

ACS NAPBC National Accreditation Program for Breast Centers
American College of Surgeons

Optimal Resources for Breast Care 2024: Improving Standards; Improving Quality

NAPBC Workshop
February 22, 2024
Austin, TX

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Quality Standards

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Disclosures

- Founder and Minority Stock Owner; Elucet Medical
- Institutional PI; no salary support; Perimeter Medical

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Quality – “The Why” – for our patients

Rationale

The Institute of Medicine's high-quality care by design report identifies the need for high-quality care that addresses the needs of patients and their families.

You

Write a problem statement for a quality problem in breast cancer care

ChatGPT

Problem Statement:

In contemporary breast cancer care, there persists a significant quality issue concerning the standardization and consistency of diagnostic procedures, treatment protocols, and post-treatment monitoring practices. Despite advancements in medical technologies and treatment modalities, the variance in clinical practices across healthcare institutions leads to disparities in patient outcomes, unnecessary delays in diagnosis, suboptimal treatment decisions, and inconsistent follow-up care. This lack of uniformity not only compromises the efficacy of breast cancer management but also undermines patient trust and satisfaction in healthcare services. Addressing these quality gaps is imperative to ensure equitable access to high-quality care, improve survival rates, enhance patient experiences, and ultimately reduce the burden of breast cancer on individuals and society.

Priority to patient-centric, data-driven initiatives of the

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Standard 7.1: Quality Measures

In Development

7.1 Quality Measures

Definition and Requirements

The National Accreditation Program for Breast Centers (NAPBC) requires accredited programs to treat patients with breast disease or breast cancer in accordance with all nationally accepted quality measures. The NAPBC approves such nationally accepted quality measures based on a determination of need for quality or accountability regarding a specific aspect of breast care. All approved quality measures must be reviewed and implemented by the NAPBC-accredited program. The timeline for implementation and the expected compliance rate for all new quality measures is determined by the NAPBC. The Breast Program Leadership Committee (BPLC) must monitor the accredited programs' adherence with all required quality measures.

Standard 7.1 is in development. Compliance is not being evaluated at this time.

- NAPBC will develop and introduce quality measures in association with CoC
- Quality measures must be reviewed and implemented by the NAPBC-accredited program
- BPLC must monitor adherence with all required measures
- Corrective action plans must be developed and implemented for non-compliance with required measures

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CoC/NAPBC Breast Quality Measures

Timeliness

Measure	Acronym	Launch	Set EPR (Estimated Performance Rate)
First therapeutic breast surgery in a non-metastatic setting is performed within and including 60 days of diagnosis for patients with AJCC Clinical Stage I-III breast cancer	BCSOx	June 2022	June 2024
Radiation therapy, when administered, is initiated less than or equal to 60 days of definitive surgery for patients receiving breast conserving surgery for Stage I-III breast cancer who do not undergo adjuvant chemo- or immunotherapy	BCSRT	July 2023	July 2025
For patients ≤ 75 years old with HER2+ or triple negative breast cancer with any clinical N ≥ 1 or clinical T ≥ 2, neoadjuvant chemotherapy and/or immunotherapy is recommended and/or initiated within 60 days of diagnosis	BneoCT	April-May 2024	May 2026

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NCDB Data (Wiener et al. JAMA Surgery 2023)

Figure 2. Histogram of Time From Breast Cancer Diagnosis to Surgery With Percentile Overlays of Patients Receiving Surgery by Each Time Point in the Overall Cohort

Table 2. Results From Multivariable Cox Regression Analysis of Overall Survival in Patients Undergoing Primary Surgery for Breast Cancer, Controlling for Age and Tumor Characteristics (N = 373 334)

Characteristic	Hazard ratio (95% CI)	P value
Time to surgery		
0-4 wk (1-28 d)	1 [Reference]	
5 wk (29-35 d)	0.97 (0.93-1.01)	.11
6 wk (36-42 d)	1.00 (0.96-1.04)	.93
7 wk (43-49 d)	1.00 (0.95-1.05)	.90
8 wk (50-56 d)	1.03 (0.98-1.10)	.24
9 wk (57-63 d)	1.15 (1.08-1.23)	<.001
10 wk (64-70 d)	1.16 (1.07-1.26)	<.001
11 wk (71-77 d)	1.19 (1.08-1.31)	.001
12 wk (78-84 d)	1.32 (1.18-1.48)	<.001
>12 wk (84 d)	1.47 (1.39-1.57)	<.001

Approximately 10% of patients fall outside the 60 days

Medicaid/no insurance and lower income status led to prolonged time to surgery

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Standard 7.2 Quality Improvement Initiative

- Program must design and implement at least **one** breast cancer-specific quality improvement (QI) initiative each calendar year
- Utilize a consistent quality improvement methodology (PDSA/DMAIC)
- Status reports to the BPLC twice per year
- Final presentation summary after the QI initiative is complete
- Projects may extend into a second year, but a new project must also be started for the next calendar year

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Performance Improvement Tools

Lean –FOCUS/PDCA	Six Sigma - DMAIC
Find a Process to Improve Organize a Team	Define: the problem and convene the team inclusive of the customer
Clarify current state Understand variation	Measure: Establish baseline processes
Select the improvement	Analyze: Identify root causes
Plan and Do the improvement	Improve: Develop and pilot test solutions then collect data to measure improvements.
Check the results Act and Determine next steps	Control: Create a Monitoring Plan to continue measuring the performance of the process

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An A3 Problem-Solving Template (Proposal Stage)

Title: The problem being addressed. **Owner:** **Date:**

<p>Background Why is the problem important? Consequences (e.g. harm, frustration, waste) For whom? Severity? Frequency?</p> <p>Current Situation What is actually happening? Current level of performance? (prior to background) How to work alone (new processes), who is involved?</p> <p>Problem Statement What is the performance gap (actual vs. expected)?</p> <p>Goal What target condition or specific performance is desired? By when? (e.g. SMART: Specific, Measurable, Achievable, Relevant and Timely)</p> <p>Analysis What is contributing to the problem? What are its root causes? (How were root causes identified?) Fishbone Diagram Root Cause Tree Diagram Pareto Chart</p>	<p>Countermeasures What options/alternatives were considered? Criteria Matrix</p> <p>What countermeasures or strategies are proposed? [How directly are countermeasures linked to root causes?]</p> <p>Action Plan To pilot & implement the selected countermeasures: What activities will be required? Who will be responsible for each activity? When will activities be performed? Monitor implementation of action plan: What will be monitored, by whom, when?</p> <p>Follow-up Plan Has desired goal(s) been achieved? What will be checked/measured? Who will perform the check/measurement? When will it be performed?</p>
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Toyota originated the A3 tool. This template was modified from earlier versions used by Leon Teichner, David Vesile, John Y. Stock, David Larkins, and John E. Bell

Jennifer S Myers et al. *BMJ Qual Saf* 2022;31:e287-296

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BMJ Quality & Safety

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Find a Process to Improve

- How do you know you have a problem?
 - Review of National Cancer Database
 - Review of patient surveys
 - Delayed time to "events" – surgery, chemotherapy, radiation, biopsies; etc.
 - Missed appointments – social determinant barriers

- What will happen if the problem is not solved?
 - Impacts on recurrence, mortality?
 - Impacts on complications, patient satisfaction, growth, organizational goals

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Organize a Team

- Who has the subject matter knowledge?

- Who else may provide insight?

- What patients/stakeholders need to be included (staff, patients)?

- Who needs to be on the team versus consulted?

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Current State/SMART Goal

- What data or information will clarify the current state?
- What tools or methods could you use to better understand the process?
- Develop a SMART Goal
 - Specific, Measurable, Achievable, Relevant, and Time-bound.
 - We will [improve, increase, decrease] the [number, amount, percent] of [the process] from [baseline measure] to [goal measure] by [date].

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Example: Provider Handoff Communication

- How often do you receive a verbal handoff from a partnering clinic when a patient is transitioning all / some care to your clinical site?
Never, Rarely, Sometimes, Often, Always
- How often do you provide a verbal handoff to a partnering clinic when a patient is transitioning all / some of their care to a different site?
Never, Rarely, Sometimes, Often, Always
- Do you utilize a standardized template for providing verbal handoff when transitioning care between cancer clinic sites?
Y/N
If yes, what is the template?
- Do you feel that you have all the information you need when a patient is transferring care?
Never, Rarely, Sometimes, Often, Always
- Do you know who / how to contact a clinical site to quickly answer questions for a patient that is transferring care?
Never, Rarely, Sometimes, Often, Always
- How would you rate your current level of satisfaction with transitions of care between sites
0-5 scale

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Example: Reduce Time to Diagnostic Mammogram/US

IF completed requested build on 4/28/2019. Changed assessment for aim statement from 7/1/2019 to 8/15/2019.

Month	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Current	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Target	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

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Standard 7.2 Quality Improvement Initiative

Common Stumbling Blocks

- QI initiatives must be data-driven and based on an identified problem known to exist within the accredited program
- A problem statement must be fully developed with baseline data demonstrating a need for improvement
- Interventions implemented to drive improvement must be measurable against the baseline data

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Updates on Quality Improvement Projects

- NAPBC leadership is evaluating a potential national QI project for NAPBC sites for 2025. Ideas include:
 - Genetic testing for individuals with triple negative breast cancer
 - Use of sentinel node surgery in patients >age 70 with cT1 ER positive breast cancer
- NAPBC Sites can do a second PROMPT QI project for 2024 if it is different than the prior year
 - Contact (brp@northshore.org) to get the template

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Thank You

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