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Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection Program and Care in the Community Report: Mammography Services and Breast Cancer Care

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Figure 1. *Veterans Affairs Building, Washington, DC.*
Source: https://www.gsa.gov/real-estate/gsa-properties/visiting-public-buildings/veterans-affairs-building (accessed June 24, 2021).

Abbreviations

BI-RADS	Breast Image Reporting and Data System
CHIP	Comprehensive Healthcare Inspection Program
CITC	Care in the Community
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
3D	three-dimensional

Report Overview

The Making Advances in Mammography and Medical Options for Veterans Act of 2022 requires the VA Office of Inspector General (OIG) to report on mammography services and breast cancer care provided to veterans.[1] In accordance with this requirement, the OIG conducted an evaluation of mammography services delivered through the outpatient settings of randomly selected VA medical facilities and community providers. The OIG also assessed the performance of VA's Women's Oncology System of Excellence and patients' accessibility to a comprehensive care team, for those diagnosed with breast cancer, as required by the legislation.[2]

Because veterans receive mammography services and breast cancer care through VA and community providers, the OIG deployed teams from both its Comprehensive Healthcare Inspection Program (CHIP) and Care in the Community (CITC) program to gather data for this inspection. CHIP conducts routine oversight of VA medical facilities that provide healthcare services to veterans, and the CITC program evaluates selected aspects of care for veterans referred to community providers.

The CITC teams inspected eight Veterans Integrated Service Networks (VISNs) from October 1, 2021, through September 30, 2022.[3] CHIP teams conducted unannounced inspections at 21 VA medical facilities with mammography programs from November 15, 2021, through February 8, 2023.[4] These inspections involved interviews with key staff and evaluations of clinical and administrative processes. The findings in this report may help VA leaders identify vulnerable areas or conditions that, if properly addressed, could improve healthcare quality.

[1] Making Advances in Mammography and Medical Options for Veterans Act of 2022, Pub. L. No. 117-135, 136 Stat. 1244 (2022) § 106.

[2] In October 2020, VA introduced the Women's Oncology System of Excellence, aiming to provide exceptional care to women veterans with oncology needs. This System of Excellence was established to provide "oncology patients with cutting edge care and access to potentially lifesaving clinical trials." "VA Creates National Women Veterans Oncology System of Excellence in Fight against Breast Cancer," Department of Veterans Affairs, October 20, 2020, accessed February 22, 2023, https://www.va.gov/opa/pressrel/pressrelease.cfm?id=5549.

[3] VA administers healthcare services through a nationwide network of 18 regional systems referred to as VISNs. VISN leaders are responsible for overseeing the care of patients referred to community providers by VA providers at their local medical facilities and community-based outpatient clinics.

[4] A mammography program is a "specific VA Radiological subspecialty department operating on-site within the larger context of a VHA [Veterans Health Administration] facility's physical plant." VHA Directive 1105.03, *Mammography Program Procedures and Standards*, May 21, 2018. The OIG inspected 20 facilities during fiscal year 2022 and 1 facility in fiscal year 2023.

Results Summary

In accordance with the Making Advances in Mammography and Medical Options for Veterans Act of 2022, the OIG evaluated and did not observe concerns related to

- patient access to and adequacy of staffing to perform mammograms,
- use of three-dimensional mammography,
- availability and quality of mammogram reports,
- incorporation of mammogram reports into electronic health records,
- timely communication of mammogram results to ordering providers and patients, and
- access to a comprehensive breast cancer care team.

The OIG also evaluated and did identify concerns related to the Women's Oncology System of Excellence and local cancer registry databases. The OIG found most VA facility leaders and staff were not aware of the Women's Oncology System of Excellence, and more than two years after its launch, leaders acknowledged there was less progress than they projected. The OIG also found that VA facility staff were not entering oncology data into local cancer registry databases in a timely manner.

The OIG issued three recommendations for improvement to the Under Secretary for Health, VISN directors, facility leaders, and National Oncology Program staff. The number of recommendations should not be used as a gauge for the overall quality of care provided through VA. The intent is for leaders to use recommendations to help improve operations and clinical care.

VA Comments

The Under Secretary for Health agreed with the inspection findings and recommendations and provided acceptable improvement plans (see pages 17–18 for the full text of the Under Secretary for Health's comments). The OIG considers recommendation 1 closed. The OIG will follow up on the planned actions for the open recommendations until they are completed.

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Contents

Introduction

The Office of Inspector General (OIG) conducted healthcare inspections to report on mammography services provided to female veterans in response to the Making Advances in Mammography and Medical Options for Veterans Act of 2022. This legislation required the OIG to assess

> (1) the access of veterans to mammography screenings, whether at a facility of the Department or through a non-Department provider, including any staffing concerns of the Department in providing such screenings;
>
> (2) the quality of such screenings and reading of the images from such screenings, including whether such screenings use three-dimensional mammography;
>
> (3) the communication of the results of such screenings, including whether results are shared in a timely manner, whether results are shared via the Joint Health Information Exchange or another electronic mechanism, and whether results are incorporated into the electronic health record of the veteran;
>
> (4) the performance of the Women's Breast Oncology System of Excellence of the Department; and
>
> (5) the access of veterans diagnosed with breast cancer to a comprehensive breast cancer care team of the Department.[1]

Because veterans receive mammography services and breast cancer care through VA and community providers, the OIG deployed inspectors from the Care in the Community (CITC) program and the Comprehensive Healthcare Inspection Program (CHIP) to gather data for this inspection. The CITC healthcare inspection program evaluates selected aspects of care for veterans referred to community providers, and CHIP conducts routine oversight of VA medical facilities that provide healthcare services to veterans.

Screening for Breast Cancer

Breast cancer is the most diagnosed cancer among women in the United States.[2] Timely screening, diagnosis, notification, and treatment are essential to early detection and optimal patient outcomes.

[1] Making Advances in Mammography and Medical Options for Veterans Act of 2022, Pub. L. No. 117-135, 136 Stat. 1244 (2022) § 106.

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

A mammogram is an x-ray of breast tissue to detect cancer.[3] A screening mammogram is typically performed for women of average risk for developing breast cancer who are not experiencing any concerning symptoms.[4] Most mammograms performed are digital, meaning the x-ray is a two-dimensional electronic image. Providers can share the digital image electronically and manipulate it to create a larger or smaller view. A newer type of mammography, known as digital tomosynthesis, creates a three-dimensional (3D) view of the breast.[5] According to the American College of Radiology, 3D images have "shown to be an advance over digital mammography, with higher cancer detection rates and fewer patient recalls for additional testing."[6]

Digital tomosynthesis mammograms are not available at every imaging center, and they cost more than two-dimensional mammograms. The American Cancer Society's breast cancer screening guidelines do not specify which type of mammogram a person should receive, deferring the decision to patients and their healthcare providers.[7]

[3] "Mammograms," National Cancer Institute, accessed March 29, 2023, https://www.cancer.gov/types/breast/mammograms-fact-sheet#what-is-a-mammogram.

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

[5] "Mammograms," National Cancer Institute.

[6] "ACR [American College of Radiology] Statement on Breast Tomosynthesis," American College of Radiology, accessed November 14, 2023, https://www.acr.org/Advocacy-and-Economics/ACR-Position-Statements/Breast-Tomosynthesis.

[7] "American Cancer Society Recommendations for the Early Detection of Breast Cancer," American Cancer Society, accessed May 1, 2023, https://www.cancer.org/cancer/breast-cancer/screening-tests-and-early-detection/american-cancer-society-recommendations-for-the-early-detection-of-breast-cancer.html.

Scope and Methodology

The Making Advances in Mammography and Medical Options for Veterans Act of 2022 requires the OIG to report on mammography services and breast cancer care provided to veterans.[8] In accordance with this requirement, the OIG specifically evaluated

- patient access to and adequacy of staffing to perform mammograms, including use of 3D mammography,
- availability and quality of mammogram reports and incorporation of the reports into electronic health records,
- timely communication of mammogram results to ordering providers and patients,
- performance of the Women's Oncology System of Excellence, and
- access to a comprehensive breast cancer care team.[9]

The OIG also evaluated timeliness of staff entering data into local cancer registry databases. The inspection teams reviewed the electronic health records of

- 992 randomly selected female patients between the ages of 45 and 74 as of July 1, 2020, who received a screening mammogram at a VA medical facility from July 1, 2020, through June 30, 2021, and
- 639 randomly selected female patients referred to community providers who received a screening or diagnostic mammogram from July 1, 2020, through June 30, 2021.

From October 1, 2021, through September 30, 2022, CITC teams interviewed leaders at eight Veterans Integrated Service Networks (VISNs), which are responsible for overseeing all care, including breast cancer screening and follow-up provided by their associated medical facilities, community-based outpatient clinics, and community providers (see appendix A).[10]

Concurrently, CHIP teams inspected 21 randomly selected VA medical facilities with mammography programs from November 15, 2021, through February 8, 2023 (see

[8] Making Advances in Mammography and Medical Options for Veterans Act § 106.

[9] The OIG noted different titles for the Women's Oncology System of Excellence, including National Women Veterans Oncology System of Excellence, Breast and Gynecologic Oncology System of Excellence, Breast and Gynecologic System of Excellence, and Breast and Gynecologic Cancer System of Excellence. For consistency, the OIG will refer to it as the Women's Oncology System of Excellence in this report.

[10] VA administers healthcare services through a nationwide network of 18 regional systems referred to as VISNs.

appendix B).[11] Each unannounced inspection involved interviews with key staff and managers and reviews of clinical and administrative processes.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[12] 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.

This report's recommendations for improvement address problems that can influence the quality of patient care significantly enough to warrant OIG follow-up until VA leaders complete corrective actions. The Under Secretary for Health's responses to the report recommendations appear on pages 17–18. The OIG accepted the action plans that the Under Secretary for Health developed based on the reasons for noncompliance.

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.

[11] A mammography program is a "specific VA Radiological subspecialty department operating on-site within the larger context of a VHA facility's physical plant." VHA Directive 1105.03. The OIG inspected 20 facilities during fiscal year 2022 and 1 facility in fiscal year 2023.

[12] Inspector General (IG) Act of 1978, as amended, 5 U.S.C. §§ 401–424.

Inspection Results

Access to Mammograms

The OIG observed that Veterans Health Administration (VHA) ensured patients had access to mammograms, including 3D mammography. Although the OIG found patients waited an average of 38 days to receive mammograms at VA facilities, the OIG did not make a recommendation because the most common reasons for wait times greater than 30 days were appointment no-shows or cancellations and patients rescheduling appointments multiple times due to COVID-19 pandemic concerns.

VHA requires that all eligible and enrolled women veterans have access to "timely, equitable, high-quality, [and] comprehensive health care services" in a "sensitive and safe environment."[13] Facilities must, therefore, ensure "all enrolled women Veterans have access to appropriate services, regardless of the VHA site of care."[14]

VHA mammography programs range in "complexity and configuration from a comprehensive on-site program that provides screening, diagnostic mammography, and interventional procedures" to those that coordinate services through community providers.[15] Veterans may be eligible for care through community providers if a service is not available at a VA medical facility, or because of long wait or drive times to receive care at a VA medical facility.[16]

VHA established wait time goals for completed appointments of 30 calendar days or less from the clinically indicated date.[17] The OIG found an average of 38 days elapsed from the order date, clinically indicated date, or the patient's preferred date to the date the patient received the mammogram at a VA medical facility.[18] Facility staff reported during interviews that appointment no-shows or cancellations and patients rescheduling appointments multiple times due to COVID-19 pandemic concerns adversely affected the timeliness of screenings. Facility staff also described placing some mammogram services on hold due to the pandemic, which also

[13] VHA Directive 1330.01(3), *Health Care Services for Women Veterans*, February 15, 2017, amended June 29, 2020. (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.)

[14] VHA Directive 1330.01(3).

[15] VHA Directive 1105.03.

[16] "Eligibility for Community Care outside VA," Department of Veterans Affairs, accessed February 12, 2024, https://www.va.gov/resources/eligibility-for-community-care-outside-va/.

[17] Assistant Deputy Under Secretary for Health for Clinical Operations, "Veterans Health Administration (VHA) Outpatient Radiology Scheduling Policy and Interim Guidance (UPDATED)," memorandum to Network Directors, August 12, 2016. (VHA replaced this memo with VHA Directive 1234, *Radiology Outpatient Scheduling and Orders Management,* July 25, 2023.)

[18] If the patient's preferred date was not documented, the OIG used the ordering date of the mammography screening for this calculation.

delayed screenings. Staff stated patients were offered the choice of community care but generally opted to wait to have their screening at a VA medical facility.

Most facility leaders reported no staff vacancies in their mammography departments. Leaders at those facilities who did report staff vacancies described using contract staff or referring patients to care in the community to ensure access to mammogram screenings.

The OIG found that the 639 female patients referred to community care received their mammograms within an average of 47 days from the date the test was ordered. The OIG noted the time between referral and mammogram completion ranged from 1 to 270 days, with longer times due to difficulties reaching the patient for scheduling or patients rescheduling their appointments multiple times.

Use of 3D mammography is associated "with higher cancer detection rates and fewer patient recalls for additional testing."[19] For 2 of 21 VA facilities inspected, leaders reported not having access to on-site 3D mammography at the time of the inspection.[20] However, leaders stated 3D mammography was available to patients through care in the community or another VA facility if the ordering or interpreting physician recommended it or the patient requested it. In a review of 629 screenings reported by community providers, 536 (85.2 percent) used 3D mammography.[21]

Quality of Mammography Reports

The OIG did not observe concerns related to the availability or quality of mammogram reports or the incorporation of the reports into electronic health records. VHA requires mammogram reports to contain the date the examination was performed, the patient's name plus an additional identifier, the interpreting physician's name, and one "overall assessment category for the entire mammographic examination based on the most suspicious lesion or finding."[22] The interpreting physician must also include recommendations for any follow-up actions due to the mammogram findings.[23]

Mammogram results receive a Breast Image Reporting and Data System (BI-RADS) code as designated by the American College of Radiology, categorized from 0 through 6 based on the most suspicious lesion or finding.[24] From the electronic health records reviewed, the OIG

[19] "ACR Statement on Breast Tomosynthesis," American College of Radiology.

[20] Staff at the VA Long Beach Healthcare System in California and Central Texas Veterans Health Care System in Temple reported not having access to on-site 3D mammography at the time of the inspection.

[21] There were 639 mammography exams included in the review. Community providers did not return 10 reports to VHA, leaving 629 reports to evaluate for the use of 3D mammography.

[22] VHA Directive 1105.03.

[23] VHA Directive 1105.03.

[24] BI-RADS 0 is an incomplete result and requires evaluation, BI-RADS 1 and 2 indicate "no mammographic evidence of malignancy," BI-RADS 3 is "almost certainly benign," BI-RADS 4 is "suspicious," BI-RADS 5 indicates a high probability of cancer, and BI-RADS 6 is "known biopsy proven malignancy." VHA Directive 1105.03.

estimated that VA radiologists documented required mammogram report components for 98.0 (95% CI: 94 to 100) percent of patients.[25] The OIG also found all mammograms had results reported using a BI-RADS code.

Communication of Mammography Results

The OIG did not identify concerns with timely communication of mammogram results to ordering providers or communication of results requiring action to patients within VHA-defined time frames.

VHA Mammogram Results

Staff at all VA and non-VA radiology and mammography programs are required to provide written reports of mammogram results to patients and ordering providers within 30 days of the examination. Ordering providers, or their designees, must communicate results that require action to patients within 7 calendar days from the date the results are available.[26] If the mammogram results are BI-RADS 4 or 5, providers must communicate them to patients as soon as possible. Providers must also document the communication in the electronic health records.[27]

Based on the electronic health records reviewed, the OIG estimated that interpreting physicians provided mammogram results to ordering providers within 30 days 99.9 percent of the time. The OIG also estimated that for mammogram results requiring action, ordering providers communicated results to patients within 7 calendar days from when the results were available 86.1 (95% CI: 69.4 to 100.0) percent of the time.[28]

Community Care Mammogram Results

Community providers must submit mammogram reports to VHA ordering providers within 30 days, and VHA staff are required to upload the reports into patients' electronic health records.[29] VHA ordering providers must communicate the results of normal mammograms

[25] 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.

[26] The mammogram report must include whether any additional actions need to be taken. VHA Directive 1105.03. Examples of mammogram results requiring action include BI-RADS 0, 3, 4, or 5. Acting Deputy Under Secretary for Health for Operations and Management, "Mammography Results Notification," memorandum to Veterans Integrated Service Network Directors, February 13, 2019; VHA Directive 1330.01(3).

[27] VHA Directive 1105.03; VHA Directive 1330.01(3).

[28] The OIG's electronic health record sample contained one BI-RADS 4 and no BI-RADS 5 results. The one electronic health record with a BI-RADS 4 result included documented communication to the interpreting physician and patient within 5 days of the examination.

[29] VHA Directive 1105.03.

(BI-RADS 1 or 2) completed through community care to patients within 14 calendar days of receiving them and document the communication in the electronic health record.[30]

VHA also requires VISN and facility staff to implement and sustain an electronic health information exchange.[31] The Veterans Health Information Exchange allows VHA and community providers to share patients' health information electronically and is an additional means for community providers to return mammogram reports to VHA.[32] The OIG evaluated community providers' submission of mammogram reports to VHA ordering providers, including the extent to which community providers submitted the reports through the Veterans Health Information Exchange.

The OIG did not identify concerns with community providers submitting mammogram reports to VHA ordering providers, or VHA staff uploading the reports into patients' electronic health records. The OIG noted that community providers submitted 9 of 629 reports (about 1 percent) through the health information exchange (see figure 2).

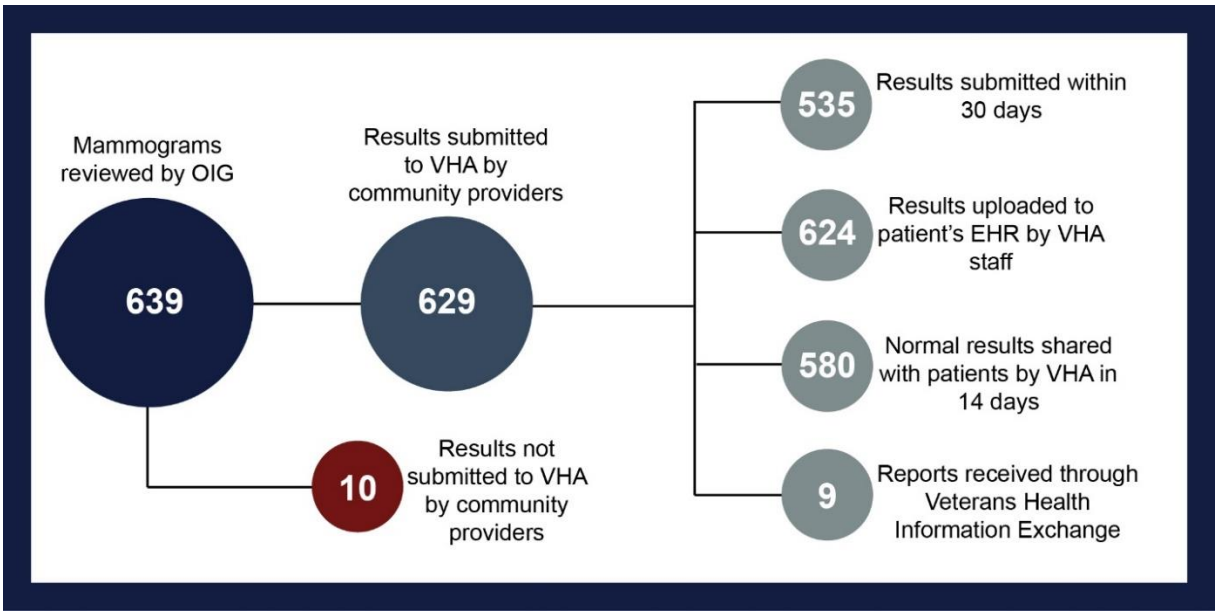

Figure 2. *Community providers' submission of mammogram results to VHA ordering providers.*
Source: VA OIG analysis of VHA data.
EHR = electronic health record

[30] Acting Deputy Under Secretary for Health for Operations and Management, "Mammography Results Notification," memorandum.

[31] VHA Directive 6371, *Electronic Health Information Exchange for Treatment*, April 30, 2019.

[32] Department of Veterans Affairs, *Sharing Health Information with Community Providers: Toolkit for Outreach Partners,* March 2020; "Veterans Health Information Exchange, Why Partner with VHIE [Veterans Health Information Exchange]," Department of Veterans Affairs, accessed December 5, 2023, https://www.va.gov/VHIE/Why_Partner_with_VHIE.asp; "What Are the Benefits of Health Information Exchange?," Office of the National Coordinator for Health Information Technology, January 8, 2019, accessed May 5, 2023, https://www.healthit.gov/faq/what-are-benefits-health-information-exchange.

Women's Oncology System of Excellence

The OIG identified two concerns with the Women's Oncology System of Excellence for veterans diagnosed with breast cancer. First, most leaders and staff at the VA medical facilities inspected were not aware of the system of excellence or its strategic partnerships. Second, more than two years after its launch, leaders acknowledged there was less progress than they originally projected. The OIG made two recommendations to VHA regarding the Women's Oncology System of Excellence.

The VA's National Oncology Program aims to provide the best cancer care to the nearly 50,000 veterans diagnosed and treated for cancer every year. To achieve this goal, VA established Oncology Systems of Excellence for prostate, lung, gynecologic, and breast cancers. According to VA, "Systems of Excellence are spreading best practices in cancer care across VA so veterans can receive the best cancer care no matter their geographical location."[33]

In October 2020, VA introduced the Women's Oncology System of Excellence.[34] This system of excellence aimed to offer women veterans with oncology needs "cutting edge care and access to potentially lifesaving clinical trials."[35] VHA leaders reported services available in this system of excellence included assistance with treatment and care coordination within and outside the VA healthcare system. However, VHA leaders acknowledged limited availability of breast cancer clinical trials within VA. To address this issue, VHA leaders described offering patients access to clinical trials through partnerships with the National Cancer Institute Designated Cancer Centers, adding that patients referred to community providers also had opportunities to participate in clinical trials.[36] VHA leaders also reported plans to offer rehabilitative services in 2023 but they were delayed until 2024 and were currently working on recruitment actions for a newly created position.

The OIG interviewed facility leaders and staff to assess their knowledge of VA's Women's Oncology System of Excellence and its partnerships with medical, research, and academic institutions. Of 21 facilities inspected, leaders and staff at only 5 reported being aware of the system of excellence or its partnerships.

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[33] "Oncology Systems of Excellence," VHA National Oncology Program, accessed April 20, 2023, https://dvagov.sharepoint.com/sites/vhasoe. (This website is not publicly accessible.)

[34] "VA Creates National Women Veterans Oncology System of Excellence in Fight against Breast Cancer," Department of Veterans Affairs.

[35] "VA Creates National Women Veterans Oncology System of Excellence in Fight against Breast Cancer," Department of Veterans Affairs.

[36] The National Cancer Institute Designated Cancer Centers "meet rigorous standards for transdisciplinary, state-of-the-art research focused on developing new and better approaches to preventing, diagnosing, and treating cancer." "NCI [National Cancer Institute]-Designated Cancer Centers," National Cancer Institute at the National Institutes of Health, accessed May 17, 2023, https://www.cancer.gov/research/infrastructure/cancer-centers.

The OIG reviewed information available on VA's website for the Oncology Systems of Excellence and noted that VA's Prostate System of Excellence provided "a network of medical centers and a range of clinical trials providing state-of-the-art precision oncology care for Veterans with prostate cancer."[37] For veterans diagnosed with lung cancer, VA "identified sites across all 18 VISNs to serve as centralized sites that can leverage VA facilities for screening capabilities, radiation oncology, research pharmacists, and equipment."[38] Regarding the Women's Oncology System of Excellence, the website mentions its partnerships with external institutions and states it is "building the infrastructure necessary to screen for and aggressively treat the breast and gynecological cancers impacting Veterans."[39]

In an interview, VHA leaders reported there was less progress with the Women's Oncology System of Excellence than they projected, but the right team was in place and was moving in the right direction.[40]

Access to Comprehensive Breast Cancer Care

The OIG observed that veterans diagnosed with breast cancer who received care at VA facilities had access to a comprehensive breast cancer care team.

"An estimated 700 women veterans enrolled in VA healthcare are diagnosed with breast cancer each year."[41] Because cancer treatment is multifaceted, comprehensive care is necessary for the best patient outcomes. Optimal treatment of breast cancer requires an individualized plan of care developed collaboratively between a multidisciplinary team of healthcare providers and the patient. Multidisciplinary teams can include oncologists, pathologists, radiation oncologists, radiologists, genetic counselors, surgical oncologists, and palliative care specialists.

The OIG interviewed VHA leaders and reviewed documents to determine patients' accessibility to a comprehensive care team within VHA for those diagnosed with breast cancer.[42] VHA leaders described comprehensive breast cancer care as involving multidisciplinary teams to care for patients through the course of the disease. VHA leaders stated they use telehealth modalities to increase access to comprehensive cancer care. Through telehealth, patients can receive specialized care from VHA healthcare providers without the burden of traveling long distances.

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[37] "Systems of Excellence," VA National Oncology Program, accessed November 20, 2023, https://www.cancer.va.gov/CANCER/systems-of-excellence.html.

[38] "Systems of Excellence," VA National Oncology Program.

[39] "Systems of Excellence," VA National Oncology Program.

[40] The OIG conducted the interview in February 2023.

[41] "Tester, Boozman, Hirono, Collins Unveil Bipartisan Legislation to Improve Veteran Access to Breast Cancer Screening & Care," US Senate Committee on Veterans' Affairs, July 29, 2021, https://www.veterans.senate.gov/2021/7/tester-boozman-hirono-collins-unveil-bipartisan-legislation-to-improve-veteran-access-to-breast-cancer-screening-and-care.

[42] Making Advances in Mammography and Medical Options for Veterans Act § 106. The OIG conducted the interview in February 2023.

The OIG noted that VA has a National Virtual Tumor Board for patients with breast cancer.[43] This board provides cancer care through a multidisciplinary care team of healthcare providers by reviewing patients' conditions and formulating comprehensive plans of care.

Cancer Registry Database

The OIG identified concerns with VA facility staff not entering data into local cancer registry databases in a timely manner. Although the OIG was not required to evaluate use of cancer registry databases as part of the Making Advances in Mammography and Medical Options for Veterans Act of 2022, the timely and accurate collection of patient information is important for VHA's overall breast cancer treatment strategies.[44]

VHA requires each "facility to maintain a cancer registry" database and facility directors to ensure staff enter complete and accurate information into the database in a timely manner.[45] When staff enter data timely, leaders can generate local and national reports of cancer diagnoses and treatments and base patient care decisions on quality information.[46]

The OIG reviewed VA data entered as of July 12, 2023, and found that staff at multiple facilities did not enter information into the cancer registry database for at least a year, including staff at two facilities who had not entered information since 2018. During an interview, National Oncology Program leaders acknowledged personnel were behind on data entry and identified inadequate staffing and information technology issues as causing the delay.[47]

National Oncology Program leaders recognized the difficulty facing facility directors in hiring employees with the necessary experience and skills to complete the data entry task at a low level of compensation. The leaders described hiring additional oncology program staff and using contract employees during the previous two years to help enter the data; however, they reported

[43] "A tumor board is a multidisciplinary case conference that convenes at individual VA medical facilities and nationally to discuss the diagnosis, staging, and management of patients with cancer." VHA Directive 1415, *VHA Oncology Program*, April 9, 2020.

[44] Making Advances in Mammography and Medical Options for Veterans Act § 106.

[45] "Cancer registries are data information systems that manage and analyze data on cancer patients and survivors. Cancer registries are maintained to ensure that health officials have accurate and timely information on cancer incidence, treatment, and survivorship." "Become a Cancer Registrar," National Cancer Registrars Association, accessed February 6, 2024, https://www.ncra-usa.org/About/Become-a-Cancer-Registrar/What-is-a-Cancer-Registry. VA's cancer registry system "provides a systematic approach to (1) identifying patients with a diagnosis of cancer, (2) gathering standardized structured information about each patient with cancer, and (3) generating reports on the population of patients with cancer in VA health care." VHA Directive 1412(1), *Department of Veterans Affairs Cancer Registry System*, May 29, 2019.

[46] Timely is defined by the System Supervisor, VA Cancer Registry System. VHA Directive 1412(1). In an interview, the System Supervisor, VA Cancer Registry System did not provide a specific definition for timely but reported monitoring facility data and providing feedback to individual sites on entering accurate, complete, timely data.

[47] The OIG conducted the interview in July 2023.

continued delays and were beginning to meet with VISN leaders to discuss further interventions to improve data entry.

The Executive Director of the National Oncology Program stated updated software with new information technology tools were necessary to meet the need for accurate, timely, and complete cancer reports in VA. National Oncology Program leaders reported that software issues beginning in 2022 caused some facility data to be missing from national cancer reports. National Oncology Program leaders described monitoring information in the national database and contacting facility staff to resolve the problem when they noticed changes in data trends.

Recommendations 1–3

1. The Under Secretary for Health, in conjunction with the National Oncology Program and Veterans Integrated Service Network directors, ensure facility leaders and staff are aware of the services offered to veterans diagnosed with breast cancer through the Women's Oncology System of Excellence.
2. The Under Secretary for Health and National Oncology Program staff offer a range of services for patients diagnosed with breast cancer, including rehabilitative services, through the Women's Oncology System of Excellence.
3. The Under Secretary for Health, Veterans Integrated Service Network directors, and facility leaders ensure staff enter data into the local cancer registry database in a timely manner.

Appendix A: VISNs Inspected during CITC Reviews

Table A.1. VISNs Inspected
(October 1, 2021, through September 30, 2022)

VISN	Name	City, State
VISN 1	VA New England Healthcare System	Bedford, MA
VISN 2	New York/New Jersey VA Health Care Network	Bronx, NY
VISN 5	VA Capitol Health Care Network	Linthicum, MD
VISN 6	VA Mid-Atlantic Health Care Network	Durham, NC
VISN 8	VA Sunshine Healthcare Network	Tampa, FL
VISN 12	VA Great Lakes Health Care System	Westchester, IL
VISN 19	VA Rocky Mountain Network	Glendale, CO
VISN 20	VA Northwest Health Network	Vancouver, WA

Source: VA OIG.

Appendix B: VA Facilities Inspected during CHIP Visits

Table B.1. VA Facilities Inspected (November 15, 2021, through February 8, 2023)

Name	City, State
New Mexico VA Health Care System	Albuquerque, NM
VA North Texas Health Care System	Dallas, TX
VA Texas Valley Coastal Bend Health Care System	Harlingen, TX
VA Pacific Islands Health Care System	Honolulu, HI
Michael E. DeBakey VA Medical Center	Houston, TX
Central Arkansas Veterans Healthcare System	Little Rock, AR
VA Loma Linda Healthcare System	Loma Linda, CA
VA Long Beach Healthcare System	Long Beach, CA
VA Greater Los Angeles Healthcare System	Los Angeles, CA
Louisville VA Medical Center	Louisville, KY
VA Northern California Health Care System	Mather, CA
Tennessee Valley Healthcare System	Nashville, TN
VA Southern Nevada Healthcare System	North Las Vegas, NV
VA Palo Alto Health Care System	Palo Alto, CA
Corporal Michael J. Crescenz VA Medical Center	Philadelphia, PA
Phoenix VA Health Care System	Phoenix, AZ
VA Pittsburgh Healthcare System	Pittsburgh, PA
South Texas Veterans Health Care System	San Antonio, TX
VA San Diego Healthcare System	San Diego, CA
Central Texas Veterans Health Care System	Temple, TX
Southern Arizona VA Health Care System	Tucson, AZ

Source: VA OIG.

Appendix C: Office of the Under Secretary for Health Memorandum

Department of Veterans Affairs Memorandum

Date: March 28, 2024

From: Under Secretary for Health (10)

Subj: OIG Draft Report, CHIP and Care in the Community Report: Mammography Services and Breast Cancer Care (VIEWS 11538984)

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on the OIG draft report on mammography services and breast cancer care. The Veterans Health Administration (VHA) concurs with the recommendations and provides an action plan in the attachment.
2. VHA appreciates the work performed by the OIG. VHA's on-site mammography programs are equipped to offer state-of-the-art three-dimensional mammography examinations which have been found by the American College of Radiology to result in higher cancer detection rates and fewer patient recalls. We continue to ensure all Veterans have timely and equitable access to high-quality breast imaging, in a sensitive and safe environment, either at an on-site mammography program or in the community.
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

Office of the Under Secretary for Health Response

Recommendation 1

The Under Secretary for Health, in conjunction with the National Oncology Program and Veterans Integrated Service Network directors, ensure facility leaders and staff are aware of the services offered to veterans diagnosed with breast cancer through the Women's Oncology System of Excellence.[1]

Under Secretary for Health Comments

Concur.

Target date for completion: Completed

The Women's Oncology System of Excellence is referred to as the Breast and Gynecologic Oncology System of Excellence (BGSoE) within VHA. Since the inspection was completed in February 2023, VA communicated extensively both to Veterans and VA staff the capabilities of the BGSoE. In the last 6 months, VA developed and distributed three VA blogs (January 2024–February 2024), two VA flyers (February 2024–March 2024), developed one video (October 2023), and distributed an all-hands VHA message from the USH regarding the capabilities of the BGSoE (October 2023). VA will continue to provide awareness and distribute materials for both Veterans and VA staff on cancer.va.gov and through VA communication channels.

Recommendation 2

The Under Secretary for Health and National Oncology Program staff offer a range of services for patients diagnosed with breast cancer, including rehabilitative services, through the Women's Oncology System of Excellence.

Under Secretary for Health Comments

Concur.

Target date for completion: December 2024

Since the inspection was conducted, VA now offers a range of services through the BGSoE. VA offers TeleOncology for breast and gynecologic cancers, a high-risk breast clinic, co-management (along with the Clinical Cancer Genetics Service) for patients with hereditary breast and gynecologic cancer syndromes, and second opinions for systemic therapy, surgery, and

[1] The OIG reviewed evidence sufficient to demonstrate that leaders completed improvement actions and therefore closed the recommendation as implemented before publication of the report.

radiation. There is a virtual tumor board for multidisciplinary discussion of patients with breast and gynecologic cancers. VA also offers nurse navigation services providing patients with individualized assistance to overcome barriers to care. Additionally, BGSoE offers a weekly breast and gynecologic cancer support group. In 2024, BGSoE is on track to hire a physical therapist to begin offering breast rehabilitation services.

Recommendation 3

The Under Secretary for Health, Veterans Integrated Service Network directors, and facility leaders ensure staff enter data into the local cancer registry database in a timely manner.

Under Secretary for Health Comments

Concur in Principle.

Target date for completion: March 2025

There is a nationwide shortage of certified cancer registrars which significantly impacts VA's ability to address this recommendation although the VA fully endorses the intended outcome. VA has taken steps to address the shortage in staffing by improving efficiency through the creation of tools that optimize case finding and abstraction. VA continues to improve systems and navigate the shortage of registrars.

VA is providing education and guidance on how to use the tools that are available. We are also in the process of acquiring a modern application that will replace and dramatically improve the legacy system and we have allocated resources to assist facilities who are behind in abstracting and requesting support.

VA is revising VHA Directive 1412 Department of Veterans Affairs Cancer Registry System to provide clear standards for timely entry of data into local cancer registries. VA expects to publish the updated Directive 1412 by March 2025.

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