

# VA HIV REPORT



Published by the Public Health Strategic Health Care Group, Veterans Health Administration, Department of Veterans Affairs  
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## Note from the HIV Program Office

With this first issue of VA HIV Report, we begin the periodic publication of information relating to VA's HIV programs and data from the Immunology Case Registry. This newsletter will be produced and distributed twice yearly, and will include information that we hope will be useful to managers, clinicians, and others interested in HIV prevention and treatment. My colleague and co-editor, Michael Howe, will continue production and distribution of the very successful electronic HIV/Hepatitis C News Service, which summarizes recent research findings and relevant news items.

The centerpiece of each newsletter will be summary reports from the Immunology Case Registry. The reports in this issue include data through the end of the 2003 fiscal year. While the overall numbers of patients in care has remained relatively stable, approximately ten percent of patients with activity in 2003 were added to the ICR for the first time during this year. This includes patients newly diagnosed as well as those previously diagnosed, but new to the VA system. Inpatient utilization continues to decline. The number of patients on antiretroviral therapy has not changed significantly since FY2002, but there are shifts toward utilization of newer antiretrovirals, like tenofovir, and ongoing increases in use of efavirenz and lopinavir/ritonavir.

Michael Howe and I would very much like to hear from you with suggestions and feedback about how we can improve this publication. As always, many thanks for the dedication, expertise and hard work you bring to the care of veterans with and at risk for HIV. VA truly leads the nation in HIV care!

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## New HIV Risk Assessment and Testing Brochure in English, Spanish Available for Use in Waiting Rooms, Other Public Sites in VA Facilities

The Public Health Strategic Health Care Group is pleased to announce the release of a patient education brochure developed to increase veterans' awareness about risk for HIV and the importance of HIV testing for early detection. Copies of the brochure have been mailed to Directors of VA Medical Centers and Vet Centers. This full color brochure comes with one of two veteran-specific covers, "Be Courageous Again. Get Tested" and "Veterans Have Stood the Tests of Time. Now Get Tested Again". The brochure is also available in Spanish: "Tenga Valor Otra Vez. Hágase La Prueba."

This brochure provides veterans with information about how to assess their risk for HIV and how to talk with a health care provider about their sexual or drug use history, as well as information about the availability of HIV testing and HIV care in VA. The CDC estimates that over 200,000 Americans have HIV and don't know it. Our message to veterans is that "with HIV, it's what you don't know that can hurt you."

Please use these brochures in your facility waiting rooms so veterans can learn more about their risk and how to get help. To order additional copies, contact the Forms and Publications Control Officer at your facility and request that they place an order to the VA Publications Depot. The IB Numbers for the brochures in English are 10-167 (P#95971) and 10-167A (P#95972) and the IB Number for the Spanish version is 10-167SP (P#95973). If you do not know who your local VHA Forms and Publications Control Officer is, you can locate that information on the VA Intranet at <http://vaww.va.gov/vhacio/comm/index.cfm> under the heading "Forms and Publications Officers."

If you have any questions, please contact Dr. Kim Hamlett-Berry, Director of the Public Health National Prevention Program, at [kim.hamlett@hq.med.va.gov](mailto:kim.hamlett@hq.med.va.gov) or (202) 273-8567.



## Reports from the Immunology Case Registry

National Trends in Antiretroviral (ARV) Drug Use								
	FY 1996	FY 1997	FY 1998	FY 1999	FY 2000	FY 2001	FY 2002	FY 2003
<b>Number of patients on any ARV</b>								
Any antiretroviral	9593	11918	12789	13511	13979	14448	14755	14860
<b>Number of patients on each class of ARV</b>								
Any nRTI	9518	11869	12680	13396	13836	14273	14583	14716
Any nnRTI	19	1024	2695	5071	6466	6919	7090	7374
Any PI	2608	8018	10368	10657	9969	9487	9034	8390
<b>Number of patients on each ARV</b>								
Abacavir			1	1336	2150	2394	2304	2234
Abacavir/lamivudine/zidovudine						556	1463	1786
Amprenavir				443	1025	1032	765	553
Atazanavir								325
Delavirdine	1	166	481	302	180	166	150	129
Didanosine	1927	2236	2646	2920	2694	2728	2767	2629
Efavirenz			43	2798	4111	4524	4728	5108
Emtricitabine								18
Enfuvirtide								134
Indinavir	1776	6034	5529	4456	3810	3167	2456	1784
Lamivudine	6493	10750	10015	7018	6192	5813	5685	5773
Lamivudine/zidovudine			3420	5248	5944	6095	5690	5251
Lopinavir/ritonavir					6	1659	2794	3565
Nelfinavir		1892	4818	5451	4632	3887	3256	2599
Nevirapine	18	888	2291	2547	2525	2508	2459	2382
Ritonavir	287	879	1691	1811	2517	2441	1842	1562
Saquinavir	985	1840	2438	2259	1852	1284	930	836
Stavudine	2654	5993	7168	7380	7207	7040	6338	5109
Tenofovir							1808	4096
Zalcitabine	1477	876	567	377	240	155	106	82
Zidovudine	6887	7994	5324	1839	1071	840	738	699
Data source: Immunology Case Registry, data through 10/01/03. Antiretrovirals received as part of a research study and those labelled as investigational drugs are not included.								

Inpatient Care		
	FY 2002	FY 2003
Inpatient discharges	8917	8645
Patients with inpatient discharges	4688	4570
Mean length of stay (LOS) in days	15.0	15.8
Median LOS	6	6
Discharges with LOS of the following duration:		
1 day	232	260
2-3 days	2069	2068
4-7 days	2788	2668
8-14 days	1925	1801
More than 14 days	1903	1848
LOS (length of stay) = discharge date minus admit date + 1. Other sources of VA data may calculate LOS differently. LOS is calculated for all types of inpatient facilities, including acute and long term care hospitals, nursing homes and domiciliary facilities. Data source: Immunology Case Registry, data through 10/01/03		

Patients Added to ICR*		
	FY 2002	FY 2003
Female	57	42
Male	1862	1912
<b>TOTAL</b>	<b>1919</b>	<b>1954</b>
American Indian/Alaskan native	4	4
Asian/Pacific Islander	2	2
Black (Not Hispanic)	846	770
Hispanic	142	119
Mixed race	11	10
Unknown	266	432
White (Not Hispanic)	648	617
*Those for whom the date of first transmission of a record was during the given time period Data source: Immunology Case Registry, data through 10/02/03		

Selected Immunology Case Registry Data on Demographics of Patients in Care								
	Patients in care	Sex*		Race				
	Total	Male	Female	Black (Not Hispanic)	Hispanic	White	Unknown	all other
FY 2002	20035	19530	502	9501	1486	7061	1152	835
FY 2003	19610	19128	480	9073	1444	6956	1349	788

\*3 patients in FY02 and 2 in FY03 were designated unknown or both male and female  
Source of data: Immunology Case Registry, data through 10/01/03

Selected Immunology Case Registry Data by VISN							
VISN #	VISN Name	Patients in care		Deaths		All CD4 < 200*	
		FY 2002	FY 2003	FY 2002	FY 2003	FY 2002	FY 2003
1	New England Healthcare System	563	534	33	32	112	106
2	Healthcare Network Upstate New York	267	253	18	12	57	47
3	NY/NJ Veterans Healthcare Network	2142	1993	139	108	428	391
4	Stars & Stripes Healthcare Network	928	881	71	52	208	196
5	Capitol Health Care Network	1462	1381	92	67	315	270
6	Mid-Atlantic Health Care Network	1137	1135	71	63	288	281
7	Atlanta Network	1857	1844	120	82	403	371
8	Sunshine Healthcare Network	2536	2497	151	136	477	433
9	Mid South Healthcare Network	604	551	40	39	132	142
10	Healthcare System of Ohio	472	457	22	11	101	94
11	Veterans in Partnership	616	624	35	31	114	100
12	Great Lakes Health Care System	772	701	51	34	160	149
15	Heartland Network	457	450	22	25	84	90
16	South Central VA Health Care Network	1758	1734	90	86	382	391
17	Heart of Texas Health Care Network	894	934	42	36	157	160
18	Southwest Health Care Network	552	555	44	34	122	122
19	Rocky Mountain Network	311	311	24	20	63	57
20	Northwest Network	513	524	21	30	99	100
21	Sierra Pacific Network	1068	1036	54	56	184	174
22	Desert Pacific Healthcare Network	1724	1774	71	67	299	303
23	Midwest Health Care Network	244	244	11	16	48	46

Data source: Immunology Case Registry, data through 10/01/03  
\*Patients whose quantitative CD4 lymphocyte counts were all less than 200 cell/mm<sup>3</sup> during the time period

The Immunology Case Registry is VA's database of veterans infected with HIV receiving care in VA facilities. Data are collected directly from the electronic medical records of all patients entered into the registry by local facilities. For more information on the ICR, visit the Web site of the Center for Quality Management in Public Health: <http://vaww.vhaco.va.gov/phshcq/cqm/TOC.htm>

The Public Health Strategic Health Care Group includes the HIV and Hepatitis C Program Office, the Center for Quality Management in Public Health, the Center for HIV Research Resources, the Public Health Prevention Program, and support services for education and training, communication, and information management. For more information about the work of the Public Health Strategic Health Care Group, visit our Web site: <http://vaww.vhaco.va.gov/phshcg/> (VA Intranet) or <http://www.publichealth.va.gov/> (Internet)

## Best Practices: Manhattan Campus Targets Antiretroviral Adherence

Adherence to antiretroviral (ARV) medication is key to successful outcomes. The VA HIV Collaborative team from New York Harbor Manhattan Campus tested and implemented simple changes that improved ARV adherence among their population of over 600 HIV+ patients, and ended up changing local policy.

The team evaluated ARV adherence rates by reviewing refill patterns in the Computerized Patient Records System (CPRS). Although 90% of patients had filled prescriptions in the prior month, only 60% had consistently filled prescriptions on time over the prior three months. Interviews with non-adherent patients identified contributing factors and revealed that providers often made false assumptions about which patients were adherent. Psychiatric illness, mental health and substance abuse issues threatened adherence, and some patients said they “just forgot”. Paradoxically, as patients’ conditions improved, adherence sometimes decreased because they resumed responsibilities such as jobs that made it difficult to get their refills. Local policy restricted ARV drugs to a 30-day supply dispensed at the window. The team also learned that letters and automated appointment reminder calls seldom reached patients because contact information was often out of date.

Based on this information, the team introduced these changes:

- Routine use of a three item adherence questionnaire (last missed dose, # doses missed in last week, most problematic dose schedule)
- Verification and updating of contact information (to include cell phone) at each clinic visit
- Scheduled refill appointments
- Adherence counseling session using a patient handout as a guide, documented with a CPRS note template sent to the medical provider for co-signature
- Local policy change to allow 60 to 90 day refills for patients evaluated as adherent by their providers, and not to allow pharmacist refills if off meds for more than 2 weeks or no provider visit in 4 months.

Following these changes the team observed an increase in the rate of timely refills from 60% to 82% within a three month period, increase in documented adherence assessment from 60% to 87%, as well as other benefits, including:

- Fewer walk-ins to clinic, HIV pharmacist and emergency room for late refills
- Fewer phone calls to physicians for refills
- Fewer reported days of missed medications
- Fewer claims of lost medications and improved patient satisfaction
- Identification of previously unrecognized non-adherence
- Increased calls to clinic nurses for refills and medication education.

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## Policy Corner: Disclosure of Veterans’ HIV Status to Local Health Departments

VA facilities, as institutions of the federal government, are not legally obliged to comply with a state’s mandatory HIV reporting law. However, since the VA recognizes the important public health benefit of complete surveillance, VA providers are allowed and encouraged to comply with the requests for the reporting of persons with HIV infection provided there is a state law requiring this and public health authorities have made a written request to the VA for this information, and the request does not create an undue administrative burden for the facility.

The proper procedure for state authorities to obtain HIV results from testing performed by the VA is by written request from the state agency. Upon receipt of such a request, the facility should consult their Regional Counsel’s office to determine if the request meets requirements for VA to comply. In the most recent Office of General Counsel (OGC) guidance (August 13, 2002) regarding this issue, the release of information to public health authorities is allowed if the following criteria are met:

- A protected record is involved
- The requester is a public health authority
- The proper individual has made the request
- The state law says that reporting is mandatory
- The request is for the purpose authorized by the mandatory disclosure.

OGC has also stated that when a request meets all the legal requirements, VA facilities may release information including but not limited to HIV test results without the consent of the patient. This is one of the few instances in which such information can be released without specific written consent from the patient.

VA Information Letter 10-2001-002 addresses these issues in more detail. A copy can be viewed on the Public Health Strategic Health Care Group Web site: <http://vawww.vhaco.va.gov/pshscg/ils/TOC.htm>