Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-02198-284

Community Based Outpatient Clinic Summary Report

Evaluation of CBOC Cervical Cancer Screening and Results Reporting

September 23, 2014

Washington, DC 20420

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Executive Summary

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted a systematic review of the Veterans Health Administration's (VHA's) Community Based Outpatient Clinics (CBOCs) to evaluate for compliance with selected VHA requirements regarding cervical cancer screenings and results reporting.

The objectives were to determine (1) whether women veterans, ages 23–64, received cervical cancer screening (CCS) and (2) whether ordering providers and patients received notification of cervical cancer screening results within the timeframes established by VHA policy (timeliness). Inspectors performed this evaluation during CBOC reviews conducted from October 1, 2012, through September 30, 2013.[1]

Cervical cancer is the second most common cancer in women worldwide.[2] Each year in the United States, approximately 12,000 women are diagnosed with cervical cancer. The first step of care is screening women for cervical cancer with the Papanicolaou or "Pap" test. Screening with the Pap test is one of the most reliable and effective cancer screening tests available. With timely screening, diagnosis, notification, and treatment, the cancer is highly preventable and associated with long survival and good quality of life.

Women now make up 11 percent of veterans from Operating Enduring Freedom and Operation Iraqi Freedom (OEF/OIF), and this equates to nearly 98,000 women veterans. The American Medical Association, the Centers for Disease Control and Prevention, the US Preventive Services Task Force, and others have issued recommendations in support of CCS.[3,4,5] Women veterans should have CCS at regular intervals, and those at high risk may need to be screened more often. VHA also has specific timelines for the reporting of normal and abnormal test results and requires documentation in each patient's electronic health record (EHR).[6]

From our initial sample of 2,180 VHA women veterans with at least two primary care appointments during FY 2011 or FY 2012, we found 1,989 women veterans who had EHR documentation of CCSs performed or refused. Based on this evaluation sample, we estimated that 50.7 percent (95%CI: 41.35–60.09) had CCS performed at a CBOC, 23.0 percent (95%CI: 15.79–32.31) had CCS performed at the assigned VHA parent facility, and 0.3 percent (95%CI: 0.17–0.71) had CCS performed through fee-basis agreement during the study period.

[1] Includes CBOCs in operation before October 1, 2011.
[2] U.S. Cancer Statistics Working Group, United States Cancer Statistics: 1999–2007 Incidence and Mortality Web-based report.
[3] Woolf, S.H. & Harris, R. (2012). The Harms of Screening; New Attention to an Old Concern. *The Journal of the American Medical Association (JAMA);*Vol. 307, No. 6; pgs. 565–566.
[4] American Cancer Society (January 4, 2012). Health groups issue proposed cervical cancer screening guidelines.
[5] Centers for Disease Control and Prevention. CDC Home. Retrieved from: http://www.cdc.gov/cancer/cervical.
[6] VHA Handbook 1330.01.

We then further evaluated this subset of 1,416 EHRs which included those who had CCSs performed at their assigned CBOC, VHA parent facility, or through fee-basis agreement. Based on the review of this subset, we estimated that 99.2 percent (95%CI: 97.95–99.66) of the test results were documented in the laboratory package of the EHR and that the ordering provider notification rate (as documented in the EHR) for normal results was 90.7 percent (95%CI: 73.79–97.14).

However, we estimated that the VHA rate of provider notification of abnormal results was 80.8 percent (95%CI: 67.37–89.59) and that the patient notification rate (as documented in the EHR) of normal and abnormal results was 84.1 percent (95%CI: 76.56–89.50) and 67.7 percent (95%CI: 58.28–75.85), respectively. These VHA compliance rates are statistically significantly different from the 90 percent benchmark.

We recommended that the Interim Under Secretary for Health ensure that a consistent process is established for notifying ordering providers of abnormal cervical cancer screening results within the required timeframe and that notification is documented in the EHR. We also recommended that the Interim Under Secretary for Health ensure that a consistent process is established for notifying women veterans of normal and abnormal cervical cancer screening results within the required timeframe and that notification is documented in the EHR.

Comments

The Interim Under Secretary for Health concurred with the findings and recommendations. (See Appendix B, pages 10–12, for the full text of the comments.) The implementation plans are acceptable, and we will follow up until all actions are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted a systematic review of the Veterans Health Administration's (VHA's) Community Based Outpatient Clinics (CBOCs) to evaluate for compliance with selected VHA requirements regarding cervical cancer screenings and results reporting.

Our objectives were to determine (1) whether women veterans, ages 23–64, received cervical cancer screening (CCS); and (2) whether ordering providers and patients received notification of CCS results within the timeframes established by VHA policy (timeliness).

Background

Since 1995, VHA has transitioned from a hospital bed-based system of care to one that is rooted in ambulatory and primary care. CBOCs are an important component of the VA health care delivery system as they aim to improve access to primary care and other health care services while providing high-quality care in a cost effective manner. As requested in House Report 110-775, to accompany H.R. 6599, Military Construction, Veterans Affairs, and Related Agencies Appropriation Bill, fiscal year (FY) 2009, the VA OIG has been systematically reviewing VHA CBOCs since April 2009.

A VHA CBOC is a health care site that is geographically distinct and separate from a parent medical facility and may be a site that is VA-operated and/or contracted. VHA CBOCs can provide primary, specialty, subspecialty, mental health (MH) care, or any combination of health care delivery services that can be appropriately provided in an outpatient setting. This includes health promotion (screening and counseling), disease prevention, and management of acute minor illnesses and chronic conditions. Each CBOC is affiliated with a single VA medical center (VAMC) or parent facility that is administratively responsible for that CBOC. One standard of care must be maintained at the parent facility and CBOCs.

Because of the number of women on active duty and the numbers entering military service, the percentage of veterans who are female is projected to increase from 7.7 percent in 2008 to 10 percent in 2018 and to 14.3 percent in 2033. Women now make up 11 percent of veterans from Operating Enduring Freedom and Operation Iraqi Freedom (OEF/OIF)—equating to nearly 98,000 women veterans. Among OEF/OIF women veterans, 42.6 percent are enrolled and 28.5 percent are users of VHA services.[7] VHA has established the minimum clinical requirements to ensure that all eligible and enrolled women veterans, irrespective of where they obtain care in VHA, have access to all necessary services as clinically indicated.[8]

[7] OEF/OIF Utilization Data, FY2008, 2nd Quarter, Kang H. Dept Veterans Affairs, OPHEH
[8] VHA Handbook 1330.01, *Health Care Services for Women Veterans,* May 21, 2010.

Cervical cancer is the second most common cancer in women worldwide.[9] Each year in the United States, approximately 12,000 women are diagnosed with cervical cancer. The first step of care is screening women for cervical cancer with the Papanicolaou or "Pap" test. Screening with the Pap test is one of the most reliable and effective cancer screening tests available. With timely screening, diagnosis, notification, and treatment, the cancer is highly preventable and associated with long survival and good quality of life.

The American Medical Association, the American College of Obstetricians and Gynecologists, the American Cancer Society, the Centers for Disease Control and Prevention, and the US Preventive Services Task Force have issued recommendations in support of cervical cancer screening.[10,11,12] Women veterans should have CCS at regular intervals, and those at high risk may need to be screened more often. VHA also has specific timelines for the reporting of normal and abnormal test results and requires documentation in each patient's electronic health record (EHR).[13]

Scope and Methodology

Scope. The study population consists of all women veterans between the ages of at least 23 as of October 1, 2009, and younger than 65 as of June 30, 2012, who were treated in the parent facility CBOCs for at least two Primary Care visits during FY 2011 and/or FY 2012.

Methodology. We reviewed local policies, meeting minutes, and other documents relevant to CCS and results reporting. We also evaluated EHRs and interviewed clinical managers and staff.

We used a two-stage complex probability sample design to select patients from the study population for the EHR reviews. In the first stage of sampling, we statistically randomly selected 55 VAMCs stratified by the 12 catchment areas of the OIG's Office of Healthcare Inspections regional offices. Then we compiled a list of eligible CBOC patients who were assigned to the parent facility for each of the selected 55 VAMCs.[14]

In the second stage of sampling, we randomly selected 50 patients from each of the 55 patient lists for our EHR reviews. If a VAMC had fewer than 50 eligible CBOC patients who met the criteria for the focused review, we reviewed all of the patients on the list.

We reviewed the EHRs of these sampled women veterans to determine if a CCS had been performed at the parent facility, CBOCs, or through fee-basis assignment. For the

[9] U.S. Cancer Statistics Working Group, United States Cancer Statistics: 1999–2007 Incidence and Mortality Web-based report.
[10] Woolf, S.H. & Harris, R. (2012). The Harms of Screening; New Attention to an Old Concern. *The Journal of the American Medical Association (JAMA);*Vol. 307, No. 6; pgs. 565–566.
[11] American Cancer Society (January 4, 2012). Health groups issue proposed cervical cancer screening guidelines.
[12] Centers for Disease Control and Prevention. CDC Home. Retrieved from: http://www.cdc.gov/cancer/cervical.
[13] VHA Handbook 1330.01.
[14] Includes all CBOCs in operation before October 1, 2011.

female veterans who received CCS at the parent facility, its respective CBOCs, or through a fee-basis agreement during the study period (October 1, 2009, through September 30, 2012), we reviewed the EHR to determine if the following review elements were documented according to VHA policy:[15]

- Test results were documented in the Laboratory Package of the Computerized Patient Records System (VA's EHR).

- Results of normal cervical pathology were reported to:

    - The ordering provider within 30 calendar days of the issuance of the pathology report, and

    - The patient within 14 calendar days from the date of pathology report availability to the provider.

- Results of abnormal cervical pathology were reported to:

    - The ordering provider within five business days, and

    - The patient within five business days of the issuance of the report.

Statistical Analysis. We estimated the VA compliant percentages for each of the quality measures, taking into account the complexity of our multi-stage sample design. We used Horvitz-Thompson sampling weights (reciprocal of sampling probabilities) to account for unequal probability sampling and the Taylor expansion method to obtain the sampling errors for the estimates. We considered a VAMC compliant with policy if at least 90 percent of its eligible patients met CCS requirements.

We presented 95 percent confidence intervals (95% CI) for the estimates of the true values (parameters) of the study population. A confidence interval gives an estimated range of values (being calculated from a given set of sample data) that is likely to include an unknown population parameter. The 95% CI indicates that among all possible samples we could have selected of the same size and design, 95 percent of the time the population parameter would have been included in the computed intervals.

Percentages can only take non-negative values from 0 to 100, but their logits can have unrestricted range so that the normal approximation can be used. Thus, we calculated the confidence intervals for percentages on the logit scale and then transformed them back to the original scale to ensure that the calculated confidence intervals contained only the proper range of 0 to 100 percent. All data analyses were performed using SAS statistical software, version9.3 (TS1M0), SAS Institute, Inc. (Cary, North Carolina).

OHI conducted this inspection during CBOC reviews beginning October 1, 2012, through September 30, 2013. Facility-specific review results were reported in 55 CBOC

[15] VHA Handbook 1330.01.

reports. For this report, we aggregated and analyzed the data collected from the individual evaluations.

We conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Inspection Results

Inspection Results

Our initial sample consisted of 2,180 VHA women veterans with at least two primary care appointments during FY 2011 or FY2012. Of these, we found 1,989 women veterans who had EHR documentation of CCSs performed or refused. Based on this evaluation sample, we estimated that 50.7 percent had CCS performed at a CBOC during the study period, and we are 95 percent confident that the true screening rate at the CBOCs is somewhere between 41.35 to 60.09. We also estimated that 23.0 percent (95%CI: 15.79–32.31) had CCS performed at the assigned VHA parent facility and 0.3 percent (95%CI: 0.17–0.71) had CCS performed through fee-basis agreement. Table 1 lists the results.

Table 1. Cervical Cancer Screenings

Cervical Cancer Screenings Noted in EHR Reviews	Frequency	Estimated VA Compliance		
		Percent	95 Percent Confidence Interval Limits	
			Lower	Upper
Performed at Assigned CBOC	820	50.7	41.35	60.09
Performed at VHA Parent Facility	587	23.0	15.79	32.31
Performed by Private Sector (non-VA funded care)	366	17.6	16.02	19.37
Performed at Another Previously Visited VHA Facility	97	4.4	3.50	5.60
Patient Refused	110	3.8	2.78	5.22
Performed Through Fee-Basis Agreement	9	0.3	0.17	0.71
Total	**1989**	**100.0**		

Issue 1: Documentation of Results in EHR

We then further evaluated this subset of 1,416 EHRs consisting of those who had CCSs performed at their assigned CBOC, VHA parent facility, or through fee-basis agreement. Based on the review of this subset, we estimated that 99.2 percent of the test results were documented in the laboratory package of the EHR, and we are 95 percent confident that the true documentation rate for the VA patients who had CCSs performed at their own CBOCs, parent facilities, or through fee-basis is somewhere between 97.95 to 99.66, which is statistically significantly above the 90 percent benchmark.

Issue 2: Timeliness of Provider Notification of Results

Based on the subset of 1,416 women veterans mentioned above, we estimated that VA provider (documented in the EHR) notification rate for normal results was 90.7 percent (95%CI: 73.79–97.14), which is not statistically significantly different from the 90 percent benchmark. However, the VA rate of provider notification of abnormal results within

5 business days was 80.8 percent (95%CI: 67.37–89.59), which is statistically significantly different from the 90 percent benchmark.

Issue 3: Timeliness of Patient Notification of Results

Based on the subset of 1,416 women veterans mentioned above, we estimated that patient notification rate (as documented in the EHR) of normal results within 14 days of pathology report availability was 84.1 percent (95%CI: 76.56–89.50), and the notification of abnormal results within 5 business days of the issuance of the report was 67.7 percent (95%CI: 58.28–75.85). The VA compliance rates for women veteran notification of both normal and abnormal results are statistically significantly different from the 90 percent benchmark.

Conclusions

From our initial sample of 2,180 VHA women veterans with at least two primary care appointments during FY 2011 or FY2012, we found 1,989 women veterans who had EHR documentation of CCSs performed or refused. Based on this evaluation sample, we estimated that 50.7 percent (95%CI: 41.35–60.09) had CCS performed at a CBOC, 23.0 percent (95%CI: 15.79–32.31) had CCS performed at the assigned VHA parent facility and 0.3 percent (95%CI: 0.17–0.71) had CCS performed through fee-basis agreement during the study period.

We then further evaluated this subset of 1,416 EHRs which included those who had CCSs performed at their assigned CBOC, VHA parent facility, or through fee-basis agreement. We estimated that 99.2 percent (95%CI: 97.95–99.66) of the test results were documented in the laboratory package of the EHR and that the ordering provider notification rate for normal results was 90.7 percent (95%CI: 73.79–97.14).

However, we estimated that the VHA rate of provider notification of abnormal results within 5 business days was 80.8 percent (95%CI: 67.37–89.59). We also estimated that the patient notification rate (as documented in the EHR) of normal results within 14 days of pathology report availability was 84.1 percent (95%CI: 76.56–89.50) and that of abnormal results within 5 business days of the issuance of the report was 67.7 percent (95%CI: 58.28–75.85). These VHA compliance rates are statistically significantly different from the 90 percent benchmark.

Recommendations

1. We recommended that the Interim Under Secretary for Health ensure that a consistent process is established for notifying ordering providers of abnormal cervical cancer screening results within the required timeframe and that notification is documented in the electronic health record.

2. We recommended that the Interim Under Secretary for Health ensure that a consistent process is established for notifying women veterans of normal and abnormal cervical cancer screening results within the required timeframe and that notification is documented in the electronic health record.

Parent Facilities Reviewed[16]

Names	Locations
Alaska VA Healthcare System	Anchorage, AK
Amarillo VA Health Care System	Amarillo, TX
Asheville VA Medical Center	Asheville, NC
Battle Creek VA Medical Center	Battle Creek, MI
Captain James A. Lovell Federal Health Care Center	North Chicago, IL
Carl Vinson VA Medical Center	Dublin, GA
Central Arkansas Veterans Healthcare System	Little Rock, AR
Central Texas Veterans Health Care System	Temple, TX
Chalmers P. Wylie Ambulatory Care Center	Columbus, OH
Charlie Norwood VA Medical Center	Augusta, GA
Cheyenne VA Medical Center	Cheyenne, WY
Chillicothe VA Medical Center	Chillicothe, OH
Coatesville VA Medical Center	Coatesville, PA
Dayton VA Medical Center	Dayton, OH
Durham VA Medical Center	Durham, NC
Edith Nourse Rogers Memorial Veterans Hospital	Bedford, MA
Edward Hines Jr. VA Hospital	Hines, IL
Fargo VA Healthcare System	Fargo, ND
G.V. (Sonny) Montgomery VA Medical Center	Jackson, MS
Hunter Holmes McGuire VA Medical Center	Richmond, VA
Iowa City VA Health Care System	Iowa City, IA
Jack C. Montgomery VAMC	Muskogee, OK
James A. Haley Veterans' Hospital	Tampa, FL
Jesse Brown VA Medical Center	Chicago, IL
John J. Pershing VA Medical Center	Poplar Bluff, MO
Kansas City VA Medical Center	Kansas City, MO
Louis A. Johnson VA Medical Center	Clarksburg, WV
Manchester VA Medical Center	Manchester, NH
Marion VA Medical Center	Marion, IL
Mann-Grandstaff VA Medical Center	Spokane, WA
James H. Quillen VA Medical Center	Mountain Home, TN
North Florida/South Georgia Veterans Health System	Gainesville, FL
Northern Arizona VA Health Care System	Prescott, AZ
Northport VA Medical Center	Northport, NY
Oklahoma City VA Medical Center	Oklahoma City, OK
Philadelphia VA Medical Center	Philadelphia, PA
Richard L. Roudebush VA Medical Center	Indianapolis, IN
Robley Rex VA Medical Center	Louisville, KY
Salem VA Medical Center	Salem, VA
San Francisco VA Medical Center	San Francisco, CA
Sheridan VA Medical Center	Sheridan, WY
Sioux Falls VA Health Care System	Sioux Falls, SD
VA Butler Healthcare	Butler, PA
VA Central California Health Care System	Fresno, CA
VA Connecticut Healthcare System	West Haven, CT
VA Greater Los Angeles Healthcare System	Los Angeles, CA
VA Maine Healthcare System	Augusta, ME

[16] This report refers to the CBOCs for these randomly selected parent facilities.

Names	Locations
VA Maryland Health Care System	Baltimore, MD
VA New Jersey Health Care System	East Orange, NJ
VA Pacific Islands Health Care System	Honolulu, HI
VA Palo Alto Health Care System	Palo Alto, CA
VA Pittsburgh Healthcare System	Pittsburgh, PA
VA Texas Valley Coastal Bend Health Care System	Harlingen, TX
VA Western New York Healthcare System	Buffalo, NY
William S. Middleton Memorial Veterans Hospital	Madison, WI

Interim Under Secretary for Health Comments

Department of Veterans Affairs **Memorandum**

Date: September 5, 2014

From: Interim Under Secretary for Health (10)

Subject: **OIG Draft Report, Community Based Outpatient Clinic Summary Report – Evaluation of CBOC Cervical Cancer Screening and Results Reporting (2014-02198-HI-0466)** (VAIQ 7518044)

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review the draft Community Based Outpatient Clinic (CBOC) Summary Report – Evaluation of CBOC Cervical Cancer Screening and Results Reporting. I have reviewed the draft report and concur with the report's recommendations.

2. Attached is VHA's corrective action plan for recommendations one and two.

3. Should you have any questions, please contact Karen M. Rasmussen, M.D., Director, Management Review Service (10AR), at (202) 461-6643 or email at VHA10ARMRS2@va.gov.

Carolyn M. Clancy, M.D.

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)

Action Plan

OIG Draft Report, Community Based Outpatient Clinic Summary Report – Evaluation of CBOC Cervical Cancer Screening and Results Reporting

Date of Draft Report: August 5, 2014

Recommendations/ Actions	Status	Completion Date

Recommendation 1. We recommended that the Interim Under Secretary for Health ensure that a consistent process is established for notifying ordering providers of abnormal cervical cancer screening results within the required timeframe and that notification is documented in the electronic health record.

VHA Comments

Concur.

VA Directive 2009-19, *Ordering and Reporting of Test Results*, provides the details for a consistent process that VA established in 2009 for notifying ordering providers of abnormal test results and how that notification is documented in the electronic health record. VHA will monitor this notification through existing VA External Peer Review Process (EPRP) report mechanisms. Additional requirements for the reporting of Cancer results are contained in VHA Handbook 1106.1, *Pathology and Laboratory Medicine Service Procedures*. Updates to both these policies are in the formal concurrence process.

In process Target date for completion: May 29, 2015

To complete this action plan, VHA will provide documentation of:

- VHA Directive 2009-19, *Ordering and Reporting of Test Results*
- VHA Handbook 1106.1, *Pathology and Laboratory Medicine Service Procedures*
- Two quarters of EPRP review results of provider notification of cervical cancer screening. The first quarterly report is due January 30, 2015.

Recommendation 2. We recommended that the Interim Under Secretary for Health ensure that a consistent process is established for notifying women veterans of normal and abnormal cervical cancer screening results within the required timeframe and that notification is documented in the electronic health record.

VHA Comments

Concur.

To ensure consistent communication of cervical cancer screening results to patients, the current policy requirements will be communicated to the field on the national Women's Health Call and national Primary Care Call by December 31, 2014. During these calls, examples of locally developed strong practices, such as template results letters and tracking systems, will be shared.

Additionally, an email will be sent to all Primary Care Chiefs, Women's Health Medical Directors, Women Veteran Program Managers, the VA Gynecology list serve, and Chiefs of Surgery prior to December 31, 2014 requesting that Women Veteran Program Managers communicate with Community Based Outpatient Clinic (CBOC) Women's Health Liaisons to ensure that a consistent procedure is established at each CBOC.

The EPRP program will begin measuring cervical cancer screening results notification in fiscal year 2015 and report results on a quarterly basis to monitor sustained improvement. These reports will be monitored and shared with Veterans Integrated Service Network and facility leadership. Each facility EPRP Liaison will receive monthly lists of cases not meeting the required time frames for communication of normal and abnormal cervical cancer screening results. A message will be sent to the EPRP Liaisons encouraging them to work closely with their Women's Health teams to ensure proper follow-up has occurred for those patients that lack communication documentation.

In process Target date for completion: July 31, 2015

To complete this action plan, VHA will provide documentation of:

- Notes from the Women's Health Call and national Primary Care Call communicating current policy requirements.
- The email sent to all Primary Care Chiefs, Women's Health Medical Directors, Women Veteran Program Managers, the VA Gynecology list serve, and Chiefs of Surgery requesting that Women Veteran Program Managers communicate with CBOC Women's Health Liaisons to ensure that a consistent procedure is established at each CBOC.
- Two quarters of EPRP review results of patient notification of cervical cancer screening. The first quarterly report is due January 30, 2015.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
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This report is available on our web site at www.va.gov/oig

Endnotes

[1]References used for the WH review included:

- American Cancer Society (January 4, 2012). Health groups issue proposed cervical cancer screening guidelines.
- Centers for Disease Control and Prevention. CDC Home. Retrieved from: http://www.cdc.gov/cancer/cervical.
- OEF/OIF Utilization Data, FY2008, 2nd Quarter, Kang H., Department of Veterans Affairs, OPHEH.
- U.S. Cancer Statistics Working Group, United States Cancer Statistics: 1999-2007 Incidence and Mortality Web-based report.
- VHA Handbook 1330.01, *Health Care Services for Women Veterans*, May 21, 2010.
- VHA Office of Policy and Planning, August 2008.
- Woolf, S.H. & Harris, R. (2012). The Harms of Screening; New Attention to an Old Concern. *The Journal of the American Medical Association (JAMA);* Vol. 307, No. 6; pgs. 565-566.