | - - | $64,176 | 1.44% |
| e. Health Education/Risk Reduction | | - - | $23,280 | 0.52% | | - - | $23,280 | 0.52% |
| f. Housing Services | | - - | $12,389 | 0.28% | | - - | $12,389 | 0.28% |
| g. Legal Services | | - - | | 0.00% | | - - | $0 | 0.00% |
| h. Linguistics Services | | - - | | 0.00% | | - - | $0 | 0.00% |
| i. Medical Transportation Services | | - - | $63,082 | 1.42% | | - - | $63,082 | 1.42% |
| j. Outreach Services | | - - | $54,014 | 1.21% | | - - | $54,014 | 1.21% |
| k. Psychosocial Support Services | | - - | $30,595 | 0.69% | | - - | $30,595 | 0.69% |
| l. Referral for Health Care/Supportive Services | | - - | | 0.00% | | - - | $0 | 0.00% |
| m. Rehabilitation Services | | - - | | 0.00% | | - - | $0 | 0.00% |
| n. Respite Care | | - - | | 0.00% | | - - | $0 | 0.00% |
| o. Substance Abuse Residential Services | | - - | | 0.00% | | - - | $0 | 0.00% |
| p. Treatment Adherence Counseling | | - - | | 0.00% | | - - | $0 | 0.00% |
| **3. Total** | **$0** | **- -** | **$4,450,409** | **100.00%** | **$0** | **- -** | **$4,450,409** | **100.00%** |

| Section E: MAI Allocations by Program Component | MAI Award | |
|---|---|---|
| | Amount | Percentage |
| 1. Education to increase minority participation in ADAP | | 0.00% |
| 2. Outreach to increase minority participation in ADAP | $148,954 | 100.00% |
| 3. Clinical Quality Management [2] | | 0.00% |
| 4. Grantee Planning & Evaluation Activities [3] | | 0.00% |
| 5. Grantee Administration [3] | | 0.00% |
| **6. Total MAI Allocations [5]** | **$148,954** | **100%** |

**FOR OFFICE USE ONLY:**

☐ Grantee received waiver for 75% core medical services requirement.

(1) In the *Base Award* column ONLY, this cell will automatically calculate based on the detail you provide in Section D.

(2) May not exceed 5% of the Part B award, or 3 million, whichever amount is smaller.

(3) May not exceed 10% of the Part B award for either *Planning & Evaluation* or *Grantee Admin.* Additionally, the combined costs for these two categories may not exceed 15% of the Part B award.

(4) This amount must equal the combined total of the Part B Base, ADAP, ADAP Supplemental, and Emerging Communities awards.

(5) All services in this column are considered *Support Services.*

(6) In the Emerging Communities Column ONLY, the Total Allocations should equal the combined total of Rows 4 + 5 in Section C, Column 3.

## Appendix B
**Part B, Part D and/or MHI Funded Care Providers FY08/09**

**HIV/AIDS Prevention and Intervention Section**
**Division of Health, Wellness and Disease Control**

| Agency | Program | Contact |
|---|---|---|
| **AIDS Partnership Michigan**<br>2751 E. Jefferson, #301<br>Detroit, MI 48207<br>(313) 446-9800<br>FAX: (313) 446-9839 | Community re-entry services (Part B)<br><br>Case management & support services to women, infants & children (Part D) | Barbara Murray<br>Executive Director<br>murray@aidspartnership.org<br><br>Hank Millbourne<br>Associate Executive Director<br>Director of Prevention<br>millbourne@aidspartnership.org<br><br>Finance: Doug Pizzala<br>pizzala@aidspartnership.org |
| **Central Michigan District Health Department**<br>2012 E. Preston Avenue<br>Mt. Pleasant, MI 48858<br>(989) 773-5921<br>FAX: (989) 773-4319 | Case management, ambulatory/outpatient medical care, food, transportation, nutritional counseling, and emergency financial assistance. | Christopher Lauckner<br>Director Health Education Services<br>clauckner@cmdhd.org<br>(989) 773-5921, ext. 160 |
| **Community AIDS Resources and Education Services (CARES)**<br>629 Pioneer Street<br>Kalamazoo, MI 49008 | Case management, food bank, transportation, emergency financial assistance, minority outreach (Part B), mental health, advocacy, case management to women and children (Part | David Kirby<br>Executive Director<br>dkirby@caresswm.org |

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|---|---|---|
| (269) 381-2437<br>FAX: (269) 381-4050 | D) | URS: Patricia M. Clark<br>Finance: Amy Bartell<br>abartell@caresswm.org |
| **Detroit Department of Health & Wellness Promotion**<br>1151 Taylor Room 145A<br>Detroit, MI 48202<br>(313) 876-4000 (Main Line)<br>FAX: Varies, Depending on Where Staff are Located in the Building | Health Education (Part D)<br>Mobil Medical Services – Mobile Van/Staff and Related Supplies | Calvin Trent, Ph.D.<br><br>Linda Gillam, Ph.D.<br>HIV Prevention Manager<br>gillaml@health.ci.detroit.mi.us<br>(313) 870-2755<br><br>Andrea Roberson<br>Operations Manager<br>Roberson@health.ci.detroit.mi.us<br>Maxine Guy – her assistant<br>(313) 876-0399<br>Mailing address –same except add Room 403C |
| **Detroit Medical Center**<br>3663 Woodward Avenue, Suite 200<br>Detroit, MI 48201<br>Phone:<br>FAX: | Extended medical, psychosocial, and support services to women, infants, children and youth | Barbara Moe<br>Grants Accounting<br>3663 Woodward Avenue<br>Administration Building, 4th Floor<br>bmoe@dmc.org<br><br>Program: Dr. Jonathan Cohn<br>DMC-UHC<br>4201 St. Antoine, 7D<br>jcohn@med.wayne.edu<br>(313) 993-0930<br><br>Finance: Carolle Battiste<br>Administrative Manager<br>DMC-UHC, 3990 John R.<br>5 Hudson, Room 5931<br>(313) 745-7101<br>FAX: (313) 993-0302<br>cbattiste@med.wayne.edu |

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| **District Health Department #10**<br>916 Diana Street<br>Ludington, MI 49431<br>(231) 845-7381 (Main Line)<br>FAX: (231) 845-0438 | Case management, emergency financial assistance, transportation | Sarah Oleniczak (231-316-8562)<br>Health Promotion Director<br>soleniczak@dhd10.org<br><br>URS: Deb Wright<br>DebWright7@aol.com<br>(231) 845-7381 |
| **Mercy Health Partners – Hackley Campus**<br>1700 Clinton Street<br>P.O. Box 3302<br>Muskegon, MI 49442<br>Toll Free: 1-866-727-5571<br>FAX: (231) 728-5674 | Case management, health education/risk reduction, emergency financial assistance, transportation, mental health, ambulatory/outpatient medical care, outreach, food, nutritional counseling<br><br>Bonnie Gustavison-Clinic Supervisor<br>bgustavi@hackley-health.org | Kim Maguire<br>Chief Nursing Operations<br>Maguirek@trinity-health.org<br>(231) 672-3752<br><br>Erin Hopson<br>Client Services Coordinator<br>ehopson@hackley-health.org<br>(231) 727-4253<br><br>URS: Mary Byers<br>mbyers@hackley-health.org<br>(231) 727-5571<br>Finance: Laura Martin<br>lmartin@hackley-health.org<br>(231) 728-5756 |
| **Health Delivery, Inc.**<br>501 Lapeer<br>Saginaw, MI 48607<br>(989) 792-8751<br>FAX: (989) 755-3603 | Ambulatory/outpatient medical care, mental health and case management | Angelia Williams<br>Ang2002612@aol.com<br>Program Director<br>FAX: (989) 907-2781<br><br>Finance: Sharon Gallop<br>Chief Financial Officer<br>sgallop@healthdelivery.org<br>(989) 759-6443<br><br>John Rezayi, Comptroller<br>jrezayi@healthdelivery.org<br>(989) 759-6442 |

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| **HIV/AIDS Resource Center**<br>3075 Clark Road, #203<br>Ypsilanti, MI 48197<br>(734) 572-9355<br>FAX: (734) 572-0554 | Ambulatory/outpatient medical care, mental health, case management, emergency financial assistance, food bank, transportation, mental health | Jimena Loveluck, MSU<br>President/CEO<br>loveluck@r2harc.org<br><br>Patricia Love<br>Director of Client Services<br>patlove@r2harc.org<br><br>Finance/URS: Suzanne Hill<br>suzanne@r2harc.org |
| **Ingham County Health Department**<br>5303 South Cedar Street<br>P.O. Box 30161<br>Lansing, MI 48909<br>(517) 887-4434<br>FAX: (517) 887-4310 | Outpatient/ambulatory medical care | Jason T. Fournier, DC, MPH<br>Deputy Health Officer, Community Care Services<br>jfournier@ingham.org<br>Noreen Allman – assistant<br>(517) 887-4311<br>nwebb@ingham.org<br>Finance: John Jacobs, CFO<br>jjacobs@ingham.org |
| **Lansing Area AIDS Network**<br>913 W. Holmes, Suite 115<br>Lansing, MI 48910<br>(517) 394-3719<br>FAX: (517) 394-1298 | Ambulatory/outpatient medical care, mental health, case management, emergency financial assistance, food bank, transportation, oral health, emergency financial assistance | Jacob A. Distel, Jr.<br>Executive Director<br>jdistel@laanonline.org<br>(517) 394-3719 ext. 13<br><br>URS: Audrey Matisoff, Deputy Director, ext. 28<br>amatisoff@laanonline.org<br>Finance: Dave Knechtges, ext 15<br>dknechtges@laanonline.org |

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|---|---|---|
| **Marquette County Health Department**<br>184 U.S. Hwy 41, East<br>Negaunee, MI 49866<br>(906) 475-7651<br>FAX: (906) 475-4435 | Ambulatory/outpatient medical care, case management, health education/risk reduction, transportation, emergency financial assistance | Laura Fredrickson<br>HIV/AIDS Coordinator<br>lfredrickson@mgtcty.org<br><br>URS: Barb Eheman, ext. 231<br>beheman@hline.localhealth.net<br><br>Finance: Jim Rahoi<br>jrahoi@mgtcty.org |
| **Munson Medical Center**<br>1221 Sixth Street, Suite 206<br>Traverse City, MI 49684<br>(231) 935-5085<br>FAX: (231) 935-5093<br>Toll Free: 1-800-4-MUNSON, ext. 55085 | Case management, emergency financial assistance, outpatient medical care, nutritional counseling, nutritional supplements, mental health, transportation, food, HERR, outreach | Mary Dillinger MS, RN, ACRN<br>Clinical Nurse Specialist/Case Manager<br>mdilling@mhc.net<br><br>URS: Mary Dillinger<br>Finance: Michelle Kasper<br>mkasper@mhc.net<br>(231) 935-7800 |
| **Sacred Heart Rehabilitation Center, Inc.**<br>**(Bay Area Social Intervention Services, Inc. – BASIS)**<br>400 Stoddard Road<br>P.O. Box 41038<br>Memphis, MI 48041-1038<br>(810) 392-2167<br>FAX: (810) 392-3385 | Case management, emergency financial assistance, food bank, mental health, transportation, outreach, substance abuse services, medication adherence, health education and risk reduction | Grady Wilkinson<br>President/CEO<br>gwilkinson@sacredheartcenter.com<br><br>URS: Tim Neal<br>tneal@sacredheartcenter.com<br>(989) 895-3701<br><br>Finance: Marcia J. Lott<br>mlott@sacredheartcenter.com |
| **St. Mary's Health Care**<br>**McAuley Health Services**<br>310 Lafayette, SE, Suite 410<br>Grand Rapids, MI 49503<br>(616) 913-8200 (main line)<br>FAX: (616) 774-0158 | Case management, mental health, transportation, emergency financial (oral health) | Kristin Durell<br>Program Manager<br>durellk@trinity-health.org<br>(616) 913-8218<br><br>URS: Kristin Durell<br>Finance: Jeff Klug<br>klugj@trinity-health.org |

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|---|---|---|
| **University of Detroit, Mercy School of Dentistry**<br>2700 Martin Luther King Jr. Blvd.<br>Detroit, MI 48208-2576<br>(313) 494-6600 | Oral health | Mert N. Asku, DDS, JD, MHSA<br>Associate Dean, Clinic Administration<br>(313) 494-6750<br><br>Laura Wright (313) 745-4595<br>Financial Services Asst.<br>wrightla@udmercy.edu<br><br>Finance: Maureen Lennox<br>Business Manager School of Dentistry<br>lennoxml@udmercy.edu<br><br>Professor Pamela Zarkowski<br>Academic VP and Provost (contract signee) |
| **Visiting Nurse Association of Southeast Michigan**<br>25900 Greenfield Road, Suite 600<br>Oak Park, MI 48237<br>(248) 967-8320<br>FAX: (248) 967-8720 | Case management for women & children | Kathleen J. Holycross<br>President & CEO<br><br>Kathy Kustowski<br>kkustowski@vna.org<br><br>Finance: Natalia Mistiouk<br>Senior Accountant<br>(248) 967-8714<br>nmistiouk@vna.org |
| **Wayne State University/AREC**<br>2727 Second Avenue, Suite 138<br>Detroit, MI 48201<br>(313) 962-2000<br>FAX: (313) 962-4444 | Education and Training, provider education | Jon Cohn, MD, MPH<br>jcohn@med.wayne.edu<br><br>Mary Rose Forsyth<br>Program Coordinator<br>forsyth@sun.science.wayne.edu<br><br>URS: N/A |

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|---|---|---|
| **Wayne State University/Children's Hospital**<br>**Pediatric Prevention Research Center**<br>UHC 6D5<br>Detroit, MI 48201<br>(313) 745-4875<br>FAX: (313) 745-4993 | Treatment adherence counseling | Dr. Sylvie Naar-King<br>Director, Project Challenge<br>snaarkin@med.wayne.edu<br><br>URS: Sylvie Naar-King |
| **Wellness AIDS Services, Inc.**<br>311 E. Court Street<br>Flint, MI 48502<br>(810) 232-0888<br>FAX: (810) 232-2418 | Case management, mental health, ambulatory/outpatient medical care, food bank, transportation, emergency financial assistance, health education/risk reduction, outreach, substance abuse, psychosocial support (Part B)<br><br>Case management services to women & children (Part D) | Amna Osman<br>Executive Director<br>aosman@wellnessaids.org<br><br>URS/Finance: Amna Osman |
| **Westminster Presbyterian Church**<br>47 Jefferson Avenue, S.E.<br>Grand Rapids, MI 49503<br>(616) 456-6115<br>FAX: (616) 456-1461 | Food bank | Chuck Strikwerda<br>Food Pantry Director<br>chucks@westminstergr.com<br><br>URS/Finance: Chuck Strikwerda |

## Appendix C
## Part A and Part B Fundable Program Services List

| Part A and Part B Allowable Program Services | |
|---|---|
| **Core Medical Services** | |
| a. | Outpatient /Ambulatory health services |
| b. | AIDS Drug Assistance Program (ADAP) treatments |
| c. | AIDS Pharmaceutical Assistance (local) |
| d. | Oral health care |
| e. | Early Intervention Services |
| f. | Health Insurance Premium & Cost Sharing Assistance |
| g. | Home health care |
| h. | Home and Community-based Health Services |
| i. | Hospice Services |
| j. | Mental health services |
| k. | Medical Nutrition Therapy |
| l. | Medical Case Management (including Treatment Adherence) |
| m. | Substance abuse services–outpatient |
| **Support Services** | |
| n. | Case Management (non-Medical) |
| o. | Child care services |
| p. | Emergency financial assistance |
| q. | Food bank/home-delivered meals |
| r | Health education/risk reduction |
| s | Housing services |
| t | Legal services |
| u | Linguistics Services |
| v | Medical Transportation Services |
| w | Outreach services |
| x | Psychosocial support services |
| y | Referral for health care/supportive services |
| z | Rehabilitation services |
| aa. | Respite care |
| ab. | Treatment adherence counseling |

**NOTE**: **Part A and B Ryan White grant funds may be used to support ONLY the service categories listed above**. The *Ryan White Program Service Category Definitions* list includes additional categories that are fundable under Part C and/or Part D only.

## Appendix C
## Ryan White Program Services Definitions

### CORE SERVICES

**Service categories:**

**a.** *Outpatient/Ambulatory medical care (health services)* is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings. Services includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). *Primary medical care* for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies. **NOTE: Early Intervention Services provided by Ryan White Part C and Part D Programs should be included here under *Outpatient/ Ambulatory medical care*.**

**b.** ***AIDS Drug Assistance Program (ADAP treatments)* is a** State-administered program authorized under Part B of the Ryan White Program that provides FDA-approved medications to low-income individuals with HIV disease who have limited or no coverage from private insurance, Medicaid, or Medicare.

**c.** *AIDS Pharmaceutical Assistance (local)* includes local pharmacy assistance programs implemented by Part A or Part B Grantees to provide HIV/AIDS medications to clients. This assistance can be funded with Part A grant funds and/or Part B base award funds. Local pharmacy assistance programs are **not** funded with ADAP earmark funding.

**d.** ***Oral health care*** includes diagnostic, preventive, and therapeutic services provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries, and other trained primary care providers.

**e.** ***Early intervention services (EIS)*** include counseling individuals with respect to HIV/AIDS; testing (including tests to confirm the presence of the disease, tests to diagnose to extent of immune deficiency, tests to provide information on appropriate therapeutic measures); referrals; other clinical and diagnostic services regarding HIV/AIDS; periodic medical evaluations for individuals with HIV/AIDS; and providing therapeutic measures.

**NOTE: EIS provided by Ryan White Part C and Part D Programs should NOT be reported here. Part C and Part D EIS should be included under *Outpatient/ Ambulatory medical care*.**

***f.*** **Health Insurance Premium & Cost Sharing Assistance** is the provision of financial assistance for eligible individuals living with HIV to maintain a continuity of health insurance or to receive medical benefits under a health insurance program. This includes premium payments, risk pools, co-payments, and deductibles.

***g.*** ***Home Health Care*** includes the provision of services in the home by licensed health care workers such as nurses and the administration of intravenous and aerosolized treatment, parenteral feeding, diagnostic testing, and other medical therapies.

***h.*** *Home and Community-based Health Services* include skilled health services furnished to the individual in the individual's home based on a written plan of care established by a case management team that includes appropriate health care professionals. Services include durable medical equipment; home health aide services and personal care services in the home; day treatment or other partial hospitalization services; home intravenous and aerosolized drug therapy (including prescription drugs administered as part of such therapy); routine diagnostics testing administered in the home; and appropriate mental health, developmental, and rehabilitation services. Inpatient hospitals services, nursing home and other long term care facilities are **NOT** included.

***i.*** ***Hospice services*** include room, board, nursing care, counseling, physician services, and palliative therapeutics provided to clients in the terminal stages of illness in a residential setting, including a non-acute-care section of a hospital that has been designated and staffed to provide hospice services for terminal clients.

***j.*** ***Mental health services*** are psychological and psychiatric treatment and counseling services offered to individuals with a diagnosed mental illness, conducted in a group or individual setting, and provided by a mental health professional licensed or authorized within the State to render such services. This typically includes psychiatrists, psychologists, and licensed clinical social workers.

***k.*** *Medical nutrition therapy* is provided by a licensed registered dietitian outside of a primary care visit and includes the provision of nutritional supplements. Medical nutrition therapy provided by someone other than a licensed/registered dietitian should be recorded under psychosocial support services.

***l.*** *Medical Case management services (including treatment adherence)* are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication.

***m.*** *Substance abuse services outpatient* is the provision of medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) in an outpatient setting, rendered by a physician or under the supervision of a physician, or by other qualified personnel.

## SUPPORT SERVICES

***n.*** Case Management (non-Medical) includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does.

***o.*** *Child care services* are the provision of care for the children of clients who are HIV-positive while the clients attend medical or other appointments or Ryan White Program-related meetings, groups, or training.

**NOTE:** This does not include child care while a client is at work.

***p.*** *Pediatric developmental assessment and early intervention services* are the provision of professional early interventions by physicians, developmental psychologists, educators, and others in the psychosocial and intellectual development of infants and children. These services involve the assessment of an infant's or child's developmental status and needs in relation to the involvement with the education system, including early assessment of educational intervention services. It includes comprehensive assessment of infants and children, taking into account the effects of chronic conditions associated with HIV, drug exposure, and other factors. Provision of information about access to Head Start services, appropriate educational settings for HIV-affected clients, and education/assistance to schools should also be reported in this category.

***q.*** *Emergency financial assistance* is the provision of short-term payments to agencies or establishment of voucher programs to assist with emergency expenses related to essential utilities, housing, food (including groceries, food vouchers, and food stamps), and medication when other resources are not available.

NOTE: Part A and Part B programs must be allocated, tracked and report these funds under specific service categories as described under 2.6 in DSS Program Policy Guidance No. 2 (formally Policy No. 97-02).

***r.*** *Food bank/home-delivered meals* include the provision of actual food or meals. It does not include finances to purchase food or meals. The provision of essential household supplies such as hygiene items and household cleaning supplies should be included in this item. Includes vouchers to purchase food.

***s.*** *Health education/risk reduction* is the provision of services that educate clients with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes the provision of information; including information dissemination about medical and psychosocial support services and counseling to help clients with HIV improve their health status.

***t.*** *Housing services* are the provision of short-term assistance to support emergency, temporary or transitional housing to enable an individual or family to gain or maintain medical care. Housing-related referral services include assessment, search, placement, advocacy, and the fees associated with them. Eligible housing can include both housing that does not provide direct medical or supportive services and housing that provides some type of medical or supportive services such as residential mental health services, foster care, or assisted living residential services.

***u.*** *Legal services* are the provision of services to individuals with respect to powers of attorney, do-not-resuscitate orders and interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the Ryan White Program. It does **not** include any legal services that arrange for guardianship or adoption of children after the death of their normal caregiver.

**v.** *Linguistics services* include the provision of interpretation and translation services.

**w.** Medical transportation services include conveyance services provided, directly or through voucher, to a client so that he or she may access health care services.

**x.** *Outreach services* are programs that have as their principal purpose identification of people with unknown HIV disease or those who know their status so that they may become aware of, and may be enrolled in care and treatment services (i.e., case finding), not HIV counseling and testing nor HIV prevention education. These services may target high-risk communities or individuals. Outreach programs must be planned and delivered in coordination with local HIV prevention outreach programs to avoid duplication of effort; be targeted to populations known through local epidemiologic data to be at disproportionate risk for HIV infection; be conducted at times and in places where there is a high probability that individuals with HIV infection will be reached; and be designed with quantified program reporting that will accommodate local effectiveness evaluation.

**y.** *Permanency planning* is the provision of services to help clients or families make decisions about placement and care of minor children after the parents/caregivers are deceased or are no longer able to care for them.

**z.** *Psychosocial support services* are the provision of support and counseling activities, child abuse and neglect counseling, HIV support groups, pastoral care, caregiver support, and bereavement counseling. Includes nutrition counseling provided by a non-registered dietitian but excludes the provision of nutritional supplements.

**aa.** *Referral for health care/supportive services* is the act of directing a client to a service in person or through telephone, written, or other type of communication. Referrals may be made within the non-medical case management system by professional case managers, informally through support staff, or as part of an outreach program.

**ab.** *Rehabilitation services* are services provided by a licensed or authorized professional in accordance with an individualized plan of care intended to improve or maintain a client's quality of life and optimal capacity for self-care. Services include physical and occupational therapy, speech pathology, and low-vision training.

**ac.** *Respite care* is the provision of community or home-based, non-medical assistance designed to relieve the primary caregiver responsible for providing day-to-day care of a client with HIV/AIDS.

**ad.** *Treatment adherence counseling* is the provision of counseling or special programs to ensure readiness for, and adherence to, complex HIV/AIDS treatments by non-medical personnel outside of the medical case management and clinical setting.

# Appendix D: Key Documents

1. *2006 Michigan Statewide Coordinated Statement of Need (SCSN).* See the following website for the most recent draft: http://www.mihivnews.com/

2. *2006 Part B HIV/AIDS Care Needs Assessment.* See the following website for the most recent draft: http://www.mihivnews.com/

3. *2003 Detroit Eligible Metropolitan Area HIV/AIDS Care Needs Assessment.* See the following website for the most recent draft: http://www.mihivnews.com/

4. *The Epidemiologic Profile of HIV/AIDS in Michigan.* See the following website for the most recent profile: http://www.michigan.gov/hivstd

5. *RWCA Part B FY2007 Grant Application.* Contact DHWDC-HAPIS for application.

6. *Michigan Go Local Website:* www.medlineplus/gov/mi

7. *User Friendly Manual Website:* List of resources for PLWH/A residing in the the DEMA: www.lib.wayne.edu.dcal

# Appendix E Ryan White Part B Implementation Plan

**Grantee:** **Michigan Department of Community Health** **Fiscal Year** **FY2008** **Page 1 of 9 Pages**

| | | | | | |
|---|---|---|---|---|---|
| **Service Priority Name:** Outpatient/Ambulatory Medical Care | | | | **Total Priority Allocation:** $305,922 | |
| **Service Priority Number: N/A (Part B does not prioritize services)** | | | | | |
| **Service Goal: To ensure that eligible PLWH/A in under-served regions of the State have access to quality medical care services.** | | | | **Reference Current Comprehensive Plan:** Page 17 (focus on core services), Page 21 (Critical Issue A, Goal 3, bullet #5), and Attachment F | |
| **1. Objectives:** List quantifiable time-limited objectives related to the service priorities listed above | **2. Service Unit Definition:** Define the service unit to be provided | **3. Quantity** | | **4. Time Frame:** Indicate the estimated duration of activity relating to the objective listed. | **5. Funds:** Provide the approximate amount of funds to be used to provide this service. |
| | | 3a) Number of people to be served | 3b) Total Number of service units to be provided | | |
| a: Provide resources to contractors to pay for eligible medical care services for PLWH/A who are un- or underinsured, as payer of last resort. | Office Visit | 1,500 | 8,000 | Apr 08– Mar 09 | $305,922 |
| b: | | | | | |
| c: | | | | | |
| d: | | | | | |
| e: | | | | | |
| **6. Select a minimum of two objectives and list planned client level outcomes/indicators to be tracked, and include benchmarks for each:** 1) 65% of HIV+ clients with medical care services will have a CD4 count at least every six months. 2) 65% of HIV+ clients with medical care services will have a viral load test at least every six months. | | | | | |

| | |
|---|---|
| **Service Priority Name:** Outpatient Medical Care Treatment Adherence Counseling | **Total Priority Allocation:** $142,404 |
| **Service Priority Number: N/A** | |
| **Service Goal: To facilitate adherence to critical pharmaceutical regimens.** | **Reference Current Comprehensive Plan:** (See above references. This is a component of medical care and |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | is provided in a clinical setting.) |
| **1. Objectives:** List quantifiable time-limited objectives related to the service priorities listed above | **2. Service Unit Definition:** Define the service unit to be provided | **3. Quantity** | | **4. Time Frame:** Indicate the estimated duration of activity relating to the objective listed. | **5. Funds:** Provide the approximate amount of funds to be used to provide this service. |
| | | 3a) Number of people to be served | 3b) Total Number of service units to be provided | | |
| a: Provide resources to Detroit Children's Hospital to deliver treatment adherence services to help HIV-positive clients (women, infants, children and youth) adhere to complex treatment regimens. | Treatment adherence counseling contact/event. | 100 | 500 | Apr 08-Mar 09 | $142,404 This amount is included in "medical care" on the Planned Allocations report because it is clinically based adherence counseling. |
| b: | | | | | |
| c: | | | | | |
| d: | | | | | |
| e: | | | | | |
| **6. Select a minimum of two objectives and list planned client level outcomes/indicators to be tracked, and include benchmarks for each:** 1) 60% of HIV+ clients on ART will receive HIV medication adherence counseling at least every six months. | | | | | |

**Ryan White Part B Implementation Plan**

**Page 2 of 9 Pages**

**Grantee: Michigan Department of Community Health Fiscal Year FY2008**

| | | | | |
|---|---|---|---|---|
| **Service Priority Name:** Oral Health Care | | | | **Total Priority Allocation:** $785,975 |
| **Service Priority Number: N/A** | | | | |
| **Service Goal: To provide quality dental care to eligible PLWH/A who are enrolled in the Michigan Dental Program (MDP), or whose care is reimbursed through case management providers.** | | | | **Reference Current Comprehensive Plan:** Page 17 (focus on core services), Page 21 (critical issue B, Goal 1), Attachment F |
| **1. Objectives:** | **2. Service Unit** | **3. Quantity** | **4. Time Frame:** | **5. Funds:** |

| List quantifiable time-limited objectives related to the service priorities listed above | **Definition:** Define the service unit to be provided | 3a) Number of people to be served | 3b) Total Number of service units to be provided | Indicate the estimated duration of activity relating to the objective listed. | Provide the approximate amount of funds to be used to provide this service. |
|---|---|---|---|---|---|
| a: Ensure the provision of quality dental care to eligible PLWH/A through reimbursement to qualified dentists. | Office Visit | 950 | 4,000 | Apr 08– Mar 09 | $785,975 |
| b: | | | | | |
| c: | | | | | |
| d: | | | | | |
| e: | | | | | |

**6. Select a minimum of two objectives and list planned client level outcomes/indicators to be tracked, and include benchmarks for each:** By March 31, 2009, 950 clients will receive 4,000 units of dental services.

| **Service Priority Name:** Mental Health Services | **Total Priority Allocation:** $130,206 |
|---|---|
| **Service Priority Number: N/A** | |
| **Service Goal: To provide quality mental health care services to eligible PLWH/A who have a diagnosed mental illness, to improve mental health status so that they are more likely to obtain and maintain HIV health care services.** | **Reference CurrentComprehensive Plan:** Page 17 (focus on core services), Pages 13-14, item 7., and Attachment F |

| **1. Objectives:** List quantifiable time-limited objectives related to the service priorities listed above | **2. Service Unit Definition:** Define the service unit to be provided | **3. Quantity** | | **4. Time Frame:** Indicate the estimated duration of activity relating to the objective listed. | **5. Funds:** Provide the approximate amount of funds to be used to provide this service. |
|---|---|---|---|---|---|
| | | 3a) Number of people to be served | 3b) Total Number of service units to be provided | | |
| a: Provide resources to contractors to deliver quality mental health care services to eligible PLWH/A to promote mental stability and improve the capacity of clients to attend to health care needs related to HIV disease. | Office Visit | 250 | 1,000 | Apr 08-Mar 09 | $130,206 |
| b: | | | | | |
| c: | | | | | |
| d: | | | | | |
| e: | | | | | |

**6. Select a minimum of two objectives and list planned client level outcomes/indicators to be tracked, and include benchmarks for each:**
75% of clients enrolled for mental health treatment will receive 2 or more mental health services by March 31, 2009.

**Ryan White Part B Implementation Plan**

**Grantee:** Michigan Department of Community Health **Fiscal Year** FY2008 **Page** 3 **of** 9 **Pages**

| **Service Priority Name:** Early Intervention Services (Part B type) | | | | | **Total Priority Allocation:** $130,000 |
|---|---|---|---|---|---|
| **Service Priority Number: N/A** | | | | | |
| **Service Goal: To provide early intervention services to hard to reach populations in Metro Detroit via a mobile van.** | | | | | **Reference Current Comprehensive Plan:** Page 21, Critical Issue B, Goal 2 (identify individuals not in care); and Page 18 (coordinate with other Titles) |
| **1. Objectives:** List quantifiable time-limited objectives related to the service priorities listed above | **2. Service Unit Definition:** Define the service unit to be provided | **3. Quantity** | | **4. Time Frame:** Indicate the estimated duration of activity relating to the objective listed. | **5. Funds:** Provide the approximate amount of funds to be used to provide this service. |
| | | 3a) Number of people to be served | 3b) Total Number of service units to be provided | | |
| a: Provide resources to the Detroit Department of Health and Wellness Promotion, for the provision of mobile HIV medical care and other early intervention services to persons with HIV living in the Detroit Eligible Metropolitan Area who are out of care. | Contact/visit | 100 | 250 | Apr 08– Mar 09 | $130,000 |
| b: | | | | | |
| c: | | | | | |
| d: | | | | | |
| e: | | | | | |
| **6. Select a minimum of two objectives and list planned client level outcomes/indicators to be tracked, and include benchmarks for each:** 85% of HIV+ clients seen on the mobile van will be engaged in primary medical care by March 31, 2009. | | | | | |
| **Service Priority Name:** Medical Case Management | | | | | **Total Priority Allocation:** $1,862,628 |
| **Service Priority Number: N/A** | | | | | |
| **Service Goal: To obtain and maintain health care and supportive services for PLWH/A through care coordination and treatment adherence monitoring in order to improve their health status and quality of life.** | | | | | **Reference Current Comprehensive Plan:** Page 21, focus on core services, Page 22, Critical Issue C, Goal 1 (standards of care), and |

| | | | | | Attachment F |
|---|---|---|---|---|---|
| **1. Objectives:** List quantifiable time-limited objectives related to the service priorities listed above | **2. Service Unit Definition:** Define the service unit to be provided | **3. Quantity** | | **4. Time Frame:** Indicate the estimated duration of activity relating to the objective listed. | **5. Funds:** Provide the approximate amount of funds to be used to provide this service. |
| | | 3a) Number of people to be served | 3b) Total Number of service units to be provided | | |
| a: Provide resources to contractors to deliver medical case management services consistent with the *Standards of Service for HIV/AIDS Medical Case Management in Michigan* to facilitate access to medical care and supportive services. | 1 unit = 15 minutes | 1,500 | 40,000 | Apr 08-Mar 09 | $1,862,628 |
| b: | | | | | |
| c: | | | | | |
| d: | | | | | |
| e: | | | | | |
| **6. Select a minimum of two objectives and list planned client level outcomes/indicators to be tracked, and include benchmarks for each:** 90% of clients with HIV will have a case management care plan documented and updated at least every six months. | | | | | |

**Ryan White Part B Implementation Plan**

**Grantee: Michigan Department of Community Health Fiscal Year FY2008** **Page 4 of 9 Pages**

| | | | | | |
|---|---|---|---|---|---|
| **Service Priority Name:** Medical Nutrition Therapy | | | | | **Total Priority Allocation:** $8,315 |
| **Service Priority Number: N/A** | | | | | |
| **Service Goal: To improve the health of clients through the provision of services of a licensed registered dietitian.** | | | | | **Reference Current Comprehensive Plan:** No reference |
| **1. Objectives:** List quantifiable time-limited objectives related to the service priorities listed above | **2. Service Unit Definition:** Define the service unit to be provided | **3. Quantity** | | **4. Time Frame:** Indicate the estimated duration of activity relating to the objective listed. | **5. Funds:** Provide the approximate amount of funds to be used to provide this service. |
| | | 3a) Number of people to be served | 3b) Total Number of service units to be provided | | |

| | | | | | |
|---|---|---|---|---|---|
| a: Provide resources to contractors to deliver medical nutrition therapy to clients to maintain and improve health status while undergoing HIV treatment. | Visit/contact | 45 | 120 | Apr 08– Mar 09 | $8,315 |
| b: | | | | | |
| c: | | | | | |
| d: | | | | | |
| e: | | | | | |

**6. Select a minimum of two objectives and list planned client level outcomes/indicators to be tracked, and include benchmarks for each:** By March 31, 2009 45 clients will receive 120 units of medical nutrition therapy.

| | |
|---|---|
| **Service Priority Name:** AIDS Drug Assistance Program | **Total Priority Allocation:** $125,000 |
| **Service Priority Number: N/A** | |
| **Service Goal: To monitor the health status of ADAP clients through laboratory testing.** | **Reference Current Comprehensive Plan:** Attachment F |

| **1. Objectives:** List quantifiable time-limited objectives related to the service priorities listed above | **2. Service Unit Definition:** Define the service unit to be provided | **3. Quantity** | | **4. Time Frame:** Indicate the estimated duration of activity relating to the objective listed. | **5. Funds:** Provide the approximate amount of funds to be used to provide this service. |
|---|---|---|---|---|---|
| | | 3a) Number of people to be served | 3b) Total Number of service units to be provided | | |
| a: Provide resources to the MDCH laboratory to perform viral load, CD4, and genotype tests for ADAP clients, to monitor health status. | Tests performed | 725 | 2,125 | Apr 08-Mar 09 | $50,000 Base<br>$50,000 ADAP |
| b: Provide resources to Monogram Biosciences for an assay test needed by ADAP clients to determine appropriateness of Maraviroc. | Tests performed | 12 | 24 | Apr 08-Mar 09 | 25,000 |
| c: | | | | | |
| d: | | | | | |
| e: | | | | | |

**6. Select a minimum of two objectives and list planned client level outcomes/indicators to be tracked, and include benchmarks for each:** By March 31, 2009, 725 ADAP clients will receive 2,125 units of laboratory services.

**Ryan White Part B Implementation Plan**

Grantee: Michigan Department of Community Health Fiscal Year FY2008

| | | | | | |
|---|---|---|---|---|---|
| **Service Priority Name:** AIDS Drug Assistance Program | | | | | **Total Priority Allocation:** $10,537,615 |
| **Service Priority Number: N/A** | | | | | |
| **Service Goal: To ensure uninterrupted access to life-saving medication necessary to effectively treat HIV disease for eligible PLWH/A.** | | | | | **Reference Current Comprehensive Plan:** Page 17, focus on core services; Page 20, collaboration with Dept. of Corrections; Attachment F |
| **1. Objectives:** List quantifiable time-limited objectives related to the service priorities listed above | **2. Service Unit Definition:** Define the service unit to be provided | **3. Quantity** 3a) Number of people to be served | 3b) Total Number of service units to be provided | **4. Time Frame:** Indicate the estimated duration of activity relating to the objective listed. | **5. Funds:** Provide the approximate amount of funds to be used to provide this service. |
| a: Reimburse pharmacies for approved medications delivered to PLWH/A who are enrolled in Michigan's ADAP or who are referred to ADAP for interim emergency medications. | One script filled. | 2,750 | 80,000 | Apr 08– Mar 09 | $10,171,773 ADAP<br>$325,842 Base |
| b: Provide a 30-day supply of approved HIV medications to releasing prisoners who are ADAP eligible, through an agreement with the MDOC. | One script filled. | 30 | 150 | Apr 08– Mar 09 | $40,000 |
| c: | | | | | |
| d: | | | | | |
| e: | | | | | |

**6. Select a minimum of two objectives and list planned client level outcomes/indicators to be tracked, and include benchmarks for each:**
The ADAP will routinely verify client eligibility, and by March 31, 2009 will transition at least 180 ADAP clients to other HIV medications programs, e.g., Medicare Part D or Adult Benefit Waiver, for which they qualify, thus maximizing use of ADAP resources.

| | |
|---|---|
| **Service Priority Name:** Health Insurance | **Total Priority Allocation:** $910,000 |
| **Service Priority Number: N/A** | |
| **Service Goal: To ensure uninterrupted access to life-saving medication necessary to effectively treat HIV disease for eligible PLWH/A.** | **Reference Current Comprehensive Plan:** Page 19, Goal 2, bullet #5; and |

| | | | | | Attachment F. |
|---|---|---|---|---|---|
| **1. Objectives:** List quantifiable time-limited objectives related to the service priorities listed above | **2. Service Unit Definition:** Define the service unit to be provided | **3. Quantity** | | **4. Time Frame:** Indicate the estimated duration of activity relating to the objective listed. | **5. Funds:** Provide the approximate amount of funds to be used to provide this service. |
| | | 3a) Number of people to be served | 3b) Total Number of service units to be provided | | |
| a: Ensure that persons who have COBRA insurance are able to extend benefits beyond customary coverage period through an interdepartmental agreement with the Department of Human Services. | One month of COBRA premium paid. | 200 | 1,650 | Apr 08-Mar 09 | $910,000 |
| b: | | | | | |
| c: | | | | | |
| d: | | | | | |
| e: | | | | | |

**6. Select a minimum of two objectives and list planned client level outcomes/indicators to be tracked, and include benchmarks for each:** By March 31, 2009, document and report the cost savings to ADAP that result from the provision of health insurance through payment of COBRA premiums.

**Ryan White Part B Implementation Plan**

**Grantee: Michigan Department of Community Health Fiscal Year FY2008**

**Page 6 of 9 Pages**

| **Service Priority Name:** Case Management (non-Medical) | | | | **Total Priority Allocation:** $475,034 |
|---|---|---|---|---|
| **Service Priority Number: N/A** | | | | |
| **Service Goal: To provide advice and assistance to eligible PLWH/A in obtaining medical, social, community, legal, financial, and other needed services.** | | | | **Reference Current Comprehensive Plan:** See references for Medical Case Management above. At the time of most recent Comprehensive Plan, there was no distinction between medical and non-medical case management. |
| **1. Objectives:** | **2. Service Unit** | **3. Quantity** | **4. Time Frame:** | **5. Funds:** |

| List quantifiable time-limited objectives related to the service priorities listed above | **Definition:** Define the service unit to be provided | 3a) Number of people to be served | 3b) Total Number of service units to be provided | Indicate the estimated duration of activity relating to the objective listed. | Provide the approximate amount of funds to be used to provide this service. |
|---|---|---|---|---|---|
| a: Provide resources to contractors to serve PLWH/A who request assistance in obtaining medical and supportive services, but do not require or desire ongoing medical monitoring. | 1 unit = 15 minutes | 1,000 | 3,500 | Apr 08-Mar 09 | $475,034 |
| b: | | | | | |
| c: | | | | | |
| d: | | | | | |
| e: | | | | | |

**6. Select a minimum of two objectives and list planned client level outcomes/indicators to be tracked, and include benchmarks for each:**
85% of non-medical case management clients will be referred for health and supportive services within 2 weeks of intake.

| **Service Priority Name:** Outreach | **Total Priority Allocation:** $54,014 |
|---|---|
| **Service Priority Number: N/A** | |
| **Service Goal: To find and bring into care eligible HIV+ individuals who are not yet enrolled in care and treatment services.** | **Reference CurrentComprehensive Plan:** Page 21, Critical Issue B, Goal 2 (identifying people not in care); Attachment F (support services) |

| **1. Objectives:** List quantifiable time-limited objectives related to the service priorities listed above | **2. Service Unit Definition:** Define the service unit to be provided | **3. Quantity** | | **4. Time Frame:** Indicate the estimated duration of activity relating to the objective listed. | **5. Funds:** Provide the approximate amount of funds to be used to provide this service. |
|---|---|---|---|---|---|
| | | 3a) Number of people to be served | 3b) Total Number of service units to be provided | | |
| a: Provide resources to HIV/AIDS case management providers, in targeted areas of the state, to perform outreach aimed at bringing PLWH/A who are not yet in care into case management so they can be linked to health care and other needed services. | Outreach contacts with PLWH/A that result in service enrollment. | 50 | 250 | Apr 08- Mar 09 | $54,014 |
| b: | | | | | |
| c: | | | | | |
| d: | | | | | |
| e: | | | | | |

| **6. Select a minimum of two objectives and list planned client level outcomes/indicators to be tracked, and include benchmarks for each:**<br>By March 31, 2009, 50 new case management clients will be enrolled for service following outreach contacts. |
|---|

**Ryan White Part B Implementation Plan**

**Grantee: Michigan Department of Community Health** **Fiscal Year FY2008**



| **Service Priority Name:** Psychosocial Support Services | | | | | **Total Priority Allocation:** $30,595 |
|---|---|---|---|---|---|
| **Service Priority Number: N/A** | | | | | |
| **Service Goal: To provide support and counseling services to eligible PLWH/A and their families, including support groups, pastoral care, caregiver support, and bereavement counseling.** | | | | | **Reference Current Comprehensive Plan:** Attachment F (support services) |
| **1. Objectives:** List quantifiable time-limited objectives related to the service priorities listed above | **2. Service Unit Definition:** Define the service unit to be provided | **3. Quantity** | | **4. Time Frame:** Indicate the estimated duration of activity relating to the objective listed. | **5. Funds:** Provide the approximate amount of funds to be used to provide this service. |
| | | 3a) Number of people to be served | 3b) Total Number of service units to be provided | | |
| a: Provide resources to contractors to deliver psychosocial support services to PLWH/A to combat the negative effects of loneliness, isolation, and grief caused by HIV that can impair their ability to maintain their health. | Visit/Day in which service is provided (as reported through CAREWare) | 150 | 800 | Apr 08-Mar 09 | $30,595 |
| b: | | | | | |
| c: | | | | | |
| d: | | | | | |
| e: | | | | | |
| **6. Select a minimum of two objectives and list planned client level outcomes/indicators to be tracked, and include benchmarks for each:**<br>By March 31, 2009, 150 HIV+ clients will receive 800 psychosocial service visits. | | | | | |
| **Service Priority Name:** Medical Transportation Services | | | | | **Total Priority Allocation:** $63,082 |
| **Service Priority Number: N/A** | | | | | |
| **Service Goal: To provide transportation services to eligible PLWH/A to facilitate access to medical care appointments.** | | | | | **Reference CurrentComprehensive Plan:** page 13, item 5 (socioeconomic vulnerability); |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | Attachment F (support services) |
| **1. Objectives:** List quantifiable time-limited objectives related to the service priorities listed above | **2. Service Unit Definition:** Define the service unit to be provided | **3. Quantity** | | **4. Time Frame:** Indicate the estimated duration of activity relating to the objective listed. | **5. Funds:** Provide the approximate amount of funds to be used to provide this service. |
| | | 3a) Number of people to be served | 3b) Total Number of service units to be provided | | |
| a: Provide resources to contractors to deliver transportation for PLWH/A to get to medical care. | 1 one way trip | 850 | 10,000 | Apr 08-Mar 09 | $63,082 |
| b: | | | | | |
| c: | | | | | |
| d: | | | | | |
| e: | | | | | |
| **6. Select a minimum of two objectives and list planned client level outcomes/indicators to be tracked, and include benchmarks for each:** By March 31, 2009, 850 individuals will receive transportation services to medical care appointments. | | | | | |

**Ryan White Part B Implementation Plan**

**Grantee:** **Michigan Department of Community Health** **Fiscal Year** **FY2008**

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| | | | | | |
|---|---|---|---|---|---|
| **Service Priority Name:** Emergency Financial Assistance | | | | | **Total Priority Allocation:** $29.242 |
| **Service Priority Number: N/A** | | | | | |
| **Service Goal: To assist eligible PLWH/A to maintain health by providing short-term assistance in obtaining health care services, including medications, when other sources of payment are unavailable, and to meet other short-term critical needs that affect client health and stability.** | | | | | **Reference Current Comprehensive Plan:** page 13, item 5 (socioeconomic vulnerability); Attachment F (support services) |
| **1. Objectives:** List quantifiable time-limited objectives related to the service priorities listed above | **2. Service Unit Definition:** Define the service unit to be provided | **3. Quantity** | | **4. Time Frame:** Indicate the estimated duration of activity relating to the objective listed. | **5. Funds:** Provide the approximate amount of funds to be used to provide this service. |
| | | 3a) Number of people to be served | 3b) Total Number of service units to be provided | | |

| | | | | | |
|---|---|---|---|---|---|
| a: Provide resources to contractors to pay for short-term emergency needs, including expenses related to medical care, dental care, transportation, food, housing, rent, utilities and medications when other resources are not available, or when the enrollment/eligibility determination process is incomplete. | Service Event (Services will be reported under category where money is spent except for emergency medications.) | 350 | 1,000 | Apr 08– Mar 09 | $29,242 |
| b: | | | | | |
| c: | | | | | |
| d: | | | | | |
| e: | | | | | |

**6. Select a minimum of two objectives and list planned client level outcomes/indicators to be tracked, and include benchmarks for each:**
By March 31, 2009, 350 clients will receive short term financial assistance to purchase prescribed medications and other eligible EFA services.

| | |
|---|---|
| **Service Priority Name:** Housing Services | **Total Priority Allocation:** $12.389 |
| **Service Priority Number: N/A** | |
| **Service Goal: To provide short-term housing services to eligible PLWH/A to enable an individual or family to gain or maintain medical care.** | **Reference CurrentComprehensive Plan:** page 13, item 5 (socioeconomic vulnerability); Attachment F (support services) |

| **1. Objectives:** List quantifiable time-limited objectives related to the service priorities listed above | **2. Service Unit Definition:** Define the service unit to be provided | **3. Quantity** | | **4. Time Frame:** Indicate the estimated duration of activity relating to the objective listed. | **5. Funds:** Provide the approximate amount of funds to be used to provide this service. |
|---|---|---|---|---|---|
| | | 3a) Number of people to be served | 3b) Total Number of service units to be provided | | |
| a: Provide resources to contractors to deliver housing assistance services to eligible PLWH/A to ensure access to health care and supportive services. | Day of service provision as reported in CAREWare. | 200 | 1000 | Apr 08-Mar 09 | $12,389 |
| b: | | | | | |
| c: | | | | | |
| d: | | | | | |
| e: | | | | | |

**6. Select a minimum of two objectives and list planned client level outcomes/indicators to be tracked, and include benchmarks for each:**
By March 31, 2009, 200 clients will receive housing assistance services to support access to health care.

**Ryan White Part B Implementation Plan**

**Grantee:** __Michigan Department of Community Health_____ **Fiscal Year** _FY2008_____



| | | | | | |
|---|---|---|---|---|---|
| **Service Priority Name:** Food Bank/Home-Delivered Meals | | | | | **Total Priority Allocation**: $64,176 |
| **Service Priority Number: N/A** | | | | | |
| **Service Goal: To provide food, meals or nutritional supplements to eligible PLWH/A to help them obtain the nutrition necessary to maintain their health.** | | | | | **Reference Current Comprehensive Plan:** page 13, item 5 (socioeconomic vulnerability); Attachment F (support services) |
| **1. Objectives:** List quantifiable time-limited objectives related to the service priorities listed above | **2. Service Unit Definition:** Define the service unit to be provided | **3. Quantity** | | **4. Time Frame:** Indicate the estimated duration of activity relating to the objective listed. | **5. Funds:** Provide the approximate amount of funds to be used to provide this service. |
| | | 3a) Number of people to be served | 3b) Total Number of service units to be provided | | |
| a: Provide resources to contractors and local health departments to provide food, meals, nutritional supplements and essential household items to eligible PLWH/A to assist with maintaining health. | Food voucher, box or meal. | 450 | 3,525 | Apr 08– Mar 09 | $64,176 |
| b: | | | | | |
| c: | | | | | |
| d: | | | | | |
| e: | | | | | |
| **6. Select a minimum of two objectives and list planned client level outcomes/indicators to be tracked, and include benchmarks for each:** By March 31, 2009, 450 clients will receive 3,525 meals or food vouchers to support good nutrition for optimal health. | | | | | |
| **Service Priority Name:** Health Education/Risk Reduction | | | | | **Total Priority Allocation:** $23,280 |
| **Service Priority Number: N/A** | | | | | |
| **Service Goal: To educate HIV positive clients about HIV transmission in order to improve their health status and to reduce the risk of HIV transmission.** | | | | | **Reference Current Comprehensive Plan:** Attachment F (support services) |
| **1. Objectives:** List quantifiable time-limited objectives related to the service priorities listed above | **2. Service Unit Definition:** Define the service unit to be provided | **3. Quantity** | | **4. Time Frame:** Indicate the estimated duration of activity relating to the objective listed. | **5. Funds:** Provide the approximate amount of funds to be used to provide this service. |
| | | 3a) Number of people to be served | 3b) Total Number of service units to be provided | | |

| | | | | | |
|---|---|---|---|---|---|
| a. Provide resources to contractors to provide health education and risk reduction information to persons infected with HIV. | Education session | 225 | 450 | Apr 08– Mar 09 | $23,280 |
| b: | | | | | |
| c: | | | | | |
| d: | | | | | |
| e: | | | | | |

**6. Select a minimum of two objectives and list planned client level outcomes/indicators to be tracked, and include benchmarks for each:**
By March 31, 2009, 225 clients will receive risk reduction and health information services to help manage their HIV disease and limit its transmission.

# Appendix F

# Division of Health, Wellness and Disease Control

## 2007 - 2010 Strategic Plan

**MICHIGAN DEPARTMENT OF COMMUNITY HEALTH**

Michigan Department of Community Health
MDCH
Jennifer M. Granholm, Governor
Janet Olszewski, Director

December 2007

# DIVISION OF HEALTH, WELLNESS AND DISEASE CONTROL 2007-2010 STRATEGIC PLAN

## BACKGROUND

Under the direction of Loretta Davis-Satterla, a Strategic Plan Steering Committee was convened in the fall of 2001 to begin a strategic planning process for the Division of HIV/AIDS-STD. With the assistance of a planning consultant, the Committee launched an effort to accomplish the following:

1. The creation of a vision statement for the Division of HIV/AIDS-STD that is consistent with the Department of Community Health's vision;
2. The creation of a mission statement for the Division of HIV/AIDS-STD that is consistent with the Department's mission;
3. The clarification of the values that guide how members of the Division of HIV/AIDS-STD will conduct their business;
4. The clarification of the roles and responsibilities of the Division of HIV/AIDS-STD leadership, in terms of administrative and programmatic issues;
5. The identification of both administrative and programmatic outcomes for the Division of HIV/AIDS-STD.

The strategic planning process included getting feedback from a wide variety of audiences of the Division of HIV/AIDS-STD. Those providing input were leadership within the Division of HIV/AIDS-STD and within the Department of Community Health , local public health entities, private service providers, customers and potential customers, and management and staff. Given the Division of HIV/AIDS-STD's mission and values, the realities of the diseases, and the desire to be effective, a number of strategic issues were identified. These issues became the major focus for the Division of HIV/AIDS-STD for the next 18-24 months. The issues were:

1. The **Prevention of HIV and STDs**, to assure the Division of HIV/AIDS-STD is doing all it can to effectively and efficiently prevent infections;
2. The **Effective management of staff**, to assure management is accessible to staff, responsive to staff needs, and conducts itself in such a way as to instill a strong sense of confidence from staff;
3. The **Effective development of staff**, to assure staff have the opportunity for learning, for developing new job skills, and for professional advancement;
4. The **Effective management of staff performance**, to assure strong performance is recognized and encouraged and poor performance is addressed directly, timely and fairly;
5. **Effective and efficient communication**
   a. With staff, to assure staff understand the Division of HIV/AIDS-STD's strategic plan, receive ongoing communication about the status of the plan, and are kept informed about the Division of HIV/AIDS-STD's major initiatives;
   b. With external audiences, to assure they understand the role of the Division of HIV/AIDS-STD, its mission and values;
6. The **Effective use of technology**, to assure staff have access to and know how to use data and findings about the diseases, by maximizing the latest testing, treatment, patient management and information management technologies;
7. The **Continuum of Care for persons living with HIV/AIDS and STDs**, to assure the Division of HIV/AIDS-STD is providing effective treatment and care, especially to targeted risk groups and those without resources;
8. The **Implementation of Continuous Quality Improvement (CQI)**, to assure all programs and services of the Division of HIV/AIDS-STD, including those with contractors, achieve desired outcomes in a cost-effective manner.

Focusing on reducing racial and ethnic health disparities across the state, the Department of Community Health created the Health Disparities Reduction and Minority Health Office. This entity was added as a Section to the Division in 2004. The Division changed its name to the Division of Health, Wellness and Disease Control (DHWDC) in 2004 to better reflect the inclusion of the new Section.

In 2006, the Division and the Continuous Quality Improvement Workgroup streamlined the Division's objectives as follows:

**A. Prevention Services**

Objective #1: Reduce the number of new HIV infections by increasing the proportion of at risk individuals who receive targeted, sustained and evidence-based HIV prevention interventions.

Objective #2: Reduce the number of new HIV infections by increasing the proportion of HIV positive persons who are linked to appropriate prevention, care and treatment services.

Objective #3: Reduce the number of perinatal HIV transmissions by increasing the number of women who are tested for HIV during the early stages of pregnancy.

Objective #4: Reduce the number of perinatal HIV transmissions by decreasing the number of mother-to-child HIV transmissions that occur due to missed opportunities for prenatal HIV testing.

Objective #5: Reduce the number of new STD infections by assuring an effective, timely and complete STD surveillance system.

Objective #6: Reduce the number and rate of new STD infections by increasing targeted screening for priority STDs (gonorrhea, chlamydia, and syphilis).

Objective #7: Establish strategies to increase utilization of primary and secondary health care services for ethnic and minority populations.

Objective #8: Reduce health disparities by educating the public, healthcare providers, community leaders, and interested others regarding infectious, chronic, and environmental health disparities.

Objective #9: Reduce health disparities by promoting and supporting interventions proven successful in decreasing or eliminating health disparities.

**B. Care Services**

Objective #1: Increase access to drug therapies and other care and treatment services, with special emphasis on minority and disproportionately impacted populations.

Objective #2: Assure timely interviewing, investigating, and treatment of infected individuals and their partners.

Objective #3: Develop partnerships with health care providers to deliver care and treatment services consistent with recognized standards.

**C. Effective Management of Staff**

Objective #1: Facilitate professional development and skills enhancement.

Objective #2: Maintain a system to monitor, evaluate and improve individual performance.

Objective #3: Assure management accessibility and responsiveness to staff.

**D. Effective Use of Communication and Technology**

Objective #1: Develop, implement and maintain a communication system to increase the quality of internal and external communication.

Objective #2: Promote and support effective utilization of computer and other technology.

**E. Continuous Quality Improvement (CQI)**

Objective #1: Revise the Division's Strategic Plan every three (3) years.

Objective #2: Develop annual reports on implementation of the Strategic Plan.

Objective #3: Routinely monitor DHWDC's programs for ongoing implementation of CQI and quality assured services.

# NEW PLAN

In 2007, the Division and the Continuous Quality Improvement Workgroup continued streamlining the Division's objectives. The new objectives, on which this report is based, will remain in effect through 2010, when the strategic plan will again be reviewed and/or revised. The new objectives are:

**By 2010:**

**A. Prevention Services**

Objective #1: Ensure the number of newly diagnosed HIV infections will be no more than 937 overall, and 163 for youth ages 13 – 24.

Objective #2: Reduce the number of perinatal HIV transmissions to no more than two (2) per year.

Objective #3: Reduce the number of reported cases of new STD infections by 5% for gonorrhea and chlamydia and 10% for primary & secondary syphilis.

Objective #4: Ensure timely interviewing and investigation of infected individuals and their partners.

- 97% of primary & secondary syphilis cases will be interviewed within 30 days from the date of specimen collection

Objective #5: Establish strategies to increase utilization of primary and secondary health care services for ethnic and minority populations.

Objective #6: Reduce health disparities by educating the public, healthcare providers, community leaders, and interested others regarding infectious, chronic, and environmental health disparities.

Objective #7: Reduce health disparities by promoting and supporting interventions proven successful in decreasing or eliminating health disparities.

**B. Care Services**

Objective #1: Increase access to drug therapies and other care and treatment services, with special emphasis on minority and disproportionately impacted populations.

- 65% of clients with HIV in care will have a CD4 count and viral load at least every six months.
- 75% of eligible female clients with HIV infection in care will have a minimum of one Pap/pelvic examination annually.
- 60% of clients with HIV infection on ARV therapy will receive HIV medication adherence counseling at least every six months.
- 75% of clients with HIV in care will have a medical visit with an HIV specialist at least every six months.
- 90% of clients with HIV enrolled in case management services will have a case management care plan documented and updated at least every six months.

Objective #2: Train Care-funded agency staff to deliver care and treatment services consistent with the Universal Standards, Culturally and Linguistically Appropriate Services Standards, and Medical and Non-medical Case Management Standards of Care.

Objective #3: Assure timely investigation and treatment of infected individuals and their partners.

- 70% of contacts to primary & secondary syphilis that are prophylacticly treated or newly diagnosed and treated will be dispositioned within 30 days of interview.

**C. Effective Management**

Objective #1: Maintain a system to monitor, evaluate and improve staff performance.

Objective #2: Develop and implement a system to provide feedback to managers on their performance and interaction with staff.

Objective #3: Ensure staff have opportunities for professional development and skills enhancement.

**D. Effective Use of Communication and Technology**

Objective #1: Develop and implement effective utilization of computer and other technology to enhance the quality of internal and external communication.

# VISION

The Division of Health, Wellness & Disease Control operates within the Department of Community Health, which is part of the State of Michigan's governmental system. Michigan's Leadership Blueprint identifies the following as the Vision for all of its Departments and Divisions:

> "*Everything we do in our daily jobs is aimed at providing the highest quality service to our customers."*

# MISSION

The **Department of Community Health** strives for a healthier Michigan, guided by its mission to:

- *Promote access to the broadest possible range of quality services and supports;*
- *Take steps to prevent disease, promote wellness and improve the quality of life; and*
- *Strive for the delivery of those services and supports in a fiscally prudent manner."*

The mission of the **Public Health Administration** is to:

- *Promote health and safety, prevent disease and assure its treatment and management, accomplishing these through community, population and evidence-based strategies.*

The mission of the **Division of Health, Wellness & Disease Control** is to promote the public health and provide leadership to:

- *Prevent the spread of HIV and STDs;*
- *Provide care to those infected and affected by these diseases;*
- *Reduce health disparities by supporting a portfolio of social/behavioral interventions that will have the greatest impact among racial and ethnic minorities;*
- *Utilize science-based strategies with proven effectiveness; and*
- *Deliver quality prevention and care initiatives with highly skilled and culturally competent staff.*