March 20, 2019

George Sigounas, MS, PhD
Administrator
Health Resources and Services Administration
Parklawn Building
Rockville, MD 20857

Dear Dr. Sigounas:

The Infectious Diseases Society of America and the HIV Medicine Association appreciate efforts underway to build the health care workforce capacity necessary to respond to the opioid epidemic. Our societies represent over 11,000 infectious diseases and HIV clinicians, scientists, public health and other healthcare practitioners. We write to offer recommendations and support to the agency to help ensure that the communities impacted by the opioid epidemic have the health care provider resources and expertise to meet the range of health care needs associated with substance use disorders, including infectious diseases.

We also offer background on the scope of the infectious diseases (ID) impact of the opioid epidemic and the current challenges facing the ID and HIV medical workforce. We recognize the important role that HRSA will play in the administration's End the HIV Epidemic initiative and in refining its National Viral Hepatitis Action Plan and urge the agency to take steps at this critical time to address ID/HIV workforce shortages particularly in light of the synergies of HIV and viral hepatitis epidemics with the opioid epidemic.

The opioid epidemic is driving higher rates of infectious diseases including viral hepatitis, infective endocarditis (a severe heart infection), HIV, serious skin and soft tissue infections, and others. While data indicate troubling increases in infectious diseases related to drug use, even these data do not capture the full burden, as many infections remain underreported. New hepatitis C virus (HCV) rates increased almost 300 percent in five years and hepatitis B (HBV) cases have remained steady since 2012 after decades of decline. Injection drug use is the cause of most new HCV infections. Increases in new HIV cases linked to drug use are on the rise, as one in ten HIV diagnoses are among people who inject drugs.

The increases in infections linked to drug use are affecting the health of individuals with opioid use disorder and health care systems. New models of care are needed to focus both upon improving health outcomes and reducing healthcare costs. New strategies include ID/HIV providers initiating Medication Assisted Treatment in HIV or ID clinics or participating in multi-disciplinary teams to more effectively manage substance use disorder and other conditions including HIV, hepatitis C, endocarditis or other infections.

Recommendations to Improve ID/HIV Prevention to Prevent and Respond to ID Outbreaks Linked to the Opioid Epidemic

<u>ID and HIV Clinician Eligibility for the National Health Service Corps (NHSC) Substance Use Disorder Workforce Loan Repayment Program and the New Loan Repayment Program Authorized in 2018 by the SUPPORT Act</u>

While the pressing need for a robust infectious diseases and HIV workforce continues to grow in response to the opioid crisis and other public health epidemics and emerging infections, fewer physicians are pursuing this career path, due in large part to financial barriers. We urge HRSA to include ID and HIV clinicians diagnosing and treating infections related to substance use in loan repayment programs designed to boost the workforce needed to care for patients with substance use disorders. This will be important for the recently launched NHSC Substance Use Disorder Workforce Loan Repayment Program and the new loan repayment program authorized by the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) Act that has yet to be fully funded or implemented.

HRSA Ryan White-funded Clinic Designation as Eligible National Health Service Corps (NHSC) Sites

The CDC has predicted that the U.S. will face a significant shortfall of HIV medical providers this year relative to demand.[1] Insufficient treatment and care providers were partly implicated in the 2015 HIV outbreak in Scott County, Indiana. The Centers for Disease Control and Prevention has warned that 220 counties in 26 states across the country are at risk for similar HIV outbreaks.[2] While roughly half of the clinics that receive Ryan White Part C funding are based at community health centers (CHC) that are automatically designated as NHSC sites, those that are not CHCs also serve low-income patients. Many also have HIV in addition to substance use disorders and other comorbidities. These clinics serve as the medical home for their patients with HIV. Similar to CHC, these medical offices face serious challenges recruiting HIV/ID clinicians and substance use treatment providers because of the complex patient population that they serve. Expanding loan forgiveness opportunities to safety-net clinics including Ryan White HIV clinics was proposed in the 2011 report of the Negotiated Rulemaking Committee.[3] Expanding opportunities for providers to receive loan forgiveness in exchange for service at all HRSA Ryan White-funded clinics will help to attract the HIV/ID providers and substance use treatment providers where they are urgently needed.

Background on Infectious Disease Impacts of the Opioid Epidemic

While HIV and hepatitis are the infectious diseases most commonly associated with substance use disorders, the Center of Disease Control and Prevention and others have reported significant increases in a number of other bacterial and viral infections as described below

Invasive bacterial infections, including endocarditis, osteomyelitis, and skin and soft tissue infections, have increased in areas where the opioid epidemic is expanding. These infections can result in hospitalizations, surgeries, amputations and even death. While national surveillance data is not available, an evaluation of hospital admission data in North Carolina found a 12-fold increase in drug dependence-associated endocarditis linked to injection drug use from 2010 to 2015. During that time total annual hospital costs increased 20-fold, from $1.1 to $22.2 million. A significant challenge in treating endocarditis in patients who inject drugs is successfully transferring their care to clinics or

[1] Weiser J. West BT. Duke CC, Gremel GW, Skarbinski J. Qualifications, Demographics, Satisfaction, and Future Capacity of the HIV Care Provider Workforce in the United States, 2013–2014. Clinical Infectious Diseases. 2016;63(7):966–75.

[2] Caitlin C, et al. Community outbreak of HIV infection linked to injection drug use of oxymorphone -Indiana, 2015. MMWR. May 1, 2015 / 64(16);443-444.

[3] Negotiated Rulemaking Committee on the Designation of Medically Underserved Populations and Health Professional Shortage Areas Final Report to the Secretary (10/31/11). Online at: https://www.hrsa.gov/advisorycommittees/shortage/nrmcfinalreport.pdf.

facilities in the community that can meet both their substance use treatment and infectious disease treatment needs. These linked health issues lead to more extended hospital stays and higher costs, taxing local healthcare providers and resources.

Antimicrobial resistance can make infections associated with substance use even more difficult to treat, underscoring the need for expert care. People who inject drugs are 16 times more likely to develop invasive MRSA infections. The proportion of invasive MRSA cases that occurred among persons who inject drugs increased from 4.1% in 2011 to 9.2% in 2016.

ID/HIV Workforce Challenges

The need for a robust ID/HIV workforce is clear and is important to Administration initiatives to end the HIV epidemic as well as the National Viral Hepatitis Action Plan and National HV/AIDS Strategy. This need will not be met without interventions such as increased loan forgiveness opportunities for ID and HIV providers responding to significant public health challenges, including the opioid and HIV epidemics. From 2011-2016 there was a more than 20 percent decline in individuals pursuing infectious diseases fellowship training. While IDSA and HIVMA have developed programs to engage medical students and residents in ID and HIV, our efforts are insufficient to address the scope of the problem. In the last year's match, nearly one-third of ID training programs failed to fill all of their fellowship positions. Of those programs, almost 47 percent did not fill any of their slots.

Financial challenges are a key factor driving new physicians away from ID and HIV. Due to the lower reimbursement level for cognitive services, ID/HIV clinicians are among the lowest paid specialties. The prospect of lower salaries coupled with medical school debt of $200,000 on average places tremendous pressure on young physicians to pursue more lucrative areas of medicine. Loan repayment opportunities for physicians providing ID and HIV care are urgently needed to make this career path more financially feasible and help meet the demand for ID/HIV expertise in medically underserved areas and medically underserved populations throughout the country.

We appreciate the central role that HRSA programs are playing in responding to the opioid, HIV and hepatitis C epidemics, including through its critical workforce programs. We would be happy to discuss our recommendations with you or your staff. Please contact the IDSA Senior Vice President for Public Policy and Government Affairs Amanda Jezek at ajezek@idsociety.org or the HIVMA Executive Director Andrea Weddle at aweddle@hivma.org.

Sincerely,

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