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## NATIONAL HEPATITIS C PROGRAM

**1. PURPOSE:** This Veterans Health Administration (VHA) Directive defines the policies and programs relating to the VHA Hepatitis C Program.

### 2. BACKGROUND

a. Hepatitis C virus (HCV) infection is a major public health problem in the United States (U.S.) because of its potential to lead to cirrhosis, hepatocellular carcinoma, and other life-threatening conditions. Chronic hepatitis C is the most common bloodborne infection in the U.S. It affects approximately 1.3 percent of the general U.S. population. The Centers for Disease Control and Prevention (CDC) estimate that over 3 million Americans are chronically infected with HCV. A paper published by Dominitz *et al.* found a prevalence rate of 5.4 percent among a patient population of veterans who use VHA for their health care. The Dominitz paper (see subpar. 5b) reported that the seroprevalence rate in veterans who used VHA for their health care was three times that of the general U.S. population; the majority of these veterans have chronic infection. One-fourth of veterans with HCV infection are also infected with human immunodeficiency virus (HIV), not only putting them at risk for the acquired immunodeficiency syndrome (AIDS), but also increasing their risk of developing life-threatening complications from HCV infection. VHA recognized the significance of HCV infection in veterans early and has taken steps to address the issue.

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

(1) In 1998, an Under Secretary for Health's Information Letter outlined standards for provider evaluation and testing for hepatitis C in VHA.

(2) On March 17, 1999, the Department of Veterans Affairs (VA) conducted a nationwide surveillance activity and tested over 26,000 veterans for hepatitis C. The testing revealed a prevalence rate of 6.6 percent with a wide variation by geography and era of military service. *NOTE: A paper published by Roselle et al. reported the findings from this surveillance activity (see subpar. 5c).*

(3) In January 1999, VHA established two Centers of Excellence in Hepatitis C located at the VA Medical Center Miami, FL, and the VA Medical Center, San Francisco, CA.

(4) On June 28, 2000, the Under Secretary for Health designated an additional \$20 million to be distributed to the 22 Veterans Integrated Service Networks (VISNs) for outreach, testing, counseling, and treating veterans with hepatitis C.

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(5) VHA Directive 2000-019, mandated the installation and use of Veterans Health Information Systems and Technology Architecture (VistA) software on clinical reminders that support the hepatitis C reporting process.

(6) On August 24, 2000, the Policy Board designated specific Veterans Equitable Resource Allocation (VERA) reimbursement based on hepatitis C treatment for hepatitis C patients on antiviral therapy.

(7) In 2000, as part of the Public Health Strategic Health Care Group, the National Hepatitis C Program was created.

(8) In 2000, the National Hepatitis C Technical Advisory Group was created.

(9) In 2001, the Hepatitis C Clinical Case Registry was created through the Center for Quality Management.

(10) In 2001, VA issued a solicitation for applications to establish Hepatitis C Resource Centers (HCRC). Four sites were funded: San Francisco, Northwest (Seattle, WA and Portland, OR), West Haven, CT, and Minneapolis, MN.

(11) In 2001, a Veterans' National Hepatitis C Community Advisory Board was created with its first meeting in Washington DC.

(12) In 2002, hepatitis C screening and testing guidelines were published for VA primary care, mental health, and substance abuse clinics.

(13) Between 2002 and 2006, multiple educational meetings on hepatitis C were designed and conducted by the HCRCs for VA providers, including preceptorships and Advanced Liver Disease Resource Programs.

(14) Between 2002 and 2006, multiple meetings were held by the Hepatitis C Program to catalyze VA research on hepatitis C.

(15) In 2003, a toolkit for creating HCV support groups was published on the VA's Hepatitis C Web site ([www.hepatitis.va.gov](http://www.hepatitis.va.gov)).

(16) In 2003, the Department of Veterans Affairs' recommendations for treatment of patients with cirrhosis were published on the VA's Hepatitis C Web site ([www.hepatitis.va.gov](http://www.hepatitis.va.gov)).

(17) In 2006, VA recommendations for treatment of patients with hepatitis C were published on the VA's Hepatitis C Web site ([www.hepatitis.va.gov](http://www.hepatitis.va.gov)) and in the Journal of the American Gastroenterology Association.

c. Since the beginning of the National Hepatitis C Program, data have been collected through the External Peer Review Program (EPRP), a national chart review to track and monitor efforts. Results show that over 95 percent of people who come into VA for care have been

screened for risk factors and over 90 percent of those persons found to be at risk have been tested for hepatitis C. However, only 35 percent of veterans infected with HCV have been tested for HIV infection; given the potential for interactions between these two infections, increasing HIV testing rates of HCV-positive veterans is a high priority for VA.

d. Hepatitis C treatment is rapidly evolving and new improved antiviral therapies continue to have an impact on the approximately 225,000 veterans who have been identified as having hepatitis C infection in VHA. Funding of the four HCRC programs has been renewed for an additional 5 years (through Sept 30, 2011). Hepatitis C continues to have a high priority and visibility in VHA.

e. Specific components of the National Hepatitis C Program include:

(1) A continuation of a Veterans' Hepatitis C Awareness Program that aggressively works within VA and with external groups to improve awareness about hepatitis C among veterans.

(2) Ongoing Hepatitis C Clinician Education Programs that ensure all VA clinicians are provided the most up-to-date scientific information about hepatitis C in order to deliver the highest quality care to veterans, as well as to prevent those at risk from becoming infected with the virus that causes hepatitis C.

(3) Continuation of a Hepatitis C Screening, Testing, and Counseling Program that provides multiple avenues of access to veterans who wish to be tested for hepatitis C.

(4) Programs to improve rates of HIV testing among veterans with hepatitis C.

(5) A Hepatitis C Care Program that delivers the highest standard of care to veterans with hepatitis C. **NOTE:** *Treatment recommendations for patients with hepatitis C are available at <http://vaww.hepatitis.va.gov/vahep?page=prtop04-gd-2006-00>.*

(6) A Veterans' Hepatitis C Quality Management and Database Program that works with existing VA data systems, collecting and analyzing quantitative data on hepatitis C, utilization, and quality parameters in order to continually improve hepatitis C care and prevention. The Hepatitis C registry was launched in 2002 and provides facilities the ability to produce local reports and do their own quality control; the registry was revamped in 2006 to improve its utility for HCV clinicians. **NOTE:** *Reports are available at: <http://vaww.hepatitis.va.gov/vahep?page=prin-cmg-01>.*

f. Goals for the new funding cycle for the National Clinical Public Health Program Office and the HCRC program include:

(1) Improvements in the management and treatment of the growing patient population with advanced liver disease and its complications;

(2) The evaluation of the implementation and application of the knowledge, products, and clinical practices developed by the HCRC program across the entire VA system;

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(3) The preparation of the health care system for meeting the demand that will occur when new and better HCV treatment becomes available, which is likely in the next five years; and

(4) A cross-cutting component of the previous three goals is the management of co-morbidities in patients with hepatitis C such as mental illness, HIV infection and substance use.

**3. POLICY:** It is VHA policy that each VA Medical Center Director must designate a Hepatitis C Lead Clinician to be the principal point-of-contact for all clinical hepatitis C program information and reporting between the facility, the Clinical Public Health Program office, and other facility program offices.

### 4. ACTION

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

a. Designating a Hepatitis C Lead Clinician to be the principal point of contact for all clinical hepatitis C communications and reporting.

b. Reviewing the Hepatitis C Lead Clinician list, to ensure that the information for their facility is correct, and providing the correct information to the Clinical Public Health Programs Office (13B) at (202) 273-6243, or by email to [publichealth@va.gov](mailto:publichealth@va.gov) if needed.

c. Ensuring, that by July 15 of each year, the following information is faxed to the Clinical Public Health Programs Office (13B) at (202) 273-6243, or by email to [publichealth@va.gov](mailto:publichealth@va.gov) , the name, address, phone, fax, e-mail address, and other locator information for the Hepatitis C Lead Clinician.

d. Ensuring that if the facility Hepatitis C Lead Clinician changes, the following information is faxed to the Clinical Public Health Programs Office (13B) at (202) 273-6243, or via email to [publichealth@va.gov](mailto:publichealth@va.gov): the name, address, phone, fax, e-mail address, and other locator information for the facility Hepatitis C Lead Clinician.

### 5. REFERENCES

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e. Huckans MS, Blackwell AD, Harms TA, Indest DW, Hauser P. "Integrated hepatitis C virus treatment: addressing comorbid substance use disorders and HIV infection," AIDS.19 Supplement 3:S106-15: 2005.

f. VHA Hepatitis C web page at: [www.hepatitis.va.gov](http://www.hepatitis.va.gov).

**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 202-273-8567, or at [publichealth@va.gov](mailto:publichealth@va.gov).

**7. RECISSIONS:** VHA Directive 2001-009 is rescinded. This VHA Directive expires July 31, 2012.

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DISTRIBUTION: CO: E-mailed 7/27/2007  
FLD: VISN, MA, DO, OC, OCRO, and 200 – E-mail 7/27/2007