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Michael R. Bloomberg
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Thomas R. Frieden, MD, MPH
Commissioner of Health and Mental Hygiene

HIV EPIDEMIOLOGY PROGRAM 3RD QUARTER REPORT

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What's in this report?

Publication schedule: This report reflects events occurring through September 30, 2004, and reported by June 30, 2005. It represents diagnoses made through nine months prior to the publication date because case reporting is 85% complete by that time. Because cases continue to be reported for many months, the final numbers can be expected to be higher.

To receive this report via e-mail, send an e-mail request to:
hivreport@health.nyc.gov

For electronic versions of this and other HIV-related reports, visit:
http://www.nyc.gov/html/doh/html/dires/hivepi.shtml

HIV Epidemiology Program
346 Broadway, Room 706, CN44, New York, NY 10013
Tel: (212) 442-3388 Fax: (212) 788-2520

NOTICE TO READERS

Important Changes in the Regulations Governing HIV Testing and HIV Reporting in New York State

On June 1, 2005, important changes in the regulations that govern HIV testing and named HIV reporting were introduced in New York State (NYS). These changes affect the laboratory reporting of viral loads, CD4 counts, and genetic resistance profiles of HIV-positive persons, and they introduce a new, simplified consent form that provides for greater flexibility in HIV testing and counseling.

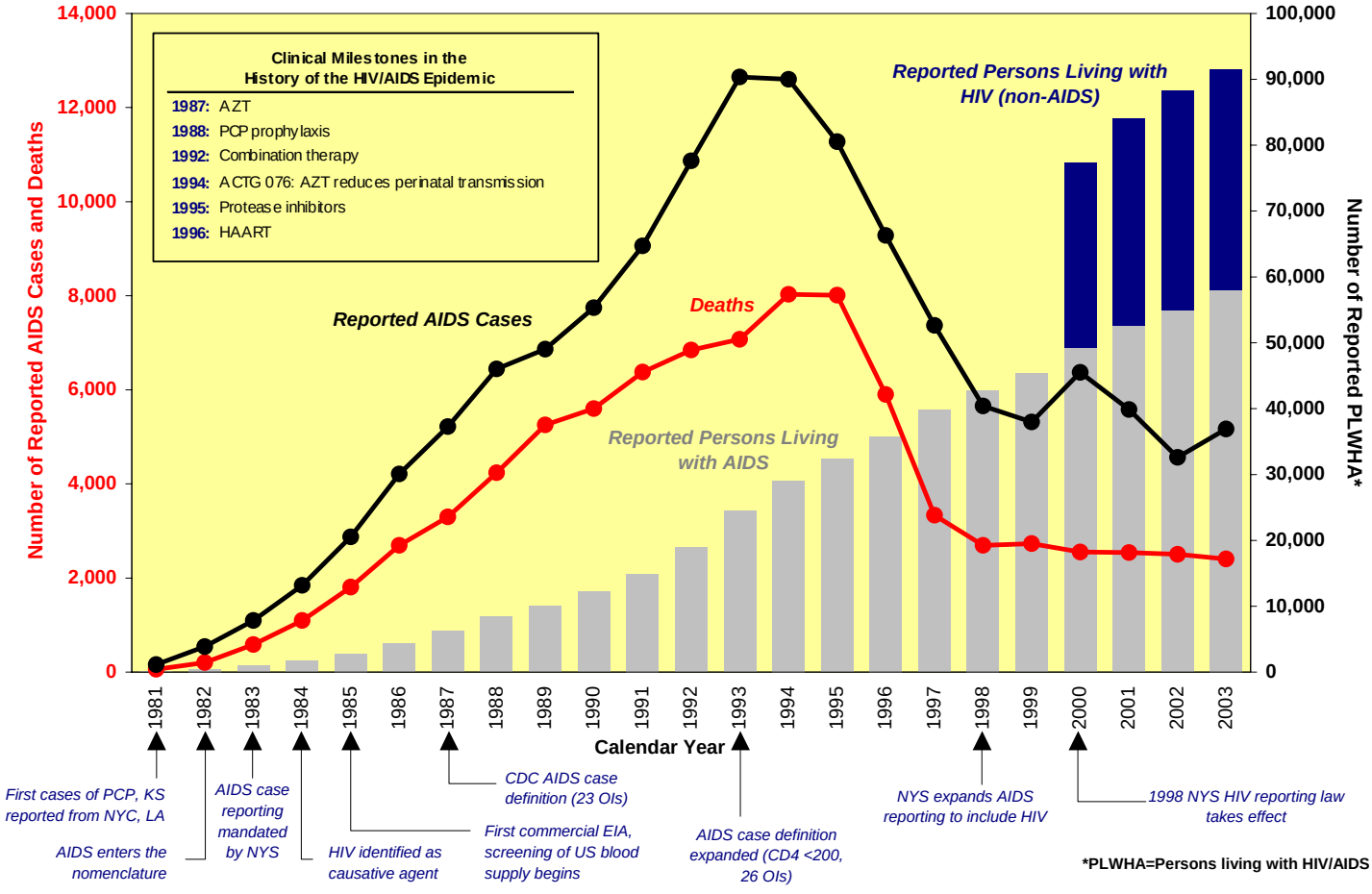
As of June 1, 2005:

- ❑ All viral load results are now reportable (even if undetectable)
- ❑ All CD4 counts are now reportable
- ❑ Nucleotide sequences obtained for genotypic resistance testing are now reportable
- ❑ Providers are required to use a new, simplified, easier-to-understand consent form (see page 3 for details)

These reporting changes affect laboratory reporting, not provider reporting. Providers must still use the NYS Department of Health Provider Report Form (PRF) to report all new diagnoses of HIV and AIDS and HIV-related illness in a previously unreported person.

The new regulations can be downloaded from:
http://www.dos.state.ny.us/info/register/2005/may11/pdfs/Rules.pdf (pages 9-12)
Copies of the updated consent form and medical release form can be found at:
http://www.health.state.ny.us/diseases/aids/forms

Reported AIDS Cases, PLWHA* and Deaths, New York City 1981 – 2003



Reported HIV/AIDS diagnoses and deaths occurring January 1, 2004 through September 30, 2004, and reported persons living with HIV/AIDS as of September 30, 2004[1], in New York City

	HIV diagnoses 1/1/2004–9/30/2004[1]						AIDS diagnoses 1/1/2004–9/30/2004[3]		PLWHA as of 9/30/2004		Deaths 1/1/2004–9/30/2004	
	Total		Without AIDS		Concurrent with AIDS diagnosis[2]							
	N	%	N	%	N	%	N	%	N	%	N	%
Total	**2,789**	**100.0**	**1,998**	**71.6**	**791**	**28.4**	**3,345**	**100.0**	**93,581**	**100.0**	**1,361**	**100.0**
Sex												
Male	1,918	68.8	1,368	68.5	550	69.5	2,310	69.1	64,981	69.4	890	65.4
Female	871	31.2	630	31.5	241	30.5	1,035	30.9	28,411	30.4	471	34.6
Unknown	0	0.0	0	0.0	0	0.0	0	0.0	189	0.2	0	0.0
Race/Ethnicity												
Black	1,492	53.5	1,048	52.5	444	56.1	1,690	50.5	41,541	44.4	739	54.3
Hispanic	800	28.7	568	28.4	232	29.3	1,035	30.9	29,755	31.8	429	31.5
White	414	14.8	321	16.1	93	11.8	539	16.1	20,014	21.4	180	13.2
Asian/Pacific Islander	58	2.1	40	2.0	18	2.3	55	1.6	1,032	1.1	6	0.4
Native American	*	*	*	*	*	*	*	*	69	0.1	*	*
Other/unknown	20	0.7	17	0.9	*	*	23	0.7	1,170	1.3	*	*
Age group (years)[4]												
0-12	14	0.5	11	0.6	*	*	*	*	1,169	1.2	*	*
13-19	86	3.1	80	4.0	6	0.8	34	1.0	1,374	1.5	8	0.6
20-29	569	20.4	473	23.7	96	12.1	334	10.0	5,336	5.7	25	1.8
30-39	902	32.3	677	33.9	225	28.4	1,009	30.2	21,729	23.2	224	16.5
40-49	791	28.4	507	25.4	284	35.9	1,229	36.7	37,176	39.7	544	40.0
50-59	321	11.5	197	9.9	124	15.7	568	17.0	20,347	21.7	414	30.4
60+	106	3.8	53	2.7	53	6.7	166	5.0	6,450	6.9	144	10.6
Borough of residence												
Manhattan	743	26.6	565	28.3	178	22.5	914	27.3	29,023	31.0	365	26.8
Brooklyn	747	26.8	517	25.9	230	29.1	834	24.9	23,041	24.6	416	30.6
Bronx	685	24.6	485	24.3	200	25.3	769	23.0	20,373	21.8	376	27.6
Queens	416	14.9	271	13.6	145	18.3	452	13.5	12,580	13.4	126	9.3
Staten Island	52	1.9	39	2.0	13	1.6	51	1.5	1,685	1.8	26	1.9
Unknown/outside NYC	146	5.2	121	6.1	25	3.2	325	9.7	6,879	7.4	52	3.8
Transmission risk												
Men who have sex with men	995	35.7	789	39.5	206	26.0	874	26.1	25,797	27.6	156	11.5
Injection drug use history	269	9.6	195	9.8	74	9.4	605	18.1	22,174	23.7	571	42.0
Heterosexual[5]	628	22.5	415	20.8	213	26.9	677	20.2	17,275	18.5	249	18.3
Perinatal	14	0.5	11	0.6	*	*	13	0.4	2,438	2.6	11	0.8
Other	13	0.5	9	0.5	*	*	21	0.6	546	0.6	9	0.7
Unknown/under investigation[6]	870	31.2	579	29.0	291	36.8	1,155	34.5	25,351	27.1	365	26.8
Clinical status as of 9/30/2004												
HIV (non-AIDS)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	33,382	35.7	130	9.6
AIDS	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	60,199	64.3	1,231	90.4

PLWHA=Persons living with HIV/AIDS. Cells representing 1-5 person(s) are marked with an asterisk (*).

1 *For events reported by June 30, 2005.*

2 *HIV diagnosed concurrently with AIDS (within 31 days of HIV diagnosis).*

3 *AIDS was diagnosed in 2004 and includes concurrent HIV/AIDS diagnosis.*

4 *For HIV and AIDS diagnoses, age at diagnosis; for PLWHA, age as of September 30, 2004; and for deaths, age at death.*

5 *Includes persons with CDC-defined heterosexual risk in addition to persons with probable heterosexual transmission defined as a history of: a) sex with an HIV+ person of the opposite sex, an injection drug user, a bisexual male, or a person with hemophilia/coagulation disorder, b) heterosexual prostitution, c) sex with a prostitute of the opposite sex, d) multiple sex partners of the opposite sex, e) sexually transmitted disease, f) crack/cocaine use, or g) immigration from a country where heterosexual transmission of HIV predominates.*

6 *Includes individuals with no risk information reported by the provider and for whom an expanded investigation has not been completed.*

Which HIV-related events are reportable in New York State, and who is required to report?

In 1998, New York State expanded AIDS case reporting to include HIV (Chapter 163 of the Laws of 1998, PHL Article 21). The law took effect on **June 1, 2000** and was amended on **June 1, 2005**. All diagnostic and clinical providers (doctors, nurses, physician assistants, and all others diagnosing HIV or providing care to HIV+ persons) and laboratories are required by law to report the following events:

Events reportable by providers on the required New York State Provider Report Form (PRF)

- Diagnoses of HIV infection
- Diagnoses of HIV illness in a previously unreported individual (i.e., HIV illness not meeting the AIDS case definition)
- Diagnoses of AIDS-defining conditions

Events reportable by laboratories

- All positive Western blot test results
- All viral load test results (detectable and undetectable)
- All CD4 test results
- All viral nucleotide sequence results

For assistance in reporting a case of HIV/AIDS, to receive Provider Report Forms, or to obtain more information, please call (212) 442-3388

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New York State law also requires that PRFs contain names of sexual or needle-sharing partners of the infected person known to medical providers or those whom the infected person wishes to have notified of their possible exposures. Providers can utilize and/or refer HIV+ persons to the NYC DOHMH Contact Notification Assistance Program (**CNAP**) at **(212) 693-1419** for assistance in carrying out partner notification. **For more information about the New York State HIV reporting and partner notification law and CNAP, visit:** **www.health.state.ny.us/nysdoh/hivaids/hivpartner/intro.htm**

Rates of reported HIV diagnoses, PWHA, and deaths among PWHA in New York City, 2003[1]

	HIV diagnoses[2] per 100,000 population	Reported PWHA per 100 population (%)	Age-adjusted mortality rate per 1,000 PWHA[3]	Population from 2000 Census
Total	**52.5**	**1.2**	**26.1**	**8,008,278**
Sex				
Male	75.1	1.7	25.2	3,794,204
Female	32.1	0.7	28.2	4,214,074
Age group (years)[4]				
0-12	1.7	0.1	6.8	1,429,677
13-19	16.3	0.2	4.6	723,773
20-29	62.9	0.4	12.6	1,270,490
30-39	104.2	1.7	17.6	1,348,263
40-49	106.0	3.2	27.1	1,133,497
50-59	58.2	2.2	35.3	850,372
60+	13.0	0.5	44.5	1,252,206
Race/Ethnicity				
Black	111.3	2.1	30.2	1,962,154
Hispanic	59.0	1.4	28.1	2,160,554
White	23.1	0.7	17.2	2,801,267
Asian/Pacific Islander	9.5	0.1	8.9	783,058
Native American	46.2	0.4	18.0	17,321
Borough of residence				
Manhattan	76.6	1.9	21.8	1,529,375
Brooklyn	46.0	0.9	32.1	2,465,326
Bronx	78.2	1.5	31.3	1,327,690
Queens	27.1	0.5	23.0	2,242,159
Staten Island	16.5	0.4	27.5	443,728

This table reports rates of three HIV-related measures: new HIV diagnoses, persons with HIV/AIDS (PWHA), and deaths. Rates represent the number of events ("numerator") divided by the size of the population at risk ("denominator"), and therefore may provide a different picture of the epidemic than the number of events alone (see table on page 2).

- The rates of new HIV diagnoses and PWHA are more than two times higher in males than females
- Rates of new HIV diagnoses are highest in persons 30-39 (104.2 per 100,000) and 40-49 (106.0 per 100,000)
- Blacks have the highest rates of new HIV diagnoses, PWHA and death compared with other racial/ethnic groups. Compared with whites, the rate of new HIV diagnoses in blacks is 4.8 times higher, the rate of PWHA is 3.0 times higher, and the mortality rate is 1.8 times higher
- The rate of new HIV diagnoses is highest in Manhattan (76.6 per 100,000) and the Bronx (78.2 per 100,000). However, death rates are higher in Brooklyn (32.1 per 1,000 PWHA) and the Bronx (31.3 per 1,000 PWHA) compared with other boroughs

PWHA=Persons with HIV/AIDS

1 *Based on data reported to the New York City Department of Health and Mental Hygiene through December 31, 2004.*
2 *Includes diagnoses of HIV without AIDS and HIV concurrent with AIDS.*
3 *Age-adjusted to the city-wide population of PWHA at the end of 2003, except for age-specific rates.*
4 *For HIV diagnoses, age at diagnosis; for PWHA, age as of December 31, 2003; and for deaths, age at death.*

New HIV consent form provides greater flexibility in counseling and testing

A new HIV consent form has been introduced by New York State to provide greater flexibility in counseling and testing. The new form is simpler, easier to read, and still covers all of the required elements for written informed consent. For those who test positive, the new form also includes authorization for resistance, incidence, and viral load testing. For pregnant women, the new form can be used to authorize more than one test during the pregnancy.

The goals of the new form are to reduce barriers to HIV testing, to allow providers to make HIV testing more routine, and to better tailor pre-test counseling to the patient's needs. The current practice of lengthy face-to-face counseling was never a requirement of the original law (NYS Public Health Law Article 27-F), although it may be needed by certain persons. In other instances, the new consent form, other print materials, or a videotape may be used to provide the same information.

The new form continues to protect confidentiality of test results and protects persons from discrimination based on HIV status. Written informed consent is still required, as is full post-test counseling.

Summary of Changes to Guidance for HIV Counseling and Testing

	Before June 1, 2005	After June 1, 2005
Written informed consent	Required	Required
Consent form	Required	Simplified
Tests covered	HIV EIA and WB	HIV EIA, WB, viral load, genotypic resistance, and incidence
Pre-test counseling	Required – flexible format	Required – flexible format
Post-test counseling	Required	Required
Confidentiality of results	Required	Required
Anti-discrimination	Required	Required
HIV medical release form	Required	Simplified, allows for use of a single form that assures HIPAA compliance

Risk Behavior in an HIV-Infected Population in New York City

Computer Assisted Behavior Survey (CABS) – A Self-Administered Survey to Measure Risk Behavior

AIDS case rates in New York City have declined since 1993, yet thousands of new HIV cases are reported each year, indicating that individuals are still engaging in risk behaviors that may lead to transmission. An objective of CABS was to assess risk behaviors in HIV-infected patients at four hospital-based primary care HIV clinics in NYC.

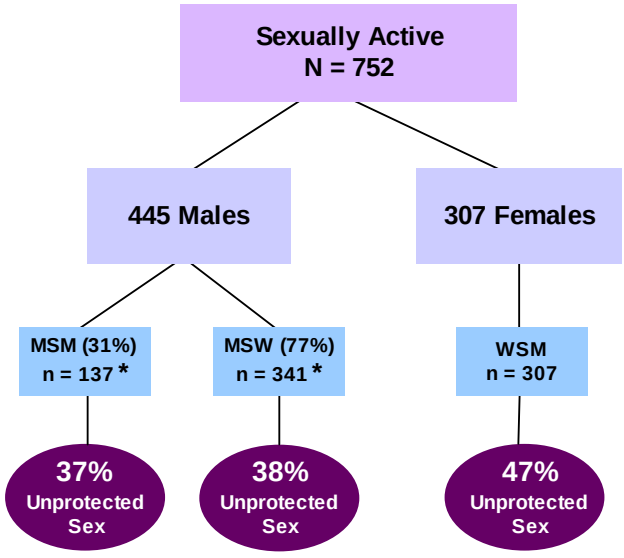
DOHMH staff enrolled patients from June through December 2004. Eligible patients were on antiretroviral therapy, 18 years or older, and English literate. The survey was conducted with a tablet, laptop with mouse, or touch-screen device with an audio component. An anonymous, computerized survey was used to encourage more open reporting of risk behaviors.

Interviews from 752 sexually active respondents are included in this analysis. 59% were male and 41% were female, and the median age was 45 years. The race/ethnicity of the patients was predominantly black (42%) and Hispanic (38%). The majority of patients (62%) had at least a high school education.

Definitions

- Sexually active – one or more partners in the past 12 months
- Sexual behaviors:
  - MSM – men who have sex with men
  - MSW – men who have sex with women
  - WSM – women who have sex with men
- Unprotected sex – no condom use during anal or vaginal sex
- Serodiscordant partner – a partner of negative or unknown HIV status

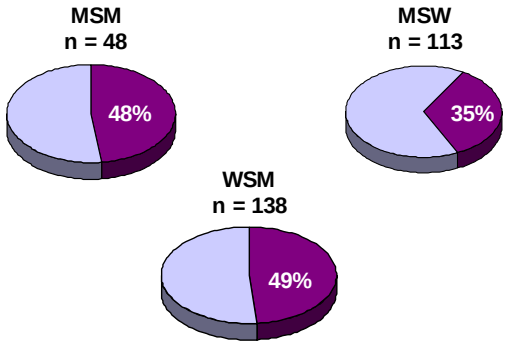
Unprotected Sex In Previous 12 Months



* *33 (8%) male respondents reported both MSM and MSW behaviors and were counted in both behavior categories.*

Sexually active females were more likely than sexually active males to report unprotected sex in the previous 12 months.

Unprotected Sex with a Serodiscordant Partner During Most Recent Sexual Encounter



Among respondents who had unprotected sex, 48 MSM, 113 MSW and 138 WSM reported their partner's serostatus. During their most recent sexual encounter, WSM and MSM were more likely than MSW to have unprotected sex with a serodiscordant partner.

Non-Injection Drug Use During Sex In Previous 12 Months

	MSM (n=137)	MSW (n=341)	WSM (n=307)
	%	%	%
Any Drug	**20**	**16**	**10**
Marijuana	10	6	5
Crack	9	9	5
Cocaine	4	4	1
Heroin	0.7	6	2
Crystal	3	0	0

MSM reported a higher percentage of non-injection drug use during sex compared to MSW and WSM.

Conclusions

- A high proportion of HIV-infected persons are at risk of transmitting HIV through unprotected sex with serodiscordant partners.
- Ongoing prevention efforts are needed to promote and maintain safe sex among HIV-infected persons.
- HIV care providers may require prevention training and assessment tools in order to implement targeted interventions aimed at reducing risk behaviors.

Recommendations for incorporating HIV prevention into care are outlined in the following publication from the CDC, the Health Resources and Services Administration, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America:

"Incorporating HIV Prevention into the Medical Care of Persons Living with HIV"

MMWR July 18, 2003 / 52(RR12);1-24

http://www.cdc.gov/mmwr/PDF/rr/rr5212.pdf