

2022–2026 Integrated HIV Prevention and Care Plan and Coordinated Statement of Need

**Final Report of the Michigan Department of Health and Human
Services**

December 8, 2022

Acknowledgements

The Michigan Department of Health and Human Services (MDHHS) would like to thank the following partners for their efforts and commitment to developing the Integrated HIV Prevention and Care Plan and Coordinated Statement of Need.

- The Michigan HIV AIDS Council (MHAC), Michigan's HIV Care and Prevention combined planning body, 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
- Public Sector Consultants for facilitating the planning process and preparing the final plan

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Section One: Executive Summary

Overview

The Michigan Department of Health and Human Services (MDHHS) utilized a multi-pronged approach to develop a new Integrated Plan submission for 2022. This submission built off the extensive planning process conducted to develop the Ending the HIV Epidemic (EHE) plan in Wayne County plan, which is integrated into this submission to reflect needs and opportunities in Southeast Michigan (Appendix A). This submission extends beyond Southeast Michigan to feature new state-level epidemiologic analysis and expanded community and stakeholder engagement activities for Michigan's remaining (non-Metro Detroit) counties statewide. The resulting 2022–2026 HIV Care and Prevention and STI Integrated Plan consists of seven sections, each of which are described in further detail below:

- Section One: Executive Summary
- Section Two: Community Engagement and Planning Process
- Section Three: Contributing Data Sets and Assessments
- Section Four: Situational Analysis
- Section Five: 2022–2026 Goals and Objectives
- Section Six: 2022–2026 Integrated Planning Implementation, Monitoring and Jurisdictional Follow Up
- Section Seven: Letters of Concurrence

Approach

To administer and support this statewide planning process, MDHHS engaged Public Sector Consultants (PSC), the same objective, nonpartisan third-party research and consulting firm that coordinated the earlier Wayne County plan. MDHHS also assembled a planning body consisting of unit leadership from across the MDHHS Bureau of HIV and STI Programs (BHSP). MDHHS staff leads met with PSC biweekly and the full planning body and PSC met monthly to coordinate and monitor the planning process, which included both extensive engagement with providers and people with HIV (PWH) statewide (Section Two) and extensive epidemiologic research and analysis of state surveillance, programming, and financial data (Section Three). Finally, MDHHS leadership and PSC coordinated with the Michigan HIV/AIDS Council (MHAC) and Southeast Michigan HIV/AIDS Council (SEMHAC) to ensure transparency and alignment between and across the Planning Body and partner organizations. PSC conducted interviews with MHAC membership, and both MDHHS and PSC presented progress to, and solicited input from, MHAC members on a quarterly basis during MHAC's standing meetings.

Lastly, PSC compiled and distributed a cumulative summary of plan research and provider and community member input (Section Four) to the planning body and facilitated a formal strategic planning process based on these findings. PSC led the planning body members through a situational assessment (SWOT analysis) and consensus-building strategy development process to identify actionable objectives for each pillar of the Integrated Plan (Prevention, Detection, Treatment, and Response) (Section Five). PSC and MDHHS refined the resulting strategic objectives for clarity and actionability and MDHHS Staff added further detail about internal operations, implementation, and monitoring to the document (Section Six). Lastly, the entire plan was thoroughly vetted and approved by MDHHS and MHAC leadership (Section Seven).

The MDHHS Bureau of HIV/STI Programs encompasses HIV prevention, HIV care and STIs, but not viral hepatitis. However, in the spirit of syndemic approaches, the epidemiologic snapshot does include some hepatitis findings.

Key Findings

HIV prevalence and risk are highest among Black men who have sex with men (MSM) living in and around metropolitan and micropolitan centers statewide. Detroit, Michigan's largest city, is also home to the highest number, and largest percentage, of people with HIV (PWH) statewide, as reflected in this document and the earlier EHE in Wayne County strategic plan. Across all races, more PWH are in care than are virally suppressed and more people are virally suppressed than undetectable. However, Black PWH also have the lowest percentage of people who are in care, virally suppressed, and maintained undetectable among all races statewide.

Primary contributors to HIV transmission statewide unprotected sex with multiple partners, intravenous drug use, and limited awareness of or access to harm-reduction services (such as condoms or needle exchange programs) and Pre- or Postexposure Prophylaxis (PrEP and PEP). Providers and community members said stigma and limited availability of HIV testing combine to limit HIV detection, although they provided numerous recommendations for how to improve testing rates. Social determinants of health (SDoH) – predominantly limited access to affordable housing, food, transportation, and mental healthcare – each undermine linkage-to-care and continuation in treatment statewide. Lastly, few areas of the state have experienced rapid HIV transmission (aka “emerging networks”) or expressed particular concern about their ability to respond.

Funding for prevention efforts is the least sufficient and flexible relative to the need in specific regions and across the state. While goals and objectives put forth in this plan span the care continuum, many attempt to focus existing resources on geographies and demographics at highest risk, and leverage resources to bolster prevention among these populations wherever possible.

Documents Submitted to Meet Requirements

The following have been submitted to meet the requirements of the IP:

- An epidemiologic snapshot of HIV and STI diagnosis, treatment, prevention, and response in Michigan (Section Three)
- An inventory of financial resources dedicated to HIV treatment and prevention in Michigan (Section Three)
- A needs assessment based on conversations with provider and community members across the state (Section Three)
- A situational analysis based on the above plan elements (Section 4)
- A plan including goals and objectives for each of the four pillars (diagnosis, treatment, prevention, and response) (Section 5)
- A plan for implementation, monitoring, and jurisdictional follow up for the IP (Section 6)
- Letters of concurrence from MHAC for the 2020–2025 Ending the HIV Epidemic in Wayne County Strategic Plan and for the 2022–2026 Integrated HIV Prevention and Care Plan and Coordinated Statement of Need (Section 7)
- The 2020–2025 Ending the HIV Epidemic in Wayne County Strategic Plan (Appendix A)

Section Two: Community Engagement and Planning 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 the Integrated HIV Prevention and Care Plan (Integrated Plan) and Coordinated Statement of Need. 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 working group of MDHHS HIV and STI Division staff to advise on the development of the plan and the community engagement process and facilitation of community input sessions and interviews and provider discussion groups. In addition, the goals and objectives in the Integrated Plan incorporate data gathered for the *Ending the HIV Epidemic in Wayne County 2020–2025 Strategic Plan* (EHE Strategic Plan), which can be found in Appendix A.

MDHHS engaged Public Sector Consultants (PSC), a public policy research and consulting firm based in Lansing, Michigan, to facilitate the planning process. PSC staff facilitated the working group meetings, as well as the community and provider input sessions and interviews described below.

Jurisdictional Planning Process

Working Groups and Planning Bodies

EHE Strategic Plan

For the EHE planning process, the working group comprised 17 individuals representing a diverse range of backgrounds, including members from SEMHAC and MHAC, community members, providers, HIV outpatient ambulatory health service clinicians, community-based agency representatives, and city and county government officials. The working group met a total of four times over the course of the initiative.

Integrated Prevention and Care Plan

MDHHS established a working group to assist in developing the Integrated Plan. This group comprised 12 individuals representing different units in the MDHHS Bureau of HIV and STI Programs, some of whom are MHAC members.

The working group advised the planning team on the planning process; reviewed data and information presented in the epidemiologic 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 eight times over the course of the initiative.

MDHHS presented the planning process to the Michigan HIV/AIDS Council (MHAC), the primary planning body for the state, to answer questions and further refine the planning process. PSC also conducted interviews with nine randomly selected MHAC members at the beginning of the planning process to learn about the current strengths, challenges, and opportunities facing Michigan's HIV/STI care and prevention systems from their perspectives. Additionally, MDHHS and PSC provided plan updates to MHAC at their monthly council meetings.

Community Input

EHE Strategic Plan

For the EHE Strategic Plan in Wayne County, 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. 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 each participant received a \$50 gift card as compensation for their travel and time. In cases where transportation

assistance was needed for participants, DHD helped coordinate transportation to the session using Uber.

EXHIBIT 1. EHE Strategic Plan Community Input Sessions (2020)

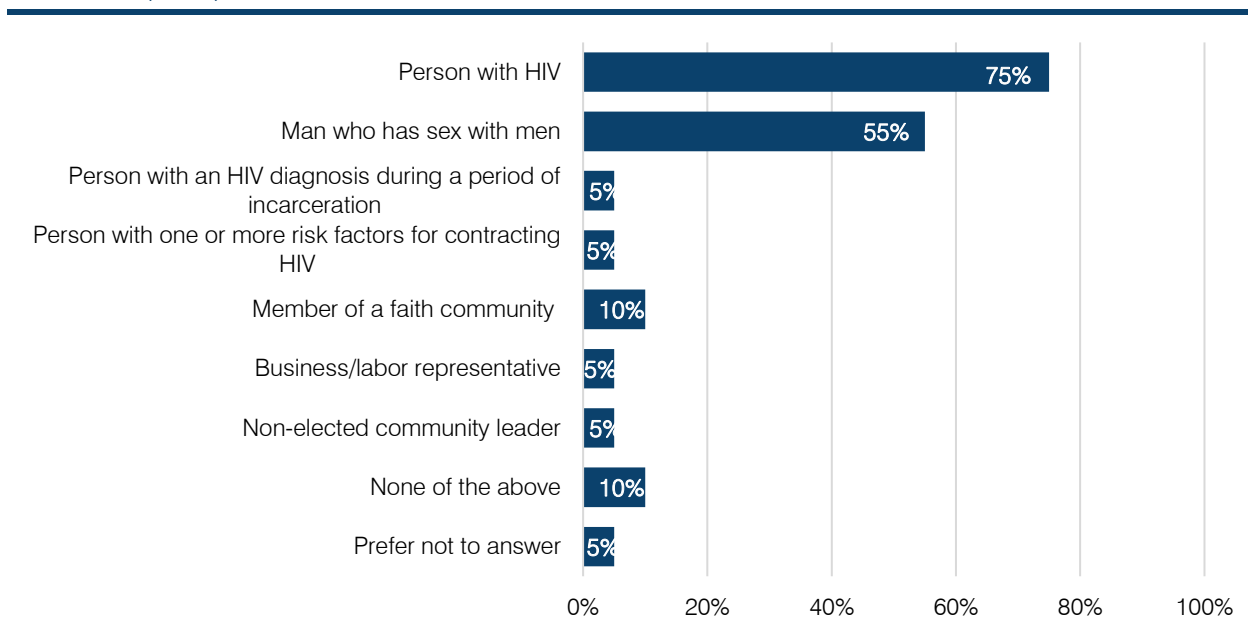
Community Input Session	Date	Location
African American Detroit Residents	February 22	Unified HIV Health and Beyond Detroit Office Detroit, MI
African American out-Wayne County residents	March 4	Wayne County Health Department Wayne, MI
Latinx, Chicanx, and/or Hispanic residents	February 21	Brilliant Detroit 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

Integrated Prevention and Care Plan

To ensure the plan reflects the priorities and needs of people living with or at risk of contracting HIV or STIs in Michigan, PSC conducted virtual or telephone interviews with 18 community members across the state. Additionally, one virtual community discussion group was held with men who have sex with men. These discussions were used to identify ways in which community members experience barriers to accessing HIV and STI diagnosis, prevention, and treatment services and ways in which community members could be better served by the state’s HIV and STI systems. Each participant received a \$50 gift card as compensation for their time.

Community members participating in an interview or discussion group were asked to complete an anonymous survey to help MDHHS understand the demographic makeup of the people who were engaged. Three-quarters of community members responding to the survey said they are a person with HIV and over half are a man who has sex with men (Exhibit 2). One participant is a person with an HIV diagnosis during a period of incarceration (within the last three years) at a federal, state, or local correctional facility, and one is a person with one or more risk factors for contracting HIV. Additionally, two are members of a faith community, one is a business/labor representative, and one is a non-elected community leader.

EXHIBIT 2. Demographics of Community Members Interviewed for the Integrated Prevention and Care Plan (2022)

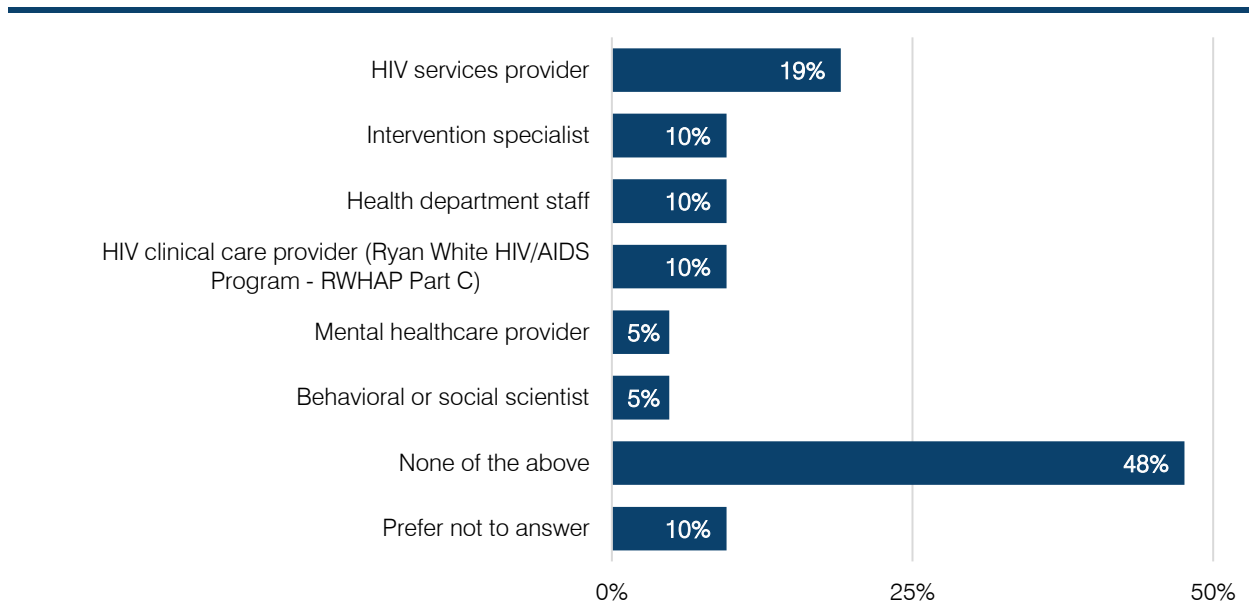


N = 21

Note: Percentages total more than 100 because participants could select more than one response.

While almost half of community members did not work as a provider or health department staff, 19 percent of community members who provided input are also HIV services providers, and 10 percent are either intervention specialists, health department staff, or HIV clinical care providers (Exhibit 3). Similarly, nearly half of community members did not represent any healthcare or human services entity or program, while 19 percent did represent community-based organizations serving populations affected by HIV, and 14 percent represented community healthcare centers or healthcare planning agencies (Exhibit 4).

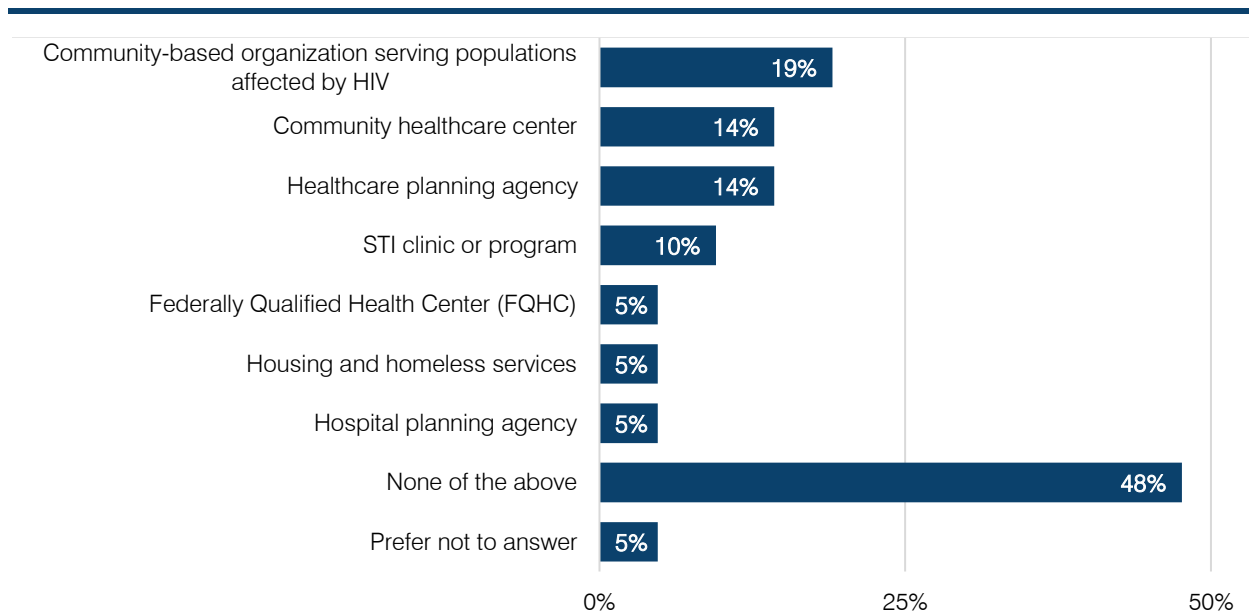
EXHIBIT 3. Community Members Interviewed for the Integrated Prevention and Care Plan who Also Provide HIV-related Services (2022)



N = 21

Note: Percentages total more than 100 because participants could select more than one response.

EXHIBIT 4. Community Members Interviewed for the Integrated Prevention and Care Plan who Work for a Community-based Organization (2022)

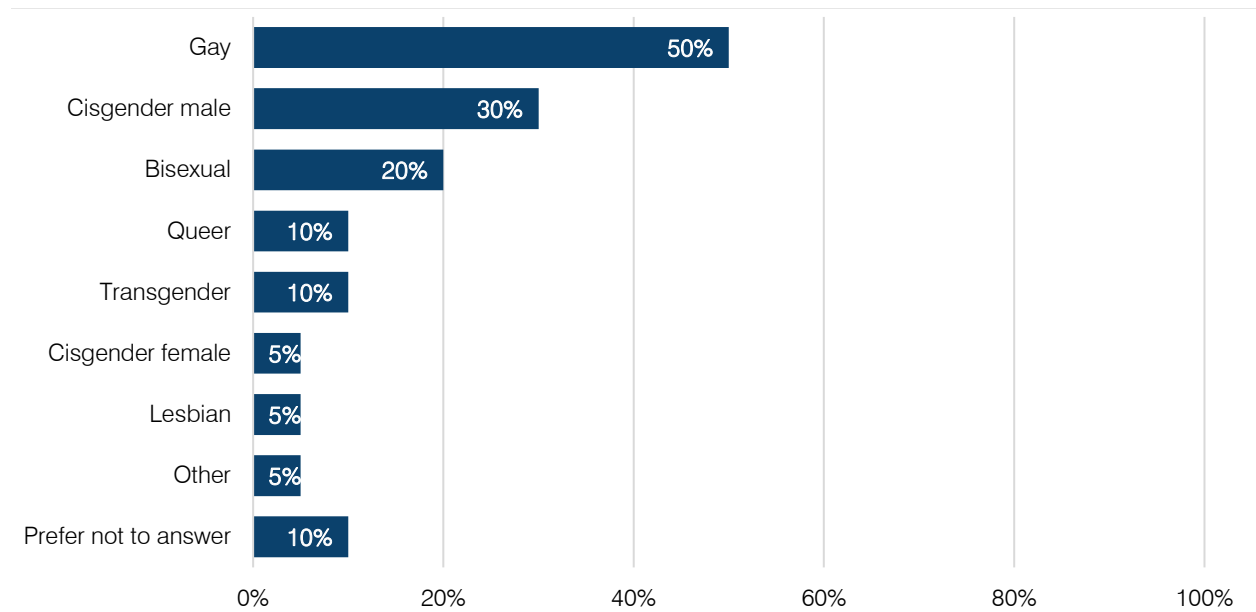


N = 21

Note: Percentages total more than 100 because participants could select more than one response.

Half of the community members engaged in the process identify as gay, 30 percent identify as cisgender male, and 20 percent identify as bisexual (Exhibit 5). Nearly half of the community members participating in an interview or discussion group identified as a person of color (Exhibit 6). Most community members were at least 30 years old, with 43 percent being 30–54 years and 33 percent being 55 years or older (Exhibit 7).

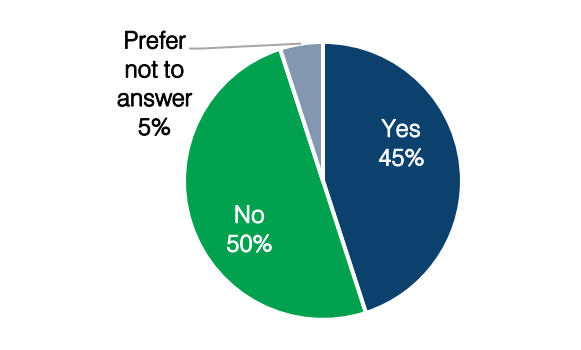
EXHIBIT 5. Gender Identify of Community Members Interviewed for the Integrated Prevention and Care Plan (2022)



N = 20

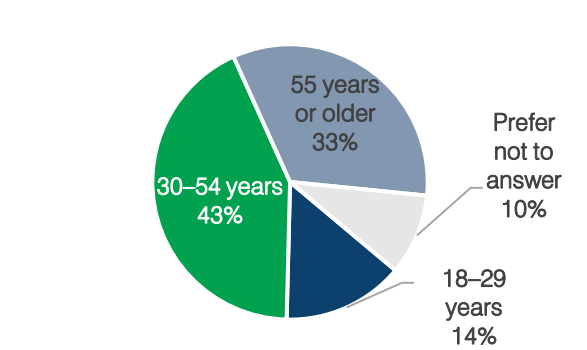
Note: Percentages total more than 100 because participants could select more than one response.

EXHIBIT 6. Percentage of Integrated Prevention and Care Plan Community Member Interviewees Who Are People of Color (2022)



N = 20

EXHIBIT 7. Community Members Interviewed for the Integrated Prevention and Care Plan by Age (2022)



N = 21

Provider Input

EHE Strategic Plan

During the EHE strategic planning process, 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, representatives of organizations addressing social determinants of health (e.g., transportation, housing, food security, and behavioral health), representatives of non-healthcare related youth-service organizations, school sex education providers, and law enforcement agency representatives.

In addition to focusing on the systemic strengths, challenges, and opportunities related to getting needed prevention and treatment services to people who need, them these forums were also used to identify opportunities for new partnerships across the different organizations to support HIV prevention and care in the county.

Integrated Prevention and Care Plan

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 diagnosis, prevention, and treatment may not be their primary purpose. PSC conducted six virtual discussion groups with providers across the state. Providers were placed in a discussion group based on which region of the state they serve. A total of 55 providers participated in a regional discussion group. In addition to the regionally based discussions, PSC conducted two sessions with tribal health directors and providers, and one with randomly selected MDHHS Bureau of HIV and STI Programs unit staff (Exhibit 8).

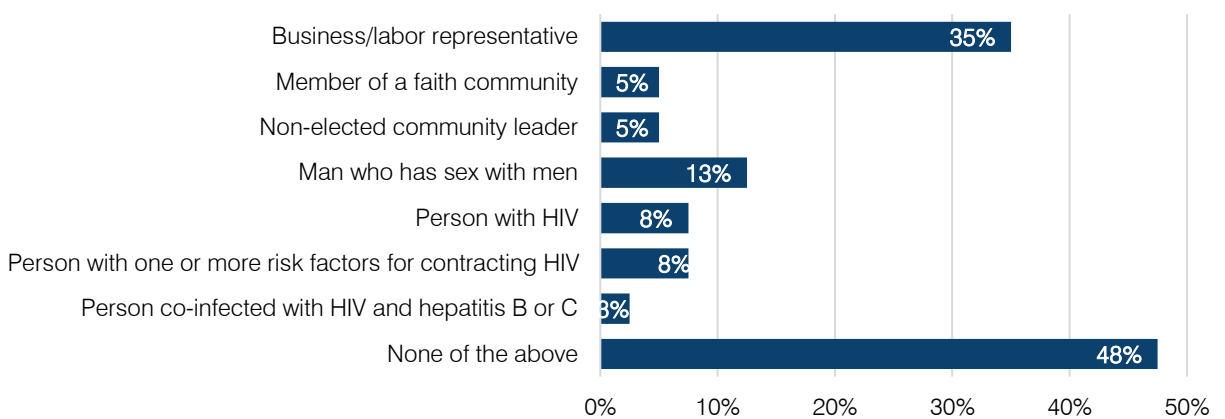
EXHIBIT 8. Integrated Plan Provider Discussion Groups (2022)

Region or Organization Representation	Date	Number of Participants
Northern Michigan and the Upper Peninsula	March 15	5
East Michigan	March 15	7
Mid-Michigan	March 16	12
West Michigan	March 17	15
Southwest Michigan	March 17	11
Southeast Michigan (excluding Wayne County)	March 18	5
Tribal Health Directors	July 14	10
MDHHS Bureau of HIV and STI Programs	August 11	8
Tribal Health Center Providers	October 5	7

The forums focused on the systemic strengths, challenges, and opportunities associated with diagnosing all people with HIV as early as possible, treating people rapidly and effectively to achieve sustained viral suppression, preventing HIV by using proven interventions, including PrEP and SSPs, and responding quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them (refer to Appendix C for the Provider Discussion Guide).

Providers who participated in a regional discussion group were asked to complete the same anonymous survey as community member participants. Forty of the 55 participants responded. Of these, 35 percent are business/labor representatives and 5 percent are members of the faith community or non-elected community leaders (Exhibit 9). Additionally, 13 percent are men who have sex with men and 8 percent are people with HIV or people with one or more risk factors for contracting HIV.

EXHIBIT 9. Demographics of Providers Engaged in the Integrated Prevention and Care Plan (2022)

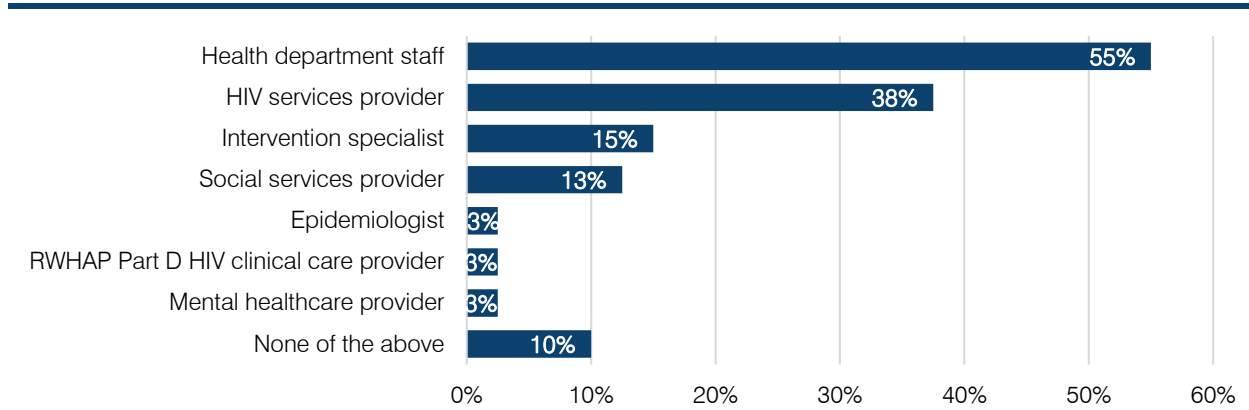


N = 40

Note: Percentages total more than 100 because participants could select more than one response.

More than half of the providers participating in the regional discussion groups are health department staff, and 38 percent are HIV services providers (Exhibit 10). Additionally, 15 percent are intervention specialists and 13 percent are social services providers. Furthermore, over half represent an STI clinic or program, and 43 percent represent a community-based organization serving populations affected by HIV (Exhibit 11).

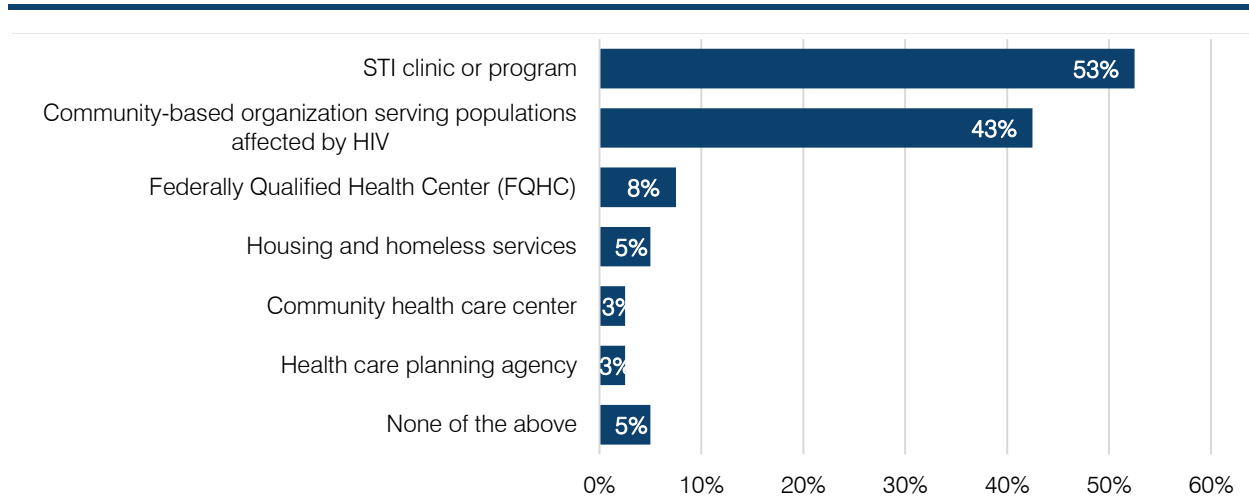
EXHIBIT 10. Providers Engaged in the Integrated Prevention and Care Plan by Provider Type (2022)



N = 40

Note: Percentages total more than 100 because participants could select more than one response.

EXHIBIT 11. Providers Engaged in the Integrated Prevention and Care Plan by Organization Type (2022)

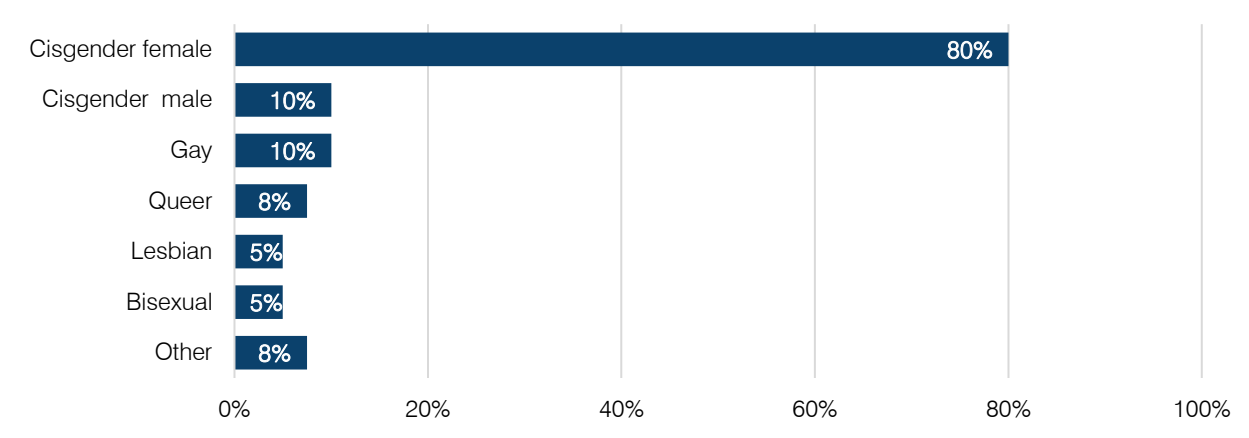


N = 40

Note: Percentages total more than 100 because participants could select more than one response.

Most of the providers participating in discussion groups are cisgender females, not people of color, and are between 30 and 54 years old (Exhibits 12, 13, and 14).

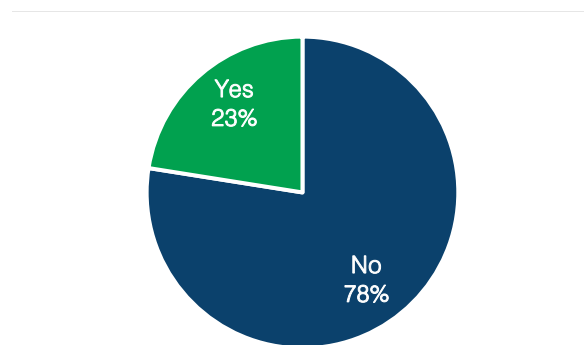
EXHIBIT 12. Gender Identity Providers Engaged in the Integrated Prevention and Care Plan (2022)



N = 40

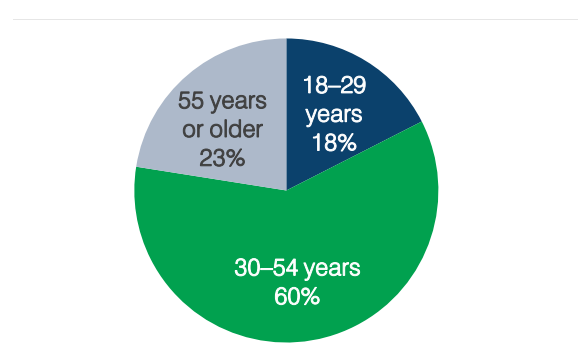
Note: Percentages total more than 100 because participants could select more than one response.

EXHIBIT 13. Percentage of Providers Engaged in the Integrated Prevention and Care Plan Who Are People of Color (2022)



N = 40

EXHIBIT 14. Providers Engaged in the Integrated Prevention and Care Plan by Age (2022)



N = 40

Priorities

The key priorities that arose out of the planning and community engagement process are below.

Cross-cutting challenges

- Transportation challenges
- Stigma
- Not enough Community and Provider Outreach and Education

Pillar One: Diagnosing All Persons with HIV as Early as Possible

- Lack of Knowledge about Testing Resources
- Lack of Testing Resources
- Limits on Services that Can Be Offered in Schools
- Limited Mobile Testing
- At-home HIV Tests

Pillar Two: Treating HIV Rapidly and Effectively to Achieve Sustained Viral Suppression

- Other Needs (e.g., housing, mental health, transportation) Interfering with HIV Treatment
- Difficulty with Linkage to Care

Pillar Three: Preventing New HIV Transmissions Using Proven Interventions

- Limited Insurance Coverage Hinders PrEP Access and Education
- Limited PrEP Education
- Limited PEP Access and Education

Pillar Four: Respond Quickly to Potential HIV Outbreaks

- Lack of timely data from tools like SHiNE
- Limited technological infrastructure in some regions
- Siloed data modernization Section Three: Contributing Data Sets and Assessment

Section Three: Contributing Data Sets and Assessment

Data Sharing and Use

General reports for HIV and STI's are updated annual and published on the MDHHS website (www.michigan.gov/hivsti). These include HIV and STI trends, HIV prevalence and care, and STI diagnoses. The topics are displayed in tables broken down by demographic and geographic areas of interest, and a slide set is produced highlighting the most important findings from each report. The annual report tables were used to create the epidemiologic profile of the Integrated Plan. In addition to these publicly disseminated reports, BHSP has access to various other databases through DSA's with the following MDHHS divisions to assist with program planning: Vital Statistics, Medicaid, Communicable Disease, and Immunizations.

Vital Statistics: provides BHSP with timely birth and death data to monitor HIV pediatric exposures, monitor testing among HIV pediatric exposures, monitor missed opportunities for HIV testing during pregnancy, update vital status in eHARS for accurate care and mortality statistics

Medicaid: monitors HIV testing, diagnosis, and viral suppression rates among Medicaid beneficiaries

Communicable disease: monitors coinfection rates for integrated service planning (i.e., tuberculosis, COVID, MPV), exchange HIV/HCV transmission network data, exchange HIV/HCV data for SSP planning

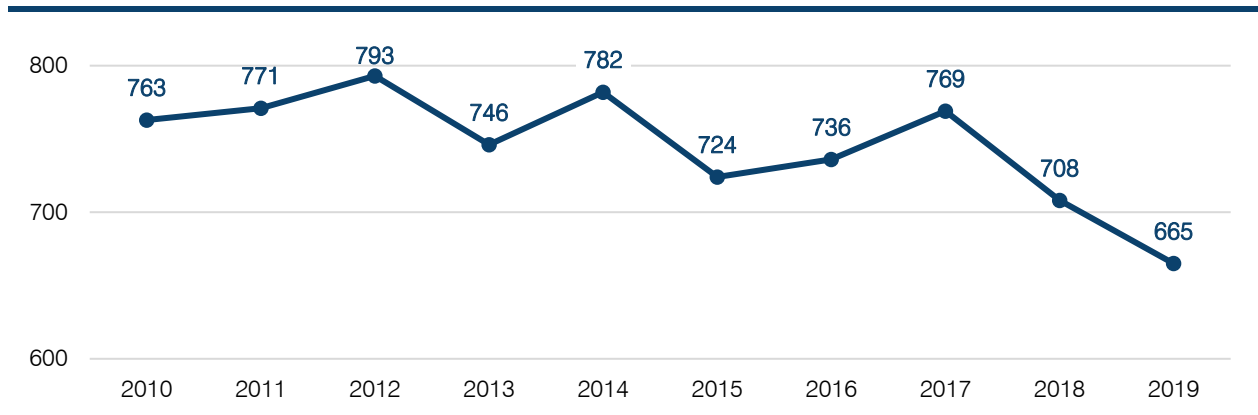
Immunizations: monitor vaccination uptake for PLWH for integrated service planning (i.e., monkeypox and COVID vaccinations)

Epidemiologic Snapshot

People with HIV and New HIV Diagnoses

As of December 31, 2019, there were 16,967 people with HIV (PWH) in Michigan, which translates to a prevalence rate of 169.9 per 100,000 residents. There were 665 newly diagnosed HIV cases (a prevalence rate of 6.7) in 2019, which is a decrease in new cases over the ten years prior (Exhibit 15).

EXHIBIT 15. Number of New HIV Diagnosis over Time

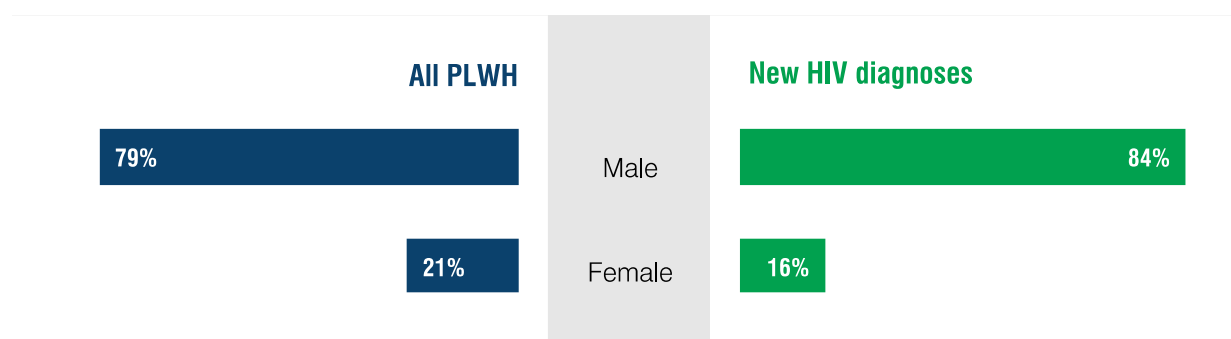


Source: MDHHS, HIV Trend Tables, 2020

Prevalence by Demographic

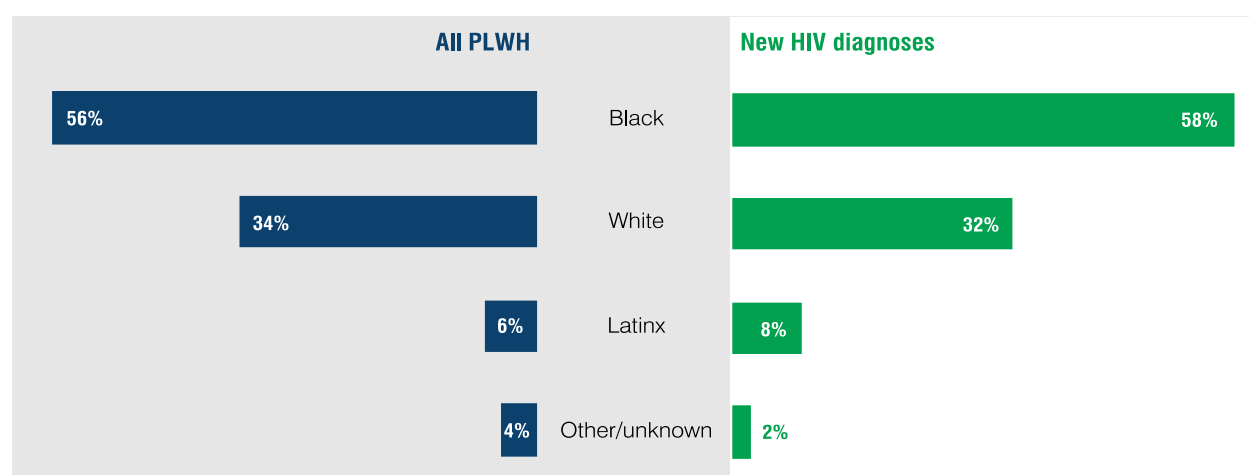
In 2019, 79 percent of PWH in Michigan were male (Exhibit 16) and more than half (56 percent) were Black (Exhibit 17). In comparison, slightly less than half of the state's population is male and only 14 percent is Black. Conversely, while 78 percent of Michigan's entire population is white, only one-third (34 percent) of PWH were white. Males made up 84 percent of those newly diagnosed in 2019 and 58 percent of people with a new HIV diagnosis were Black.

EXHIBIT 16. HIV Prevalence by Sex, 2019



N = 16,967 (all PWH); 665 (newly diagnosed)
Source: MDHHS, HIV Prevalence State Tables, 2020

EXHIBIT 17. HIV Prevalence by Race/Ethnicity, 2019

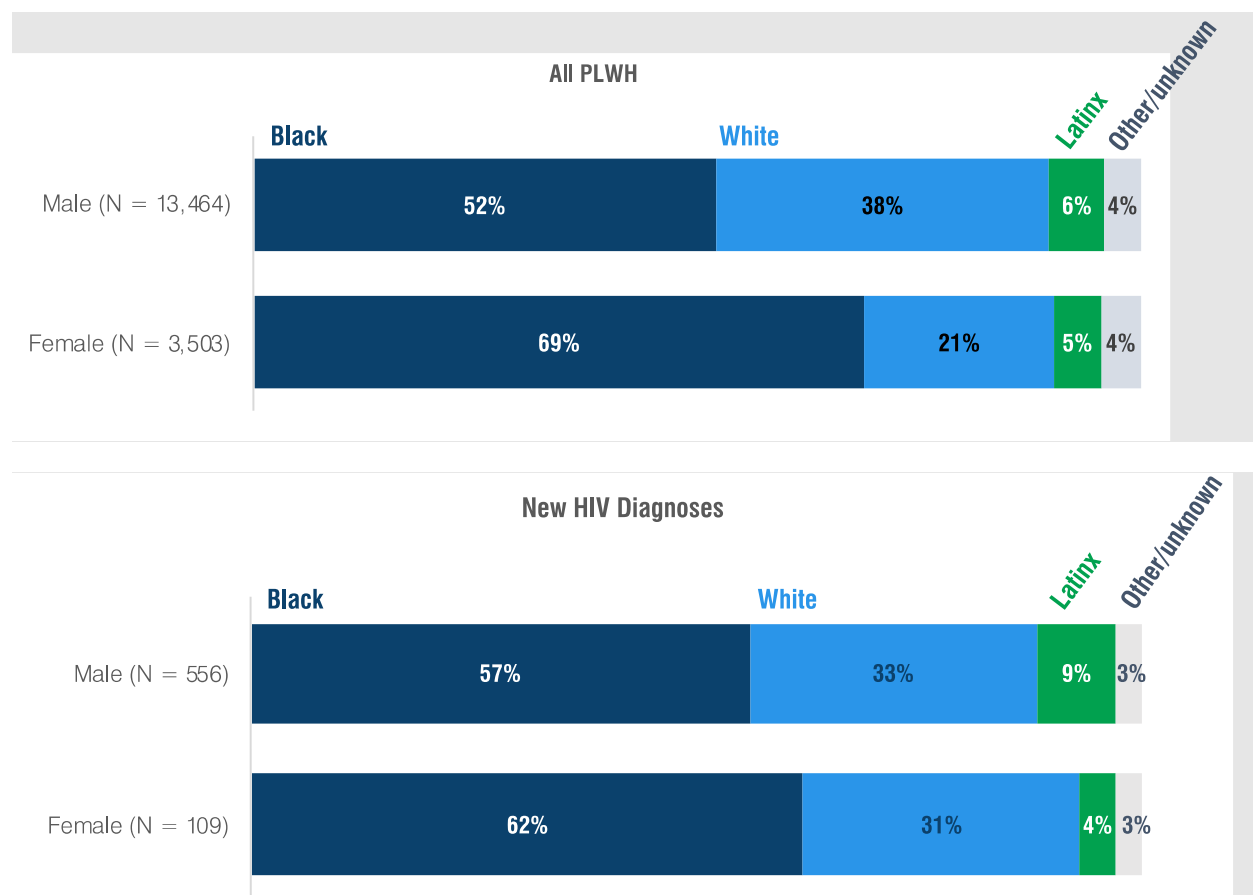


N = 16,967 (all PWH); 665 (newly diagnosed)
Source: MDHHS, HIV Prevalence State Tables, 2020

According to the 2019 Michigan Behavioral Risk Factor Surveillance System (MI-BRFSS), an estimated 47 percent of Michigan adults reported ever being tested for HIV. Females reported a significantly higher prevalence of HIV testing (53 percent) than males (42 percent). Black, non-Hispanic adults reported a significantly higher prevalence of HIV testing (72 percent) than both white, non-Hispanic (43 percent) and Hispanic adults (52 percent). The prevalence of HIV testing decreased with increasing household income level. Adults with disabilities were more likely to have been tested for HIV (54 percent) than adults without disabilities (45 percent). From 2011 to 2016, the prevalence of HIV testing among Michigan adult remained stable, increasing slightly from 41 percent in 2016 to 47 percent in 2019.

Over half (52 percent) of all males living with HIV in 2019 were Black and 38 percent were white (Exhibit 18). Over two-thirds (69 percent) of all females living with HIV were Black and 21 percent were white. Black males represent a greater percentage of all males newly diagnosed with HIV in 2019 than of all males living with HIV in 2019 (57 percent compared to 52 percent). The percentage of newly diagnosed males who were white (33 percent) was slightly lower than the percentage of white males among all males living with HIV (38 percent). The opposite was true for newly diagnosed females when compared to all females living with HIV. Black females represent a smaller percentage of all females newly diagnosed with HIV in 2019 than of all females living with HIV in 2019 (62 percent compared to 69 percent), and the percentage of newly diagnosed white females (31 percent) was higher than the percentage of white females living with HIV (21 percent).

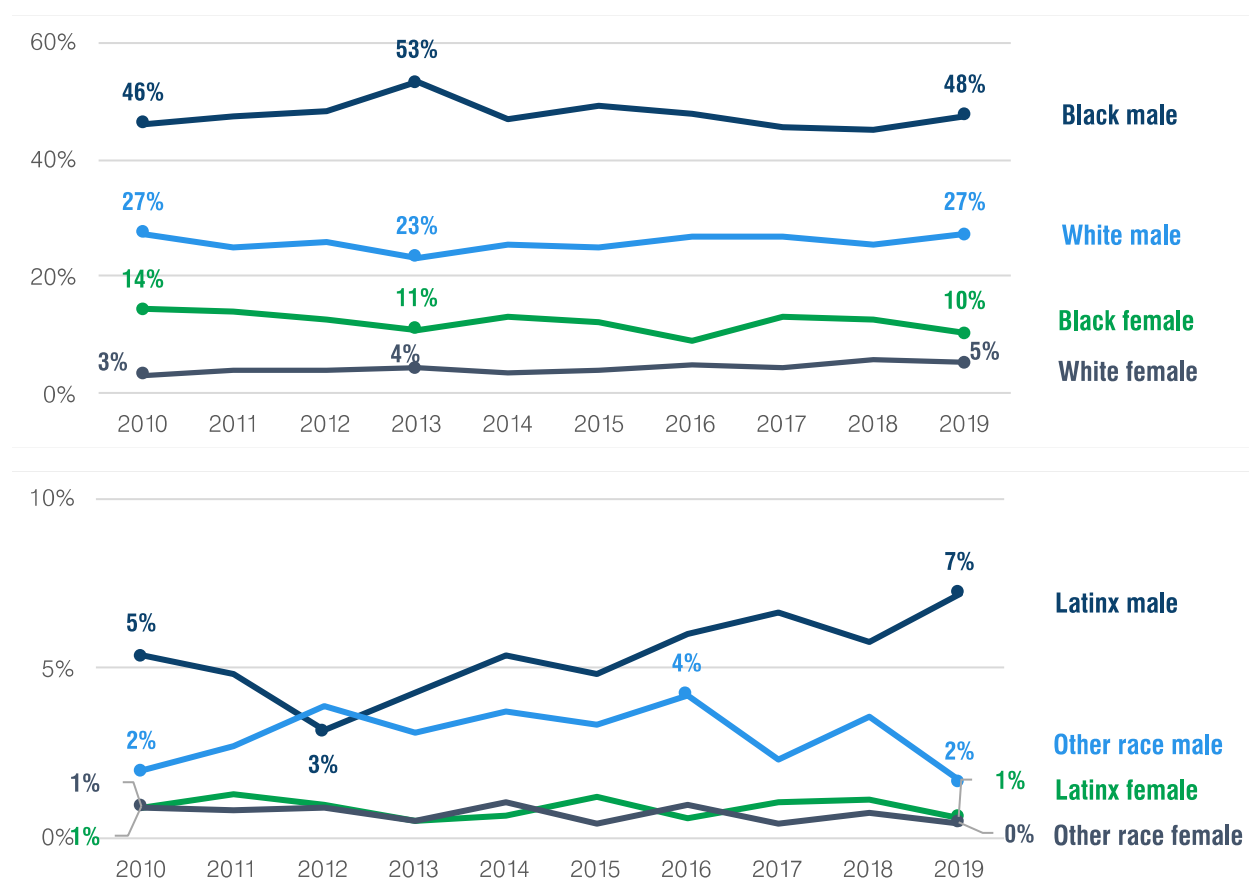
EXHIBIT 18. HIV Prevalence by Sex and Race/Ethnicity, 2019



N = 16,967 (all PWH); 665 (newly diagnosed)
Source: MDHHS, HIV Prevalence State Tables, 2020

Over the past ten years, new HIV diagnoses by sex and race have remained relatively consistent, with the exception of a larger increase in the percentage of Black males among those newly diagnosed in 2013 (Exhibit 19).

EXHIBIT 19. New HIV Diagnoses over Time, by Sex and Race

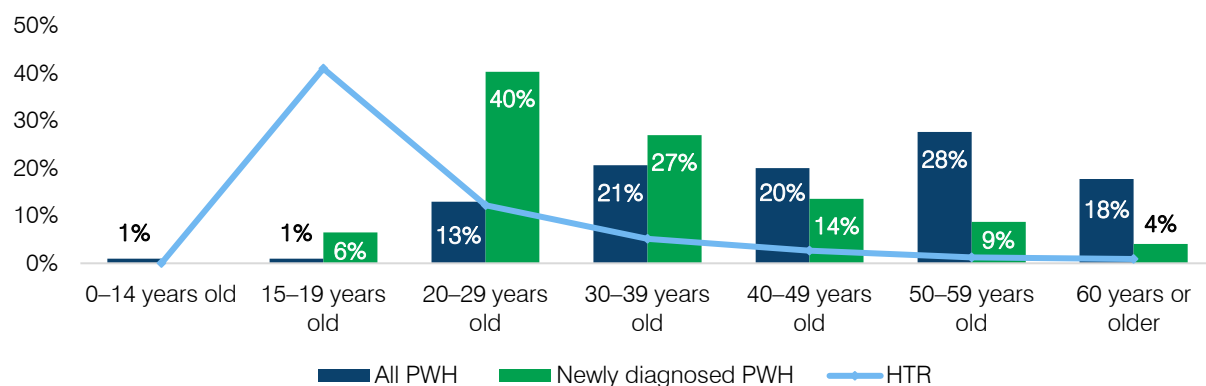


N varies by year of diagnosis.

Source: MDHHS, HIV Trend Tables, 2020

In 2019, nearly all PWH in Michigan were 30 years old or older, with 46 percent being 50 or older. Dissimilarly, 46 percent of people newly diagnosed with HIV were under the age of 30. This age group also had the highest HIV transmission rate (HTR)—that is, the number of new HIV diagnoses divided by the number of PWH in a particular group—indicating a greater probability that they will transmit HIV to others (Exhibit 20). New HIV diagnoses over the past ten years have remained relatively consistent when examined by age group, with a slight increase in the percentage of those between the ages of 20 and 39 years old diagnosed in 2019 compared to those diagnosed in that age group in 2010 (Exhibit 21).

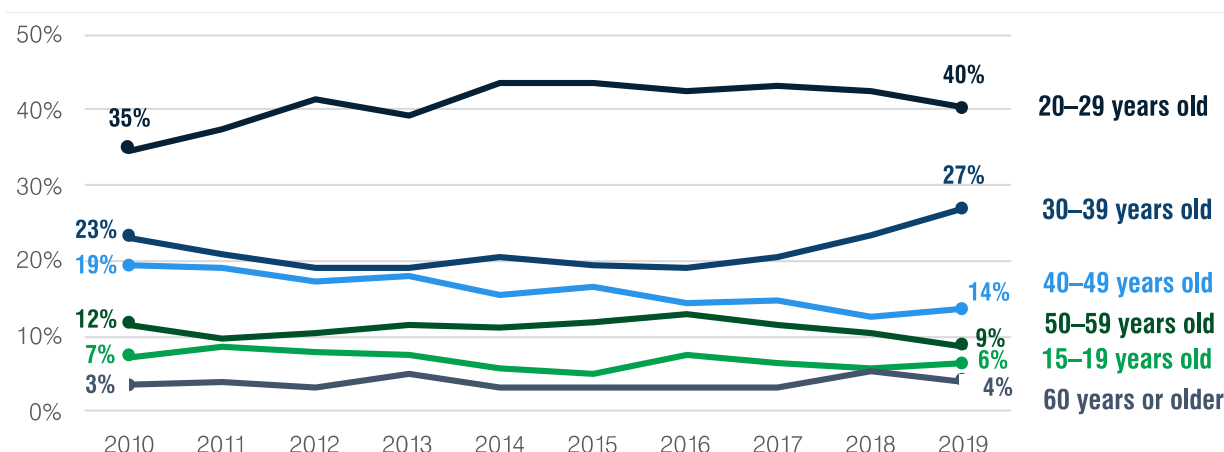
EXHIBIT 20. PWH Prevalence by Age, 2019



N = 16,967 (all PWH); 665 (newly diagnosed).

Source: MDHHS, HIV Prevalence State Tables, 2020

EXHIBIT 21. New HIV Diagnoses over Time, by Age



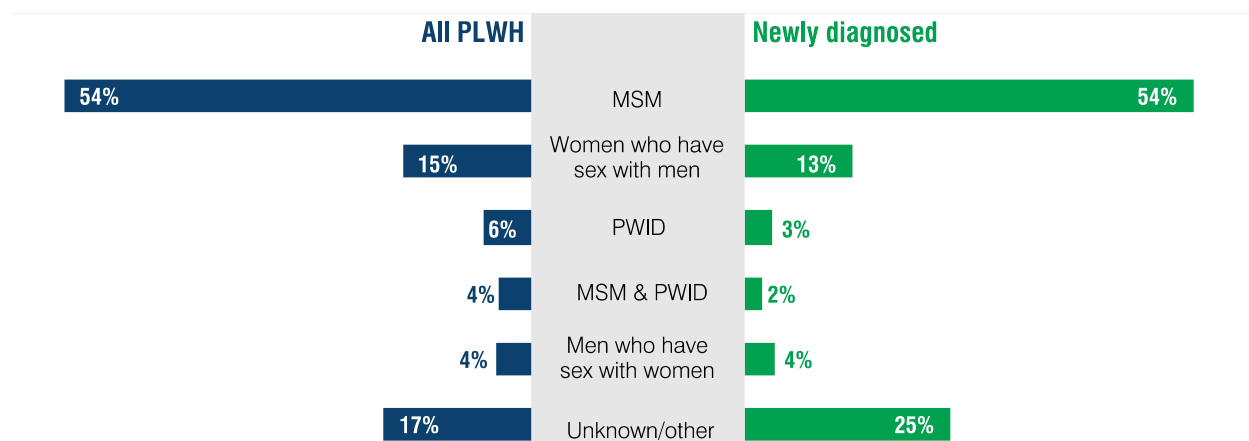
N varies by year of diagnosis.

Source: MDHHS, HIV Trend Tables, 2020

In 2019, more than half (54 percent) of PWH in Michigan were men who have sex with men (MSM), and 15 percent were women who have sex with men (WSM). Similarly, 54 percent of newly diagnosed PWH were MSM, and 13 percent were WSM. Only 5 percent of PWH were persons who inject drugs (PWID), 4 percent were MSM and PWID, and another 4 percent were men who have sex with women (Exhibit 22). The percentage of PWH whose risk factor is either unknown or other was 17 percent for all PWH and 25 percent for those newly diagnosed in 2019. Most of these (14 percent and 22 percent, respectively) were actual unknowns. The remaining 3 percent included in the “other” category were transgender people who have sex with men or women, transgender people who are PWID and have sex with men, and perinatal or pediatric. As with the other demographic categories, newly diagnosed cases by risk factor remained

relatively constant over the past ten years, with around 70 percent of all new cases being men or women who have sex with men and around 20 percent having unknown risk factors.

EXHIBIT 22. PWH Prevalence by Risk Factor, 2019



N = 16,967 (all PWH); 665 (newly diagnosed).

Note: The “Unknown/other” category is made up of 80 percent unknowns. “Other” includes gender unknown who have sex with men; transgender people who have sex with men; transgender people who have sex with women; transgender people who have sex with men and are PWID; and perinatal or pediatric.

Source: MDHHS, HIV Prevalence State Tables, 2020

HIV Prevalence by Local Health Department

Michigan has 45 local health departments (LHDs), with 30 serving residents in a single county and 14 serving residents in multiple counties. The Detroit Health Department (DHD) is the only LHD serving residents of a single city. Due to small numbers of PWH and new HIV diagnoses in some LHD jurisdictions, some data presented in this report is for combined LHD jurisdictions to ensure anonymity and provide more meaningful analysis. HIV prevalence rates by LHD ranged from 22.6 to 696.3 per 100,000 residents, with an average of 116.2 and a median of 70.5 (Exhibit 23). New HIV diagnosis rates per 100,000 residents ranged from zero to 27.2, with an average of 4.3 and a median of 2.6.

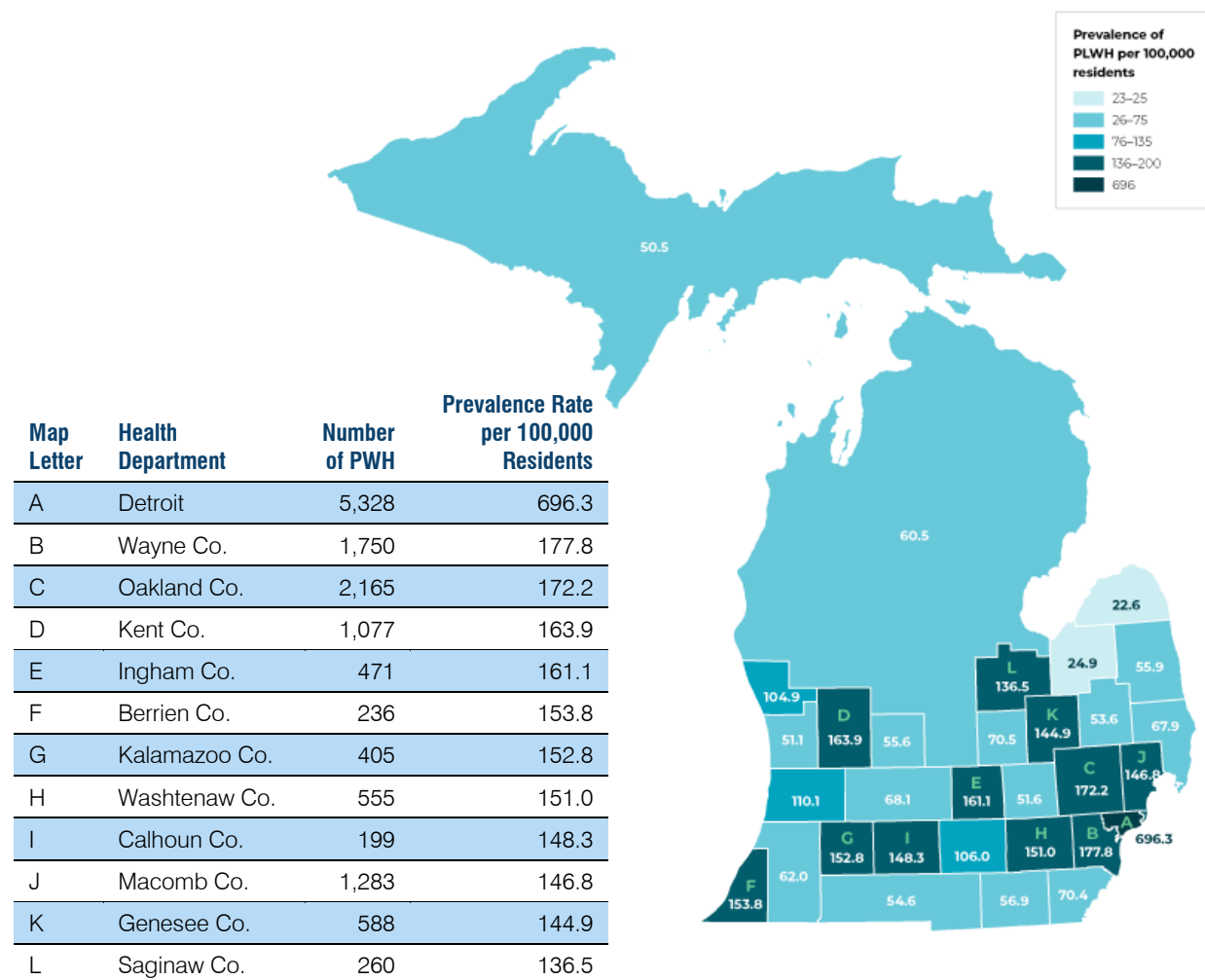
EXHIBIT 23. HIV Prevalence Rates per 100,000 Residents, 2019

	Range	Average	Median
HIV prevalence rate per 100,000 residents	22.6–696.3	116.2	70.5
New HIV diagnosis rate per 100,000 residents	0.0–27.2	4.3	2.6

Source: MDHHS, HIV Prevalence State Tables, 2020

The highest concentration of PWH and new HIV diagnoses per 100,000 residents in 2019 was in the southern part of the lower peninsula (Exhibits 24 and 25). The DHD had the highest HIV prevalence rate per 100,000 residents (696.3) of all LHDs in Michigan, followed by Wayne County (177.8) and Oakland County (172.2). Residents served by the DHD also had the highest rate of new HIV diagnoses (27.2) in 2019, followed by Kalamazoo County (10.2).

EXHIBIT 24. Highest Michigan HIV Prevalence Rates per 100,000 Residents by LHD, 2019

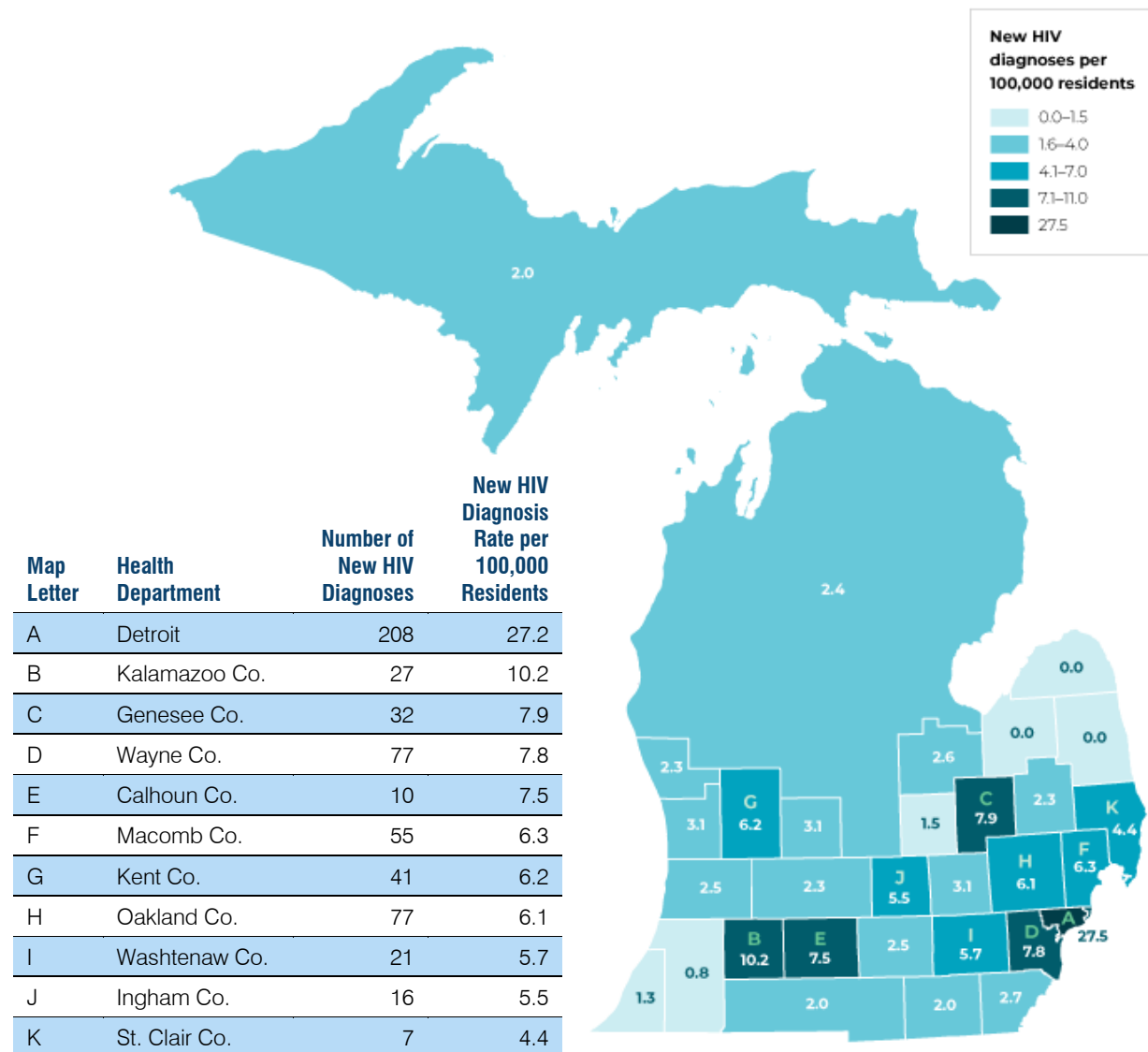


Source: MDHHS, HIV Prevalence State Tables, 2020

Note: The color ranges were determined using the Jenks natural breaks classification, which is based on creating data groupings based on similar values that maximize the differences between groups.¹

¹ The Upper Peninsula region comprises Chippewa County Health Department, Dickinson-Iron District Health Department, Luce-Mackinac-Alger-Schoolcraft Health Department, Marquette County Health Department, Public Health of Delta & Menominee Counties, and Western Upper Peninsula District Health Department. The Mid and Northern Lower Peninsula region comprises Benzie-Leelanau District Health Department, Central Michigan District Health Department, District Health Department #2, District Health Department No. 4, District Health Department #10, Grand Traverse County Health Department, and Health Department of Northwest Michigan.

EXHIBIT 25. Highest Rates of New HIV Diagnosis per 100,000 Residents by LHD, 2019

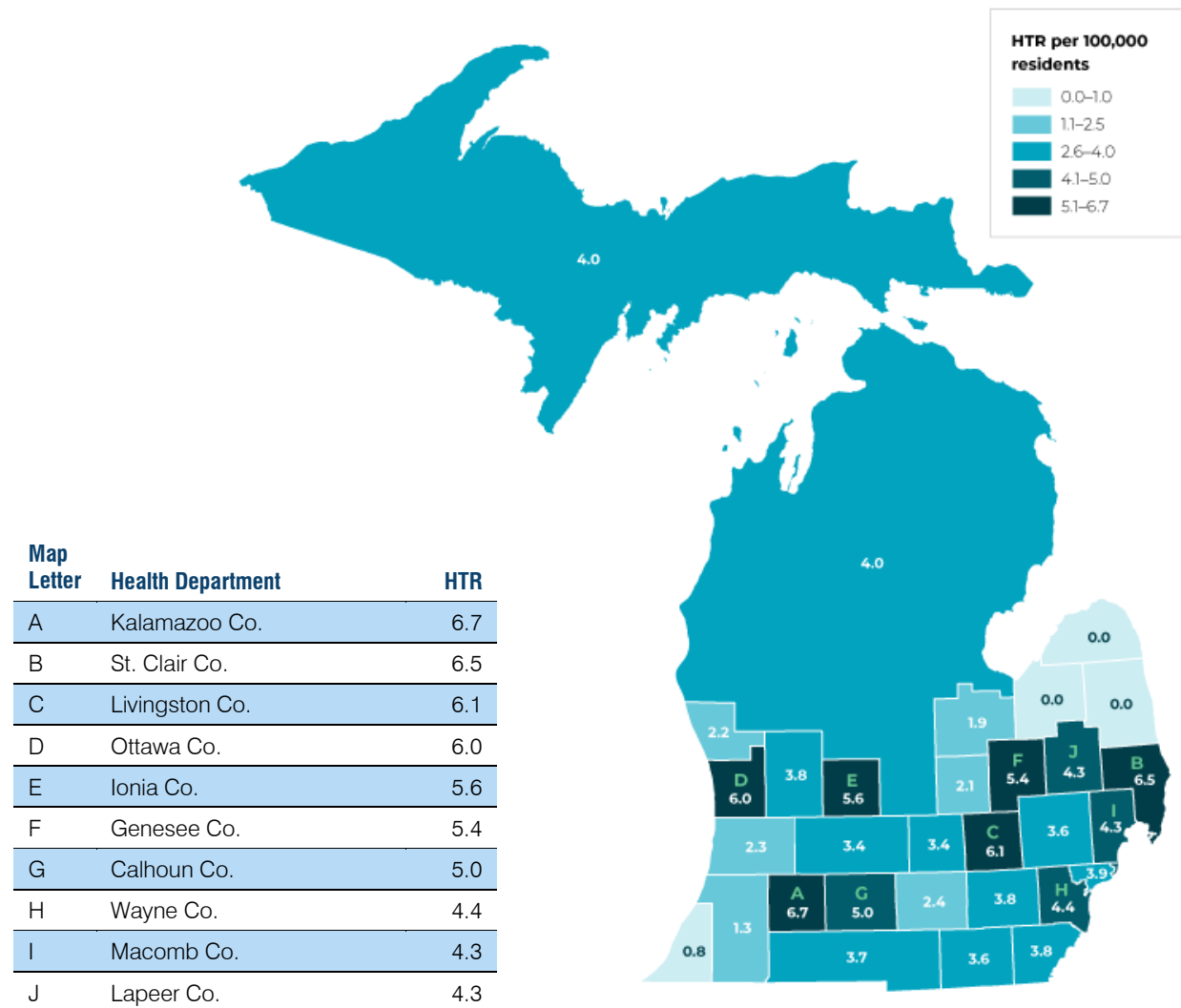


Source: MDHHS, HIV Prevalence State Trend Tables, 2020

Note: The color ranges were determined using the Jenks natural breaks classification, which creates data groupings based on similar values that maximize the differences between groups.

A high HTR (the number of new HIV diagnoses divided by the number of PWH in a given geographic area) indicates a higher likelihood of HIV transmission. HTRs among LHDs ranged from zero to 6.7, with an average of 3.5 and a median of 3.8. Counties with the highest HTRs in the state included Kalamazoo (6.7), St. Clair (6.5), Livingston (6.1), and Ottawa (6.0) (Exhibit 26).

EXHIBIT 26. Highest HTR by LHD Jurisdictions, 2019



Source: MDHHS, HIV Prevalence State Tables, 2020

Note: The color ranges were determined using the Jenks natural breaks classification, which creates data groupings based on similar values that maximize the differences between groups.

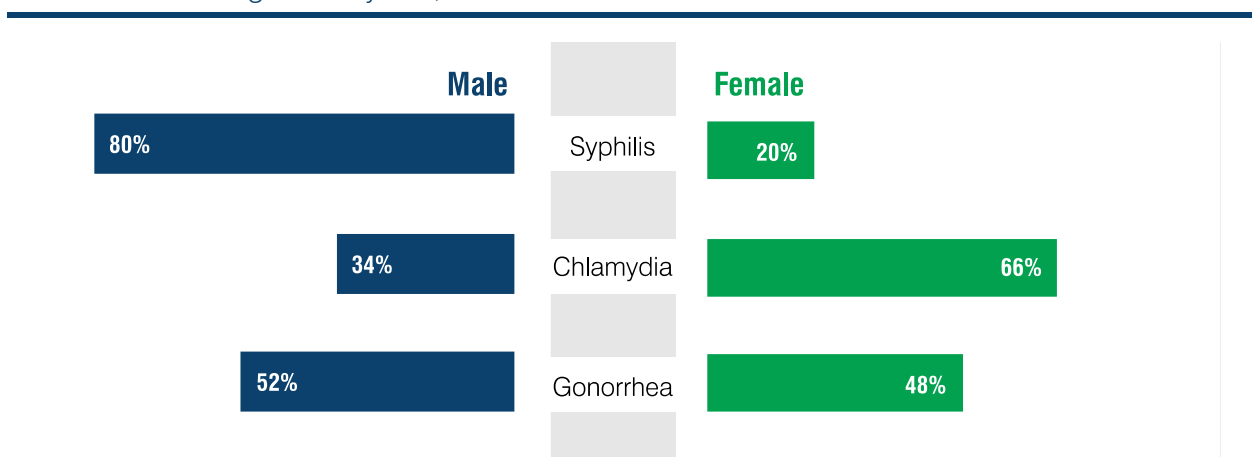
New STI Diagnoses

MDHHS focuses on three STIs in addition to HIV: chlamydia, gonorrhea, and syphilis. In Michigan, there were over 50,000 cases of chlamydia diagnosed and over 18,000 cases of gonorrhea in 2019 (MDHHS 2020c). The total number of people diagnosed with syphilis was 1,900 (MDHHS 2020d). The number and rate of chlamydia cases per year followed a very small upward trend from 2010 to 2019, and gonorrhea rates increased 4 percent annually, with most of the increases occurring in the last 5 years (MDHHS 2020e). Statewide, primary and secondary (P&S) syphilis rates have increased annually by 10 percent since 2010 (MDHHS 2020e).

New STI Diagnoses by Demographic

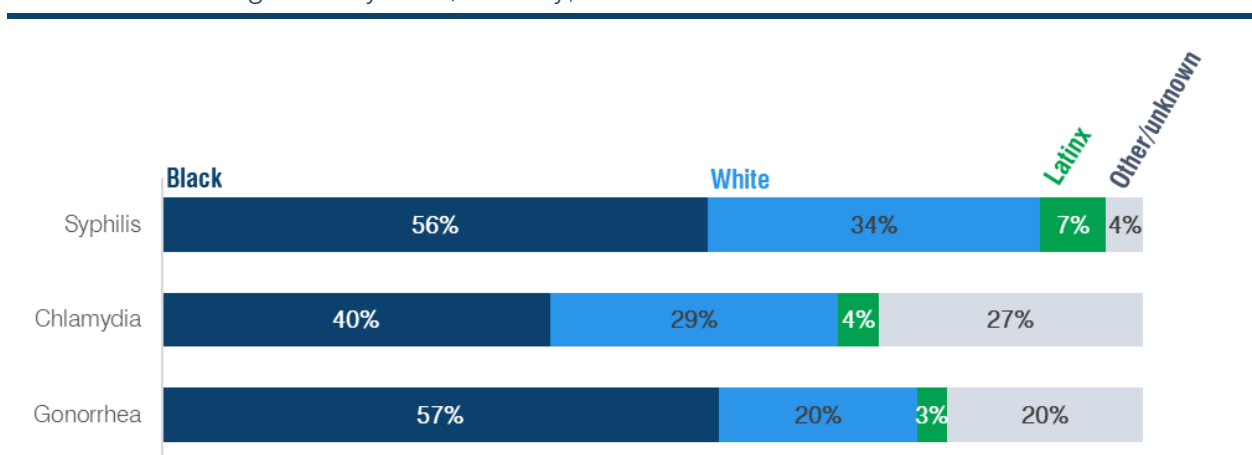
In 2019, STI diagnoses by sex varied depending on the STI. Most (80 percent) of those diagnosed with syphilis were male and 66 percent of those diagnosed with chlamydia were female (Exhibit 27). The breakdown by sex was more even for gonorrhea, with 52 percent being male and 48 percent being female. Black people made up the largest percentage of people diagnosed with each of the three STIs. Over half of those diagnosed with syphilis (56 percent) and gonorrhea (57 percent) were Black, and 40 percent of those diagnosed with chlamydia were Black (Exhibit 28).

EXHIBIT 27. STI Diagnoses by Sex, 2019



N = 1,899 (syphilis); 50,352 (chlamydia); 18,260 (gonorrhea)
Source: MDHHS 2020d

EXHIBIT 28. STI Diagnoses by Race/Ethnicity, 2019

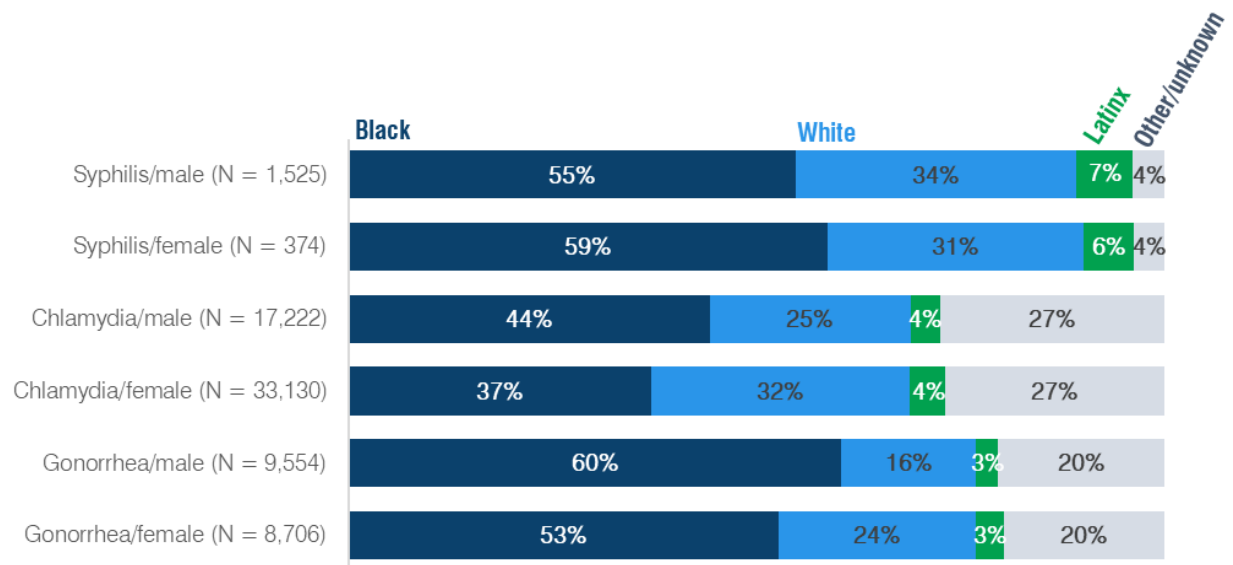


N = 1,899 (syphilis); 50,352 (chlamydia); 18,260 (gonorrhea)

Note: Most of the “other/unknown” category were true others and unknowns. A few people in this category were Asian, Native Hawaiian, Other Pacific Islander, American Indian, or Alaska Native.
Source: MDHHS 2020d

When examining STI diagnoses by sex and race and ethnicity, Black males and Black females made up the largest percentage for each of the three STIs (Exhibit 29). For example, 55 percent of males diagnosed with syphilis were Black, as were 59 percent of females diagnosed with syphilis.

EXHIBIT 29. New STI Diagnoses by Sex and Race/Ethnicity, 2019



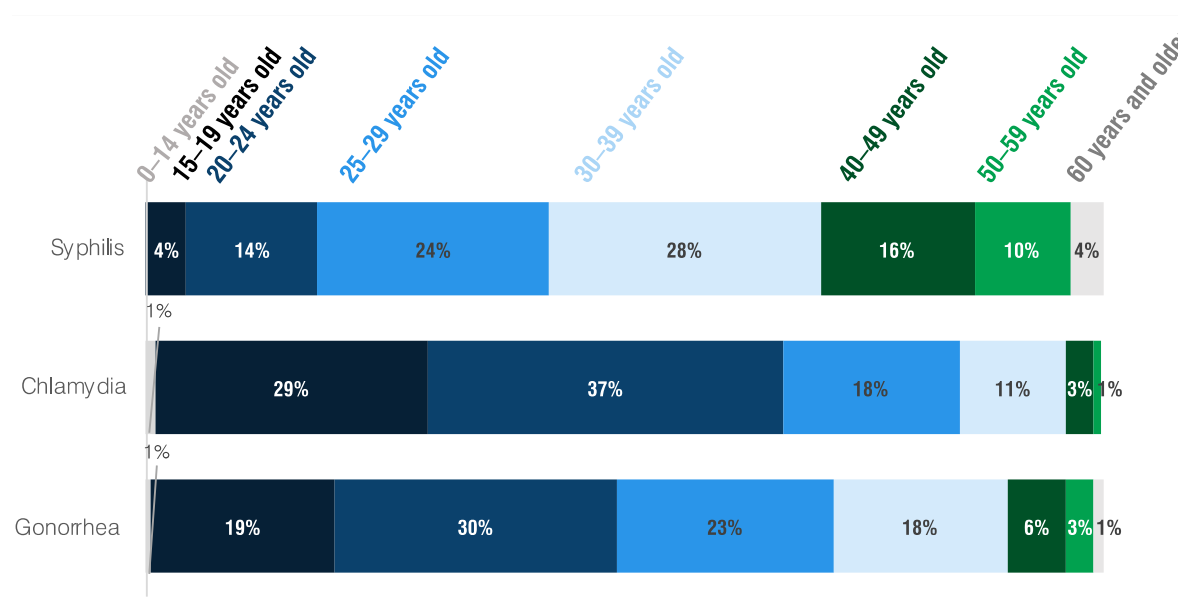
N = 1,899 (syphilis); 50,352 (chlamydia); 18,260 (gonorrhea)

Note: Most of the “other/unknown” category were true others and unknowns. A few people in this category were Asian, Native Hawaiian, Other Pacific Islander, American Indian, or Alaska Native.

Source: MDHHS 2020d

Young people aged 15 to 24 accounted for two-thirds (67 percent) of new chlamydia diagnoses and half (50 percent) of new gonorrhea diagnoses. New syphilis diagnoses, however, were more likely to occur in older age groups. About half (52 percent) of those diagnosed with syphilis were between the ages of 25 and 39 and nearly one-third were 40 years old or older (Exhibit 30).

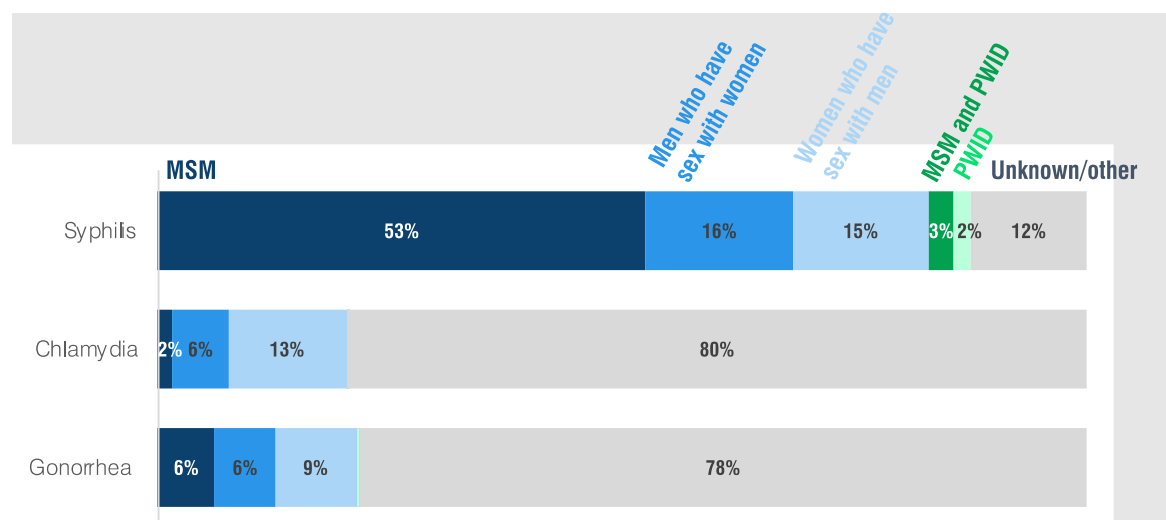
EXHIBIT 30. New STI Diagnoses by Age, 2019



N = 1,900 (syphilis); 50,374 (chlamydia); 18,264 (gonorrhea)
Source: MDHHS 2020d

The transmission risk factors for those diagnosed with chlamydia and gonorrhea in 2019 were largely unknown, 80 percent and 78 percent, respectively, which can make it difficult to identify effective prevention strategies. Over half (53 percent) of those diagnosed with syphilis were MSM (Exhibit 31).

EXHIBIT 31. New STI Diagnosis by Risk Factor, 2019



N = 1,900 (syphilis); 50,374 (chlamydia); 18,264 (gonorrhea)
Note: All people in the “unknown/other” category had undetermined risk factors.
Source: MDHHS 2020d

New STI Diagnoses by Local Health Department

STI diagnosis rates per 100,000 residents varied among LHD jurisdictions, ranging from zero for P&S syphilis to 1,663.4 for chlamydia (Exhibit 32). The average rates were 3.7 for syphilis, 115.7 for gonorrhea, and 385.3 for chlamydia.

EXHIBIT 32. STI Diagnoses Rates per 100,000 residents, 2019

	Range	Average	Median
P&S syphilis diagnosis rate	0.0–37.5	3.7	2.1
Chlamydia diagnosis rate	142.0–1,663.4	385.3	291.1
Gonorrhea diagnosis rate	9.7–870.9	115.7	55.2

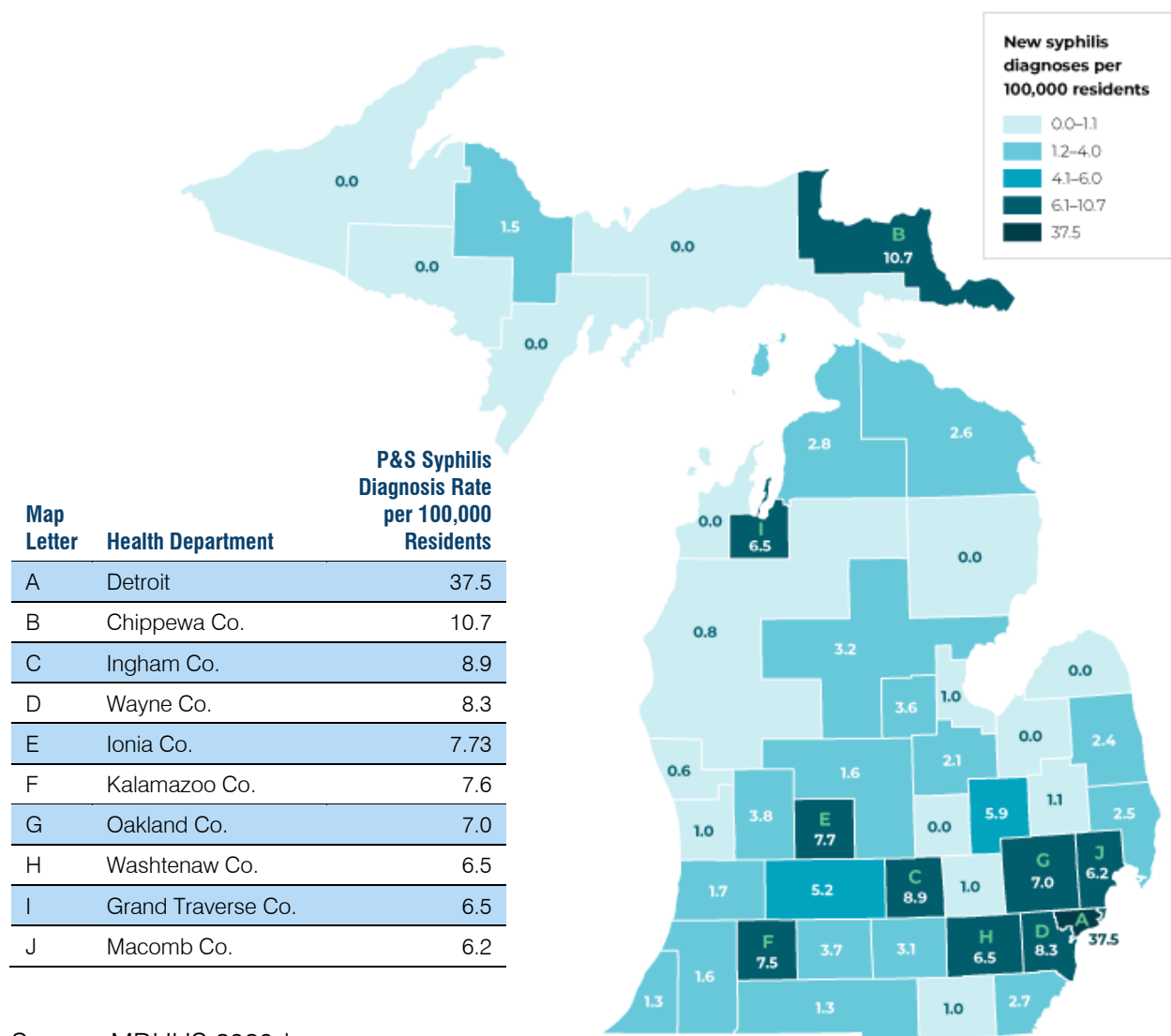
Source: MDHHS 2020d

The DHD had the highest diagnosis rate for each of the three STIs (Exhibits 33–35).² Outside of Detroit, however, Kalamazoo County Health Department had the highest diagnosis rates per 100,000 residents for both chlamydia and gonorrhea at 875.3 and 408.6, respectively. Muskegon County Health Department’s chlamydia diagnosis rate was the third highest in the state at 763.4, and Saginaw County Health Department’s gonorrhea diagnosis rate was the third highest in the state at 378.4. Chippewa County Health Department had the second-highest P&S syphilis rate per 100,000 residents at 10.7, followed by Ingham County Health Department at 8.9. Those with rates in the top ten for all three STIs included the Detroit, Ingham County, and Kalamazoo County health departments.

Some of the LHDs with diagnosis rates in the top ten are primarily rural, including Berrien County (chlamydia and gonorrhea), Calhoun County (chlamydia and gonorrhea), Chippewa County (syphilis), and Grand Traverse (syphilis).

² For full STI table, see Exhibit A3 in Appendix A.

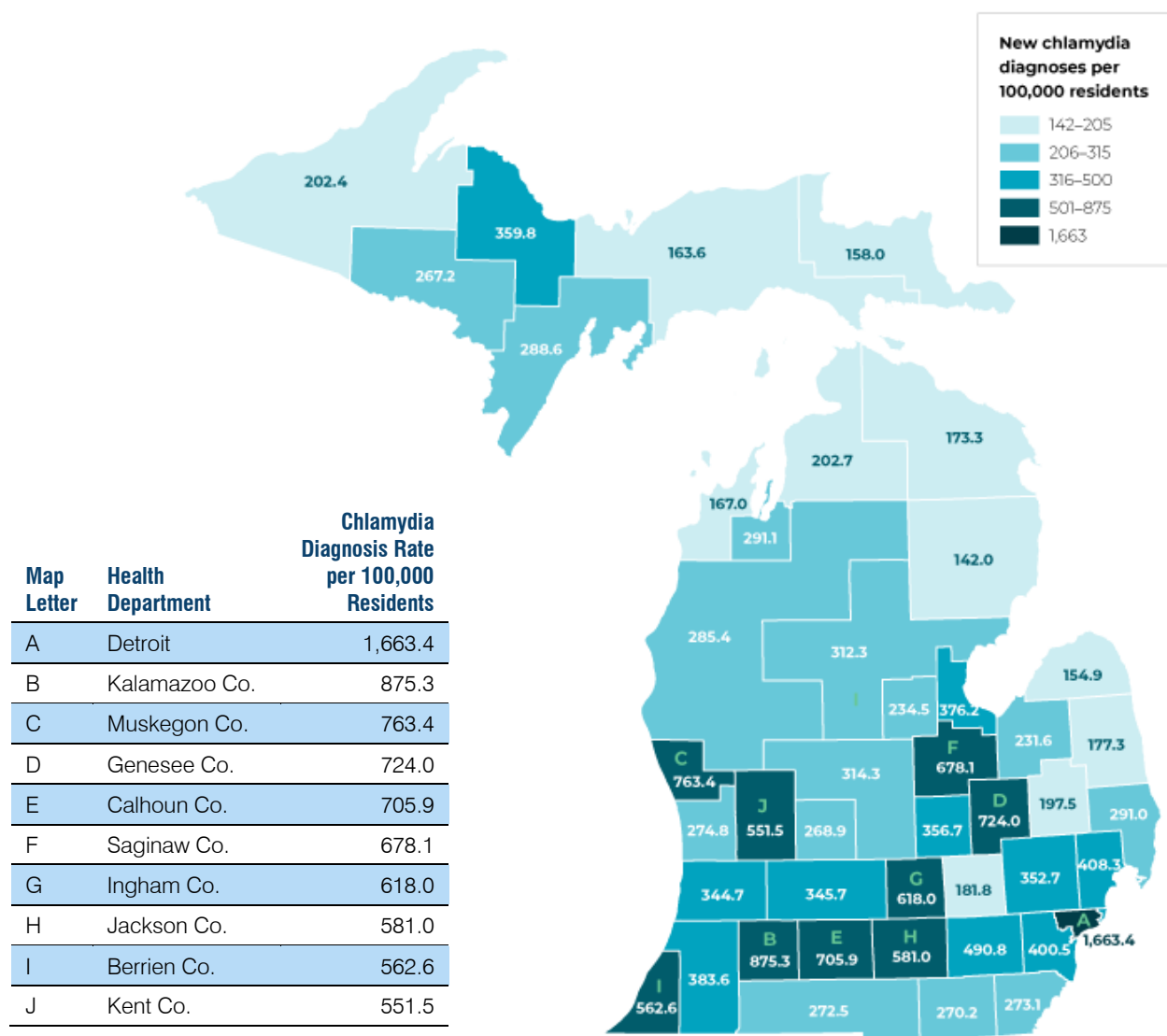
EXHIBIT 33. Highest Syphilis Diagnosis Rates by LHD, 2019



Source: MDHHS 2020d

Note. The color ranges were determined using the Jenks Natural Breaks classification, which creates data groupings based on similar values that maximize the differences between groups.

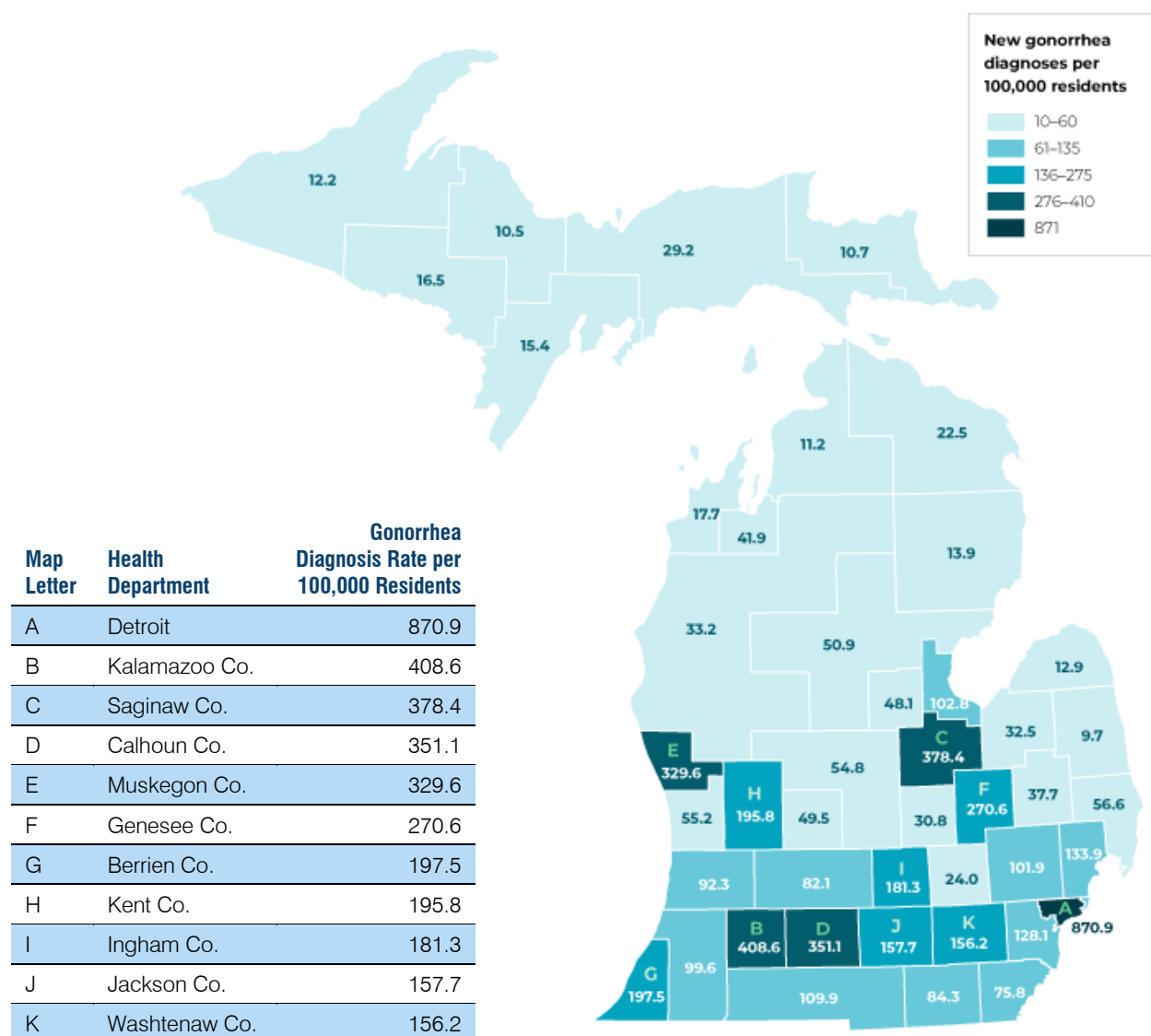
EXHIBIT 34. Highest Chlamydia Diagnosis Rates by LHD, 2019



Source: MDHHS 2020d

Note: The color ranges were determined using the Jenks Natural Breaks classification, which creates data groupings based on similar values that maximize the differences between groups.

EXHIBIT 35. Highest Gonorrhea Diagnosis Rates by LHD, 2019



Source: MDHHS 2020d.

Note: The color ranges were determined using the Jenks Natural Breaks classification, which creates data groupings based on similar values while maximize the differences between groups.

HIV and STI Coinfection

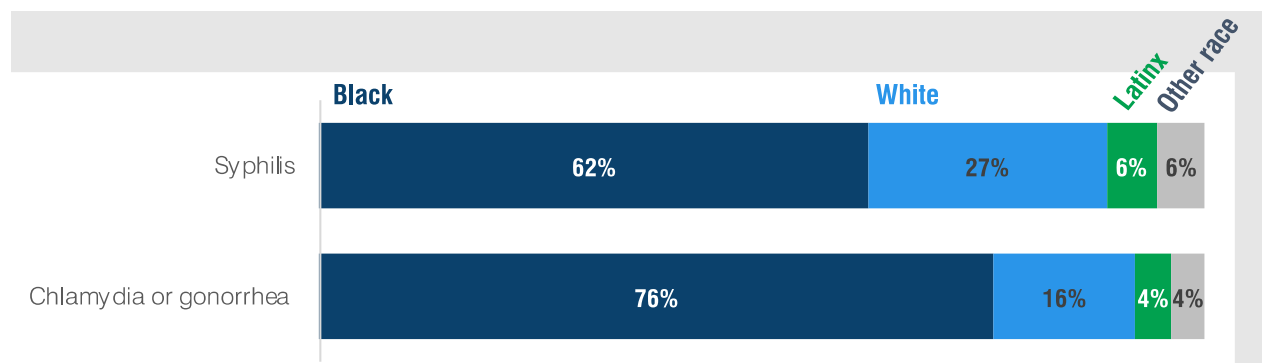
STIs and HIV affect many of the same people and populations, and a PWH is considered coinfectd when they are diagnosed with an STI after they are diagnosed with HIV. Identifying where coinfections occur and the HIV care outcomes of coinfectd people may inform health service delivery and targeted prevention strategies for STI/HIV programs (MDHHS 2020c). For example, HIV-negative persons diagnosed with an STI are often good candidates for PrEP, and PWH may be at higher risk of contracting a STI (Jennifer Miller, pers. comm.).

In Michigan, HIV coinfection is relatively uncommon among people diagnosed with chlamydia or gonorrhea. In 2019, only 1 percent of those diagnosed with chlamydia and 4 percent of those diagnosed with gonorrhea were also PWH. For this reason, chlamydia and gonorrhea coinfection data are combined below. HIV coinfection with syphilis was more prevalent, with 31 percent of those diagnosed in 2019 being coinfecting with HIV (MDHHS 2020e).

Coinfections by Demographic

Coinfection patterns mirror HIV health disparities in Michigan. Almost all PWH who were diagnosed with an STI in 2019 were male—99 percent of those with syphilis and 92 percent of those with chlamydia or gonorrhea. Nearly two-thirds of PWH diagnosed with syphilis were Black and over three-quarters of those diagnosed with chlamydia or gonorrhea were Black (Exhibit 36).

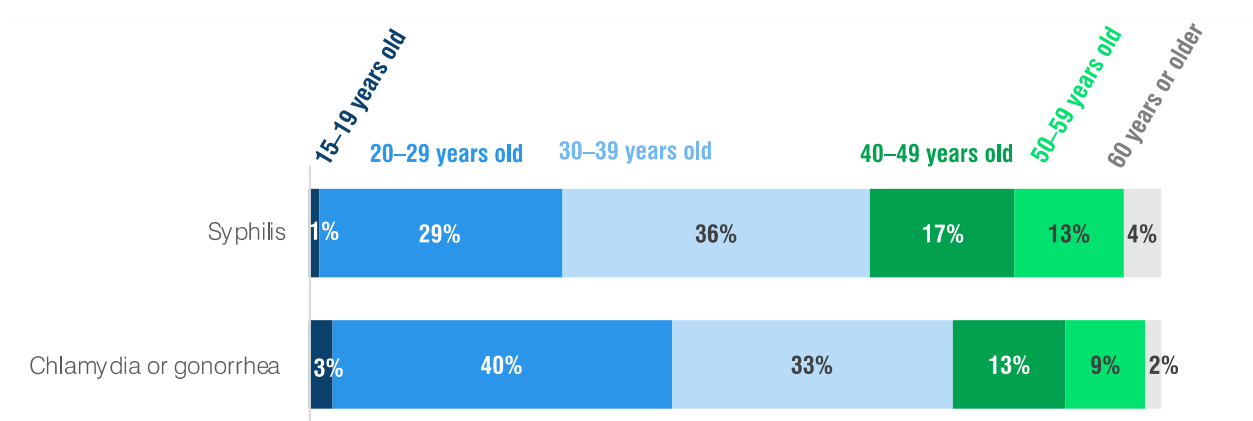
EXHIBIT 36. PWH with New STI Diagnoses by Race/Ethnicity, 2019



N = 578 (PWH diagnosed with syphilis); 900 (PWH diagnosed with chlamydia or gonorrhea)
 Source: MDHHS, STI Prevalence State Tables, 2020

In 2019, nearly two-thirds of PWH in Michigan coinfecting with syphilis (65 percent) and nearly three-quarters coinfecting with chlamydia or gonorrhea (73 percent) were between the ages of 20 and 39 years old (Exhibit 37).

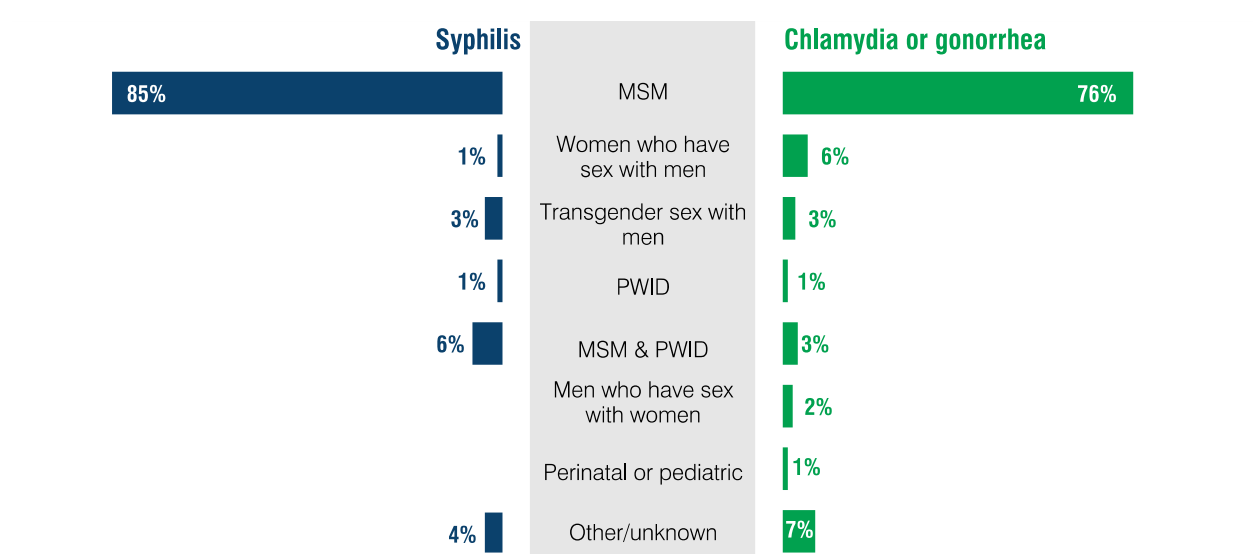
EXHIBIT 37. PWH with New STI Diagnoses by Age, 2019



N = 578 (people living with syphilis); 900 (people living with chlamydia or gonorrhea)
Source: MDHHS, STI Prevalence State Tables, 2020

Most PWH who were coinfectd with one of these STIs in 2019 were MSM—85 percent of those diagnosed with syphilis and 76 percent of those diagnosed with chlamydia or gonorrhea (Exhibit 38).

EXHIBIT 38. PWH with New STI Diagnoses by Risk Factor, 2019



N = 578 (PWH with new syphilis diagnoses); 900 (PWH with new chlamydia or gonorrhea diagnoses)
Source: MDHHS, STI Prevalence State Tables, 2020

Coinfections by Local Health Department

Among LHD jurisdictions the percentage of PWH who were diagnosed with syphilis ranged from zero to 4.9 percent, with an average and median of 2.3 percent (Exhibit 39). The percentage of PWH who were diagnosed with either chlamydia or gonorrhea ranged from zero to 8.8 percent, with an average of 2.7 percent and a median of 1.8 percent.

EXHIBIT 39. HIV-STI Coinfections by LHD Jurisdiction, 2019

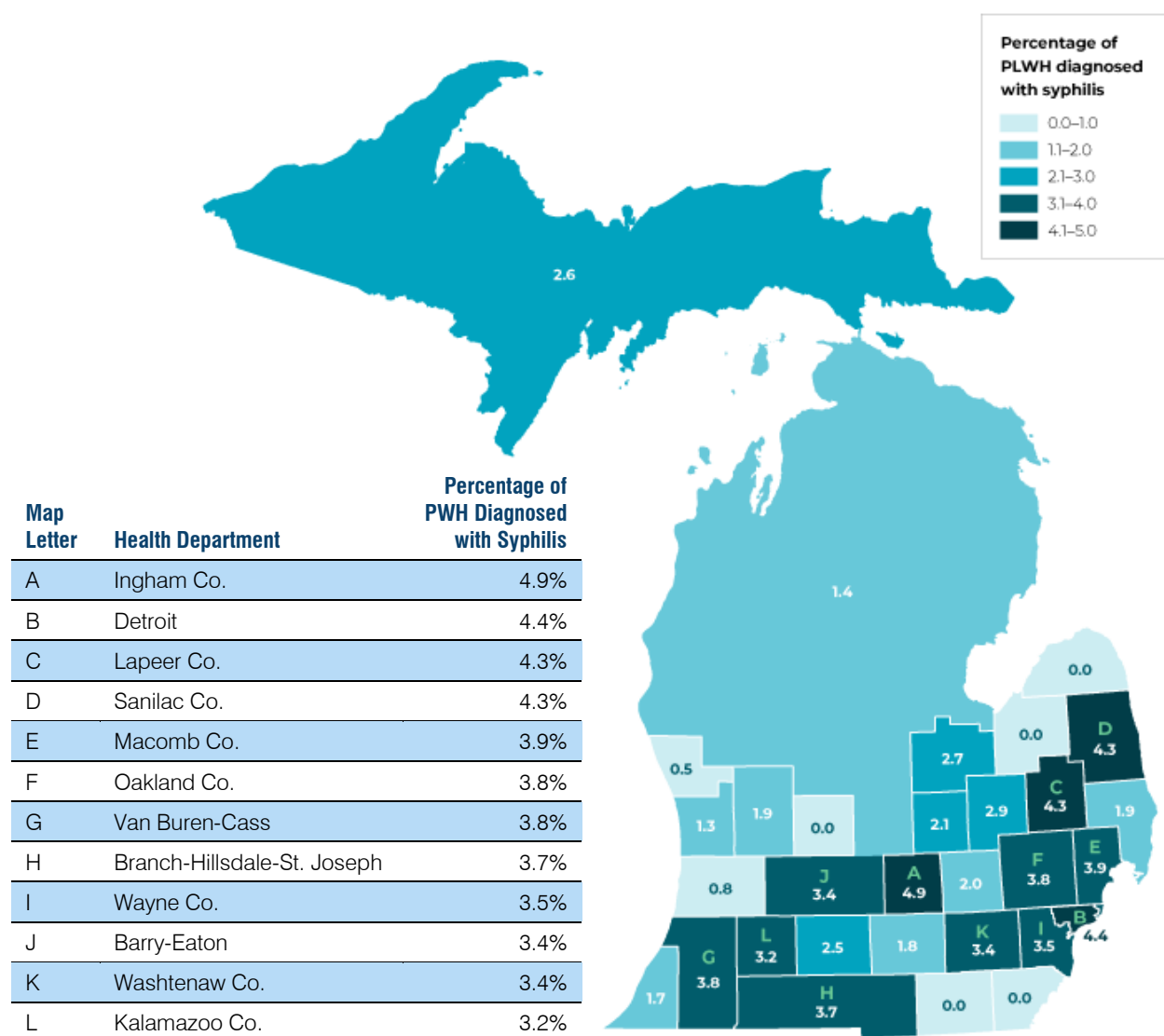
	Range	Average	Median
HIV and syphilis coinfection	0–4.9%	2.3%	2.3%
HIV and chlamydia or gonorrhea coinfection	0–8.8%	2.7%	1.8%

Source: MDHHS, STI Prevalence State Tables, 2020

In 2019, the Ingham County Health Department had the highest percentage of PWH diagnosed with syphilis (4.9 percent), followed by the DHD at 4.4 percent and Lapeer and Sanilac Counties at 4.3 percent each (Exhibit 40). The Saginaw County Health Department had the highest percentage (8.8 percent) diagnosed with chlamydia or gonorrhea, followed by the DHD at 8.1 percent and Kalamazoo County at 6.2 percent (Exhibit 41).³

³ For full HIV-STI coinfection table by LHD Jurisdiction, see Exhibit A4 in Appendix A.

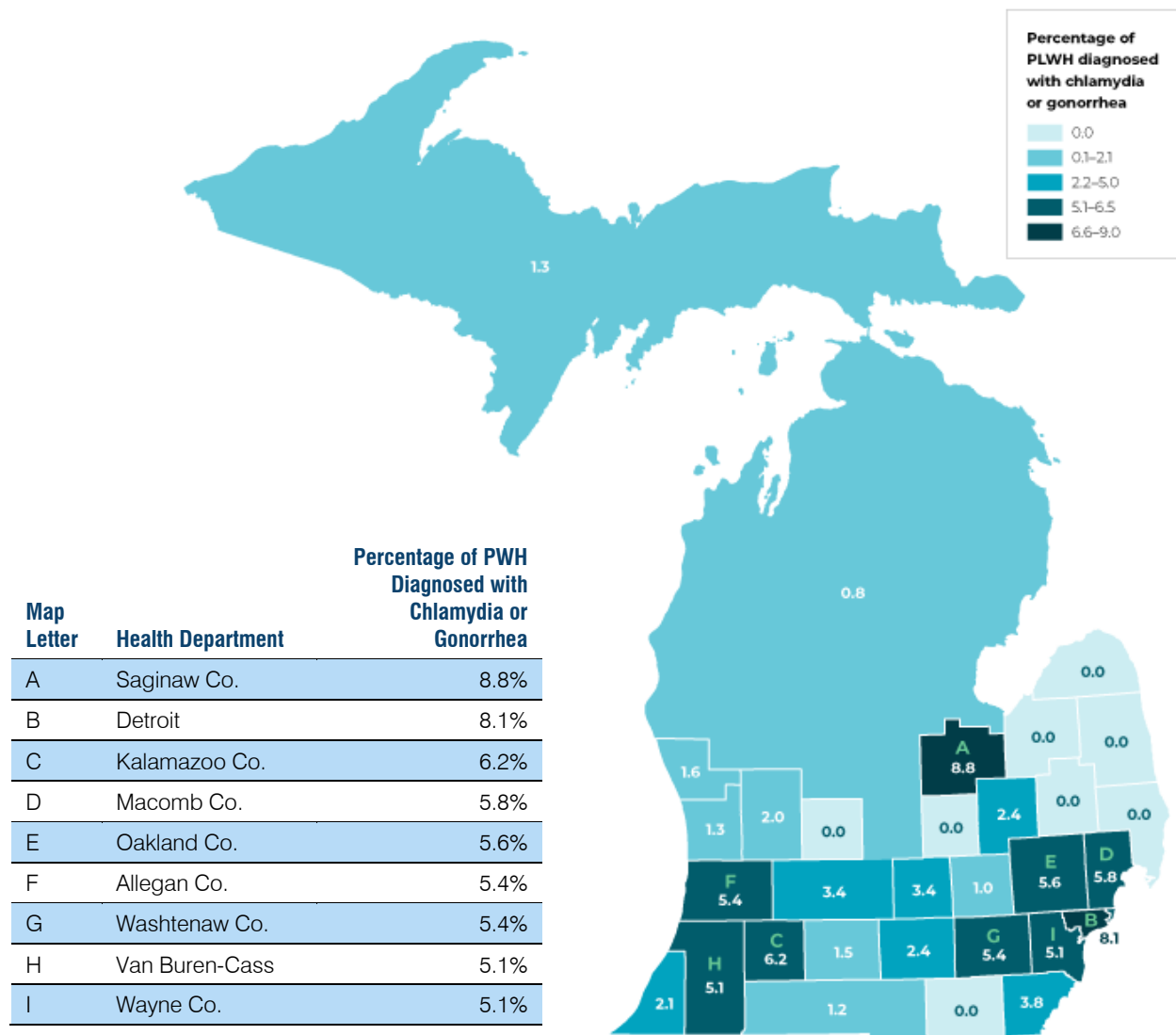
EXHIBIT 40. Highest Rates of HIV-Syphilis Coinfections, 2019



Source: MDHHS, STI Prevalence State Tables, 2020.

Note: Note: The color ranges were determined using the Jenks Natural Breaks classification, which creates data groupings based on similar values while maximize the differences between groups.

EXHIBIT 41. Highest Rates of HIV-Chlamydia or Gonorrhea Coinfections, 2019



Source: MDHHS, STI Prevalence State Tables, 2020.

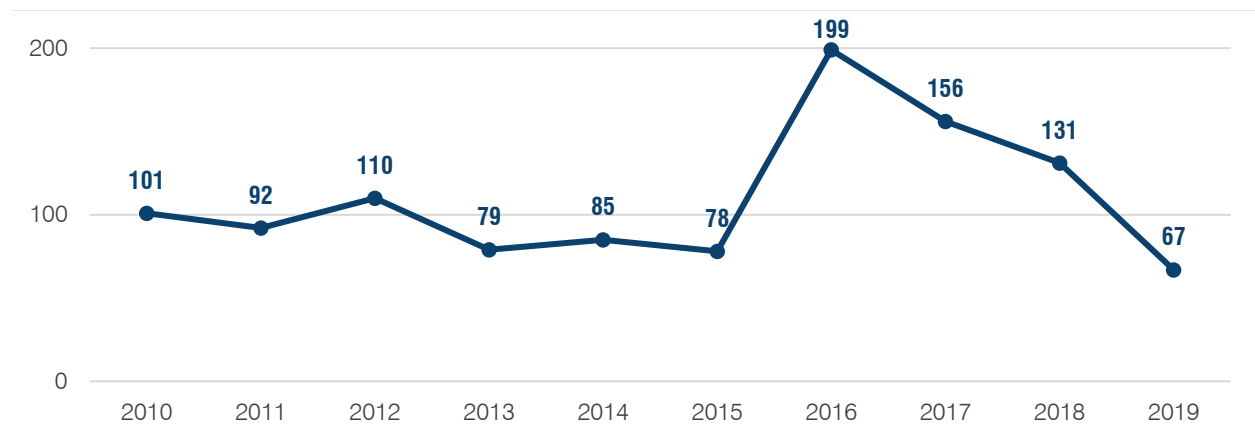
Note: Note: The color ranges were determined using the Jenks Natural Breaks classification, which creates data groupings based on similar values while maximize the differences between groups.

HIV and Hepatitis C Virus Coinfections

Certain PWH (e.g., MSM, PWID) may be at higher risk of contracting Hepatitis C virus (HCV) and vice versa, because the two infections share common transmission risk factors (MDHHS 2020c). Ensuring that people with HIV and/or HCV are identified is crucial to improving their treatment and care, not least because these individuals may also be at higher risk of resulting medical complications and harm compared to those infected with only one of these STIs (CDC 2020b).

HCV and HIV coinfections remained relatively stable in Michigan between 2010 and 2015, with a slight downward trend followed by a peak in 2016 likely caused by a new HCV case definition (MDHHS 2019 Hep B and C Report). Since 2016, coinfections have trended downward, reaching a ten-year low of 67 cases in 2019 (Exhibit 42).

EXHIBIT 42. HIV-HCV Coinfections, 2010–2019



Source: MDHHS 2020b

HIV Care and Viral Suppression

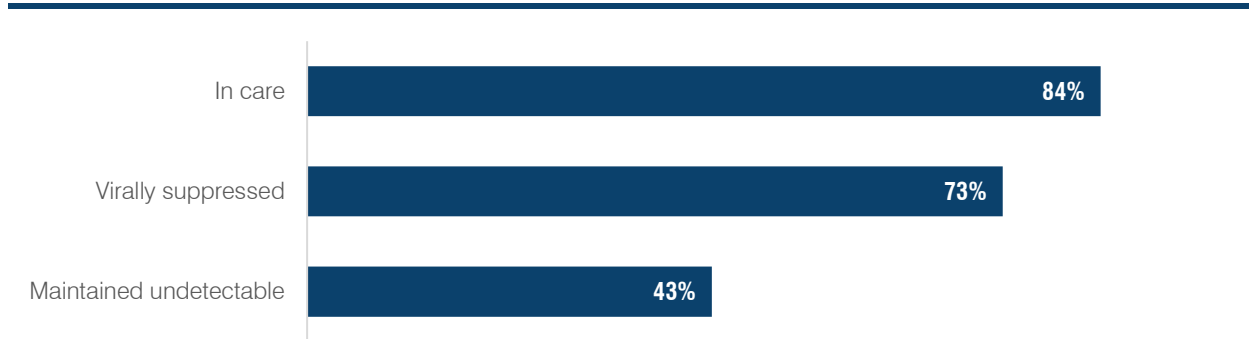
The goal of HIV treatment is to achieve and maintain viral suppression,⁴ which emphasizes the importance of the HIV Continuum of Care (CoC). Michigan's HIV CoC⁵ has four stages—diagnosis, in care, virally suppressed, and maintained undetectable⁶—and aims to move PWH quickly from diagnosis to care to viral suppression. In 2019, 84 percent of PWH in Michigan were in care (up from 70 percent in 2010), 73 percent were virally suppressed (up from 44 percent in 2010), and 43 percent were considered maintained undetectable (up from 25 percent in 2010) (Exhibit 43). These increases have begun to level off over the past two to three years (Exhibit 44).

⁴ PWH with less than 200 copies of HIV virus per milliliter of blood are considered virally suppressed.

⁵ The HIV Care Continuum Report includes persons who were diagnosed with HIV before January 1 of the given year who are still living in Michigan as of December 31 of the same year. Therefore, the total number of PWH included in the care report is less than other reports displaying prevalence.

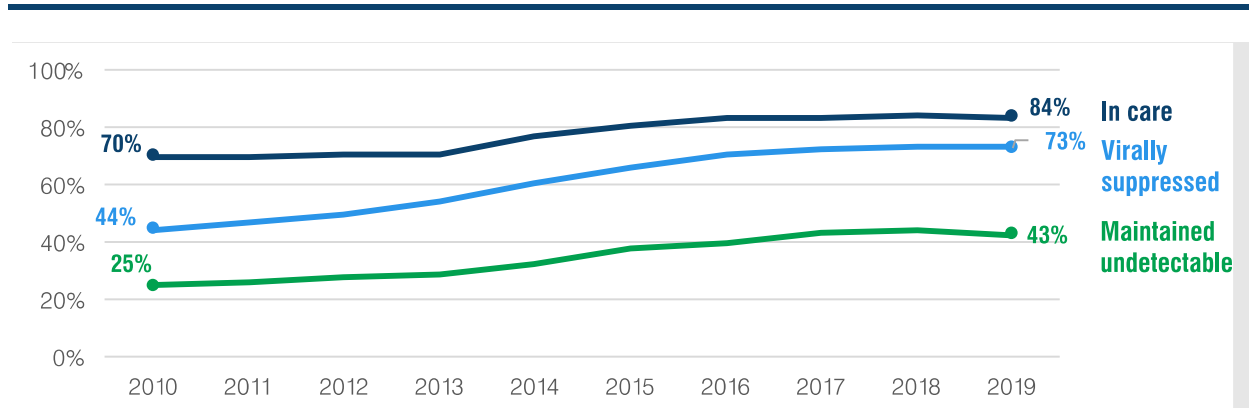
⁶ PWH who maintained viral load levels <200c/mL for at least four to eight months.

EXHIBIT 43. PWH in Care, Virally Suppressed, and Maintained Undetectable, 2019



Note: N = 16,281 for each category
Source: MDHHS 2020a

EXHIBIT 44. PWH in Care, Virally Suppressed, and Maintained Undetectable over Time

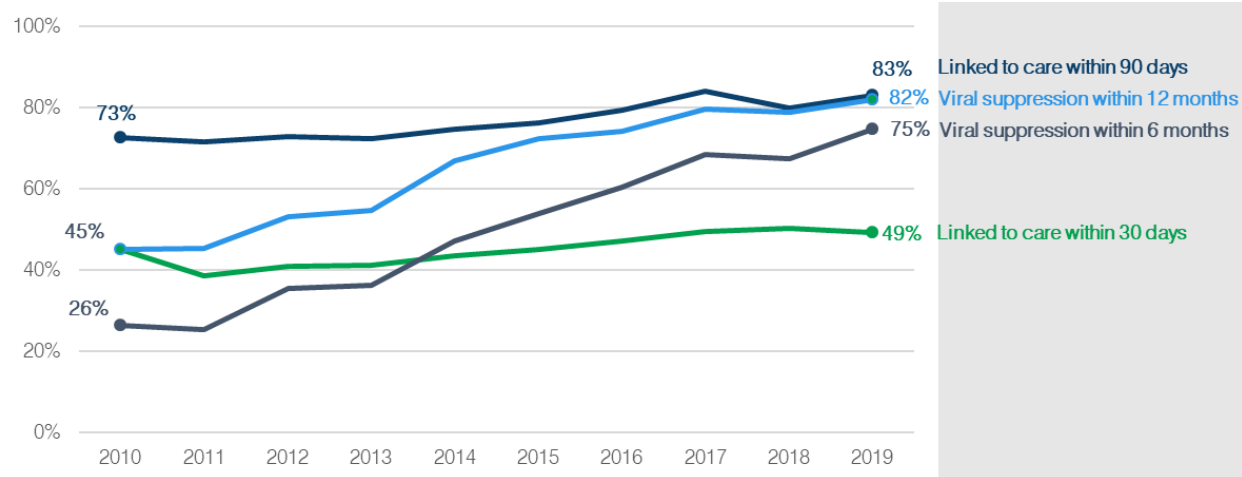


Source: MDHHS 2020a

Early linkage to care following an HIV diagnosis improves prognosis and reduces transmission risk. The proportion of people newly diagnosed with HIV who were linked to care within 30 and 90 days increased in Michigan between 2010 and 2019. The percentage of those linked to care within 30 days increased by 4 percent, and the percentage of those linked to care within 90 days increased by 10 percent (Exhibit 45).

Early viral suppression likely indicates that a PWH was linked to and retained care early in their diagnosis. In Michigan, the percentage of PWH who were virally suppressed within six months and 12 months of diagnosis has also increased over the past ten years. The percentage of those virally suppressed within six months increased by 49 percentage points between 2010 and 2019 and the percentage of those virally suppressed within 12 months increased by 37 percentage points (Exhibit 45).

EXHIBIT 45. Linkage to Care and Time to Viral Suppression

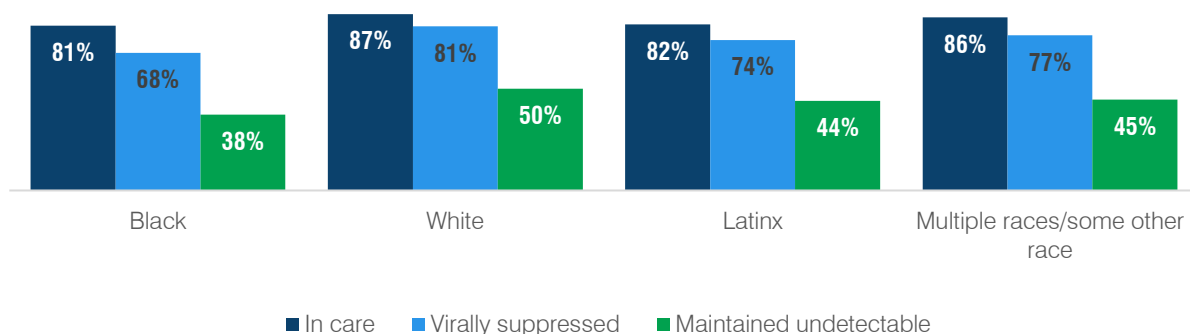


Source: MDHHS 2020b

Care and Viral Suppression Demographics

PWH who are white were somewhat more likely to be in care, virally suppressed, and considered maintained undetectable than those who are Black or Latinx (Exhibit 46). For example, 87 percent of white PWH were in care, whereas 81 percent of Black PWH and 82 percent of Latinx PWH were in care. Males were just slightly more likely than females to be in care, virally suppressed, and considered maintained undetectable (Exhibit 47). The age group least likely to be in care, virally suppressed, and considered maintained undetectable was 20- to 29-year-olds, followed by 30- to 39-year-olds (Exhibit 48).

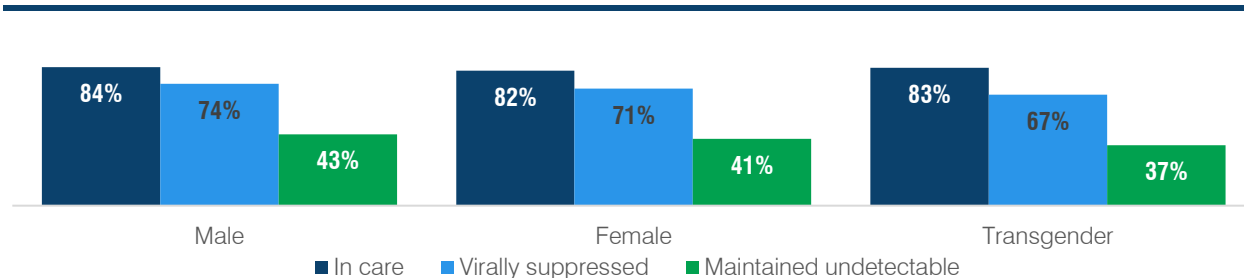
EXHIBIT 46. Percentage of PWH Who Are In Care, Virally Suppressed, and Considered Maintained Undetectable by Race/Ethnicity, 2019



N = 9,038 (Black); 5,587 (white); 969 (Latinx); 683 (multiple races or some other race)

Source: MDHHS 2020a

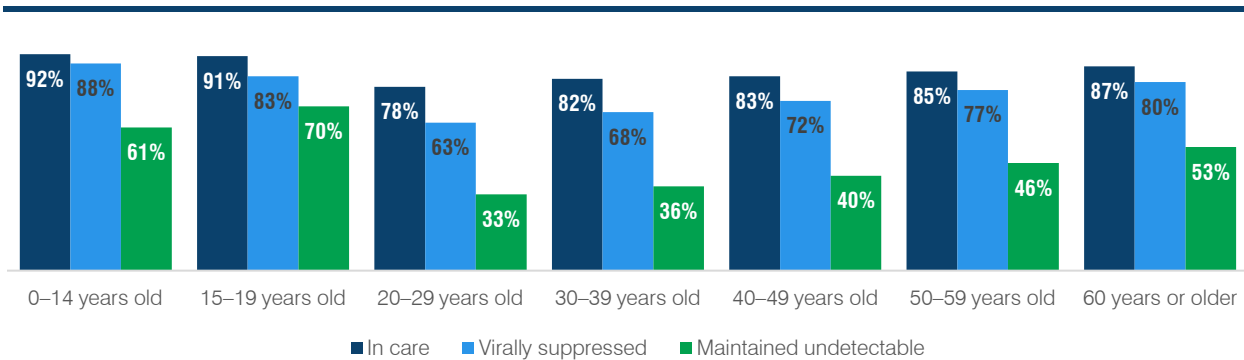
EXHIBIT 47. Percentage of PWH Who Are in Care, Virally Suppressed, and Considered Maintained Undetectable by Sex, 2019



N = 12,663 (male); 3,389 (female); 229 (transgender)

Source: MDHHS 2020a

EXHIBIT 48. Percentage of PWH Who Are in Care, Virally Suppressed, and Considered Maintained Undetectable by Age, 2019



N = 77 (0–14 years old); 70 (15–19 years old); 1,926 (20–29 years old); 3,295 (30–39 years old); 3,312 (40–49 years old); 4,630 (50–59 years old); 2,971 (60 years or older)

Source: MDHHS 2020a

Care and Viral Suppression by Local Health Department

The percentage of PWH who were in care in Michigan ranged by LHD from 72 percent to 100 percent, with an average of 84 percent and a median of 85 percent. The percentage of PWH who were virally suppressed ranged by LHD from 63 percent to 92 percent, with an average and median of 77 percent (Exhibit 49).

EXHIBIT 49. Percentage of PWH in Care and Virally Suppressed by LHD, 2019

	Range	Average	Median
In care	72–100%	84%	85%
Virally suppressed	63–92%	77%	77%

Source: MDHHS 2020a

Exhibit 50 shows the distribution of LHDs by the percentage of PWH who were in care and virally suppressed. For the purpose of this chart, health departments with an above average percentage of PWH in care are considered to have a high percentage in care, and those with a below average percentage of PWH in care are considered to have a low percentage in care. The same holds true for the high and low percentage of PWH who are virally suppressed. Over 40 percent of health departments had a high percentage of PWH both in care and virally suppressed, and 35 percent had a low percentage both in care and virally suppressed.

EXHIBIT 50. Comparison by LHD of the Percentage of PWH in Care and Virally Suppressed, 2019

High percentage in care (>84%) and low percentage virally suppressed (<77%)	High percentage in care (>84%) and virally suppressed (>77%)
<ul style="list-style-type: none"> • Kalamazoo Co. • Ingham Co. • Jackson Co. • Wayne Co. 	<ul style="list-style-type: none"> • Allegan Co. • Barry-Eaton • Central Michigan/Northern Districts • Huron Co. • Ionia Co. • Kent Co. • Livingston Co. • Muskegon Co. • Oakland Co. • Saginaw Co. • Shiawassee Co. • Tuscola Co. • Van Buren-Cass
Low percentage in care (<84%) and virally suppressed (<77%)	Low percentage in care (<84%) and high percentage virally suppressed (>77%)
<ul style="list-style-type: none"> • Berrien Co. • Calhoun Co. • Detroit • Genesee Co. • Lapeer Co. • Lenawee Co. • Macomb Co. • Marquette/UP • Monroe Co. • St. Clair Co. • Washtenaw Co. 	<ul style="list-style-type: none"> • Branch-Hillsdale-St. Joseph • Ottawa Co. • Sanilac Co.

Source: MDHHS 2020a

Note: As of Oct 1, 2020, the viral suppression goal was 87 percent for all MDHHS-funded LHDs statewide.

HIV Prevention

Partner Services

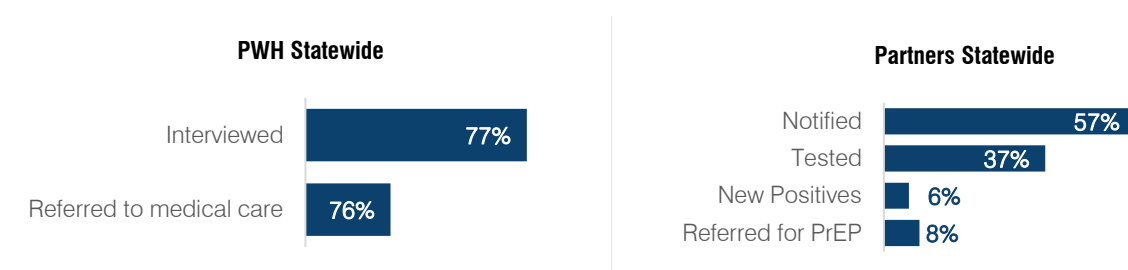
Partner Services are offered to people with sexually transmitted infections (STIs) (including, but not limited to, HIV), their partners, and other people who are at increased risk of HIV in an effort to prevent transmission. This includes contact tracing to identify and locate the sexual contacts of PWH and other people at risk of HIV and referring them for care and treatment, as appropriate (CDC 2020).

In 2019, 19 agencies reported partner services data for Michigan. All these entities were located in Michigan's Lower Peninsula. Combined, they reported providing partner services for a total of

810 PWH and identifying a total 667 partners across these PWH. Partners include sexual partners and people with whom a PWH shared intravenous drug paraphernalia.

The extent and outcomes of these services varied, and success overall was limited. Jurisdictions identified between zero (five jurisdictions) and 5.6 partners (Jackson Prison) per PWH, with a median of less than one partner (0.86) per PWH. Furthermore, only 57 percent of identified partners were notified that they may have been exposed to HIV and only 37 percent were tested for HIV (Exhibit 51). It should be noted that entities other than MDHHS and its partner agencies provide some partner services (e.g., interviews, notification, testing, etc.), which artificially decreases these rates. However, a comprehensive and effective partner services system aims to ensure that all newly diagnosed PWH are linked to care within 30 days, if possible, and interviewed. It also aims to ensure that all (100 percent) interviewees' partners are identified, notified, tested, and resourced according to their needs, such as pre-exposure prophylaxis (PrEP) or HIV treatment.

EXHIBIT 51. Partner Services

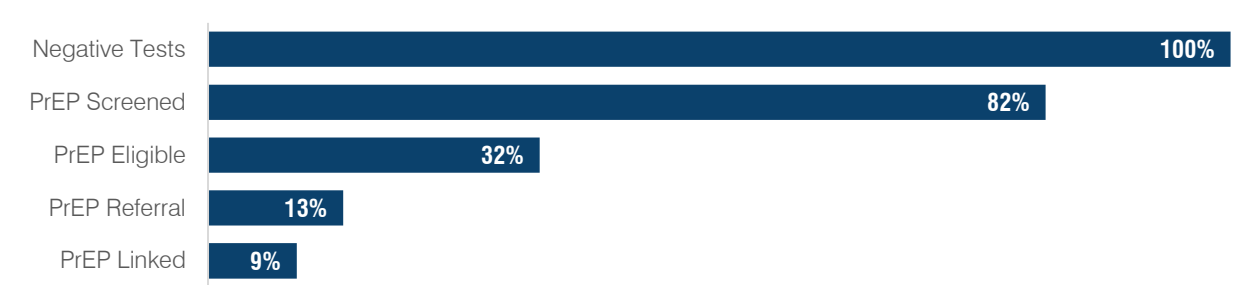


*Of the 19 jurisdictions reporting,
N = 810 (PWH); 667 (Partners)
Source: MDHHS, Testing and Partner Services, 2019

Pre-exposure Prophylaxis

People at risk for HIV who test negative can be good candidates for PrEP, an HIV prevention method in which HIV medication is taken to reduce the risk of contracting the virus. In 2019, there were over 45,000 negative HIV tests performed in Michigan. Of those testing negative, 82 percent were screened for PrEP eligibility and 32 percent were found to be eligible. However, only 13 percent were referred for PrEP and only 9 percent were linked to PrEP resources (Exhibit 52).

EXHIBIT 52. Statewide PrEP Screening and Referral, 2019



N = 45,350 for each category

Source: MDHHS, Testing and Partner Services, 2019

Given the high syphilis-HIV coinfection rate, syphilis patients who are HIV negative are given HIV prevention counseling and may be referred to PrEP to prevent HIV infection. However, only 10 percent of PrEP-eligible syphilis patients were already on or had been referred for PrEP in 2019 (Exhibit 53).

EXHIBIT 53. Syphilis PrEP Screening and Referral, 2019



N = 1,900 (all syphilis); 1,312 (PrEP eligible)

Source: MDHHS 2020c

HIV Prevention by Agency

Among the 66 agencies that had people test negative for HIV in 2019, 80 percent linked at least one person to PrEP resources. The number of negative tests varied greatly among these agencies, ranging from 5 negative tests at the Benzie-Leelanau District Health Department to 8,667 at Oakland County Health Division (Exhibit 54). The percentage of people who were PrEP eligible ranged from zero to 99 percent, with an average of 34 percent and a median of 26 percent. The percentage linked to PrEP resources by these agencies ranged from zero to 97 percent, with an average of 15 percent and a median of just 5 percent. The Lansing Area AIDS Network linked the highest percentage of those with negative HIV tests to PrEP resources (97 percent), followed by ACCESS (96 percent), Community Health Awareness Group (89 percent), and Health Emergency Lifeline Programs (83 percent).

EXHIBIT 54. Percentage of People with Negative HIV Tests Linked to PrEP, 2019

	Range	Average	Median
Number of negative tests	5–8,667	687	161
Percentage PrEP screened	0–100%	74%	86%
Percentage PrEP eligible	0–99%	34%	26%
Percentage referred for PrEP	0–98%	20%	8%
Percentage linked to PrEP	0–97%	15%	5%

Source: MDHHS, Testing and Partner Services, 2019

Note: Due to changes in PrEP variables and definitions, the data represented has limitations and does not accurately reflect PrEP eligibility and access in the jurisdiction.

Exhibit 55 shows the distribution of these 66 agencies by the percentage of people who tested negative for HIV who were considered PrEP eligible and linked to PrEP resources. For the purpose of this chart, agencies with an above average percentage of people who were PrEP eligible are considered to have a high percentage in eligible, and those with a below average percentage PrEP eligible are considered to have a low percentage eligible. The same holds true for the high and low percentage of people linked to PrEP resources. Over half (54 percent) of all agencies had a low percentage of people who were PrEP eligible and linked to PrEP resources, and around 20 percent had a high percentage who were both eligible and linked to resources. Another 20 percent had a high percentage of people who were PrEP eligible and a low percentage linked to PrEP resources. The Lansing Area AIDS Network had the highest percentage of people (99 percent) identified as PrEP eligible and the highest percentage linked to PrEP resources (97 percent); whereas Matrix had 99 percent of PrEP eligible clients with only 3 percent linked to resources.

EXHIBIT 55. Comparison of the Percentage of People Who Are PrEP Eligible Linked to PrEP Resources by Agency, 2019

High percentage PrEP eligible (>34%) and low percentage linked to PrEP resources (<15%)		High percentage PrEP eligible (>34%) and linked to PrEP resources (>15%)	
<ul style="list-style-type: none"> • Branch-Hillsdale-St. Joseph Community Health Agency • Detroit Receiving Hospital 1 • Genesee Co. HD • Grand Rapids Red Project • Ionia Co. HD • Kalamazoo Co. HD • Matrix 	<ul style="list-style-type: none"> • McClees Clinic • Midland Co. HD • Monroe Co. HD • Unified • Van Buren-Cass District HD • WSU-SOM-STD/HIV Clinic 	<ul style="list-style-type: none"> • ACCESS • Bay Co. HD • CARES-Southwest Michigan • Chippewa Co. HD • Community Health Awareness Group • Gospel Against AIDS • Health Emergency Lifeline Programs 	<ul style="list-style-type: none"> • Lansing Area AIDS Network • MDHHS Detroit DIS • MDHHS Outstate DIS • Washtenaw Co. HD • Wellness AIDS Services • WSU- Adult Clinic • WSU Horizon Project
Low percentage PrEP eligible (<34%) and linked to PrEP resources (<15%)		Low percentage PrEP eligible (<34%) and high percentage linked to PrEP resources (>15%)	
<ul style="list-style-type: none"> • Allegan Co. HD • Barry-Eaton District HD • Benzie-Leelanau District HD • Berrien Co. HD • Calhoun Co. HD • Detroit Community Health Connection • Dickinson-Iron HD • District HD #10 • District HD #2 • District HD #4 • DMC - Detroit HD • Grand Traverse Co. HD • Health Delivery • Hearth Home • Henry Ford Health System • Huron Co. HD • Ingham Co. HD • Jackson Co. HD • Lenawee Co. HD • Livingston Co. HD 	<ul style="list-style-type: none"> • Luce-Mackinaw-Alger-Schoolcraft District HD • Macomb HD • Marquette Co. HD • Mid-Michigan District HD • Muskegon Co. HD • Northwest Michigan HD • Oakland Co. Health Division • Ottawa Co. HD • Public Health Delta and Menominee Counties • Saginaw Co. HD • Sanilac Co. HD • Shiawassee Co. HD • St. Clair Co. HD • Tuscola Co. HD • UNIFIED - Detroit HD • Wayne Co. HD • Western Upper Peninsula District HD 	<ul style="list-style-type: none"> • Central Michigan District HD • Kent Co. HD 	

Source: MDHHS, Testing and Partner Services, 2019

Note: Due to changes in PrEP variables and definitions, the data represented has limitations and does not accurately reflect PrEP eligibility and access in the jurisdiction.

National HIV Behavioral Surveillance (NHBS) data from 2015-2019 was used to highlight PrEP awareness and use in the Detroit Metropolitan Area (DMA). Awareness of PrEP increased from 6 percent to 36 percent between 2011 and 2019 and PrEP usage increased from less than 1 percent to 10 percent in the same period. Awareness and use of PrEP is consistently highest among MSM as compared to heterosexually active increased-risk persons (HET) and PWID. Awareness is highest among those aged 35-44 years and PrEP usage is highest among those aged 18-24 years. There is a gap in PrEP usage among females (35 percent are aware, 2 percent have ever used) and Black persons who accounted for 67 percent of new diagnoses between 2017-2019 but only 49 percent of those who have ever taken PrEP in the same period.

Three quarters (77 percent) of heterosexually active increased-risk adults in the DMA were ever tested for HIV according to 2019 NHBS data. Nearly one third (32 percent) of those persons had been tested within the previous 12 months. Concerningly, nearly four in five DMA participants (79 percent) agreed that most people would discriminate against someone with HIV. Over half (52 percent) agreed that most people would not be friends with someone with HIV. Only two in five (40 percent) agreed that most people would support the rights of a person with HIV to live and work wherever they wanted; and 28 percent agreed that most people think that people who got HIV through sex or drug use have gotten what they deserve.

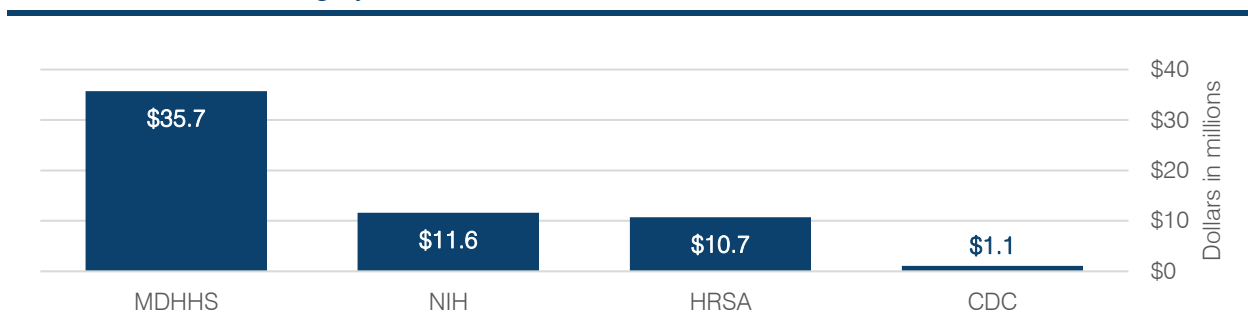
Cluster Detection and Response

In 2019 five clusters and networks were identified and addressed across the state. Three of the networks were identified by MDHHS' Time-space monitoring program and the other two were identified, and then reported to MDHHS, by astute local health workers or medical providers. Two of the five networks were in the Detroit/Wayne County region. Two of the networks were in western Michigan (Kalamazoo and Grand Rapids). The final network was identified in Marquette County, in the upper peninsula. All networks were investigated and tracked per the MDHHS HIV response plan, and no additional growth was observed.

HIV Prevention, Care, and Treatment Resource Inventory

During fiscal year 2019 (FY 2019), 75 organizations received funding to provide HIV and STI diagnosis, care, and prevention services across the state. In total, these organizations received \$59.2 million from MDHHS and grants from the Centers of Disease Control and Prevention (CDC), Health Resources and Services Administration (HRSA), and National Institutes of Health (NIH). Sixty percent of HIV funding—\$35.7 million—was provided to organizations by MDHHS (includes Ryan White Rebate funds) (Exhibit 56). This amount included funds from the state general fund, the Michigan Health Initiative grant, and other federal funding passed through the state. The remaining 40 percent of funding was received by the organizations directly from federal grant programs.

EXHIBIT 56. Total Funding by Source, FY 2019

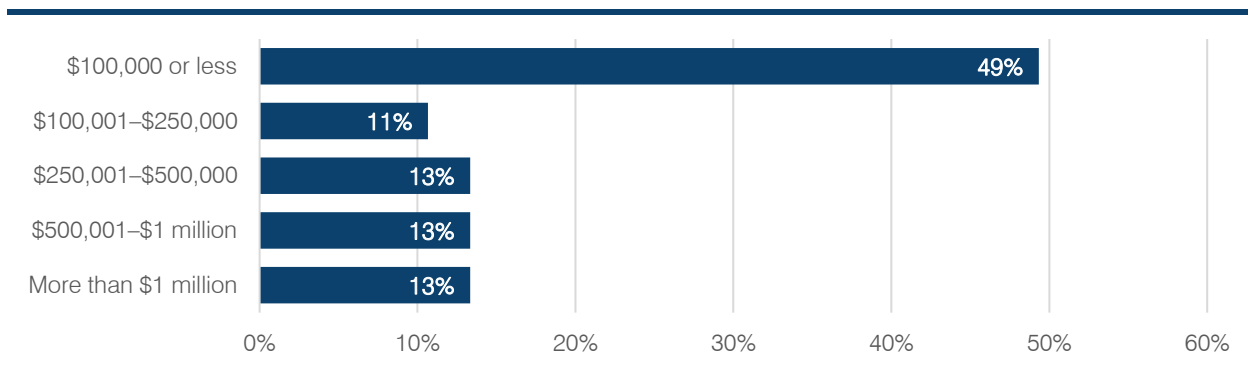


Source: MDHHS; TAGGS

MDHHS Funding

The amount of funding provided to organizations by MDHHS ranged from \$20,000 to \$5.2 million with an average of \$475,836 and a median of \$111,094. Nearly half of the 75 funded organizations received \$100,000 or less through state agreements, and 13 percent received more than \$1 million (Exhibit 57).

EXHIBIT 57. Percentage of Funding by Amount, FY 2019



Source: MDHHS; TAGGS

The organization receiving the largest amount of funding—\$5.2 million—was the Michigan Public Health Institute (MPHI), followed by Wayne State University (\$4.4 million) and Southeastern Michigan Health Association (SEMHA) (\$3.3 million). Both MPHI and SEMHA funding is mainly for staffing support. Nearly 30 percent of organizations received the lowest amount of \$20,000 for HIV prevention activities, including HIV testing and linkage to care.

MDHHS Funding by Project Grant Type or Category

In FY 2019, MDHHS provided funding for 171 different contracts across the funded agencies. Much of this funding was provided through state contracts for HIV Care Coordination, Prevention, and Medical Care grants and HIV Data to Care, Ryan White Part B, and Ryan White Part D funding. Other funded contracts generally fell into the categories of HIV and STI data and surveillance projects, HIV and STI education and outreach projects, and STI services and control.

Nearly half (46 percent) of funded contracts went toward HIV care and treatment, accounting for 71 percent of total funding. Under the care category, HIV Care Coordination grant contracts and Ryan White Part B contracts received 19 percent of the total funding in FY 2019; however, they accounted for only 4 percent and 9 percent of the total number of funded contracts, respectively. Similarly, 11 percent of contracts were HIV Data to Care, with only 3 percent of total funding going to these contracts. Twelve percent of contracts fell into the data and surveillance category, receiving 13 percent of total funding. Nearly 40 percent of the contracts were funded through HIV prevention grants, and these contracts received 21 percent of total FY 2019 funding—\$7.4 million. Another 13 percent of funded contracts were STI services, which accounted for only 4 percent of total FY 2019 funding (Exhibit 58).

EXHIBIT 58. Funding by Grant/Category, FY 2019

Category/Grant	Number of Contracts	Percentage of Contracts	Total Funding	Percentage of Total Funding
HIV Care and Treatment*				
HIV Care Coordination Grants	7	4%	\$6,759,281	19%
Ryan White Part B Funding	15	9%	\$6,656,533	19%
Data and Surveillance Projects	20	12%	\$4,680,295	13%
HIV Medical Care Grants	13	8%	\$3,994,639	11%
Ryan White Part D Funding	3	2%	\$1,646,939	5%
HIV Data to Care Grants	18	11%	\$1,160,174	3%
Unspecified HIV Care Service	1	<1%	\$175,000	<1%
Ryan White Part B Minority AIDS Initiative Funding	2	1%	\$174,728	<1%
Subtotal	79	46%	\$25,247,589	71%
HIV Prevention				
HIV Prevention Grants	65	38%	\$7,447,789	21%
Subtotal	65	38%	\$7,447,789	21%
Other				

Category/Grant	Number of Contracts	Percentage of Contracts	Total Funding	Percentage of Total Funding
Education and Outreach Projects	5	3%	\$1,699,592	5%
STI Services	22	13%	\$1,292,717	4%
Subtotal	27	16%	\$2,992,309	8%
Grand Total	171		\$35,687,687	100%

*Note: Detroit, Michigan also received an additional \$9,588,058 through Ryan White Part A, as follows:

FY2021 Final Formula Award:	\$5,855,186
FY2021 Final Supplemental Award:	\$2,914,225
FY2021 Final MAI Award:	\$818,647

MDHHS Funding by Project Category and Geography

Nearly 40 percent of funded contracts in FY 2019 were run by organizations located in Southeast Michigan, with those organizations receiving nearly half of all MDHHS funding, or \$17.6 million. Statewide organizations received the next highest percentage of total funding at 15 percent, followed by organizations in eastern Michigan at 10 percent. Organizations in West and Southwest Michigan each received 7 percent of total funds, and those in mid-Michigan and the northern Lower Peninsula received 6 percent. The lowest percentage of funding (1 percent) was received by organizations in the Upper Peninsula (Exhibits 59 and 60).

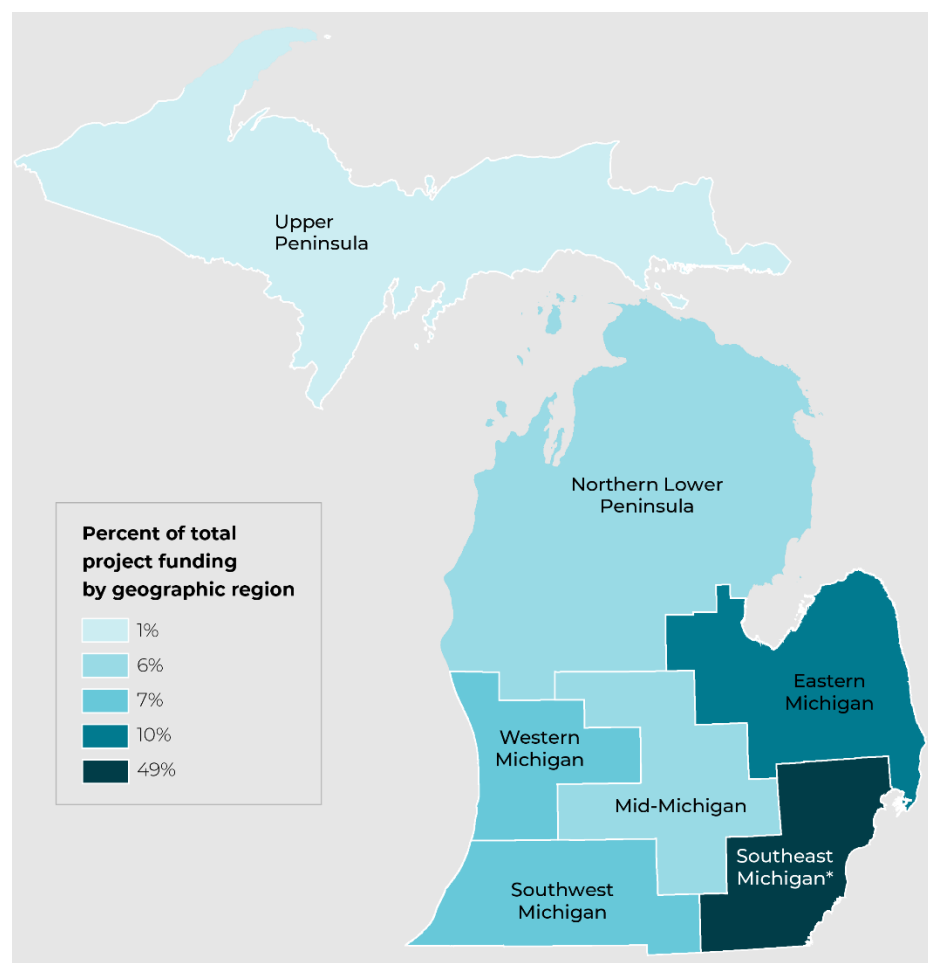
EXHIBIT 59. Funding by Grant/Category and Region, FY 2019

Region	Number of Funded Contracts	Percentage of Funded Contracts	Total Project Funding	Percentage of Total Project Funding
Southeast Michigan	66	39%	\$17,605,854	49%
Statewide	13	8%	\$5,249,334	15%
Eastern Michigan	19	11%	\$3,406,368	10%
Western Michigan	17	10%	\$2,528,826	7%
Southwest Michigan	19	11%	\$2,377,898	7%
Mid-Michigan	14	8%	\$2,090,341	6%
Northern Lower Peninsula	14	8%	\$1,977,655	6%
Upper Peninsula	9	5%	\$451,411	1%
Total	171	100%	\$35,687,687	100%

Source: MDHHS State Amendments and analyzed by PSC.

Note: A portion of funding in Southeast Michigan may fund programs located in Jackson and Livingston County, which are included in the Mid-Michigan region, and St. Clair County, which is included in the Eastern Region.

EXHIBIT 60. Funding by Grant/Category and Region, FY 2019



Source: MDHHS State Amendments and analyzed by PSC.

Note: A portion of funding in Southeast Michigan may fund programs located in Jackson and Livingston County, which are included in the Mid-Michigan region, and St. Clair County, which is included in the eastern region.

Activity Provided by Project Grant Type or Category

There were a total of 409 service activities among the 171 funded contracts. While many of the funded contracts included only one or two HIV or STI services activities, some included a variety of these activities. For example, while most of the contracts for HIV prevention grants only provided HIV testing and linkage to care, many Ryan White Part B and HIV Care Coordination contracts included a number of activities such as early intervention services, emergency financial assistance, food assistance, health education and risk reduction services, medical and nonmedical case management, medical transportation, mental health services, outpatient ambulatory medical care, psychosocial support service, and outpatient substance abuse treatment services (Exhibit 61).

EXHIBIT 61. Activity by Grant Project Type or Category, FY 2019

Grant Category/Activity	Number of Contracts Providing Activity	Percentage of Total Contracts Providing Activity
HIV Prevention Grants (N = 65)		
HIV testing	59	91%
Linkage to care	59	91%
Partner Services	15	23%
Interventions	9	14%
PrEP navigation	6	9%
Syringe service program	5	8%
PrEP clinic/provider	3	5%
Social media/marketing	2	3%
Education and outreach	1	2%
FQHC education	1	2%
HIV/STI hotline	1	2%
Noncategorical prevention	1	2%
MATEC/Provider education	1	2%
HIV Care Coordination Grants (N = 7)		
Medical case management	6	86%
Mental health	6	86%
Early intervention services	5	71%
Emergency financial assistance	5	71%
Medical transportation	5	71%
Food provision	4	57%
Nonmedical case management	4	57%
Outpatient ambulatory medical care	4	57%
Health education/risk reduction	3	43%
Outpatient substance abuse treatment services	3	43%
Psychosocial support	2	29%
Education and outreach	1	14%
Unspecified HIV care coordination activity	1	14%
Ryan White Part B Funding (N = 15)		
Medical case management	12	80%
Medical transportation	12	80%
Nonmedical case management	12	80%
Emergency financial assistance	9	60%

Grant Category/Activity	Number of Contracts Providing Activity	Percentage of Total Contracts Providing Activity
Psychosocial support	9	60%
Food provision	8	53%
Linguistic services	7	47%
Early intervention services	6	40%
Outpatient ambulatory medical care	5	33%
Mental health services	4	27%
Health education/risk reduction	3	20%
Medical nutrition therapy	3	20%
AIDS care	1	7%
Data and Surveillance Projects (N = 20)		
HIV PrEP data collection	10	50%
Core HIV surveillance	2	10%
HIV surveillance support	1	5%
Component A surveillance	1	5%
Component B surveillance	1	5%
HIV Care IT and Data Project	1	5%
Gonococcal Isolate Surveillance Project	1	5%
Medical Monitoring Project	1	5%
National HIV Behavioral Surveillance System	1	5%
STD Neisseria Gonorrhoeae Enhanced Surveillance Project	1	5%
STI surveillance and intervention program	1	5%
HIV Medical Care Grants (N = 13)		
Outpatient ambulatory medical care	7	54%
Medical transportation	4	31%
Early intervention services	3	23%
Mental health services	3	23%
Medical case management	2	15%
Unspecified HIV medical care activity	2	15%
AIDS Drug Assistance Project	1	8%
Emergency financial assistance	1	8%
Food provision	1	8%
Housing	1	8%
Linguistic services	1	8%
Nonmedical case management	1	8%

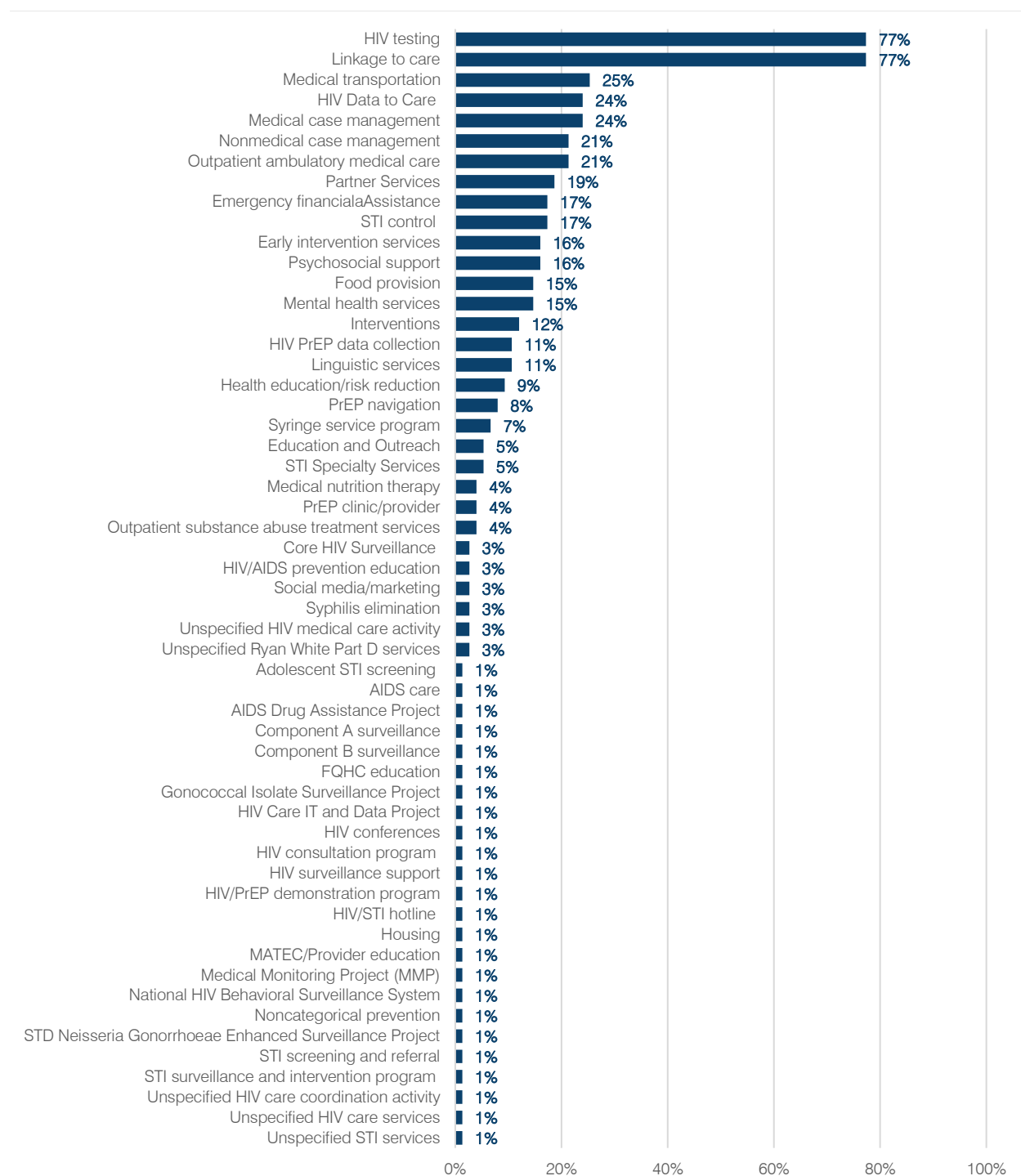
Grant Category/Activity	Number of Contracts Providing Activity	Percentage of Total Contracts Providing Activity
Psychosocial support	1	8%
Education and Outreach Projects (N = 5)		
HIV/AIDS prevention education	2	40%
HIV conferences	1	20%
HIV consultation program	1	20%
HIV PrEP demonstration program	1	20%
Ryan White Part D Funding (N = 3)		
Unspecified Ryan White Part D services	2	67%
Health education/risk reduction	1	33%
Medical case management	1	33%
Medical transportation	1	33%
Mental health services	1	33%
Nonmedical case management	1	33%
Outpatient ambulatory medical care	1	33%
Psychosocial support	1	33%
STI Services (N = 22)		
STI control	13	59%
STI specialty services	4	18%
Syphilis elimination	2	9%
Adolescent STI screening	1	5%
STI screening and referral	1	5%
Unspecified STI services	1	5%
HIV Data to Care Grants (N = 18)		
HIV Data to Care	18	100%
Unspecified HIV Care Services (N = 1)		
Unspecified HIV care services	1	100%
Ryan White Part B Minority AIDS initiative Funding (N = 2)		
Education and outreach	2	100%
Total	409	

Activity Provided by Organization

In FY 2019, over three-quarters of the funded organizations provided HIV testing and linkage to care services (Exhibit 62). Around one-quarter each provided medical transportation, HIV Data to Care, and medical case management. Around 20 percent provided nonmedical case management, outpatient ambulatory medical care, and Partner Services. Other services provided by more than 10 percent of the organizations included emergency financial assistance,

STI control, early intervention services, psychosocial support, food provision, mental health services, interventions, HIV PrEP data collection, and linguistic services.

EXHIBIT 62. Percentage of Organizations Providing Service, FY 2019



Source: MDHHS; TAGGS

Direct Federal Funding

Several organizations in addition to the State of Michigan also received funding directly from HRSA or CDC for programs and direct patient care. These grants totaling over \$21 million, with amounts ranging from \$56,500 to over \$9 million per organization (Exhibit 63). NIH funding is not displayed here but several academic and research institutions in Michigan, including Henry Ford Health System, Wayne State University and the University of Michigan are funded for NIH research grants. Michigan does not receive direct federal assistance for HRSA Ryan White Dental Programs or AIDS Education and Training Centers.

EXHIBIT 63. Direct Federal Funding Recipients

Organization/Grant Name	Funding Source	Funding Amount
CDC HIV Prevention		
Community Health Awareness Group	CDC	\$441,625
Detroit Recovery Project	CDC	\$761,625
Matrix Human Services	CDC	\$441,625
Ryan White Part A		
City of Detroit Health Department	HRSA	\$9,588,058
HIV Emergency Relief Project Grants	HRSA	\$9,663,664
Ryan White Part C		
Detroit Community Health Connection	HRSA	\$56,500
The Regents of the University of Michigan	HRSA	\$86,750
Trinity Health Corporation	HRSA	\$108,405
Wayne State University	HRSA	\$136,301
Ryan White Part D		
Ingham County Health Department	HRSA	\$483,774

Strengths and Gaps

Nearly 40 percent of the 171 MDHHS-funded contracts across the state provided HIV prevention services in FY 2019. Among the prevention services offered, over three-quarters of funded organizations provide HIV testing and linkage to care services. The next largest percentage of funded services were STI services at 13 percent, followed by data and surveillance contracts at 12 percent and HIV Data to Care grants at 11 percent. Areas with the fewest funded contracts included HIV care coordination grant projects, education and outreach projects, and Ryan White Part D-funded projects.

When assessing these contracts by total amount of funding, HIV prevention grants received the most funding in FY 2019 with 21 percent of total funding, followed closely by HIV care coordination grants and Ryan White Part B funding at 19 percent each. Areas receiving the smallest percentage of total funding included education and outreach projects, Ryan White Part D funding, STI services, and HIV Data to Care grants.

Approaches and Partnerships

MDHHS coordinates with Viral Hepatitis programs to support Syringe Service Programs (SSPs) and capacity building within the jurisdiction. Although BHSP only supports six SSPs, the State of Michigan funds other programs around the state through the Opioid Crisis Cooperative Agreement, SAMSHA Block Grants, and the State Opioid Response Grants. These programs are also funded to provide HIV and HCV testing along with providing referrals to substance use treatment and medical care services. Capacity building efforts to support a syndemic approach include providing HIV and HCV rapid test training along with coordinating site visits to be inclusive of these different services, developing new HIV prevention contracts with organizations currently funded to address Hepatitis, and implementing webinars and other learning opportunities that discuss health and prevention services for people who use drugs.

The BHSP has an ongoing relationship with the MDHHS Housing Opportunities for Persons with AIDS (HOPWA) program that provides housing opportunities for PWH in 77 of Michigan's 83 counties. HOPWA formula grantees cover the remaining six counties—Wayne, Oakland, Macomb, Livingston, St. Clair, and Lapeer. Part of the collaboration with MDHHS HOPWA includes supporting a HOPWA Coordinator to facilitate integration and coordination of HOPWA services with Ryan White B providers. The coordinator administers \$2,250,649 as of 2022 across seven service providers. In addition to core HOPWA services, BHSP works with the coordinator to offer capacity building opportunities including a Ryan White Housing Collaborative, trainings on emergent housing and HIV topics, and a semi-annual Ryan White Housing Summit. The trainings and summit are made available to all Ryan White-funded partners including case managers and medical case managers.

Needs Assessment

Background

PSC conducted focus groups with HIV/STI providers and interviews with community members. The following is a summary of feedback gathered through conversations with providers, community members, MDHHS staff, and the Michigan HIV/AIDS Council. The focus groups collected data from more than 100 providers from various regions of the state who have lived and/or professional experiences with HIV. More than 120 community members, representing a variety of perspectives, participated in focus groups and interviews. Findings from those conversations, including strengths, weaknesses, and opportunities for improvement, are

provided below. Topics covered included services people need to access HIV testing and care, barriers to existing HIV testing, and services that people with HIV need to stay in HIV care.

Cross-cutting Themes

While providers and community members were asked to discuss the strengths and challenges related to each objective separately, several themes arose in multiple objectives: transportation, stigma, community and provider outreach and education, distrust of medical providers and provider bias, and telehealth. These are described here, including how they relate to the State of Michigan's objectives for addressing HIV.

Transportation

A priority across the various objectives was the need for improved transportation options. A few participants mentioned that local organizations offer transportation services to help connect clients with services. Some people can receive transportation services through their insurance provider, but this is not a well-known option among community members nor is it available to everyone. One provider noted that if they did not take their patients to their appointments, they would not be able to stay virally suppressed. Some communities also lack adequate public transportation or have services spread out across long distances. Providers in these areas said they do not have enough money in their budgets to help with transportation when a taxi ride can cost \$200. A tribal health provider said they are able to connect community members with transportation to reach HIV services but noted that infectious disease specialist can be more than an hour away.

Stigma

Providers in several regions identified stigma as a barrier for quickly diagnosing people with HIV and engaging them in treatment. They said some medical providers are afraid to ask patients if they would like to be tested or to connect them with HIV testing and resources. Some providers noted that HIV is the only STI with laws requiring people to disclose their status even though STIs like syphilis can lead to death without treatment. They said this can prevent people from getting tested because they fear having to disclose their status if they are diagnosed with HIV. Providers in rural communities mentioned how stigma can impact concerns about confidentiality in smaller, tight-knit communities and that this can lead to delayed testing and treatment for patients.

In addition to stigma being a barrier to care providers noted how stigma surrounding HIV and denial on the part of the client can create challenges for treating HIV. They noted that some patients go through multiple rounds of testing after their positive test because they are ashamed and in denial. This can cause some patients to delay treatment for several months.

Community members echoed that shame and stigma are primary barriers to accessing services. They noted that people are afraid of receiving a positive test because of the stigma and possibility of being shamed by their loved ones. In addition, some participants who had engaged

in sex work described how they would not feel comfortable accessing services when they were engaged in sex work because of the stigma associated with their work.

Community and Provider Outreach and Education

Community outreach and education was another area that was consistently identified across objectives. Providers and MDHHS staff indicated that community outreach and education is one way they can prevent the spread of HIV in their community. Providers use social media and attend community events like local pride celebrations to connect with community members. MDHHS particularly emphasized that it was important to engage with community partners that are not involved in HIV diagnosis and care. By attending community events, MDHHS and providers can meet people where they are, create positive interactions, and bring people into its service locations.

In addition, providers also noted the challenges that come with engaging detained populations. A community member who has experience with the system affirmed that barriers to accessing care in prison exist. They noted that care was only given in an emergency and that staff disregard privacy around medical information. They noted that more work needs to be done when people enter prison to connect them with medication and other resources to support their health.

Several community members noted that there is still a lot of misinformation about HIV among community members and medical providers. One community member noted that when they were initially diagnosed, their doctor told them they would never be able to have sex again while another stated they have to continuously educate medical providers about HIV and what they need for care. Another community member noted that people do not understand that undetectable equals untransmittable (U=U), and how they only learned this information recently. Community members also noted that there is still a misperception that HIV is a “gay” disease, and that heterosexual people cannot contract it. Many people do not fully understand that people with HIV can live long, healthy lives.

Distrust of Medical Providers and Provider Bias

Several providers noted that medical provider offices in some regions lack diverse staff who reflect the population being served. One provider described how having a provider in their office who is gay has allowed them to make some community members feel more comfortable discussing topics related to sexual health. Black, Latinx, and transgender clients face similar challenges with a lack of representation and not always receiving affirming care. Black and Latinx community members mentioned that medical racism was a barrier to them receiving care. One individual noted that the care they received compared to their white partner was not the same. Their needs were not taken seriously, and they had to advocate to receive appropriate medical care while their white partner was able to receive adequate care without having to self-advocate.

In addition, providers and community members said many medical providers lack in-depth knowledge about HIV or have incorrect assumptions about a patient's risk for HIV and STIs. Testing at primary care appointments does not happen unless the patient requests it. Providers believe this leads to medical providers underestimating people's risk profiles and not connecting them with testing. One provider stated that a medical provider turned down an educational opportunity about HIV because they did not think it was necessary for the population they worked with. They said older doctors in particular do not screen patients who they assume would not be at risk for HIV or other STIs. Younger doctors were described as more likely to conduct near-universal screening and making fewer assumptions about people's risk levels.

Telehealth Services

Telehealth services was a prominent topic across the various objectives. Several community members mentioned that they enjoyed having the option to use telehealth to access services. They mentioned that this was a great option for people who may not feel comfortable accessing services in a doctor's office or who do not have access to reliable transportation. Telehealth services work well for patients who have an established relationship with their treatment provider. Fewer community members preferred in-person services while others acknowledged that test results should be delivered in office to create opportunities for education and resource connections.

Pillar One: Diagnosing All Persons with HIV as Early as Possible

Strengths

Partner Services

Providers indicated that partner services is something that is working well right now. They stated partner services allows at-risk individuals to be identified and connected with HIV testing resources to be diagnosed quickly. One provider described how their partner services team ensures timely testing of partners with potential HIV exposure while also engaging patients to help them understand their risk.

Testing Options

Providers in multiple regions identified access to rapid testing as a strength in their region, rapid test typically require a finger prick and provide results in less than thirty minutes. Providers mentioned that because rapid testing is less invasive than drawing blood, people feel more comfortable with the rapid test.

Providers also mentioned that offering walk-in services at health departments and HIV service agencies for community members provided access to quick HIV testing and results and other STI/STD services. Several providers across different sessions mentioned that this was something that worked well in their region.

Routine Testing and HIV Testing as an Opt-out Service

Providers spoke about how routine testing and framing HIV testing as an opt-out service is another successful strategy for early diagnosis. One provider said it should be considered part of standard sexual health visits and not an additional step. Another provider recommended testing on a schedule that aligns with a person's risk level, with lower risk individuals testing less frequently. Several community members noted that testing should focus on testing everyone during regular health screenings regardless of their perceived risk.

Availability of Multiple Testing Locations

Providers indicated that having access to multiple testing locations was a strong tool for ensuring early diagnosis. Having options at health departments, HIV service agencies, community partners, and outreach events allow patients to easily access testing and resources. One provider mentioned that testing at community events and holding open hours for testing at health departments increases access to testing. Some providers indicated that prevention is underfunded and there needs to be a push to expand testing access to more locations.

Good Partnerships and Collaboration

Some providers described good partnerships and strong collaboration in their regions. Some said they communicate with medical providers in their communities about HIV/STI-related trends and resources to help the medical providers make appropriate referrals and help patients navigate diagnosis and treatment. Providers also mentioned that it was important for them to understand and have relationships with other types of providers in their community so they can help patients find other services.

Providers said partnerships with schools have helped them reach the youth population. One provider described how they were able to work with a local school and gain the trust of the community, which enabled them to form a strong partnership and provide realistic information about HIV/STIs and their transmission rates. Providers believed that educating students about this at a younger age enables students to have a more informed understanding of the importance of testing and how to access services.

Culturally Sensitive Care and Trusted Resources

Community members stated that having access to culturally sensitive care was something that made them more comfortable connecting to testing resources. Community members mentioned how this, along with having providers that represent their identities, was important for connecting marginalized communities with care. In addition to this, community members discussed the need for more opportunities for PWH to work in the field.

In addition, community members said that people who engage in sex work, people of color, people in the LGBTQ+ community, and especially those with intersecting identities are underserved. People who engage in sex work are wary of receiving services due to possible persecution and shaming while discrimination is a barrier for communities of color and LGBTQ+ individuals.

Several community members noted that they identified providers by talking to trusted friends and peers who have had similar experiences. This was one of the primary methods for identifying resources along with going to organizations like Planned Parenthood that had established connections with the community.

Barriers and Challenges

Lack of Knowledge about Testing Resources

Some providers mentioned that community members are not fully aware of the resources that exist to support PWH and others who need testing resources. Providers said the system is so complex that they sometimes struggle to understand all the resources that exist.

Several community members said that without the internet they would not know where to find testing resources if they were not already connected with HIV resources. Some said most of the information they get about testing or other HIV/STI resources comes from peers and others in their community they trust.

Community members identified that more advertising of testing and treatment resources is necessary. Although some people in the community know where to go to receive resources the average person does not. MDHHS should do more advertising on where people can access resources and how HIV can impact anyone.

Lack of Testing Resources

Community members in rural areas and those in economically disadvantaged communities also identified a lack of adequate testing resources in their community. Some community members said they did not have any testing resources near their communities, which limited their access to testing services. Some said mobile testing units were the primary access point for testing in their community. One community member noted that urgent care locations lack adequate training to competently provide services to patients who need HIV testing, describing cases of outdated test being used and medical staff having to refer people to local health departments for testing.

Tribal health providers also mentioned that they do not have adequate HIV/STI testing resources to diagnose community members, saying availability of these resources has been overshadowed by needs related to COVID and MPV.

Limited HIV Funding

Providers in multiple regions listed lack of funding among the barriers to HIV/STI testing and diagnosis. They said providers tend to have limited funding to advertise their services, which limits the number of community members they are able to reach. Providers also said the process to offer incentives like gift cards is restrictive because they are required to get receipts from clients, which is challenging for the providers and stigmatizing for patients. They strongly believe this rule should be changed because it is a state requirement and is not required by the federal government, which is the primary funder of HIV prevention and treatment services. HIV

funding was also described as being competitive, which can stifle collaboration, especially in smaller communities.

Limits on Services that Can Be Offered in Schools

Providers described being able to offer limited services in K–12 schools. One provider stated that they were allowed to treat STIs on campus but are not allowed to hand out condoms to prevent the spread of STIs. They noted that many schools are also unaware of the services that health departments and other community organizations can offer, so they are not able to help connect students with testing and other appropriate services.

Mobile Testing

Community members identified mobile testing as a resource that is not being properly engaged to reach people who need testing. Some communities do not have access to physical testing locations, which is something mobile testing connects them to. Several community members also noted that this would be a great resource for meeting community members where they are to provide them with services. MDHHS staff mentioned that mobile testing is another way to connect with people who are at risk, but it is more difficult to provide mobile care.

One suggestion to increase access to testing is to offer more testing in communities via mobile syringe service program (SSP) and community events. A participant noted that SSP units operated in their community; however, they only provided clean needles and did not offer testing resources. Offering testing via these mobile units allow communities without brick-and-mortar testing locations to still access quick and reliable test.

At-home HIV Tests

Several community members noted that HIV home test should become more widely used. However, many expressed concerns that people who receive a positive test would not be connected to resources and treatment. For those with a negative test result, they identified it as a missed opportunity to connect people with resources like PrEP.

Pillar Two: Treating HIV Rapidly and Effectively to Achieve Sustained Viral Suppression

Strengths

Linkage to Care, Medication, and Other Services

A few providers noted that newly diagnosed clients can be connected to care in their regions quickly after being diagnosed. They reported that clients are supported from the time they test positive until they are virally suppressed. Another provider noted that the time between testing positive and a person's first appointment is typically less than one week. When providers in these regions lack the resources to handle certain aspects on the care continuum, they said they can refer clients to other organizations.

Community members noted that they can get connected with resources that help them cover transportation and medication cost to access services. Another community member who provides HIV services noted that so many doors open for a person when they test positive, and providers can connect them with resources. Several providers and community members noted that the Michigan Drug Assistance Program (MDAP)—a program that covers the cost of medication for qualifying people with HIV—and other programs have helped make cost less of a barrier to accessing HIV medication. MDHHS staff noted that lack of insurance and limited funding for prevention are major barriers. They said paying for the cost of medications and other things goes to treatment services, rather than prevention. MDAP helps pay for HIV treatment medications, but there is not a similar program for people who are at risk of getting HIV.

One-stop Service Locations

Providers stated having multiple services located within one location was a strength. One-stop locations where multiple services are offered allow clients to get tested and easily connected to other necessary services. Some community members also noted the benefit of having one-stop locations to access resources. This makes it easier for people to access services, especially for those with few transportation options or other barriers. MDHHS acknowledged that more one-stop locations are needed to adequately serve people who may struggle to get to multiple locations for services; co-located services allow those who are under resourced to access as many services as possible during their visits.

Good Patient Communication

Providers noted that having good patient communication is important for rapid and effective HIV treatment. One provider noted that they maintain regular contact with patients through texting and other modes of communication. They noted younger clients tend to prefer texting, but they always use their clients' preferred communication method. Meeting clients where they are allows for providers to educate them about various systems they may have to interact with.

Advancements in Medications

Some community members, particularly those who lived through the initial HIV epidemic in the 1980s, noted that medications have significantly improved. They described how some people still do not know that HIV can be treated by taking one pill a day instead of several different medications. They also noted that there are injectable treatment options that require one shot every two months that make it even easier for people with HIV to stay healthy. Providers also noted that advances in HIV medication is something that has helped people adhere to their medication regimen.

Peer Support

A common theme in discussions with community members was the importance of having a strong peer support network. They stated that support from organizations that provide services for people with HIV needs to be supplemented with good peer relationships. Community

members emphasized that having someone in their personal life who cares about them was an important factor in their treatment adherence. Some said attending local support groups for people with HIV was one way for them to establish these relationships and has been beneficial for them in maintaining treatment. Providers also noted the importance of peer-to-peer education and offering a judgement free environment for ensuring adequate treatment.

Barriers and Challenges

Other Needs Interfering with HIV Treatment

Providers noted that clients often have other needs, such as mental health challenges, that make it difficult to maintain treatment for HIV/STIs if their other needs go unmet. MDHHS staff also emphasized the importance of providing holistic care. Staff recognized that housing and mental health supports should be components of HIV care. Community members offered a similar sentiment and identified not having holistic care as a barrier to accessing treatment and care. They said needs related to housing or mental health need to be addressed to support their ability to maintain HIV treatment.

Other community members identified that, even when they have access to programs that can connect them with affordable housing and other resources, these services also have limitations. One community member participated in a program that would cover their housing cost for a period of time, but they could not find something affordable after that coverage ended.

Difficulty with Linkage to Care

Some providers noted that it can be difficult to link people to care, especially when someone is transient or moves between counties. As an example, one provider noted that when people move to different states, it is difficult to know if they are still receiving treatment.

In addition, when people are tested at nontraditional locations like blood and plasma donation centers, they generally are given a generic informational packet and may not receive any follow-up communication, which means they are unlikely to be connected to additional resources.

Pillar Three: Preventing New HIV Transmissions Using Proven Interventions

Strengths

Easy Access to Needed Medications and Supplies

Providers in multiple regions indicated that medications and supplies were easily accessible for their clients. Providers specifically mentioned that they were able to easily provide clients with condoms and lubrication but also noted that having conversations about starting PrEP with patients being tested for HIV or hepatitis C was helpful for preventing and limiting transmission in their area.

Barriers and Challenges

Limited Insurance Coverage Hinders PrEP Access and Education

Several community members identified lack of insurance coverage as a barrier to accessing PrEP. Some community members that worked for religious institutions noted that their insurance would not cover PrEP. Other community members noted that they did not know whether their insurance providers would cover PrEP.

PrEP Education

Some community members identified that PrEP is not well known by community members. They said it seems like older gay men are more knowledgeable about PrEP while younger people may not be as aware of the medication. Some people do not know that PrEP can affect men and women differently. They also indicated that some people are not aware that it only prevents HIV and that it does not prevent other STIs.

Community members and providers identified that more education about PrEP and post-exposure prophylaxis (PEP) is needed; community members particularly noted that younger people do not know about PEP and PrEP. A few community members said they worry that people who are prescribed PrEP do not adhere to the treatment regimen, thus increasing their chance of contracting HIV if they are exposed to it. This might be addressed through more education about the importance of continuing to take PrEP. Providers also noted that they do not have money to advertise things like PEP and PrEP, which limits general knowledge of these options.

PEP Access and Education

Community members and providers noted that not enough people are aware of PEP. Due to a lack of knowledge about PEP, several community members noted that accessing PEP was difficult in their community. For some people it is only available in the ED, which is not always easily accessible. Providers mentioned emergency rooms in their area would not have enough PEP on hand to provide patients with a full round of treatment (28 days). This meant that some EDs only offer treatments to those who meet certain seemingly arbitrary criteria. MDHHS staff acknowledged that because PEP is not commonly known pharmacies need to be educated to ensure they are carrying enough for adequate treatment.

Pillar Four: Responding Quickly to Potential Outbreaks to Get People Prevention and Care

Providers mentioned that the outbreak response could benefit from more communication. Tools like SHiNE are useful but they don't always offer timely data. Local providers notice problems before the State does, but they need state approval before they can act. One provider mentioned that having a dashboard like the one used during the COVID pandemic would be a helpful tool for identifying if something is heading in the direction of an outbreak. MDHHS staff also noted that it was important to build community buy in and support to ensure organizations are

working collaboratively to address outbreaks. Providers also noted that the state-level requirement for case managers to have a bachelor's degree was a barrier for allowing people with HIV to enter the field.

In addition, providers mentioned that there are not enough resources in the state to handle outbreaks. Some counties do not have the ability to test and find outbreaks or they do not have access to SSP. This issue is highlighted when labs are not entered into the system quickly enough and people are instead identified through partner services; providers also noted that disease intervention specialist staff are maxed out and do not have the additional capacity to do community outreach.

Section Four: Situational Analysis

The MDHHS Working Group reviewed the Epidemiologic Profile, Resource Inventory, and Needs Assessment, and a recent regional situational analysis for Southeast Michigan, and identified several strengths, challenges, and needs related to HIV and STI prevention and care in Michigan. The Situational Analysis is organized by pillar (diagnose, treat, prevent, and respond) and provides a foundation for the 2022-2026 Goals and Strategies described in Section V.

Diagnose all people with HIV as early as possible

Strengths

Providers described strong partnerships between providers and schools in some regions. They also noted strong collaboration between HIV services providers and medical providers in some communities, which have helped medical providers make appropriate referrals for testing and treatment.

In addition, providers and community members indicated that partner services has been very successful at ensuring timely testing of partners with potential HIV exposure while also engaging patients to help them understand their risk. Mobile testing in areas where clinics are not easily accessible as well as new testing options like self-testing have made testing more accessible according to providers and community members.

Challenges

While some gains have been made in access to testing, community members indicated that testing is still difficult to access in some regions, especially rural areas. They also said that stigma remains a barrier to people seeking out testing. Providers indicated that lack of funding in many regions across the state is a barrier to HIV testing and diagnosis.

In addition, providers and community members said that lack of knowledge about HIV risks and treatment prevents people from seeking out testing. And community members said primary care

and other healthcare providers tend not to test people who they do not perceive to be at risk for HIV.

Identified Needs

Providers and community members offered several suggestions for increasing HIV and STI testing:

- Expand testing locations to include local health departments, HIV service agencies, community-based organizations, syringe services programs, and outreach events to support early diagnosis.
- Make HIV testing an opt-out service and/or part of standard health screenings regardless of a person's risk level
- Make improvements to partner services to reach more sexual partners of people diagnosed with HIV as soon as possible

Treat people with HIV rapidly and effectively to reach sustained viral suppression

Strengths

Great strides have been made in the rapid and effective treatment of HIV as well as sustained viral suppression in Michigan over the past decade. The percentage of PWH in Michigan who are in care, virally suppressed, and maintained undetectable increased considerably from 2010 to 2019 (See Exhibit 44). The percentage of PWH who were virally suppressed within six months and 12 months of diagnosis also increased in that time period (See Exhibit 45).

Community members and providers lauded the Michigan Drug Assistance Program (MIDAP)—a program that covers the cost of medication for qualifying people with HIV—and other programs that have helped make cost less of a barrier to accessing HIV medication. Providers noted that one-stop locations where multiple services are offered have allowed clients to get tested and easily connected to other necessary services, especially for those with few transportation options or other barriers.

Challenges

People aged 20 to 40 are least likely to be in care, virally suppressed, and considered maintained undetectable (Exhibit 48). The rate of viral suppression varies by local health department, with over 40 percent of health departments having a high percentage of PWH both in care and virally suppressed, and 35 percent having a low percentage both in care and virally suppressed (Exhibit 50).

Providers noted that clients often have other needs, such as mental health challenges, that make it difficult to maintain treatment for HIV/STIs if their other needs go unmet. Community members commented that follow-up communication about additional resources and treatment

options is often absent when people are tested at nontraditional locations like blood and plasma donation centers.

Identified Needs

Given the success of one-stop locations, providers and community members said more of these should be established to serve people who struggle to access multiple locations for services. They also called for increased access to services that support needs related to housing or mental health to increase the likelihood of maintaining HIV treatment.

Prevent new HIV transmissions by using proven interventions, including pre-exposure prophylaxis (PrEP) and syringe services programs (SSPs)

Strengths

National HIV Behavioral Surveillance (NHBS) data show that awareness of PrEP increased from 6 percent to 36 percent between 2011 and 2019 in the Detroit Metropolitan Area, and PrEP usage increased from less than 1 percent to 10 percent in the same period.

Providers in multiple regions indicated that medications and HIV/STI prevention supplies (e.g., condoms, lubricants) are easily accessible for their clients. They also said they are having conversations about starting PrEP with patients being tested for HIV or hepatitis C as a strategy for preventing and limiting transmission in their area.

Challenges

Partner services and PrEP are both important strategies in HIV treatment and prevention. Of agencies that reported partner services data in 2019, only 57 percent of identified partners were notified that they may have been exposed to HIV and only 37 percent were tested for HIV (Exhibit 51).

The percentage of people who are referred for or linked to PrEP after testing negative for HIV is very low (Exhibit 52). The percentage of people linked to PrEP following a negative HIV test varies greatly by testing agency, ranging from zero to 97 percent, with an average of 15 percent (Exhibit 54).

Community members commented that lack of insurance coverage is a barrier to accessing PrEP. They also said PEP can be difficult to access because it is often only available in EDs, where there is often not enough PEP on hand to provide patients with a full round of treatment.

Identified Needs

Providers and community members describe the need for more education about PrEP and PEP among providers and younger people. Providers said additional funding to help providers advertise things like PEP and PrEP to increase knowledge of these options would be useful.

Respond quickly to potential HIV outbreaks to get needed prevention and treatment services to people who need them

Strengths

Data on outbreak response is limited and providers had little to say about the strengths of current identification and response efforts. They did note, however, that partnerships exist across multiple levels in the state between providers as well as between MDHHS and providers.

Challenges

Providers indicated that tools like SHiNE are useful, but they do not always offer timely data. They said local providers notice problems before the State does, but they need state approval before they can act.

Some providers noted that some counties, especially in rural areas, lack some of the necessary technological infrastructure to test and find outbreaks. In addition, data modernization efforts are siloed and/or do not communicate effectively to establish the necessary infrastructure to support outbreak identification.

Identified Needs

Providers recommended implementing a dashboard similar to the one used during the COVID pandemic to improve communication about outbreaks from the state to local providers. They also said increased buy-in within communities is necessary to ensure organizations are working collaboratively to address outbreaks.

Priority Populations

The community engagement and planning process along with the contributing data sets and assessments demonstrate that PWH and people newly diagnosed with HIV are disproportionately Black, male, and MSM. In addition, PWH and new HIV diagnoses are heavily concentrated in the southern part of the lower peninsula. The Detroit Health Department had the highest HIV prevalence rate per 100,000 residents (696.3) of all LHDs in Michigan, followed by Wayne County (177.8) and Oakland County (172.2). Residents served by the DHD also had the highest rate of new HIV diagnoses (27.2) in 2019, followed by Kalamazoo County (10.2).

While access to care and viral suppression has increased among all PWH, those who are Black or Hispanic were somewhat less likely to be in care, virally suppressed, and considered maintained undetectable than those who are white. For example, 87 percent of white PWH were in care, whereas 81 percent of Black PWH and 82 percent of Hispanic PWH were in care. In addition, younger populations are the least likely to be in care, virally suppressed, and considered maintained undetectable was 20- to 29-year-olds, followed by 30- to 39-year-olds.

The goals and objectives laid out in the following section are for the entire state; however, implementation of the objectives will target these priority populations. Many objectives call for partnering with organizations serving high-risk or underserved demographics to improve HIV testing, linkage to care, and prevention practices. In addition, objectives designed to increase education of providers and community members, offer more testing opportunities and locations, and increase one-stop service offerings will be informed and guided by prevalence and need for these activities and resources.

Section Five: 2022–2026 Goals and Objectives

The following goals and objectives reflect strategies that will ensure a unified, coordinated approach for all HIV prevention and care funding in Michigan and are informed by the community engagement and planning process as well as the data sets reviewed for the plan.

Goal One: Increase the number of people tested for HIV/STI statewide by 3,000 over 2022 baseline by 2027.

Objectives:

- 1.1 Implement mandatory, opt-out-only HIV testing in emergency rooms by modifying 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 by September 30, 2026.
- 1.2 Expand access to online HIV/STI testing appointments; offer discreet self-testing or at-home testing, ensure privacy, and reduce stigma by September 30, 2025.
- 1.3 Conduct public health detailing activities to support providers and health systems to increase testing and increase the number of providers receiving MDHHS HIV/STI education by 5 percent over 2022 baseline by September 30, 2026.
- 1.4 Formalize at least one new pilot partnership with an organization serving high-risk or underserved demographics to improve, identify, or replicate their HIV/STI testing practices with other agencies by September 30, 2027.
- 1.5 Increase the number of mobile testing opportunities in areas of greatest health disparities by September 30, 2026.
- 1.6 Increase the number of partners and services provided (including syringe service programs) at mobile testing events to help reduce stigma and offer holistic-status neutral care by September 30, 2026.
- 1.7 Increase the number of females of childbearing age, over the 2022 baseline, who are screened for syphilis in all healthcare settings, including emergency departments and urgent care facilities.
- 1.8 Increase the number of pregnant people, over the 2022 baseline, who are screened for syphilis at recommended points in pregnancy with an emphasis on increasing testing in the third trimester.

- 1.9 Conduct at least six school wide STI screening events targeting young adults and adolescents annually.
- 1.10 Planning body will continue to conduct outreach at Pride and health education events to increase sexual health awareness, engagement in HIV/STI testing activities to help reduce stigma.
- 1.11 Provide updated trainings for HIV/STI workforce annually around topics including LGBTQ+ cultural humility, reducing misinformation, and new information about HIV testing options
- 1.12 Host a bi-annual conference that provides continuing education on relevant and emerging topics presented by national and local leaders for people working in the field of HIV/STI prevention

Key partners: Faith-based organizations, substance use disorder treatment programs, SSPs, Tier 1 and Tier 2 MDHHS-funded agencies, organizations serving people who are homeless, local health departments, community-based organizations, FQHCs, correctional facilities, school-based clinics, women's health clinics, providers, hospitals.

Potential funding sources:

- CDC prevention funding
- MHI

Outcomes:

- Increased number of people who are aware of their HIV/STI status
- Increased number of providers testing for HIV/STIs
- Increased detection of HIV/STI cases
- Increased number of people connected to sexual health services
- Decreased stigma around HIV/STI screening

Monitoring data source:

- Aphirm (cloud-based data system used to capture data from HIV testing and partner services outcomes)
- Michigan Disease Surveillance System (MDSS)
- Lab management system (LMS)
- CAREware (electronic health and social support services information system for HRSA's Ryan White HIV/AIDS Program recipients and providers)
- eHARS (Enhanced HIV/AIDS Reporting System)
- EGrAMS (Electronic Grants Administration & Management System)
- Michigan Drug Assistance Program (MIDAP) Online
- Script Guide RX (SG RX)

Expected impact on the HIV Care Continuum: The proportion of PWH who are aware of their status will increase.

Goal Two: Increase retention of people with HIV in ongoing care and treatment by 5 percent (1,000 people) above 2022 baseline in five years.

Objectives:

- 2.1 Systematize bureau and agency access to, and use of, aggregate data on patient retention and sustained viral suppression to identify gaps in services to inform targeted BHSP support by September 30, 2024.
- 2.2 Increase the number of full-service syndemic, status neutral centers offering HIV/STI testing and care, food, and housing per person living with HIV by September 30, 2026.
- 2.3 Improve statewide linkage-to-care rate of people newly diagnosed with HIV/STIs by centralizing data-to-care activities, utilizing out-of-medical care lists, and establishing new prescription-to-care with pharmacy partners by September 30, 2027.
- 2.4 Formalize at least one new partnership with an organization serving high-risk or underserved demographics to improve, identify, or replicate their care retention practices with other agencies by September 30, 2027.
- 2.5 Increase the number of collaborations between pharmacists and care team providers to improve the number of ART-prescribed consumers who are linked to medical care teams by 25 percent over 2022 baseline by using strategies such as Data to Care Rx.
- 2.6 Expand tele-health services for HIV care to address transportation barriers.
- 2.7 Update MDHHS Ryan White documentation including the Standards of Care, educational materials, and ongoing communications to reflect affirming and non-stigmatizing language and terminology by 2023.
- 2.8 Implement initiatives that provide wraparound care services to address barriers and social determinates of health with a whole person approach to care on an ongoing basis.
- 2.9 Institute a new requirement for Ryan White staff at CBOs and funded medical facilities providing direct services participate in five professional development trainings to enhance their knowledge of HIV treatment and management, strategies to reduce stigma around HIV and sexual health, and expand understanding of LGBTQ+ health needs by September 30, 2023.
- 2.10 Institute the requirement for Ryan White staff at CBOs and funded medical facilities submit documentation of attendance of a diversity equity and inclusion related training annually.
- 2.11 Provide ongoing Sexual Orientation Gender Identify and Expression (SOGIE) trainings for service and medical providers to help destigmatize patient care experiences and address historical medical mistrust.
- 2.12 Host a bi-annual conference that provides intensive training to nurses around HIV care, cultural humility, the intersectionality of comorbidities, approaches to interdisciplinary care, wholistic-status neutral medical, and other emerging topics.

- 2.13 Host a bi-annual conference that provides continuing education on relevant and emerging topics presented by national and local leaders for people working in the field of HIV care.
- 2.14 Increase the number campaigns developed by local CBOs that include individuals reflective of the populations experiencing the greatest impact of social determinates of health by September 30, 2026.
- 2.15 Collaborate with Medicaid to create actionable data reports for PWH who are not in care by September 30, 2024
- 2.16 Increase access to housing for PWH by September 30, 2027, by partnering with CBOs and investing in housing navigation services.
- 2.17 Improve HIV care outcomes by providing tele-health options for clients receiving housing navigation services.

Key partners: PWH, Pharmacists, local health departments, FQHCs, community-based organizations, MDHHS staff, correctional facilities, school-based clinics, women’s health clinics, providers, hospitals, AIDS service organizations (CBOs) and Medicaid.

Potential funding sources:

- Ryan White B
- Ryan White D
- Ryan White Rebate

Outcomes:

- Retain Ryan White eligible participants in care
- Improve the percent of people linked to HIV care by partner services program
- Decrease the number of people on the Ryan White “not-in-care” list
- Increase the number of participants in MIDAP and Ryan White Increase the number of people adherent to ART to improve viral suppression rates

Monitoring data source:

- Ryan White “not-in-care” list
- LMS
- MIDAP
- CAREWare
- eHARS
- Aphirm
- CareConnect 360 Medicaid case management system

Expected impact on the HIV Care Continuum: The proportion of PWH in care will increase and the rate of viral suppression will increase. The proportion of people virally suppressed withing 6 months of diagnosis will increase.

Goal Three: Increase PrEP referral among eligible people who test negative for HIV above 2022 baseline by 2,500 people in five years.

Objectives:

- 3.1 Systematize bureau access to, and use of, Medicaid PrEP prescription data to target MDHHS support where needed most by September 30, 2024
- 3.2 Formalize at least one new pilot partnership with an organization serving high-risk or underserved demographics to improve, identify, or replicate their PrEP uptake practices by September 30, 2027
- 3.3 Improve fidelity of funded partner data entry on PrEP eligibility
- 3.4 Increase the number of sexual health service provider workforce trainings provided to help reduce stigma and improve knowledge of HIV prevention options.
- 3.5 Increase the number of sexual health service provider participants per training (among those not currently receiving MDHHS funding).
- 3.6 Determine the number of providers actively prescribing PrEP in Michigan geographies with highest need.
- 3.7 Increase the number of providers actively prescribing PrEP in Michigan geographies with highest need.
- 3.8 Increase the reach of community PrEP education campaigns to help improve awareness and knowledge and reduce stigma by September 30, 2026.
- 3.9 Host a bi-annual conference that provides continuing education on relevant and emerging topics presented by national and local leaders to improve awareness and expand access to PrEP.

Key partners: Local health departments, community-based organizations, federally qualified health centers (FQHCs), clinics and providers offering sexual health services, health systems, Medicaid health plans.

Potential funding sources:

- CDC prevention
- MHI

Outcomes:

- Increased access to PrEP services
- Increased capacity to provide PrEP services
- Increased number of PrEP prescriptions
- Increased adherence to PrEP medication

Monitoring data source:

- Afirm
- MDSS
- CareConnect 360

Expected impact on the HIV Care Continuum: The number of HIV-negative clients screened for PrEP at agencies will increase.

Goal Four: Increase capacity and implementation of activities for detecting and responding to HIV networks and outbreaks in five years.

Objectives:

- 4.1 Systematize bureau and agency access to, and use of, HIV network detection and response data by September 30, 2024
- 4.2 Partner with at least one organization serving high-risk or underserved to identify and implement specific improvements to MDHHS's HIV network detection and response system by September 30, 2027
- 4.3 Establish a community advisory board (CAB) or create a subcommittee within an existing CAB or community planning group, focused on HIV network detection and response to inform the implementation, use, and dissemination of data related to network detection and response efforts by September 30, 2024
- 4.4 Increase knowledge and awareness of providers and consumers regarding the collection and use of public health data and information related to HIV network detection and response by September 30, 2027
- 4.5 Increase coordination among and sharing of best practices from HIV network detection and response efforts across all levels of government, public and private healthcare providers, community-based organizations, academic partners, and the community by September 30, 2027
- 4.6 Host a bi-annual conference that includes sessions and information about ongoing activities related to HIV network detection and response.

Key partners:

- Michigan HIV AIDS Council (MHAC)
- Southeast Michigan HIV AIDS Council (SEMHAC)
- Henry Ford Health Consultation Program and Prevention and Care Programs
- Community based organizations
- LHDs (including but not limited to Detroit Health Dept, Wayne Co Health Dept.)
- CDC-funded sites including, but not limited to Matrix, Detroit Recovery Project, Community Health Awareness Group, Corktown Health

- WSU MATEC
- AIDS United
- On-site clinics at institutes of higher education

Potential funding sources:

- Prevention
- Ending the HIV Epidemic

Outcomes:

- Networks are identified and responded to
- Increased public knowledge and awareness
- Informed process based on advisory board membership and collaboration
- A cohesive communication avenue to a network when identified
- Increased technical assistance and data requests

Monitoring data source:

- STI/HIV Operations and Resource System (SHOARS)
- eHARS
- Website traffic for MDHHS (public awareness)
- Community advisory attendance tracking and membership

Expected impact on the HIV Care Continuum: By sharing this information and responding more quickly, more individuals will be connected and in treatment, increasing targeted testing, connection to prevention, and individuals maintaining viral suppression. Informed choices about programming based on gaps made clear by increased data access.

Section Six: 2022–2026 Integrated Planning Implementation, Monitoring, and Jurisdictional Follow Up

Implementation of the 2022 – 2026 integrated plan will require strong coordination of infrastructure, procedures, and systems that will support the key phases of integrated planning. An overview of processes and tools for plan implementation, monitoring, evaluation and improvement, and reporting and dissemination is provided below.

Implementation

MDHHS will build on and strengthen relationships it has already cultivated with the partners identified in Section 5 above, including agencies receiving state and federal funds for HIV and STI prevention and care, to achieve the integrated plan objectives and goals. In addition, the department will identify new partners who can provide new avenues for reaching people at-risk of HIV to increase testing and PrEP uptake as well as PWH who need to be engaged in care.

MDHHS will engage partners through existing avenues, including current funding relationships, while also identifying opportunities to use HAB and CDC funding to support activities, including increasing HIV/STI testing at sites across the state, improving linkage-to-care rates, and increasing the number of providers actively prescribing PrEP. MDHHS will also establish a network detection and response community advisory board or subcommittee within the existing community advisory board to support response to newly identified clusters. Key partners will be contacted based on jurisdiction of network. Cross jurisdiction communication and data sharing will occur as needed.

Monitoring, Evaluation, and Improvement

Due to the scope of the proposed activities and strategies within Michigan's plan and the diverse composition of stakeholders, engagement will be frequent and constant across all phases of program development, implementation, monitoring, evaluation, and utilization of findings. MDHHS will monitor and evaluate implementation and outcomes of the goals and objectives through a variety of strategies. Stakeholder engagement and utilization of findings are essential to improving programming and subsequent health outcomes. A mixed methods approach will be utilized to collect robust and usable data. Monitoring will be ongoing with quarterly review to identify progress as well as address any concerns. Annual process evaluation will assess progress on implementation as well as factors contributing to implementation including: facilitators, barriers, lessons learned, and best practices. Quantitative data from metrics and qualitative data from providers and clients obtained through surveys, focus groups, or other appropriate methods will inform program improvement activities.

MDHHS will build upon an already strong internal capacity to conduct program evaluation and monitoring for the activities outlined in the plan. The evaluation will be completed by the Quality and Evaluation Unit team, which includes program evaluators and quality management staff members. Data will be pulled from client level data sources, financial data sources, and survey data.

Reporting of the evaluation results will be shared initially with internal staff and connected partner organizations to drive continuous quality improvement and inform resource allocation across funding streams. Deidentified results of the evaluation will be shared externally with MHAC and external community partners on an annual or semi-annual basis as appropriate. This will include sharing access to a dashboard on the MDHHS website via the BHSP external newsletter, during sub-recipient and collaborative meetings with HIV Prevention, EHE, and Ryan White B and D service providers.

The plan will provide a framework for determining activities and strategies for achieving the objectives as well as monitoring progress toward the goals. MDHHS will continue to provide routine updates to MHAC and SEMHAC, as well as other HIV/AIDS councils and consortia across the state, on progress and seek their input on and support for actions taken to advance the plan. The department will work closely with SEMHAC, in particular, to ensure statewide

activities align with those included in the Plan for Ending the HIV Epidemic in Wayne County, developed in 2020.

The goals and objectives of the integrated plan will be monitored and evaluated through assessment of progress and data analysis associated with each strategy and its accompanying activities. Data to support monitoring and improvement include HIV/AIDS surveillance data for the entire state and a range of program data, including client-level service data, prevention services data including outreach, education, training, PrEP and nPEP, MIDAP, and partner services tracking data. This will build off the current evaluation activities for EHE conducted by the BHDP Quality and Evaluation Unit. Data will be reviewed on a routine basis, dependent on the source and frequency with which it is updated. The data review process will involve state and local planning bodies and other stakeholders and will be used to amend and improve the plan as needed.

Reporting and Dissemination

The integrated plan will be posted on the MDHHS website along with a dashboard that will be updated on a semi-annual basis to share progress toward the goals and objectives. Data will be shared, as appropriate with planning bodies, such as MHAC and SEMHAC at their regularly scheduled meetings. MDHHS will also engage PWH, people at risk of HIV, and HIV service providers through annual community and provider forums, where it will share progress on the plan and identify what strategies are working well and where improvements are needed. In addition, the department will produce an annual network detection and response report and ensure information on network detection and response is publicly available on the MDHHS website.

The updates provided on the website will include information on plan implementation activities as well as any improvements made to the plan based on information learned through evaluation and monitoring activities.

Updates to Other Strategic Plans Used to Meet Requirements

The Ending the HIV Epidemic (EHE) Plan for Wayne County developed in 2019-2020 has been posted on the MDHHS website for public consumption. MDHHS shares information on EHE progress and data in a variety of settings such as MHAC full body meetings, SEMHC, and other community and provider forums.

MDHHS remains committed to measuring the integrity and effectiveness of all EHE programming in Wayne County. Methods used to measure effectiveness of existing programming include development of readiness assessments; routine collaboration with internal and external partners to review HIV testing data; cross references in MDHHS systems such as eHARS, LMS, and APHIRM; and analysis of client satisfaction surveys to better inform programming and address barriers. MDHHS EHE Unit also meets with all contracted agencies

monthly to provide space to provide TA and address programmatic strengths and address any barriers to implementation.

Program data utilized to plan, monitor, and evaluate activities comes mainly from program specific surveys (client satisfaction or other) and quarterly progress reports (QPRs). The QPRs are contract requirements and identify program successes, challenges, and anticipated changes from sub-recipients. This qualitative data is then used to support peer to peer learning initiatives, identify areas for program improvement or expansion, and inform resource allocation.

In 2023, MDHHS will develop an EHE specific website that highlights ongoing EHE initiatives in Wayne County, and a dashboard that will be updated on a semi-annual basis to share progress toward EHE goals and objectives. The updates provided on the website will include information on plan implementation activities as well as any improvements made to the plan based on information learned through evaluation and monitoring activities. MDHHS will also reconvene the EHE working group and expand participating to new members. Together this group will share feedback on EHE progress, identify what strategies are working well and where improvements are needed.

Since 2021, EHE implementation achievements are as follows:

- Implementation of routine opt-out testing of HIV/HCV/syphilis at the Wayne County Jail
- Integration of HIV/STI testing at an existing primary care clinic in Southgate, MI
- Initiation of a mobile unit initiative (The Pull Up Project) at Palmer Park
- Supported a variety of CBOS to implement social media campaigns to increase awareness of HIV and importance of routine HIV/STI testing
- Expanded access to syringe services programs (SSP) in Wayne County
- Increased efforts of stigma reduction in faith-based communities
- Implementation of HIV self-testing initiatives throughout Wayne County
- Provided support for temporary supportive housing and establishment of a street level clinic
- Expanded HIV testing at youth friendly organizations (i.e., Beaumont Taylor Teen)
- Established internal workgroups and supported outreach to external partners to increase data and information sharing amongst providers and CBOS as it relates to SHiNe and emerging HIV networks
- Developed a standard protocol for emerging HIV network community response efforts in Wayne County and statewide

Anticipated EHE activities in 2023

- Implementation of routine opt-out testing in at least one emergency room in Wayne County
- Development of workforce capacity initiative
- Continued expansion of SSPs in Wayne County
- Increase collaborations with grassroots organizations

- Increased focus on PrEP uptake in Wayne County
- The most significant challenge to EHE implementation has been the impact of Covid-19 on agency capacity in 2020 and 2021. During the pandemic, all capacity at LHD and CBOs were redirected toward Covid testing and mitigation efforts. This caused a significant delay in EHE
- activities. Although awarded implementation funds in August 2020, EHE activities did not really begin until Spring 2021.

MDHHS frequently references the EHE Plan (Appendix A) and consults with community to adjust EHE activities as needed. Throughout the duration of EHE, MDHHS will continue monitor and evaluate programming to ensure that community deemed priorities are addressed and implemented.

Section Seven: MHAC Letters of Concurrence

November 6, 2020

Grant Number: NU65PS923713-01-04

Rhonda Burton
Grants Management Specialist
Office of Grants Services (OGS)
Office of Financial Resources (OFR)
Centers for Disease Control and Prevention (CDC)
2939 Flowers Road, Mailstop TV2
Atlanta, GA 30341

SUBJECT: PS19-1906 Letter of Concurrence

Dear Ms. Burton:

The Michigan HIV/AIDS Council (MHAC) concurs with the following submission by the Michigan Department of Health and Human Services (MDHHS):

MHAC has reviewed the Ending the HIV Epidemic (EHE) in Wayne County 2020-2025 Strategic Plan that is to be submitted to the Centers for Disease Control (CDC) and concurs that the plan comprehensively addresses the barriers and facilitators to accessing HIV prevention and care systems in Wayne County and proposes activities that will actively promote the health and well-being of residents of Wayne County and move towards attaining the goals of EHE.

To carry out the planning initiative, MDHHS established a planning team comprising staff from MDHHS and the Detroit Health Department (DHD). 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 MHAC, the primary planning bodies for the state and for Wayne County, to answer questions and further refine the planning process.

Several MHAC members participated and collaborated in the EHE in Wayne County 2020-2025 Strategic Plan including taking part in a separate planning group that included recruitment of additional community members who served as key informants for the development of the plan. Members received ongoing status updates regarding the progression of the plan. MDHHS provided the EHE planning group with an additional opportunity to thoroughly review the plan and include the council's comments prior to submitting the plan for final draft. The final draft of the plan was then sent to the council for final review at which time the council advised MDHHS of its concurrence. The MHAC Executive Committee met on August 21, 2020 and unanimously voted in support of sending this letter of concurrence.

Thank you for your continued support of HIV Prevention services in Michigan.

Sincerely,

A handwritten signature in black ink that reads "Levi Berkshire". The script is cursive and fluid.

Levi Berkshire
Community Co-Chair

A handwritten signature in black ink that reads "Undrea D. Russell". The script is cursive and elegant.

Undrea Goodwin-Russell
Community Co-Chair

c: P. Brewer
C. Finch
D. Lukomski
K. Macomber
V. McCants



STATE OF MICHIGAN

DEPARTMENT OF HEALTH AND HUMAN SERVICES

LANSING

GRETCHEN WHITMER
GOVERNOR

ELIZABETH HERTEL
DIRECTOR

December 7, 2022

Centers for Disease Control and Prevention
Prevention Program Branch
1600 Clifton Road
Atlanta, GA 30333

Health Resources & Services Administration
Ryan White Part B Programs
5600 Fishers Ln
Rockville, MD 20852-1750

RE: CDC 1802 and HRSA RW B: Michigan HIV Prevention and Care Integrated Plan December 7th, 2022

Dear Centers for Disease Control 1802 and HRSA Ryan White Part B Project Officers:

The Michigan HIV/AIDS Council (MHAC) Statewide HIV Prevention and Care Planning Body concurs with the following submission by the Michigan Department of Health and Human Services (MDHHS) in response to the guidance set forth for health departments and HIV planning groups funded by the CDC's Division of HIV/AIDS Prevention (DHAP) and HRSA's HIV/AIDS Bureau (HAB) for the development of an Integrated HIV Prevention and Care Plan, including the Statewide Coordinated Statement of Need (SCSN) for calendar year (CY) 2022-2026.

MHAC has reviewed the Integrated HIV Prevention and Care Plan submission to the CDC and HRSA to verify that it describes how programmatic activities and resources are being allocated to the most disproportionately affected populations and geographical areas with high rates of HIV. MHAC concurs that the Integrated HIV Prevention and Care Plan submission fulfills the requirements put forth by the CDC's Notice of Funding Opportunity for Integrated HIV Surveillance and Prevention Programs for Health Departments and the Ryan White HIV/AIDS Program legislation and program guidance.

MHAC provided input via key informant interviews, focus group participation, and ongoing engagement at regular planning body meetings. A final draft of the plan was presented to the planning body's executive committee for review and the opportunity to vote on concurrence. MDHHS maintained ongoing communication and information sharing with the Detroit Health Department throughout the planning process to facilitate coordination.

The signatures below confirm the concurrence of Michigan HIV/AIDS Council (MHAC) Statewide HIV Prevention and Care Planning Body with the Integrated HIV Prevention and Care Plan. Thank you for your continued support of HIV Prevention services in Michigan.

Sincerely,

Leon Golson
Community Co-Chair
Michigan HIV/AIDS Council

Ari Hampton
Community Co-Chair
Michigan HIV/AIDS Council

Evan Hall
Community Co-Chair
Michigan HIV/AIDS Council

References

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