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Appendix A: Ending the HIV Epidemic in Wayne County 2020–2025 Strategic Plan

A copy of the full plan, including appendices, can be found online at https://www.michigan.gov/mdhhs/keep-mi-healthy/chronicdiseases/hivsti/ending-the-hiv-epidemic.

Ending the HIV Epidemic in Wayne County 2020–2025 Strategic Plan

Michigan Department of Health and Human Services

07.24.2020

MDHHS
Michigan Department of Health & Human Services

Acknowledgements

The Michigan Department of Health and Human Services (MDHHS) would like to thank the following partners for their efforts and commitment to developing a robust plan for Ending the HIV Epidemic in Wayne County:

- The Detroit Health Department for partnering with MDHHS throughout the planning process and coordinating transportation to and from input sessions for community members
- The Southeast Michigan HIV AIDS Council (SEMHAC) and Michigan HIV AIDS Council (MHAC), for participating in the planning process and offering concurrence with the final plan
- The providers and community members who offered invaluable input and ideas for tackling the HIV epidemic
- The Ending the HIV Epidemic (EHE) working group, who guided the development of the plan, sponsored community input sessions, and ensured the strategies and activities represented the needs and desires of community members
- Public Sector Consultants for facilitating the planning process and preparing the final plan

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Background

In October 2019, the Michigan Department of Health and Human Services (MDHHS), in partnership with the Detroit Health Department (DHD), kicked off the Ending the HIV Epidemic in Wayne County initiative. This is one of 48 initiatives in localities across the nation supported by the U.S. Centers for Disease Control and Prevention (CDC), the U.S. Health Resources and Services Administration (HRSA), the U.S. Indian Health Service (IHS), the U.S. Office of the Health and Human Services Assistant Secretary for Health, and the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA). The objective of these initiatives is to develop comprehensive plans for improving human immunodeficiency virus (HIV) prevention and care with an overarching goal of reducing new HIV infections by 75 percent by 2025 and at least 90 percent by 2030. This is to be accomplished through four objectives:

1. Diagnose all people with HIV as early as possible
2. Treat people with HIV rapidly and effectively to reach sustained viral suppression
3. Prevent new HIV transmission by using proven interventions, including pre-exposure prophylaxis (PrEP), postexposure prophylaxis (PEP), and syringe services programs (SSPs)
4. Respond quickly to potential HIV outbreaks to get needed prevention and treatment services to those who need them

Engagement Process

MDHHS recognizes the critical importance of thoughtfully including local communities, local community members, HIV planning bodies, HIV prevention and care providers, and new partners in the development of an Ending the HIV Epidemic plan for Wayne County. Therefore, MDHHS sought a collaborative process that relies on a partnered approach to the development and implementation of the plan. This included the establishment of a planning team for designing the planning process, the establishment of a working group of key stakeholders to advise on the development of the plan and the community engagement process, and the hosting and facilitation of eleven community input sessions and four provider forums. MDHHS engaged Public Sector Consultants (PSC), a public policy research and consulting firm based in Lansing, Michigan, to facilitate the planning process. PSC staff participated in all planning team meetings and facilitated the working group meetings, as well as the community and provider input sessions described below.

Planning Team

To carry out the planning initiative, MDHHS established a planning team comprising staff from the MDHHS Division of HIV and Sexually Transmitted Disease (STD) Programs and Detroit Health Department HIV/STD Prevention Program. The planning team met on a biweekly basis to design and advise the overall project and check in on progress. MDHHS presented the planning process to the Southeastern Michigan HIV/AIDS Council (SEMHAC) and the Michigan HIV/AIDS Council (MHAC), the primary planning bodies for Wayne County and for the state, to answer questions and further refine the planning process. Agendas for meetings with SEMHAC and MHAC can be found in Appendices A and B.

Ending the HIV Epidemic Working Group

The planning team established a working group, which comprised 17 individuals representing a diverse range of backgrounds, including members from SEMHAC and MHAC, consumers, providers, HIV outpatient ambulatory health service clinicians, community-based agency representatives, and city and county government officials. A list of all working group members is provided in Appendix C.

The working group advised the planning team on the planning process; reviewed data and information presented in the epidemiological profile; identified HIV prevention and care strengths, challenges, and needs for the situational analysis; supported the identification, recruitment, and facilitation of participants for the community input sessions and provider forums; and recommended final strategies to include in the plan. The working group met a total of four times over the course of the initiative. Appendix D contains agendas from those four meetings.

At its first meeting in October 2019, the working group reviewed MDHHS' HIV epidemiological profile for Wayne County and discussed strengths and challenges in the existing prevention and care systems in Wayne County. Working group members identified the following areas of focus for the new five-year plan beginning in 2020:

- Improving data collection methods to gather data for transgender populations
- Improving PrEP data collection methods and navigation tools
- Improving data coordination across HIV care providers
- Improving cultural competency across HIV prevention and care services
- Improving HIV prevention and care services for people who inject drugs or who have substance use disorders
- Developing case management systems for improving prevention services
- Addressing the social determinants of health (e.g. housing instability, unemployment)

During the working group's second meeting, in November 2019, the members provided guidance on and developed strategies for obtaining community and provider input. This included reviewing and commenting on discussion guides for community and provider input sessions, identifying priority populations for inclusion in the input sessions, and volunteering to help recruit community members to participate in input sessions.

The working group held its third meeting on May 7, 2020, to review findings from the input sessions and participate in a facilitated discussion on strategies proposed in the community and provider input sessions to address HIV diagnosis, treatment, and prevention. A prioritization exercise followed, during which each session participant was asked to vote for a limited number of strategies in each of the 16 groups of recommendations, which were organized within the four Ending the HIV Epidemic objectives. After each vote, working group members had an opportunity to discuss the results and offer additional input for consideration. Strategies that received the highest percentage of votes were further refined by working group members through an online survey and are included in the final strategic plan.[1] At its fourth and final meeting, on July 13, 2020, the working group reviewed and approved the final plan.

1. Complete voting results are available in Appendix G.

Community Input Sessions

To ensure the plan reflects the priorities and needs of the Wayne County community, the planning team and working group hosted a total of 11 community input sessions attended by 103 community members, each focused on gathering the perspectives of a specific population living with or at risk of contracting HIV (Exhibit 1). For the purposes of this report, out-Wayne County refers to all cities in Wayne County that are outside of Detroit. These community input sessions were used to identify ways in which community members experience barriers to accessing HIV prevention and care and the ways in which community members could be better served by the HIV prevention and care systems in the county. Each community input session was sponsored by either a working group member or another trusted member of the community to foster a sense of safety and comfort for participants. Additionally, the questions for each of the community input sessions were developed with guidance from working group members and sponsors (Appendix E). Each participant received a $50 gift card. In cases where transportation assistance was needed for participants, DHD helped coordinate transportation to the session using Uber.

EXHIBIT 1. Community Input Sessions (2020)

Community Input Session	Date	Location
African American Detroit Residents	February 22	Unified HIV Health and Beyond Detroit Office Detroit, MI
African American out-Wayne County residents	March 4	Wayne County Health Department Wayne, MI
Latinx, Chicanx, and/or Hispanic residents	February 21	Brilliant Detroit Detroit, MI
People who have returned to their community from a correctional facility	March 4	Unique Dance Hall Detroit, MI
People who inject drugs (PWID)	January 30	Detroit Recovery Project Detroit, MI
Transgender people of color	April 17–29	Qualtrics online survey (during spring 2020 pandemic stay-at-home order)
Women of color	February 6	Tolan Park Medical Building Detroit, MI
Young Black men who have sex with men (MSM) (ages 15–17)	February 6	Wayne State University Prevention Office Detroit, MI
Young Black MSM (ages 18–29)	January 28	Wayne State University Prevention Office Detroit, MI
Youth (ages 15–17)	February 21	Triumph Church - East Campus Detroit, MI
Youth (ages 18–29)	February 21	Arab Community Center for Economic and Social Services (ACCESS) Ferndale, MI

Provider Forums

The planning team and working group also recognize the importance of developing a plan that reflects the needs and priorities of the provider community. They noted the importance of developing new partnerships and solutions between the HIV provider community and other organizations that serve people living with or at risk of HIV, but for whom HIV prevention and care may not be their primary purpose. The planning team and working group hosted four provider forums that were sponsored by MDHHS and DHD and attended by 56 participants. Each forum included a diverse array of participants, including HIV prevention and care providers, medical providers, faith leaders, behavioral health, representatives of organizations addressing social determinants of health (e.g., transportation, housing, and food security), representatives of non-healthcare related youth-service organizations, school sex education providers, and law enforcement agency representatives.

The forums focused on the systemic strengths, challenges, and opportunities associated with (1) diagnosing all people with HIV as early as possible, (2) treating people rapidly and effectively to achieve sustained viral suppression, (3) preventing HIV by using proven interventions, including PrEP and SSPs, and (4) responding quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them (refer to Appendix F for the Provider Forum Discussion Guide and Session Information Sheet). The forums were also used to identify opportunities for new partnerships across the different organizations to support HIV prevention and care in the county. The forums were held on January 27, February 11, February 18, and February 25 at the Corktown Health Center in Detroit, Michigan and at the Arab Community Center for Economic and Social Services (ACCESS) clinic in Dearborn, Michigan.

Epidemiologic Profile

Following is a comprehensive epidemiological profile of people living with and at risk of HIV in Wayne County. The profile is divided into six sections: (1) about Wayne County, (2) people living with HIV and new HIV diagnoses, (3) HIV and STI co-diagnoses, (4) HIV care and viral suppression, (5) HIV prevention, and (6) HIV response. Detroit and out-Wayne County are addressed separately throughout due to significant differences in HIV distribution between the two.

Section One: About Wayne County

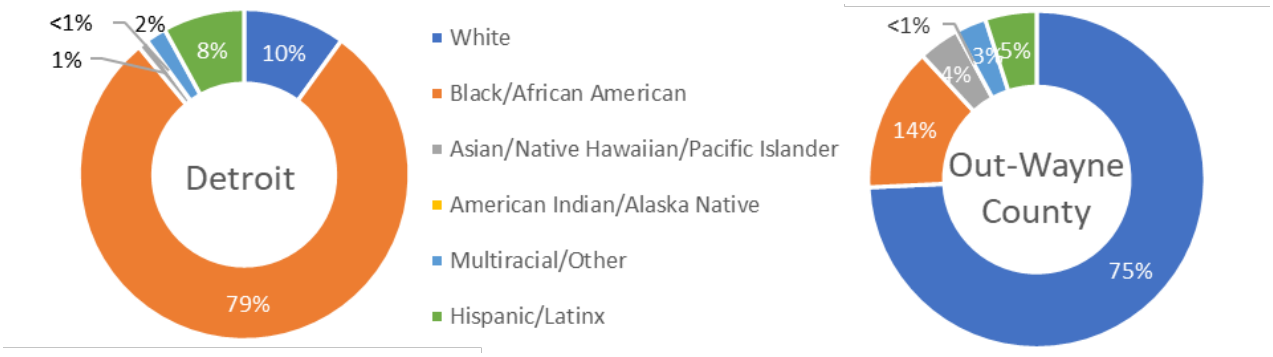
Wayne County is home to nearly 1.75 million people and spans 613 square miles of southeast Michigan, making it the most populous county in Michigan and 19th most populous county in the United States.[2] It also encompasses Michigan's most populous city—Detroit, which accounts for 39 percent of the Wayne County population. According to 2018 U.S. Census data, about 76 percent of Wayne County's population is 18 years or older with a median age of 38 years old.

Fifty percent of Wayne County residents identify as white alone, not Hispanic or Latinx; 40 percent identify as African American alone; 6 percent identify as Hispanic or Latinx; 3 percent identify as Asian, Native Hawaiian, or Other Pacific Islander alone; 2 percent identify as two or more races; and 1 percent

2. U.S. Census Bureau. "QuickFacts: Wayne County, Michigan. 2018." *United States Census Bureau.* Accessed December 6, 2019. https://www.census.gov/quickfacts/fact/table/waynecountymichigan/PST045218

identify as American Indian or Alaska Native alone.[3] However, compared to the rest of the county, Detroit's population is highly segregated by race/ethnicity and income. People of color make up nearly 90 percent of Detroit's population, with only 10 percent of residents identifying as white. Almost 80 percent of Detroit's population identify as African American. Of the rest of Wayne County's population, 75 percent are white, and 25 percent are people of color. Significantly higher proportions of Detroit residents across all racial/ethnic groups live below the federal poverty limit compared to respective racial/ethnic groups in out-Wayne County.[4]

EXHIBIT 2. Wayne County Population by Race and Ethnicity



Source: Michigan Department of Health and Human Services; Bureau of Disease Control, Prevention, and Epidemiology; Division of Communicable Disease HIV and STD Surveillance and Epidemiology Section—HIV Surveillance Office. July 1, 2019. *Ending the Epidemic: Wayne County HIV Epidemiologic Profile*. Lansing: Michigan Department of Health and Human Services.

Significant disparities in educational attainment and health insurance coverage also exist between Detroit and out-Wayne County residents. Nearly all out-Wayne County residents aged 29 and older (90 percent) have completed high school, compared to 80 percent of Detroit residents. Also, 28 percent of out-Wayne County adults aged 25 and older have obtained a bachelor's degree or higher, compared to 14 percent in Detroit. Additionally, 7 percent of out-Wayne's population was uninsured compared to 12 percent in Detroit.[5]

Section Two: People Living with HIV and New HIV Diagnoses

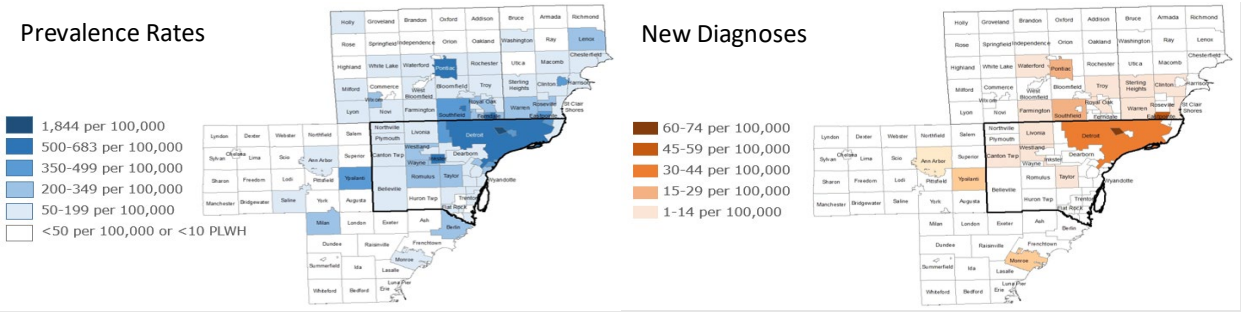
Prevalence rates for HIV are higher in some cities within the county than others. Detroit and Highland Park had the highest overall HIV prevalence rates in the county in 2018. Outside of Detroit and Highland Park, Inkster, Taylor, Wayne, Romulus, and Westland had the highest rates.

3. American Community Survey (ACS) 5-year estimates

4. U.S. Census Bureau. "QuickFacts: Wayne County, Michigan. 2017." *United States Census Bureau.* Accessed December 6, 2019. https://www.census.gov/quickfacts/fact/table/waynecountymichigan/PST045218

5. U.S. Census Bureau. "QuickFacts: Wayne County, Michigan. 2017." *United States Census Bureau.* Accessed December 6, 2019. https://www.census.gov/quickfacts/fact/table/waynecountymichigan/PST045218

EXHIBIT 3. HIV Prevalence Rates and New HIV Diagnoses per 100,000 residents, 2018



Source: MDHHS; Bureau of Disease Control, Prevention, and Epidemiology; Division of Communicable Disease HIV and STD Surveillance and Epidemiology Section—HIV Surveillance Office. July 1, 2019.

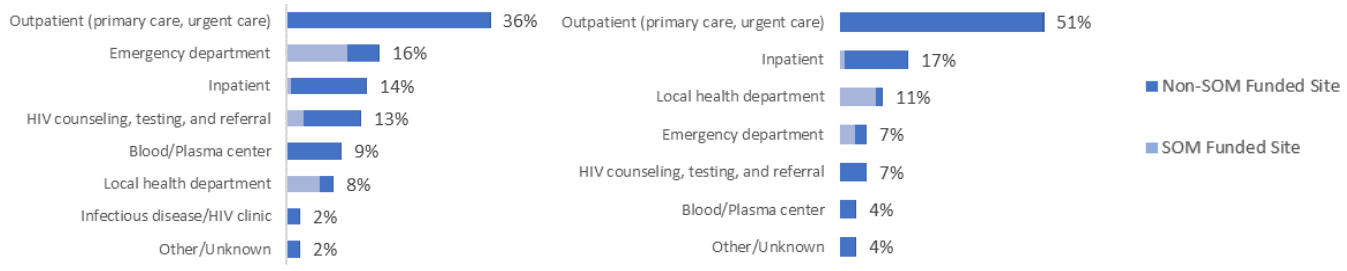
In Detroit, 4,589 residents were recorded as living with HIV in 2018. Of these, 67 percent were African American men, 62 percent were MSM, 22 percent were African American women, 19 percent were heterosexual women, 10 percent were PWID, 4 percent were MSM and PWID, and 1 percent were transgender people. In out-Wayne County, 1,983 residents were recorded as living with HIV in 2018. Of these people, 65 percent were MSM, 40 percent were African American men, 31 percent were white men, 19 percent were heterosexual women, 15 percent were African American women, 6 percent were PWID, and 4 percent were MSM and PWID.

Highland Park (surrounded by the city of Detroit) and Detroit had the highest 2018 diagnosis rates in Wayne County. Outside of Detroit and Highland Park, the cities of Livonia, Taylor, Westland, and Canton Township experienced the highest rates of new diagnosis.

In 2018, most new HIV diagnoses in Detroit and out-Wayne County were among 20–29-year-olds, African American residents, and MSM and heterosexual women. In Detroit, 72 percent of all new HIV diagnoses were among African American men, 69 percent were among MSM, 22 percent were among heterosexual women, and 17 percent of all new HIV diagnoses were among African American women. In out-Wayne County, 75 percent were among MSM, 49 percent were among African American men, 44 percent were among African American women, 28 percent were among white men, and 17 percent were among heterosexual women.

In 2018, 225 Detroit residents were diagnosed with HIV, with 21 percent of those new diagnoses being identified by state-funded agencies, primarily emergency departments (EDs). Simultaneously, 76 out-Wayne County residents were diagnosed with HIV, with only 15 percent of those new diagnoses being identified by state-funded agencies, primarily local health departments (LHDs) and EDs.

EXHIBIT 4. Facility of Diagnosis, Detroit and Out-Wayne County, 2018



225 Detroit residents were diagnosed with HIV in 2018 | 76 Out-Wayne residents were diagnosed with HIV in 2018

Source: MDHHS; Bureau of Disease Control, Prevention, and Epidemiology; Division of Communicable Disease HIV and STD Surveillance and Epidemiology Section—HIV Surveillance Office. July 1, 2019.

From 2009 to 2017, the proportion of new diagnoses that were late-stage diagnoses in Detroit and out-Wayne County have remained stable or are decreasing.[6] In Detroit, the proportion of late-stage diagnoses decreased from 32 percent in 2009 to 19 percent in 2017. In out-Wayne County, the proportion of late-stage diagnoses remained stable between 25 and 27 percent between 2009 and 2017.

Section Three: HIV and STI Co-diagnoses

Co-diagnosis with HIV is common among STI patients in Wayne County. In Wayne County, 39 percent of people who had been diagnosed with syphilis were co-diagnosed with HIV and 7 percent of people who had been diagnosed with gonorrhea were co-diagnosed with HIV.

People who have been diagnosed with syphilis have the highest rates of future HIV diagnosis among people diagnosed with STIs. Nearly 9 percent of patients in Wayne County who were diagnosed with syphilis were later diagnosed with HIV.

Of Wayne County residents newly diagnosed with HIV in 2018, 27 percent had at least one STI diagnosis between 2014 and their HIV diagnosis. This means that 27 percent of people newly diagnosed with HIV had some contact with a private or public health provider in the years leading up to their diagnosis. If those providers did not test these patients for HIV, and they were living with HIV at the time, there would have been a missed opportunity to test, diagnose, and refer these patients to care as early as possible.

In 2018, Wayne County experienced an outbreak of lymphogranuloma venereum (LGV). Of the 54 patients diagnosed with LGV, all identified as MSM, 49 lived in Detroit, and almost all (94 percent) were co-diagnosed with HIV.

Hepatitis C virus (HCV) and HIV co-diagnoses have remained relatively stable since 2010. Between 2010 and 2018, Wayne County accounted for between 8 percent and 17 percent of co-diagnosed HCV and HIV cases in Michigan. In Wayne County, there were 123 new HCV and HIV coinfections between 2010 and 2018. The majority were among women (68 percent), African Americans (51 percent), PWID (48 percent), and people ages 50 and older (56 percent).

As of December 2018, there were 46 PLWH in Wayne County who had ever been diagnosed with tuberculosis (TB). In 2018, there were 109 TB cases reported in Michigan. Of these, five people were co-diagnosed with HIV. Only one person resided in Wayne County. Co-diagnosed cases are predominantly among men (76 percent), African Americans (78 percent), MSM (39 percent), and people between the ages of 50 and 59 (46 percent).

Section Four: HIV Care and Viral Suppression

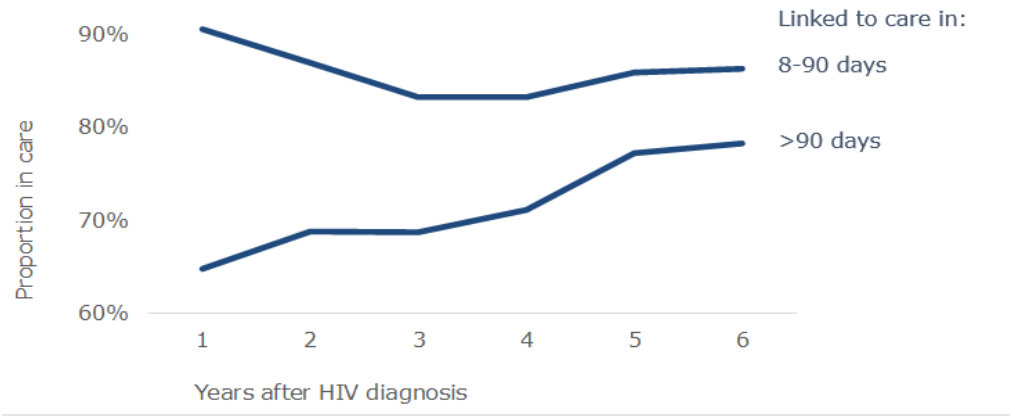
The proportion of people who had been newly diagnosed with HIV who were linked to care within 30 and 90 days increased in Detroit and out-Wayne County from 2009 to 2018. In Detroit, the 30-day linkage-to-

6. Diagnoses that progress to Stage 3 AIDS within 12 months

care rate increased from 35 percent to 44 percent between 2009 and 2018 and the 90-day linkage-to-care rate increased from 66 percent to 77 percent. In out-Wayne County, the 30-day linkage-to-care rate increased from 41 percent to 54 percent between 2009 and 2018 and the 90-day linkage-to-care rate increased from 67 percent to 84 percent.

People living in Wayne County who had been linked to care within eight to 90 days of their diagnoses were more likely to remain in care in the years following their diagnosis than those linked to care more than 90 days following their diagnosis (Exhibit 8).[7]

EXHIBIT 5. Linkage to Care Is Important for Future Care in Wayne County



Source: MDHHS; Bureau of Disease Control, Prevention, and Epidemiology; Division of Communicable Disease HIV and STD Surveillance and Epidemiology Section—HIV Surveillance Office. July 1, 2019.

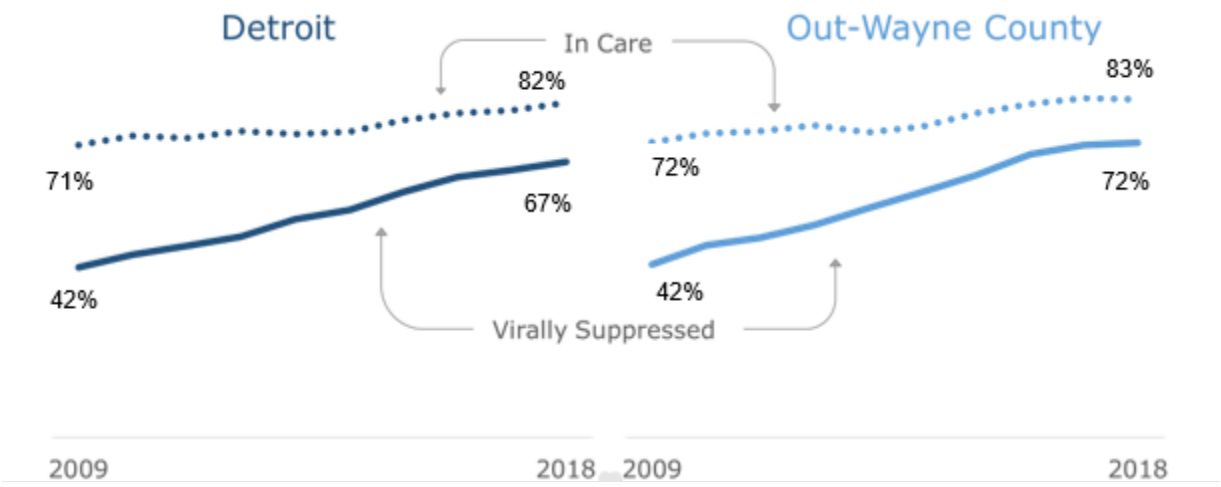
Between 2009 and 2018, the number of people who were considered in care and the number of people who were considered virally suppressed increased in Detroit and out-Wayne County.[8] The proportion of PLWH considered virally suppressed and the percentage of PLWH who have maintained undetectable viral loads were higher in out-Wayne County than in Detroit.[9] Additionally, viral suppression among persons in care was higher in out-Wayne County compared to Detroit.

7. At least one CD4 load and/or genotype test for monitoring white blood cell counts reported during the past year

8. Viral load less than 200c/ml

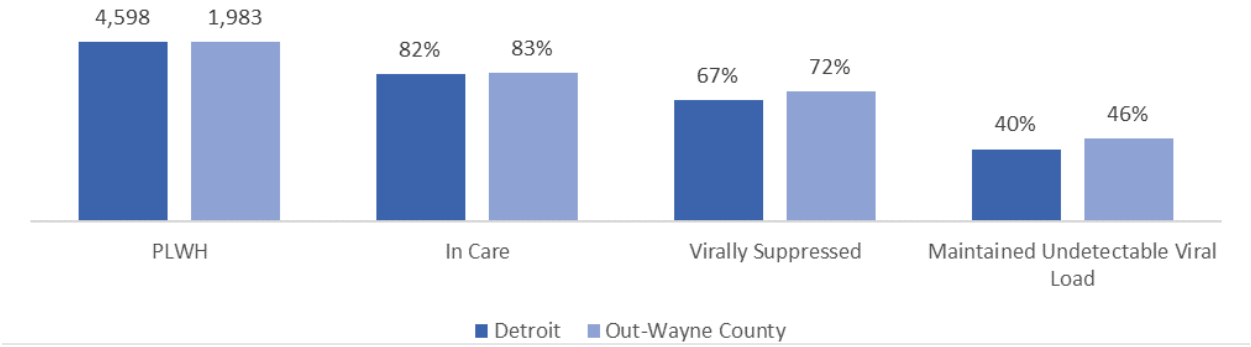
9. Viral load level less than or equal to 200 c/ml for at least four to eight months

EXHIBIT 6. Proportion of PLWH in Care and Virally Suppressed



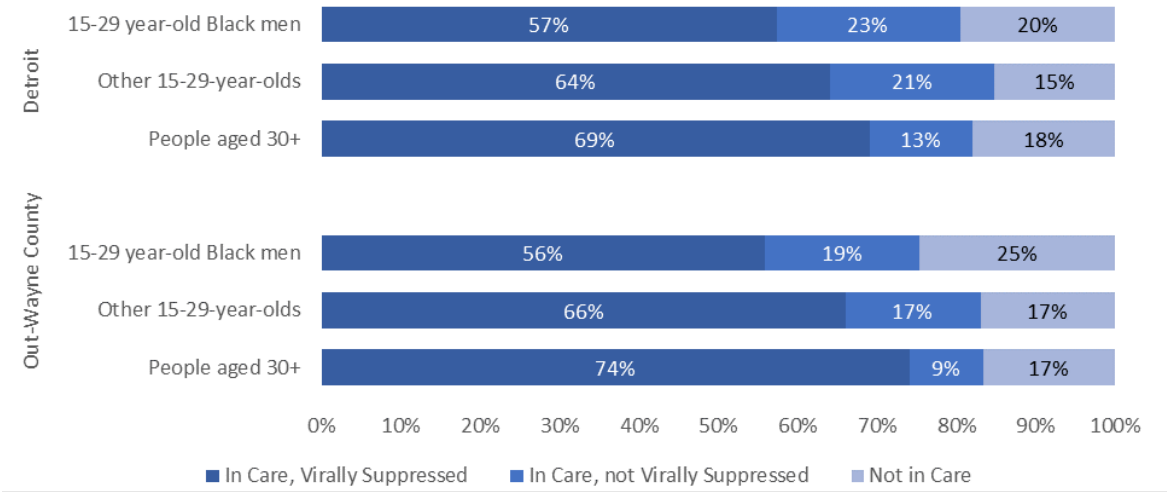
Source: MDHHS; Bureau of Disease Control, Prevention, and Epidemiology; Division of Communicable Disease HIV and STD Surveillance and Epidemiology Section—HIV Surveillance Office. July 1, 2019.

EXHIBIT 7. Proportion of PLWH in Care, Virally Suppressed, and Maintaining Undetectable Viral Loads



Source: MDHHS; Bureau of Disease Control, Prevention, and Epidemiology; Division of Communicable Disease HIV and STD Surveillance and Epidemiology Section—HIV Surveillance Office. July 1, 2019.

EXHIBIT 8. Care and Viral Suppression by Demographics



Source: MDHHS; Bureau of Disease Control, Prevention, and Epidemiology; Division of Communicable Disease HIV and STD Surveillance and Epidemiology Section—HIV Surveillance Office. July 1, 2019.

When compared to youth (ages 15 to 29) of other races and genders, Black and male Wayne County youth had lower viral suppression rates than their peers. Young Black men in Detroit had viral suppression rates of 57 percent, compared to 64 percent for youth of other races and genders. In out-Wayne County, young Black men had viral suppression rates of 56 percent, compared to 66 percent for youth of other races and genders. Youth in Detroit, particularly young Black men who received Ryan White services, had higher viral suppression rates than youth who did not receive Ryan White services.

Section Five: HIV Prevention

Since 2018, only 75 percent of those eligible were referred for PrEP and only 50 percent of those referred for PrEP were linked to PrEP resources (Exhibit 9). Partner services is one of the most effective ways to find undiagnosed people living with HIV or STIs and to link people without HIV to PrEP. Partner services find and interview persons who have been newly diagnosed; however, information regarding partner networks are practically nonexistent. Essentially, partner services are only finding one partner for every four index patients (Exhibit 10).

EXHIBIT 9. PrEP Cascade

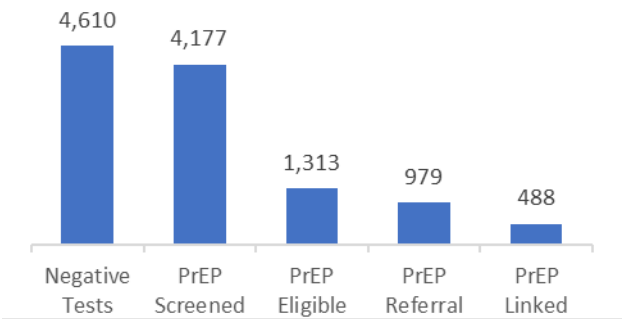
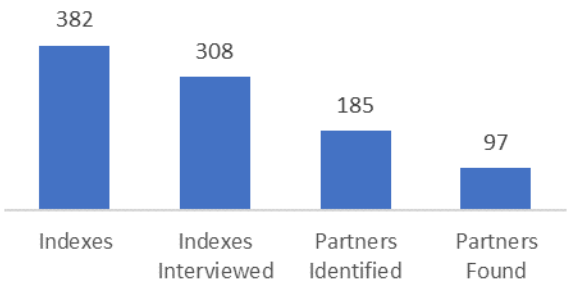


EXHIBIT 10. Partner Service Cascade

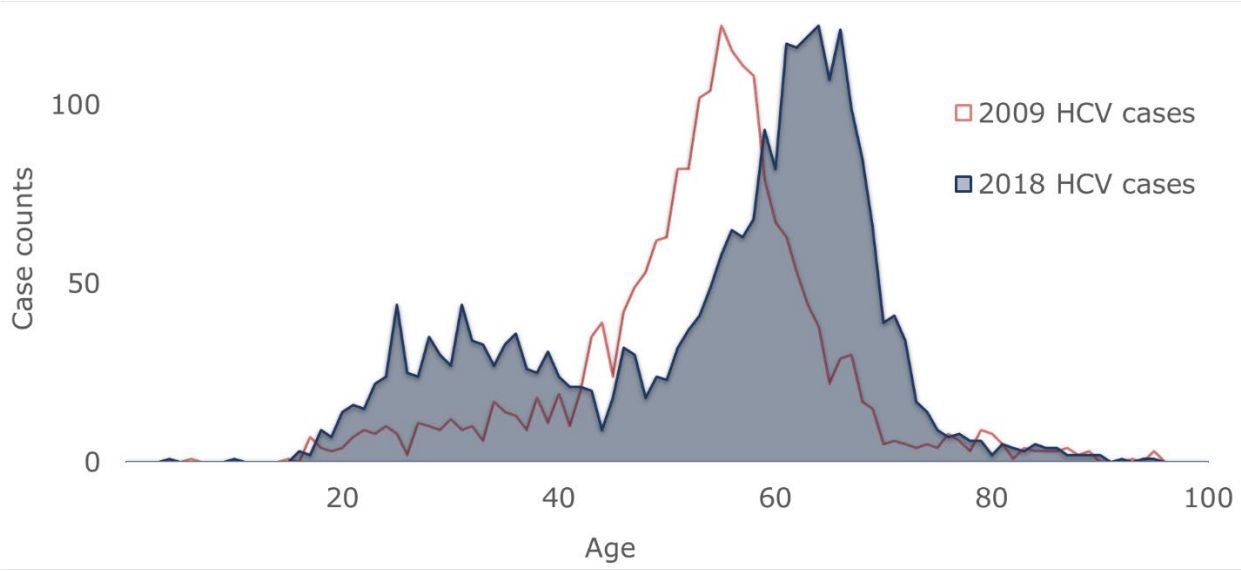


Source: MDHHS; Bureau of Disease Control, Prevention, and Epidemiology; Division of Communicable Disease HIV and STD Surveillance and Epidemiology Section—HIV Surveillance Office. July 1, 2019.

Section Six: HIV Response

MDHHS is paying special attention to HCV diagnoses among youth in Wayne County. Ten years ago, HCV was primarily found among those over 40. Today, a larger population of young people who inject drugs (ages 18–40) are being diagnosed with HCV.

EXHIBIT 11. HCV Diagnoses in Wayne County



Source: MDHHS; Bureau of Disease Control, Prevention, and Epidemiology; Division of Communicable Disease HIV and STD Surveillance and Epidemiology Section—HIV Surveillance Office. July 1, 2019.

MDHHS uses the Shared HIV Networks (SHiNe) in Wayne County to empower the community to partner with MDHHS and DHD to find previously undiagnosed persons, link persons back to care, and/or help eliminate barriers to achieving viral suppression. Of SHiNe members, 64 percent are younger than 29, 72 percent are African American, and 53 percent are MSM.

Situational Analysis and Needs Assessment

Below are strengths and challenges of the HIV prevention and care system as identified in working group member interviews, community focus groups, and provider forums.

Diagnose All People with HIV as Early as Possible

Community and provider focus group participants identified the most significant barriers and supports to getting tested for HIV and STIs and offered recommendations for how to encourage more people to get tested. These observations fell into several major categories—missed diagnoses, superficial relationships in the community, lack of confidentiality, and poor quality of care—which are described below.

Missed Diagnoses

According to participants, healthcare providers are overlooking opportunities to limit HIV transmission because they are not testing patients who present with multiple STIs over a period of time. To address this issue, participants encouraged conducting more targeted outreach to emergency departments by HIV-testing organizations. They also noted that providers do not have the same knowledge about prevention and care resources for patients they may diagnose. Lastly, participants stressed that the state could do more with prevention funding and lessen restrictions on how organizations incentivize key activities like testing.

Participants noted missed opportunities to connect with providers in the healthcare field (e.g., emergency room doctors, plasma centers, urgent cares, subspecialists in the healthcare system, and Planned Parenthood) to increase awareness about HIV, testing, and care. Providers indicated that many doctors do not fully understand the requirements of the law and, therefore, do not test for HIV for fear that they will improperly document required information. When doctors do perform testing, they are often unclear about next steps if a test is positive. Further, participants stated that providers in suburban areas resist performing tests because they do not know who needs them.

Participants also recognized that urgent care centers conduct a significant amount of testing and screening and, though their processes are improving, they still do not know how to connect patients to care once identified as high risk or HIV positive. Similarly, HIV service providers and private primary care practitioners do not know how to network with urgent cares.

Superficial Relationships in the Community

Lesbian, gay, bisexual, transgender, and queer or questioning (LGBTQ) focus group participants noted the importance of building relationships at parks and nightclubs frequented by MSM. Participants recommended building relationships at the parks before visiting the nightclubs and staffing both consistently with the same person or people. They also stressed that no one outside of the community (e.g., a straight white woman in a Black LGBTQ club) should provide resources.

Lack of Confidentiality

Confidentiality of diagnosis and care is a major concern among most demographics and is greatest among youth. Fear that their HIV status will be disclosed by others prevents high-risk community members from getting tested and seeking or continuing care. Returning citizens expressed poignant concerns about a lack of privacy during incarceration, sharing examples of how being outed in prison led to ostracization, isolation, or outright violence against PLWH. Such norms are so prevalent and traumatizing that numerous returning citizens said high-risk persons who are incarcerated or PLWH sought to avoid diagnosis during incarceration and actively avoided discussing or seeking antiretroviral (ARV) therapy after release. They noted how overt labeling (e.g., yellow sticky notes on someone's file with "HIV positive" written on it), consistent timing of ARV therapy distributions for PLWH, and conspicuous packaging of ARV therapy drugs in prisons contributed to this maltreatment.

Adult Black MSM emphasized the stigma associated with standing in a line outside of a location commonly associated with HIV testing, which may cause rumors in the community. They and providers stressed the need to hold testing in nontraditional settings.

According to some Hispanic focus group participants, sex and intimacy are not topics of conversation in more conservative Hispanic communities. Many said that simply getting tested for HIV is equated with promiscuity or homosexuality and that married couples often do not get tested because it is viewed as a lack of trust between spouses. Many in the community believe that if someone does not have several sexual partners, then they are not at risk. These participants also said Hispanic men rarely seek out medical care unless they are extremely sick, and Hispanic women only do so if they are pregnant or very ill. If HIV testing is local and free (e.g., a mobile health clinic), participants said this would increase the likelihood of people using this service.

Poor Quality of Care

All community members emphasized the private, intimate nature of sex and preferred providers who discussed their sexual behaviors in the context of their broader health and well-being. Transgender people of color noted that even office signage, e.g., "Infectious Disease Control," was intimidating and discouraged people from seeking testing. Adult MSM noted how doctors often made assumptions about sexual behaviors and resulting medical needs (e.g., automatically recommending throat swabs) or how awkwardly such conversations were broached, particularly by male physicians. They did not like feeling as if their sexual behavior and love life were simply a checklist.

According to participants, patients are very sensitive to the quality of care they receive from providers (e.g., feeling heard and respected regarding needs and medications, not feeling rushed, and feeling free to ask questions). They also wish to be treated like any other patient, which many PLWH noted has not been their experience.

Treat People with HIV Rapidly and Effectively to Reach Sustained Viral Suppression

A strength of the HIV care system in Wayne County is that providers have a goal of retaining PLWH in care services through wraparound service provision and care coordination, and linkage to care is effective due to passionate, competent providers, and improved standards for care. While many states are shifting to a medically based HIV prevention and care model, Michigan continues to maintain its nonmedically based model because of community organizations' success in providing adequate services. Providers effectively reach consumers living in Detroit and Medicaid expansion and the implementation of insurance navigation services have expanded access to prevention and care services within Wayne County.

Community and provider focus group participants were asked to identify the biggest barriers and supports to getting treated for HIV and STIs, as well as their recommendations for how to encourage more people to seek and maintain care. These observations fell into three categories: limited accessibility, lack of empathy, and distrust of undetectability.

Limited Accessibility

Providers and community members noted that limited access to care after traditional business hours prevents employed PLWH from receiving rapid and effective treatment. To ensure timely and effective treatment, they recommended DHD's Housing Assistance for People Living with AIDS program (HOPWA), rapid and affordable transportation, emergency financial services, and two- to three-week prescriptions for new HIV-positive mothers at discharge from the hospital. According to participants, case

management and Early Intervention Services (EIS) are time-limited following diagnosis, and they recommended extending the length of time these services are available.

Focus group participants noted dramatic improvement in Detroit's partner services over the past four to five years. They credited MDHHS for changing its process to focus on personal relationship building between EIS and partner notification.

Lack of Empathy

Most providers would like to "rapid start" patients on a care regimen but noted not all patients are socially or psychologically ready to accept their diagnosis and begin care. These providers said it is sometimes difficult to maintain contact with patients while getting them into therapy, educating them about transmission, and addressing social determinants of health all at once.

Fractured systems, like transportation and housing, can lead to a breakdown in care coordination for newly diagnosed patients and prevent consistent follow-up for those already in care. Numerous providers emphasized that housing stresses are a higher priority to PLWH than seeking or maintaining HIV treatment. In households with children, parents living with HIV place their children's immediate needs (e.g., purchasing food) before seeking or maintaining HIV treatment. Rather than see this as a barrier, some providers noted that working with patients to help them through these issues—rather than pushing them to enter care immediately—improved long-term trust and care maintenance once they did seek treatment. Providers also stressed that out-of-building referrals rarely worked due to both the stigma and logistical complexity associated with patient follow through to visit another location.

Many African American women focus group participants also noted experiences with not being taken seriously, being dismissed, or being stereotyped as "gold diggers" by white officials in positions of power (e.g., landlords, physicians, judges, and court clerks) for demanding access to HIV resources they feel they are equally entitled to but unable to obtain. This was particularly noticeable and detrimental when multiple factors coincided to exacerbate their situations (e.g., simultaneously beginning HIV treatment, falling behind on rent payments, getting evicted with young children, and having to respond to court or Child Protective Services demands).

Distrust of Undetectability

The message that a person with an undetectable HIV viral load cannot transmit HIV—promoted nationally through the undetectable equals untransmittable (U=U) campaign—has not reached all focus group participants. Even some people familiar with the campaign, including some PLWH whose viral loads are undetectable, distrust this concept. According to focus group participants, only 12 states have signed onto the U=U campaign, and elders in the African American community do not trust it. Even for those who do, they are not trained to know or interpret their viral load numbers or self-advocate to request these numbers from physicians. Some MSM who promote the U=U campaign—particularly those who lived through the 1980s AIDS epidemic—said they have assisted other MSM to achieve sustained viral suppression and undetectable status through long-standing support groups, but the groups' influence does not appear to extend to younger MSM or heterosexual PLWH.

Prevent New HIV Transmission by Using Proven Interventions, Including PrEP, PEP, and SSPs

Community and provider focus group participants were asked to discuss their familiarity with PrEP, PEP, and SSPs, identify the biggest barriers and supports in using HIV prevention services and options, and provide recommendations for how to encourage more people to use HIV prevention services and options. Observations about PrEP fell into six categories: (1) Ineffective PrEP advertising, (2) Inconsistent prescribing methods, (3) Harmful stereotypes, (4) Distrust of medicine, (5) Changing communal networks, and (6) Issues with affordability and payment. Observations about PEP and SSPs were limited by comparison, denoting a need for greater awareness. Following is a summary of each of these observations.

PrEP

Ineffective PrEP Advertising

Participants noted that commercial advertisements for Descovy and Truvada (the brand-name PrEP drugs) are widely recognized and frequently seen by heterosexual women of color, MSM, and providers. However, most heterosexual community members felt that, in the absence of marketing to their demographic specifically, PrEP advertising to the LGBTQ community normalized stereotypes that "HIV is a gay man's disease" and that PrEP was not for them. Within the LGBTQ community, many MSM agreed and felt that the advertisements are not affirming and, instead, perpetuate damaging stereotypes of gay men as "feminine, drag queens, or transgender." Transgender people of color echoed the need to broaden messaging and access to PrEP, arguing that not all transgender women identify as gay (nor do their male partners) and that they should not need to go to gay-coded organizations to receive PrEP care or HIV services, as is currently the norm.

Inconsistent Prescribing Methods

Participants highlighted a lack of clarity in the health provider community about who should receive PrEP as preventive care, noting that these decisions vary at the discretion of providers. Many providers are willing to provide PrEP to patients readily deemed high risk (e.g. MSM or PWID) but not to patients with fewer apparent risk factors (e.g. heterosexual African American women). The messaging does not frame PrEP as a universal preventive measure.

Harmful Stereotypes

All the Black MSM focus group participants stressed the importance of routine condom use, regardless of other forms of protection, specifically to prevent HIV exposure. Numerous Black MSM acknowledged taking PrEP but admitted feeling reluctant to make this known outside of the focus group session because of the perception among the broader LGBTQ community that people who take it are sexually promiscuous. They said people who take it are sometimes labeled as "PrEP whores."

One Black MSM noted that PrEP use was associated with higher incidence of other preventable STIs because people on this medication sometimes forgo other forms of protection, such as condoms, due to a false sense of security. Another MSM in a committed monogamous relationship said that he and his partner did not wear protection or take PrEP because they were not at risk, suggesting a need for targeted marketing to this demographic. Adult Black MSM and providers stressed the need to offer PrEP over the counter to reduce stigma.

Distrust of Medicine

Across provider and community sessions, African Americans noted significant cultural barriers to HIV prevention and treatment. One participant noted the pervasiveness of African Americans' distrust with police, social workers, and medical staff. This participant, as well as a provider in a separate session, associated this distrust of medical recommendations with the Tuskegee Study, which other participants broadly agreed with.[10]

This historical distrust is compounded by current media and personal experience. Most adult Black MSM focus group participants had seen advertisements for, and were highly aware of, a class action lawsuit surrounding Truvada and expressed related concerns about the risks of beginning or continuing PrEP. One white provider, who did not wish to share her concern openly during the focus group session, sought out the facilitator to say how detrimental these class action lawsuit advertisements had been to her patients' PrEP adherence.

Moreover, 15- to 17-year-old Black MSM said that taking PrEP caused them to get sick and shared concerns about continuing to take the medication. One, who is not taking PrEP, had contracted gonorrhea and had witnessed the effects of HIV firsthand through a relative's experience, but said that he and his peers felt fatalistic about contracting STIs (i.e., that little could be done to prevent contracting HIV anyway). All four participants visited their family practitioners, and none knew how or where to seek specialized services from other providers, if needed.

Changing Communal Networks

Strong multigenerational social networks within communities have traditionally played an important role in sex education and HIV prevention education. However, older African Americans noted that such networks have broken down in their neighborhoods and that youth are increasingly reliant on the media, peer networks, and sexual identity groups for this information. For example, these older African Americans said that, in the past, many youths learned about sex, STI prevention, and contraception from older siblings or family members. Now, MSM and youth typically learn about providers and prevention from close peers and social media and make care decisions based on that information.

Issues with Affordability and Payment

According to community members and providers, the cost of PrEP, copays, and travel to doctor visits are prohibitive for many people. Providers emphasized the detrimental role of insurance providers in overcomplicating or outright denying payment. They also stressed that lack or discontinuity of insurance, Michigan Medicaid's 30-day reauthorization requirement, and "donut holes" (coverage gaps) for medication were all barriers to continued PrEP use. One young adult noted that the cost for a 30-day supply of PrEP was prohibitive and included a $1,700 deductible on their personal insurance. According to this participant, because the U.S. does not have a generic version of the drug, peers are ordering 90-day supplies from other countries because it is cheaper and easier to access. One provider noted that people on HIV medications are routinely denied life insurance, including patients taking PrEP, not just those taking ARVs. For these reasons, providers noted that PrEP prescriptions are not prioritized in the same way as ARVs.

10. More information about this study, officially known as the Tuskegee Study of Untreated Syphilis in the Negro Male, is available here: https://www.cdc.gov/tuskegee/timeline.htm

PEP

Few, if any, MSM were aware of PEP. Very few providers have prescribed PEP, except for two who did so after patients sought it following high-risk exposures. Providers noted that the paperwork for PEP is difficult to complete, that some pharmacies may not have the medication, and that it is challenging to get the prescription filled. The University of Michigan pharmacy in Ann Arbor is the only location that consistently fills these prescriptions, although Henry Ford Hospital or the nearby children's hospital can as well. Some providers noted that patients are supposed to receive a five-day PEP starter pack following a sexual assault, but that this rarely happens. Because it is not reimbursable, they said, most emergency rooms do "almost nothing" in these instances, according to one participant. Even so, this response is better than PEP prescription rates for non-assault cases, which providers labeled inconsistent at best.

SSPs

Very few community members or service providers are aware of what SSPs are or how to access them. Those who were familiar referred to them colloquially as "sharps boxes/sharps box programs" or "needle exchanges." Some older African American Wayne County residents were aware of mobile SSPs in outdoor locations where people who are homeless congregated near schools to reduce the amount of discarded drug paraphernalia accessible to passing schoolchildren. General sentiment toward this mobile site was positive, and most focus group participants across all demographics were interested in the SSP information provided.

However, young adults (including PWID) stated that these programs have stigmas in certain communities, noting that some residents are upset with the focus on naloxone and SSPs when they have trouble obtaining insulin to manage their diabetes. According to one young adult, due to othering, generational differences in perspective, and differing politics, some see the programs as unfairly prioritizing "care for junkies instead of older people who need insulin." Some community members view it as a "zero-sum game comparing struggles" and feel that the only people who benefit from SSPs are those who access them directly.

Poor provider confidentiality was a major barrier for most high-risk groups in seeking testing or continuing treatment. PWID, in particular, felt doubly stigmatized because they did not want others to know they were using drugs.

Respond Quickly to Potential HIV Outbreaks to Get Needed Prevention and Treatment Services to People Who Need Them

MDHHS and DHD have positive working relationships with provider organizations, which are critical to a functioning care coordination system. Additionally, provider organizations maintain positive relationships with community members. Strong data collection systems exist, and data and information sharing across providers is occurring through interagency working groups and electronic medical records, strengthening care coordination.

Data collection for the transgender population is lacking. In addition, data sharing across care provider agencies needs improvement. Consumers should not need to repeatedly fill out income, health, and other information as they access new services; this data should be shared across their providers.

Cross-cutting Observations

While many community and provider focus group recommendations were specific to a particular demographic, geography, or phase of disease progression and treatment, many were broadly applicable across these categories. Such cross-cutting recommendations are listed below. Where a recommendation is tailored to a specific demographic, it is categorized accordingly.

Implement a Robust and Segmented Social Marketing Strategy with Tailored Messaging

Most community members are unaware of social marketing messages that encourage high-risk groups to get tested for HIV or those that normalize or destigmatize testing. Only providers mentioned being aware of such messages. An HIV public service announcement that aired during the Super Bowl was widely recognized among providers but was not mentioned by any community members.

Community members stressed that messages should be curated for target audiences. A singular message does not work well for all groups because there are subgroups within every demographic (e.g., masculine- vs. feminine-presenting MSM; heterosexual men and women; and different races, ethnicities, cultures, and economic statuses). Young MSM emphasized the geographic, social, and sexual diversity within the LGBTQ community and noted that any outreach or marketing efforts directed toward this population must account for its diversity. Distinguishing between subgroups has important implications for effective prevention messaging and limiting stigma regarding transmission.

Focus group participants stressed that commercials or public messaging should depict PLWH of all ages and should focus on limiting the stigma around who gets HIV and what it means to have and treat it through the lens of overall health, not just sexual health. Young MSM noted the importance of reaching young gay men with prevention and testing information within six to nine months of coming out, typically around age 16. Who delivers the message also matters to community members. They felt that the messenger should be someone whom the various groups of people respect, someone who reflects their community, and someone they can connect with (e.g., a Black woman, a person living with HIV of any age, a celebrity, a heterosexual person).

Heterosexual African American women expressed a strong desire for media that depicts HIV-positive heterosexual Black women and celebrities normalizing life with HIV and speaking in affirming, positive ways about prevention, testing, and treatment. Many women noted, at an interpersonal level, that their love lives after diagnosis were healthy; however, they expressed widely varying views about sharing their status. Some women who viewed themselves as advocates and educators shared their status to normalize it, particularly with youth. Others withheld this information, especially from sexual partners, because of many males' negative sexualized stereotypes of HIV-positive women.

Hispanic focus group participants highlighted various stigmas in the Hispanic community regarding HIV, as well as barriers to accessing HIV services. According to these participants, many have not visited a doctor in ten years for fear of being placed on an Immigration and Customs Enforcement list or being unable to afford a visit due to being uninsured. As a result, many members of this community are unaware of treatments or that PLWH lead healthy lives. Instead, focus group participants equated HIV with AIDS and assumed an HIV diagnosis was essentially a death sentence. Language barriers also limit the utility of written HIV materials, which are primarily available in English. Hispanic focus group participants stressed the need for basic Spanish-language materials about HIV, including prevention and

treatment, and emphasized that they would proactively share this information with the rest of their community.

Improve PLWH Representation in the Care System

All community groups stressed the need for better representation of PLWH at all levels of the care system, especially in clinical settings. Heterosexual women of color specifically noted the need to employ more HIV-positive Black women in these settings to help other women navigate systemic racism, Black cultural and religious mores, and the ubiquity of LGBTQ-focused resources, which they felt prevented heterosexual Black women from seeking or being able to access services. One young MSM lauded efforts to engage activists, such as himself, in HIV-reduction efforts among peers, but stressed the need for this type of work to be paid, otherwise it could become exploitative. Providers living with HIV validated this general desire to see PLWH in key leadership roles, stressing how their status had helped them better serve stigmatized community members in need of prevention, testing, or treatment services.

Lack of credentialing is a major barrier to community advocates' outreach, education, and peer-to-peer support and thus a major barrier to representation in the care system. PLWH are willing to seek training from, or operate under the supervision of, medical professionals with advanced degrees, but found it unreasonable that they are not permitted to teach or train others, particularly youth, because they do not have advanced degrees. Participants cited the need for added capacity in this area and emphasized that their expertise stems from their life experience with HIV. One heterosexual African American male participant stated that PLWH are easily tokenized in the African American community and must be compensated to work in the field, acknowledging the hardship their advocacy causes them. If compensated, this participant said he would educate his peers weekly at the local barbershop, but otherwise would not have these conversations.

Engage Key Social Institutions

Many community members emphasized the importance of targeting specific social institutions to improve prevention, testing, and treatment. The need to engage schools and African American churches was referenced repeatedly across sessions.

Heterosexual African American women focus group participants perceived HIV rates in Black churches to be high and spreading unchecked. Black MSM focus group participants viewed older relatives and church members as antagonistic and uninformed, noting that pastors and deacons perpetuate silence and stigmatize PLWH. Providers noted that they wanted to engage churches as partners in HIV prevention, detection, and treatment efforts for the past 30 years, but that this has not occurred.

According to focus group participants, stigma in the Black community about HIV-positive women being promiscuous or homosexual was a major theme preventing women from seeking or continuing treatment. It also prevented many of them from speaking privately or publicly about their status, including with their sexual partners. One older heterosexual African American woman, for example, described a time when the only HIV screening and information session available to her was intended specifically for gay MSM. Another older woman contracted HIV as a nurse from an HIV-positive patient's needle and was stigmatized by others for what they assumed to be sexual deviance. One HIV service provider, who is also a pastor, acknowledged this stigma, noting that conversations with church leadership can easily devolve from education, prevention, testing, or treatment into conversations about views of same-sex relationships, which perpetuates harmful stereotypes of HIV as solely a "gay man's disease."

Ending the HIV Epidemic in Wayne County Plan

Diagnose All People with HIV as Early as Possible

Proposed Strategies and Key Activities

- Implement mandatory, opt-out-only HIV testing in emergency rooms
    - Establish a working group with leadership from each health system serving Wayne County residents to expand adoption of opt-out-only routine HIV screening
    - Identify "champions" or key staff (e.g., physicians/nurses/intake staff) to lead activities to routinize HIV screening at intake and to lead all activities in healthcare settings needed to routinize identification of persons at ongoing risk for HIV and conduct at least annual HIV screening for this population
    - Modify the electronic medical records of at least two large health systems to routinize the offer of screening and screen all patients (at least once) for HIV regardless of risk (i.e., make testing a “hard stop” in the electronic medical record system so physicians have to perform HIV testing to complete a patient visit)
    - Standardize HIV tests for emergency room patients who are receiving a complete blood count—regardless of risk factors
- Implement universal HIV testing for those between 13 and 64 years old in settings other than the emergency room
    - Ensure that talking to all youth about HIV and testing those who present with other sexually transmitted infections for HIV are deemed routine standard of care for healthcare providers
    - Automate recurring HIV test orders for eligible patients at key healthcare encounters (e.g., annual physical exams)
    - Increase Wayne County HIV testing events in Ending the HIV Epidemic priority venues
    - Support urgent care centers in Detroit and out-Wayne County, as well as primary care providers in out-Wayne County, to conduct HIV testing and make care referrals
    - Partner with blood plasma donation centers to conduct outreach, awareness, and testing
    - Reinstate mobile HIV service units to provide incentivized testing and distribute condoms in high prevalence locations throughout Wayne County
    - Make all HIV testing appointments available online; offer discreet self-testing or at-home testing, online medicine purchases, and home delivery to ensure privacy and reduce stigma
- Promote routine opt-out HIV screening and linkage to care as part of medical intake and reentry evaluations at Wayne County correctional facilities
    - Identify best practices for protecting the health information of incarcerated people
    - Ensure adoption of stringent privacy standards for status determinations at these facilities

Treat People with HIV Rapidly and Effectively to Reach Sustained Viral Suppression

Proposed Strategies and Key Activities

- Ensure rapid linkage to HIV medical care and antiretroviral therapy (ART) initiation for all persons with newly diagnosed HIV
    - Partner, where feasible, to minimize redundant forms for different programs (e.g., Medicaid, the Housing Choice Voucher program, and the Food Assistance Program)
    - Allow pharmacy-based blood draws for HIV labs
- Offer wraparound services to address social determinants of health (e.g., housing, food, employment), mental healthcare, and physical healthcare (beyond sexual health) to make it less apparent that people are seeking HIV services, to destigmatize care, and to reduce the number of out-of-building referrals for care
    - Conduct a rapid needs assessment (e.g., housing, transportation etc.) for all persons with new HIV diagnoses and link to a disease intervention specialist and/or case manager as needed
    - Improve transportation options for Detroit and Wayne County residents
- Increase provider-to-patient and peer-to-peer support
    - Increase the number of follow-up contacts for PLWH to improve their perception of care and care providers
    - Implement a peer-to-peer or provider-to-patient support program reminding people to take their medication, including electronic-based approaches (e.g., text messaging, virtual case management)
    - Utilize support groups focused on empowerment, skill building, and peer normalizing for PLWH at all phases of diagnosis and treatment
    - Implement an incentive program where participants are provided a peer support group and person-to-person reminders to improve medication adherence; provide a gift card or other incentive to all participants who are undetectable for three months
    - Encourage doctors to offer joint appointments with partners in a relationship to encourage continued treatment and maintained undetectability
- Improve representation of PLWH in the care system to address the impacts of systemic racism
    - Create a talent pipeline for youth and others who wish to seek employment in HIV services, such as an HIV adolescent health services program
    - Expand and promote the paid train-the-trainer/speaker's bureau program that would compensate community advocates for sharing their knowledge with youth and other high-risk audiences
    - Increase women of color's representation in the HIV Care System as case managers, EIS workers, or disease intervention specialist (DIS) workers

Prevent New HIV Transmission by Using Proven Interventions, Including PrEP, PEP, and SSPs

Proposed Strategies and Key Activities

- Ensure that comprehensive sex education (including HIV prevention) is provided in schools beginning in the sixth grade
    - Establish a baseline and increase the number, frequency, and/or reach of high school educational presentations on HIV prevention, diagnosis, and treatment for children in grades six through 12
- Conduct targeted (i.e., city-specific, not generic) outreach and messaging about HIV prevalence, prevention, and care to providers and elected officials in Inkster, Ecorse, and River Rouge to encourage engagement
- Conduct a robust and segmented social marketing campaign with tailored messaging to normalize PrEP use and increase awareness of PEP
    - Create authoritative social media content posts in partnership with 25- to 35-year-old patients, equipping and encouraging them to amplify this social media content among their peer networks
    - Feature celebrities, local peer influencers, and women of faith in advertisements
    - Post educational information for any youth on social media and other apps, including Facebook, Instagram, Snapchat, YouTube, Spotify, Pandora, Google, Netflix, Hulu, TikTok, and Twitch
    - Feature educational information in beauty salons, barber shops, and on Black Entertainment Television
    - Feature HIV education on Detroit Public Television, particularly in the early morning, to reach children before they go to school, perhaps leveraging Comcast's block-off time for community members who wish to do local programming
- Reduce barriers to PrEP use
    - Institute a home visiting or telemedicine program for PrEP and PEP prescriptions, as many face barriers to visiting their doctor every three months
    - Implement assistance programs with insurance companies to reduce barriers to payment for prevention and treatment
    - Evaluate the effectiveness of Wayne County testing and adherence incentive programs and encourage consistent use of the most effective methods across HIV services providers
- Increase access to PEP by enforcing health system compliance with existing PEP prescription requirements
    - Notify health systems that noncompliance with PEP prescription requirements places their state and federal funding at risk
    - Ensure health systems consistently prescribe at least a five-day supply of PEP to eligible patients
- Increase availability, use, access to, and quality of comprehensive SSPs

  - Increase access to sterile needles and syringes for persons who inject drugs through nonprescription syringe sales in community pharmacies
  - Provide information at hospitals and churches on where to get clean needles
  - Promote and establish SSPs strategically distributed across multiple communities with the highest number of new HIV diagnoses attributed to injection drug use, highest number of new HCV diagnoses, and/or highest rates of drug overdose
  - Educate the community about the availability and evidence base for SSP services, utilizing evidence-based consumer materials and content

- Improve the quality of SSP service delivery as evident in documentation of quality management, evaluation findings, and surveillance data

- Partner with LGBTQ dating websites to add a filter indicating PrEP use for prospective sexual partners to encourage more people to seek and stay on PrEP to maintain their searchability on these platforms

Respond Quickly to Potential HIV Outbreaks to Get Needed Prevention and Treatment Services to People Who Need Them

Proposed Strategies and Key Activities

- Increase local health department and community engagement for cluster detection and response by establishing a cluster response (SHiNe) committee with community-based organizations and community members, which will meet monthly

- Improve the timeliness of data collection for reportable HIV laboratory tests and HIV surveillance data to support the real-time detection and investigation of HIV clusters

  - Review and update DIS and partner service contact tracing methods, including increased use of social media, for rapid contact tracing and partner notification

- Include cluster and outbreak response contract language in 100 percent of partner agencies within the Ending the HIV Epidemic jurisdiction to improve funding mechanisms to allow for the prompt response and containment of HIV clusters

- Publish standardized reports to improve integration across HIV, STI, and HCV data sources to visualize and respond to new and evolving HIV clusters within seven days

Acronyms and Definitions

AIDS	Acquired immunodeficiency syndrome
ARV	Antiretroviral
DHD	Detroit Health Department
DIS	Disease intervention specialist
ED	Emergency department
EIS	Early intervention services
FQHC	Federally qualified health centers
HCV	Hepatitis C virus
HIV	Human immunodeficiency virus
HOPWA	Housing Assistance for People Living with AIDS program
LGBTQ	Lesbian, gay, bisexual, transgender, and queer or questioning
LGV	Lymphogranuloma venereum
MDHHS	Michigan Department of Health and Human Services
MHAC	Michigan HIV and AIDS Council
MSM	Men who have sex with men
NOFO	Notice of funding opportunity
PEP	Postexposure prophylaxis
PLWH	People living with HIV
PrEP	Pre-exposure prophylaxis (also known by brand names Descovy and Truvada)
PWID	Persons who inject drugs
SEMHAC	Southeastern Michigan HIV and AIDS Council
SHiNe	Shared HIV Network
SSP	Syringe services program
STI	Sexually transmitted infection
U=U	Undetectable equals untransmittable

Appendix B: MDHHS HIV/STI Integrated Plan Community Member Discussion Guide

MDHHS HIV/STI Integrated Plan Community Member Discussion Guide

Introduction [15 Minutes]

Hi, and thank you for being here today.

We are _____ (name and pronouns) and _____ (name and pronouns), from Public Sector Consultants, a research, policy, and project management firm based in Lansing. I'll be leading today's discussion and _____ (name) will be taking notes.

The Michigan Department of Health and Human Services, or MDHHS, has asked us to help them develop a five-year plan for preventing, diagnosing, and treating HIV and sexually transmitted infections (STIs) in Michigan. We want to learn what you think is working and what needs improvement in three areas:

1. Diagnosing all persons with HIV as early as possible
2. Treating HIV rapidly and effectively to achieve sustained viral suppression
3. Preventing new HIV transmissions by using proven interventions, including pre-exposure prophylaxis (PrEP), postexposure prophylaxis (PEP), and syringe service programs (SSPs)

Your candid feedback is extremely important to us, so please share your honest thoughts, ideas, and opinions. We are not the State of Michigan or the local health department, but an objective third-party. With your permission, your feedback will be used to develop a comprehensive plan for improving HIV and STI prevention and care services in Michigan.

Your participation is completely voluntary and the things you share with us today will remain anonymous. We will not record any information that identifies you or anyone you mention specifically. If you have questions during the discussion, please let us know. The session should take about two hours. Please feel free to get up, move around, or use the bathroom at any point during the discussion.

Before we begin, do you have any questions for us?

If you are still interested in participating, please sign the consent form/type "I consent" in the chat box in response to the statement on the screen.

Again, thanks so much for your participation.

Warm-up [Five Minutes]

OK, we'll begin with introductions. Please introduce yourself and then invite another person to do the same. We will go around the room. Please tell us your name, your personal pronouns, and what encouraged you to participate in the session today!

Next, we would like to set a few group agreements for our discussion today so that everyone in the room can feel comfortable in sharing their thoughts and ideas. We have listed some but encourage anyone in the group to add to this list. The agreements are:

- Be present
- Be respectful
- Step up, step back (so please share, but once you've stepped up, please step back and make space for others to speak up)
- Use both/and thinking (meaning please be open to all stories, ideas, and suggestions being presented and be willing to share other and new stories, ideas, and suggestions.)
- Honor confidentiality

Session Questions [80 Minutes]

Next, we'd like to really start diving into your thoughts and ideas.

1. **General Health, Sexual Health, and Supportive Needs [Ten Minutes]**
    a. Is there a place you normally go for services to help you stay healthy?
        i. If yes:
            1. Where do you normally go for health services?
            2. How often do you go?
            3. What types of services do you get to help you stay healthy?
            4. What services were you looking for or did you need that were not available?
        ii. If no:
            1. Why not?
            2. Was there a place where you went for services to help you stay healthy in the past, but you stopped going?
                a. If yes, where did you go and why did you stop going?
    b. When you need health services, how do you find a provider?
        i. What makes you decide to choose one provider over another?

c. How comfortable are you discussing your sexual health (with medical providers, friends, family, acquaintances, sexual partners)? What could providers do differently to make their patients more comfortable discussing sexual health?

2. Objective One: Diagnosing All Persons with HIV as Early as Possible [20 Minutes]

a. If someone wanted to get tested for HIV, do you think they would know where to go? How could they find out if they didn't already know where to go?

b. If you know someone who's been tested for HIV, what do you think helped them decide to get tested?

i. How easy was it for them?

ii. What do you think is the biggest factor in helping people decide to get tested?

c. What do you think prevents people from getting tested for HIV?

i. What do you think is the biggest barrier for getting an HIV test?

d. What do you think is needed to encourage more people to get tested for HIV and STIs?

i. How might home specimen collection for HIV testing help? [This would involve collecting the specimen and sending it to the lab for testing.]

3. Objective Two: Treating HIV Rapidly and Effectively to Achieve Sustained Viral Suppression [20 Minutes]

a. What has encouraged people you know to seek out and continue treatment for HIV?

i. What do you think is the biggest factor in people seeking out and continuing treatment for HIV?

ii. To what degree does the distance to a provider affect people's willingness to seek or access treatment?

iii. Would you or others you know consider using telehealth for treatment (i.e., meeting with providers virtually)?

b. What has prevented people you know from getting or continuing treatment for HIV?

i. What do you think is the biggest barrier to people seeking out treatment for HIV?

ii. What effect, if any, has the coronavirus (COVID-19) pandemic had on accessing treatment for HIV?

c. What do you think is needed to ensure those with HIV continue receiving treatment?

4. Objective Three: Preventing New HIV Transmissions by Using Proven Interventions, including pre-exposure prophylaxis (PrEP), postexposure prophylaxis (PeP), and syringe services programs (SSPs) [20 minutes]

HIV prevention services include:

- PrEP— also known as Pre-Exposure Prophylaxis, is a once-a-day pill, that helps prevent a person from contracting HIV even before they are exposed to it. It includes medications such as Truvada and Descovy
- PeP—also known as a postexposure prophylaxis, is a prescribed medication that is taken for 4 weeks following a potential HIV exposure.
- SSPs—or syringe services programs, also called syringe exchange or needle exchange programs. SSPs are community programs that provide access to sterile needles and syringes and allow for the safe disposal of used syringes and needles. SSPs may also connect individuals to additional services and supports like HIV, STI, and substance use treatment and testing programs.

    a. How familiar are you with these or other HIV prevention services?

        i. What have you heard about HIV prevention services, such as PrEP, PeP and SSPs?

        ii. Do you think they are effective in preventing HIV? Why or why not?

        iii. What other HIV prevention services/strategies are you familiar with?

        iv. Do you think those are effective in preventing HIV? Why or why not?

        v. Where have you received education or seen educational messages about prevention services or strategies?

    b. What has encouraged people you know to use PrEP, PeP, SSPs, or other prevention services/strategies you mentioned?

        i. What do you think is the biggest factor in someone deciding to seek out and use PrEP, PeP, SSPs, or other prevention services?

    c. What do you think prevents people from seeking out or using PrEP, PeP, SSPs, or other prevention services?

        i. What do you think is the biggest barrier to people accessing these prevention services?

    d. What do you think is needed to ensure people at risk of HIV are accessing prevention services, such as PrEP and SSPs?

Closing [Five Minutes]

Is there anything that we didn't ask that we should have asked?

Is there anything else that you would like to share?

Do you have any questions for me?

Appendix C: MDHHS HIV/STI Integrated Plan Provider Discussion Guide

MDHHS HIV/STI Integrated Plan Provider Discussion Guide

Introduction [Ten Minutes]

Hi, and thank you for being here today.

We are _____ (name and pronouns) and _____ (name and pronouns), from Public Sector Consultants, a research, policy, and project management firm based in Lansing. I'll be leading today's discussion and _____ (name) will be taking notes.

The Michigan Department of Health and Human Services (MDHHS) has asked us to help them develop a five-year plan for implementing effective and innovative strategies to reduce HIV and sexually transmitted infections (STIs) in Michigan.

We are talking to representatives from HIV care and prevention, behavioral and clinical healthcare providers, and social service organizations to learn what you think are the greatest strengths, challenges, and opportunities of the current system. We are focused on four areas:

1. Diagnosing all persons with HIV as early as possible
2. Treating the infection rapidly and effectively to achieve sustained viral suppression
3. Preventing new HIV transmissions by using proven interventions, including pre-exposure prophylaxis (PrEP), postexposure prophylaxis (PEP), and syringe service programs (SSPs)
4. Responding quickly to potential HIV outbreaks to get people prevention and treatment services

Your candid feedback is extremely important to us, so please share your honest thoughts, ideas, and opinions. Your participation is voluntary, and the things you share with us today will remain anonymous. We will not record any information that identifies you, your organization, or anyone you mention specifically. If you have questions during the discussion, please let us know. The session should take about two hours. Please feel free to get up, move around, or use the bathroom at any point during the discussion.

Before we begin, do you have any questions for us?

Warm-up [Five Minutes]

OK, first we would like it if you would introduce yourself to us. Please go around the room and tell us your name, your personal pronouns, what organization (or organizations) you represent, and what encouraged you to participate in the session today.

Next, we would just like to set a few group agreements for our discussion today, so that everyone in this room can feel comfortable in sharing their thoughts and ideas. We have listed some and encourage anyone in the group to add to that list. The agreements are:

- Be present
- Be respectful
- Step up, step back (Speak up, but then step back and give space for others to speak.)
- Use both/and thinking (Be open to hearing and sharing new stories, ideas, and suggestions even if someone has a different experience or idea.)
- Honor confidentiality

Session Questions [100 Minutes]

Next, we'd like to really start diving into your thoughts and ideas around how to achieve each of the four objectives mentioned earlier [listed on slide]. Based on your experiences, what's preventing achievement of these objectives? What should be done to achieve them in the future? Let's start with objective one.

1. **Objective One: Diagnosing All Persons with HIV as Early as Possible [25 Minutes]**
    a. What do you think has been helpful in getting people diagnosed with HIV or STIs as early as possible in this region?
        i. Of those you listed, which would you say have been most helpful?
    b. In your experience, what prevents HIV and STI diagnoses from happening as early as possible? What are the challenges or barriers to early diagnosis?
        ii. Of those you listed, which would you say have been the biggest barriers?
    c. Based on what you have described, what are ways we can ensure people are being diagnosed with HIV and STIs as early as possible in this region?
        iii. Of those you listed, which do you think are most promising? (Circle those mentioned.)
    d. How can partnerships be improved across organizations serving or connected with people with HIV (PWH) or who may be at risk of HIV to ensure people are being diagnosed with HIV as early as possible?
    e. What does MDHHS do now that is helpful in supporting your work related to timely identification, testing, and diagnosing of those with HIV and/or STIs?
    f. How can MDHHS better support providers in the timely identification, testing, and diagnosis of those with HIV and/or STIs?
2. **Objective Two: Treating HIV Rapidly and Effectively to Achieve Sustained Viral Suppression [25 Minutes]**

g. In your experience, what has helped with rapidly and effectively treating HIV? What's working well in the care system?

   iv. Of those you listed, which would you say have been most helpful?

h. In your experience, what prevents people from receiving rapid and effective treatment of HIV? What are the challenges and barriers to receiving treatment? What's not working as well as it could in the care system?

   v. Of those you listed, which would you say are the biggest barriers?

i. Based on what you have described, what are ways we can ensure people are receiving rapid and effective treatment of HIV in Michigan?

   vi. Are there innovative ideas to improve early intervention services and address barriers to linkage to care after diagnosis that are within Ryan White standards and scope?

j. How can organizational partnerships be improved to ensure rapid and effective treatment of HIV in Michigan?

k. What does MDHHS do now that is helpful in supporting your work related to providing and continuing treatment for those with HIV?

l. How can MDHHS better support providers in providing and continuing treatment of those with HIV?

3. Objective Three: Preventing New HIV and STI Transmissions by Using Proven Interventions [25 Minutes]

m. In your experience, what has helped people with accessing or using interventions that are available, such as barriers like condoms and dental dams, partner services, PrEP, PEP, and SSPs?

   vii. In your experience using partner services, what has helped with identifying and finding partners of PWH?

   viii. If you have helped someone with accessing or using prevention interventions, what made them decide to use them?

   ix. Of those you listed, which would you say have been most helpful?

n. In your experience, what barriers have prevented people from accessing or using interventions that are available, such as partner services, PrEP, PEP, and SSPs?

   x. In your experience using partner services, what has been most challenging with identifying and finding partners of PWH?

   xi. Of those you listed, which would you say are the biggest barriers?

o. Based on what you have described, what are ways we can ensure transmission of HIV and STIs are being prevented in Michigan?

   xii. What would an ideal partner services system look like and why?

xiii. How would these ideas improve outcomes for people at risk of or living with HIV?

p. How can partnerships be improved across organizations serving or connected with PWH or people with STIs or who may be at risk of HIV or STIs to help people with accessing or using available interventions?

q. What does MDHHS do now that is helpful in supporting your work related to HIV and STI prevention?

r. How can MDHHS better support providers in their HIV and STI prevention activities?

4. Objective Four: Responding Quickly to Potential HIV Outbreaks to Get People Prevention and Treatment Services [25 Minutes]

According to the CDC, HIV clusters or outbreaks refer to groups of people that are experiencing rapid HIV transmission.

s. What helps the system respond quickly to potential HIV outbreaks? What's working well?

xiv. Of those mentioned, which would you say have been most helpful?

t. What do you think prevents the system from responding quickly to potential HIV outbreaks? What are the challenges or barriers to a quick response?

i. Of those mentioned, which would you say are the biggest barriers?

u. Based on what you have described, what are ways the system can be improved to ensure a rapid response to potential HIV outbreaks? (Consider improvements in coordination with Hepatitis C response efforts, SHINe networks, and others.)

i. Of those mentioned, which do you think are most promising?

v. How can partnerships and/or information sharing be improved across organizations serving or connected with PWH or who may be at risk of HIV to help the system respond quickly to potential HIV outbreaks?

Closing [Five Minutes]

Is there anything that we didn't ask that we should have asked?

Is there anything else that you would like to share?

Do you have any questions for me?

Appendix D: CY 2022–2026 CDC DHAP and HRSA HAB Integrated Prevention and Care Plan Guidance Checklist

CY 2022 – 2026 CDC DHP and HRSA HAB Integrated Prevention and Care Plan Guidance Checklist

Requirement:	New Material and/or Existing Material Used to Meet Requirement:	Document Title/File Name of Existing Material Attached to Meet Requirement	Page Number(s) Where Requirement is Addressed in Existing Material	Notes (If Applicable)
Section I: Executive Summary of Integrated Plan and SCSN				
1. Executive Summary of Integrated Plan and SCSN	New Material	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
a. Approach	New Material	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
b. Documents Submitted to Meet Requirements	New Material	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
Section II: Community Engagement and Planning Process				
1. Jurisdiction Planning Process	New Material	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
a. Entities Involved in Process	New Material	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
b. Role of the RWHAP Part A Planning Council/Planning Body (not required for state only plans)	New Material	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
c. Role of Planning	New Material	Click or tap here to	Click or tap here to	Click or tap here to

Requirement:	New Material and/or Existing Material Used to Meet Requirement:	Document Title/File Name of Existing Material Attached to Meet Requirement	Page Number(s) Where Requirement is Addressed in Existing Material	Notes (If Applicable)
Bodies and Other Entities		enter text.	enter text.	enter text.
d. Collaboration with RWHAP Parts – SCSN Requirement	New Material	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
e. Engagement of People with HIV – SCSN Requirement	New Material	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
f. Priorities	New Material	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
g. Updates to Other Strategic Plans Used to Meet Requirements	New Material	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
Section III: Contributing Data Sets and Assessments				
1. Data Sharing and Use	New Material	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
2. Epidemiologic Snapshot	New Material	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
3. HIV Prevention Care and Treatment Resource Inventory	New Material	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
a. Strengths and Gaps	New Material	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
b. Approaches and	New Material	Click or tap here to	Click or tap here to	Click or tap here to

Requirement:	New Material and/or Existing Material Used to Meet Requirement:	Document Title/File Name of Existing Material Attached to Meet Requirement	Page Number(s) Where Requirement is Addressed in Existing Material	Notes (If Applicable)
Partnerships		enter text.	enter text.	enter text.
4. Needs Assessment	New Material	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
a. Priorities	New Material	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
b. Actions Taken	New Material	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
c. Approach	New Material	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
Section IV: Situational Analysis				
1. Situational Analysis	New Material	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
a. Priority Populations	New Material	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
Section V: 2022-2026 Goals and Objectives				
Goals and Objectives Description	New Material	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
a. Updates to Other Strategic Plans used to Meet Requirements	New Material	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.

Requirement:	New Material and/or Existing Material Used to Meet Requirement:	Document Title/File Name of Existing Material Attached to Meet Requirement	Page Number(s) Where Requirement is Addressed in Existing Material	Notes (If Applicable)
Section VI: 2022-2026 Integrated Planning Implementation, Monitoring and Jurisdictional Follow Up				
1. 2022-2026 Integrated Planning Implementation Approach	New Material	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
a. Implementation	New Material	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
b. Monitoring	New Material	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
c. Evaluation	New Material	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
d. Improvement	New Material	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
e. Reporting and Dissemination	New Material	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
f. Updates to Other Strategic Plans Used to Meet Requirements	New Material	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
Section VII: Letters of Concurrence				

Requirement:	New Material and/or Existing Material Used to Meet Requirement:	Document Title/File Name of Existing Material Attached to Meet Requirement	Page Number(s) Where Requirement is Addressed in Existing Material	Notes (If Applicable)
1. CDC Prevention Program Planning Body Chair(s) or Representative(s)	New Material	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
2. RWHAP Part A Planning Council/Planning Body(s) Chair(s) or Representative(s)	New Material	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
3. RWHAP Part B Planning Body Chair or Representative	New Material	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
4. Integrated Planning Body	New Material	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.
5. EHE Planning Body	New Material	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.