Project Summary:
The advent of effective and non-toxic treatment for Hepatitis C virus (HCV) has precipitated a heated health care debate. While it is clear that HCV infection can cause substantial morbidity and mortality and that achievement of sustained viral response is an attainable goal associated with improved quality of life, stabilization of liver disease, and decreased mortality, it is not clear whether all those infected should be treated nor at what point in the disease process treatment may be most indicated. This debate is further complicated by the high costs of the newly approved directly acting antiviral (DAA) medications for HCV therapy. Despite these uncertainties, in 2012, the Centers for Disease Control (CDC) recommended screening of all those born 1945-1965, encompassing 77% of undiagnosed infections. The US Preventative Services Task Force (USPSTF) assigned an evidence grade B to this recommendation one year later.

Veterans Health Administration (VHA) has devoted substantial resources to scale up HCV screening and treatment, with potentially great benefit to the long-term health of Veterans. It is essential that these efforts lead to equitable and efficient HCV screening and treatment across all Veteran populations, including for the approximately 1/3 of Veterans who live in rural areas, where access to VHA care is often limited. Currently no data are available on how HCV screening and treatment initiatives have impacted rural Veterans.

Using Corporate Data Warehouse data from January 1st, 2000 through December 31st, 2013, we have identified all veterans in care born from 1945 to 1965. Of the 6.7 million in this cohort who have had any contact with VHA, 4.2 million have had 2 or more contacts with the system (VHA Birth Cohort) and only 51% have been tested for HCV. Among those with normal alanine transaminase (ALT) or who have not have liver function tests measured in VHA, only 46% were screened. Of note, in multivariable analyses, women (35% tested) and those 50-55 years of age (43% tested) were less likely to be tested and black patients were more likely to be tested (62%). Interestingly, although we observed large variation by site in testing and screening rates, the presence of specialized HCV centers (HCRC) did not influence testing or screening rates. Despite the major emphasis on diagnosis and treatment of HCV within VHA, testing and screening rates remain low.

We proposed to further develop this sample and use it to better understand rural urban disparities in HCV care in the era of DAAs.