

ANALYSIS of the DECLINE in CERVICAL CANCER SCREENING
At CARL R. DARNALL ARMY MEDICAL CENTER
8 October 2015

Introduction:

In September 2012, the American Society for Colposcopy and Cervical Pathology (ASCCP) along with partner societies such as the American Congress of Obstetricians and Gynecologists (ACOG) revised the cervical cancer screening guidelines.

In February 2015, the Defense Health Agency (DHA) published the methodology document for cervical cancer screening based on the 2015 Healthcare Effectiveness Data and Information set (HEDIS™) criteria. (See attachment.) Adherence is defined as the percentage of women continuously enrolled in TRICARE Prime, age 24-64 years, who had either:

-- Cervical cancer screening in the past 3 years.

-- Cervical cancer screening and human papillomavirus (HPV) co-testing in the past five years, where the woman was age 30 or greater at the time of the co-test. HPV testing must occur within 4 days of Pap testing, with Pap date as day zero. (Captured with ICD9 Code V73.81 to aid in HPV capture when laboratory testing is not available at the screening facility, resulting in a delay in resulting.)

Because of the significant changes in the methodology, there is not a performance benchmark for this fiscal year for intra-organizational comparison. Because of the interval lengthening between screenings with the new standards, performance (and future benchmark) future targets may be higher than with the previous methodology. However, CRDAMC must screen appropriately, regardless of monetary incentives (or lack thereof) for this year.

Over time, particularly since the decentralization of HEDIS patient identification and contact processes in May 2014, CRDAMC adherence for cervical cancer screening has decreased. Additionally, the numbers of women 30-64 years of age receiving only the Pap smear cytological screening test – without the high risk human papilloma virus co-test – are high compared to the number of those women being appropriately screened. This population could have longer screening intervals through Pap + HPV testing, thereby avoiding either unnecessary appointments or, since they would still be welcomed to present for an annual gynecological exam, more likely avoiding the expense of extra [unnecessary] tests – both of which will help alleviate access to care issues.

Problem statement: This study will attempt to identify contributing factors for declining screening scores by reviewing the following:

Criteria and data used:

- 1) Facility performance from the Command Management System and MHSPHP CarePoint Registries
- 2) Provider knowledge of evidence-based guidelines

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3) Screening guidelines:

- HEDIS methodology
- ACOG/ASCCP guidelines

4) Provider knowledge of ASCCP and ACOG screening guidelines.

Data source: SME prepared questionnaire

National benchmarks:

No current DHA benchmark, but historical review of performance with previous benchmarks.

Guidelines: HEDIS methodology, ACOG/ASCCP guidelines

Findings attached:

- HEDIS performance (facility and clinic level).

Data source: Command Management System

--Screening practices drawn from CarePoint patient registry without continuous enrollment requirement performance (facility and clinic level) with differentiation between adherence per HEDIS methodology versus per current ASCCP and ACOG guidelines.

Data Source MHSPHP CarePoint (Accession date: 19 September 2015).

Summary/conclusion: Review of the provider questionnaires showed a marked knowledge deficit on both the HEDIS methodology and the updated ACOG/ASCCP guidelines.

Recommendation: Develop a provider education program to improve knowledge and support increases in HEDIS performance.

Attachments:

HEDIS methodology
CMS HEDIS performance graphs
CarePoint Registry performance graphs
Results of provider knowledge questionnaires

METHODOLOGY DOCUMENT
Technical Specification (TechSpec)

- x Comprehensive Ambulatory/Professional Encounter Record (CAPER)
- x Purchased Care Claims Data (NETWORK) (M2)
- x Composite Health Care System (CHCS) Managed Care Platform National Enrollment Database (NED) module
- x MHS CHCS lab and pathology ad hocs
- x COHORT
- x AHLTA Problem List Surgical Procedure History (MDR)
- x Tri-Service Workflow (TSWF) MHSPHP AIM Form
- x Standard Ambulatory Data Record (SADR) (M2)*

*SADR use is limited to the identification of historical exclusions and NOT for the identification of patients to meet denominator criteria as specified above.

CODES:

Codes to identify cervical cancer screening in direct care or purchased care:

CPT Codes	HCPCS
88141-88143, 88147, 88148, 88150, 88152-88154, 88164-88167, 88174, 88175	G0123, G0124, G0141, G0143-G0145, G0147, G0148, P3000, P3001, Q0091

Codes to identify HPV testing in direct care or purchased care:

CPT Codes
87620-87622 *

*A military specific waiver was granted use the ICD9 Code V73.81 to identify HPV specimen date to match Pap-HPV co-testing. This code will provide a matching date for the Pap specimen dates found in patient encounters. The V73.81 specimen date must also have a completed HPV test with approved CPT and test name in the lab or encounter data within 30 days after the V73.81 specimen date.

Codes to exclude women with a hysterectomy and no residual cervix:

CPT Codes	ICD-9-CM Codes*	ICD-9-CM Procedure
51925, 56308, 57540, 57545, 57550, 57555, 57556, 58150, 58152, 58200, 58210, 58240, 58260, 58262, 58263, 58267,	618.5, 752.43	68.4-68.8

CPT Codes	ICD-9-CM Codes*	ICD-9-CM Procedure
58270, 58275, 58280, 58285, 58290-58294, 58548, 58550-58554, 58570-58573, 58951, 58953, 58954, 58956, 59135	<p>V Codes: V88.01, V88.03</p> <p>*In older records, exclusion codes must be documented in one of the first 4 diagnosis codes because the M2 professional outpatient encounter data (SADR) included only Diagnosis Codes 1-4. All CAPER sourced encounters in the last 5 years include Diagnosis Codes 1-10.</p> <p>V45.77 1 **</p> <p>** (Military specific code – Acquired absence of Uterus and Cervix. The V45.77 1 code has been replaced with V88.01. Patients previously coded with V45.77 1 will continue to be excluded; therefore, it is not necessary to recode these patients with the V88.01 code.)</p>	

ACRONYMS & DEFINITIONS:

CAPER	Comprehensive Ambulatory/Professional Encounter Record
CHCS	Composite Health Care System
DEERS	Defense Eligibility Enrollment Registration System
IESD	Index Episode Start Date
PDTS	Pharmacy Data Transaction System
TED-I	TRICARE Encounter Data Institutional
TED-NI	TRICARE Encounter Data Non-Institutional

FREQUENCY OF VALIDATION:

- MEASURE DEFINITION: ONCE A YEAR
- BENCHMARK: ONCE A YEAR
- THRESHOLD: TBD
- TARGET: TBD
- MAXIMUM: TBD
- TRIGGER(S): TBD
- REFERENCES: TBD

BENCHMARKS

EXTERNAL VALUES: Due to the methodology change (inclusion of HPV criteria in 2014), there are no official HEDIS^{AE} benchmarks available for use during metric year 2015 (which uses HEDIS^{AE} percentiles 2014). Below are the old benchmarks from 2013 that the Clinical Measures Steering Panel authorized for continued use until the new benchmarks come out in 2016.

INTERNAL VALUES : *HEDIS^{AE} Percentiles (10th — 25th — 50th — 75th — 90th)
69.19--72.89--75.68--78.55--81.94

*HEDIS^{AE} percentiles: National Committee for Quality Assurance (NCQA), State of Health Care Quality, 2013. HEDIS^{AE} benchmarks are not releasable outside of DoD.

PATIENT REGISTRY: While the HEDIS^{AE} metric only includes continuously enrolled, TRICARE Prime women age 24-64, the patient registry includes all TRICARE Prime/Plus enrolled women, age 21-64. The registry identifies women with the date of their most recently documented Pap smear, their most recently documented HPV test co-tested with a Pap exam (when age 30 or greater at time of Pap exam), and most recently documented Pap smear co-tested with a HPV test (when age 30 or greater at time of Pap exam). Those women who have not had a coded cervical cancer screening exam and/or Pap/HPV co-test during the prescribed timeframe are flagged as overdue.

Current Pap smears performed in MTFs are updated nightly on this patient list from HS_Oracle ODS. Pap/HPV co-tests will be refreshed nightly later in 2015. Tests performed in MTFs should appear on the list within 1-3 days of the certified final result. Although these tests appear on the list, only tests completed prior to the metrics date are included in the metrics.

Note: Women with a documented history of hysterectomy and no residual cervix, will not be included in the Action Report, but will appear in the Quicklook prevalence report with a Pap Date of "HYSTER."

PATIENT REGISTRY DATA ELEMENTS:

- ➔ Family Member Prefix (FMP)
- ➔ Date of Birth
- ➔ Age
- ➔ Gender
- ➔ Beneficiary Category (BENCAT)
- ➔ PCM**
- ➔ Provider Group**
- ➔ PCM ID*

- PCM IDTYPE*
- Pap Last Exam Date²
- Pap System²
- Pap Source²
- HPV Last Exam Date³
- HPV System³
- HPV Source³
- Pap/HPV Last Exam Date (based on Pap date)³
- Pap/HPV System (based on Pap date)³
- Pap/HPV Source (based on Pap date)³
- Contact Info**
- Defense Medical Information System (DMIS)
- TRO*
- Notes Detail for Cervical Cancer Screening and/or Generic notes entered by user

*TRO Action Lists only

**Direct Care Action Lists only

RECOMMENDED ACTION:

Review patient medical records identified as NOT having a cervical cancer screening or cervical cancer screening/HPV co-testing in the prescribed time frame. Schedule women over 30 who did not have a Pap plus HPV on the same date in the last 5 yrs or a Pap smear in the last 3 yrs and women under 30 without a Pap smear in the last 3 yrs for an exam.

Recommend providers use the Q0091 and V73.81 codes on encounters where cervical cancer screening and HPV testing specimens are taken to ensure the co-testing dates are within 4 days of each other. (Lab file dates represent completed, finalized test results and may not be within 4 days of each other).

NOTES:

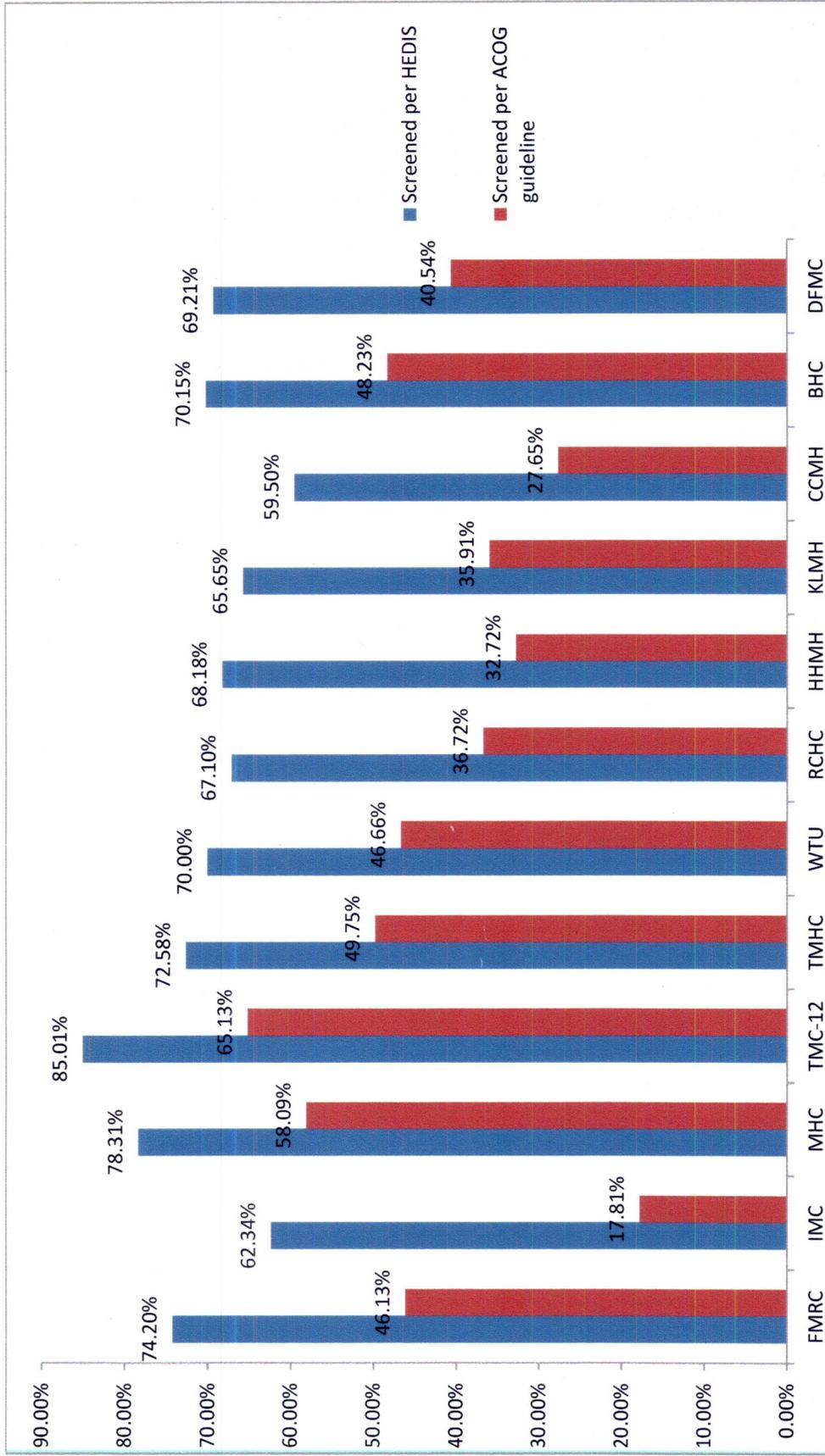
¹ Due to the record reporting lag time, not all of the previous months' records may be included in this reporting period.

² Only Pap exam dates occurring in the past three years (i.e., numerator compliant exams) are included in the "Pap Last Exam Date" column.

³ Only HPV test dates and Pap/HPV co-testing that occurred in the past five years, on or after a woman's 30th birthday (i.e., numerator compliant exams), are populated in action reports.

DRAFT

Cervical Cancer HEDIS vs ACOG (per CarePoint Registry on 19 Sep 2015)



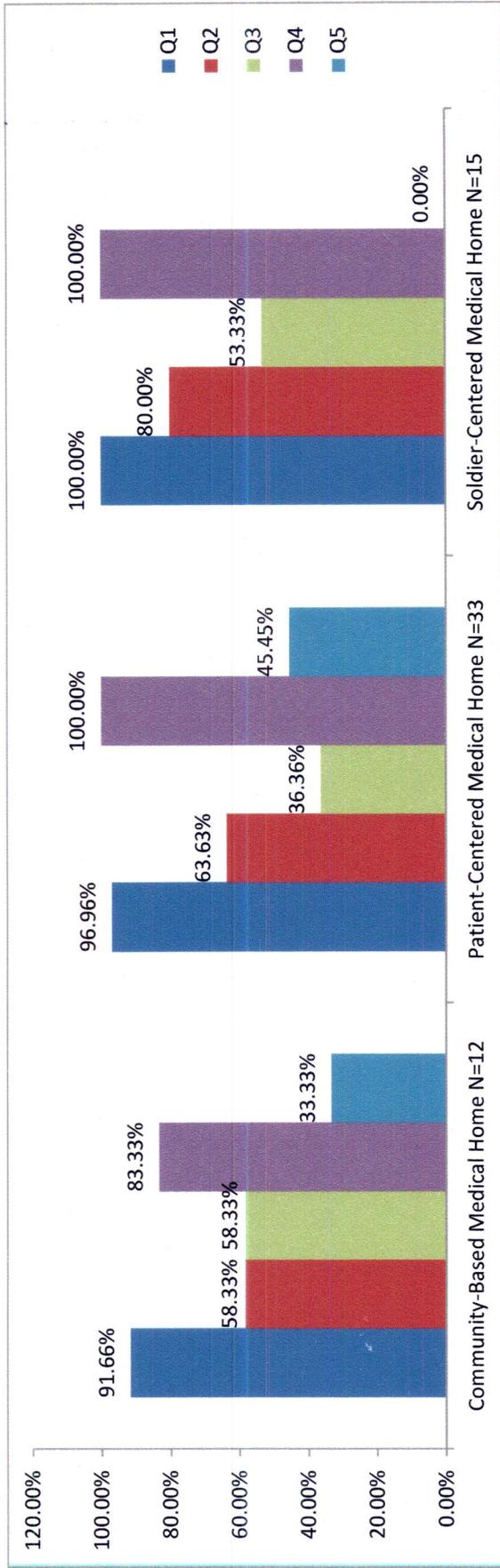
■ Screened per HEDIS

■ Screened per ACOG guideline

■ HEDIS = women 24 – 64 (three year look back) with Pap every three **and/or** every 5 with HPV

■ ACOG = women 24 - 29 (three year look back) with Pap every three years and 30-65 with Pap and HPV every 5 years

Results of the Cervical Cancer Screening Survey



1. At what age should you begin performing Pap smears?

A) Age 21 B) Age 18 C) Age 30 D) As soon as the patient is sexually active E) As soon as the patient is sexually active

2. At what age should you cease performing Pap smears?

- A) Age 65
- B) Age 65 IF a woman has not had CIN 2, CIN 3, or AIS OR has had normal Pap smears for 20 years -- otherwise she should be followed for at least 20 years after diagnosis and treatment
- C) If she has had a total hysterectomy (i.e., removal of uterus and cervix)
- D) If she has had a total hysterectomy AND has had no history of CIN 2, CIN 3, or AIS in the last 20 years
- E) B and D are correct

3. What kind of labs should you order on patients 21 years old to 29 years old?

- A) Pap smear WITH reflex HPV B) Pap smear WITH reflex HPV AND Genprobe C) Pap smear WITHOUT reflex HPV D) Pap smear WITHOUT reflex HPV AND Genprobe E) Pap smear WITHOUT reflex HPV and stand-alone high risk HPV co-test

4. How often should you perform a Pap smear on patients age 21 to 29 years old who have normal cytology results?

- A) Annually B) Every three years C) Every five years

5. What kind of labs should you order on patients aged 30 years or older?

- A) Pap smear WITH reflex HPV B) Pap smear WITH reflex HPV and other tests as indicated C) Pap smear WITHOUT reflex HPV
- D) Pap smear WITHOUT reflex HPV and any other tests as indicated E) Pap smear WITHOUT reflex HPV, HPV high-risk co-test (stand-alone), and any other tests as indicate