

**Michigan's
Statewide Coordinated Statement of Need
and
HIV/AIDS Comprehensive Plan 2012-2015**

Submitted by
The Michigan Department of Community Health
Division of Health Wellness and Disease Control
Continuum of Care Unit-Ryan White Part B Grantee

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Introduction

The Michigan Department of Community Health (MDCH), Division of Health, Wellness and Disease Control (DHWDC), Continuum of Care Unit (COC) as the Ryan White Part B grantee in Michigan is responsible for the development of the SCSN and Comprehensive Plan. The process of developing this plan provides an important opportunity to gather data and review the health outcomes of Ryan White (RW) services provided in Michigan, and to identify gaps in service, barriers to care, systems challenges, and program successes. The process of developing the plan also supports a dialogue among RW Parts providers, grantees and consumers, providing a critical impetus to explore innovative ideas to address emergent and/or persistent issues. The Michigan Comprehensive Plan is designed to cover a three-year time period, going beyond the annual implementation plan process, and provides a road map for developing a comprehensive system of care which addresses:

- Disparities in HIV care, access, and services among affected subpopulations and historically underserved communities
- Coordinating resources among other federal and local programs
- 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

This document incorporates the Statewide Coordinated Statement of Need (SCSN), which presents a detailed analysis of the most current data and epidemiological trends, the needs of people living with HIV/AIDS (PLWH/A) in Michigan, and the 2012- 2015 Comprehensive Plan.

Process

The development of the Comprehensive Plan and SCSN was guided by the Michigan HIV/AIDS Council's (MHAC) Comprehensive Plan Committee (CPC) and Needs Assessment (NA) Committee, and the MDCH, DHWDC, HAPIS, Michigan's RW Part B grantee. MHAC was established in January 2000, and is a joint prevention/care planning body with forty active members and twenty expert and at-large advisors including PLWH/A.

The Comprehensive Plan and Needs Assessment Committees include representatives from Michigan's RW funded organizations and programs. Its structure and composition is intended to facilitate equal representation and responsibility for developing the updated SCSN across all RW Parts, the MDCH Office of Drug Control Policy, Housing Opportunities for Persons with AIDS, MDCH Bureau of Epidemiology, public health agencies, and various other statewide HIV/AIDS-related organizations.

Representatives from these agencies/organizations convened an all-day face-to-face meeting, as well as, a two-hour conference call to discuss the current system of care and identify needs, barriers and gaps in service, from their own data, experience and perspective.

The primary data source for the current SCSN is current Epidemiology and Surveillance data, along with CAREWare and HIV Event System (HES) data. Data is also included from Michigan's comprehensive statewide needs assessment survey, which took place during 2010. The needs assessment process was designed to provide the State with information on unmet needs and the barriers to care experienced by PLWH/A. 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. The current document combines the 2012-2015 Comprehensive Plan with the findings of the needs assessment and the issues outlined in the SCSN, and includes the specific components detailed in the HRSA guidance. It presents a realistic scope of what can be accomplished in this plan's three-year planning cycle through 2015.

Section I. WHERE ARE WE NOW?

Snapshot of Michigan Today

2010 US Census data identifies Michigan as the eighth largest population in the U.S., with a total population of 9,883,640 persons. Michigan is made up of 83 counties; with county populations ranging from a low of 2,156 persons (Keweenaw County) to slightly less than two million persons in Wayne County. The Detroit Metropolitan Area (DMA) (Wayne, Macomb, Oakland, Monroe, St. Clair, and Lapeer Counties) represents 44% of Michigan's population. Michigan cities with populations over 100,000, in order of descending population, are Detroit, Grand Rapids, Warren, Sterling Heights, Lansing, Ann Arbor, and Flint, with populations ranging from 713,777 to 102,434.

Demographics

The racial and ethnic composition of the state was estimated to be 77% White, 14% Black, 4% Hispanic, 2% Asian, Hawaiian, Pacific Islander, and .5% American Indian. The median age of Michigan residents was estimated to be 38.9 years. The proportion of males in the overall population was lower than the proportion of females (49 v 51%).

Uninsured

In 2008 and 2009, CAREWare data show that in CY2008 of the 5,487 PLWH/A, 1,677 or 30% reported having no insurance, and in CY2009, of the 6,759 clients served, 1,767 or 26% reported having no insurance. *Kaiser Family Foundation, State Health Facts, June 2010*, reports that between 2009- 2010, 13% of Michigan residents remain uninsured.

Homelessness

The Michigan State Homeless Management Information System (MSHMIS) reports that in 2010 the number of homeless people in Michigan rose to 100,176. This follows reports in 2007 of 79,940 reported homeless in Michigan, followed by an increase to 86,189 in 2008. First time homelessness increased from 45% to 54% of total homeless.

Michigan also saw a 10.8% increase in family homelessness; and 30% of homeless families are working poor (MSHMIS, 2008). The continued increase in the numbers of homeless are reflective of Michigan's continued weak economy and increasing service need.

The proportion reporting unemployment as of April 2012 is 8.3% statewide compared to 8.1% nationally. The number of people unemployed in Michigan peaked in August 2009 at 14.2% (<http://www.milmi.org>).

Description of the HIV Epidemic in Michigan

The MDCH uses various methods to analyze data and develop conclusions to guide the development of the epidemiological profiles in Michigan which informs the SCSN and the Comprehensive Plan. Some of the methods used to analyze data for care and prevention planning include: core HIV/AIDS surveillance data, supplemental HIV/AIDS surveillance projects, communicable disease surveillance data, behavioral surveys, vital statistics, population data and service utilization data. Updated epidemiological information will be available in July 2012.

As of January 2012, there are 7,855 people currently living with Stage 3 HIV (AIDS) in Michigan, and 6,860 people currently living with HIV Stage 1 or 2 (not AIDS). HIV disease is distributed disproportionately in Michigan. Sixty-five percent of those persons currently living with HIV in Michigan reside in the DMA (9,501 of the 14,715 cases statewide), but only 43% of the general population resides in the DMA. The rest of the state, referred to as "outstate," has fewer cases compared with the general population distribution.

Currently, Black males in Michigan have both the highest prevalence rate (941) per 100,000 populations and also the highest number (6,186) of PLWH/A. Data tell us that Black males have eight times more cases than White males in the same size population (100,000), and Hispanic males have twice as many as White males. Among females, Black women (with a prevalence rate of 333) have 20 times more cases than White women (who have a prevalence rate of 17). Clearly the impact of the HIV epidemic disproportionately affects certain populations in the State.

The number of new HIV diagnoses per year increased significantly between 2004 and 2008 among Black men who have sex with men (MSM) for the third consecutive report, and decreased significantly in injection drug users for the fifth consecutive report. The proportion with heterosexually acquired infection is now greater than the proportion infected through injection drug use, although these two groups are closely intertwined. This is the fifth year in a row that the rate of new diagnoses among persons aged 13-19 years at the time of HIV diagnosis has significantly increased and this has been a major area of concern for linkage to care efforts.

Disproportionate Impact

According to 2010 Census estimates found in the *January 2012 Quarterly HIV/AIDS Analysis*, Michigan's general population is 77% White (non-Hispanic) and only 14% Black,

but among residents living with HIV or AIDS, 58% are Black and only 35% are White. The HIV/AIDS prevalence rate per 100,000 for Blacks is 622 compared to 146 for Hispanics and 67 for Whites. (In other words, the prevalence rate for Blacks is more than nine times higher than for Whites).

The *January 2012 Quarterly HIV/AIDS Analysis* reports that Black males in Michigan have both the highest prevalence rate 941 per 100,000 population and also the highest number (6,186) of PLWH/A. Black females have the second highest prevalence rate (333) and the third highest number of cases (2,417). Hispanic males have the third highest prevalence rate (225) and the fifth highest number (499) of cases, a high impact on a relatively small demographic group. White males have the second highest number of cases (4,433) and a prevalence rate of 119. Put another way, these data tell us that Black males have eight times more cases than White males in the same size population (100,000), and Hispanic males have twice as many as White males. Among females, Black women (with a prevalence rate of 333) have 20 times more cases than White women (who have a prevalence rate of 17).

Michigan residents with HIV infection continue to be predominantly MSM persons who are Black, persons aged 20-39 years at the time of HIV diagnosis, and/or residents of southeast Michigan. The number of new HIV diagnoses per year between 2006 and 2010 remained stable in Black and White MSM. This is the first time Black MSM has not showed a significant increase in five consecutive trend reports. The number of new diagnosis in injection drug users decreased significantly (average 12% per year) for the seventh consecutive report. The proportion with heterosexually acquired infection is now greater than the proportion infected through injection drug use, although these two groups are closely intertwined. The number of persons aged 13-19 years at the time of HIV diagnosis did not significantly increase between 2006 and 2010 for the first report in six trend reports; however, new diagnoses in persons aged 20-29 years during this time period did significantly increase. Clearly the impact of the HIV epidemic disproportionately affects racial, ethnic and sexual minority populations in the State.

The Impact of Co-Morbidities

A growing emphasis on the need for integration of HIV, STI, TB and hepatitis testing, programs, and services is shared by the CDC and RW Parts B and D grantee and DHWDC. It has been documented in the literature that co-morbidities and numerous chronic conditions correlate with high health care costs and add to the complexity of providing care to people with HIV and others with chronic illnesses. Instead of treating one disease or social issue, several must be addressed, thereby increasing the cost of care, depending on the co-morbidities. Most PLWH/A with co-morbidities use multiple medications so the potential for drug interactions is greater and they may experience greater difficulty with adherence to drug regimes. Additionally, due to co-morbidities, PLWH/A may experience increased rates of depression, mental illness, substance abuse, and an array of other conditions. Co-morbidities are often associated with adverse health outcomes, poor quality of life, and increased health care use and related expenditures (The University of Medicine and Dentistry of New Jersey).

Sexually Transmitted Infections (STIs)

Syphilis rates among PLWH/A were significantly higher than those in the general population. In 2011, there were 276 reported cases of syphilis among PLWH/A, 128 of which were infectious syphilis. The infectious syphilis rate among PLWH/A was 870 per 100,000. Thirty-seven percent of all syphilis cases and 47% of male syphilis cases were co-infected. Of PLWH/A with syphilis, 8 were 15-19 years old (2.8%), 51 were 20-24 (18%), 44 were 25-29 (16%), 74 were 30-39 (27%), 72 were 40-49 (26%) and 27 were older than 50 (10%) (Epidemiology, MDCH, DHWDC, 2011). The rates of co-infection vary significantly by county. Thirty-seven percent of people with syphilis in Detroit were co-infected with HIV, and there were also high levels of co-infections in Kent County (46%), Ingham County (47%), Macomb County (41%), Oakland County (45%), and Outer-Wayne County (70%). Seventy-one percent of the co-infected cases were African American. There were 259 cases of documented gonorrhea among PLWH/A in 2011. The rate of gonorrhea in 2011 among those with HIV/AIDS was 1,760 per 100,000 or over 13 times the rate in the general population. Only 35 of the cases were female and 24 of the cases were White. Eighty-six percent of cases were males and almost 59% were African American. Sixty percent of the co-infected cases were from Detroit City, 15% were from Oakland County, and 6% were from Outer-Wayne County. Sixty-seven percent of the PLWH/A who also had gonorrhea in 2011 only had gonorrhea once while 33% had one or more gonorrhea cases in that timeframe.

Rates for gonorrhea and chlamydia were higher, at 132 and 506 per 100,000 respectively. Gonorrhea rates were highest among the younger age groups, with youth 15-19 years old at 575, followed by those 20-24 years old at 668, and those 25-29 years old at 306. The gonorrhea rate for those 30-44 years old was 98. There were 13,910 cases of gonorrhea in Michigan in 2010, a significant decrease compared to the 13,070 cases reported in 2011. Of these three STIs, the number of cases of chlamydia in Michigan in 2011 was the highest at 50,063. Similar to gonorrhea, state rates of chlamydia were highest among those 15-19 years old at 2,627, followed by those 20-24 years old at 2,821, and those 25-29 years old at 1,022. A large racial disparity exists with gonorrhea and chlamydia. For gonorrhea the rate among African Americans is 25 times the White rate and for chlamydia it is 9 times the White rate.

Hepatitis

Hepatitis C (HCV) was the most common co-infection among PLWH/A during the Adult and Adolescent Spectrum of Disease (ASD) study in 2001 – 2003. Of the 1,790 persons in care and in the ASD, 353 (20%) had a diagnosis of HCV at some time during ASD follow-up, while 207 (12%) had a diagnosis of hepatitis B and 64 (4%) had a diagnosis of hepatitis A. More recent data is currently being analyzed and will be included in the **2012 Profiles of HIV in Michigan**, scheduled to be published in July 2012.

The Hepatitis C Advisory Task Force, whose responsibility is to advise MDCH on hepatitis-related issues, has cited that individuals infected with HIV, who then become infected with hepatitis C, are less likely to spontaneously clear the hepatitis virus. Rates of 15% to 25% of mono-infected versus 5% to 10% of co-infected. HIV complicates

hepatitis C diagnosis due to higher rates of false negative screening tests. The Task Force recommends that hepatitis C screening and testing be integrated into existing programming that provides services to individuals with, or at risk for HIV and STIs, with hepatitis testing being offered to all HIV infected individuals and individuals with other STIs being screened for hepatitis C risk factors and offered testing, if at risk.

Michigan's Unmet Need Framework

MDCH uses two data sources to produce the numbers in the Unmet Need Framework. The first source is eHARS (enhanced HIV/AIDS Reporting System), the surveillance database that contains information on all reported cases of HIV/AIDS in Michigan. Both HIV and AIDS are notifiable conditions in Michigan, so both are included in eHARS. The second source is the laboratory database. Michigan implemented mandatory laboratory reporting on April 1, 2005 for positive diagnostic HIV tests and July 1, 2005 for all HIV viral load (VL) and all CD4 tests. These laboratory results are contained in a Microsoft Access database maintained by the HIV Surveillance Program. Primary Medical Care was defined as having a laboratory result for a CD4 count and/or percent or a VL measure during a 12-month time period (October 1, 2009 through September 30, 2010) among patients in eHARS. Use of anti-retroviral therapy was not included in the definition of care because HIV Surveillance does not have a reliable way to collect this information. However, it is believed that the vast majority of patients on medication regularly have CD4 and VL tests run, and that there are few, if any, patients in care who are missed using laboratory data only. These external laboratory results were then joined to eHARS surveillance data and were used to determine each patient's most recent CD4 count, CD4 percent, and/or VL test date. Persons diagnosed on or after October 1, 2009 was excluded from analysis to eliminate the possibility of including those who were very recently diagnosed and had not yet obtained care. Unmet need was calculated by determining the number of persons in eHARS who were diagnosed before October 1, 2009 and had not received a VL or CD4 test between October 1, 2009 and September 30, 2010. Unmet need data contained in Table 1 show that in Michigan 37% of PLWH/A who know their status is not receiving regular HIV-related primary medical care.

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. 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. The Surveillance Program participates in Routine Interstate Duplicate Review (RIDR), in which Michigan collaborates with other states under the guidance of the CDC and Prevention to assess and resolve potential case matches between the states. This effort minimizes the effect of residency on unmet need. 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 conducts a death match annually to prevent this from happening. 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. See Table 1.

Table 1 Current residence of persons with met need compared to persons with unmet need, Michigan, as of November 2011

Current residence	Met need		Unmet need		Total		Percent unmet need
	n	(%)	n	(%)	n	(%)	
Detroit MSA	6167	(64%)	3379	(61%)	9,546	(63%)	35%
Outstate MSAs see below	3,498	(36%)	2,152	(39%)	5,650	(37%)	38%
<i>Ann Arbor</i>	392	(4%)	192	(3%)	584	(4%)	33%
<i>Benton</i>	132	(1%)	112	(2%)	244	(2%)	46%
<i>Flint</i>	302	(3%)	229	(4%)	531	(3%)	43%
<i>Grand Rapids</i>	834	(9%)	466	(8%)	1,300	(9%)	36%
<i>Jackson</i>	143	(1%)	102	(2%)	245	(2%)	42%
<i>Kalamazoo–Battle Creek</i>	292	(3%)	168	(3%)	460	(3%)	37%
<i>Lansing–East Lansing MSA</i>	363	(4%)	197	(4%)	560	(4%)	35%
<i>Saginaw–Bay City–Midland</i>	193	(2%)	135	(2%)	328	(2%)	41%
<i>All other rural counties</i>	585	(6%)	352	(6%)	937	(6%)	38%
Other/Unknown	262	(3%)	199	(4%)	461	(3%)	43%
Total	9,665	(100%)	5,531	(100%)	15,196	(100%)	36%

Unmet Need- There are currently 5,531 HIV positive persons, or 36%, not receiving the specified HIV primary medical care in Michigan. The majority of PLWH/A, whether with met or unmet need, is Black, non-Hispanic (57%) or White, non-Hispanic (36%). Hispanic persons represent only (5%) of all PLWH/A in Michigan, but they have the highest proportion of unmet need (50%) when looking at race/ethnicity.

The unmet need distribution by sex is 78% male and 22% female. It is the same among persons with met need and among all persons with HIV/AIDS, so there does not appear to be a disproportionate level of unmet need by sex. As of November 2010, both sexes report the same percentage of unmet need (38% among males and 38% among females).

Individuals living with HIV/not AIDS in Michigan continue to be more likely to have unmet need than people living with AIDS. People living with HIV/not AIDS are 42% of the total HIV/AIDS aware population, but only 38% of the total in care. In other words, 44% of people living with HIV/not AIDS have unmet need, while only 32% of people living with AIDS have unmet need.

Persons with unmet need are very similar to persons with met need when comparing age at HIV diagnosis. PLWH/A who were young adults (ages 20-24) at HIV diagnosis have a higher proportion of unmet need when compared to other age groups (42%), followed by adults ages 25-29 (41%). In general, unmet need is higher among the younger age groups than among those aged 35 or more. By risk behavior, injecting drug users have the highest percentage of unmet need (50%), while only 35% of MSM are in the unmet need group.

Current Continuum of Care

The MDCH, DHWDC, continues to build upon and improve the existing continuum of care system which strives to meet the needs of all PLWH/A, ensuring full and equal access to high quality, culturally competent care. MDCH's commitment's to decrease the number of new infections, increase the number of people who know their HIV status, encourage early entry into care following diagnosis, and preserve and maintain the health of individuals currently in care.

MDCH has recently made a number of very successful changes in the system of care to better meet the needs, with a special emphasis on rapid linkage to and retention in care for both newly diagnosed individuals and PLWH/A who have been out of care. These changes include:

- Establishing a standard quality management program through the Michigan Cross Parts Quality Collaboration (MCPQC)
- Recruiting, training and using peers as a key strategy to help increase entry and retention of PLWH/A in the HIV care system
- Using Early Intervention Services to link PLWH/A to care
- Improving provider coordination, community partnerships, availability and accessibility of HIV services and other information, and program design and policies to increase access to and retention in HIV care
- Collaboration with Midwest AIDS Training and Education Center (MATEC), which conducts targeted, multidisciplinary education and training programs for health care providers
- The Detroit Eligible Metropolitan Area (DEMA) has created a number of integrated programs to keep people in care

Michigan revised its HIV Counseling and Testing policy in 2008 to allow universal diagnostic screening for HIV with an opt-out clause. Effective September 1, 2010, HIV testing must be offered to all Michigan residents between the ages of 13 and 64 receiving hospital or primary care services (with limited exceptions). Testing must be offered to inpatients at hospitals, those seeking care in emergency departments, and to individuals receiving outpatient care at clinics or through private physicians, physician assistants, nurse practitioners or midwives. Medical providers must arrange an appointment for medical care for individuals who test positive. Regional anonymous and/or confidential HIV Counseling and Testing programs are available at local health

departments (LHD) on a walk-in or scheduled appointment basis with some evening availability.

All HIV testing services supported by the Division emphasize sexual and racial/ethnic minority populations and other historically underserved populations. Community-based organizations supported for provision of highly-targeted testing must demonstrate capacity and success in accessing priority populations. Resources supporting testing in clinical settings are concentrated in geographic areas with high HIV prevalence, most notably Detroit, and in venues which serve high-risk populations, such as STI clinics. As a result of this approach, we have successfully addressed racial/ethnic and sexual minority communities. In 2010, of the nearly 85,000 tests conducted in public sites in Michigan, 61% were for African Americans and 4% were Hispanic. Of all of the new diagnoses, 70% were MSM.

Michigan is divided into 45 local health departments (LHDs) that provide clinical services for family planning, STI screening and treatment, maternal and child health, special health care services for children, nutrition programs, and immunizations. Services also include sanitation, environmental monitoring, and epidemiologic investigations. Many LHDs provide HIV counseling, testing, and referral services.

The current continuum of care encompasses counseling, testing, and referral; linkage to care, as well as a wide range of core support services at a number of sites throughout Michigan, including the Michigan Department of Corrections (MDOC).

Once tested positive, a PLWH/A is linked to care, through counseling and testing sites, medical case management and peer navigation. Once linked to care, a PLWH/A has access to many of the core and support services described below.

- Outpatient/Ambulatory medical care
- AIDS pharmaceutical assistance
- Oral health (dental)
- Early intervention services
- Health insurance premium and cost-sharing assistance
- Home health care
- Home and community-based health services
- Hospice services
- Mental health services
- Medical nutrition therapy
- Medical case management
- Substance abuse - outpatient
- Non-medical case management
- Emergency financial assistance
- Housing related supportive services
- Adherence counseling
- Psychosocial counseling

See below a description of core services provided for clients in 2011.

Core Services per Ryan White clients, Statewide, 2011

The RW Comprehensive AIDS Resources Emergency (CARE) Act, was first enacted in 1990 to provide federal funds to help communities and States increase the availability of health care and supportive services for PLWH/A. In 2006 the CARE Act was replaced by the Ryan White HIV/AIDS Treatment Modernization Act which was reauthorized in 2009 as the Ryan White Treatment Extension Act. Under this legislation, Part A funds are allocated to Eligible Metropolitan Areas heavily impacted by the epidemic (e.g., Detroit), while Part B, including the ADAP earmark, and provides resources to States and U.S. Territories. Part C resources fund outpatient HIV early intervention services at local health care facilities and clinics, and Part D is used to coordinate and enhance services for women, infants, children and youth. RW HIV/AIDS Program resources are funds of last resort. RW funding for Michigan is approximately 30 million.

The services supported by RW funds vary by jurisdiction, but include health care services such as out-patient ambulatory medical care, medications, medical case management, mental health services, and supportive services, such as transportation, that link PLWH/A to care. MDCH is the Grantee for the Part B, ADAP and the Part D resources allocated to Michigan. The City of Detroit Department of Health and Wellness Promotion (DHWP) is the Part A Grantee designee. There are four Part C funded programs in Michigan: Wayne State University's Adult HIV/AIDS Clinic at the Detroit Medical Center, the Detroit Community Health Connection, the University of Michigan's HIV/AIDS Treatment Program in Ann Arbor, and Saint Mary's Health Care Special Immunology Services in Grand Rapids.

Data Collection

The Uniform Reporting System (URS) is a statewide client-level data standard designed to consistently document the quantity and types of services provided by agencies receiving RW funds, and describe the populations receiving the services. Statewide URS data show that in 2011, 5,683 unduplicated clients received core medical services of which 4,228 received medical case management and 3,512 received services through ADAP. SEE TABLE

Current Data Collection System

There are currently four separate CAREWare databases. The MDCH CAREWare system includes all the Part B and Part D funded programs as well as data from two Part C funded programs and from programs funded through Michigan Health Initiative (MHI). DHWP maintains another CAREWare database for Part A funded programs. MCDH and DHWP have each implemented CAREWare as a centralized database accessed by service providers through a secure internet portal. Two Part C Programs, the University of Michigan and the Detroit Community Health Connection each maintain their own individual CAREWare systems. Clients and services from the ADAP and the

Michigan Dental Program (MDP) are imported into the MDCH CAREWare database from other data systems on a regular basis. See Table 2.

Table 2	Outpatient Medical	Oral Health	Mental Health	Medical Case Management	DAP
	Care	Care	Care		(Medication Assistance)
No. of providers supplying valid data*	23	8	13	19	1
No. of unduplicated clients served**	5,683	702	724	4,228	3,512
Percent receiving the service.	78.00%	9.60%	10.00%	58.00%	48.20%
Total Days of Service***	25,342	2,784	4,626	74,237	75,335
Average no. of visits per client	4.8	3.9	4.4	18.1	32.5
Median no. of visits per client	4	3	2	11	25
Range of visits per client	Jan-47	Jan-45	Jan-51	1-286	1-231
* A provider may be included in more than 1 service category					
** Clients are unduplicated for the service across all providers and may be counted in more than one service category.					
*** The Drug Assistance service unit is a prescription filled rather than a visit or day of service.					

Current Care System Funding and Services

Part A: \$8,806,102
 Part B: \$17,498,514 (ADAP Earmark: \$12,219,172)
 Part C: \$ 2,712,857
 Part D: \$1,212,495
 AETC: \$ 200,000
 Dental: \$105,335
 SPNS: \$167,200

Ryan White funded Core and Supportive Services:

Part A Resources are allocated throughout the Detroit EMA by the DHWP. The DHWP, in collaboration with their community planning body Southeastern Michigan HIV/AIDS Council (SEMHAC), continue in their commitment to decreasing the number of new infections, increasing the number of people who know their HIV status, encouraging prompt linkage to care following diagnosis, and maintaining the health of individuals currently in care.

HIV testing is offered to all Michigan residents between the ages of 13 and 64 who are receiving hospital or primary care services. There is a mobile unit that offers

Counseling, Testing and Referral (CTR) as well as three Detroit community-based organizations, funded by the CDC. The MDOC, Wayne County jails, and the 36th District Court all offer incoming opt-out testing. The Wayne County Juvenile Detention Facility offers testing once a week. The strength of the EMA lies in its significant use of peers for linking both newly diagnosed and existing PLWH/A to care.

There are 11 funded and trained providers (14 sites), plus the mobile unit, that offer primary care services and most PLWH/A are able to access HIV-related medication since there is no waiting list for ADAP. Medical case management is client-centered, providing information and referral, advocacy, client assessment, individualized service care plans, and comprehensive care coordination and treatment adherence support. EIS and outreach in the EMA is key to identifying PLWH/A who are out of care and subsequently linking them to care.

The Detroit EMA's 2012-2015 Comprehensive Plan is Attachment X.

Part B Resources are allocated by HRSA to the MDCH for RW Part B services statewide and includes the ADAP. The ADAP pays for medications dispensed to eligible HIV+ clients. The DAP covers all HIV medications and many other medications as well, in addition to CD4 and viral load tests.

Part B services include ambulatory outpatient medical care, ADAP, dental services, health insurance coverage, medical case management, non-medical care management, peer navigation and EIS services, emergency financial assistance, mental health services, substance abuse outpatient services, transportation, nutritional counseling, food, housing supportive services, psychosocial support, and adherence counseling.

Part C Grantees include the University of Michigan, HIV/AIDS Treatment Program (HATP), Saint Mary's Health Care Special Immunology Services (SMHC), the Detroit Medical Center (DMC) and the Detroit Community Health Connection (DCHC). The following services are available through the Part C Programs: outpatient ambulatory medical care, medical case management, nutrition counseling, dental services, adherence counseling and drug counseling, dermatology, and medical case management services. Insightful information on care services, unmet needs, barriers, etc., from two Part C grantees can be found in **Attachment XX**:

Part D The RW HIV/AIDS Part D Program is located within the DHWDC, HAPIS, COC Unit. Michigan's Part D network consists of six subcontracted/partner agencies, including one major medical school in Detroit, four case management agencies located throughout Michigan, and the DHWP.

Services include: primary, infectious disease, pre- and postnatal, and psychiatric care; dental services; psychosocial support services; HIV counseling and testing; case management; patient advocacy; health education including risk reduction for the prevention of mother-to-child transmission; access to research; medication adherence classes; therapeutic programming for infected/affected children; outreach to at-risk youth and women; treatment adherence support groups for women and

infected/affected youth; and a Community Advisory Board (CAB). Geographic areas served include the six county region of southeastern Michigan, the eleven county region of southwestern Michigan, and a nine county region in mid-Michigan.

There are an estimated 19,300 people living with HIV in the state of Michigan, of whom 22% (4320) are women and 17% (3660) are youth. Michigan's number of women, infant, children and youth (WICY) reported to be living with HIV has grown by nearly 10% between 2008 and 2010. While the majority of WICY living with HIV in Michigan are women ages 25 years and older (76%), the number of youth ages 13-24 has continued to increase, with youth making up over 60% of new WICY diagnoses between 2008 and 2010. Michigan's epidemic is characterized by high rates of HIV infection among Black males (55.4%) and females (15.5%), MSM (50%), youth (particularly youth ages 20-24 at 22.8%) and southeastern Michigan residents (12.5%).

An analysis of WICY specific unmet need in Michigan shows 36% overall unmet need among WICY, which is consistent with the overall state percentage. Among WICY, unmet need is highest among women ages 25 years and older (37%), followed by youth ages 13-24 years (30%), and children ages 2-12 years (22%). Percentage of unmet need for infants in Michigan is zero.

Taken together, Michigan epidemiologic data demonstrate a continued need for services to women, an increasing need for services to youth, as well as a continued measure of services to infants and children in Michigan.

Non-Ryan White Funded Providers and Organizations

There are numerous non-funded community-based organizations, LHDs, federally qualified health centers (FQHC), hospitals, community clinics and privately funded entities that provide services to PLWH/A and those co-infected. The largest funders of non-Ryan White services in Michigan are Medicaid and Medicare.

MDCH, DHWDC, relies on many internal and external partners to provide and supplement RW- funded services such as Housing Opportunities for Persons with AIDS (HOPWA), MDCH Office of Drug Control Policy for HIV Early Intervention Services, MPCA and FQHCs, the Department of Human Services and the MDOC.

Agencies funded with RW Part B resources are required to have letters of memoranda with non-Ryan White funded and funded providers in their service catchment area. These collaborative partnerships were developed initially when regional care consortia were configured in Michigan in the early ninety's. Partnerships have grown significantly throughout the years.

How the Service System has been Affected by Budget Cuts and How the Program has Adapted

In combination with changes in federal funding and the worsening state and local economy, state and local budget cuts have contributed to continuous erosion of the

health care system, and have placed additional burden on the HIV prevention and care continuum, including the RW Part A program.

Michigan is one of the ten states that, since 2007, has implemented the most extensive revenue-raising measures. Among the rest, the State of Michigan cut public health services, services to the elderly and disabled, K-12 and early education and higher education funds, as well as State workforce funds. The State of Michigan:

- Ended a medical coverage program for 950 adults with dependent children unable to afford employer-sponsored health insurance after transitioning from welfare to work
- Dropped coverage of dental and/or vision services for adult Medicaid recipients
- Froze enrollment for long-term care services and supports that help the developmentally disabled avoid institutionalization. Some 300 people were placed on a waiting list
- Reduced by 38% funding for No Worker Left Behind, a job training and education grant program administered through the Department of Labor
- Imposed furloughs and/or pay cuts for State employees
- Established hiring freezes and/or laid off or announced plans to lay off State employees

Following the State's requirements, some of the cuts were implemented on the local level causing reductions in funds and services for child care assistance, meals for the elderly, hospice care, services for veterans and seniors, and others.

Many of the services previously provided by state or local government programs and/or community-based organizations are now no longer available to PLWH/A or are available to a lesser extent. The MDCH is working to preserve as many of the essential services as possible.

The hardship experienced by PLWH/A is often intensified by housing foreclosure or job loss. PLWH/A frequently need assistance with first- or last-month or past-due rent payments and security deposits in order to secure their housing and remain in care.

Michigan's hospitals have been laying personnel off since 2008. The hospitals continue to lose revenue due to the increasing number of unemployed and uninsured/underinsured patients. Given the existing shortage of medical personnel, layoffs of hospital personnel intensify patients' inability to access care. Another factor increasing difficulty to access care is that there are fewer and fewer numbers of specialists willing to accept Medicaid rates. The MDCH, DHWDC is working to engage some FQHCs to assist with the need for medical services.

In the past few years, enrollment into the Michigan Medicaid program has increased by 20%. The Medicaid system is growing overburdened. Medicaid adult dental benefits were cut in 2009. To meet the challenge, MDCH, DHWDC has been allocating increased funding to oral health services since 2010.

Unlike care, prevention funding has been experiencing cuts for a number of years. Some LHDs have difficulty providing consistent health services due to lack of funding. Education and testing funds are also insufficient. In response, MDCH, DHWDC is integrating services at the state and local level to ensure that providers better partner with prevention programs to identify, refer, link and retain newly diagnosed clients in the care process.

Description of Need

Individuals in Michigan who have unmet need tend to be: people with HIV/non-AIDS, those in younger age groups at time of diagnosis, and those living in certain out-state geographic areas, including Benton Harbor, Flint, Jackson County, and Saginaw-Bay City. Although there are few needs assessment data for individuals not in care, we may be able to make the assumption that based on the definition of unmet need, their service needs include medical care and appropriate laboratory testing.

Service needs identified through Michigan's most recent needs assessment of those in care (February 2010) include dental care, support group services and assistance in meeting basic needs, e.g., rent/mortgage and emergency financial assistance. Barriers to receiving services, experienced by those not in care, may include: affordability, concerns about confidentiality, stigma or quality of care, or lack of awareness of services and how to obtain them.

While in the past, MDCH has conducted its own Continuum of Care Needs Assessment and Service Utilization Analysis, resource constraints have necessitated consideration of other available data sources. MDCH will now work together with the Medical Monitoring Project (MMP) to obtain data on the needs and barriers faced by those in-care to complement unmet need data. The MMP conducts both medical chart abstractions and qualitative interviews with a representative population-based sample of people living with HIV to describe characteristics and trends, utilization of services and unmet need, and plan for improved prevention and care services.

The 2009 MMP data summary shows that 43% of patients sampled utilized auxiliary services. The most commonly used services were education sessions (77%), case management (44%), and mental health counseling or treatment (29%). For the 29% of patients with documented referrals, the most common referrals were for mental health services (51%), case management (30%), and food and housing support services (16%). Individuals not in care may have similar, but perhaps a greater magnitude of, need in these areas.

The Michigan HIV/AIDS Strategy Summit held in October 2011 was specifically crafted to allow the state of Michigan to respond to the National HIV/AIDS Strategy by gathering community input and recommendations for implementation, as well as provided information that could be utilized in the CDC Prevention FY2012 funding opportunity announcement. This event also provided an environment to provide strategies for achieving health equity in Michigan, with particular attention to racial and ethnic minority

populations, and prioritizing these recommendations for the National Partnership for Action to End Health Disparities campaign. The MDCH, DHWDC Summit Summary can be found in Attachment X.

This one-day summit consisted of two national speakers, who discussed the ramifications and the implementation of the National HIV/AIDS Strategy, as well as the importance of stakeholder involvement in National Partnership for Action to End Health Disparities. There were three breakout sessions held for discussion and recommendations on the major goals of the National HIV/AIDS Strategy: 1) Reducing new HIV infections; 2) Increasing access to care and improving health outcomes for people living with HIV; and 3) Reducing HIV-related health disparities.

The audience included staff; DHWDC contracted agencies working in Sexually Transmitted Disease prevention and treatment; HIV prevention; counseling and testing; case management; and substance abuse treatment. Participants also in attendance included representatives from local public health departments (STI clinics, TB clinics, HIV programs, and family planning programs); clinical care providers; community-based organizations (HIV prevention and counseling and testing); AIDS service organizations; health disparities organizations and health equity programs; people living with HIV/AIDS; MATEC, MDCH training staff, and community stakeholders. A total of 224 individuals attended this one-day event.

The following goals and objectives were created by Summit participants:

- Linkage to Care: Increase by 65% to 80% the number of individuals newly diagnosed with HIV who are successfully linked to care and treatment for HIV disease within three months of diagnosis.
- Retention in Care: Increase by 5% the number of PLWH/A that remains in medical care.
- Secondary Prevention: Increase by 30% the number of HIV infected clients reported in CAREWare that are tested at recommended intervals for STIs.
- Progress and Quality: Increase by 25% the quality of care for HIV infected individuals based on the five quality indicators collected by the DHWDC.
- Increase the Number and Diversity of Providers: by 2015, increase the number of Federally Qualified Health Centers that provide prevention, primary care and treatment for people living with HIV.
- Reduce Disparities and Viral Loads: Work to assure that the care and prevention needs of racial, ethnic and sexual minorities are met in a rapidly changing environment with emphasis on HIV, STIs and hepatitis C.
- Routinized Perinatal Testing: Increase by 5% the number of pregnant women being routinely tested for HIV and syphilis during pregnancy.
- Intensify HIV Prevention Efforts in Communities where HIV is most heavily impacted. By 2015, decrease the number of new STIs, HIV and hepatitis C infections.
- Expand targeted efforts to prevent HIV infections using a combination of effective, evidenced-based approaches. By 2015, increase targeting in public-

supported HIV and STI prevention, testing and treatment sites to the population most affected by these diseases.

- Educate all Americans about the threat of HIV and how to Prevent HIV. Increase by 10 percentage points the number of individuals ages 18-64 who know their HIV status, as measured by the Behavioral Risk Factor Surveillance System.
- Achieving a more coordinated “National Response” to the HIV epidemic: By 2015, increase organizational capacity and engagement of internal and external partners to address health equity.
- Intensify HIV Prevention Efforts in the Communities Where HIV is Most Heavily Concentrated: By 2015, increase targeting in public-supported HIV and STI prevention, testing and treatment sites to the population most affected by these diseases.
- Ensure that high risk groups have access to regular viral load and CD4 tests, and reduce HIV-related mortality in communities at high risk for HIV infection. Facilitate systems change necessary to improve the health status of impacted communities, with emphasis on racial and ethnic and sexual minorities.
- Promote a more holistic approach to health, and adopt community-level approaches to reduce HIV infections in high risk communities. By 2015, improve access to equitable, quality healthcare.

PLWHA Identified Needs

MDCH, COC conducted an assessment of the care and service needs of Michigan residents living with HIV/AIDS In 2010. This statewide assessment continues to inform funding priorities outlined in the COC Request for Proposals (RFPs) and to guide COC Program funding distribution throughout the state to ensure comprehensive, coordinated, culturally-competent and quality HIV/AIDS care services for Michigan residents living with HIV/AIDS.

Two data collection methods were used to inform the 2010 assessment. A needs assessment survey was distributed to PLWH/A, of which 971 valid surveys were complete and returned. Targeted focus groups were conducted to further understand and highlight the care and service needs of two priority populations of PLWH/A who reside in the Detroit Eligible Metropolitan Area (DEMA): young African American MSM and recently incarcerated individuals.

Michigan’s outstate areas, organized into eight regions, comprise the focus of this report. Outstate Michigan is defined as all geographic areas in Michigan, excluding the DEMA. See the Detroit Eligible Metropolitan Area, HIV/AIDS Comprehensive Plan

2012 – 2014, Southeastern Michigan HIV/AIDS Council for a comprehensive description of needs, gaps and barriers in the EMA. (Attachment X)

Approximately 50% of survey respondents were outstate area residents (482/971). Among outstate respondents, 81% were male (389/482); 16%, female (79/482); and 2 individuals were transgender. Respondents were: predominantly white (74%); followed

by African American (15%), Hispanic (5%) and African National (4%). Respondents ranged in age from nineteen to ninety-two years old. Thirty-two percent had an AIDS diagnosis.

The most common care priorities reported by outstate respondents were 1) cost of services, 2) confidentiality, and 3) quality of services. Similarly, for respondents reporting a lapse in care, not being able to afford care, confidentiality, and stigma/judgment or ill treatment by a provider were among common reasons. The most common unmet need reported by respondents were dental care, with 23% of outstate respondents (112/482) reporting needing and not being able to get dental care services. Other common unmet needs for outstate residents were 1) support group and buddy/companion services, and 2) resources to meet basic needs (e.g. help paying rent/mortgage and emergency financial assistance).

Participants' number one recommendation for what agencies can do to better serve them was "know what HIV-related services are available and provide referrals to them." Also of note is that several participants across the regions indicated that income-levels for programs requiring low-income eligibility for services are often set too low, leaving some ineligible for low-cost or free services and unable to pay regular fees for services. Additional needs include access to care and treatment, transportation, public assistance, competent care, culturally appropriate care and services, community support through support groups or buddy support. Barriers identified were stigma, access to resources, lack of knowledge, lack of support, mental health and substance abuse issues, depression, isolation, continued unprotected sex, feelings of low self-worth and guilt.

The most important gaps and needs for the populations who are unaware of their HIV status, include more accessible testing sites, culturally competent services, availability of non-judgmental providers, counseling and support to encourage safe sex, HIV stigma reduction training for personnel and sterile syringe and injection programs. Also, staffs who understand poverty, stigma, and access to health care play an important part in eliminating the existing barriers, gaps, and challenges to seeking prevention and care. Barriers include mistrust of the public health system, stigma, lack of personal resource, lack of family or community support, complacency, lack of coordinated systems and difficulty accessing complicated systems.

Systems barriers include a need for improved billing and reimbursement systems, implementation of social marketing campaigns to target high risk individuals, federal, state and local requirements (10% cap on administrative services and the amount and level of reporting requirements), the ability to reduce unmet need in some areas of the state, linking people to care and keeping them in care and treatment, client adherence, services needed to reduce health disparities and resources to reduce health inequities, economic downturn, unemployment, ongoing accessible provider education, technology advances and lack of training on technology, and comprehensive and coordinated data systems.

Racial and Ethnic Health Disparities

In Michigan, racial and ethnic minority populations experience poorer outcomes than the general population for almost every health and social condition (MDCH, DHWDC, and Health Equity Road Map 2009). In alignment with the National HIV/AIDS Strategy for the United States (NHAS), the MDCH, DHWDC, is committed to creating a state where new HIV infections are rare and when they do occur, “every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity or socio-economic circumstances, will have access to high quality, life-extending care, free from stigma and discrimination.” To achieve this goal, the MDCH is working to support the further development and implementation of a comprehensive HIV linkage to care system, integrating prevention and care planning and funding, and creating effective and sustained patient engagement across the continuum of care. Using the recommendations of recent linkage research (Mugavero 2011), MDCH plans to implement a statewide, coordinated approach to enhancing linkages between prevention and care services, emphasizing EIS, and peer navigation strategies.

In Michigan, as in the United States, racial and ethnic minority populations carry a disproportionately heavy burden of disease (MDCH Health Equity Road Map 2009). This burden is manifested in increased risk for disease, delayed diagnoses, inaccessible and inadequate or culturally inappropriate care, poor health outcomes and premature death, much of which is preventable. Without a focused effort to eliminate health disparities, especially HIV, the burden of poor health on Michigan’s vulnerable populations is likely to multiply, and the associated costs to the state of Michigan and the African American community will be staggering. Due to the severe reduction in Prevention funding (nearly 50%) for 2011 and forward, the goal of MDCH’s Prevention and Care units to become more fully integrated, has become a necessity, in order to maintain a critical level of “test to treat” strategies that support effective linkage to care.

It has been demonstrated that individuals who are aware of their HIV status have an HIV transmission rate three to four times lower than individuals who are living with HIV, but unaware. With proposed additional HRSA and MDCH investment in the EIS, including testing, counseling, referral, and linkage to care, many new infections could be averted at a cost of only \$114,000 per infection. (*Holtgrave DR. Cost and Consequences of Four HIV Testing or Counseling and Testing Scenarios for the State of Michigan, 2009*).

Nearly three-quarters of MDCH prevention funds are allocated to testing, both targeted and routine, in the Detroit EMA. Counseling, testing and referral and partner counseling and referral services continue to serve as a primary link between primary HIV prevention services and programs supported under the RW 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. The Division supports the DHWP, Oakland County Health Department, and Wayne County Health Department to provide HIV testing services, nine community-based organizations and

four other clinical sites. The Statewide HIV/STI information and referral hotline provides referrals to HIV testing sites. DHWDC coordinates with these and other community providers and advocates; conducting testing events around Black AIDS Awareness Day, National HIV Testing Day, National Latino AIDS Awareness Day and World AIDS Day. These events are important opportunities to raise awareness about HIV and to promote and provide access to HIV testing services for targeted populations of high-risk in their own neighborhoods and communities. Michigan's targeted early identification of individuals with HIV/AIDS (EIIHA) populations are a primary focus for these increased testing events.

With the integration of planning around Prevention and Care strategies in early 2011, several trainings have helped to shape EIS promotion of testing in the EMA and statewide. EIS workers and Peer Navigators were provided training in April and June, 2011 to focus on the need for increased HIV testing, particularly among the target groups of Young African American MSM and AAHRH, and enhanced efforts at follow-up and linkage to medical care. Peer Navigators and EIS workers have MOUs in place with high volume testing centers and are available when individuals receive results, as support and to facilitate initial engagement to medical care.

Outreach efforts have focused on connecting with private providers to encourage testing for HIV, and to raise awareness of the need to test among high-risk groups. Provider education and raising awareness of the need to test will be a major focus for Outreach during 2012-2015. DHWDC is working with the MPCA, MATEC and local providers to create a unified approach to providing HIV awareness and education in Michigan. This approach centers around the newly launched **SurviveHIV** website and media campaign described more fully in the section detailing EIIHA efforts.

Coordination with Ryan White Part A Grantee

The Division supports the DHWP HIV testing in its STI and dental clinics. It also houses its Detroit Partner Services staff in the DHWP. This necessitates ongoing coordination and collaboration with the DHWP, RW Part A grantee. Parts A and B collaborated to provide joint technical assistance to service providers in the EMA and the outstate areas of Michigan covered with Part B resources, on the role and efficacy of Peer Navigators and EIS strategies during the kickoff of the Enhancing Linkages program 2010-2011. Collaborative planning for future training and technical assistance is continuing for 2012-2013.

Allocation Distribution

Michigan's allocations continue to address the following needs or gaps identified in the 2009 Part B SCSN: medical care (including a mechanism to pay for it and additional sites for infectious disease specialty care in rural areas); modified HIV/AIDS case management services; provider and case manager education and training; dental care; emergency financial assistance; and housing. Of these, medical care, medical case management and dental care are core services.

Examples of these allocations include the following:

The allocation to health insurance continuation through the Insurance Assistance Program (IAP)-Plus has been maintained and increased from \$880,000 in FY2011 to a projected \$970,000 in FY2012. This allocation supports payment of COBRA premiums for eligible ADAP clients, and is discussed in detail in the ADAP application. An additional \$380,000 has been allocated to Michigan's state High Risk Pool for ADAP clients eligible for this insurance option under the Patient Protection and Affordable Care Act.

ADAP is a RW Part B-funded program that allows for coverage of HIV/AIDS drug costs for clients when clients are not eligible for Medicaid or other health insurance programs. ADAP reimburses pharmacies for prescription drug costs. ADAP resources support CD4, CD-8, viral load, genotype, and Monogram Biosciences Tropism testing for ADAP clients. ADAP resources are also used to cover the cost of pharmacy co-pays, which could otherwise be prohibitive. As the cost of anti-retroviral drug prescriptions and other pharmaceutical treatments increase, ADAP continues to be a valuable and necessary service. As of May 2012, there are 3,706 clients on ADAP.

Michigan continues to fund expanded medical services. The Part B allocation to medical care has been maintained at a high level in FY2012. Health Delivery, Inc., an FQHC in Saginaw, receives more than \$200,000 in Part B funds to provide infectious disease care in an area of high Unmet Need. Ingham County Health Department and Central Michigan District Health Department also receive State funds at an annual level of \$360,000 to provide infectious disease care to HIV positive clients in rural areas of Michigan.

Michigan continues to support a transition to medical case management, including a focus on monitoring clinical quality indicators to measure performance. In FY2011, more than \$2.5 million was allocated to medical case management. Michigan's FY2012 Implementation Plan proposes that \$2.4 million be expended on this core service, continuing a high level of support.

Allocations to dental care have increased substantially since the MDCH, DHWDC Michigan Dental Program (MDP) was reopened more than a year ago. Michigan has budgeted \$879,983 in Part B funds in FY2012. In addition, the DHWP has awarded \$208,097 in Part A funds to the MDCH to support oral health care in the EMA. The FY2011 RW Part D budget also included \$47,098 to support oral health care for women, children and youth.

The MDP pays for prophylactic and restorative dental services for PLWH/A in Michigan who are uninsured. The need for dental insurance is significant for PLWH/A, many of whom do not have insurance policies that cover either regular or special dental needs. Although Michigan Medicaid provides adult dental services, they do not cover periodontal care, which is covered by the MDP for PLWH/A. Enrollment for MDP remains open, and as of May, 2012, there are 1,256 clients on MDP.

The need for DAP services continues to increase because more people are living with HIV each year, more are entering into care where drugs are prescribed to treat the disease, and each year it seems that fewer have access to prescription drug coverage through other sources such as Part A.

Section II. WHERE DO WE NEED TO GO?

Evaluation of the 2009 Comprehensive Plan

The evaluation of the 2009-2012 Comprehensive Plan provided the foundation for the development of Michigan's statewide Quality Management Plan, created by the Michigan Cross Parts Quality Collaborative. The QM plan focuses on quality/performance indicators, capacity development training and revision of standards of services to assure consistent, quality services are available to all people living with HIV/AIDS. The 2009-2012 Comprehensive Plan accomplishments related to data collection, quality indicators, training, standards and improvements in quality services are discussed more fully later in this document.

Michigan's Cross Parts Quality Collaborative (MCPQC) plays an important role in encouraging RW funded grantees and providers to focus on enhancing linkages, retention in care, and prevention efforts across All Parts. HRSA funded Parts A-D and CDC funded Prevention grantees have collaborated in several statewide trainings to promote enhanced linkages to medical care through various strategies, such as peer navigation and EIS. CAREWare and HES data was combined to inform the FY2012 Part B application and CDC PS 10-10138 previously submitted, and a statewide plan for addressing EIIHA is currently being formulated. Within this plan, the proposed cross-training of prevention and care funding systems. An MDCH Data Management Consultant has recently been hired to facilitate and coordinate data sharing, referral, and reporting across data systems.

The critical target groups that the Michigan EIIHA Strategy intends to address are 1) Young African American Men who have Sex with Men (YAAMSM) and 2) African American High Risk Heterosexuals (AAHRH). The Parent Groups in the EIIHA Matrix have not changed substantially from our 2011 EIIHA Plan, as current data supports the continued need to address the unaware individuals in each of these groups. Blending funding and strategies of prevention and care, enables DHWDC to address critical needs and gaps in services in high prevalence areas.

All of the strategies and efforts described above will contribute to increasing the number of clients identified, tested, and if diagnosed as HIV positive, linked to medical care—as Michigan works to consolidate cross-part participation in the EIIHA, a fundamental focus of the Statewide QM Plan.

Enhanced Testing Initiative

HIV testing services are supported by the Division in several ways. Sixteen of Michigan's LHDs, located in high HIV prevalence areas, are funded to provide HIV

testing and PS. Testing is also provided by community-based partners who have demonstrated the ability to successfully access and engage communities most impacted by HIV, including sexual minorities and racial/ethnic minorities.

Additionally, non-governmental and community-based organizations can apply to the Division to become “designated” HIV testing sites. These organizations receive technical assistance, training, evaluation assistance, condoms, test devices and laboratory services.

The Division continues to support expansion of HIV testing in health care settings, including hospital emergency departments, jail health clinics, community health clinics and other health care settings. The Division partners with the Bureau of Substance Abuse and Addiction Services on the Early Intervention Project (EIP). The EIP targets alcohol and other drug abusers with HIV prevention (including Counseling, Testing and Referral) and EIS.

All prisoners entering any of the MDOC reception facilities are tested for HIV. Prevention counseling and PS are provided by Division staff. HIV testing is currently available to inmates of county jails in Oakland, Macomb, Jackson, Wayne, Ingham and Washtenaw Counties, which represent 6 of the 16 counties in Michigan identified as “high HIV prevalence” jurisdictions. The Division funds Wayne County jail to support provision of HIV testing, on a routine basis, to all inmates of that facility.

The Division will issue RFPs for HIV prevention services in 2012 and care services in 2013. HIV testing and other activities designed to ensure and facilitate early knowledge of serostatus and linkage to care will be prominently featured among supported activities. The COC Unit, through contracting and technical assistance, will assure that early identification of persons with HIV will continue to be a priority.

All HIV testing services supported by the Division emphasize sexual and racial/ethnic minority populations and other historically underserved populations. Community-based organizations supported for provision of highly-targeted testing must demonstrate capacity and success in accessing priority populations. Resources supporting testing in clinical settings are concentrated in geographic areas with high HIV prevalence, most notably Detroit, and in venues which serve high-risk populations, such as STI clinics. As a result of this approach, we have successfully addressed racial/ethnic and sexual minority communities. In 2010, of the nearly 85,000 tests conducted in public sites in Michigan, 61% were for African Americans and 4% were Latino. Of all of the new diagnoses, 70% were MSM.

The DHWDC has found that some populations have a perceived reluctance to seek or accept HIV testing. Our needs assessment research demonstrates that younger, African American MSM in particular, express reluctance to test for HIV because of stigma and lack of knowledge regarding risk. In addition, we continue to encounter resistance from medical providers in implementing testing related to a perception that their clients are not at risk or that HIV testing cannot be easily implemented within their

clinic flow. DHWDC supports a general media campaign targeted to African American communities to encourage testing. This community-mobilization campaign is intended to normalize HIV testing among young, African American MSM. Provider education efforts, conducted in collaboration with the AETC and the MPCA are intended to address provider concerns about barriers to testing and to encourage integration of HIV testing into routine clinical services.

The DHWDC launched a multi-media campaign, **SurviveHIV**, on June 1, 2012, targeting individuals with HIV who are not currently in care in four areas of Michigan with significant “unmet need”: Detroit, Saginaw/Flint, Grand Rapids, and Benton Harbor. In collaboration with the DHWDC, Community Partnerships Unit and the MDCH, Media Office, the campaign was developed to target young MSM, particularly African Americans. The new campaign will employ specific messages in targeted venues along with traditional print media. The messages will ask persons to visit a new website (MDCH.gov/SurviveHIV) where a variety of resources are located for easy access. The resources include a zip code search feature, where a person can identify local medical and case management resources. A Smart phone application has been developed and will be linked via banner advertisements in a variety of websites used by target communities, as well as on Facebook and Twitter. The SurviveHIV website went “live” on June 1, 2012 and preliminary media and marketing will be rolled out during LGBT Pride events in early June, 2012.

The RW program resources are an essential support of the DHWDC’s efforts to expand routine HIV testing. RW care providers are key partners in activities designed to ensure and enhance linkage with care and prevention services. There is on-going coordination of efforts between prevention and disease control/intervention programs in regard to linking individuals unaware of their HIV positive status to medical care. The combined resources of prevention and care (via RW) in Michigan allows for a more efficient and broader administration of this program at the Division level as well as a wider coverage across the state for enhanced linkages support. It is anticipated that the synergy from these two funding efforts will yield a stronger program effort and increased program effectiveness. The maximizing of resources allows for expansion of these CDC-supported efforts into some programs that have a high yield of HIV-positive diagnosis and a relatively low yield of linkage to care.

Section III. HOW DO WE GET THERE?

Developing Linkage to Care in High Unmet Need Areas of Michigan

The overall goals of increased access to and retention in HIV continuum of care services system for vulnerable and under-served populations, with an emphasis on minority populations, specifically African Americans, will be accomplished through outreach, integrated HIV, STI, TB and hepatitis C counseling and testing, referral and linkages, follow-up, enhanced PS, and increased collaboration with and training for internal and external partners.

To increase access, MDCH in collaboration with internal and external partners including the Midwest AIDS Education and Training Center (MATEC) and Wayne State University, will recruit additional minority providers through collaboration with MPCA and the MATEC-Wayne State University. MATEC supports a network of 11 regional centers and provides training which is targeted to providers who serve minority populations, the homeless, communities, incarcerated persons, community and migrant health centers and RW providers.

Proposed Statewide HIV/AIDS Plan

This section provides an overview of the cross-cutting issues and gaps identified during the SCSN process. It incorporates the Strategic Planning process conducted by the Division during 2011, and highlights the continuous process of assessing client and system needs process that informs the resource allocation decisions and activities funded by the RW Part B grantee. The RW Part B grantee, housed in the Continuum of Care unit, within the DHWDC, MDCH, conducted its own Strategic Planning process in 2011, and continues to refine and address the goals below, taking into clear account the statewide goals of integration of RW Parts, Prevention and Care planning and funding and alignment with the National HIV/AIDS Strategy. The following goals and objectives were guided by the comprehensive plans completed by multiple statewide entities, MCPQC, RW Parts A-E, MHAC, SEMHAC involved in the collaborative process of providing seamless HIV care and service delivery in Michigan.

Goal 1: To reduce the burden of STIs including HIV and hepatitis C by facilitating and providing high quality prevention, care, and disease intervention services that address social determinants of health.

Objective : Decrease the number of new STI, HIV, and hepatitis C infections

Indicator: Increase from 65% to 80% the number of individuals newly diagnosed with HIV who are successfully linked to care and treatment for HIV disease within three months of diagnosis.

Recommended Strategies

- 1. Improve Linkage to Care-**increase EIIHA efforts; integrate Prevention and Care efforts and integrate funding (HRSA and CDC); explore central intake and analyze referral process across RW Parts and other providers.
- 2. Reduce Unmet Need-**EIIHA Matrix populations focus; increase numbers of medical providers who are trained/knowledgeable in HIV care continuum.

Indicator: Increase by 30% the number of HIV-infected clients reported in CAREWare that are tested at recommended intervals for STIs.

- Work with STI Section to develop a communication plan for promoting CDC/HRSA screening guidelines statewide. Promote cross-training of Prevention

and Care staff involved in “test to treat” continuum to increase awareness of need for comprehensive testing, data reporting, and coordinated prevention and care efforts in the lives of PLWH/A.

Objective: Improve the quality of HIV/AIDS, STI, and hepatitis C-related services funded by the Division.

Target Indicator: Increase by 40% the collection and documentation of the HIV Quality Indicators identified by the Michigan Cross Parts Quality Collaborative (MCPQC).

Progress to date

- Baseline of current collection of Quality Indicators in CAREWare established.
- Training needs identified on Quality Indicators for sub-recipients (contractors).
- During 2011 and early 2012, trainings were provided to all Parts B and D sub-recipients on accurate data entry into CAREWare, and analysis and monitoring of statewide Quality Indicators. The QIs will continue to be monitored by the DHWDC Data Team staff during 2012-13, reported in Quarterly Progress Reports submitted to Part B Program staff, and analyzed by the Linkage to Care Workgroup. Outcomes will be assessed in late 2012 to identify additional training needs.

Goal 2: Facilitate systems change necessary to improve the health status of impacted communities, with emphasis on racial, ethnic and sexual minorities.

- **Data Integration and Integrity**-Integration of CW onto one server-integrating Detroit (EMA) data with Parts B and D, working on data accessibility from Part Cs.
- **CW User Data Integrity:** Discussed technical trainings provided above-
- **Promote Collaboration among RW Parts-Statewide HIV Planning goal.** MCPQC has made huge strides in creating a collaborative, inclusive planning environment, regular analysis of data and outcomes contributing to sound resource allocation decisions based on data and a Statewide HIV Plan--reducing duplication, scarcity of resources in some areas, lack of coordination of referrals and access to care—and a statewide venue for discussion of cost-effective, needs-based adaptation to the changing medical environment, as ACA is implemented.

- **Facilitate the integration and coordination of HIV, STI, hep C and TB testing and treatment; prevention and care planning and mutual support.**

Goal 3: Work to assure that the care and prevention needs of racial, ethnic, and sexual minorities are met in a rapidly changing environment, with emphasis on HIV, STIs and hepatitis C.

- Continuous analysis of unmet need in Michigan and strategies to address service quality and health disparities reduction efforts for racial, ethnic, and sexual minority populations.
- Enhance collaboration of consumers in prevention and care efforts; increase mechanisms for consumer input and feedback.

Movement toward a Statewide Quality Plan

In the past two years, Michigan has made a serious effort to endorse and support more collaborative statewide HIV planning. Nearly three-quarters of MDCH prevention funds are allocated to testing, both targeted and routine, in the Detroit EMA. Counseling, testing and referral and partner counseling and referral services continue to serve as a primary link between primary HIV prevention services and programs supported under the RW 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.

Outreach efforts have focused on connecting with private providers to encourage testing for HIV, and to raise awareness of the need to test among high-risk groups. Provider education and raising awareness of the need to test will be a major focus for Outreach in 2012. DHWDC is working with the MPCA to create a unified approach to providing HIV awareness and education in Michigan.

Michigan Cross Parts Quality Collaborative

The purpose of the MCPQC is to coordinate a statewide collaborative effort among all RW funded Parts A-D to provide high quality HIV/AIDS services to the state's residents. The Michigan RW programs, Parts A-D, provide direct and subcontracted services throughout Michigan. These services include both core and supportive services, as defined by the HRSA, HIV/AIDS Bureau (HAB).

During 2010-2011, the MCPQC reviewed the roles and responsibilities of staff members and committees overseeing and managing the CQM process. The current committee structure is comprised of the 1) Capacity Building, 2) Statewide Standards, and 3) Data Quality Committees. All MCPQC members are encouraged to participate on at least one committee annually. In 2011, the MCPQC recruited and gained several new members representing Parts A and C, as well as, CDC funded Prevention members and staff to aid

the DHWDC in integrating and coordinating Prevention and Care efforts in Michigan. The Collaborative membership is currently comprised of representatives from all RW funded Parts A-D.

Data collection and analysis, both individual client-level and statewide aggregate, is a critical focus for the collaborative. The Data Committee reviewed the 2010 quality indicators and identified the need for additional indicators that would meet current HRSA HAB definitions. The Data Team is a working group composed of the MDCH Data Project Director and Data Coordinator, and Parts B and D Quality Coordinators focused on identifying the technical assistance needs of providers. In October 2011, training was provided for all Part B and D subrecipients on the newest version of CAREWare 5.0, the new Quality Indicators and reporting responsibilities.

DHWDC/HAPIS/COC is fortunate to have several staff members who have participated in National Quality Center (NQC) QM trainings (Training-of-Trainers, Training of Quality Leaders, and Training in Coaching Basics) to enhance their abilities to lead efforts at implementing QM plans among contractors. Staff continues to work together to provide multi-layer technical assistance to contractors, including group trainings and one-on-one technical assistance with grantee or contractor QM plan development. The MCPQC's statewide CQM plan is revised annually, based on analysis of CQM data, client-level health outcomes data and identification of needs and gaps in services.

Processes are in place for ensuring that services are provided in accordance with DHHS treatment guidelines and standards of care. Established and ongoing activities to assess the quality of services provided by contractors include: 1) Monitoring adherence to Michigan's Universal Standards of Care, including specific service standards for medical and non-medical case management, and the Culturally and Linguistically Appropriate Services (CLAS) Standards; 2) Reviewing provider/contractor work plans to ensure focus on outcomes; 3) Reviewing and analyzing contractors' data and fiscal reports; 5) Reviewing utilization data, narrative progress reports, and client satisfaction surveys; and 6) Reviewing data entry and claims processing of the ADAP PBM system weekly to assure timeliness of reimbursement to pharmacies and program efficiency.

Quality-related expectations are clearly defined in all RFPs and State/Territory contracts, and contractors/subrecipients contracts include a required QM plan, as well as, quarterly reporting on statewide quality indicators.

The MCPQC will be one mechanism to monitor and evaluate the program, along with the staff mentioned previously. Each RW grantee is responsible for their individual CQM programs, yet the overall goal of the MCPQC is to develop one statewide QM Plan and evaluate that plan annually. The MCPQC reviews indicator outcome data at each meeting, and identifies ways to make continual improvements. The MCPQC conducted and will continue to conduct specific CQM trainings. The monitoring of contractors' CQM programs and quality plan is a specific emphasis of monitoring activities in FY2012.

Michigan uses the data to monitor the status of quality indicators for all funded case management providers. The data are useful in directing short-term training and capacity building efforts, as well as in longer term resource allocation. No specific changes have been made to service categories or funding levels among contractors as a result of the CQM program to date. The 2013 RFP for continuum of care services in Michigan will require applicants to identify a specific staff member responsible for CQM, who will report on the current CQM plan and implementation of site-based CQM activities. These requirements were presented and reviewed during the QM presentation given by the Parts B and D Coordinators at the September 2011 Case Management Conference.

The data collected are the quality indicators identified, from all participants in the MCPQC. A complete data report is available on request. The QM data collected and reviewed thus far show improvement over time for each provider in most of the measures. In some cases, there are data quality issues that impact the results. These issues have been addressed with the additional training described above, written guidance, and one-on-one technical assistance calls for providers.

Site visits, chart reviews, as well as contract and fiscal monitoring results, have historically been used to assess and improve service delivery and eliminate duplication of effort for the Part B service delivery system. Based on these reviews, needs assessment data, client utilization, and surveillance case report data, funding for a number of agencies has been increased, reduced or terminated (over time). The result is a more efficient and effective service delivery system and improved quality of care for PLWH/A.

Statewide Quality Indicators

Michigan's statewide RW quality indicators were reviewed and revised by the MCPQC in early 2011. The current quality Indicators reflect: (a) consistency with HRSA HAB measure timeframes for CD4 count, medication adherence counseling, medical visit, and case management care plan data collection; and (b) five additional HRSA HAB measures, to be collected by primary care providers, aligned with secondary prevention and screening standards. The following indicators are being monitored by HIV care providers receiving funding from RW Parts A, B, C and D, and MHI:

Quality Indicators

All RW Part B and D Program providers are (1) required by the MDCH to track a number of statewide MCPQC indicators and (2) are held to a specified statewide goal/standard. MCPQC indicators are listed below:

Primary Quality Indicators Measured by All Providers

- 65% of clients with HIV will have two or more **CD4 count tests** performed at least three months apart during the measurement year.
- 65% of clients with HIV will have two or more **viral load tests** performed at least three months apart during the measurement year.
- 65% of eligible female clients with HIV will have a minimum of one **Pap screening** annually.

- 60% of clients with HIV will receive **HIV medication adherence counseling** two or more times at least three months apart during the measurement year.
- 75% of clients with HIV will have a **medical visit with an HIV specialist** two or more times at least three months apart during the measurement year.
- 90% of clients with HIV who are enrolled in medical case management will have a **medical case management care plan** developed and/or updated two or more times at least three months apart during the measurement year.

***Secondary Quality Indicators Measured by Primary Care Providers Only
(Statewide goals not yet established.)***

- Percentage of clients with HIV infection who received **HIV risk counseling** within the measurement year.
- Percentage of clients for whom **Hepatitis C (HCV) screening** was performed at least once since the diagnosis of HIV infection.
- Percentage of adult clients with HIV infection who had a **test for syphilis** performed within the measurement year.
- Percentage of clients with HIV infection who received **testing with results documented for latent tuberculosis infection (LTBI)** since HIV diagnosis.
- Percentage of clients with HIV infection who have been **screened for Hepatitis B virus infection** status.

Michigan recently upgraded to CAREWare 5.0 for all CAREWare users. The Data Team presented an overview of CAREWare 5.0, and reviewed the new quality indicators at the Case Management Conference in September 2011. Three full-day trainings were offered during October 2011 to allow all users the chance to work with version 5.0, as well as, review the updated Performance Measurement Module (PMM) that is now part of the system to measure quality indicator results. All of the newly revised quality indicators have been set up in the PMM for all Part B and Part D programs.

The MCPQC identified improved data integrity as a statewide 2012 quality improvement project, and the Data Team began offering subrecipient technical assistance in January 2012. Another training for providers on effective use of the new version of CAREWare is scheduled for June 2012. Providers are able to monitor their own performance using the CAREWare PMM, and will receive additional training to assist them in follow-up on missing or incomplete data. The quality of services provided by Part B and D contractors is assessed, by program and in aggregate, on a quarterly basis.

Grantee's plan to use this data to improve quality management;

The process of collecting client level data through CAREWare has been in place in Michigan since 1995. Data is regularly monitored; and technical support and training is provided for funded entities. The CAREWare data are in a single, centralized database administered and managed by grantee staff. Just as with the Ryan White Data Report (RDR), the grantee submits the client level data to HRSA on behalf of each Part B agency.

Data and information have been used to assess the level of need and unmet need in certain parts of the state. For example, client level and HIV/AIDS reporting data are

compared and analyzed prior to allocating Part B resources during Michigan's HIV continuum of care RFP process, which occurs every three years.

To improve quality of service by providers, Michigan has:

- Issued directives, guidance, standards, and recommendations to providers;
- Revised the case management training curriculum to meet the changing epidemic and changes in federal requirements. Standards were developed for medical and non-medical case management, CLAS and agency administration;
- Provided service utilization data and various data analyses to providers, funders, and other partners;
- Convened ADAP Formulary Committee (AFC) meetings as needed; and
- Facilitated ongoing communication with providers through multiple venues.

Fiscal and Program

MDCH conducts fiscal and program monitoring on all funded contractors. Fiscal monitoring includes: review and approval of draft and final contractor budgets to monitor allowable costs and administrative caps; review of monthly FSRs; review of semi-annual reports on allocations and expenditures by service category; and, technical assistance and support to contractors through the year on fiscal issues. Comments on budgets are documented in writing and kept in the contract files.

Annually, MDCH scores contractors' level of risk is scored as low, moderate, or high. Contractors with a score of moderate or high received a fiscal site visit. In compliance with new HRSA HAB monitoring expectations the Division will begin annual site visits at all contractors during calendar year 2012, regardless of identified risk levels.

The Division also continues to monitor compliance with CLAS Standards, Universal Standards, Standards for Medical Case Management and Standards for Non-medical Case Management on an annual basis.

Vendors submit invoices (FSRs) monthly to MDCH's Accounting Operations office for payment and routinely monitored. All contractors must be registered in Michigan's vendor payment system to receive payments via electronic funds transfer. FSRs are received by MDCH Accounting Operations staff, audited, and paid by entering a payment voucher transaction into the State's accounting system.

Planned Clinical Quality Management Activities for FY 2012

QM has become the focus of more formal efforts at care and treatment sites in the past year. The MCPQC began piloting a Quality Coaching Program (QCP) in FY2011, using the skills and expertise of the MCPQC's Data Team. The goal of the QCP is to provide training, coaching, and technical support to ensure all outstate Part B contractors:

- complete CQM basic training;
- develop and implement annual CQ Improvement projects; and

- network with, and learn from, EMA contractors about ongoing CQM projects in the EMA.

The QCP is organized by MDCH Part B and D staff trained in CQM and supported by the MCPQC. The program is three-tiered including (1) basic CQM training, (2) data support, (3) mentoring, and (4) quarterly CQM webinars as described below.

Basic CQM Training-Outstate Part B contractors will complete CQM basic training and review, including Quality Management 101 and Plan, Study, Do, Act (PDSA) Cycles. The Quality Management 101 training was provided as a session at the Case Management Conference, September 2011.

Data Support-Contractors have received technical assistance with CAREWare data input, review, and monitoring; as well as guidance on using data to create their QM plans and projects, at the three trainings offered during October 2011 at the Michigan Public Health Institute in Okemos, Michigan.

CQM Webinar Series-The MCPQC is currently developing a series of webinars for interested participants. Webinars will serve to provide ongoing education, technical assistance, data collection issues, analysis of data, developing quality plans, and networking opportunities for program participants.

Current QI Project

The Prevention database HIV Event System (HES) includes information related to referrals made and completed. This enables DHWDC to monitor successful entry into care. In addition, DHWDC is able to monitor and track entry into care by matching HES data with laboratory reports of viral load and CD4 testing as well as data associated with RW-funded continuum of care services. This enhances and facilitates DHWDC's ability to monitor linkage to care among HIV-infected persons, including those who do not participate in publicly supported HIV prevention and care services. The HES includes a module for partner services (PS). This enables DHWDC to monitor PS, including the number and percentage of HIV-infected individuals who accept assistance with partner notification and the number and percentage of partners who are successfully located and accept PS, including HIV testing.

Addressing Service Challenges

1. Need to Reduce Stigma

The DHWDC has found that some populations have a perceived reluctance to seek or accept HIV testing. Our needs assessment research demonstrates that younger, African American MSM in particular, express reluctance to test for HIV because of stigma and lack of knowledge regarding risk. In addition, we continue to encounter resistance from medical providers in implementing testing related to a perception that their clients are not at risk or that HIV testing cannot be easily implemented within their clinic flow. DHWDC supports a general media campaign targeted to African American communities to encourage testing. The community-mobilization campaign described previously intended

to normalize HIV testing among young, African American MSM. Provider education efforts, conducted in collaboration with the AETC and the MPCA are intended to address provider concerns about barriers to testing and to encourage integration of HIV testing into routine clinical services.

2. Need for Accessible Testing

During 2011, DHWDC completed implementation of rapid HIV testing among all funded providers. The vast majority of HIV tests conducted by publicly supported providers are now conducted with rapid HIV tests. By ensuring that clients can obtain the results of their HIV test in one visit, rapid HIV testing also facilitates good rates of results disclosure, particularly to HIV negative clients.

3. Need for Services to Address Mental Health and Substance Abuse

PLWH/A with mental health disorders or substance abuse problems, or who are members of racial and ethnic minorities, have experienced difficulty accessing HIV health care and treatment services and achieving successful health outcomes. The AIDS mortality and morbidity in these groups continues to be higher than other populations, which is true in Michigan as well. These populations that are at high risk for HIV are also at high risk for other diseases such as diabetes, heart disease, cancer, sexually transmitted infections, hepatitis C., etc. Moreover, minorities, specifically African Americans in most areas of the state, including the Detroit and Benton Harbor MSAs, have reported numerous challenges to care including low self-esteem, psychosocial issues, stigma, isolation, incarceration, violence, ability to obtain affordable and quality dental care, supportive services, homelessness, lack of affordable housing, employment and other basic needs. African American youth experience many of the same challenges above, but also homophobia. The MDCH, DHWDCs 2010 Needs Assessment survey revealed that many minorities were challenged by lack of transportation, high cost of services and lack of medical coverage. These challenges contribute significantly to unmet need among African Americans and African American youth.

4. Need for Integrated Care

The lifetime cost of medical care for PLWH/A adults is estimated to be \$618,000 and increases with PLWH/A who have co-morbidities (viral hepatitis, STIs, mental illness, and other chronic illnesses). In FY2009, the cost of providing care to individuals through Part B, state resources and ADAP resources was \$35,548,388. The total number of people served was 5,100, of which 46.1% (2,346) were African American at a total (rough) estimated cost of \$163,522,258 or \$6,970 per person, per year. As the number of people in need of services continue to grow, it may be necessary to implement additional cost-saving strategies for ADAP and other core and supportive services, if resources are insufficient.

5. Need for a Seamless Care and Data Collection System

A fundamental need exists in Michigan for the creation of a system in which HIV testing, prevention and treatment are linked together and the multiple data systems that support prevention and care (HES and CAREWare) are integrated to provide surveillance and

client-level data analysis that can guide programming and funding decisions to support linkage of patients who have been newly diagnosed with HIV infection and retention of HIV positive patients in medical care.

6. ADAP Challenges

The December 2009 Department of Health and Human Services guidelines for antiretroviral treatment expanded the number of persons who are eligible for such medication, putting more pressure on ADAP funds and providers. In addition, state (Part B unmet need) and local (Part A unmet need) data suggest that approximately 50% of HIV positive persons estimated to be living in the Detroit EMA are either undiagnosed, or diagnosed and not in care. Therefore, there is potential demand for twice as much HIV medical care as is currently provided. HIV care providers in Michigan face the need to provide and manage antiretroviral therapy for a larger proportion of HIV positive persons and the need to manage double the number of patients accessing care, during a severe economic downturn, with level RW funding, and substantial cuts to CDC funding for Prevention. This presents a tremendous challenge.

7. Need for Linkage System

A critical area of racial disparity is in the African American HIV positive incarcerated population within the Michigan prison system. Among those incarcerated in Michigan, 75% are African American. To effectively reduce existing HIV-related health disparities, the MDCH must focus on strengthening linkage systems and retention in care, emphasizing EIS for HIV disproportionately impacted African Americans in Michigan, especially within people who re-enter their communities and young African American males.

Michigan's plan is in alignment with the National HIV/AIDS Strategy and the MDCH, DHWDC 2011 – 2015 Strategic Plan. It also addresses the following Healthy People (HP) 2020 objectives, among others, through proposed services and objectives:

- HIV-6: Reduce the number of new AIDS cases among adolescent and adult men who have sex with men.
- HIV-10: "Increase the proportion of HIV-infected adolescents and adults who receive HIV care and treatment consistent with current standards.
- HIV-9: Increase the proportion of new HIV infections diagnosed before progression to AIDS.
- HIV-13: Increase the proportion of persons living with HIV who know their serostatus.
- HIV-14: Increase the proportion of adolescents and adults who have been tested for HIV in the past 12 months.

Section IV. HOW DO WE MONITOR OUR PROGRESS?

This plan provides a roadmap for the Division to develop annual work plans within and across units and monitor progress towards stated goals. As a living document, the plan will be reviewed and refined as needed.

Implementation and will be a shared responsibility of all staff within the Division with leads within each Section and Unit. Each unit will collect data to measure success and review progress on plan goals and strategies monthly at the unit level. Cross-unit discussion of shared goals will occur at least quarterly, as will Division-level meetings to review progress.

The Strategic Plan Work Group composed of staff from all units and levels will take responsibility for monitoring and recommending refinement and revisions. The Strategic Plan Work Group will:

1. Review annual work plans to assure that they address key goals and strategies in the plan.
2. Specify collection of baseline and progress data.
3. Work with Division staff to support and assure that baseline and progress data on key indicators are obtained and reviewed to monitor progress towards plan goals.
4. Assure that all staff as well as Division stakeholders (Michigan HIV/AIDS Council) receive written summary report providing feedback on strategic plan progress and challenges.
5. Obtain regular input on external events and factors that need to be addressed by the Division and assess their implications for the Division and its stakeholders.
6. Recommend changes in plan strategies or indicators as appropriate, based on this review.

Monitoring and Evaluation Plan

In Michigan, RW Grantees (A – F) have established a high level of coordination, cooperation and partnership among stakeholders and providers seeking to improve care and treatment services for people living with HIV/AIDS. Current quality initiatives allow Michigan RW Grantees to better assess the extent to which HIV health services are consistent with Health and Human Services Guidelines and that services are consistent with guidelines for improving access to and quality of HIV services.

Monitoring: Michigan Grantees and the MCPQC routinely assess the quality of inputs, quality of service delivery according to standards and quality of outcomes in order to continually improve the continuum of care system in the State of Michigan. Systematic processes are in place for statewide planning, implementing and evaluating quality management and continuous quality improvement programs and activities by RW Grantees.

Additionally, MDCH, DHWDC has designated a Quality Management Consultant to coordinate the activities of the MCPQC and to manage quality activities of the Part B Program including training on quality indicators, quality assurance of the ADAP and the Michigan Dental Program and administrative and fiscal components of Part B. MDCH, DHWDC has developed a system and timeline to ensure routine data collection and analyses of data are conducted and reported to programs and provider organizations to assure quality improvement in data collection, documentation and service provision.

Summary Statement

Improving Client Level Data

MDCH, DHWDC has implemented the statewide deployment of CAREWare, version 5.0. 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, we now have 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 additional use of client level data with the implementation of CAREWare 5.0 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.

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.

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 include the:

- 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 indicators and 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.

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. In anticipation of the ACA, Michigan has begun to explore new models of case management, including medical case management, as implemented in Oregon and other states. Donna Yutzy, HIV Program Development Specialist, provided the keynote at our 2011 Case Management Conference, and continues to guide the Case Management Task Force and their developing role in HIV care and treatment in Michigan.

As part of COC’s vision to ensure efficiency and to evaluate our own progress, this completed SCSN and the Statewide Care Comprehensive Plan will be distributed to all HIV/AIDS providers to underline statewide progress and directions. 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 Extension Act of 2009 in order to move forward in creating a healthier Michigan.

In these difficult financial times, it is imperative that all providers of HIV/AIDS care, RW-funded, as well as those who are not, deliver the most cost effective solutions; work together collaboratively to provide a comprehensive system of care for people living with HIV/AIDS; and to continue to raise awareness of the importance and availability of testing, early intervention and its important potential in lowering the community viral load.