

April 11, 2002

## IMPLEMENTATION OF NATIONAL HEPATITIS C CASE REGISTRY

**1. PURPOSE:** This Veterans Health Administration (VHA) Directive defines policies on the need for implementation of a national Hepatitis C Case Registry system within the Veterans Health Information Systems Technology Architecture (VistA) software.

### 2. BACKGROUND

a. Hepatitis C infection, an important public health and medical problem for many veterans, is a high priority for VHA. The Under Secretary for Health has requested the creation of an electronic case registry to monitor the clinical outcomes of patients with Hepatitis C infection, as well as monitor the quality of Department of Veterans Affairs (VA) Hepatitis C care, and implement any needed improvements in the VA system.

b. The number of veterans with Hepatitis C infection is believed to be large, the data systems currently available, however, are insufficient to accurately measure the extent of the problem or to ensure that services and resources are adequately budgeted and distributed in response. A Hepatitis C Case Registry is therefore being implemented that will provide, among other things, a:

- (1) Method to measure the prevalence of known infection versus disease within VHA.
- (2) Way to ensure adequate funding and resource allocation to care for infected veterans.
- (3) Method to measure treatment outcomes across the VHA system.
- (4) Method to measure the short- and long-term effectiveness of current treatment protocols to improve clinical standards.

c. The Hepatitis C Case Registry will provide Hepatitis C program management assessment tools to improve the efficiency and quality of VHA Hepatitis C care.

d. The new Hepatitis C Case Registry system will automatically collect and create a local registry of patients with Hepatitis C infection. All of these patients will have passed the pre-defined selection rules that identify a patient with Hepatitis C (e.g., International Classification of Diseases-9<sup>th</sup> edition (ICD-9) code relating to Hepatitis C and/or positive laboratory serology test results for Hepatitis C testing).

e. Hepatitis C Case Registry software runs on the standard hardware platforms used by VA health care facilities. There are no significant changes required in the performance capacity of the VistA operating system. The following patches are required before installing the Hepatitis C Case Registry Application:

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Application Name	Patches	Special Consideration
Health Level (HL7) V. 1.6	HL*1.6*56	
	HL*1.6*57	
Laboratory V. 5.2	LR*5.2*215	Provides the mechanism for Logical Observation Identifiers Names and Codes (LOINC) code mapping of laboratory tests and results.
	LR*5.2*232	
	LR*5.2*222 & LA*5.2*46	
	LR*5.2*279	Provides backfilling of LOINC codes (job runs in less than 24 hours). This job should be run before installing the Registry application and on a weekend.
	LR*5.2*280	
National Drug File V. 4.0	PSN*4*53	Requires mapping of investigational drugs used for Hepatitis C treatment to a new drug class.

f. Clinical Case Registry (Hepatitis C) Application (ROR\_V1) basic functionality includes:

(1) The creation of a local Hepatitis C Case Registry list. This is a one-time process that may run over the course of days, but can be set to run at off-peak hours to minimize impact on users.

(2) Back load extract processing, which gathers historical data (from 1996 to the present) for each patient in the Hepatitis C Case Registry . This process runs one time only and creates flat files that are sent by File Transfer Protocol (FTP) to a pre-defined area at the Austin Automation Center (AAC). An individual at each sending facility must be identified to the AAC in order for this data to be transmitted.

(3) Daily automatic process to transmit updated data to AAC using VistA HL7 software via TCP/IP (Transmission Control Protocol/Internet Protocol) communication interface to a specified queue at AAC.

(4) Graphical User Interface (GUI) to access list of patients contained in local Hepatitis C Case Registry system once the Hepatitis C Case Registry software has been installed. The software should not create any appreciable global growth or network transmission problems. There are no memory constraints.

**3. POLICY:** It is VHA policy that Veterans Integrated Service Network (VISN) and facility Directors must provide a national Hepatitis C Case Registry by ensuring the installation, set-up, and maintenance of each facility's VistA registry software (which is ROR\_V1).

#### 4. ACTION

a. **Facility Director.** Each facility Director is responsible for ensuring that:

(1) By April 30, 2002, the appropriate contingency patches listed in subparagraph 2e are installed.

(2) One lead person is designated as the Hepatitis C Case Registry Coordinator.

(a) The Hepatitis C Case Registry Coordinator is responsible for ensuring that the validation of the local Hepatitis C Case Registry list is performed at each VistA site.

(b) The Hepatitis C Case Registry Coordinator serves as a VistA liaison between the facility, VISN, and Program Office (the Public Health Strategic Healthcare Group) responsible for maintaining the national Hepatitis C Case Registry.

(c) The Hepatitis C Case Registry Coordinator needs to have an overall understanding of the CPRS software package and be familiar with the care provided to Hepatitis C patients at that facility.

(3) The facility Information Resources Management Service (IRMS) Chief has designated one lead person to be responsible for the technical installation and maintenance of the VistA Hepatitis C Case Registry software.

(a) Support and training for both facility contacts will be coordinated through the Office of Information (OI) National Training and Education Office. Specific information on the Hepatitis C Case Registry training is available at: <http://vaww.vistau.med.va.gov/VistaU/HEPC/>.

(b) Training and support through teleconferences and audio question and answer sessions will be made available to the coordinators beginning April 30, 2002.

(4) By June 30, 2002, the installation and transmission (both historical and nightly updates) of data to the national Hepatitis C Case Registry housed at AAC is effected.

b. **Facility IRMS Contacts.** By May 10, 2002, facility IRMS contacts must submit appropriate information to allow the completion of a consolidated project using VA Form 9957, Timesharing User Access Request, to the OI Phase Manager via e-mail to Claire.Hill@med.va.gov. **NOTE:** *This access allows transmission of historical data from each facility to AAC.* The information needed includes the:

(1) Full name of the person who will be transferring the FTP file,

(2) Social Security Number (SSN),

(3) Telephone number,

(4) Position title,

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- (5) E-mail address,
- (6) Mail stop,
- (7) IP address of sending station,
- (8) Facility name,
- (9) Facility number, and
- (10) The facility street address.

c. **AAC.** AAC is responsible for contacting the facility IRMS contacts to provide the access information.

**5. REFERENCES**

a. VHA Executive Decision Memorandum approved by the Under Secretary for Health on September 20, 2000.

b. VHA Directive 2001-023, Installation Timeframes for Veterans Health Information Systems and Technology Architecture (VistA) Software Packages and Patches, dated April 20, 2001.

c. VHA Directive 2001-039, Implementation of Logical Observation Identifiers Names and Codes (LOINC®) for Laboratory Data, dated June 27, 2001.

d. VHA Directive 2001-009, National Hepatitis C Program, dated February 27, 2001.

**6. FOLLOW-UP RESPONSIBILITY:** The Chief Consultant, Public Health Strategic Healthcare Group (PHSHG) (13), and the Chief Information Officer (19) are responsible for the contents of this Directive. **NOTE:** *Technical support for the preceding actions is being provided by the OI Software Design and Development Group. Content support is being provided by the Chief Consultant, Diagnostic Services SHG.*

**7. RECISSIONS:** VHA Directive 2001-039 is rescinded. This VHA Directive expires September 30, 2002.

S/ Dennis Smith for  
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Under Secretary for Health

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