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Wonkblog

How an HIV outbreak hit rural Indiana — and why we should be paying attention

By Danielle Paquette March 30

Years ago, William Cooke sensed a crisis building. The only doctor in rural Austin, Ind., noticed that intravenous drug use was soaring in his town of roughly 4,300, where 23 percent of residents live below the poverty line. He feared that people addicted to injectible painkillers might be plucking used needles off lawns, shooting up — and passing them on.

A surge of drug overdoses hit Cooke's family practice, where he'd treat anyone with $10. More Hepatitis C infections followed. Next came an HIV diagnosis in December, rare in southeastern Scott County. By Friday, the number of new cases had climbed toward 80.

Last week, Indiana Gov. Mike Pence declared the outbreak a public health emergency, the worst in state history, authorizing a short-term needle exchange program. The announcement came as a surprise: Rates of new HIV transmission have been declining in Indiana for years, from 463 reported in 2002 to 205 in 2012.

CDC workers descended upon Austin, the epicenter, about 70 miles south of Indianapolis — prompting some to wonder: How could an HIV outbreak ravage rural Indiana?

Cooke knew drug use and infectious disease was a deadly combination. Without preventative resources, an outbreak could be triggered by one person with HIV sharing a needle.

"We saw this coming a long time ago," he said. "There's a lot of poverty and very few resources available to the community. We've been asking for help for some time."

Patients came to him already sick. Most had illegally used Opana, a prescription painkiller that delivers a potent high, especially when ground into water and injected into veins, CDC investigators found. The nearest hospital with social services and HIV testing, Cooke said, was only five miles away. But many of Austin's drug users lacked transportation.

"When you don't have a health-care system where people have access to testing and treatment, the introduction

of one infection into a community of drug users can turn into an outbreak," said Tony Fauci, director of the National Institute of Allergy and Infectious Diseases.

Injecting drugs fuels nearly 10 percent of new HIV cases in the U.S., according to a 2012 CDC study that examined a national population sample of 13,000. Nearly half of those who tested positive for HIV did not know they had it.

Abuse of painkillers — and sharing needles — compounds the risk. The problem is growing across the country. Prescription opioids are easy to find and highly addictive. Prescriptions for these drugs have increased tenfold since 1990, according to a Harvard Medical School report. Doctors wrote 259 million prescriptions in 2012 — "enough for every American adult to have a bottle of pills," the CDC reported.

Users can illegally purchase drugs like Opana in liquid form and inject it. The number of opioid-related deaths in Indiana more than tripled over the past decade, increasing from 200 in 2002 to 700 in 2012, according to the Indiana State Department of Health.

HIV outbreaks more commonly occur in urban areas, Fauci said, where drug culture is more often prominent. The last HIV outbreak he remembers outside a major metropolitan happened in Belle Glade, Fla.,, population 17,839, where doctors said poverty and drug use contributed to more than 400 AIDS deaths in the '80s and '90s.

Belle Glade's catastrophe proved that HIV is mobile. No small town is safe merely because it is a small town. A lack of both medical and social support increases any area's risk. Infrastructure also plays a role.

A National Institute of Health study from 2005 found that residents of rural areas who had driver's licenses visited a doctor more than twice as often as those who did not. People who said they used public transportation reported 4 more chronic care visits per year than people without access to a bus or train.

Beth Elaine Meyerson, co-director of the Rural Center for AIDS/STD Prevention at Indiana University, said several forces drive rural outbreaks — and not just in Austin. Communities nationwide struggle with limited access to affordable health care, counseling and testing. Many residents are uninsured. Tackling an outbreak requires far more, in these cases, than administering medication.

"We must also address those individual, social, community and policy level factors that fuel illness — like socioeconomic disadvantage and social disadvantage," Meyerson said in an e-mail. "We do this by building into systems of care strong adjunct services that support continued engagement with treatment."

HIV users who receive sustained treatment become 96 percent less infectious, she added.

But people who don't think they can afford health care tend to avoid the doctor's office, said Caitlin Priest, director of Public Policy at Covering Kids and Families of Indiana. That drives up risk for everyone.

"Part of the puzzle is ensuring access to care," Priest said, "and to that end we need to put boots on the ground in that area and conduct massive enrollment events to ensure that eligible Hoosiers are connected to the ACA Marketplace, or any other coverage program for which they may be eligible."

Cooke, who opened his practice in Austin 10 years ago, never expected to battle an HIV outbreak. Now he's on the frontlines, driving from house to house, offering free testing. He's educating residents about both painkiller addiction and HIV treatment. He's thinking through ways to implement telemedicine, bring treatment and counseling to residents' living rooms.

And with more money and resources pouring in from the state, he's no longer alone. The town's first-ever HIV clinic is scheduled to start treating patients Tuesday.

"Funding is generally limited on what can be done in rural areas," Cooke said. "In responding to this medical emergency, I'm hoping we can build a model here — something we can replicate in other rural communities."

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