January 2003

VA HEALTH CARE

Improvements Needed in Hepatitis C Disease Management Practices

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Highlights

Highlights of GAO-03-136, a report to the Chairman, Subcommittee on National Security, Veterans Affairs, and International Relations, Committee on Government Reform, House of Representatives

Why GAO Did This Study

In 1998, the Department of Veterans Affairs (VA) launched an initiative to screen and test veterans for hepatitis C—a chronic blood-borne virus that can cause potentially fatal liver-related conditions. Since 2001, GAO has been monitoring VA's hepatitis C program. This year GAO was asked to report on VA's hepatitis C disease management practices. GAO surveyed 141 VA medical facilities about their processes for notifying veterans concerning hepatitis C test results and evaluating veterans' medical conditions regarding potential treatment options. In addition, GAO reviewed medical records of 100 hepatitis C patients at 1 facility and visited 4 other facilities that used unique hepatitis C disease management processes.

What GAO Recommends

GAO recommends that VA direct facilities to make special arrangements to notify veterans about hepatitis C test results when veterans' next scheduled appointments are longer than 30 days away and to ensure that providers are promptly alerted about test results. In addition, GAO recommends that VA encourage facilities to increase reliance on primary care providers and other nonspecialists to initially evaluate the medical condition of hepatitis C-infected veterans while continuing to consult with specialists, when appropriate. VA concurred with these recommendations.

www.gao.gov/cgi-bin/getrpt?GAO-03-136.

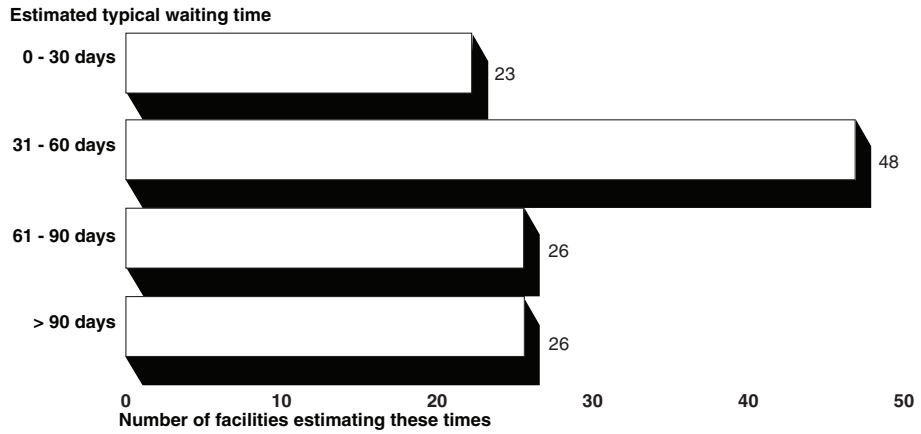
To view the full report, including the scope and methodology, click on the link above. For more information, contact Cynthia A. Bascetta, (202) 512-7101.

What GAO Found

There is considerable variation among VA facilities in the time it takes to notify veterans that they have hepatitis C. For example, 29 VA medical facilities estimated that veterans were typically notified within 7 days of testing while 16 estimated that notification times exceeded 60 days. At facilities with longer notification times, primary care providers generally notified veterans at their next regularly scheduled appointments—sometimes more than 4 months away. In contrast, facilities with shorter notification times generally scheduled special appointments focused on hepatitis C notification or notified veterans by telephone or mail. Longer notification times increase the risk that veterans may unknowingly infect others or continue to engage in behaviors, such as alcohol use, that could accelerate the damaging effects of hepatitis C on their livers.

VA medical facilities also varied considerably in the time that veterans must wait before physician specialists evaluate their medical conditions concerning hepatitis C treatment recommendations. For example, 23 facilities estimated that veterans waited 30 days or less for appointments with physician specialists while 52 facilities estimated that veterans waited over 60 days. At facilities with longer waiting times, primary care providers frequently referred all veterans to physician specialists for evaluations. In contrast, facilities with shorter waiting times often relied on nonspecialists, such as primary care providers, to conduct initial hepatitis C evaluations, referring only those with certain conditions, such as liver injury, to specialists for additional evaluations.

Estimated Waiting Times for Appointments with VA Physician Specialists for Hepatitis C Evaluations



Source: GAO.

Note: This information is from our survey of VA medical facilities. Of the 141 surveyed facilities, 18 used providers other than physician specialists to perform evaluations.