

2006 Profile of HIV/AIDS in Michigan

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Executive Summary

At the end of 2006, a total of 12,972 persons were known to be living with HIV/AIDS in Michigan, over half (52 percent) of whom have a diagnosis of AIDS. Currently, there are persons living with HIV in all but 4 counties in the state. Declines in the number of deaths of persons with AIDS since 1995 were caused primarily by the slower progression of HIV-associated immune deficiency among persons who used highly active antiretroviral therapy (HAART).

HIV disease is distributed disproportionately in Michigan. Most HIV/AIDS cases continue to be diagnosed in the Detroit Metropolitan Area, where 45 percent of the state's population lives, but where approximately two-thirds (64 percent) of all persons currently living with HIV in Michigan reside. HIV positive residents of this the Detroit Metro Area continue to be predominantly men who have sex with men, black, and ages 25-44 years old at time of diagnosis.

The proportion of persons diagnosed each year with HIV between 2000 and 2004 has not changed significantly for any race/sex group. Although the trend in new HIV infections among blacks is level, this group is still impacted disproportionately compared to the general population. Black males and females make up 14 percent of the general population in Michigan, but 57 percent of persons living with HIV/AIDS. The rate of HIV infection is currently 8.6 times higher in the black population than in the white population.

Among men in all racial groups, male-male sex is the predominant mode of exposure. For women in all racial groups, high-risk heterosexual sex is the predominant mode of exposure. However, injection drug use is still a concern for both sexes. Since 2000, however, the number of cases among injecting drug users has declined substantially.

The proportion of persons diagnosed each year with HIV infection increased significantly among those diagnosed at 13-19 years of age from 2 percent to 4 percent (22 to 43 cases) and also increased significantly among those diagnosed at 20-24 years of age from 7 percent to 15 percent (61 to 142 cases). In all other age groups, the trends in new diagnoses are level.

In 2005, Michigan implemented laboratory reporting of HIV test results, including positive western blots, all HIV viral loads, and CD4s on infected individuals. With this additional method of obtaining new cases, we expect to see an increase in the number of reported cases living with HIV/AIDS in Michigan, due to more accurate counting of cases. This also creates the need for Michigan to update the calculations used to form the estimated prevalence of HIV, which will be further assessed in late 2006.

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Introduction

This year the HIV/STD & Other Bloodborne Infections Surveillance Section is providing prevention and care planning groups with the epidemiologic profiles for the State of Michigan, the Detroit Metropolitan Area, and Out-State Michigan (including the upper peninsula and the balance of the lower peninsula). The profiles use a simplified method of ranking the priority of behavioral groups. The rank was based on the percentage of total reported HIV/AIDS cases for each behavioral group.

In order to measure prevention achievements, the number of persons who become newly infected would ideally be followed over time. Methods for measuring new infections are currently being developed, however, since surveillance is not yet able to do this, trends are analyzed among those newly diagnosed with HIV disease between 2000 and 2004. The date of new HIV *diagnosis* does not tell us when persons were first *infected*, because their HIV diagnosis may take place months or years after infection. However, this is the best current measure of how fast the epidemic is spreading among different populations. To evaluate trends over time, we approximated the number of persons newly diagnosed with HIV infection each year and determine if there was a statistically significant change from 2000 through 2004. Numbers are approximated by adjusting the number of reported cases diagnosed in 2000-2004 to account for those who may not have been reported to the health department by January 1, 2006. These adjustments are calculated by weighting the data. Over this time period No Identifiable Risk (NIR) cases were also redistributed to other risk categories based on past patterns of NIR reclassification. This method of adjustment was used to evaluate Statewide trends and also trends in the Detroit Metro Area. Numbers of reported HIV and AIDS cases in Out-State Michigan were insufficient to apply this methodology. Because trends cannot be reported for Out-State Michigan, the chapter dedicated to this geographic area presents figures created using raw numbers instead of trends. Be sure not to compare trends in the Statewide or Detroit Metro Area chapters with raw numbers in the Out-State chapter. In addition, the HIV/STD & Other Bloodborne Infections Surveillance Section will continue to track trends for AIDS cases since these trends measure changes in treatment effectiveness and access to care.

The presentation of risk or transmission percentages is different in this document than in past Epidemiologic Profiles of HIV in Michigan. Historically, this was presented as the number that makes up a group, for example men who have sex with men, divided by those with a known risk. This year, that number is divided by all cases in order to show the number and percent without an known risk. It may appear that proportions have decreased when comparing to the 2002 Epidemiologic Profile of HIV/AIDS in Michigan, however, that is untrue.

The HIV/STD & Other Bloodborne Infections Surveillance Section creates these profiles every other year, however, statewide and some county statistical analyses are created and disseminated on a quarterly basis. When reading either of these documents, the reader must keep in mind that they are based on two different populations. The HIV/AIDS Quarterly Analyses (statewide and county) use cases of HIV/AIDS whose **residence at diagnosis** was Michigan (cases that were diagnosed in Michigan can presently be living elsewhere). The Epidemiologic Profiles of HIV/AIDS in Michigan use cases of HIV/AIDS that are **currently living** in Michigan. There are 991 more persons included when we use the HIV infected population **currently living** in Michigan. The reason different populations are used is to satisfy questions on both populations. Therefore, there may be differences in numbers, percents, and rates when comparing the two types of documents.

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Introduction (continued)

There are many new additions to the profiles this year, including an increase in the number of data sources. Descriptions on the general population of Michigan have been added, as well as discussions on special populations such as foreign born, homeless, commercial sex workers, rural, and incarcerated. Additionally, a section highlighting health disparities has been added. Finally, discussions on individuals who were diagnosed with HIV and AIDS at the same time (concurrent diagnoses) were added. As always, ideas on ways to improve the profiles are welcome.

Staff from the MDCH HIV/STD & Other Bloodborne Infections Surveillance Section are available to assist in interpretation of these profiles as well as to provide additional analyses. Questions or comments about these profiles should be directed to your county contact. With your assistance, surveillance data will continue to guide HIV prevention strategies and resource allocation for care services in Michigan. For the statewide and Out-State profiles, please call (517) 335-8165. For the statewide and Detroit Metro Area profiles, please call (313) 876-0353.

Profiles Strengths and Limitations

When making planning decisions, it is important to consider the overall strengths and limitations of this document. Although the profile is comprehensive and draws from a number of data sources, there are many things that the profile cannot explain.

Although the HIV/AIDS surveillance system in Michigan is extensive, it is based on data for persons who have been confidentially tested for HIV. Consequently, infected persons who have not been tested, have tested anonymously, or have tested by name but not reported, are not included. Therefore, HIV infections are under-detected and underreported. However, HIV/AIDS Surveillance data are considered to be among the most complete compared with other notifiable diseases and infections. In order to compensate for these uncounted infections, estimates are provided in several tables.

The data presented in this report do not necessarily represent the characteristics of persons who have been recently infected with HIV, nor do they provide a true measure of HIV incidence because persons are tested at differing times after they become infected, and many persons are not tested until HIV infection has progressed to AIDS (concurrent diagnoses).

Analyses of many different data sets are presented to provide robust representations of particular subpopulations. However, demographic and geographic subpopulations are disproportionately sensitive to differences and changes in access to health care, HIV testing patterns, and specific prevention programs and services. All of these issues must be carefully considered when interpreting HIV/AIDS data. Therefore, it is important to make comparisons across data sources to get the most complete picture.

The most current analysis available is presented for each source of data; however, the most recent data differ from one source to another. For example, the most recent data available for Supplement to HIV/AIDS Surveillance Project (SHAS) are from 2004, whereas some data (e.g., Community Intervention Trial for Youth (CITY)) were collected in 1999. In addition, more detailed analyses are available for some sources. The information in this report is for statewide planning, but some local data are presented. Strengths and limitations are further discussed in the Data Sources section.

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Data Sources

Data were compiled from a variety of sources to provide the most complete picture possible. When interpreting the data, keep in mind that each of the data sources has strengths and limitations. A brief description of each of the data sources follows.

Core HIV/AIDS Surveillance

HIV/AIDS Surveillance Data

In 1983, the Michigan Department of Community Health (MDCH) established a surveillance system to track newly diagnosed AIDS cases. This surveillance system is managed by the HIV/STD & Other Bloodborne Infections Surveillance Section and was expanded in 1989 to include confidential name-based HIV reporting. Finally, in 2005, laboratory reporting was added to the surveillance system. Standardized case report forms and laboratory reports are used to collect sociodemographic information, mode of exposure, laboratory and clinical information, vital status (i.e., living or dead), and referrals for treatment or services. These data are obtained from medical record abstractions. Patients are NOT interviewed. HIV surveillance data may underestimate the number of recently infected persons because some infected persons either have not been tested or have been tested, but not yet reported to MDCH. Persons who tested positive at an anonymous test site and have not sought medical care (where they would probably be confidentially tested) are not included in HIV surveillance statistics because cases without names cannot be unduplicated. Therefore, HIV infection data provide minimum estimates of the number of persons known to be HIV infected. In addition, newly diagnosed cases may be reported to the health department at any point along the clinical spectrum of disease. Consequently, HIV infection data do not necessarily represent characteristics of persons who have been recently infected with HIV. In order to provide a more concise measure of the impact of HIV, MDCH provides an estimate of the prevalence of HIV. This estimate includes measures of those HIV infected individuals who have been tested, but not reported to the health department, as well as those HIV infected individuals who have not yet been diagnosed and represents all infected persons regardless of whether they have been tested or reported.

Supplemental HIV/AIDS Surveillance Projects

Adult/Adolescent Spectrum of HIV Disease (ASD) Study

The Adult/Adolescent Spectrum of Disease (ASD) was a multi-site national surveillance project sponsored by the Centers for Disease Control and Prevention (CDC). The HIV/STD & Other Bloodborne Infections Surveillance Section collected ASD data in six-month follow-up intervals from the medical records of HIV-infected persons in care, from the time they first contacted an ASD site until they died or were lost to follow-up. The information collected from these medical records may differ from those who do not report for care. Michigan ASD includes data on a representative sample of HIV-infected persons who presented for care at the Henry Ford Health System, Detroit campus (HFHS) or at the Detroit Medical Center (DMC). Michigan participated in ASD from its inception in 1990 through its closure in 2004. More than 5,500 patients were enrolled in Michigan ASD, and at the end of the project 2,667 patients had died, 1,492 had moved or were otherwise lost to follow-up, and 1,392 were still living. ASD collected data on demographics, opportunistic illnesses, other infections such as Hepatitis B and C, other conditions such as cancers, depression, hypertension, substance abuse, mental illness, and other variables such as CD4+ T-cell counts, viral load measurements, prescription of medications, and many others.

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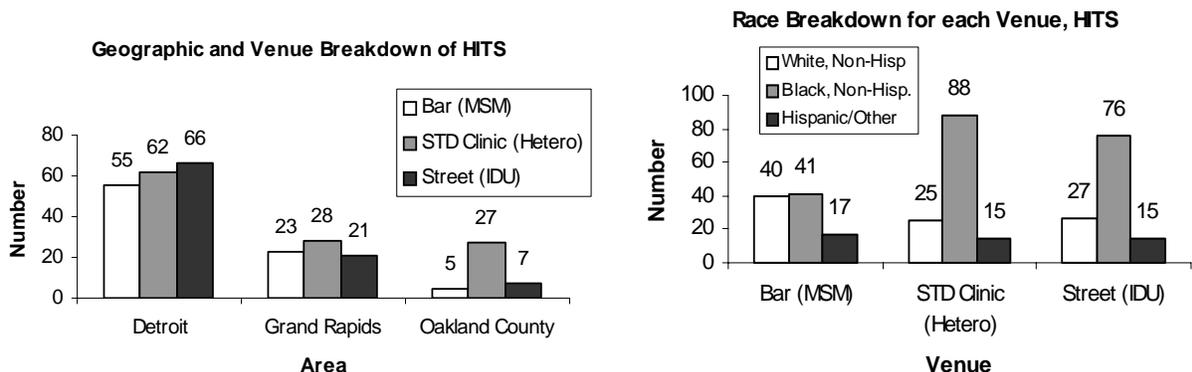
Data Sources (continued)

Supplement to HIV/AIDS Surveillance (SHAS) Project

Supplement to HIV/AIDS Surveillance was a one-time, cross-sectional interview project that collected self-reported behavioral information from individuals infected with HIV and/or AIDS who present for care. This project was managed by the HIV/STD & Other Bloodborne Infections Surveillance Section. The behaviors reported by these interviewed individuals may differ from those who do not report for care or are uninfected. Data were collected from 1990 to 2004 among persons 18 years of age and older. Individuals who presented for care at one of three entities at five Detroit locations - two large tertiary medical centers, two neighborhood clinics, and one health care center were eligible for an interview. Data were collected on demographic and socioeconomic factors, drug use (alcohol, ingested and/or injected drugs), needle sharing and cleaning, access to drug treatment, sexual behaviors, condom use, medical and social services, compliance with drug therapies, and, for women, reproductive history and child health. SHAS data are useful for informing health department policymakers, HIV community planning groups, and enhancing public health prevention programs and services. Understanding the specific behaviors of infected persons can help with understanding risk and make for a more targeted prevention intervention. Prevention and care planning groups are encouraged to contact the MDCH HIV/STD & Other Bloodborne Infections Surveillance Section for additional data from this project. Summaries of the 1990-2000 SHAS data (SHAS I 2,205 interviews) and 2000-2004 SHAS data (SHAS II, 1,174 interviews) are available on-line at: www.michigan.gov/mdch.

HIV Testing Survey (HITS)

In 2002, as part of behavioral HIV/AIDS surveillance efforts, the Centers for Disease Control and Prevention (CDC) funded Michigan's HIV/STD & Other Bloodborne Infections Surveillance Section to do an interview survey for uninfected persons at risk for HIV. This multi-site project, the HIV Testing Survey (HITS), was conducted in fifteen cities or states across the country, using a standard protocol that had been used successfully in other cities in the United States. In Michigan, the project was conducted in Detroit (183 surveys) and Oakland (Cities of Pontiac, Southfield, and Royal Oak, 39 surveys) and Kent (City of Grand Rapids, 72 surveys) counties. Data from these areas are combined in the Detroit Metro Area and Out-State Michigan profiles to maintain statistical power. The participants for this survey were recruited from three types of public venues: street locations for injection drug users (including needle exchange venues), public health sexually transmitted disease (STD) clinics for high-risk heterosexuals, and bars for men who have sex with men. Before the survey began formative research was conducted. The objectives of the formative research were to better understand the demographic characteristics of the populations at risk who were included in the study, and to identify the sites (i.e., clinics, bars, street settings) where the interviews were conducted.



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Data Sources (continued)

Behavioral Surveys

Family of Seroprevalence Surveys

The Family of HIV Seroprevalence Surveys monitored HIV prevalence among high-risk populations in southeastern Michigan and was managed by the HIV/STD & Other Bloodborne Infections Surveillance Section. These surveys were administered from 1988 through 1999 in various public health clinics and facilities. Survey data were collected annually and consisted of demographics, sexual risk behaviors, clinical diagnosis, illicit drug use, and laboratory results. Data were abstracted from patient files and no additional information was asked for the purpose of the survey. Only remnant sera from routine collected sera were tested for HIV antibodies after personal identifiers were removed. Data were used to monitor trends in HIV infection, assess changes in risk behaviors and assist in the planning and evaluation of prevention programs. These specimens were used in the early 2000s to estimate HIV incidence in selected populations by applying the STARHS algorithm (See Appendix B) to the stored specimens that were previously collected. (STARHS testing on routine specimens collected for HIV testing began March 2005 at two pilot sites and is currently being expanded statewide for newly reported cases.)

Community Intervention Trial for Youth (CITY)

During the summer of 1999, the Center for AIDS Intervention Research at the Medical College of Wisconsin in collaboration with the Michigan-based Midwest AIDS Prevention Project conducted a survey in Milwaukee, Wisconsin and Detroit, Michigan. The survey was called the Community Intervention Trial for Youth (CITY) and aimed to collect baseline behavior data from young men who have sex with men. Men were randomly recruited outside of venues frequented by young men who have sex with men (i.e. bars, coffee shops, cruising areas). A total of 547 men were interviewed, 48.3% were from Detroit. The mean age was 21, with a range of 15 to 25 years old. Topics of interview questions were basic demographics, sexual identity, female partners, male partners (main and non-main), drug use, condom use, social support, anti-retroviral knowledge, and exposure to interventions.

Youth Risk Behavior Survey (YRBS)

The Youth Risk Behavior Survey (YRBS) is conducted every other year in Michigan by the Department of Education and assesses a broad range of health practices among a representative sample of the state's students in grades 9 through 12. Data are weighted so that survey results can be generalized to all high school students in the state. Michigan is one of only a handful of states with high enough response rates on five consecutive YRBS survey administrations (1997, 1999, 2001, 2003 and 2005) to have scientific trend data. The YRBS collects information on six categories of behaviors related to the leading causes of mortality and morbidity among both youth and adults. Sexual behaviors that contribute to unintended pregnancy and STDs including HIV infection constitute one of the six categories. Questions in this category ask about HIV prevention education, sexual activity (age at initiation, number of partners, condom use, past drug or alcohol use, forced sex), contraceptive use, and pregnancy history. The YRBS is a standardized questionnaire, so comparisons can be made between states, participating cities, and the nation on core questions. States and cities may also add questions of local interest. Michigan has added two questions to the sexual behavior section: one on parent-child communication and the other on age of first sexual partner. Because the YRBS relies upon self-reported information, sensitive behavioral information may be underreported or over-reported. Also, because the YRBS questionnaire is administered in school, the data are representative only of adolescents who are enrolled in school and cannot be generalized to all adolescents. For example, students at highest risk, who may be more likely to be absent from school or to drop out of school, may be underrepresented in this survey, especially those in upper grades. The Michigan questionnaire does not include questions about sexual orientation or gender of sexual partner.

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Data Sources (continued)

Behavioral Sources (continued):

The Bureau of Juvenile Justice Youth Risk Behavior Survey (YRBS)

The BJJ Youth Risk Behavior Survey (BJJ YRBS) is an expansion of the Youth Risk Behavior Survey that is conducted every other year in Michigan by the Department of Education. The BJJ assesses a broad range of health practices among a representative sample of the state's students in state-operated residential Bureau of Juvenile Justice facilities attending grades 9 through 12. The one time BJJ administration occurred in the spring of 2002. Unlike the general education YRBS, which uses a two stage sampling process, the BJJ YRBS was a census of youth in these facilities (9 sites within 6 centers). A total of 470 youth were eligible to participate. All sites, centers, and classrooms participated. A total of 418 usable questionnaires were analyzed, for a final student participation rate of 89 percent. The results of the BJJ YRBS should be compared with the Michigan general education YRBS with caution because the students may not be comparable in age, race/ethnicity, and gender. However, the BJJ respondents were roughly the same age as their general education counterparts in grades 9-12, with 83 percent between the ages of 15 and 18. The BJJ used the core general education Michigan YRBS survey instrument with some questions omitted, added, and adapted to better meet the needs of the youth in the residential facilities. Questions assessing the incidence of risk behaviors "in the past 30 days," were modified to say, "in the 30 days before you entered the facility." The instrument included questions in all six categories of behaviors included on the main YRBS. Additional questions in the sexual behavior section assessed sexual orientation, gender of sexual partner, and history of HIV testing. The survey provides a picture of the behaviors of a sub-population of youth who are at considerably greater risk than their counterparts in school. A second BJJ YRBS will be conducted in 2006.

HIV/AIDS and Health Related Needs Among Commercial Sex Workers in Michigan—December 2004

This study was conducted by the Midwest AIDS Prevention Project to fill a gap in existing knowledge in the State of Michigan on the needs of a population known to be at high risk for HIV/AIDS: commercial sex workers (CSWs). The study involved 59 structured interviews with people who self-reported exchanging sex for money, drugs, or other goods on a regular basis. Participants included CSWs from five communities around Michigan: Benton Harbor, Detroit, Flint, Grand Rapids, and Ypsilanti. Quota and network sampling methodology were used to access participants on streets, around drug access points, and in drug treatment centers.

HIV/AIDS and Health Related Needs Among Homeless Persons in Michigan—January 2006

This study was conducted by the Midwest AIDS Prevention Project to determine the HIV prevention-related needs of homeless persons in the state of Michigan. The state has no previous needs assessment data from this population; therefore, the goal of this project was to determine if, where, and how to target HIV prevention-related services to this population. The study involved 98 structured interviews with people who self-reported as homeless. Participants included those accessing food banks and shelters in six communities around Michigan: Ann Arbor, Benton Harbor, Detroit, Flint, Grand Rapids, and Lansing. A quota sampling methodology was employed.

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Data Sources (continued)

Behavioral Sources (continued):

HIV/AIDS and Health Related Needs and Risk Perceptions Among African-American Men who Have Sex with Men in Michigan —October 2005

This study was conducted by the Midwest AIDS Prevention Project to understand the needs of African American men who have sex with men (MSM). The study involved 32 structured interviews and 6 focus groups ($N = 37$) with people who self-reported as male or transgendered, African American, and behaviorally homosexual or bisexual. The interviews and focus groups covered many of the same issues, but the protocols were different. Participants were from six communities around Michigan: Benton Harbor, Detroit, Flint, Grand Rapids, Lansing, and Ypsilanti. Quota and network sampling methodology were used to access participants on streets, in parks, at clubs, and at community-based organizations known to serve MSM.

Communicable Disease Surveillance

TB Registry

The Michigan Department of Community Health, Section of Communicable Diseases conducts statewide surveillance of cases of tuberculosis. All TB cases reported in the State of Michigan are reported using the CDC Report of a Verified Case of Tuberculosis (RVCT) form. Surveillance information and laboratory reports on active and suspect TB cases are maintained in the Tuberculosis Information Management System (TIMS) database. Surveillance data are analyzed to monitor statewide tuberculosis trends, including HIV/TB co-infection, as well as to determine appropriate treatment regimen, drug susceptibility results and completion of TB therapy status. TIMS is also currently utilized to report Michigan's verified TB cases to the Centers for Disease Control and Prevention (CDC). Each year, the TB registry is matched to the HIV/AIDS surveillance data. Outcomes from the match include documenting progression from HIV to AIDS, completing TB infections reported directly to HIV surveillance and, occasionally, new HIV cases.

STD Reporting System

The Michigan Department of Community Health, Division of Health Wellness and Disease Control conducts statewide surveillance to determine the number of reported cases of STDs, monitor trends, provide partner counseling, and referral services for examination and treatment. All of these objectives aim at reducing the spread of STDs in the community. In Michigan, gonorrhea, chlamydia, syphilis, lymphogranuloma venereum, chancroid, and granuloma inguinale are reportable by physicians and laboratories. There are significant variations in the completeness of data coming from public and private providers. Approximately 67 percent of female cases and 43 percent of male cases come from private providers. Among public providers, only 5 percent of race data is missing, however, 58 percent of race data is missing in reports from private providers. Gonorrhea is the second most frequently reported communicable disease in Michigan, while chlamydia is the most frequently reported of all reportable communicable diseases. Michigan does not collect standardized sexual orientation data for gonorrhea or chlamydia cases. However, these data are collected for syphilis cases. For data on STD cases in Michigan, by age and sex, please refer to http://www.mdch.state.mi.us/PHA/OSR/chi/std_h/frame.html

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Data Sources (continued)

Vital Statistics Data

Birth and Death Data

The National Center for Health Statistics receives information on births and deaths in the United States through a program of voluntary cooperation with state government agencies (i.e., state departments of health, state offices of vital statistics) called the Vital Statistics Cooperative Program. States use standard forms to collect birth and death data. The birth certificate form includes demographic information on the newborn and the parents, insurance status, prenatal care, prenatal risk factors, maternal morbidity, mode of delivery, pregnancy history, and clinical characteristics of the newborn. Death certificates include demographics, underlying cause of death, and contributions of selected factors to the death (i.e., smoking, accident, or injury) of all deceased persons. Reporting is virtually 100 percent complete for births and deaths. Therefore, inferences can be made concerning the number of live births in a service area. The data can also be used to determine the effect of deaths related to HIV infection in a service area. The data on birth certificates that are obtained from patient medical records (i.e., smoking history, morbidity) may be incomplete. In addition, deaths resulting from, or whose underlying cause was, HIV infection may be underreported on a death certificate. Clinical information related to HIV or AIDS may be missing.

Population Data

U.S. Bureau of the Census (Census Bureau)

The Census Bureau collects and provides timely information about the people and economy of the United States every 10 years. The Census Bureau's Web site (<http://www.census.gov>) includes data on demographic characteristics (e.g., age, race, Hispanic ethnicity, sex) of the population, family structure, educational attainment, income level, housing status, and the proportion of persons who live at or below the poverty level. Summaries of the most requested information for states and counties are provided, as well as analytical reports on population changes, age, race, family structure, and apportionment. State- and county-specific data are easily accessible, and links to other Web sites with census information are included. The Michigan-specific Census data used in these profiles was obtained using the American Fact Finder (<http://www.census.gov/main/www/cen2000.html>), supported by the U.S. Census Bureau. This website is a user-friendly way to obtain Census data. The data used in these profiles are from the 2000 census.

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Data Sources (continued)

Ryan White CARE Act Data: The State of Michigan Uniform Reporting System Data Collection Process

The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, first enacted in 1990, provides federal funds to help communities and States increase the availability of primary health care and support services for people living with HIV/AIDS disease (PLWH/A). CARE Act funds are allocated to Title I (for Eligible Metropolitan Areas heavily impacted by the epidemic), Title II (for States and U.S. Territories) which includes funding earmarked for AIDS Drug Assistance Programs (ADAP), Title III (for outpatient HIV early intervention services) and Title IV (to coordinate and enhance services for women, infants, children and youth). CARE Act funds are funds of last resort.

Available CARE Act services vary by jurisdiction, but usually include primary out-patient medical care, medications, case management, mental health services, transportation, and other supportive services. The Michigan Department of Community Health (MDCH), Division of Health, Wellness and Disease Control, HIV/AIDS Prevention & Intervention Section (HAPIS), is the Grantee for the Title II, ADAP and Title IV resources allocated to Michigan through the CARE Act. The City of Detroit Department of Health and Wellness Promotion (DHWP) is the Title I Grantee, and there were four Title III funded programs in Michigan in 2005: 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 Program in Ann Arbor, and St. Mary's McAuley Health Center in Grand Rapids.

MDCH also coordinates a statewide client-level data system, known as the Uniform Reporting System (URS), developed by the Health Resources Services Administration (HRSA) to document the services delivered and describe the populations being served by the Ryan White CARE Act. Michigan received demonstration project funding to establish and maintain the URS data system between October 1994 and September 2003. During the demonstration project, MDCH collaborated with the Title I Grantee, to establish and maintain the URS and to promote its use across all CARE Act Titles in Michigan. Until 2005, the URS data included records from all programs funded by Title I, Title II, and Title IV of the CARE Act, and three of the four Title III programs. In 2004 and 2005 the DHWP implemented a new data system for Title I funded programs while MDCH continued collecting data with its existing system. Differences between the two systems made it difficult to assemble compatible data, so the 2005 annual URS data include only partial representation of Title I funded programs (14 of 24).

The URS data files submitted to MDCH by individual service agencies are combined and unduplicated across all providers using an encrypted client identifier, so that all services received by a client are combined into a single client record. All HIV+ clients served by funded providers are included in the URS, even if the CARE Act did not directly fund the reported service. Services reported in the URS include outpatient medical care, dental care, mental health services, case management, and a wide range of support services. The URS data also include records from the AIDS Drug Assistance Program (ADAP) and the Michigan Dental Program (MDP).

URS data are collected, compiled, and unduplicated on a quarterly basis and at the end of each calendar year. The data are used to prepare the annual CARE Act Data Reports (CADR) for each funded provider, reports that must be submitted each year to HRSA, the Federal agency charged with administering the Ryan White CARE Act. In addition to satisfying these CARE Act reporting requirements, the URS data are regularly used for local program planning and evaluation.