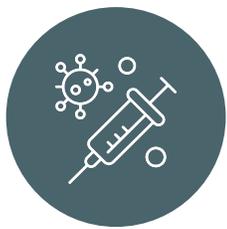


Michigan's State Plan on Eliminating Hepatitis C



STATE OF MICHIGAN
Department of Health + Human Services
Viral Hepatitis Surveillance + Prevention Unit
333 South Grand Ave
Lansing, MI 48933

Gretchen Whitmer, Governor

Elizabeth Hertel, Director, Michigan Department of Health + Human Services
Dr. Joneigh Khaldun, Chief Medical Executive + Chief Deputy Director for Health
Joseph Coyle, Section Manager, HAI, Body Art, Tuberculosis + Viral Hepatitis

MDHHS VISION

All recipients of public mental health services are empowered to exercise their rights and are able to fully participate in all facets of their lives.

MDHHS MISSION

To protect and promote the constitutional and statutory rights of recipients of public mental health services and empower recipients to fully exercise these rights.



STATE OF MICHIGAN

DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

GRETCHEN WHITMER
GOVERNOR

ELIZABETH HERTEL
DIRECTOR

May 7, 2021

Dear Colleagues,

The Hepatitis C Virus (HCV) epidemic has sometimes been referred to as the “silent epidemic” because HCV can be transmitted unknowingly, and persons impacted by the virus may not experience symptoms for years or decades. This silent transmission of HCV has led to rising healthcare costs, increases in liver cancer and liver transplants, and has unnecessarily shortened lives. Like many health conditions, disparities can be seen in HCV-related health outcomes that are driven by social determinants of health, stigma, and inequality. No longer can we be silent about HCV.

Unfortunately, over 100,000 Michiganders are known to be infected with HCV. National estimates indicate that only 50% of persons impacted by the virus have been tested and are aware of their infection, suggesting that the prevalence of HCV in Michigan could be upwards of 200,000. Importantly though, all-oral HCV treatment regimens can cure HCV infection in 8-12 weeks. Regrettably, far too few persons diagnosed with HCV have had access to these life-saving medications.

HCV is a winnable battle which makes every missed opportunity unacceptable. We should no longer tolerate morbidity and mortality associated with HCV. We know how to prevent HCV transmission (by limiting exposure to blood, implementation syringe service programs, and treating those carrying the virus), we know how to test and diagnose HCV (a simple blood test), and we have medications to cure anyone with HCV infection (8 weeks of pills). We have all the tools necessary to eliminate HCV as a health threat. To that end, I am excited that the Michigan Department of Health and Human Services (MDHHS) is rolling out Michigan’s State Plan on Eliminating Hepatitis C. The plan is attached for your convenience.

This Plan helps to articulate the State’s vision on how to eliminate HCV from the Michigan population – using a data-driven, evidence-based, and culturally competent approach to promote HCV awareness, build clinical capacity, and reduce stigma and disparities especially among persons with a history of substance use, among communities of color, and among persons experiencing incarceration. Partnerships will be necessary for this vision to materialize and the construction of this plan demonstrates the engagement of many of our State’s HCV stakeholders.

I want to personally thank the individuals and organizations that helped in the development of Michigan HCV Elimination Plan and who will undoubtedly be leaders in changing the landscape for patients impacted by HCV in Michigan. Thank you to state and local health department staff, community-based organizations, persons impacted by HCV, the clinical community, health plans, associations, and institutions who participated in the construction of the Plan. You have helped create a solid foundation from which the State can build.

But now the work begins. Let us all join forces to bring about a future where HCV no longer is a threat to the health of Michiganders. Please reach out to Joseph Coyle at CoyleJ@michigan.gov with any questions or concerns.

Sincerely,



Joneigh Khaldun, MD, MPH, FACEP
Chief Medical Executive
Chief Deputy Director for Health

JK:eal

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Introduction

The State of HCV
in Michigan

EXECUTIVE SUMMARY

THE BEGINNING

The Michigan Department of Health + Human Services (MDHHS) embarked on a process to create a Hepatitis C Virus (HCV) Elimination Plan in March 2020 (referenced throughout as *the Elimination Plan*). Michigan HCV leaders saw a unique opportunity to strategically align recent efforts in HCV treatment and prevention and identified funding to support a state-wide strategic planning process.

The development of *the Elimination Plan* took place from March to December 2020. Due to the COVID-19 pandemic, all planning activities and events were completed virtually, using online platforms. MDHHS partnered with the Michigan Public Health Institute (MPHI) to guide the development of *the Elimination Plan* and serve as a neutral convener and facilitator.

During the beginning of the planning process, stakeholders and partners that supported this effort collaboratively created vision and mission statements to guide the plan development process, as well as HCV elimination work more broadly.

THE PLAN

The planning process resulted in three state-wide action plans that were developed by a diverse group of partners, stakeholders, and community members. The action plans were created by workgroups charged with creating goals, objectives, strategies, and outcomes in four critical areas:

1. DATA + STRATEGIC INFORMATION
2. COMMUNITY-BASED RESPONSES + INTERVENTIONS
3. ADULT CLINICAL STRATEGIES
4. PEDIATRIC CLINICAL STRATEGIES

Michigan residents will have equitable access to programs and services to prevent the spread of HCV, which will be a curable disease for all.

VISION

+

MISSION

Creating a collaborative approach to eliminate HCV in Michigan by improving quality of life through equitable and affordable access to testing, curative treatment, and services and supports that are stigma- and barrier-free.

EXECUTIVE SUMMARY

OVERARCHING GOALS

The workgroups met virtually to create focused goals, objectives and strategies to meet those goals, and completed detailed action plans to drive the work towards the overarching goal of *the Elimination Plan*: that Michigan residents will have equitable access to programs and services to prevent the spread of HCV, which will be a curable disease for all. The goals directly address the key barriers to the diagnosis, treatment, and prevention of reinfection of HCV.



SCOPE OF IMPACT

The MDHHS will have the data collection strategies and systems to quantitatively demonstrate the impact of HCV infection and treatment on Michigan residents.



CULTURAL COMPETENCE

The MDHHS will use data to better describe the populations impacted by HCV to inform prevention strategies and program planning.



STIGMA

Reduce stigma and increase engagement in communities that are disproportionately impacted by HCV.



ACCESSIBILITY

All Michigan residents will have access to quality, equitable, and comprehensive HCV screening, testing, and treatment options, regardless of location, age, race, and income.



PROVIDER EDUCATION

All providers eligible to provide care to Michigan residents to test and treat for HCV will have the education and training they need to provide quality and equitable care.

This report serves as a summary document that outlines the process Michigan undertook to conceptualize this work and serves as a guide for tangible strategies to be deployed to meet the goal of elimination of HCV in Michigan.

HCV IN MICHIGAN

FUN FACTS ABOUT OUR STATE

Michigan is a large, diverse state. The state consists of two peninsulas, connected by one of the world's largest suspension bridges, and 38,575 square miles of Great Lakes water area (The Library of Michigan). Michigan is the 10th largest state in the nation, with 456 miles from its northwest to southeast corner. Michigan's first people were the Ojibwa, Ottawa, and Potawatomi Native Americans, and there are 12 sovereign, federally recognized Tribal governments in the state today. Although manufacturing played a significant role in Michigan's history and continues to be a significant player in the state's economy, other sectors from agriculture, tourism, health, and education are major employers today.



MICHIGAN HAS A POPULATION OF 9,986,857

According to the American Community Survey, in July of 2019 Michigan had approximately 9,986,857 residents. Much of the State's population lives in the southern half of the Lower Peninsula and 40% of the population lives in Southeast Michigan. It is important to note that Michigan is also home to a significant Arab/Chaldean population, who are counted as 'white' by the Census.



OVER 90% OF MICHIGAN'S ADULTS HAVE GRADUATED HIGH SCHOOL

Among those aged 25 years and older, 91.1% of Michigan's population graduated high school, which is higher than the national benchmark of 88.3%. A higher percentage of the national population, however, completed a bachelor's degree than did those from the state of Michigan (32.6% - national vs 29.6% - Michigan).



MICHIGAN RESIDENTS HAVE LOW INCOME LEVELS

The Michigan population has lower levels of income than that of the U.S. population. The average per capita income for Michigan (\$32,206) was 9% lower than the U.S. average (\$32,397), and the median household income for Michigan (\$56,697) was approximately 7.7% below the national median (\$61,397).



THE AI/AN COMMUNITY EXPERIENCES THE HIGHEST RATE OF POVERTY

In 2018, a family of four would be considered in poverty if the household income in the past 12 months was under \$25,701. The American Indian/Alaskan Native community in Michigan had the highest rate of poverty in 2018 (23.7%), while the Asian population (10.8%) and White/Caucasian population (10.9%) had the lowest rates of poverty. The Black/African American and Hispanic/Latino populations, along with the multiracial population, showed similar percentages under the poverty line (approximately 16-23%).



THE MAJORITY OF MICHIGANDERS ARE INSURED

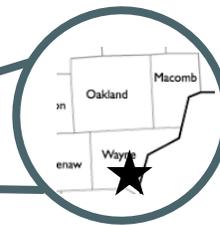
In 2018, about 95% of Michigan's population was covered by public or private insurance, which was slightly higher than the U.S. population (91%). 23% of Michigan's population was covered by Medicaid/Child Health Insurance Program (CHIP) as of July 2018. Nearly 750,000 Michigan residents are enrolled in expanded Medicaid as of mid-2020, 650,000 before the COVID-19 pandemic began. Consequently, the uninsured proportion of Michigan's population was smaller than the national proportion (5.4% vs 8.9%).

HCV IN MICHIGAN



HCV HOTSPOTS

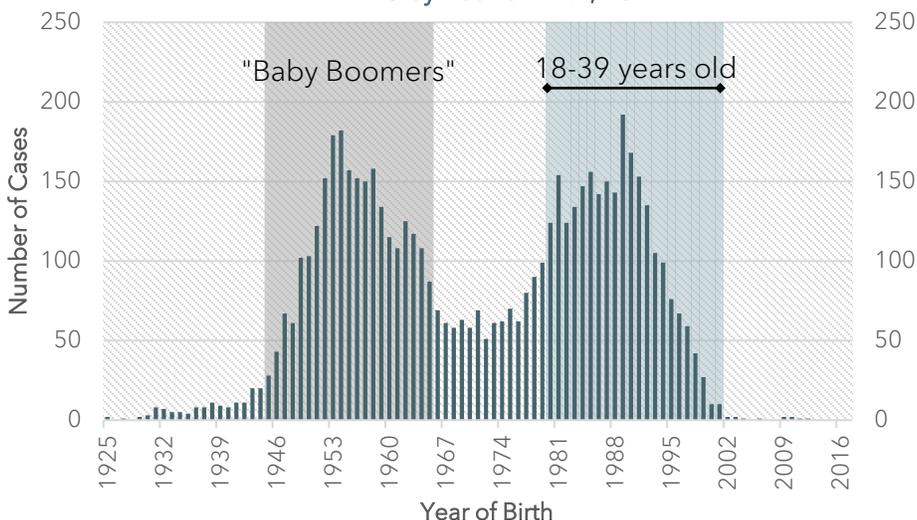
In 2019, a total of 6,036 new chronic HCV diagnoses and 133 acute HCV cases were reported to MDSS. In 2019, 2,847 new HCV diagnoses (~46%) occurred among residents of Southeast Michigan in the City of Detroit and Wayne, Oakland, and Macomb counties.



AGE DISTRIBUTION

The majority of new chronic diagnoses were among individuals born between 1945 and 1965, but Michigan is also observing increases in HCV diagnoses in young adults under the age of 40 associated with the co-occurring prescription opioid and heroin epidemics. From 2010 through 2019, the proportion of all chronic HCV cases by year in adults under 40 years old has nearly doubled from 22% in 2010 to 41% in 2019. Where risk data were available, over 80% of these cases in 2019 reported a history of ever injecting drugs.

Number of Chronic Hepatitis C Cases Reported to MDHHS by Year of Birth, 2019



REPORTING

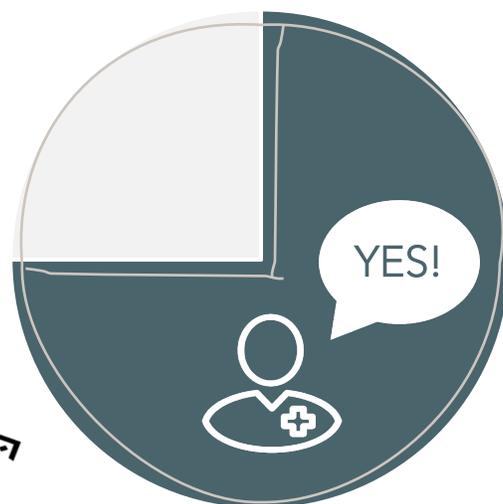
All reactive/positive and (starting in 2019) non-reactive/negative HCV antibody, RNA, and genotype tests are required to be reported to the MDHHS in accordance with the Michigan Public Health Act 368 Communicable Disease Rules: R 325.171-3, 333.5111. MDHHS performs surveillance for acute, chronic, and perinatal HCV. Communicable disease data is reported to the Michigan Disease Surveillance System (MDSS).

HCV IN MICHIGAN

INSURANCE COVERAGE

Recent data shows that Michigan Medicaid/CHIP covers approximately 2.3 million persons. With an estimated 1-2% HCV infection rate in the population, there would be 23,000-46,000 Medicaid-insured persons with HCV infection. According to the data, 5,800 unique persons treated for HCV—approximately 12-25% of the HCV-infected Medicaid population— has been prescribed an HCV direct-acting antiviral (DAA). DAAs first reached the market in 2013, offer an 8-12-week treatment program, and are known to have minimal side effects; however, from 2018 to 2019, patients being prescribed HCV medications decreased by 40.0%. Therefore, MDHHS sought to develop a survey to assess providers' HCV testing and treating capacity to better understand and identify barriers to HCV testing and treatment. Currently, Michigan Medicaid has sobriety and prescriber restrictions; therefore, an objective of the *Elimination Plan* is to have those restrictions removed to increase the use of DAAs and improve testing and treatment outcomes.

75% of physicians and advanced practice providers would be open to treating for HCV in their practice if insurance policy hurdles related to HCV treatment were removed (132 answered).



CALL TO ACTION

MDHHS recognized the unique positioning that potential policy changes amongst payers offered for Michigan residents impacted by HCV. As such, MDHHS chose to begin the instrumental process of convening partners and stakeholders to learn about critical needs and gaps in the care delivery system in Michigan for residents impacted by HCV. Notably, MDHHS also recognized the need to convene local community partners to learn about the needs at the community level to improve the conditions in which people work, play, and live to prevent the transmission of HCV. While this planning effort and subsequent *Elimination Plan* is a pivotal step forward, this is just the beginning of the work that Michigan plans to undertake and support to make elimination of HCV a reality. In order to be successful, both existing and new partners will need to join efforts and band resources together to reach the elimination goals.

Michigan has an HCV prevalence of 69,100, which ranks 7th among all states in the U.S.

(Rosenberg et al 2018, <https://www.ncbi.nlm.nih.gov/pubmed/30646319>)

DESCRIBING THE NEED FOR AN ELIMINATION PLAN

HCV IS A FAIRLY PREVALENT CONDITION THAT IS ON THE RISE

Published studies have shown that 50% of persons chronically infected with HCV are unaware of their status and, despite the availability of curative therapies, less than 10% of those infected with HCV have been successfully treated. As a result, morbidity and mortality associated with chronic HCV infection have been on the rise. HCV now causes more deaths per year than all other nationally notifiable communicable diseases combined, and the National Cancer Institute's 2016 report highlights how liver cancer incidence and mortality are growing faster than any other common cancer (mostly related to viral hepatitis infection). These outcomes are largely avoidable with the right infrastructure that tests at-risk persons for HCV, links them to the appropriate care, and provides curative HCV treatment.

WE KNOW HOW TO PREVENT HCV

The CDC published a county-level vulnerability index that placed 11 Michigan counties at risk for rapid dissemination of HCV and/or HIV infection among persons who inject drugs (PWIDs) and indicated that Michigan has the fifth most vulnerable counties of all states in the U.S. Indeed, Michigan has observed increases in drug poisoning deaths, opioid-specific and heroin-specific overdose deaths, increases in neonatal abstinence syndrome, increases in HCV infection, and a state-wide outbreak of Hepatitis A Virus (HAV) driven by substance-using populations. In 2016, the MDHHS was the first in the country to submit a CDC Determination of Need Request; the hope being that the department could receive permission to work with funded agencies to direct federal dollars towards syringe service programs (SSPs).



“Michigan is experiencing an increase in viral hepatitis or HIV infections due to injection drug use. The submitted data provide sufficient evidence to determine a need for SSPs within the jurisdiction.” - CDC

WE KNOW HOW TO DIAGNOSE AND TREAT HCV

MDHHS has worked to expand our harm reduction efforts in recent years, using (SOR) and (SAMHSA) Prevention Block grant funding, to increase the number of agencies receiving funding for syringe access from four to 27. A data-driven approach was used to prioritize geographic areas of greatest need using CDC's vulnerability index, Michigan's home-grown county-level vulnerability index, and the 1702 situational analysis (see attached appendix). While these partnerships have previously focused on syringe access, we can leverage these relationships to build sustainable testing efforts for adults 18 and older and push for curative therapies as a standard of care for those testing positive. With the combination of normalized HCV testing and push towards DAAs, we can diagnose early and treat effectively and eliminate the HCV crisis in Michigan.

KEY PARTNERS

The *Elimination Plan* was informed by three key groups of partners and stakeholders from across the state of Michigan. The **Core Team**, comprised of MDHHS staff and MPHI consultants, was charged with providing the day-to-day oversights and keeping the planning process moving forward. The Core Team selected a broader group of stakeholders that were invited to participate on a **Steering Committee**, represented by multiple clinicians treating persons infected with HCV, local health department staff, researchers, and state government partners. The Steering Committee used their individual expertise to provide collective recommendations to the Core Team. A broad **Stakeholder Group**, including community members directly impacted by HCV, was asked to provide general insight, feedback, and considerations for *the Elimination Plan*. The key partners for each of the three groups are listed on the following pages. Special thanks to each and every person who contributed to the development of *the Elimination Plan*.



THE ELIMINATION PLAN CORE TEAM

Responsible for day-to-day oversight + decision making

Name	Role	Organization
Joseph Coyle, MPH	HBTV Section Manager	MDHHS
Seth Eckel, MPH	Viral Hepatitis Unit Manager	MDHHS
Vanessa Estibeiro, MD, MPH	COVID-19 Epidemiologist	MDHHS
Teresa Juridico, MPH	Viral Hepatitis Prevention Coordinator	MDHHS
Brandon Hool	Harm Reduction Analyst	MDHHS
Jeremy Kuo, MPH	COVID-19 Epidemiologist	MDHHS
Macey Ladisky, MPH	Linkage to Care Coordinator	MDHHS
Marjorie Oswald, MPH	Viral Hepatitis Epidemiologist	MDHHS
Adam Hart, MPH	Viral Hepatitis Epidemiologist	MDHHS
Kim Kirkey, PhD, MPH	Viral Hepatitis Epidemiologist	MDHHS
Mary Miller, MSN, RN	Harm Reduction Analyst	MDHHS
Lauren LaPine, MPH	Special Projects Coordinator	MPHI
Erin Edgerton, MPH	Research Associate + Project Lead	MPHI

KEY PARTNERS



THE ELIMINATION PLAN STEERING COMMITTEE

Responsible for providing recommendations + expertise

Name	Organization
Adam Hart, MPH	MDHHS
Amy B. Jessop, PhD, MPH	Western Michigan University
Brandon Hool	MDHHS
Christie Clement, MSN, RN	Oakland County Health Department
Jonathan Cohn, MD, MS, FACP, FIDSA	Wayne State University, School of Medicine, Infectious Diseases
Peter Gulick, DO, FACP, FIDSA, FACOI	Forest Community Health Center/ Michigan State University
Elaine Engelsman, DNP, FNP-BC	Mercy Health
Elizabeth Secord, MD	Wayne State University, Department of Pediatrics, Pediatric Specialist
Emily Pratt, BS, CHES	Marquette County Health Department
Faiyaz Syed, MD, MPH	Michigan Primary Care Association
Joseph Coyle, MPH	MDHHS
Katie Macomber, MPH	MDHHS
Kim Kirkey, PhD, MPH	MDHHS
Macey Ladisky, MPH	MDHHS
Marjorie Oswald, MPH	MDHHS
Marti Kay Sherry	MDOC
Mary Miller, MSN, RN	MDHHS
Mary Rose Forsyth, MSN, NP	Wayne State University MATEC
Minerva Galang, MD	Mercy Health, Infectious Disease Specialist
Mirissa Bosch	MDHHS, HIV
Ponni Perumalswami, MD, MsCR	University of Michigan, GI/Hepatology
Rita Subhedar, JD	MDHHS, Medicaid
Rosemary Olivero, MD	Spectrum Health, Helen DeVos Children's Hospital, Pediatric Infectious Disease
Seth Eckel, MPH	MDHHS
Steve Alsum	Grand Rapids Red Project
Teresa Juridico, MPH	MDHHS
Theodore Jones, MD	Beaumont Health, OB/GYN, Maternal Fetal Medicine

KEY PARTNERS



THE ELIMINATION PLAN STAKEHOLDER GROUP

Responsible for providing general insight, feedback, + considerations

ACADEMIC INSTITUTIONS

- Forest Community Health Center/Michigan State University
- Wayne State University School of Medicine
- Western Michigan University

ADVOCACY ORGANIZATIONS

- Detroit Recovery Project
- Grand Rapids Red Project
- Harm Reduction Michigan
- Michigan AIDS Education + Training Center Program
- Michigan Primary Care Association

LOCAL PUBLIC HEALTH

- Central Michigan District Health Department
- Chippewa County Health Department
- Detroit Health Department
- District Health Department #2
- District Health Department #10
- Genesee County Health Department
- Grand Traverse County Health Department
- Ingham County Health Department, Internal Medicine/HIV/HCV
- Kent County Health Department
- Macomb County Health Department
- Marquette County Health Department
- Muskegon County Health Department
- Oakland County Health Division
- St. Clair County Health Department
- Washtenaw County Health Department
- Wayne County Department of Health, Veterans, + Community Wellness
- Western Upper Peninsula District Health Department

STATE GOVERNMENT

- Michigan Department of Health + Human Services
 - Viral Hepatitis Unit
 - Child + Adolescent Health Center Program
 - HIV/STD
 - Housing + Homeless Services
 - Medicaid
 - Office of Minority Health
 - Office of Recovery Oriented Systems of Care
 - Perinatal Hepatitis B Program
 - Bureau of Laboratories Testing
- Michigan Department of Corrections

ADULT + CLINICAL PROVIDERS

- Beaumont Health, Maternal/Fetal Medicine
- Beaumont TB Clinic - Westland/Sunstrum Medical Associates
- BeWell Medical Center, Family Medicine/HIV Specialist
- Bronson Healthcare, Gastroenterology
- Cherry Health Family Practice
- CMU Health
- Gastro + Hepatology Associates of Mid-Michigan
- GI Medicine Associates
- Great Lakes Bay Health Center
- Henry Ford Allegiance, Infectious Disease
- Henry Ford Health System - Department of Emergency Medicine
- Henry Ford Health System, Digestive Health Center of Michigan
- Henry Ford Hospital Transplant Institute
- Honor Community Health
- Infectious Disease Consultants - Munson, Traverse City
- Lakeland Care Network, Infectious Diseases
- Memorial Healthcare - Infectious Disease (Flint)
- Mercy Health, Muskegon
- Munson Medical Center/Thomas Judd Care Center
- Sparrow Health System
- Spectrum Health, Helen DeVos Children's Hospital
- Sunshine Family Care Clinic
- The Oakland Medical Group, Madison Heights
- Thomas Judd Care Center of Munson Medical Center
- U.P. Health System Marquette - Gastroenterology
- U.P. Health System Marquette - Infectious Disease
- VA Ann Arbor Healthcare System, University of Michigan, SCAN-ECHO
- Wayne State University Physicians Group, Gastroenterology



The Plan for Elimination

Research and Development of
Michigan's Plan to Eliminate Hep C

MICHIGAN'S KEY PREVENTION INITIATIVES

EXISTING CAPACITY

There are numerous prevention initiatives aimed to address HCV currently in place across the state. These initiatives are just a select handful of the many efforts in place across Michigan. As Michigan moves towards implementation of the *Elimination Plan*, initiatives such as these will be pivotal levers to make elimination of HCV a reality. Four key initiatives are detailed below.

WE TREAT HEP C INITIATIVE

In alignment with World Hepatitis Day on July 28, 2020, the MDHHS launched the We Treat Hep C Initiative to announce important steps MDHHS is taking towards HCV elimination in Michigan. The initiative is designed to bring down the cost of HCV medications for Michigan Medicaid and the Michigan Department of Corrections (MDOC) populations. MDHHS announced a Request for Proposal for drug manufacturers of HCV direct-acting antivirals (DAA) to provide a significant discount to these programs. In return for the discount, the product will be the preferred DAA for Medicaid and MDOC, with minimal prior authorization requirements.

HCV EMERGING THREATS PROJECT

In 2018, the Michigan Legislature approved a \$1 million annual appropriation to support local health departments to increase HCV testing, case investigation, and patient navigation. The ten local health departments with the greatest 2017 HCV case burden funded under this project include:

- Detroit City
- Wayne County
- Oakland County
- Macomb County
- Genesee County
- Kent County
- Ingham County
- St. Clair County
- Muskegon County
- Kalamazoo County

1702-SUPPLEMENTAL PROJECT

The CDC published a competitive Notice of Funding Opportunity, 1702-Supplemental, to address the infectious disease consequences of the opioid crisis by awarding resources to jurisdictions with identified risks for viral hepatitis and HIV among PWIDs. Michigan was one of seven recipients to be awarded funding under the 1702-Supplemental project. MDHHS is collaborating with five partner organizations in designated high-burden areas to conduct HCV testing and linkage to care in high-impact settings, including syringe services programs, substance abuse treatment facilities, and correctional facilities.

EXPANSION OF STATEWIDE HARM REDUCTION CAPACITY

In 2015, CDC published a county-level vulnerability index that placed 11 Michigan counties at-risk for rapid dissemination of HCV/HIV infection among PWIDs, five of which being the most vulnerable in the U.S., MDHHS has worked diligently to expand harm reduction efforts. The expansion efforts included increasing the number of agencies receiving funding for syringe access from four to 27 to ensure residents of Michigan have access to sterile supplies and high-quality services to reduce the transmission of infectious diseases, particularly those who use substance.

PLAN DEVELOPMENT PROCESS

The MDHHS contracted with the Michigan Public Health Institute - Center for Healthy Communities (MPHI-CHC) to support the development of *the Elimination Plan*. MPHI-CHC led four workgroups comprised of MDHHS staff and key partners through action planning and consensus workshops to produce action plans. Due to the COVID-19 pandemic, MPHI facilitated all workgroups and meetings to support the development of the plan virtually, using Zoom and other supportive virtual tools. An overview of the directives of the four key workgroups are outlined below. One important note, is while the adult and pediatric clinical strategies workgroups were facilitated separately, there was a great degree of overlap in the key themes that emerged in those discussion. As a result, the pediatric clinical strategies and adult clinical strategies information was merged into one comprehensive clinical action plan, which is outlined later in this report.

THE WORKGROUPS

ADULT CLINICAL STRATEGIES

The adult clinical strategies workgroup was tasked with creating goals, objectives, strategies, and outcomes designed to improve the quality of care provided to adults over the age of 18. The workgroup was tasked with creating strategies to prevent HCV transmission, and strategies to improve care delivered to individuals diagnosed with HCV.

PEDIATRIC CLINICAL STRATEGIES

The pediatric clinical strategies workgroup was tasked with creating goals, objectives, strategies, and outcomes to improve the quality of care provided to pregnant persons and infants. The workgroup was tasked with creating strategies to prevent HCV transmission, and strategies to improve care delivered to both expecting persons infected with or newborns exposed to HCV.

COMMUNITY-BASED RESPONSES + INTERVENTIONS

The community-based responses and interventions workgroup was tasked with developing goals, strategies, and outcomes to be deployed at the local level to both prevent transmission of HCV, and support community-based organizations offering services and supports to residents infected with HCV.

DATA + STRATEGIC INFORMATION

The data and information workgroup was tasked with developing goals, objectives, strategies, and outcomes that would strengthen the data and strategic information available to state-wide partners working to eliminate HCV.

One of the first discussions each workgroup had was to identify strengths and weaknesses of HCV prevention, screening, and treatment in Michigan, as well as the opportunities and challenges Michigan faces. The key themes from those discussions are summarized on the following page.

STRENGTHS

- Medications are easy for patients to take, are effective, and require minimal follow-up
- Michigan's corrections system has a robust treatment program
- Specialty pharmacies are supportive of Physician Assistants and assistance programs
- Pharmaceutical industry provides educational materials to patients to support beginning a medication regimen
- Michigan has robust education programs and materials available at the community-level
- MDHHS has the epidemiological capacity needed to support data analysis
- MDHHS has processes and procedures in place to support data sharing
- MDHHS has a strong passive disease surveillance system in place
- Michigan has processes in place that ensure babies born in hospitals are screened for HCV
- Guidance is well-established for providers on managing infants that are born exposed to HCV
- Universal HCV testing is recommended, diagnosis can be made from a single blood draw, and there are expedited treatment algorithms

WEAKNESSES

- Michigan lacks reliable transportation necessary for patients to access medical appointments
- Sobriety restrictions limit the number of patients who can be treated for HCV
- Providers do not have the time or clerical support to screen for HCV
- Providers experience restrictions on their ability to prescribe medications to treat HCV
- Providers lack a reliable infrastructure to follow-up and remain in contact with patients
- Delays in Medicaid reporting and lab results pose challenges to providers and patients
- Michigan continues to experience specialty care provider shortages (i.e., Hepatology, Infectious Disease, etc.)
- Providers do not have access to the necessary training required to stay up to date on best practices for HCV screening and treatment
- Delays of medication authorizations impacts patient's ability to get the medications they need
- There continues to be a need for trust building in patient-provider relationships

OPPORTUNITIES

- Recent and upcoming changes with payers offers potential improvements in available HCV care
- Michigan has numerous academic institutions with longstanding research and studies into HCV
- Michigan has clinical partners willing to support and develop newer clinical providers
- Health education in schools offer an opportunity to prevent HCV infection and transmission
- The MDOC and MDHHS continue to have a close relationship and work to decrease HCV transmission in jails

THREATS

- There continues to be a risk of reinfection after a successful treatment regimen
- Stigma continues to be a threat to patients seeking the care they need and deserve
- Changes to insurance coverage and 'discount' drug company programs pose a threat to HCV treatment
- Changes to the Affordable Care Act could increase patient costs and copays
- Continued prescriber restrictions will limit the number of patients that can be treated for HCV
- Lack of screening for HCV in pregnant persons poses an increased threat to newborn HCV transmissions
- The state does not control HCV coverage policies for private insurance agencies

ADDRESSING THE BARRIERS TO ACCESSING CARE

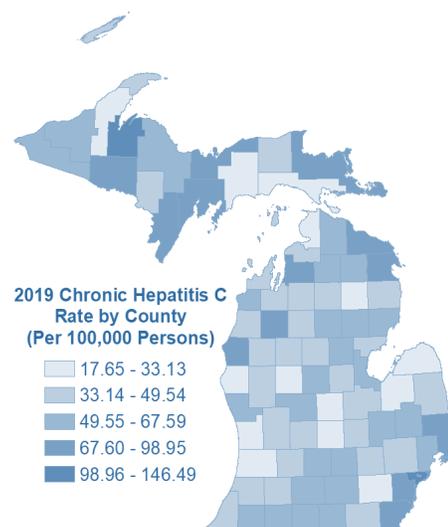
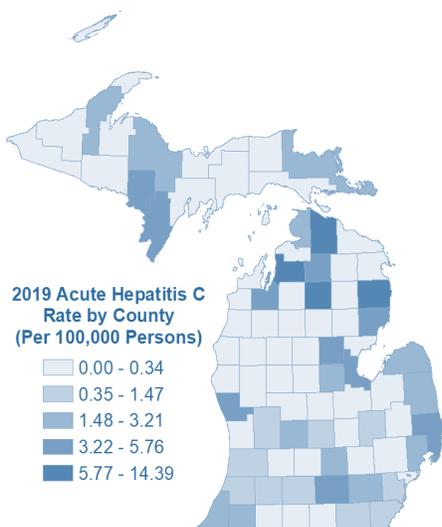
SOCIAL DETERMINANTS OF HEALTH

In addition to challenging stigma, insurance providers, and drug manufacturers, we must work together as a state to address the social determinants of health (SDOH) that may impact an individual's risk of becoming infected with HCV. To prevent HCV and provide effective treatment for people who are already infected, it is important to understand the complex interplay between these factors and HCV risk. For example, injection drug use is a strong predictor of HCV infection, while injection drug use is, in turn, prevalent among people who are homeless and currently/formerly incarcerated people. Likewise, HCV status has also been shown to be linked to poverty, unemployment, lower levels of education, absence of support systems, and racism. As we work to end the epidemic, Michigan must also address structural and institutional policies and practices that contribute therein by collaborating to end insufficient housing, poverty, education gaps, and poor access to mental health care, and by challenging systems that compromise the well-being of communities of color.

SDOH, such as socioeconomic status, education, neighborhood, employment, social support, and access to healthcare, are linked to a person's lack of opportunity and resources to protect, improve, and maintain their health.

TIMELY TREATMENT

HCV can be a short-term, mild illness that lasts only a few weeks when diagnosed and treated timely; this is called acute HCV. When left untreated, however, acute HCV can turn into a more serious, long-term illness that can cause severe damage to the liver and many other health problems- such as liver failure, cirrhosis, cancer, and even death; this is called chronic HCV. With streamlined efforts in confirmatory testing, combating stigma, addressing insurance barriers, and considering the social determinants of health, it is the hope that treatment will be administered early to help prevent the spread of acute HCV and onset of chronic HCV.



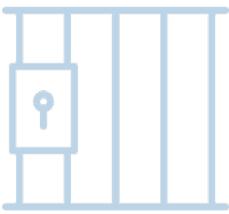
PRIORITY POPULATIONS

All persons impacted by HCV should be able to achieve HCV clearance, but identifying groups who are disproportionately impacted by HCV is an important step for focusing prevention and treatment efforts. *The Elimination Plan* focuses on **five specific priority populations**. While each of these are considered a priority, it is important to note that persons infected with HCV oftentimes fit into more than one priority population category; they are not mutually exclusive. For this reason, identifying places of intersectionality is extremely important to help streamline efforts to reach at-risk individuals; and to tailor the approaches for each community, so that they are culturally competent and provide the most effective and efficient prevention and treatment strategies possible.



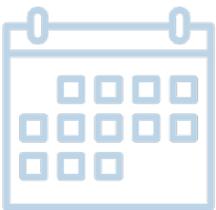
PERSONS WHO INJECT DRUGS

PWIDs are at risk for acquiring and spreading HCV infection through the sharing of needles and any equipment used to prepare and inject drugs that may be contaminated with blood. Nationally, an emerging HCV epidemic has developed among young PWID, driven by the prescription opioid and heroin epidemics. Michigan is no exception. The proportion of HCV diagnoses occurring among Michigan adults under 40 years old has nearly doubled from 2010 to 2019, with over 80% of these individuals reporting a history of injecting drugs in 2019 (where risk data were available). PWIDs are among the most vulnerable populations and could benefit the most from HCV testing, linkage to care, and co-location of critical social and health services.



PEOPLE IN JAILS OR PRISONS

HCV infection disproportionately affects individuals in correctional settings, which include jails and prisons. About 1% of the population of the United States is living with HCV and the rates among people incarcerated are much higher. Approximately 30% of individuals living with HCV infection in the United States pass through the correctional system in a given year.



INDIVIDUALS BORN BETWEEN 1945-1965

Although individuals born between 1945–1965 (often called “Baby Boomers”) comprise about one fourth of the population nationally, they account for approximately three fourths of all HCV infections. They are five times more likely to be infected with HCV than any other age group in the United States. This is because the peak of HCV transmission occurred in the 1970s and 1980s, most likely through blood transfusions, non-sterile medical procedures, and recreational drug use. There are many people in this age group who were infected during this time who still are not aware they have it. In many cases, the infection does not cause any initial symptoms, and can take 20 to 40 years for complications to appear. Because of these factors, people in this age group are also at greatest risk of HCV-related liver disease, cancer, and death.

PRIORITY POPULATIONS



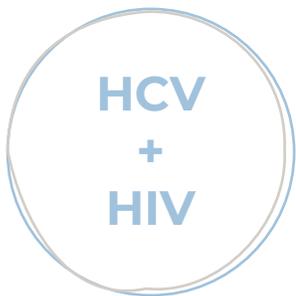
AMERICAN INDIANS & ALASKAN NATIVES

American Indians/Alaskan Natives (AI/AN), although smaller in population size, have been disproportionately affected by the current HCV epidemic. This group has had the highest rates of acute HCV and a rate of death related to HCV that is 2.7 times higher than non-Hispanic whites nationally. An MDHHS analysis of 2019 data from persons under 40 years old found that the reported rate of Chronic HCV was highest among AI/AN (97.95 cases per 100,000), compared to White and Black/African American Michiganders (76.94 and 37.72 cases per 100,000 respectively).



WOMXN OF REPRODUCTIVE AGE

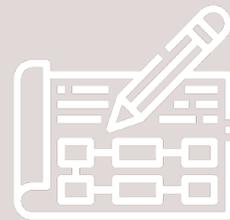
Pregnant womxn can pass HCV to their babies close to the onset of labor or during labor and delivery in a process known as “vertical transmission.” Thankfully, vertical transmission of HCV is relatively uncommon nationally, with only six out of 100 babies born to HCV-infected mothers ultimately testing positive for HCV. That said, recent reports from CDC found that cases of HCV among reproductive aged womxn have essentially doubled with the rise of the prescription drug and heroin epidemics, indicating there may be an increase in HCV infection among pregnant womxn and infants.



PERSONS CO-INFECTED WITH HCV/HIV

There is considerable overlap between HCV and HIV, as both blood-borne viruses can be transmitted in similar ways and affect some of the same social groups. Approximately 21% of persons living with HIV in the U.S. have HCV co-infection; among HIV positive persons who inject drugs, co-infection rates can be as high as 80%. Unfortunately, HIV/HCV co-infected patients suffer significantly higher mortality, liver-related mortality, liver cancer, and liver decompensation than HCV patients alone.

Between 2004 and 2018, 1,687 Michiganders were recorded as HIV/HCV co-infected by MDHHS. Although injection-drug use and age (persons over 30 years old) were the most common transmission risk factors over this time frame, sexual contact between Men who have Sex with Men (MSM) was the most predominant risk factor in 2019 and the age distribution shifted slightly towards younger persons. While sexual transmission of HCV is rare, it has been reported in MSM populations infected with HIV.



Our Action Plans

Goals and Strategies for
Implementing the Elimination Plan

ELIMINATION PLAN GOALS

The workgroups developed five overarching goals to drive improvements in the treatment and care of HCV in Michigan. Each goal was reviewed and vetted by the MDHHS staff. While some goals are specific to the MDHHS, others are more broadly applicable to partners and stakeholders across the state. The MDHHS is a critical partner in all five goals, but also recognizes that significant improvement and systems change towards the elimination of HCV in the state of Michigan is only possible by engaging and leveraging the extensive experience and expertise of partners across the state.

A comprehensive improvement plan with key indicators for monitoring improvement will be developed to monitor and track progress on the action plans that follow in the next section of *the Elimination Plan*.



DATA & INFORMATION

The MDHHS will have the data collection strategies and systems to quantitatively demonstrate the impact of HCV infection and treatment on Michigan residents.



DATA & INFORMATION

The MDHHS will use data to better describe the populations impacted by HCV to inform prevention strategies and program planning.



COMMUNITY-BASED INTERVENTIONS

Reduce stigma and increase engagement in communities that are disproportionately impacted by HCV.



CLINICAL STRATEGIES

All Michigan residents will have access to quality, equitable, and comprehensive HCV screening, testing and treatment options regardless of location, age, race, and income.



CLINICAL STRATEGIES

All providers eligible to provide care to Michigan residents to test for and treat for HCV will have the education and training they need to provide quality and equitable care.

DATA + STRATEGIC INFORMATION

OBJECTIVE 1.1

MDHHS will be able to quantify the prevalence of HCV in Michigan.

STRATEGIES

1. Improve measurements of how many people are diagnosed and how many are cleared of infection by working with laboratories to increase reporting of positive and negative HCV tests to surveillance system.
2. Improve measurements of how many people are diagnosed, expire, and move out of Michigan by integrating surveillance system with vital records system to allow for automatic updates.
3. Conduct statistical modeling to predict the prevalence based on existing information.

OBJECTIVE 1.2

MDHHS will leverage more data sources to better assess health outcomes for persons infected with HCV (e.g., morbidity and mortality).

STRATEGIES

1. Increase linkages to vital records program area (registries for births, deaths, cancer, morbidities) and to Medicaid data program area.
2. Create person-based linkages between HCV and other datasets (to determine which of HCV cases have particular outcomes).

OBJECTIVE 1.3

MDHHS will model the Cascade of Care of HCV in Michigan

STRATEGIES

1. Increase reporting on linkages to care within surveillance system.
2. Devise surveillance-based case definitions for various stages in cascade (e.g., linkages to care, viral clearance).
3. Work with partners to develop a validation process to demonstrate the efficacy of the Cascade definitions (e.g., chart review).

OBJECTIVE 1.4

MDHHS will model the Cascade of Care of HCV in Michigan

STRATEGIES

1. Determine what gaps are most valuable to know, and what audiences need to know them.
2. Determine who to disseminate what information to and how.

GOAL ONE

The MDHHS will have the data collection strategies and systems to quantitatively demonstrate the impact of HCV infection and treatment on Michigan residents.

DATA + STRATEGIC INFORMATION

OBJECTIVE 2.1

MDHHS will use data to identify underserved groups in the HCV care continuum.

STRATEGIES

1. Develop systems capable of stratifying care continuum data by Department of Corrections, Medicaid users, Race/Ethnicity, Geographies, etc. using automated updates from linked data systems.
2. Utilize surveillance data to better understand which populations, geographies, etc. move from being infected to cleared, and which do not.
3. Build algorithm to utilize HCV test data to understand which populations are being infected and which are being cured.

OBJECTIVE 2.2

MDHHS and Partners will use data to identify gaps and barriers to testing and treatment for underserved groups.

STRATEGIES

1. Utilize enhanced data to understand system, policy, provider, and patient barriers to testing and treatment for underserved groups.
2. Track the number of HCV medications prescribed in Michigan and the number of clinicians writing scripts for HCV DAAs.

OBJECTIVE 2.3

MDHHS and Partners will use underserved group data to inform outreach, testing, and treatment.

STRATEGIES

1. Use location data showing where new case clusters are forming to target technical assistance/scale-up of support to do more outreach and testing.
2. Leverage HCV data to deploy additional prevention strategies for other comorbidities in addition to HCV, for at-risk populations (i.e., hepatitis B vaccination, hepatitis A vaccination, HIV testing, etc.).
3. Support the integration of services to identify ways to streamline the data collection efforts around outreach, testing, and treatment.

GOAL TWO

The MDHHS will use data to better describe the populations impacted by HCV to inform prevention strategies + program planning.

COMMUNITY-BASED RESPONSES + INTERVENTIONS

OBJECTIVE 3.1

Support stigma reduction and HCV education through the engagement of the following stakeholders:

- Health care providers and clinicians
- Community-based organizations
- Substance use disorder treatment centers
- Correctional facilities and jails
- Medical and nursing schools
- Community members and the public
- Persons with lived experience with HCV

STRATEGIES

1. Seek feedback and/or input on how to reduce stigma from impacted groups and communities and involve them in the efforts.
2. Provide education at community-based activities (fliers, literature, FAQs, facts/statistics about HCV, social media, etc.).
3. Provide clinical education (education about specific sub-groups to physicians/nurses); education to the community members (public knowledge about HCV); and partnering with universities, treatment centers, and community-based organizations to provide education on specific groups.
4. Identify the at-risk sub-groups (PWID, incarceration, homelessness, etc.) to prioritize education efforts and meet them where they are with information that is relevant to them (e.g., mobile HCV unit).
5. Create culturally competent evidence-based educational materials for all groups, with community involvement.

OBJECTIVE 3.2

Expand access to HCV testing and treatment among vulnerable populations, such as:

- Persons Who Inject Drugs (PWID)
- Justice-involved populations
- American Indians or Alaskan Natives
- Blacks or African Americans

STRATEGIES

1. Identify facilities as “controlled environment” (emergency departments, urgent care, substance abuse treatment centers, homeless shelters, correctional facilities, SUD group homes, etc.).
2. Provide screening resources to staff in controlled environments.
3. Train staff in controlled environments to screen for HCV and how/where to refer for treatment.
4. Increase education/awareness to vulnerable populations about the symptoms of HCV and where to go for testing/treatment while in a controlled environment.
5. Work to establish peer-coaching in controlled environments.

GOAL THREE

Reduce stigma +
increase
engagement in
communities that
are
disproportionately
impacted by HCV

COMMUNITY-BASED RESPONSES + INTERVENTIONS

OBJECTIVE 3.3

Promote provider involvement in community-based activities for individuals with HCV.

STRATEGIES

1. Identify where community-based activities for individuals with HCV are occurring and promote provider participation to help positively impact provider-patient relationships (trust).
2. Identify different ways to improve community-provider partnerships.
3. Investigate a mobile-unit option to meet individuals where they are.

OBJECTIVE 3.4

Utilize a data-driven approach, identify populations and geographies vulnerable to HCV.

STRATEGIES

1. Survey HCV positive patients and providers in the area about barriers to complete treatment.
2. Use positive testing reports, SES, and SDOH to determine and prioritize where testing sites should be located.

OBJECTIVE 3.5

Establish a formal referral system tailored to specific communities to provide seamless services, from initial screening to prevention of reinfection, using all available resources.

STRATEGIES

1. Use community health workers/patient advocates/community connectors to link knowledge and awareness of available resources to vulnerable and at-risk community members
2. Have advocates at medical facilities that follow a patient's journey through the healthcare system to eliminate the gaps/barriers between a patient being diagnosed with and getting treatment for HCV
3. Increase knowledge and awareness of available resources in each community
4. Assess at the community level where the gaps in services are (via survey in persons infected with HCV locations - ED, clinical care, etc.):



How are people finding out what services exist? Where do people in the community get their information (i.e. church bulletin board, social media, etc.)?

5. Make sure the process to activate benefits relevant to HCV treatment is as efficient and effective as possible (i.e. DOC discharges mid-treatment, early release dates, etc.)
6. Identify existing and establish new non-traditional community partners:
 - Assess each community to determine where accessible providers are
 - Disseminate list in accessible locations for community members



What non-traditional partners exist?

What support can non-traditional partners provide?

What support do the community partners need from the state?

PEDIATRIC + ADULT CLINICAL STRATEGIES

OBJECTIVE 4.1 (ADULT CLINICAL)

MDHHS Division of Communicable Disease will partner with Medicaid & commercial insurers to remove the prescriber and sobriety restrictions for HCV treatment.

STRATEGIES

1. Work with Medicaid to remove policy barriers.
2. Work with commercial insurers to remove policy barriers.

OBJECTIVE 4.2 (ADULT CLINICAL)

Establish a systemwide care coordination strategy to support follow-up for HCV positive tests.

STRATEGIES

1. Add screening recommendations into EMR systems across Michigan.
2. Raise awareness of screening recommendations with clinicians and specific subgroups.
3. Develop comprehensive process map to detail appropriate follow-up for positive HCV screening results.
4. Identify and provide additional funding for care coordinators and care navigators to mitigate billing challenges.

OBJECTIVE 4.3 (ADULT CLINICAL)

Streamline process for prior authorization to align across insurance coverages.

STRATEGIES

1. Partner and learn from MiDAP program.
2. Expand policies to enable Primary Care Providers (PCPs) to prescribe HCV medications.
3. Increase the number of medical assistants and office support staff to minimize paperwork burden.

OBJECTIVE 4.4 (ADULT CLINICAL)

Increase the number of providers prescribing HCV medications.

GOAL FOUR

All Michigan residents will have access to quality, equitable, and comprehensive HCV screening, testing, and treatment options regardless of location, age, race, and income.

PEDIATRIC + ADULT CLINICAL STRATEGIES

OBJECTIVE 4.5 (ADULT CLINICAL)

Expand HCV automatic reflex testing among all adults 18 years and older (one-time testing), among pregnant persons during every pregnancy, and among individuals with ongoing risk factors through:

- Engagement with emergency departments, substance use disorder treatment centers, SSPs, FQHCs, OB/GYNs, primary care, etc.

STRATEGIES

1. Identify clinicians, practices, and health care facilities that do not offer HCV testing
2. Offer resources to provide testing (federal/state funded clinics)
3. Utilize Michigan Primary Care Association provider survey results to identify providers not offering HCV screening and/or testing.
4. Identify policy barriers and lobby for discounted PCR tests
5. Identify those that do not offer confirmatory reflex testing

OBJECTIVE 4.6 (PEDIATRIC CLINICAL)

Educate OB/GYNs, pediatricians, and clinicians who treat children on current screening recommendations

STRATEGIES

1. Create a simple comprehensive guide on how to test and follow-up on perinatally exposed infants
2. Ensure providers are aware of screening resources
3. Draft an updated health alert or best practice summary and disseminate throughout MI (or major medical centers)
4. Work with professional organizations and Medicaid Office/LARA to disseminate educational information
5. Collaborate with birthing hospitals and the perinatal Hep B group webinars

OBJECTIVE 4.7 (PEDIATRIC CLINICAL)

Educate medical providers who care for children on the evaluation of exposed infants

STRATEGIES

1. Draft an updated health alert or best practice summary and disseminate throughout MI (or major medical centers)
2. Work with professional organizations and Medicaid Office/LARA to disseminate educational information
3. Collaborate with birthing hospitals and the perinatal Hep B group webinars

PEDIATRIC + ADULT CLINICAL STRATEGIES

OBJECTIVE 4.8 (PEDIATRIC CLINICAL)

Educate pediatric infectious disease clinicians on anti-viral management of children infected with HCV.

STRATEGIES

1. Draft an updated health alert or best practice summary and disseminate throughout MI (or major medical centers).
2. Work with professional organizations and Medicaid Office/LARA to disseminate educational information.
3. Collaborate with birthing hospitals and the perinatal Hep B group webinars.

OBJECTIVE 4.9 (PEDIATRIC CLINICAL)

MDHHS advocacy with payers for reimbursement for HCV screening in pregnancy and of exposed infants.

STRATEGIES

1. Engage with payers and educate them on screening recommendations (advocacy).
2. Engage with stakeholders and other clinical groups to help advocate/provide professional expertise.
3. Understand which payers are reimbursing and which ones are not.

PEDIATRIC + ADULT CLINICAL STRATEGIES

OBJECTIVE 5.1 (ADULT CLINICAL)

MDHHS launches tab on the MDHHS website that enables Michigan residents to search for HCV providers.

STRATEGY

1. Create a catalogue of HCV providers.

OBJECTIVE 5.2 (ADULT CLINICAL)

Establish formal agreements with clinicians to offer provider training/mentorship on HCV treatment.

STRATEGY

1. Investigate possibilities for partnership with University of Michigan Health System.

OBJECTIVE 5.3 (ADULT CLINICAL)

Increase the number of clinical settings requiring provider education/training.

STRATEGIES

1. Investigate potential partners with University of Washington and leverage their training through MiTrain.
2. Investigate potential to partner with Dr. Sanjeev Arora at the University of New Mexico to offer ECHO in Michigan.

OBJECTIVE 5.4 (PEDIATRIC CLINICAL)

Remove prescriber restrictions.

STRATEGY

1. Engage with payers.

OBJECTIVE 5.5 (ADULT CLINICAL)

Develop a menu of options of training modules for providers.

GOAL FIVE

All providers eligible to provide care to Michigan residents to test and treat for HCV will have the education and training they need to provide quality and equitable care.

PEDIATRIC + ADULT CLINICAL STRATEGIES

OBJECTIVE 5.6 (PEDIATRIC CLINICAL)

Advocate for Payer reimbursement for follow-up testing that is required for children infected with HCV.

STRATEGIES

1. Engage with payers and educate them on screening recommendations (advocacy).
2. Engage with stakeholders and other clinical groups to help advocate/provide professional expertise.
3. Understand which payers are reimbursing and which ones are not.

OBJECTIVE 5.7 (PEDIATRIC CLINICAL)

Increase number of prescribers

STRATEGIES

1. Provide education and training on prescribing.
2. Provide consultation resources.
3. Assess current prescribers, and their comfort level for prescribing through a survey focused on pediatric population.
4. Increase comfort level with prescribing HCV DAAs.

OBJECTIVE 5.7 (PEDIATRIC CLINICAL)

Define scenarios where antiviral treatment should be undertaken.

STRATEGY

1. Make a treatment guideline/adapt existing treatment guidelines.

COMMUNITY PARTNERSHIPS

It is important to acknowledge that *the Elimination Plan* cannot be successful without the contributions and collaborations with crucial partners in HCV affected communities. These community partners include, but are not limited to, the following people, groups, and organizations:

DATA + STRATEGIC INFORMATION	COMMUNITY-BASED RESPONSES + INTERVENTIONS	PEDIATRIC + ADULT CLINICAL STRATEGIES
<ul style="list-style-type: none"> • MDHHS • Medicaid • Academic Institutions • Hospital Systems • Local Health Departments 	<ul style="list-style-type: none"> • Primary Care Physicians/PAs • Specialty Care Physicians • Nurse-Practitioners/ RNs • Case Managers • Care Coordinators • Commercial Insurers • Medicaid Partners • Community-Based Organizations • Patient Advocates • Community Members 	<ul style="list-style-type: none"> • Primary Care Physicians/PAs • Specialty Care Physicians • Nurse-Practitioners/ RNs • Case Managers • Care Coordinators • Commercial Insurers • Medicaid Partners • MDHHS Communications • Academic Institutions

CONCLUSION

HCV is a serious public health crisis in Michigan. There are growing rates of infection among younger people who inject drugs, increases in illness and death among Baby Boomers from HCV-related causes, and expanding racial and geographic disparities in infection rates. Healthcare systems and medical providers struggle to provide appropriate preventive services, testing, diagnosis, linkage to care, and treatment; and patients and their communities struggle with the burden of stigma and widespread misunderstanding of HCV. Now is the time to use proven tools to eliminate this public health threat. The development of *Michigan's State Plan on Eliminating HCV* represents the continuation of our state's commitment to eliminate this public health threat once and for all. With this planning phase complete, the initiative will move into the implementation phase. We must work together, and move quickly, to initiate the recommendations contained within this plan. During the implementation phase, we will use indicators like the ones below to monitor our progress and inform our pivots to ensure we are successful in eliminating the threat of HCV in Michigan.

INDICATORS TO MONITOR SUCCESS



WE SEE AN INCREASE IN HCV TESTING

To eradicate HCV, we first must have a more accurate understanding of the burden of HCV in the state of Michigan. To make this possible, we must see an increase in the availability and accessibility of HCV testing across the state, with a concentrated effort to conduct regular monitoring among the populations and geographies most at risk.



WE SEE AN INCREASE IN THE NUMBER OF PROVIDERS TREATING FOR HCV

In order to ensure Michiganders can receive timely curative treatment for HCV, we will need to see growth in the number of medical providers offering care. In addition to expanding the number and reach of Infectious Disease specialists, success will also include support and trainings for primary care and OBGYN providers to manage patients' HCV care. Thus, increasing accessibility to HCV care and persons prescribed HCV DAAs.



WE EXPAND HARM REDUCTION PROGRAMS

We know that persons who inject drugs (PWIDs) are at risk for acquiring and spreading HCV through the sharing of needles and other equipment used to prepare and inject drugs. Access to sterile supplies through harm reduction programs reduces the risk of contracting HCV from injecting drugs. A growth in this type of programming will indicate greater opportunity for safer practices among PWID, ultimately leading to stronger prevention of HCV in Michigan.



WE SEE A REDUCTION IN HCV INCIDENCE

With stronger, more collaborative primary prevention efforts effectively targeting those most at risk, we will see fewer and fewer new cases in Michigan each year, until we reach our goal of a future without HCV.

Appendices

ACRONYMS & KEY TERMS

The list below defines the acronyms and key terms that are referenced throughout this report:

<p>CDC Centers for Disease Control & Prevention</p>	<p>PWID Persons who Inject Drugs</p>
<p>DAAs (Direct-Acting Antivirals) Medication used in the treatment of HCV</p>	<p>SES Socioeconomic Status</p>
<p>ED Emergency Department</p>	<p>SDOH Social Determinants of Health</p>
<p>EMR Electronic Medical Record</p>	<p>SSP Syringe Service Programs</p>
<p>HCV Hepatitis C Virus</p>	<p>PREVALENCE The proportion of persons in a population who have a particular disease or attribute at a specified point in time or over a specified period of time. (CDC, 2012)</p>
<p>LARA Licensing & Regulatory Affairs</p>	<p>INCIDENCE Refers to the occurrence of new cases of disease or injury in a population over a specific period of time. (CDC, 2012)</p>
<p>MDOC Michigan Department of Corrections</p>	<p>MORTALITY RATE A measure of the frequency of occurrence of death in a defined population during a specified interval. (CDC, 2012)</p>
<p>MDHHS Michigan Department of Health + Human Services</p>	<p>MORBIDITY Any departure, subjective or objective, from a state of physiological or psychological well-being.(CDC, 2012)</p>
<p>MDSS Michigan Disease Surveillance System</p>	<p>STIGMA The disapproval of, or discrimination against, a person based on perceivable social characteristics that serve to distinguish them from other members of a society. Social stigmas are commonly related to culture, gender, race, age, intelligence, and health. Stigma can also be against oneself, stemming from a negatively viewed personal attribute that results in a "spoiled identity"</p>
<p>MPHI Michigan Public Health Institute</p>	
<p>MIDAP Michigan HIV/AIDS Drug Assistance Program</p>	
<p>PCR (Polymerase chain reaction) Test Determines whether person is currently infected by the virus or you could stay established whether the virus is still active and needs treating</p>	
<p>PCP Primary Care Providers</p>	

FOR IMMEDIATE RELEASE: July 28, 2020

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MDHHS announces initiative to eliminate hepatitis C in Michigan on World Hepatitis Day

LANSING, Mich. – In recognition of World Hepatitis Day, the Michigan Department of Health and Human Services (MDHHS) is launching the We Treat Hep C Initiative to take important steps towards eliminating hepatitis C in Michigan. This initiative is designed to bring down the cost of hepatitis C medication for Medicaid and the Michigan Department of Corrections.

Organizations around the world, including the World Health Organization and Centers for Disease Control and Prevention, commemorate World Hepatitis Day on July 28 to raise awareness about viral hepatitis. Viral hepatitis – a group of infectious diseases known as hepatitis A, B, C, D and E – affects millions of people worldwide, causing both acute and chronic liver disease, and can be fatal.

hepatitis C (HCV) is a viral infection that causes liver inflammation, sometimes leading to serious liver damage. The hepatitis C virus spreads through contaminated blood. Approximately 115,000 people in Michigan are known to have HCV, though when taking undiagnosed persons into account that number may be as high as 200,000. In recent years, Direct-Acting Antivirals (DAA) were developed to treat HCV. This oral medication can cure the disease when taken every day for two to six months. With success rates of more than 90 percent, these drugs have the potential to virtually eliminate the disease.

Over the past several years, MDHHS has covered the cost of hepatitis C medications for thousands of Medicaid and Healthy Michigan Plan (HMP) beneficiaries, and MDOC has covered the cost of these medications for thousands of incarcerated individuals. However, the high prices associated with these drugs have strained program budgets.

In the coming weeks MDHHS will announce a Request for Proposals (RFP) for drug manufacturers of DAAs to provide a significant discount to these programs. In return for this discount, the product will be the preferred DAA for Medicaid and MDOC, with minimal prior authorization requirements. The RFP will be posted on the State of Michigan Vendor Self Service System, found at

[Michigan.gov/vsslogin](https://michigan.gov/vsslogin).

“MDHHS is committed to working with clinicians throughout the state to ensure that persons impacted by HCV can access these lifesaving medications wherever they live,” said Dr. Joneigh Khaldun, chief medical executive and chief deputy for health at MDHHS. “We endeavor to achieve a future where HCV is no longer a threat to the health of Michiganders.”

In addition, MDHHS has partnered with the Michigan Public Health Institute to engage stakeholders and community partners on testing, linkage to care and treatment of HCV.

Testing and treatment capacity for HCV are highly dependent on engaging, training and eliminating barriers within the clinical community.

For more information, visit [Michigan.gov/Hepatitis](https://michigan.gov/Hepatitis).

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STATISTICAL FIGURES

HCV AND HIV CO-INFECTION DATA, MICHIGAN 2019

Source: MDSS (HCV) and eHARS (HIV)

Variable	2019 HCV/HIV Co-infections	2004-2018 HCV/HIV Co-infections
Total Co-infections	67	1,687
Sex		
Male	54 (80.6%)	1,233 (73.1%)
Female	13 (19.4%)	445 (26.4%)
Unknown	0 (0.0%)	9 (0.5%)
Race		
White or Caucasian	27 (40.3%)	557 (33.0%)
Black or African American	34 (50.7%)	982 (58.2%)
Hispanic	4 (6.0%)	72 (4.3%)
Asian	0 (0.0%)	13 (0.8%)
American Indian or Alaskan Native	0 (0.0%)	1 (0.1%)
Multi/Other/Unknown	2 (3.0%)	62 (3.7%)
HIV Transmission Risk		
MSM	29 (43.3%)	409 (24.2%)
IDU	19 (28.4%)	677 (40.1%)
MSM/IDU	6 (9.0%)	213 (12.6%)
Blood Recipient	0 (0.0%)	43 (2.5%)
Heterosexual	6 (9.0%)	188 (11.1%)
Perinatal	0 (0.0%)	3 (0.2%)
Unknown/Undetermined	7 (10.4%)	154 (9.1%)
Age at Coinfection		
0-19	0 (0.0%)	11 (0.7%)
20-29	12 (17.9%)	135 (8.0%)
30-39	23 (34.3%)	246 (14.6%)
40-49	10 (14.9%)	462 (27.4%)
50-59	8 (11.9%)	599 (35.5%)
60+	14 (20.9%)	234 (13.9%)

STATISTICAL INFORMATION

2019 ANNUAL REPORT MAPS

Source: MDSS

