HIV Health & Human Services
PLANNING COUNCIL OF NEW YORK
A Mayoral Council established by the Ryan White C.A.R.E. Act of 1990

Meeting Minutes
NEEDS ASSESSMENT COMMITTEE
Lee Hildebrand, DSW, Chair

February 24, 2010
Cicatelli, 505 Eighth Avenue, 20th Floor, Blue Room
3:00-5:00 pm

Members Present: Angela Aidala, PhD, Martin Bruner, Guillermo Garcia-Goldwyn, Jose Gonzalez, Lee Hildebrand, DSW, Sabina Hirshfield, PhD (alt. for Mary Ann Chiasson, DrPH), Jennifer Irwin, Rebecca Kim, Fabienne Laraque, MD, MPH, Rosemary Lopez, Frank Machlica, Jan Carl Park, Glen Phillip, Kate Sapadin, PhD

Members Absent: Barbara Kobrin, Julie Lehane, PhD, Don McVinney, Freddy Molano, MD, Ricardo Vanegas-Plata, DDS

NYC DOHMH Staff Present: Marybec Griffin-Tomas, JoAnn Hilger, Nina Rothschild, DrPH, Anthony Santella, DrPH, Terri Wilder

Public Health Solutions Staff Present: Lauren Feldman Hay

Others Present: Don Des Jarlais, PhD, Marthe Sende, Leonardo Vando, MD

Material Distributed:

- Agenda
- Minutes from the NA Committee Meeting on December 15, 2009
- Minutes from the NA Committee Meeting on January 19, 2010
- Presentation by Dr. Don Des Jarlais on The Big Epidemic of HIV Among Drug Users in New York
- Presentation by Dr. Leonardo Vando on Buprenorphine Treatment in a Harm Reduction Setting
- Planning Council Calendar for February 2010

Welcome/Moment of Silence/Introductions/Review of the Meeting Packet/Review of the December and January Minutes: Dr. Lee Hildebrand welcomed meeting participants. Members observed a moment of silence.

Committee members introduced themselves. Nina Rothschild reviewed the contents of the meeting packet. All members present voted to approve the December meeting minutes with no votes in opposition and three abstentions. All members present voted to accept the January minutes with no votes in opposition and no abstentions.

Drug Injecting and HIV: Dr. Anthony Santella stated that the Care, Treatment, and Housing Program of the Bureau of HIV/AIDS Prevention and Control will re-bid its harm reduction service category and is bringing in speakers, examining professional literature, and asking colleagues for recommendations regarding this population.

Dr. Des Jarlais's presentation is available on the Planning Council website at nyhiv.org. A brief summary follows:

- Over 60,000 cases of AIDS in IDU (injection drug users) and approximately 100,000 cases of HIV in IDU have occurred in New York City over the course of the epidemic.
- HIV was introduced into the IV drug-using population in the mid-1970s. Over time, the prevalence increased from 9% of the IV drug-using population to more than 50% by the 1980s.
- Syringe Exchange Programs (SEP) were at first underground but were exchanging 3 million needles per year by the late 1990s. SEPs do more than just exchange needles; for example, they also do HIV counseling and testing, STD testing, and provide vaccinations for hepatitis A and B. Most IDUs in NY have been tested for HIV.
- Between 1990 and 1992, 4% of uninfected drug users were becoming infected with HIV. With expanded SEPs, the City saw an 80% reduction in new infections among IDUs.
- Passing on of used needles and syringes fell to 17%. Now, only 1% of people who are HIV-positive are passing on used needles and syringes to other IDUs.
- The average age at first injection is 28, but most IDUs have a lot of risky behavior from activities such as smoking crack and sniffing heroin and cocaine before they start injecting.
- We don't have a platform for delivering good services for non-injection drug users. Other cities also don't have good services for non-IDUs.
- A vaccine for cocaine addiction may be in the works. Although the initial steps are promising, the project has a long way to go. Also, an injection wouldn't necessarily expose drug users to other services to help them recover from addiction.
- Cocaine is frequently acquired through sex-for-drugs exchanges, unlike heroin.

- A study at Beth Israel found that HIV prevalence among IDUs and never-injectors was about the same.
- Herpes increases the likelihood of acquiring and transmitting HIV and has no cure. MSM behavior is associated with high levels of herpes and HIV. Female non-IDUs are close to saturation with herpes. The strong association between herpes and HIV is found here and in many sub-Saharan countries.
- About one-third of the patients have clinical depression; a total of approximately two-thirds have depression, anxiety, and/or PTSD.
- About half of the members of the HIV+ population are receiving ARVs.

Dr. Hildebrand asked why herpes is not a reportable disease, given that the test is pretty reliable. Dr. Laraque responded that herpes isn't reportable because possible interventions by providers are limited. The disease is different from syphilis, where disease intervention specialists can track down, test, and treat partners. In response to Dr. Des Jarlais's statement that approximately half of the HIV-positive patients are receiving ARVs, Dr. Laraque noted that a promising feature of HIV prevention strategy now is to test and treat, thereby reducing the community viral load and reducing the number of new infections.

Lessons Learned from the Lower East Side Harm Reduction (LESHR) Buprenorphine Program: Dr. Leonardo Vando's presentation is available on the Planning Council website. A brief summary follows:

- Both medical research and psychosocial research for treating drug users are important.
- The program at LESHR includes one or more psychiatrists, social workers, CASACs, case managers, and outreach workers. At LESHR, no one is turned away. Some members of the patient population are quadruple-diagnosed – mentally ill, chemically abusing, HIV-positive, and Hepatitis-infected. Out of 105 patients, less than 10% are infected with HIV.
- Patients must be abstinent from other opiates before they can start Buprenorphine. Buprenorphine is an outpatient treatment. It is safe in combination with benzodiazepine use (both licit and illicit).
- Buprenorphine is often illegally diverted. Some non-opiate users have tried to obtain Buprenorphine, even though it wouldn't help them, because they want to sell it.
- People use Buprenorphine in different ways. Some use it as a bridge from methadone. Some use it for a few days until they can obtain some money to buy drugs. Most clients don't think of Buprenorphine as a long-term option.

- Most clinicians are not well informed about Buprenorphine, even though it is a safe alternative to methadone. Only MDs can prescribe Buprenorphine.
- Every insurance program, including ADAP, covers Buprenorphine.
- Addiction treatment is the only treatment where doctors punish patients. A cardiologist, by contrast, doesn't withhold heart medications because his or her patient ate a food that is not heart-healthy.
- Communicating with methadone counselors is virtually impossible.

An audience member noted that some Ryan White-funded programs don't want to provide Buprenorphine for a variety of reasons. Marybec Griffin-Tomas noted that alcohol and other drug treatment is one of the most challenging service categories into which providers can try to refer clients.

Adjournment: The meeting was adjourned.