US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection Summary Report: Evaluation of Breast Cancer Surveillance in Veterans Health Administration Facilities

CHIP Report | **23-01178-116** | **March 27, 2024**

BE A
VOICE FOR
VETERANS
REPORT WRONGDOING
vaoig.gov/hotline | 800.488.8244

OUR MISSION

To serve veterans and the public by conducting meaningful independent oversight of the Department of Veterans Affairs.

CONNECT WITH US

Subscribe to receive updates on reports, press releases, congressional testimony, and more. Follow us at @VetAffairsOIG.

PRIVACY NOTICE

In addition to general privacy laws that govern release of medical information, disclosure of certain veteran health or other private information may be prohibited by various federal statutes including, but not limited to, 38 U.S.C. §§ 5701, 5705, and 7332, absent an exemption or other specified circumstances. As mandated by law, the OIG adheres to privacy and confidentiality laws and regulations protecting veteran health or other private information in this report.

Figure 1. *Veterans Affairs Building, Washington, DC.*
Source: https://www.gsa.gov/real-estate/gsa-properties/visiting-public-buildings/veterans-affairs-building/ (accessed June 20, 2023).

Abbreviations

OIG	Office of Inspector General
VHA	Veterans Health Administration

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program report evaluates notification and surveillance for patients with mammogram results requiring action during the COVID-19 pandemic. The OIG initiated unannounced, virtual inspections at 12 randomly selected Veterans Health Administration (VHA) medical facilities from January 11 through May 3, 2023. The inspections involved interviews with key staff and evaluations of clinical processes. The OIG reviewed providers' notification of mammogram results requiring action to patients within VHA's defined time frame and patients' completion of the recommended actions.[1]

Results Summary

The OIG did not observe concerns related to notification and surveillance for patients with mammogram results requiring action during the COVID-19 pandemic and issued no recommendations. The number of recommendations should not be used as a gauge for the overall quality of care provided within VHA. The results are detailed on page 3 of the report.

VA Comments

The Under Secretary for Health agreed with the comprehensive healthcare inspection findings (see appendix B, page 5).

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

[1] Examples of recommended actions include a diagnostic mammogram, breast biopsy, or ultrasound. VHA Directive 1105.03, *Mammography Program Procedures and Standards*, May 21, 2018.

Contents

Introduction

Breast cancer is the most diagnosed cancer among women in the United States.[1] Cancer screening and early detection of breast cancer may result in improved health and better survival rates.[2]

The *Journal of Clinical Oncology* reported the COVID-19 pandemic disrupted routine screening programs, including those for breast cancer.[3] Comparing 2019 pre-pandemic and 2020 pandemic data in two Veterans Health Administration (VHA) primary care clinics, the *Journal of the National Medical Association* reported a 12 percent decrease in mammography screenings and a 25 percent decrease in new breast cancer diagnoses.[4]

To evaluate notification and surveillance for patients with mammogram results requiring action during the pandemic, the Office of Inspector General (OIG) conducted virtual, focused evaluations at 12 randomly selected VHA medical facilities. The OIG reviewed

- providers' notification of mammogram results requiring action to patients within VHA's defined time frame, and
- patients' completion of the recommended action such as a diagnostic mammogram, breast biopsy, or ultrasound.[5]

[1] "Breast Cancer Facts & Figures," American Cancer Society, accessed April 26, 2023, https://www.cancer.org/research/cancer-facts-statistics/breast-cancer-facts-figures.html.

[2] Krishna. P. Sharma et al., "Preventing Breast, Cervical, and Colorectal Cancer Deaths: Assessing the Impact of Increased Screening," *Preventing Chronic Disease* 17 (October 8, 2020), https://doi.org/10.5888/pcd17.200039.

[3] Jessica Star et al., "Cancer Screening in the United States During the Second Year of the COVID-19 Pandemic," *Journal of Clinical Oncology* 41, no. 27 (2023), https://ascopubs.org/doi/10.1200/JCO.22.02170.

[4] Neiha Kidwai, "Routine Cancer Screening Delays Due to Pandemic at Veteran Affairs," *Journal of the National Medical Association* 114, no. 1 (2022): 12–15, https://doi.org/10.1016/j.jnma.2021.08.033.

[5] VHA Directive 1105.03, *Mammography Program Procedures and Standards*, May 21, 2018.

Scope and Methodology

The OIG conducted unannounced, virtual inspections at 12 VHA medical facilities from January 11 through May 3, 2023 (see appendix A). The inspections involved interviews with key staff and evaluations of clinical processes. The facilities reviewed represented a mix of size and Veterans Integrated Service Networks.[6]

The OIG also reviewed the electronic health records of 565 randomly selected patients who received a screening or diagnostic mammogram at one of the 12 medical facilities during the study period of October 1, 2019, through December 31, 2021.[7]

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[8] The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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

[6] VA administers healthcare services through a nationwide network of 18 regional systems referred to as Veterans Integrated Service Networks.

[7] The OIG selected the study period to evaluate records of patients who had mammogram results requiring action during the pandemic.

[8] Inspector General Act of 1978, as amended, 5 U.S.C. §§ 401–424.

Inspection Results

The OIG found general compliance with the VHA requirements for notification and surveillance for mammogram results requiring action during the pandemic.

VHA has established a time frame for the ordering provider or designee to notify patients of mammogram results. VHA requires the ordering provider or designee to communicate mammogram results requiring follow-up action to patients within seven calendar days from the date the results are available.[9] Based on the electronic health records reviewed, the OIG estimated that providers communicated mammogram results requiring action within the required time frame to 79.9 (95% CI: 69.2 to 90.4) percent of patients.[10] The OIG also estimated that 96.8 (95% CI: 93.1 to 99.4) percent of the patients who had follow-up actions scheduled had completed the actions recommended from the mammogram results. The OIG noted that nine patients did not have their recommended follow-up actions scheduled.

Staff from the facilities inspected reported that providers were waiting on prior mammogram images to compare to the current ones. Facility staff identified challenges receiving prior images from outside medical centers, stating the typical time to receive them during the review period was three to four weeks. Facility staff also reported numerous unsuccessful patient contact attempts and appointment cancellations because some patients were hesitant to come into the facilities for follow-up during the pandemic.

The OIG did not observe concerns related to notification and surveillance for patients with mammogram results requiring action during the COVID-19 pandemic and issued no recommendations.

[9] VHA Directive 1105.03; VHA Directive 1330.01(3), *Health Care Services for Women Veterans*, February 15, 2017, amended June 29, 2020, and January 8, 2021 (1330.01(4)). (These directives were in place for the time frame reviewed for this report. VHA subsequently amended this directive several times, most recently with VHA Directive 1330.01(7) on May 14, 2023. The directives contain the same or similar language related to services for women veterans.)

[10] A confidence interval (CI) is a range of estimates, computed based on a statistical sample, for an unknown true value. The 95% confidence level indicates that among confidence intervals computed from all possible samples with the same sample size and the study design, the true value would have been covered by the confidence intervals 95 percent of the time.

Appendix A: VHA Facilities Inspected

Table A.1. VHA Facilities Inspected
(January 11 through May 3, 2023)

VHA Facility Name	Location
Samuel S. Stratton VA Medical Center	Albany, New York
VA Maryland Health Care System	Baltimore, Maryland
Bay Pines VA Healthcare System	Bay Pines, Florida
Louis A. Johnson VA Medical Center	Clarksburg, West Virginia
Columbia VA Health Care System	Columbia, South Carolina
Miami VA Healthcare System	Miami, Florida
Minneapolis VA Health Care System	Minneapolis, Minnesota
VA NY [New York] Harbor Healthcare System	New York, New York
Hunter Holmes McGuire VA Medical Center	Richmond, Virginia
W.G. (Bill) Hefner VA Medical Center	Salisbury, North Carolina
VA Caribbean Healthcare System	San Juan, Puerto Rico
James A. Haley Veterans' Hospital	Tampa, Florida

Source: VA OIG.

Appendix B: Office of the Under Secretary for Health Memorandum

Department of Veterans Affairs Memorandum

Date: March 11, 2024

From: Under Secretary for Health (10)

Subj: Office of Inspector General (OIG) Draft Report, Comprehensive Healthcare Inspection Summary Report: Evaluation of Breast Cancer Surveillance in Veterans Health Administration (VHA) Facilities (VIEWS 11489464)

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on OIG's draft report on breast cancer surveillance in VHA facilities. VHA concurs with the draft report.
2. Veterans requiring breast imaging during the Coronavirus Disease 2019 (COVID-19) pandemic were tracked, contacted, and provided access to high-quality care with no delay in care or follow-up. Communication of mammogram results to the ordering provider as well as to the Veteran through the pandemic was accomplished without deviation from the standard of care. Veterans who required follow-up actions after mammography during the COVID-19 pandemic received the recommended care without delay.
3. Comments regarding the contents of this memorandum may be directed to the GAO OIG Accountability Liaison Office at VHA10BGOALACTION@va.gov.

(Original signed by:)

Shereef Elnahal M.D., MBA

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Melinda Alegria, AuD, CCC-A, Project Leader Jennifer Frisch, MSN, RN Robert Ordonez, MPA Elizabeth Whidden, MS, APRN
Other Contributors	Limin Clegg, PhD Kaitlyn Delgadillo, BSPH Reynelda Garoutte, MHA, BSN Justin Hanlon, BAS LaFonda Henry, MSN, RN Cynthia Hickel, MSN, CRNA Amy McCarthy, JD Scott McGrath, BS Joan Redding, MA Larry Ross, Jr., MS Erika Terrazas, MS Jarvis Yu, MS

Report Distribution

VA Distribution

Office of the Secretary
Veterans Benefits Administration
Veterans Health Administration
National Cemetery Administration
Assistant Secretaries
Office of General Counsel
Office of Acquisition, Logistics, and Construction
Board of Veterans' Appeals
Veterans Integrated Service Network Directors (1–23)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Accountability
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget

OIG reports are available at www.vaoig.gov.