



## Testing: It isn't as easy as 1, 2, 3

by Barb Wood

**A**t the Michigan HIV/AIDS Council (MHAC) meeting in March the discussion got a bit heated when the topic of the federal Centers for Disease Control and Prevention (CDC)'s revised recommendations for HIV testing in health care settings arose (*See box on page 12*). For a government agency that first required community input into the planning process for HIV prevention, it seemed to many that these recent CDC guidelines had been created in a bureaucratic vacuum, with little input from the community before implementation.

There are many stakeholders in the issue of HIV testing, all with different needs and concerns. Everyone is not on the same page with the new CDC recommendations for HIV testing in health care settings.

Liisa Randall, PhD has been with MDCH through all of the transformations of the HIV/AIDS program since 1988, with the HIV/AIDS Prevention and Intervention Section (HAPIS) Community Partnerships Prevention Unit since it was created in 1999 and is currently Unit Manager. Randall also acts as a consultant to the National Alliance of State and Territorial AIDS Directors (NASTAD), so she has a good perspective of this issue nationally as well as historically from the State government.

I had a chance to speak with Liisa Randall at the HAPIS Rally for National HIV Testing Day, held in April, about the issues related to HIV testing in health care settings. "CDC was trying – appropriately – to promote a new tool for helping unidentified persons learn their serostatus. This was an underutilized tool screening in health care settings. There was fairly good evidence that suggests that unidentified infections were being

missed in health care settings and that screening programs would be a useful tool to identify these infections, particularly in high prevalence areas." And there was research suggesting that "screening in these areas would be cost-effective. I think the policy was advanced because it made sense scientifically to do that," said Randall.

She thinks the CDC screening recommendations that came out in fall 2006 were taken a little bit out of context. "This is very much viewed (by CDC) as a tool, a complement in an arsenal of prevention tools. Targeted approaches are still essential... At the same time the targeted approaches are not reaching everyone they could or should get," she said. Randall said she thinks the way the recommendations were rolled out by CDC left room for being misinterpreted.

One issue for the HIV community and service providers is the increased need for care that could result from expanded HIV testing, with implementation of the new screening. Randall said she thinks the questions that arose at the MHAC meeting around universal access to health care for people who are infected were valid and that these have not been addressed at a national level the way they should. "While this is a well intended and appropriate approach to take and a valuable tool to use, I don't think...the question has been answered on how to pay for the care for individuals identified as having HIV infection. And I think this needs to be raised in terms of a public policy debate," she said.

Who can speak for those who do not know they are HIV-infected? What are their needs to make knowing their HIV status translate into taking prevention measures, to get them to follow up on referrals to care?

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## DHWDC News

*MDCH Division of Health Wellness and Disease Control*

### Division Direction

Loretta Davis-Satterla, who had been division director since 1999, accepted a new position as director/health officer for Wayne County Department of Public Health in April. DHWDC direction is being provided by the three section managers, Barbara Harris-Ellis, Debra Szejda and Mark Miller.

### Partner Notification Enhancement Effort

MDCH is implementing a comprehensive plan to improve partner notification for patients/clients with the four reported sexually transmitted infections of most concern to public health; syphilis, chlamydia, gonorrhea and HIV. Rapid identification and investigation of partners with the appropriate follow-up will result in early treatment, less transmission, morbidity and mortality, fewer complications and long term saving in healthcare expenses.

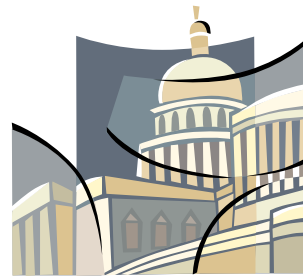
The targeted outreach to high-risk populations in Detroit, in response to the 2002 increase in syphilis in Michigan's largest city, has been successful. Michigan now has one of the lowest rates of syphilis since 1997. Partnerships with community programs have brought STD education and care to populations who rarely seek medical services, and more important, may not otherwise have had access. Syphilis remains a concern, with neighboring states' metro areas experiencing large outbreaks.

In April CDC made a major recommendation for gonorrhea treatment, based on a surveillance system which indicated an 11-fold increase in fluoroquinolone resistant gonorrhea rates among heterosexual males. Remov-

ing fluoroquinolones leaves only one class of antibiotics, cephalosporins, and all four of these drugs have issues, two are not even available in MI.

### HDRMH – Health Disparities

The Check Up! Check Out! Project phase two will target 1,400 African American male Molina HMO members residing in the City of Detroit to increase their awareness of the importance of receiving a preventative health check up. Personalized mailers, introducing the physician and inviting the men to set up preventative health checkups, will help initiate better communication lines between physicians and their African American male patients.



### HAPIS Care Unit

#### Michigan Dental Program (MDP)

The Michigan Dental Program (MDP), administered by the Division, is holding an open enrollment, which began on May 1, 2007 and ends on June 30, 2007. HIV+ persons in the state may get applications and other eligibility information by contacting their case manager or by calling the MDP office at 1-888-826-6565.

### ETRDU – Training Unit Social Work CECs Available

The National Association of Social Workers – Michigan Chapter, has recently approved the Training Unit as a provider of continuing education credits (CECs) for social workers for 12 months. Social workers will now be able to receive CECs for Modules 1, 2 & 3 (both for CBOs and LHDs). For more information, please contact Rhonda Bantsimba at (313) 456-3322.

*Continued on page 4*

## “AIDSWatch Hits Capitol Hill”

**H**undreds of AIDS activists took part in the annual AIDSWatch lobbying effort (in April), visiting Washington to talk with members of Congress to discuss HIV/AIDS issues and funding priorities.

One measure bringing advocates together is the Early Treatment for HIV/AIDS Act. ETHA would empower states to offer Medicaid treatment to low-income people with HIV before they advance to AIDS.

If enacted, ETHA “could reduce the death rate of people living with HIV/AIDS in the United States by 50 percent,” said Robert Greenwald, director of the Treatment Access Expansion Project. Most members of Congress do not know that about half of US HIV patients do not have health care access, he said. The Ryan White Act provides 17 percent of treatment funding; Medicaid provides 51 percent; and Medicare provides 26 percent, he said.

In the House, Speaker Nancy Pelosi (D-Calif.) and Rep. Ileana Ros-Lehtinen (R-

Fla.) are sponsoring ETHA. Sens. Gordon Smith (R-Ore.) and Hillary Rodham Clinton (D-N.Y.) are lead sponsors in the upper chamber.

However great the need, the bottom line remains money - or rather, the lack of money, said Greg Smiley, lobbyist for the American Academy of HIV Medicine. “You know things are bleak when the [National Institutes of Health], one of the most popular

programs in Congress, is getting flat-funded,” he said. “Some congressional staff aides have acknowledged that these programs have been starved for the last five years; we can’t make all of that up in one year,” he said.

Among those taking part were representatives from the National Association of People With AIDS, the Human Rights Campaign, and AIDS Action. CDC NPIN Summary from Bay Area Reporter (San Francisco), (04.26.2007) Bob Roehr



### GLOBAL ISSUES



### Honored

Patricia Pérez of Argentina, nominated for the 2007 Nobel Peace Prize for her activism

on behalf of women living with HIV. She was diagnosed HIV-positive in 1986.

### Vaccines

May 18, 2007 marked the 10th HIV Vaccine Awareness Day, an opportunity to reflect upon the more than two decade search for a safe and effective HIV vaccine.

The urgency of finding a safe and effective HIV vaccine is underscored by sobering statistics: Forty million people are currently living with HIV infection. Every day, another 11,000 become infected, most of whom live in resource-poor countries.

In this country, available data indicate that approximately two-thirds of new HIV diagnoses (40,000 last year) occur among African Americans and Hispanics, and more than one-quarter of new HIV diagnoses are in women. NIH Statement (5/14/07)

According to a recent United Press International (UPI) report, advanced trials of HIV vaccines are underway in Africa and China. International AIDS Vaccine Initiative President Seth Berkley said the vaccines are specific to the HIV strains found in the trial regions.

HIV vaccine candidates likely will be moderately effective against the virus, Berkley said, but even a small reduction in HIV incidence is worth pursuing.

The UPI report stated that scientists are trying to develop a more effective vaccine that uses a modified strain of simian immunodeficiency virus (SIV) made harmless to humans. According to Berkley, SIV “works better than anything else” scientists have tested so far at preventing HIV infection. Kaiser HIV/AIDS Daily Report (5/11/07)

### HIV PATIENT NAMES TO BE TRACKED IN ALL 50 STATES BY YEAR'S END

**B**y the end of 2007, all 50 states will use a name-based reporting system for HIV surveillance. This fiscal year marked the first time federal Ryan White funding has been tied to name-based reporting: More than \$1.4 billion in federal money for patient medications and health services will be distributed based on new formulas that include the numbers of HIV cases counted by states using names.

For some states, millions of dollars are at stake. The last states not using name-based reporting - Vermont, Maryland, and Hawaii - are quickly moving in that direction. Eight other states and the District of Columbia started collecting the names of HIV patients last year, and Massachusetts began in January.

The shift marks a victory for federal health officials. In 1999, CDC announced its support of name-based reporting. CDC said code-based systems burdened health

care providers and, in some cases, led to double-counting. ‘After many evaluations of code-based systems, it became clear that those systems do not meet CDC standards for HIV data,’ said Dr. Timothy Mastro, deputy director of the agency’s Division for HIV/AIDS Prevention. In 2005, CDC strengthened its support to a recommendation.

Some AIDS advocates maintain that code-based systems offer more confidentiality for patients. ‘I’ve not so much changed my opinion as surrendered,’ said Ron Johnson, deputy executive director of AIDS Action in Washington. ‘I still believe code-based reporting is valid and is preferable for HIV reporting.’ Public health officials are working to reassure people who test HIV-positive that strong security measures protect the databases. CDC NPIN (4/4/07) AP

# MHAC's A4C: the New Activists

**T**he Michigan HIV/AIDS Council's (MHAC) new African American AIDS Advisory Committee (A4C) is a force to be reckoned with. Formerly the African American Workgroup, this collective of individuals from around the state added muscle when MHAC approved its status increase to a standing committee of the Council in November.

With 59% of the reported HIV cases (59% of AIDS cases) in Michigan among blacks, the awareness work that the A4C does is very important. In Feb-March the group celebrated its 3rd Annual Black AIDS Awareness Campaign (BAAC) with a notable kick-off town hall meeting at the Second Ebenezer Church in Detroit having over 100 in attendance, and a growing list of activities held around the state.

BAAC activities were held in 29 Michigan cities with 26 agencies participating from February 7 through March 18. This year, 10 new agencies joined the Cam-

paign. BAAC activities include free HIV counseling and testing, STD screening, press conferences, proclamations from local and state dignitaries, prayer breakfasts, display tables, news releases, a poetry slam, mobile outreach, information in church bulletins, materials distribution, educational programs, the showing of the ABC Primetime "Out of Control – AIDS in Black America" video documentary, and a woman's health conference.

This group of movers and shakers, now called A4C, has been growing under the leadership of Co-Chairs Amna Osman, CEO of Wellness AIDS Services in Flint and Ricardo Bowden, Saginaw's Hearth Home executive director, as co-chair with Osman. They are on the move to recruit new members statewide with a newly named Event Recruitment Workgroup.

A4C has been taking advantage of the excellent advocacy resources of the Michigan Positive Action Coalition (MI-POZ),

providing legislative training to its members this year. Once trained, members then participated in a Legislative Briefing on April 26 in Lansing, in collaboration with the HIV/AIDS Alliance of Michigan (HAAM). The Committee also plans on developing lunch and learns or a community dialogue around National Test Day, June 27.

For more information on MHAC's A4C, contact Belinda Chandler (517) 241-5926 or [chandlerbel@michigan.gov](mailto:chandlerbel@michigan.gov).



## MHAC Update

**Holly Joseph** was unanimously re-elected as community co-chair at the March Michigan HIV/AIDS Council Meeting. According to a policy change approved at the meeting, she will serve a new two-year term for co-chairs.

**Traci Goulding** was recognized by MHAC for all her hard work over the years as a HAPIS staff support.

## Are You Certified to Do That?

*HAPIS Training Unit Report Continued from page 2*

A recent review of the counselor certification database revealed that there were several staff at CBOs and LHDs whose certification had lapsed yet they are still conducting counseling and testing. Staff with lapsed certification must cease counseling and testing and will have to either provide proof of current certification status or be recertified by taking the Module training series again.

Update of certification must happen every two years after certification to remain current. For details about certification update options, please refer to page 6 in the DHWDC Training calendar (available at [www.mihivnews.com/train.htm](http://www.mihivnews.com/train.htm)).

For more information, please contact

Rhonda Bantsimba at (313) 456-3322 or [bantsimbar@michigan.gov](mailto:bantsimbar@michigan.gov).

### New Web-based Training Tool

The Training Unit has been developing a new web-based version of day one of the Module 1: HIV/AIDS Basic Knowledge Training. Participants choosing this option must complete the web course and an exam at the end with at least 80%. They are then required to attend and successfully complete the second portion of the training in a face-to-face class to receive a certificate of completion.

For more information, please contact Rachel Mroz at (313) 456-2626 or [mrozr@michigan.gov](mailto:mrozr@michigan.gov). Mroz, who headed up the project, will be leaving HAPIS for a new position at the end of June.

### New PRP Appeal Process

The material submission and review process of the Program Review Panel (PRP) has recently been revised. A new appeal process allows the submitting agency the right to appeal the decision if the Program Review Panel disapproved an item. The revised Frequently Asked Questions (FAQs) outlines the appeal process. (<http://www.mihivnews.com/prp.htm>)

HIV prevention funded agencies submitting curricula must first submit the item to their contract monitor for a technical review before submitting to the PRP. The agency is then responsible for submitting the curriculum to the PRP chair directly.

For more information, contact PRP Chairperson Christina Bolden at (517) 241-5929 or [boldenc@michigan.gov](mailto:boldenc@michigan.gov).

**Table 1: Characteristics of Michigan Residents Living with HIV and AIDS as of April 1, 2007**

	Estimate of HIV Prevalence <sup>1</sup>	Estimated Prevalence Rate <sup>2</sup>	Reported Living with AIDS <sup>3</sup>		Reported Living with HIV not AIDS <sup>3</sup>	
			Number	Percent	Number	Percent
<b>MICHIGAN TOTAL</b>	<b>17,000</b>	171.1	6,673	100%	6,091	100%
<b>SEX</b>						
Male	<b>13,070</b>	268	5,280	79%	4,530	74%
Female	<b>3,930</b>	78	1,393	21%	1,561	26%
<b>BEHAVIOR</b>						
Male-Male Sex	<b>7,910</b>	N/A	3,251	49%	2,687	44%
Injecting Drug Use <sup>4</sup>	<b>2,160</b>	N/A	930	14%	694	11%
IDU w/ heterosexual	<b>990</b>	N/A	424	6%	320	5%
IDU w/o heterosexual	<b>1,170</b>	N/A	506	8%	374	6%
Male-Male Sex/IDU	<b>760</b>	N/A	319	5%	253	4%
Blood Products	<b>190</b>	N/A	91	1%	55	1%
Heterosexual <sup>5</sup>	<b>2,220</b>	N/A	855	13%	813	13%
Partner IDU	<b>660</b>	N/A	248	4%	245	4%
Partner Bisexual	<b>140</b>	N/A	41	1%	61	1%
Partner Rec'd Bld	<b>60</b>	N/A	23	0%	20	0%
Partner HIV +	<b>1,370</b>	N/A	543	8%	487	8%
Perinatal	<b>200</b>	N/A	44	1%	104	2%
Undetermined	Not Applicable	N/A	1,183	18%	1,485	24%
Presumed Heterosexual <sup>6</sup>	Not Applicable	N/A	942	14%	1,039	17%
Other <sup>7</sup>	Not Applicable	N/A	241	4%	446	7%
<b>AGE AT DIAGNOSIS</b>						
0 -12 years	<b>200</b>	11	38	1%	115	2%
13 -19 years	<b>460</b>	45	74	1%	269	4%
20 -24 years	<b>1,610</b>	250	344	5%	867	14%
25 -29 years	<b>2,440</b>	373	773	12%	1,058	17%
30 -34 years	<b>3,130</b>	442	1,228	18%	1,119	18%
35 -39 years	<b>3,310</b>	420	1,466	22%	1,021	17%
40 -44 years	<b>2,590</b>	319	1,182	18%	759	12%
45 -49 years	<b>1,600</b>	218	761	11%	440	7%
50 -54 years	<b>940</b>	148	452	7%	251	4%
55 -59 years	<b>430</b>	88	205	3%	115	2%
60 -64 years	<b>190</b>	50	93	1%	50	1%
65 years and over	<b>110</b>	9	57	1%	24	0%
Unspecified	Not Applicable	N/A	0	(0%)	3	(0%)
<b>RACE / ETHNICITY</b>						
White, Non-Hisp.	<b>6,100</b>	78	2,428	36%	2,155	35%
Black, Non-Hisp.	<b>9,970</b>	711	3,875	58%	3,613	59%
Hispanic	<b>650</b>	201	277	4%	213	3%
Asian/Pacific Islander	<b>80</b>	45	33	0%	25	0%
American Indian	<b>60</b>	112	16	0%	29	0%
Unspecified/Multi-race	Not Applicable	N/A	44	(1%)	56	(1%)

**Footnotes for Table 1**

1. This estimate includes all persons living in Michigan at diagnosis of HIV or AIDS, including those not reported or not yet diagnosed. All estimates are rounded to the nearest ten, and the minimum estimate given is 10. See below for explanation of this estimate.
2. Rates are calculated per 100,000 population in 2000.
3. Includes reports that contain patient name or are otherwise unduplicated.
4. Age, sex, race, and behavior percentages are calculated excluding missing data. The percentages of total cases missing this demographic information are given in parentheses.
5. The IDU risk category is further subdivided to indicate the number and percentage of persons who also had a sexual partner who is considered to be a "high risk" heterosexual, (i.e., partner is an IDU, a bisexual male (for females), a recipient of HIV infected blood or blood products or a person who is known to be infected with HIV).

Continued on page 6

# New Risk Assessment Form

Collecting accurate information on how HIV-infected persons became HIV positive continues to be an important part of surveillance. Surveillance data are used to plan prevention programs and in order to do this in as focused a manner as possible it is vital that we know what behaviors are leading to HIV infection and how these behaviors change over time.

In order to assist providers with obtaining this information MDCH HIV Surveillance has a form to give to patients that asks specific behavioral questions. The completed form can sent directly or used to complete the new case report form. You may find a PDF copy of the form entitled "HIV Risk Assessment Questionnaire" on the MI HIV News website. [www.mihivnews.com/surveillance\\_in\\_mi.htm](http://www.mihivnews.com/surveillance_in_mi.htm).

## Trend Documents

These annual reviews of the epidemic in Michigan and Southeast Michigan, were released on May 7 and are available on the website.

## Coming Soon!

By this summer MDCH is expected to unveil a combined HIV/STD website. This new site will combine the information that is currently in different locations on the state website.

**HIV RISK ASSESSMENT QUESTIONNAIRE**

In order to understand your risk factors for HIV, we have to ask you some very personal questions. Knowing your risk factors for HIV may help keep you and others you care about healthier. All information is kept strictly confidential. Be sure to answer each question YES or NO.

**SECTION I- The questions in this section are about you before you found out you were HIV positive:**

- Did you have sex with males?  Yes  No
- Did you have sex with females?  Yes  No
- Did you use needles to inject heroin, cocaine, steroids or any other drug not prescribed by a doctor?  Yes  No
- Were you or any of your sex partners in jail or prison?  Yes  No  Don't know
- The following are currently unlikely ways to get HIV. However, we would like to know if you have had any of the following happen to you. *Please check ALL that apply:*
  - Transfusion of blood or blood products  Yes  No Date: \_\_\_\_\_ Location: \_\_\_\_\_
  - Hemophilia or other bleeding disorder  Yes  No
  - Organ/tissue transplant  Yes  No Date: \_\_\_\_\_ Location: \_\_\_\_\_
  - Artificial insemination  Yes  No Date: \_\_\_\_\_ Location: \_\_\_\_\_
- Did you work in a health care or laboratory setting where you might have been exposed to human blood or other body fluids? If yes, please state your occupation: \_\_\_\_\_
- How do you think you got infected with HIV? \_\_\_\_\_  
If sexually, from sex with: \_\_\_\_\_ men \_\_\_\_\_ women

**SECTION II- Please answer these questions only if you had a sex partner of ~~the~~ the opposite sex before you found out you were HIV positive:**

- Did any of your opposite sex partners use needles to inject heroin, cocaine, steroids or any other drug that was not prescribed by a doctor?  Yes  No  Don't know
- Did any of your opposite sex partners receive a transfusion of blood/blood products or organ/tissue transplant before they found out they had HIV or AIDS?  Yes  No  Don't know
- To your knowledge, did any of your opposite sex partners have HIV or AIDS?  Yes  No  Don't know
- Were any of your opposite sex partners born outside of the United States?  Yes  No  Don't know. If yes, where: \_\_\_\_\_
- Did any of your opposite sex partners live or work outside the United States?  Yes  No  Don't know. If yes, where: \_\_\_\_\_
- Did you have a sexually transmitted disease, i.e. chlamydia, gonorrhea, herpes or syphilis?  Yes  No
- Did you trade sex for money, drugs, shelter or other items/services of value?  Yes  No
- Did you use crack, cocaine or crystal meth?  Yes  No
- Did you have more than one sex partner in the year before you found out you were HIV positive?  Yes  No
- Women only** Did any of your male sex partners have sex with other men?  Yes  No  Don't know

Final April 25, 2007

**Table 3: Michigan Residents Reported Living with HIV or AIDS: Sex by Race by Behavior April 1, 2007**

<b>MALES:</b>	White		Black		Hispanic		Other or Unknown		TOTAL	
Male-Male Sex	2,967	75%	2,711	51%	189	51%	71	49%	5,938	61%
Injecting Drug Use	178	4%	753	14%	49	13%	10	7%	990	10%
Male-Male Sex/IDU	228	6%	322	6%	14	4%	8	5%	572	6%
Blood Recipient	85	2%	32	1%	4	1%	2	1%	123	1%
Heterosexual	93	2%	343	6%	35	9%	4	3%	475	5%
Perinatal	15	0%	62	1%	2	1%	3	2%	82	1%
Undetermined	416	10%	1,086	20%	80	21%	48	33%	1,630	17%
<i>Presumed Heterosexual</i>	260	7%	774	15%	64	17%	24	16%	1,122	11%
<i>Other</i>	156	4%	312	6%	16	4%	24	16%	508	5%
<b>Male Subtotal</b>	<b>3,982</b>	<b>(41%)</b>	<b>5,309</b>	<b>(54%)</b>	<b>373</b>	<b>(4%)</b>	<b>146</b>	<b>(1%)</b>	<b>9,810</b>	<b>100%</b>
<b>FEMALES:</b>	White		Black		Hispanic		Other or Unknown		TOTAL	
Injecting Drug Use	109	18%	494	23%	21	18%	10	18%	634	21%
Blood Recipient	14	2%	6	0%	2	2%	1	2%	23	1%
Heterosexual	308	51%	807	37%	59	50%	19	33%	1193	40%
Perinatal	13	2%	46	2%	6	5%	1	2%	66	2%
Undetermined	157	26%	826	38%	29	25%	26	46%	1038	35%
<i>Presumed Heterosexual</i>	128	21%	685	31%	26	22%	20	35%	859	29%
<i>Other</i>	29	5%	141	6%	3	3%	6	11%	179	6%
<b>Female Subtotal</b>	<b>601</b>	<b>(20%)</b>	<b>2,179</b>	<b>(74%)</b>	<b>117</b>	<b>(4%)</b>	<b>57</b>	<b>(2%)</b>	<b>2,954</b>	<b>100%</b>
<b>GRAND TOTAL</b>	<b>4,583</b>	<b>36%</b>	<b>7,488</b>	<b>59%</b>	<b>490</b>	<b>4%</b>	<b>203</b>	<b>2%</b>	<b>12,764</b>	<b>100%</b>

6. The heterosexual category includes only those persons with "high risk" heterosexual partners as defined in footnote 5.  
7. This subset of undetermined includes persons who had heterosexual sex but their partner(s)' risk is unknown. This includes unconfirmed occupational exposures (1).

8. Includes persons with confirmed exposure in the health care setting in the U.S. (2) or other countries (1), and pediatric cases with probable sexual mode of transmission (2).  
Statistics, provided by the MDCH HIV/AIDS Surveillance Section, are from *HIV/AIDS Quarterly Analysis*.

**For complete Michigan and latest National statistics:**  
[www.mihivnews.com/stats.htm](http://www.mihivnews.com/stats.htm)

# Michigan HIV Trends

## *Michigan Annual HIV/AIDS Trend Reports Released*

The Michigan Department of Community Health HIV Surveillance released its annual reports in May that review trends in the epidemic between 2001 and 2005. One report is for Michigan, the other for SE Michigan. In both analyses, adolescent and young adult HIV diagnoses have increased for the second consecutive year and these newly diagnosed cases are disproportionately black. Blacks continue to be disproportionately infected although trends over time by race and sex are level. "We are continuing to see decreases in new HIV diagnoses among IDU's and perinatally infected children. New this year for the state as a whole, we are seeing decreases among persons diagnosed in their thirties," stated the MDCH HIV Surveillance report release. Both reports are available at [http://www.mihivnews.com/surveillance\\_in\\_mi.htm](http://www.mihivnews.com/surveillance_in_mi.htm).

## National Research & Reports

### **Characteristics of Persons With Recently Acquired HIV Infection: Application of the Serologic Testing Algorithm for Recent HIV Seroconversion in 10 US Cities**

J Acquir Immune Defic Syndr. 2007;44(1):112-115.

This reported research on the STARHS project, a relatively new testing strategy that can distinguish persons whose HIV infection was acquired, on average, in the past 6 months from those who have been HIV infected longer. Using data collected as part of a multisite study of primary HIV drug resistance, the researchers compared the characteristics of persons whose HIV diagnosis was made within 6 months of acquiring HIV infection with characteristics of persons whose HIV diagnosis was made more than 6 months after infection.

Authors of the study included Garald Goza, MS, Manager, MDCH, HIV/STD & Bloodborne Infections Surveillance Section. Mescap summary (3/14/07) [http://www.medscape.com/viewarticle/551828\\_print](http://www.medscape.com/viewarticle/551828_print)

### **HIV Testing: State of the Field and Current Research**

By Laura M. Bogart, PhD

This Medscape on-line article can provide CME/CEs and is available at <http://www.medscape.com/viewarticle/553272>

The Author's Conclusion: "Rapid HIV testing gives healthcare settings great flexibility to provide testing to individuals who may not visit usual healthcare settings or who may not intend to be tested. Moreover, rapid HIV testing is cost-effective, feasible, and acceptable to staff and clients."

"Healthcare settings should work with staff and clients to overcome barriers to providing rapid HIV testing in a way that is culturally tailored and feasible. In response to CDC recommendations to streamline HIV counseling and testing protocols, innovative programs are being developed for diverse populations of clients in hospitals, community clinics, and CBOs...If barriers are overcome, increased rapid HIV testing in the United States will ultimately help to realize the CDC's goals of universal awareness of HIV status, and linking all those who test positive into care, in a way that is feasible and acceptable for both clients and providers."

### **Effects of a Behavioral Intervention to Reduce Risk of Transmission Among People Living With HIV: The Healthy Living Project Randomized Controlled Study**

J Acquir Immune Defic Syndr. 2007;44(2):213-221.

The program included fifteen 90-minute sessions covering three modules.

Authors conclusion: "Cognitive behavioral intervention programs can effectively reduce the potential of HIV transmission to others among PLH who report significant transmission risk behavior."

Read this article on Medscape: <http://www.medscape.com/viewarticle/554851?src=mp>

### **Early Archiving and Predominance of Nonnucleoside Reverse Transcriptase Inhibitor-Resistant HIV-1 Among Recently Infected Infants Born in the United States**

Journal of Infectious Diseases (2007;195:1402-1410).

Drug-resistant HIV strains that pass from mother to infant can go undetected in the baby's immune system cells and remain there for years, according to a study by Dr. Deborah Persaud of Johns Hopkins University School of Medicine and colleagues.

Mother-to-child HIV transmission in the United States has been slowed by the practice of treating both mother and baby at delivery, though it remains a major cause of infection in the developing world. Without treatment, around 25 percent of newborns become infected, either during birth or later during breastfeeding.

In addition, drug-resistant HIV is on the rise globally. HIV patients may develop resistance to their HIV drugs, and this resistant strain can then pass from person-to-person.

Persaud and colleagues studied 21 HIV-infected infants in 10 US states. Five of the infants had been infected with drug-resistant HIV from their mothers.

The researchers found the infants' virus moved quickly to inactive or resting CD4 T-cells. While the virus was resistant to the non-nucleoside reverse transcriptase inhibitors class of drugs, another class, protease inhibitors, worked.

"The initial transmitted drug-resistant virus will likely never be cleared from that infant with currently available treatments," said Persaud.

CDC NPIN Summary of Reuters, (04.30.2007), "AIDS Virus Hides Quickly Inside Babies' Blood"

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## Hope on Horizon

### Early Treatment 3-Combo with Backup

Early treatment with a combination therapy of three classes of antiretroviral drugs can reduce viral loads quickly according to a study published in the June 15 issue of the *Journal of Infectious Disease*. This raises the possibility that HIV could then be eliminated following aggressive treatment with new drug classes.

The study found that early treatment with the three-drug combination therapy reduced the number of infected resting T cells by 50% every 4.6 months. Based on the results, the researchers estimated that 7.7 years of the combination therapy could all but eliminate HIV among people who began treatment early.

According to NIAID Director Anthony Fauci, the next step is to see if the aggressive treatment, along with Roche's Fuzeon and Merck's Isentress, can eradicate the virus.

Fuzeon and Isentress attack parts of HIV that are not affected by other classes of antiretrovirals\*, Bloomberg reports. Such drugs have the best chance of eradicating HIV because the virus likely has not mutated to develop defenses against the new medications, Fauci said. He added that the proposed study also might help physicians decide when and how to use currently available antiretrovirals. If doctors could get HIV-positive people completely off their treatment regimens, it might be worth the risk of the aggressive treatment, Fauci said. (Lauerman, Bloomberg, 5/15). The study is available online: [www.journals.uchicago.edu/JID/journal/issues/v195n12/37645/brief/37645.abstract.html](http://www.journals.uchicago.edu/JID/journal/issues/v195n12/37645/brief/37645.abstract.html)

*\*Fuzeon (enfuvirtide, T20) is the first fusion inhibitor, a class of antiretrovirals that keep HIV from getting into cells in the first place.*

*Isentress blocks an enzyme called integrase. HIV needs integrase to integrate its newly translated DNA into the DNA of human cells. More on Isentress at: <http://www.medscape.com/viewarticle/552986>*

### HIV TREATMENT & COMPLICATIONS

Report reprinted with permission from What's New at The Body, May 9, 2007 [www.thebody.com](http://www.thebody.com)

#### Women Respond Better Than Men to HIV Meds, Study Finds

Women do better on HIV therapy than men, according to the results of a large Spanish study. Researchers found that women on treatment had higher CD4 counts and lower viral loads throughout the yearlong trial. The study authors say the differences between genders could not be explained by different adherence to medications; the women's immune systems simply appeared to respond better to the drugs. Women were also at less risk for AIDS-related illness and death during the study, but were more likely to have side effects from the HIV meds. (Web highlight from [aidsmap.com](http://aidsmap.com))

#### HIV Meds May Be Less Effective in African Americans, Study Suggests

Research has repeatedly shown that African Americans with HIV don't do as well on treatment as whites, but it's still not clear why that is. A new study suggests that biological differences, not just social inequalities, may be at least partly to blame. Researchers at Walter Reed Army Medical Center compared white and African-American HIVers who began treatment; they found that African Americans were much less likely than whites [sic] to reach a viral load below 400, even though everybody received the same level of care. However, several possible non-biological factors weren't studied, like HIV medication adherence and the quality of the patient-doctor relationship, which may help explain the difference. This study was published in the April 1 issue of the *Journal of Acquired Immune Deficiency Syndromes*.

#### No Imminent Epidemic of Heart Disease Among HIVers on Meds, Expert Says

If you're HIV positive and on meds, you're not automatically in imminent danger of dropping dead from a heart attack, according to an expert on cardiovascular problems and HIV. In an editorial written in a prominent medical journal, Dr. James Stein acknowledges that new study findings link the use of protease inhibitors to a greater risk of heart attack. But Dr. Stein points out that even with the increased risk, the odds that a person taking protease inhibitors will have a heart attack is very low — and other factors, like smoking or simply being a man, appear to play a much bigger role than protease inhibitors do. Dr. Stein's editorial appears in the April 26 issue of the *New England Journal of Medicine*. You can't read it without paying for it, but you can read an abstract of the study he wrote his editorial about. The study, part of an ongoing clinical trial known as D:A:D, found a small increase in heart attack risk among people taking protease inhibitors, but found no increased risk among people taking NNRTIs.

#### Experimental CCR5 Inhibitor, PRO 140, Passes First Clinical Trial

The United States is likely to soon approve maraviroc (brand name: Celsentri), the first drug in a new class of HIV meds known as CCR5 inhibitors. But maraviroc isn't the only CCR5 inhibitor in the development pipeline: Early research shows good prospects for a drug called PRO 140, which works similarly to maraviroc but must be injected rather than taken in pill form.

**Statewide Training**

Schedules and/or contacts for training provided by CHAG, MAPP, the MATEC Michigan AIDS Education and Training Center and MDCH are provided on the website ([www.mihivnews.com/train.htm](http://www.mihivnews.com/train.htm)).

**MDCH Training**

You will find on the website the complete Division of Health Wellness and Disease Control training schedule for 2007. Following is a listing of those with registration deadlines through September. Application forms are available at: [www.mihivnews.com/dhwdc\\_train.htm](http://www.mihivnews.com/dhwdc_train.htm).

Please be aware that **HAPIS Lansing trainings will no longer be held at the Comfort Inn**. Trainings will now be held in multiple locations in the Greater Lansing area. Please refer to training confirmation letters for location and directions to individual trainings. If you register for a training and have not received a confirmation letter within five days prior to the training, please contact Julie Babb at (517) 241-5909.

**Certified Addiction Counselor**

**Credits:** All the trainings included in this calendar can be used to obtain continuing education credits for certified addiction counselors (CAC).

**HAPIS HIV Prevention/Test Counselor Related Training**

For more details on these trainings please see the entire calendar on the website. To register for prevention/test counselor trainings, contact Training Unit Secretary Julie Babb at (517) 241-5903.

**Nurses Contact Hours:** Nurses may obtain contact hours for the Module 1-3 Training. There is a \$10.00 administration fee charged per course payable at the door by check or money order to "State of Michigan" or cash payment.

**Module 1: Basic Knowledge Training**

Dates	Location	Reg.
July 12-13	Lansing	June 22
July 23-24	Detroit	June 29
August 15-16	Lansing	July 20
September 6-7	Lansing	August 17
September 27-28	Detroit	Sept. 7

**Module 2: HIV Prevention Specialist Certification Training**

Dates	Location	Reg.
July 18-19	Lansing	June 22
August 2-3	Detroit	July 13
August 27-28	Lansing	August 3
September 17-18	Lansing	August 24
October 3-4	Detroit	Sept. 7

**Module 3: HIV Test Counselor and PCRS Certification Training for CBOs**

Dates	Location	Reg.
August 6-7	Lansing	July 13
August 22-23	Detroit	August 3
September 19-20	Lansing	August 24
October 11-12	Detroit	Sept. 21

**Module 3: HIV Test Counselor and PCRS Certification Training for LPH**

Date	Location	Reg.
September 19-21	Detroit	August 24
October 10-12	Detroit	Sept. 14

LPH Staff: to register please use the PCRS Training Application form. Contact Tracy Peterson-Jones for more information at (313) 456-4422.

**One-Day HIV Prevention Specialist/ Test Counselor Update**

*Topic: HIV in the Deaf Community*

Learn the about the cultural aspects of working with Deaf consumers and the unique barriers that need to be addressed. This class will provide you with additional resources for this population and basic instruction will be given in American Sign Language.

Dates	Location	Reg.
September 12	Lansing	August 17

*Topic: Health Disparities*

This will focus on disparities in health and health care among people of color; review current disparities in several areas of health, including cancer, infant mortality and HIV; examine factors that contribute to disparities; and build a plan of action for addressing health disparities in your HIV work.

Dates	Location	Reg.
October 24	Detroit	Sept. 28

Please see the complete training calendar for additional update options.

**Specialized HIV Training Courses**

Complete "HIV Training Application Form" and fax/mail. Approximately three weeks prior to the training, applicants will be notified by mail regarding acceptance/rejection. For more information, contact Julie Babb at (517) 241-5903 [babbj@michigan.gov](mailto:babbj@michigan.gov).

**Partner Counseling and Referral Services (PCRS)**

Contact Tracy Peterson-Jones at (313) 456-4422 or [PetersonT@michigan.gov](mailto:PetersonT@michigan.gov). PCRS training is required for those individuals who will provide HIV test counseling, elicitation and/or field investigations, and are currently working at an LPH Dept. receiving HIV categorical funding.

**Certification Update**

This is a **required** course that PCRS staff must complete at least **every two years** to maintain their PCRS certification.

*Topic: Staying Safe in the Field*

This update will focus on personal techniques for staying safe in the field while conducting PCRS activities. Participants will have an opportunity to network with other staff that conduct PCRS and learn new strategies to enhance overall partner elicitation/investigation productivity.

Dates	Location	Reg.
August 16,	Ypsilanti	July 27

**Specialized PCRS Courses**

Application: Please note application deadlines. Compete the PCRS Training Application Form For more information, contact Tracy Peterson-Jones at (313) 456-4422 or [PetersonT@michigan.gov](mailto:PetersonT@michigan.gov). For more information, contact Tracy Peterson-Jones at (313) 456-4422 or [PetersonT@michigan.gov](mailto:PetersonT@michigan.gov). PCRS & the Internet Workshop coming in October.

**HIV/AIDS Case Management Certification Training**

For information please contact Jane DuFrane (517)241-5933 or [DuFraneJ@michigan.gov](mailto:DuFraneJ@michigan.gov).

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Conti Training is designed to certify HIV/AIDS case managers who are required to adhere to the *Principles and Standards of Service for HIV/AIDS Case Management in Michigan*.

Participants must have already completed the HIV Test Counselor Certification Training. Complete the "Case Manager Certification Application Form."

Date	Location	Reg.
August 28-31	Lansing	August 3
October 23-26	Detroit	Sept.28

All MDCH-certified HIV/AIDS case managers must be recertified every two (2) years. See the complete 2007 DHWDC training calendar on the website: [www.mihivnews.com/dhwdc\\_train.htm](http://www.mihivnews.com/dhwdc_train.htm).

### HAPIS Community Partner Trainings

June 14-15 Detroit  
Prevention Supervisor Training  
CHAG-CORE  
Contact: Ricardo Marble  
313-963-3434  
[ricardomarble@yahoo.com](mailto:ricardomarble@yahoo.com)

June 27 Grand Rapids  
New Responses to Old Infections – STD Course for Medical Providers  
Kent County Health Department  
Contact: Michelle Johnson  
616-632-7284  
[michelle.johnson@kentcounty.org](mailto:michelle.johnson@kentcounty.org)

July 20 Grand Rapids  
Prevention w/Positives Training for Community and Clinical Setting Providers

August 10 Detroit  
Venue Outreach – Special Issues in Bar and Internet Outreach

### Statewide Meetings

#### HIV/STD and Adolescents Networking Committee

This committee is for professionals in youth serving agencies. The next meeting is ~~June 20 in Lansing~~ cancelled. **Contact:** Chair Ardith Alderdyce AAardith@sbcglobal.net for fall rescheduling.

### MHAC

The Michigan HIV/AIDS Council is the statewide planning group for prevention and care. The next meeting will be held in Eaton Rapids on Thursday, September 20. **Contact:** Belinda Chandler (517) 241-5926.

### Program Review Panel (PRP)

*New Members Welcomed* - The next meeting is August 24 in Detroit. The materials deadline is August 17. **Contact:** Christina Bolden at (517) 241-5929 or e-mail: [boldenc@michigan.gov](mailto:boldenc@michigan.gov).

### Conferences and Events

#### Michigan Conferences and Events

Sept 16  
AIDS Walk Detroit - Royal Oak

September 29-30  
AIDS Walk Michigan

Save the Dates:  
November 1-2 Ypsilanti  
*STD & HIV Conference*  
Marriott Eagle Crest Conference Center

#### National Conferences and Events

June 27  
*National HIV Testing Day*  
Sponsored by NAPWA. For more information, visit the NAPWA website. [www.napwa.org/hivtestday.html](http://www.napwa.org/hivtestday.html)  
For Michigan events planned, contact Lisa Taton-Murphy at HAPIS (517) 241-5932 or [tatonl@michigan.gov](mailto:tatonl@michigan.gov).

October 15  
*National Latino AIDS Awareness Day*  
[www.omhrc.gov/hivaidsobservances/latino/index.html](http://www.omhrc.gov/hivaidsobservances/latino/index.html); for Michigan events planning contact Legia Romero at LAAN (517) 394-3560.

### WHERE TO CALL

#### National Prevention Information Network: (800) 458-5231

Expanded resource center, contracted by CDC, includes STDs and TB.

#### HOTLINES

##### CDC INFO:

(800) CDC-INFO (800-232-4636)

(888) 232-6348 TTY

Hours: 24/7

##### Michigan AIDS Hotline:

(800) 872-AIDS (2437)

Hours: 9 a.m. to 5 p.m. weekdays

##### Hotline for Women:

(800) 554-4876

Hours: 2 p.m. to 9 p.m. Monday, Wednesday, Friday

##### National HIV/AIDS Treatment

##### Hotline:

(800) 822-7422

Hours: 9 a.m. to 5 p.m. weekdays, 1 p.m. to 7 p.m. Saturday

Confidential treatment information by phone call provided by Project Inform. Volunteer operators (most are PLWH/As) can answer questions on HIV treatments and related diseases.

#### New Resource:

##### Michigan Go Local

Wayne State University's Shiffman Medical Library staff has put together a tremendous new resource for locating HIV/AIDS related services in Michigan on the Internet. Linked through the National Library of Medicine (NLM), the Michigan Go Local resource is part of a large National Institutes of Health project and is connected to Medline Plus.

[www.mihivnews.com/resource.htm](http://www.mihivnews.com/resource.htm)

# Testing Not as Easy as 1, 2, 3

*Continued from page 1*

In Michigan, we have a group who will speak up for those who are infected, Michigan Positive Action Coalition. MI-Poz Director Mark Peterson is also the technical assistance coordinator for the Midwest AIDS Prevention Project's Prevention with Positives program. With nine programs up and running around the state, in FY 06/07 that means Mark spends his time up and running around the state. There is no one person better to check the current pulse of PWH/As in Michigan.

"It's everyone's right to know their HIV serostatus by whatever method or mechanism that is right for them," said Peterson. "Whether that be counseling and testing provided by community-based organizations, rapid testing, home testing, testing through a physicians office – whatever makes sense for them – I think is important. People deserve to know their HIV status."

Peterson is concerned however with informed consent and counseling issues that arise with the new testing recommendations for health care settings. "It's not only diagnosis that I am concerned with but also reducing risk behavior." The client-centered counseling model used along with testing in Michigan has been shown to be effective, he said. "One, in making sure folks know what the test result means for them, and also begins to address their risk behavior – and it's their specific, individual risk behavior. That's a process; it's an intervention; it's an ac-

tivity. If we do just informational-based testing or just diagnostic screening without that (counseling) I think we are really missing an opportunity to impact risk behavior."

The CDC recommendations indicate that HIV prevention counseling should not be a required part of HIV screening programs but they simultaneously encourage provision of prevention counseling to persons at "high risk" for HIV. Randall agrees that prevention counseling has not been addressed well in all of the discussion surrounding the CDC recommendations for HIV testing in health care settings. "It is not feasible in high prevalence, high volume health care clinic settings with limited resources," she said. However, if we rely primarily on referrals for prevention counseling or other prevention services, many patients who could benefit from prevention counseling, may never receive these services.

CDC has predicated its recommendations, in part, on a relatively small number of studies which suggest that knowledge of HIV status is sufficient to initiate behavior change.

"There is relatively limited evidence of sustained behavior change associated solely with knowledge of serostatus,"

said Randall. "We know from our own prevention for positives programs, which are based on research, that people remain sexually active, remain at-risk and that it's difficult for them to sustain that behavior change. Primary prevention continues to have a key role to play in our prevention efforts and I think its short sighted, as well as an oversimplification, to say test everyone and send them somewhere else for prevention."

Informed consent is another issue that surfaced from community members at the MHAC meeting. Consent for HIV testing can be rolled into a general consent form according to the CDC recommendations. Along with language barrier problems to understanding, Peterson said there are also state-of-mind issues for someone who has come into a clinic for urgent care. Without the counseling component, community advocates are concerned that signed consent forms, may not reflect true comprehension. In Michigan, by law, all patients must provide consent, specific to HIV testing, prior to being testing.

In a position paper<sup>3</sup> in response to the CDC recommendations, "The importance of informed consent and counseling in HIV Testing," the ACLU stated, "Logic and common sense tell us that

"Targeted approaches are still essential... At the same time the targeted approaches are not reaching everyone they could or should get," Liisa Randall, PhD

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1 POP and other Prevention with Positives programs in Michigan: There are five POP (Prevention Options for Positives; see the feature story in the Winter 2006 Issue) programs (LAAN, CARES, HARC, APM and Hearth Home) There are two Partnership for Health clinic-based programs, at DMC and St. Mary's McAuley, one prevention case management program at Wellness Flint, and one project for HIV+ MSM in Grand Traverse.

2 CDC recommendations suggest that written informed consent need not be required. This is superseded by Michigan law which continues to require written consent, specific to HIV testing, be obtained in advance of HIV testing. Note: The Illinois House was considering a bill that would remove a state requirement for written consent prior to HIV testing to enact the CDC recommendations. Bill 980 ended up with a compromise – informed consent is preserved, but may be noted in the patient's chart by the physician.

3 Increasing Access to Voluntary HIV Testing: The Importance of Informed Consent and Counseling in HIV Testing, by the ACLU AIDS Project and Lambda Legal was one of several reports on May 2, 2007, including one on Stigma, Discrimination and Testing. PDF files can be found soon at: <http://data.lambdalegal.org/pdf/publications/hiv/>.

*Continued from page 11*

many medical providers may believe the time it takes to obtain consent for HIV testing or to do pre-test prevention counseling is not worth it, especially if they're not reimbursed by insurance companies for that time. However, in several of the studies that the CDC claims show that specific written consent and counseling are barriers to testing, a majority of providers actually stated that neither were significant barriers to testing."

The ACLU paper also references how the New York City Health and Hospitals Corporation (HHC) found a successful way to keep CTR intact. It was able "to increase the number of patients tested in HHC hospitals by 63% in 2006, by streamlining pre-test counseling, using educational videos and pamphlets and expanding the pool of staff who were trained to give counseling. Through the use of rapid tests and making HIV testing a routine offer of care for patients in emergency departments, outpatient clinics, and other health care settings, HHC was able to more than double the number of HIV-positive patients identified. All this was done consistent with New York law, which requires written informed consent, and patients overwhelmingly agreed to be tested," stated the report.

Another concern of Peterson's with the recommendations for routine testing in health care settings is what he refers to as "mining" of funding from proved prevention programs. "We are not getting new dollars into HIV prevention...so the money for this activity has got to come from somewhere. It's going to come from those prevention programs that we know are based on science, that have proven effective, but they're longer, they cost more and they traditionally have been done in community-based organizations (CBOs)."

The Michigan Department of Community Health (MDCH) recently released a position statement addressing HIV screening in health care settings (available on the website). The MDCH supports HIV screening, as a valuable prevention tool and as a means to facilitate early diagnosis and access to needed care and

treatment. MDCH views screening as an important complement, but not a replacement for, targeted and community-based approaches to HIV testing.

Michigan has actually been of the vanguard for clinic-based testing. Being "very strategic" in where they have supported HIV testing in clinical settings, Randall said three years ago MDCH was one of only three jurisdictions nationally with a formal collaboration to provide testing in some form in an emergency or urgent care clinic.

The MDCH has for many years supported HIV testing in clinical settings such as sexually transmitted disease clinics. More recently, the MDCH has implemented HIV testing in community health clinics and hospital emergency departments operating in areas of high HIV prevalence, using a screening model, in an effort to provide additional opportu-

nities and resources by which people can learn their HIV status.

To help health care providers in their initial adoption of HIV screening, the MDCH issued a Request for Applications for Implementation Planning Grants HIV Screening in High Prevalence Health Care Settings in April. In essence, these short term funds are viewed as "seed grants" designed to help health care providers design and implement HIV screening in facilities operating in areas of high (0.1% or more) HIV prevalence.

HAPIS expects to award grants totaling approximately \$400,000 for a six month period beginning July 1, 2007 and ending December 31, 2007. See the RFP supporting documents including the MDCH position statement addressing HIV screening in health care settings on the Michigan HIV News website at: [www.mihivnews.com/hapis\\_screening\\_rfa\\_07.htm](http://www.mihivnews.com/hapis_screening_rfa_07.htm).

## CDC Revised Recommendations

### for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings - Summary

These recommendations for human immunodeficiency virus (HIV) testing are intended for all health-care providers in the public and private sectors, including those working in hospital emergency departments, urgent care clinics, inpatient services, substance abuse treatment clinics, public health clinics, community clinics, correctional health-care facilities, and primary care settings. The recommendations address HIV testing in health-care settings only. They do not modify existing guidelines concerning HIV counseling, testing, and referral for persons at high risk for HIV who seek or receive HIV testing in nonclinical settings (e.g., community-based organizations, outreach settings, or mobile vans). The objectives of these recommendations are to increase HIV screening of patients, including pregnant women, in health-care settings; foster earlier detection of HIV infection; identify and counsel persons with unrecognized HIV infection and link them to clinical and prevention services; and further reduce perinatal transmission of HIV in the United States. These revised recommendations update previous recommendations for HIV testing in health-care settings and for screening of pregnant women (CDC. Recommendations for HIV testing services for inpatients and outpatients in acute-care hospital settings. MMWR 1993;42[No. RR-2]:1—10; CDC. Revised guidelines for HIV counseling, testing, and referral. MMWR 2001;50[No. RR-19]:1—62; and CDC. Revised recommendations for HIV screening of pregnant women. MMWR 2001;50[No. RR-19]:63—85). <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm>