NATIONAL HUMAN IMMUNODEFICIENCY VIRUS (HIV) PROGRAM

1. REASON FOR ISSUE: This Veterans Health Administration (VHA) Directive defines policy for the VHA National Human Immunodeficiency Virus (HIV) Program.

2. SUMMARY OF MAJOR CHANGES: This updated VHA Directive gives the VHA National HIV Program, within the Office of Public Health/Clinical Public Health (OPH/CPH), the responsibility to provide primary guidance and advice to the Under Secretary for Health on VHA policy and services related to HIV infection and to lead coordination of quality improvement activities using population-based approaches for prevention, diagnosis, and care of Veterans with HIV across the VHA health care system. Significant changes include:

   a. A policy change in 2009 that revised the Department of Veterans Affairs (VA) HIV testing policy (see paragraph 2.c.);

   b. Renaming the Public Health Strategic Healthcare Group to Clinical Public Health (CPH); and

   c. Renaming the Clinical Public Health Program to the HIV, Hepatitis, and Public Health Pathogens Program (HHPHP).

3. RELATED ISSUES: None.

4. RESPONSIBLE OFFICE: The Director, HIV, Hepatitis, and Public Health Pathogens Programs (HHPHP), is responsible for the content of this Directive. Questions may be addressed at 202-461-1040 or by e-mail at publichealth@va.gov.


6. RECERTIFICATION: This VHA Directive is scheduled for recertification on or before the last working day of November, 2019.

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NATIONAL HUMAN IMMUNODEFICIENCY VIRUS (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. 

AUTHORITY: 38 U.S.C. 7301(b).

2. BACKGROUND:

a. Despite many preventive and therapeutic advances, HIV infection remains a major public health problem, both for the United States (U.S.) and for VHA. The U.S. Centers for Disease Control and Prevention (CDC) estimate that over 1,000,000 Americans are infected with HIV (see paragraph 5.a.); as many as 18 percent have not been diagnosed and are at risk for complications of HIV infection, particularly Acquired Immunodeficiency Syndrome (AIDS). Over 26,000 Veterans with HIV infection are receiving care at VA medical facilities, making VHA the largest single provider of care to HIV-infected individuals in the country.

b. The VHA HIV National Program has used a comprehensive approach emphasizing clinical care and prevention through testing, counseling, delivering high quality care, educating, and to a lesser extent, collaborating with researchers.

(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 Office of Public Health/Clinical Public Health (OPH/CPH) 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 guidelines and Directives (i.e., VHA Directive 2009-036, Testing for Human Immunodeficiency Virus in Veterans Health Administration Facilities), on testing, diagnosis, prevention, and treatment of HIV infection; compliance with relevant Federal laws and regulations; 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 educate providers and Veterans on issues related to HIV prevention, treatment, and anti-discrimination based on HIV status. NOTE: Published VHA Directives, guidelines, educational materials, and other resources dealing with HIV infection can be found on the VHA Web site at http://www.hiv.va.gov.

(3) In 2006, VHA introduced the HIV Clinical Case Registry (CCR) as a facility-level tool, accessible from within VHA’s Computerized Patient Record System (CPRS), to replace the National Immunology Case Registry introduced in 1996 to track resource utilization among Veterans with HIV infection in VHA care (see paragraph 5.b.). The CCR package provides local population health reporting tools, managed by a locally-designated CCR Coordinator, enabling facilities to utilize local data to improve outcomes for their Veterans in care with HIV infection. It also serves as the source of data for the National HIV CCR.

(4) VHA has rapidly adopted new therapies for HIV infection and its complications, particularly combination antiretroviral therapy (cART). VHA follows the U.S. Department of Health and Human Services guidelines for antiretroviral therapy, which are available at
http://www.hiv.va.gov (see paragraph 5.c.). These therapies have transformed HIV infection from an almost universally fatal condition into a chronic disease requiring integration of primary care into the management of HIV-infected patients. Such integration has allowed VHA to achieve superior outcomes for control of both HIV infection and the co-morbidities that emerge in aging HIV-infected patients (see paragraph 5.d.).

c. Although in 2006 the CDC recommended offering HIV testing in health care settings regardless of risk factors (see paragraph 5.e.), VA had been barred by Federal law and regulations until 2009 from performing wide-spread, routine HIV testing. In 2009, VA revised its regulations following a change in law enacted in the previous year and no longer required written informed consent or scripted pre-test and post-test counseling for HIV testing, which allowed VHA to align its official policies with the CDC’s recommendations (see paragraph 5.f.) and to rapidly implement routine HIV testing. Two years after these changes, HIV testing rates within VHA had already doubled (see paragraph 5.g.). VA HIV testing data from calendar year 2012 shows seropositivity rates in all Veterans Integrated Service Networks (VISN) of 0.1 percent or greater, exceeding the CDC’s threshold for recommending routine HIV testing in health care settings.

d. Given VHA’s advances in treatment and care for Veterans with HIV infection and the reduction in systemic barriers to HIV testing, current priorities for VHA include:

(1) Earlier diagnosis of HIV infection;

(2) Improved access to care, particularly for rural or disabled HIV positive (HIV+) Veterans through initiatives such as telehealth and Specialty Care Access Network-Extension for Community Healthcare Outcomes (SCAN-ECHO);

(3) Reducing disparities in care among rural; homeless; female; Lesbian, Gay, Bisexual, and Transgender (LGBT); and African American, Hispanic, and Native American Veterans;

(4) The integration of HIV care and primary care;

(5) Providing ongoing prevention services to Veterans living with HIV infection; and

(6) The integration of mental health and substance use disorders (MH/SUD) services into HIV care and assessing and augmenting care for an aging HIV+ patient population.

e. Earlier diagnosis of HIV infection is particularly important, given evidence that there is a high prevalence of previously undiagnosed HIV infection among Veterans tested for HIV at some VA medical facilities (see paragraph 5.h.).

f. VHA also places a high priority on its role as a lead agency in the National HIV/AIDS Strategy for the United States (NHAS) (see paragraph 5.i.), as well as a designated participant in the Federal HIV Care Continuum Initiative (see paragraph 5.j.).

3. POLICY: It is VHA policy that Veterans with HIV infection receive patient-centered, state-of-the-art diagnosis, care, and treatment that reflects their individual values and goals.
4. RESPONSIBILITIES:

a. National HIV Program. The Director, HHPHP, OPH/CPH, is responsible for:

   (1) Advising the Under Secretary for Health on matters of VHA policy and services related to HIV infection;

   (2) Leading VA efforts related to the NHAS and Federal HIV Care Continuum Initiative;

   (3) Collaborating with the VHA National Center for Health Promotion and Disease Prevention on testing and prevention policy and services (e.g., screening, immunization, and health behavior counseling) related to HIV infection;

   (4) Collaborating with the VHA Office of Mental Health Services on policies and programs to improve mental health services, particularly access to MH/SUD care, among Veterans with HIV infection;

   (5) Collaborating with the VHA Office of Mental Health Operations to develop and implement methods for monitoring the availability of MH/SUD care among Veterans with HIV infection;

   (6) 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 to VA medical facilities and VISNs;

   (7) Developing educational and informational products to support VA clinicians providing care for patients living with HIV;

   (8) Providing assistance in the development of VA medical facility or VISN plans to support facility HIV Lead Clinicians (see paragraph 4.d.) in monitoring and caring for patients with, or at risk for HIV infection;

   (9) Working with Population Health, an office within OPH, to provide data reports and quality indicator information on national, VISN, and facility-level demographic and quality indicator reports on Veterans with HIV, including HIV testing rates and data related to the HIV Continuum of Care (see paragraph 5.j.) for local facility use;

   (10) Working with Occupational Health, an office within OPH, to develop and communicate national VHA policy and educational products on prevention of healthcare-associated occupational infections including HIV, hepatitis, and other Public Health pathogens for VHA employees and employee health clinicians;

   (11) Working with the VHA Office of Patient Care Services and senior OPH/CPH leadership to:

       (a) Develop and implement strategies (e.g., electronic clinical reminders) for early identification of patients with HIV infection; and
(b) Assist in developing integrated care delivery systems, using the Patient-Aligned Care Team (PACT) model for patients living with chronic HIV infection, that meet the primary care, prevention, mental health, substance use, and socioeconomic needs of these patients.

(12) Assembling, coordinating, and obtaining input on national HIV policy issues from a multidisciplinary Technical Advisory Group, the Veterans’ Community Advisory Board, and ad hoc meetings of HIV providers and VA medical facility clinicians and administrative staff;

(13) Collaborating with the VA Employee Education System (EES) to conduct national educational programs on HIV infection; and

(14) Ensuring the accuracy, completeness, and currency of information on the VHA HIV Web site at [http://www.hiv.va.gov](http://www.hiv.va.gov) and VHA’s internal Web site at [http://vaww.hiv.va.gov](http://vaww.hiv.va.gov). **NOTE:** This is an internal VA Web site that is not available to the public.

b. **VISN Director.** The VISN Director is responsible for establishing a system of regular and consistent communication with HIV Lead Clinicians at each facility (see paragraph 4.d.) on issues related to coordination of HIV diagnosis, care and treatment as well as allocation of necessary resources to improve the prevention and testing of Veterans at risk for HIV. The mode of communication (e.g., in person or teleconference) as well as the frequency and content of this communication may vary by VISN with an ideal goal of VISN leadership meeting with HIV Lead Clinicians at least 1 to 2 times per year, with additional meetings as needed to address any relevant issues that emerge. During these meetings, the following topic areas should be included:

(1) General epidemiological trends for HIV testing and treatment outcomes across the VISN (available at: [http://vaww.hiv.va.gov](http://vaww.hiv.va.gov)). **NOTE:** This is an internal VA Web site and not available to the public;

(2) Variability in HIV patient care management and treatment across the VISN with respect to the care of medical and psychiatric co-morbidities; and

(3) Resource considerations and vulnerabilities in HIV prevention, testing, and care across the VISN.

c. **Medical Facility Director.** The medical facility Director is responsible for:

(1) Identifying a facility HIV Lead Clinician to be the principal point-of-contact for all HIV program information and reporting between the facility and HHPHP, and providing sufficient time for the Lead Clinician to carry out their responsibilities (see paragraph 4.d.).

(2) Responding to an annual request from the VHA Assistant Deputy Under Secretary for Health for Clinical Operations to provide updated contact information for the facility HIV Lead Clinician.

d. **Facility HIV Lead Clinicians.** Facility HIV Lead Clinicians are responsible for:
(1) Advocating for excellence in patient-centered diagnosis and care of HIV-infected Veterans;

(2) Using facility-level HIV data (see paragraph 4.a.(7)) to develop recommendations to facility leadership on increasing HIV testing rates and quality improvement related to the HIV Continuum of Care;

(3) Collaborating with facility-level Mental Health and Substance Use Services to assess and address unmet MH/SUD needs among Veterans with HIV infection;

(4) Advising the VISN and facility Directors, facility pharmacy leadership, and other facility patient-centered management teams on issues related to coordination of HIV care, allocation of necessary resources, and system redesign changes indicated to improve diagnosis, prevention, treatment, and care of Veterans with or at risk for HIV infection;

(5) Serving as points of contact for communications to and from HHPHP;

(6) Serving as the HIV Lead Clinician is considered a collateral duty for a local VA HIV provider working with the facility’s HIV Clinic and HIV patients; and

(7) Working with the local HIV CCR Coordinator at the facility level to optimize the use of local population management tools and to report to the facility Chief of Staff and medical facility Director (see paragraph 5.b.).

5. REFERENCES:


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


