Purpose and Objectives:
We propose to use the newly created VHA Birth Cohort to:

Objective I: Describe HCV testing and screening by rural vs. urban Veteran residence, and facility rurality, in both unadjusted analyses and analyses adjusted for race, age, ethnicity and prevalence of HCV.

Hypothesis 1: testing rates will be lower among Veterans living in rural areas, and in facilities serving higher proportions of rural Veterans.

Hypothesis 2: testing rates will be strongly influenced by the proportion of positive tests among all tests sent from a facility. In other words, providers will be much more likely to test at facilities where perceived HCV prevalence is high.

Hypothesis 3: FIB 4 levels (indicator of fibrosis) will be higher among those who test positive in rural versus urban residences and facilities suggesting substantial delay in diagnosis.

Objective 2: Among those who test positive for HCV, describe dissemination of DAA treatment in unadjusted analyses and analyses adjusted for race, age, ethnicity, prevalence of HCV, and FIB 4 level (estimated risk of liver fibrosis).

Hypothesis 4: treatment rates will be lower – and time to treatment longer - among Veterans living in rural areas, and in facilities serving higher proportions of rural Veterans.

Hypothesis 5: treatment with DAAs will be much more common in facilities with higher HCV prevalence.

Hypothesis 6: FIB 4 levels will be higher among those initiating DAAs from rural versus urban residences and facilities suggesting substantial delay in treatment.