May 7, 2018

CDC/HRSA Advisory Committee on HIV, Viral Hepatitis and STD Prevention and Treatment (CHAC)
c/o Jonathan Mermin, MD, MPH, Designated Federal Officer
Director, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
Centers for Disease Control and Prevention
Atlanta, GA 30329

Dear CHAC Members:

On behalf of the HIV Medicine Association (HIVMA), Infectious Diseases Society of America (IDSA), and Pediatric Infectious Diseases Society (PIDS), we thank you for the opportunity to provide public comments and to express the urgency of addressing the infectious consequences of the national opioid epidemic. IDSA represents nearly 12,000 physicians, scientists and other healthcare professionals who specialize in infectious diseases (ID), HIVMA represents more than 6,000 clinicians and researchers working on the front lines of the HIV, viral hepatitis and other STD epidemics, and PIDS represents 1100 professionals dedicated to the treatment, control and eradication of infectious diseases affecting children.

Many of our members grew alarmed recently by the rising rates of infections they have seen in their clinics and hospitals as a consequence of opioid use. IDSA and HIVMA formed a joint working group to address the opioid epidemic and its associated infections, including HIV and viral hepatitis. ID and HIV providers also are seeing more cases of injection-related bacterial infections, such as infective endocarditis and skin and soft tissue infections. Together, the public health, economic, and human costs of these infections are taking a substantial toll on our institutions, patients, their families, and communities.

Our organizations recently released both a fact sheet explaining these complications and a comprehensive set of policy recommendations including screening for HIV and viral hepatitis, surveillance for infective endocarditis, and access to coordinated ID, substance use and mental health treatment to prevent relapse and new infections. While the national attention on preventing overdose deaths and treating addiction is crucial to reversing the course of this public health crisis, our response must be comprehensive and must also address the infectious diseases associated with opioid use and other substance use disorders.

We highlight below key high-impact recommendations identified by IDSA, HIVMA, and PIDS:

**Expand access to syringe services programs, safe injection or consumption sites, and other evidence-based prevention strategies:**

Syringe services programs are highly effective for preventing transmission of HIV, hepatitis B (HBV), hepatitis C (HCV) and other infections through injection drug use. We strongly support CDC efforts to expand access to syringe access programs. CDC should also continue educating on the effectiveness and public health benefits of syringe access programs and providing technical assistance and financial support. With recent outbreaks of HIV linked to injection drug use in Kentucky, Ohio and Massachusetts, it is imperative that we expand access to this low cost, highly effective intervention. IDSA and HIVMA also
support safe consumption sites as venues to provide supervised and hygienic access to sterile equipment for individuals who inject drugs that also provide access to overdose management and prevention, screening for infectious diseases, health education, and linkage to opioid addiction treatment and other medical care. This public health crisis demands innovative and comprehensive responses that employ all available tools to reduce harms and connect individuals with substance use disorder to effective healthcare and treatment.

**Take steps to evaluate the magnitude of the impact of infective endocarditis and other infections that are complications of injection drug use. Generate national and regional data to help inform the development of prevention and treatment programs:**

The rates of infective endocarditis are increasing dramatically among people who inject drugs, but no public health system is in place to monitor this condition. National data to evaluate the scope of the problem is urgently needed to help affected communities identify outbreaks earlier. This is critical because HIV and HCV are often asymptomatic for years, but infective endocarditis will cause hospital admission in a matter of days or weeks due to the severity of symptoms. Our members report increasing morbidity and mortality rates due to infective endocarditis among young adults who inject drugs. The associated healthcare expenditures are significant, with costs reaching $5 million annually for opioid use disorder patients being reported by one hospital. We urge CDC to continue evaluating appropriate methods for monitoring and analyzing trends in infective endocarditis and other bacterial infections. Such data will help identify outbreaks early and inform more effective prevention and treatment interventions. IDSA and HIVMA support legislation currently considered in Congress that would authorize $40 million in new funding for CDC to increase capacity for conducting surveillance on HIV, viral hepatitis and infective endocarditis as well as to expand clinician training, including for ID and HIV providers.

**Ensure an adequate and qualified healthcare workforce by expanding access to loan forgiveness programs to healthcare providers caring for individuals with substance use disorder and related infectious diseases. Leverage telehealth to improve access to expert HIV and ID care and substance use treatment. Work with the Substance Abuse and Mental Health Services Administration to provide HIV and ID providers with the training and supports necessary to provide medication-assisted treatment (MAT) to patients with HIV and other infectious diseases who also have substance use disorders:**

The pressing need for a sufficient ID and HIV workforce continues to grow in response to emerging infections and ongoing public health epidemics including the opioid crisis. Yet, fewer physicians are entering fields of ID and HIV medicine largely due to significant medical school debt. The average medical school debt rests at $200,000. This burden places tremendous pressure on young physicians to pursue more lucrative careers in medicine. Alarmingly, there has been a 20 percent decline in individuals pursuing ID fellowship training over the past five years, and the CDC predicts a serious shortfall in HIV providers by 2019.

To build the necessary workforce capacity for the opioid epidemic, we support bills being considered in Congress that would expand loan forgiveness for healthcare providers including infectious disease and HIV clinicians who care for individuals with substance use disorder. We also continue to recommend the designation of Ryan White-funded clinics as approved sites for the National Health Service Corps program to incentivize physicians-in-training to consider working at Ryan White clinics, all of which serve vulnerable and underserved populations.
Telehealth programs such as Project ECHO have also demonstrated effectiveness at increasing provider knowledge and improving patient outcomes. We urge HRSA to increase support for these programs and work with the Centers for Medicare and Medicaid Services to ensure adequate reimbursement for the range of services and associated consultation and preparation that can be provided by telehealth.

ID and HIV providers stand squarely at the intersection of infectious diseases and the opioid epidemic. They are a critical and logical resource to build capacity and increase access to MAT. Limited physician education and stigma are barriers to prescribing medical treatment for addictive diseases. Limited reimbursement for treatment and essential supportive services, such as care management, is a major obstacle to expanding MAT. We urge HRSA to provide greater access to training in addiction medicine and other supportive resources, including guidance to support the integration of MAT into ID/HIV clinical practices through the AIDS Education and Training Centers and other programs. We also urge exploration of mechanisms to provide adequate reimbursement for provision of services necessary to treat addictive diseases.

Leverage the HRSA Ryan White HIV/AIDS Program and its successful model for treating HIV and serious co-occurring conditions to ensure that people with HIV are effectively treated for substance use disorders and to build capacity to serve individuals with substance use disorders not yet infected with HIV who need treatment for viral hepatitis and other infectious diseases:

Since 1990, Ryan White-funded clinics have created and sustained the public health infrastructure necessary to provide the kind of comprehensive care required to successfully treat a complex chronic infection like HIV, while managing serious coexisting conditions in a patient population challenged by low income, unstable housing, lack of access to transportation, and high rates of substance use and mental health disorders. Over the last six years, viral suppression rates for Ryan White patients increased from 70% to 85% despite level funding, demonstrating the program’s effectiveness. Ensuring access to substance use and mental health treatment for the large percentage of patients in need is one of the biggest challenges faced by Ryan White-funded sites. This existing national infrastructure with multi-disciplinary care supported by the Ryan White Program should be leveraged by prioritizing the clinics for non-Ryan White funding to expand capacity for substance use treatment, case management and care coordination for individuals not yet infected with HIV but who need treatment for viral hepatitis and other infectious diseases.

Thank you for your consideration of our views. Please call on us as a resource as the Committee considers how to enhance the federal response to the infectious diseases consequences of the opioid crisis. We can be reached through HIVMA senior policy manager George Fistonich at gfistonich@hivma.org, IDSA program officer for public health policy Colin McGoodwin at cmcgoodwin@idsociety.org, and PIDS executive director Christy Phillips at cphillips@idsociety.org.

Sincerely,

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Chair, HIVMA

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