

December 5, 2008

NATIONAL HIV PROGRAM

1. PURPOSE: This Veterans Health Administration (VHA) Directive defines the general policies and programs relating to the VHA Human Immunodeficiency Virus (HIV) Program.

2. BACKGROUND

a. Despite many preventive and therapeutic advances, HIV infection remains a major public health problem, both for the United States and for VHA. The Centers for Disease Control and Prevention (CDC) estimate that over 1,000,000 Americans are infected with HIV (see subpar. 5a); as many as 25 percent have not been diagnosed and are at risk for complications of HIV infection, particularly Acquired Immunodeficiency Syndrome (AIDS). Over 22,000 veterans with HIV infection are in care at VHA facilities making VHA the largest single provider of care to HIV-infected individuals in the country.

b. The VHA HIV Program has used a comprehensive approach emphasizing clinical care and prevention through testing, counseling, research, and education.

(1) At a national level, the VHA AIDS Service, established in 1985 to develop VHA policy regarding HIV infection, has provided VHA guidelines for diagnosis and treatment of HIV infection, and educated providers and patients about HIV testing, prevention, and treatment. The Public Health Strategic Healthcare Group (PHSHG) is the successor unit currently responsible for the original mission of the AIDS Service.

(2) The AIDS Service and its successor units have responded to the HIV pandemic with broad educational, public health, and policy efforts, including directives on diagnosis, prevention, and treatment of HIV infection; compliance with relevant Federal law; and multiple guidelines, educational meetings, and publications dealing with HIV infection. The Veterans Benefits and Services Act of 1988, Public Law 100-322, requires VHA to provide comprehensive health services to veterans with HIV, and to educate providers and veterans on HIV prevention and treatment issues. *NOTE: Published VHA directives, guidelines, educational materials, and other resources dealing with HIV infection can be found at the VHA Web site at: www.hiv.va.gov.*

(3) In 1992, VHA introduced the Immunology Case Registry to track resource utilization. The Registry was updated in 1998 and superseded in 2006 by the Clinical Case Registry (CCR) software developed and managed by the Center for Quality Management in Public Health. Today, the new CCR package provides local population management tools and national, system-wide data on veterans in care with HIV infection for use in safety, quality, and research initiatives.

(4) VHA has rapidly adopted new therapies for HIV infection and its complications,

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particularly combination anti-retroviral therapy (cART). VHA follows the United States Department of Health and Human Services guidelines for HIV care that are available at www.hiv.va.gov. A study by Holodniy *et al.* demonstrated that VHA prescribing trends for cART regimens generally predate national guideline recommendations by 6-12 months (see subpar. 5b). These therapies have transformed HIV infection from a usually fatal condition into more of a chronic disease requiring integration of primary care into the management of HIV-infected patients.

c. Now that HIV can be seen as a treatable chronic disease, priorities for VHA include: the need for earlier diagnosis of HIV infection, improved access to care for HIV-infected veterans; the integration of HIV and primary care, providing ongoing prevention services to veterans living with HIV, and a focus on high-quality care as the HIV-positive veteran population ages. The first priority is particularly important, given that the CDC has recommended making HIV testing part of routine medical care (see subpar 5a), and that there may be a high prevalence of undiagnosed HIV infection among veterans seen at some VHA facilities (see subpar 5c).

3. POLICY: It is VHA policy that veterans with HIV infection receive state-of-the-art diagnosis and treatment that reflects their individual values and goals.

4. ACTION

a. **Clinical Public Health Program (CPHP) Office.** The CPHP Office is responsible for:

(1) Developing and communicating national VHA policy on HIV to ensure patient-centered state-of-the-art therapy and timely access to diagnosis and HIV care.

(2) Developing informational and other products to support VHA facility clinicians providing care for patients living with HIV.

(3) Providing assistance in the development of local or Veterans Integrated Service Network (VISN) plans designed to aid HIV Lead Clinicians in monitoring and caring for local populations.

(4) Working with the Center for Quality Management in Public Health and senior leadership in the PSHHG to provide national, VISN, and local demographic and quality indicator reports on veterans with HIV for local facility use.

(5) Working with the Office of Patient Care Services and senior PSHHG leadership to:

(a) Develop mechanisms for early identification of patients with HIV infection.

(b) Assist in developing integrated models of care for patients living with chronic HIV infection that meet the primary care and prevention needs of these patients.

(6) Assembling, coordinating, and obtaining input on national HIV policy issues from a multidisciplinary Technical Advisory Group, the veterans' Community Advisory Board, ad hoc meetings of HIV providers, and VHA facility clinicians and administrative staff.

(7) Collaborating with the Employee Education System (EES) to conduct national educational programs on HIV.

(8) Ensuring the accuracy, completeness, and currency of information on the VHA HIV Web site at: www.hiv.va.gov.

b. **Facility Director.** The facility Director is responsible for:

(1) Identifying an HIV Lead Clinician to be the principal point of contact for communications and reporting from, and to, on HIV-related issues. The HIV Lead Clinician must be a provider committed to excellence in the diagnosis and care of HIV-infected veterans.

(2) Reviewing, on an annual basis, the contact information for the facility's HIV Lead Clinician. Any changes in staffing or the contact information need to be faxed by January 15 of each year to the CPHP at 202-273-6243, or sent by email to publichealth@va.gov (include the name, address, phone, fax, e-mail address, and other locator information for the HIV Lead Clinician).

c. **Facility HIV Lead Clinician.** The HIV Lead Clinician is responsible for:

(1) Serving as an advocate for excellence in patient-centered diagnosis and care of HIV-infected veterans.

(2) Serving as a point of contact for communications to and from the CPHP office regarding the VHA HIV Program.

(3) Working with the local HIV CCR Coordinator to optimize the use of local population management tools and for reporting to Chief of Staff and Facility Director. **NOTE:**

Responsibilities of the CCR Coordinator can be found at:

http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1383

5. REFERENCES

a. CDC. Revised recommendations for HIV testing of adults, adolescents, and pregnant women in health-care settings. MMWR 2006; 55 (No. RR-14):1-17.

b. Holodniy M, Hornberger J, Rapoport D, *et al.* Relationship between antiretroviral prescribing patterns and treatment guidelines in treatment-naive HIV-1-infected U.S. veterans (1992-2004). J Acquir Immune Defic Syndr 2007;44:20-9.

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c. Owens DK, Sundaram V, Lazzeroni LC, *et al.* Prevalence of HIV infection among inpatients and outpatients in department of veterans affairs health care systems: Implications for screening programs for HIV. *Am J Public Health* 2007; 97:2173-8.

6. FOLLOW-UP RESPONSIBILITY: The Chief Consultant of the Public Health Strategic Healthcare Group (13B) is responsible for the contents of this Directive. Questions may be referred to 202-461-7240, or to publichealth@va.gov.

7. RECISSIONS: None. This VHA Directive expires December 31, 2013.

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