STANDARD 1.1
Level of Responsibility and Accountability

The organizational structure of the breast disease program gives the Breast Program Director (BPD) and Breast Program Leadership Committee (BPLC) responsibility and accountability for provided breast disease program services.

DEFINITION AND REQUIREMENTS

Breast Program Director
There must be a single Breast Program Director with authority and accountability for the operation of the program. This individual must be a physician.

Qualifications of the BPD must include:
- Requisite breast disease expertise and documented educational and administrative experience
- Current certification in the specialty by the appropriate board, specialty qualifications that are acceptable to the Review Committee, and current medical licensure and appropriate active medical staff appointment

Breast Program Leadership Committee
The Breast Program Leadership Committee is the governing body of the breast disease program and is chaired by the BPD. There must be a core group of health care professionals from different disciplines who contribute to the diagnostic and treatment decisions for all breast disease patients treated at that center, including pathology, radiology, surgery, medical oncology, radiation oncology, research, nursing, social work, hospital administration, and other members deemed necessary by the BPD.

The BPLC must be comprised of a minimum of three individuals.

Qualifications of the BPLC must include:
- The physician committee members must have current specialty board certification in their area of specialty or be in the process of obtaining board certification within five (5) years of completing training
- The physician committee members must possess current medical licensure and appropriate active medical staff appointment
- The nonphysician committee members must have appropriate qualifications/certifications in their field and hold appropriate breast program relationships and accountability as outlined in the applicable standards
- The committee members must establish and maintain an environment of professional development and scholarship
- The committee members must regularly participate in organized clinical discussions, journal clubs, and conferences

The BPD and the BPLC are responsible for goal setting, as well as planning, initiating, implementing, evaluating, and improving all breast-related activities in the center.

Breast Care Team
The breast center must have a designated Breast Care Team (BCT). The BCT includes any health care professional(s) who contributes to the active assessment, treatment, and dissemination of information to a breast disease program patient, including pathology, radiology, surgery, medical oncology, radiation oncology, cancer registry, physician assistants, radiology technologists, registered
nurses, licensed practical nurses, nurse practitioners, genetic counselors, patient navigators, social workers, and other members deemed necessary by the BPLC.

The BCT members are required to:

- Have appropriate qualifications/certifications/registrations in their field and have a contractual relationship with the breast program or its parent organization that ensures the qualifications of the practitioner, defines the scope of service provided, and sets standards for service and professional performance
- Provide specialty-appropriate patient care management before and after a diagnosis of breast disease has been established
- Collaborate and develop a treatment plan that will lead to the best possible quality outcome for the breast disease patient
- Provide patient care in accordance with institutional policies and in compliance with National Accreditation Program for Breast Centers (NAPBC) Standards
- Attend the multidisciplinary conference in compliance with the NAPBC Standard
- Participate in annual continuing education sessions in compliance with NAPBC requirements

All professionally credentialed members of the BCT must have specialty certification.

All physician team members are required to be board certified or in the process of obtaining board certification within five (5) years of completion of training.

Other Program Personnel
The program must ensure the availability of all necessary administrative personnel for the effective administration of the program. Some examples include, but are not limited to:

- Chief executive office/dean
- Center/hospital administration
- Marketing director
- Administrative assistants
- Data analysts

PROCESS REQUIREMENTS
Breast center or medical staff office process requirements:
The breast center or medical staff formally establishes the responsibility, accountability, and multidisciplinary membership required for the breast program leadership to fulfill its role.

The center documents the BPD’s and the BPLC’s responsibility and accountability using a method appropriate to the center’s organizational structure.

Examples include, but are not limited to:

- The center bylaws designate the BPLC as a subcommittee of the cancer committee within a larger institution with authority defined
- The medical staff bylaws designate the BPLC to be a standing committee with authority defined
- Policies and procedures for the center define authority of the BPD and the BPLC
- Policies and procedures for the medical staff define the authority of the BPD and the BPLC
The breast center must have a defined multidisciplinary Breast Care Team with a minimum of one appointed physician member from each of the following specialties: surgery, pathology, radiology, medical oncology, and radiation oncology.

**BPD process requirements:**
- Be familiar with and comply with NAPBC Survey policies and procedures as outlined in the NAPBC Standards Manual
- Designate an individual to prepare and submit all information required and requested by the NAPBC (including program changes/requests), and ensure that the information submitted is accurate and complete. This information includes, but is not limited to:
  - Program application forms
  - Annual program updates
  - Center name updates/changes
  - Satellite site information
  - Change of Breast Program Director
  - Voluntary withdrawal
  - Deficiency resolution
  - Appeals
- Oversee and monitor the quality of clinical patient care at all sites that provide care, including all participating satellite centers, according to institutional policies and with a frequency sufficient to ensure compliance with the NAPBC Standards
- Ensure the medical staff bylaws, policies, and regulations designate and define the BPLC authority and reporting accountability
- Approve the selection of BCT members as appropriate, and confirm that all professionally credentialed members of the BCT have specialty certification
- Define the policies and procedures for the BCT and other breast program personnel
- Distribute policies and procedures to the BPLC and BCT

**BPLC process requirements:**
- Meet a minimum of four times per year and make all important decisions as requested by the BPD and the breast disease administration
- In conjunction with the BPD, plan, develop, implement, and evaluate all activities of the breast program
- Establish and define the roles of the BCT members
- Review all program data annually
- Address areas of noncompliance with NAPBC Standards
- Monitor and evaluate the multidisciplinary breast disease conference frequency, multidisciplinary and individual participant attendance, and prospective and total case presentation annually (Standard 1.2)
- Identify and reference evidence-based breast care evaluation and management guidelines (Standard 1.3)
- Define and implement the standard of practice (SOP)/policy and procedure for multidisciplinary patient evaluation and management (Standard 2.1)
• Evaluate the rate of breast-conserving surgery in the eligible patients treated at the breast center annually, and comment on whether the rate is appropriate and expected in the community (Standard 2.3)
• Review compliance with Standard 2.4 Sentinel Node Biopsy annually
• Design a surveillance plan using evidence-based guidelines for follow-up surveillance (Standard 2.5)
• Develop a SOP/policy and procedure to monitor physician use of American Joint Committee on Cancer (AJCC) staging in treatment planning for breast disease patients (Standard 2.6)
• Adopt nationally recognized mammography screening guidelines, and advise and educate the medical community affiliated with the breast center on the selected guidelines (Standard 2.8)
• Review compliance with Standard 2.9 Needle Biopsy annually
• Review compliance with Standard 2.12 Radiation Oncology annually
• Review compliance with Standard 2.15 Support and Rehabilitation annually
• Review compliance with Standard 2.18 Reconstructive Surgery annually
• Determine the nationally recognized guidelines that will be used to evaluate and manage patients with benign breast disease at the center (Standard 2.19)
• Develop a SOP/policy and procedure for preparation and dissemination of a comprehensive breast cancer treatment summary and survivorship care plan; compliance is reviewed annually (Standard 2.20)
• Review compliance with Standard 3.2 Clinical Trial Accrual annually
• Determine appropriate intervals to schedule education, prevention, and early detection programs, and define and implement a process for follow-up with patients with positive findings from early-detection programs (Standard 4.1)
• Select annual center-specific studies and set specific quality improvement goals based on study outcomes; compliance is reviewed annually (Standard 6.1)
• Monitor the annual performance rates and develop an action plan for correction of any identifiable performance issues; compliance is reviewed annually (Standard 6.2)

DOCUMENTATION
Complete all required standard fields in the Survey Application Record (SAR).
Upload/describe the organizational structure of the breast center.
Complete and upload the Breast Care Team Worksheet.
Upload BPLC meeting minutes for the last three years.
Upload bylaws or policy and procedures, or other center-approved methods, used to document the level of responsibility and accountability designated to the BPD.
Complete and upload the BPLC annual audit template.

EVALUATION
The surveyor will discuss the organizational structure of the center and review and discuss all required documentation at the time of survey.
RATING COMPLIANCE

Compliance:
1. The organizational structure of the breast center gives the BPD and BPLC responsibility and accountability for provided breast center services.

Noncompliance: The center does not fulfill one or more of the compliance criteria.

RESOURCES
NAPBC Accreditation Resources, [facs.org/quality-programs/napbc/accreditation/resources](http://facs.org/quality-programs/napbc/accreditation/resources)
STANDARD 1.2
Multidisciplinary Breast Care Conference

The Breast Program Leadership Committee (BPLC) establishes, monitors, and evaluates the multidisciplinary breast care conference (MBCC) frequency, Breast Care Team (BCT) attendance, prospective and total annual case presentation, including American Joint Committee on Cancer (AJCC) staging, and discussion of nationally accepted guidelines.

DEFINITION AND REQUIREMENTS
Breast care conferences are integral to improving the care of breast cancer patients by contributing to patient management and outcomes while providing education to physicians and other staff in attendance. Input should be encouraged from all BCT members.

The breast disease program must ensure the multidisciplinary breast care conferences are scheduled to permit attendance on a regular basis. Conferences must include prospective multidisciplinary case evaluation by the BCT.

This comprehensive approach allows the BCT to:

- Promote inclusion of a broad range of physician specialists to address early diagnosis, quality of life, ethics, or other relevant topics
- Improve patient care, promote effective management of resources, and make decisions which reflect the patient's goals for treatment
- Discuss treatment options, including investigational therapy, for breast cancer patients to offer a collaborative recommendation

Monitoring of breast cancer conference activity by the BPLC, including multidisciplinary representation and individual attendance, ensures that conferences provide consultative services for patients as well as offer education to physicians and allied health professionals. The confidentiality of all information disclosed at these conferences is to be maintained by all participants.

Individual BCT members from surgery, medical oncology, and radiation oncology attend at least 50 percent of MBCCs held each calendar year.

For pathology and radiology, BCT member attendance may be calculated by specialty. Each specialty attends at least 50 percent of MBCCs held each calendar year.

Centers with fewer than 100 analytic breast cancer cases per year have the option of including these cases as part of a general cancer conference and are required to meet no less frequently than every two weeks or twice monthly, or more frequently at the discretion of the BPLC. Eighty-five percent (85%) of cases reviewed must be prospective.

Centers with 101 to 250 analytic breast cancer cases per year are required to meet no less frequently than every two weeks or twice monthly, or more frequently at the discretion of the BPLC. Case presentation thresholds are determined by the BPLC.

Centers with more than 250 analytic breast cancer cases per year are required to meet weekly. Case presentation thresholds are determined by the BPLC.

The MBCC is focused on treatment planning for newly diagnosed patients, patients who have treatment decisions to be made, and patients with recurrent breast cancer. It must include the following:
• Representation from surgery, medical oncology, radiation oncology, pathology, and radiology
• Consideration of nationally recognized guidelines at the conference (for example, the National Comprehensive Cancer Network); these guidelines must be available for reference during the conference
• Visual display of pathology slides and radiology imaging and a discussion regarding radiology-pathology correlation
• Discussion regarding clinical trials, genetics risk, and reconstructive options
• A presentation of relevant H&P elements, including family history
• A discussion of stage, risk profile, surgical options/presurgical options
• An open discussion by all conference participants

Prospective case reviews include, but are not limited to:
• Comprehensive clinical summary provided by attending physician or designee
• Imaging and pathology reviews
• Newly diagnosed breast cancer and treatment not yet initiated
• Newly diagnosed breast cancer and treatment initiated, but discussion and additional treatment is needed
• Previously diagnosed, initial treatment completed, but discussion of adjuvant treatment or treatment recurrence or progression is needed
• Consideration for clinical trials
• Previously diagnosed and discussion of supportive or palliative care is needed

PROCESS REQUIREMENTS
The BPLC establishes and monitors the MBCC frequency.

The BPLC establishes and monitors specialty and individual member attendance requirements for the BCT.

The BPLC establishes and monitors a case presentation threshold for the MBCC.

DOCUMENTATION
Complete all required standard fields in the Survey Application Record (SAR).

Upload the breast disease program MBCC policy.

Upload a copy of the MBCC schedule/calendar from the last complete year, prior to the date of survey.

Complete and upload the NAPBC Multidisciplinary Breast Cancer Conference Attendance Tracking form.

EVALUATION
The surveyor will attend a breast cancer conference to observe the multidisciplinary involvement in case presentations at the time of survey.

RATING COMPLIANCE
Compliance:
1. The BPLC establishes, monitors, and evaluates the MBCC frequency, BCT attendance, prospective and total annual case presentation, including AJCC staging, and discussion of nationally accepted guidelines.

Noncompliance: The center does not fulfill one or more of the compliance criteria.
STANDARD 1.3
Evaluation and Management Guidelines

The Breast Program Leadership Committee (BPLC) adopts evidence-based breast disease patient management and treatment guidelines. The guidelines are referenced by the Breast Care Team (BCT) during the multidisciplinary breast cancer conference (MBCC).

DEFINITION AND REQUIREMENTS
Patient management and treatment guidelines promote an organized approach to providing care. National organizations that have developed breast care guidelines include, but are not limited to:

- American Society of Clinical Oncology (ASCO)
- American Society for Radiation Oncology (ASTRO)
- National Comprehensive Cancer Network (NCCN)

Examples of referencing the guidelines include having web access, a PowerPoint presentation, or handouts available during the MBCC.

PROCESS REQUIREMENTS
The BPLC will implement breast disease management and treatment guidelines developed by national organizations appropriate to the patients who are diagnosed and treated by the center. Guidelines adopted by the BPLC are reviewed and documented in the BPLC meeting minutes annually.

The BPLC establishes the concordance rate for adherence to adopted guidelines being used by the center and monitors utilization through review of a random sample of cases for which these guidelines are applicable. The monitoring activity is reported to the BPLC on a regular basis. The BPLC addresses compliance levels that fall below the established concordance rates.

DOCUMENTATION
Complete all required standard fields in the Survey Application Record (SAR).

EVALUATION
The surveyor will review the documentation and ensure that these guidelines are referenced during the MBCC at the time of survey.

RATING COMPLIANCE
Compliance:
1. The BPLC adopts evidence-based breast disease patient management and treatment guidelines.
2. The guidelines are referenced by the BCT during the multidisciplinary MBCC.

Noncompliance: The center does not fulfill one or more of the compliance criteria.
STANDARD 2.1
Multidisciplinary Patient Management

Management of patients with breast disease is conducted by a multidisciplinary team.

DEFINITION AND REQUIREMENTS
The National Accreditation Program for Breast Centers (NAPBC) has identified 17 Breast Center Components, required for accreditation, in the spectrum of breast disease diagnosis, treatment, surveillance, and rehabilitation/support.

PROCESS REQUIREMENTS
The center must provide the 17 NAPBC Breast Center Components either at the center (on-site) or by referral.

The Breast Program Leadership Committee (BPLC) defines and implements the standard of practice (SOP)/policy and procedure for multidisciplinary patient evaluation and management.

DOCUMENTATION
Complete all required standard fields in the Survey Application Record (SAR).

Complete the Breast Center Components section of the NAPBC center portal indicating which services are provided on-site or by referral.

Upload the SOP/policy and procedure for multidisciplinary patient evaluation and management at your center.

EVALUATION
The surveyor will discuss the process for multidisciplinary patient management at the time of survey. Multidisciplinary care will be confirmed during medical record review.

RATING COMPLIANCE
Compliance:
1. The center provides all of the NAPBC breast center components at the center (on-site) or by referral.

2. Patient evaluation and management is conducted by a multidisciplinary team according to the BPLC standard of practice SOP/policy and procedure.

Noncompliance: The center does not fulfill one or more of the compliance criteria.
STANDARD 2.2
Patient Navigation

A patient navigation process is in place to guide the patient with a breast abnormality through provided and referred services.

DEFINITION AND REQUIREMENTS
Patient navigation refers to individualized assistance offered to patients, families, and caregivers to help overcome health care system barriers and facilitate timely access to quality health and psychosocial care throughout the continuum of care.

Breast disease patient navigation can and should take on different forms in different communities as dictated by the needs of the patient, his or her family, and the community.

The patient navigation process includes consistent care coordination throughout the continuum of care and an assessment of the physical, psychological, and social needs of the patient. The anticipated results are enhanced patient outcomes, increased satisfaction, and reduced costs of care. This process may involve different individuals at each point of care.

Examples of patient navigation include, but are not limited to:
- Providing education, support, and coordination to assist patients in securing appointments
- Providing educational resources on breast health, breast cancer, and breast care
- Connecting patients and families to resources and support services
- Promoting communication between the patient and health care providers
- Coordinating services throughout the continuum of care

Benefits of patient navigation include:
- Enhancing the patient’s quality of life, sense of autonomy, and self-determination for managing her own health
- Reinforcing the physician-patient relationship

PROCESS REQUIREMENTS
Patient navigation is provided by a professional (for example, nurse, social worker) who is trained to provide individualized assistance to breast disease patients, families, and caregivers at risk.

If patient navigation is provided by a lay navigator, then he or she is required to have documented patient navigation training from a recognized professional organization.

DOCUMENTATION
Complete all required standard fields in the Survey Application Record (SAR).

Upload certification(s) of patient navigator(s) into the SAR.

Identify the individual(s) who provide patient navigation in the center along with their qualifications and role.

EVALUATION
The surveyor will discuss the patient navigation process and will review the credential(s) and/or documentation of the individual(s) providing patient navigation at the time of survey.

RATING COMPLIANCE
Compliance:
1. The breast center has a patient navigation process to guide patients with a breast abnormality from pre-diagnosis through provided and referred services.

2. Patient navigators are trained professionals or trained lay navigators.

Noncompliance: The center does not fulfill one or more of the compliance criteria.
STANDARD 2.3
Breast Conservation

Breast-conserving surgery is offered to appropriate patients with breast cancer. A target rate of at least 50 percent of all eligible patients diagnosed with early-stage breast cancer (Stage 0, I, II) is treated with breast conserving surgery.

DEFINITION AND REQUIREMENTS
Breast-conserving surgery for patients with early-stage breast cancer is a nationally accepted standard of care in appropriately selected patients.

Patients are generally considered eligible for breast-conserving surgery if the tumor is localized and can be completely removed with negative margins, leaving a cosmetic result that is acceptable to the patient, and if they are candidates for radiation treatment.

PROCESS REQUIREMENTS
Accession List and Data Review Requirements for Survey
The center is required to provide a de-identified accession (case) list of breast cancer cases diagnosed and/or treated at the center (class of case 10–22) prior to the survey date. Class of case is defined in the Facility Oncology Registry Data Standards (FORDS) manual.

Despite strong evidence supporting the safety of breast-conserving surgery for the treatment of early-stage breast cancer, an increasing number of women are opting for mastectomy. There appear to be regional differences in the patient’s preference of operation, making a target rate for breast-conserving surgery difficult to apply across the country. The Breast Program Leadership Committee (BPLC) evaluates the rate of breast-conserving surgery in the eligible patients treated at the breast center annually and comments on whether the rate is appropriate and expected in their community. The BPLC should consider the influences that are driving the decision making and discuss approaches to understanding the driving forces.

Compliance is reviewed annually by the BPLC.

DOCUMENTATION
Complete all required standard fields in the Survey Application Record (SAR).

Document the annual audit by the BPLC in the meeting minutes. Include the calculation and discussion of the breast-conserving surgery rate.

EVALUATION
The surveyor will review a random sample of breast cancer patient medical records during the medical records review portion of the survey to evaluate compliance with the use of breast-conserving surgery.

RATING COMPLIANCE
Compliance:
1. Breast-conserving surgery is offered to appropriate patients with breast cancer as evidenced by the medical records review.

2. A target rate of at least 50 percent of all eligible patients diagnosed with early-stage breast cancer (Stage 0, I, II) is treated with breast-conserving surgery.

3. The breast-conserving surgery rate is evaluated during the annual audit by the BPLC and documented in the meeting minutes.

Noncompliance: The center does not fulfill one or more of the compliance criteria.
RESOURCES
Society of Surgical Oncology (SSO)-American Society for Radiation Oncology (ASTRO) and SSO-ASTRO-American Society of Clinical Oncology (ASCO) Consensus Guidelines on Breast-Conserving Surgery
STANDARD 2.4
Sentinel Node Biopsy

Axillary sentinel lymph node biopsy is considered or performed for patients with early-stage breast cancer (Clinical Stage I, II).

DEFINITION AND REQUIREMENTS
Patients currently considered candidates for axillary sentinel lymph node biopsy include those with:

- American Joint Committee on Cancer (AJCC) Stage I, IIA, and IIB invasive breast cancer with no suspicious axillary lymph nodes
- Resectable, locally advanced, invasive breast cancer, either before or after neoadjuvant systemic therapy
- Extensive ductal carcinoma in situ (DCIS) requiring total mastectomy, no suspicious axillary nodes
- DCIS requiring wide excision in an anatomic location interfering with future, accurate sentinel lymph node mapping, no suspicious axillary nodes
- Unilateral or bilateral prophylactic mastectomy

Some patients who meet the criteria above may be deemed inappropriate for sentinel node biopsy. An example of such a patient might be an elderly, debilitated patient with a clinically negative axilla.

This technique most commonly utilizes a combination of radionuclide and blue dye, although some centers utilize radionuclide or blue dye alone.

The accuracy of sentinel lymph node biopsy may be compromised in patients who have had previous ipsilateral breast-conserving surgery, axillary surgery, or breast radiation therapy.

PROCESS REQUIREMENTS
Accession List and Data Review Requirements for Survey
The center is required to provide a de-identified accession (case) list of breast cancer cases diagnosed and/or treated at the center (class of case 10–14) prior to the survey date. Class of case is defined in the Facility Oncology Registry Data Standards (FORDS) manual.

When sentinel node biopsy is not offered, the medical record should indicate a discussion held amongst the Breast Care Team (BCT).

Patients can decline sentinel node biopsy. The medical record should indicate that this procedure has been offered.

Compliance is reviewed annually by the Breast Program Leadership Committee (BPLC).

DOCUMENTATION
Complete all required standard fields in the Survey Application Record (SAR).

Document the annual audit by the BPLC in the meeting minutes.

EVALUATION
The surveyor will review a random sample of breast cancer patient medical records during the medical records review portion of the survey to evaluate compliance with sentinel lymph node biopsy utilization.
RATING COMPLIANCE

Compliance:
1. Axillary sentinel lymph node biopsy is considered or performed for patients with early-stage breast cancer (Clinical Stage I, II).

2. Compliance is reviewed annually by the BPLC and documented in the meeting minutes.

Noncompliance: The center does not fulfill one or more of the compliance criteria.
STANDARD 2.5
Breast Cancer Surveillance

A plan is in place for ensuring evidence-based guidelines are followed for surveillance of breast cancer patients.

DEFINITION AND REQUIREMENTS
A plan is in place to ensure that patients are returning for follow-up evaluation.

PROCESS REQUIREMENTS
The Breast Program Leadership Committee (BPLC) designs a surveillance plan using evidence-based guidelines for follow-up surveillance, which can be used for most patients.

DOCUMENTATION
Complete all required standard fields in the Survey Application Record (SAR).

Upload/describe the plan designed by the BPLC that defines surveillance by specialty.

Surveillance documentation reflecting follow-up outlined in the center’s surveillance plan is included in patient medical records.

EVALUATION
The surveyor will review and discuss the surveillance documentation during the medical records review portion of the survey.

RATING COMPLIANCE
Compliance:
1. The BPLC designs and implements a surveillance plan using evidence-based guidelines for follow-up surveillance.
2. Surveillance documentation reflecting follow-up outlined in the center’s surveillance plan is included in patient medical records.

Noncompliance: The center does not fulfill one or more of the compliance criteria.

RESOURCES
American Society of Clinical Oncology (ASCO) breast cancer follow-up guidelines
National Comprehensive Cancer Network (NCCN) guidelines
STANDARD 2.6
Breast Cancer Staging

The Breast Program Leadership Committee (BPLC) develops a standard of practice (SOP)/policy and procedure to monitor physician use of American Joint Committee on Cancer (AJCC) staging in treatment planning for breast cancer patients.

DEFINITION AND REQUIREMENTS
Accurate clinical and pathologic staging of breast cancer patients enables the physician to determine appropriate treatment. Staging facilitates the reliable evaluation of treatment results and outcomes reported to various institutions on a local, regional, and national basis. AJCC staging is assigned using the criteria outlined in the current edition of the AJCC Cancer Staging Manual.

The BPLC develops an AJCC staging SOP/policy and procedure for breast cancer patient treatment defining:
- Where stage is recorded
- When staging is performed
- Who performs staging

All staging classifications—and, most importantly, clinical and pathological classifications—should be documented in the medical record.¹

All physician members of the Breast Care Team (BCT) are encouraged to prospectively stage and identify the stage grouping.

PROCESS REQUIREMENTS
Accession List and Data Review Requirements for Survey
The center is required to provide a de-identified accession (case) list of breast cancer cases diagnosed and/or treated at the center (class of case 10–22) prior to the survey date. Class of case is defined in the Facility Oncology Registry Data Standards (FORDS) manual.

The BPLC develops and reviews the use of the AJCC staging SOP/policy and procedure and discusses the results of the review with the BCT.

Compliance is reviewed annually by the BPLC.

DOCUMENTATION
Complete all required standard fields in the Survey Application Record (SAR).

Upload/describe the AJCC staging SOP/policy and procedure for breast cancer patient treatment.

Staging is documented in the patient medical record.

Document the BCT discussion of the staging SOP/policy and procedure review, and the annual audit by the BPLC, in the meeting minutes.

EVALUATION
The surveyor will review the staging SOP/policy and procedure, and a random sample of breast cancer patient medical records during the medical records review portion of the survey, to confirm the use of AJCC staging in treatment planning for breast cancer patients.

RATING COMPLIANCE
**Compliance:**

1. The BPLC develops a SOP/policy and procedure to monitor physician use of AJCC staging in treatment planning for breast cancer patients.

2. The BPLC reviews the use of the AJCC staging SOP/policy and procedure and discusses the results of the review with the BCT.

3. Compliance is reviewed annually by the BPLC and documented in the meeting minutes.

**Noncompliance:** The center does not fulfill one or more of the compliance criteria.

**RESOURCES**
American Joint Committee on Cancer, cancerstaging.org

**REFERENCES**
STANDARD 2.7
Pathology

The College of American Pathologists (CAP) guidelines are followed for all breast cancers, including estrogen and progesterone receptors and Her2 status for all invasive breast cancers. Estrogen receptor status is recommended for ductal carcinoma in situ (DCIS) but not required by CAP. Outside pathology slides are reviewed prior to first course of treatment.

DEFINITION AND REQUIREMENTS
The National Accreditation Program for Breast Centers (NAPBC) requires that all breast cancer pathology reports contain the required (core) data elements outlined on the CAP cancer protocol template.

Estrogen and progesterone receptors and Her2 studies need to be performed on only one specimen (such as the core biopsy or excision specimen).

Imaging studies should be correlated with pathology when feasible.

The NAPBC requires that all breast cancer pathology with the intent of definitive surgical treatment is reported in synoptic format.

If the biopsy is performed at an outside facility, the biopsy pathology slides must be reviewed at the breast center or the affiliated pathology department prior to first course of treatment.

PROCESS REQUIREMENTS
Accession List and Data Review Requirements for Survey
The center is required to provide a de-identified accession (case) list of breast cancer cases diagnosed and/or treated at the center (class of case 10–22) prior to the survey date. Class of case is defined in the Facility Oncology Registry Data Standards (FORDS) manual.

Report all breast cancer pathology in accordance with the CAP guidelines.

Report all breast cancer pathology with the intent of definitive surgical treatment in synoptic format.

Review all outside pathology slides prior to first course of treatment at the center.

DOCUMENTATION
Complete all required standard fields in the Survey Application Record (SAR).

EVALUATION
The surveyor will review a random sample of breast cancer patient medical records during the medical records review portion of the survey to evaluate compliance with pathology reporting.

RATING COMPLIANCE
Compliance:
1. The CAP guidelines are followed for all breast cancers, including estrogen and progesterone receptors and Her2 status for all invasive breast cancers.

2. All breast cancer pathology with the intent of definitive surgical treatment is reported in synoptic format.

3. All outside pathology slides are reviewed prior to first course of treatment.
Noncompliance: The center does not fulfill one or more of the compliance criteria.

RESOURCES
College of American Pathologists, cap.org
STANDARD 2.8
Breast Imaging

The Breast Program Leadership Committee (BPLC) is required to adopt nationally recognized mammography screening guidelines and advise and educate the medical community affiliated with the breast center on the selected guidelines.

DEFINITION AND REQUIREMENTS
Federal law mandates that mammography must be performed at Mammography Quality Standards Act (MQSA)-certified facilities.

Diagnostic mammography is used to evaluate a patient with abnormal clinical findings—such as a breast lump or nipple discharge—that have been found by the woman or her doctor. Diagnostic mammography may also be done after an abnormal screening mammogram in order to evaluate the area of concern on the screening exam.¹

Screening mammography is an exam performed on an asymptomatic woman to detect early, clinically unsuspected breast cancer.

Medical community, for the purposes of this standard, is defined as all providers affiliated with the breast center.

PROCESS REQUIREMENTS
Mammographic Screening
There are several guidelines published suggesting when to start and stop screening mammography and how frequently it should be performed. The BPLC is required to adopt nationally recognized screening mammography guidelines that include:

1. Women of average risk can begin routine, annual screening at age 40 but no later than age 45.
2. Screening under age 40 may occur for women who are at increased risk for breast cancer.
3. The screening schedule should continue as long as the woman is in good health.

The BPLC will advise and educate the medical community affiliated with the breast center on the selected guidelines annually.

Diagnostic Imaging
Centers performing breast magnetic resonance imaging (MRI) must have the capacity to perform all of the following:

- Mammographic correlation
- Directed breast ultrasound
- MRI-guided intervention

If the center does not have the capacity to perform all of the above services, the center must have an established referral relationship with a local facility that can provide these services. The National Accreditation Program for Breast Centers (NAPBC) strongly recommends that the referred facility is accredited by the American College of Radiology (ACR) for breast MRI.

DOCUMENTATION
Complete all required standard fields in the Survey Application Record (SAR).

Mammographic Screening
The BPLC adopts nationally recognized screening mammography guidelines as outlined above.
In the BPLC meeting minutes, document when and how the medical community affiliated with the breast center was advised and educated regarding the selected guidelines. Mechanisms include, but are not limited to, letters, lectures, small group sessions, and newsletters.

**Diagnostic Imaging**  
For breast MRI, provide documentation of Breast Imaging Center of Excellence (BICOE) accreditation or ACR accreditation. If the center refers breast MRI services to a local facility, the surveyor will review the referral relationship.

**EVALUATION**  
The surveyor will review and discuss the required documentation at the time of survey.

**RATING COMPLIANCE**  
**Compliance:**

1. The BPLC adopts nationally recognized mammography screening guidelines.

2. The BPLC has advised and educated the medical community affiliated with the breast center on the adopted mammography screening guidelines annually.

3. Centers performing breast MRI meet one of the following criteria:
   a. BICOE accreditation
   b. ACR accreditation for breast MRI
   c. Has a referral relationship with a local facility to provide all breast MRI services

**Noncompliance:** The center does not fulfill one or more of the compliance criteria.

**RESOURCES**  
- American College of Radiology (ACR) guidelines for mammographic screening, diagnostic imaging, and breast MRI
- American Cancer Society (ACS) guidelines for mammographic screening
- National Comprehensive Cancer Network (NCCN) guidelines for mammographic screening

**REFERENCES**

STANDARD 2.9
Needle Biopsy

Palpation-guided or image-guided needle biopsy is the initial diagnostic approach rather than open biopsy.

DEFINITION AND REQUIREMENTS
Either fine-needle aspiration for cytologic evaluation or core needle biopsy constitutes the initial diagnostic approach for palpable or occult lesions. Open surgical biopsy as an initial approach should be avoided, as it does not allow for treatment planning and is associated with a high reexcision rate. In those instances when open surgical biopsy is used, the reason for its use is documented in the medical record.

PROCESS REQUIREMENTS
Accession List and Data Review Requirements for Survey
The center is required to provide a de-identified accession (case) list of breast cancer cases diagnosed and/or treated at the center (class of case 10–22) prior to the survey date. Class of case is defined in the Facility Oncology Registry Data Standards (FORDS) manual.

When open surgical biopsy is used, the reason for its use is documented in the medical record.

Compliance is reviewed annually by the Breast Program Leadership Committee (BPLC).

DOCUMENTATION
Complete all required standard fields in the Survey Application Record (SAR).

Calculate and record the overall needle biopsy rate for the last year for cancer patients (overall needle biopsy rate is calculated by the number of needle biopsies performed/total number of biopsy of cancer patients).

Document the annual audit by the BPLC in the meeting minutes.

EVALUATION
The surveyor will review a random sample of breast cancer patient medical records during the medical records review portion of the survey to evaluate the utilization of palpation-guided or image-guided needle biopsy and open surgical biopsy.

RATING COMPLIANCE
Compliance:
1. Palpation-guided or image-guided needle biopsy is the initial diagnostic approach rather than open biopsy.

2. When open surgical biopsy is used, the reason for its use is documented in the medical record.

3. Compliance is reviewed annually by the BPLC and documented in the meeting minutes.

Noncompliance: The center does not fulfill one or more of the compliance criteria.
STANDARD 2.10
Ultrasonography

Diagnostic ultrasound and/or ultrasound-guided needle biopsy are performed at an American College of Radiology (ACR) ultrasound-accredited facility or by an American Society of Breast Surgeons (ASBrS) breast ultrasound-certified surgeon.

DEFINITION AND REQUIREMENTS
The National Accreditation Program for Breast Centers (NAPBC) requires radiologists who perform breast ultrasound and/or ultrasound-guided breast biopsy in a hospital setting or breast center setting to provide confirmation that their facility is accredited through the ACR Breast Ultrasound Accreditation Program.

Radiologists in facilities performing breast ultrasound and/or ultrasound-guided breast biopsy need to provide documentation of ACR accreditation or verification of application at the time of survey.

The NAPBC requires surgeons who perform breast diagnostic ultrasound and/or ultrasound-guided breast biopsy in a hospital, breast center, or private practice office to be certified in these procedures through the ASBrS Breast Ultrasound Certification Program. Surgeons performing breast diagnostic ultrasound and/or ultrasound-guided breast biopsy will need to provide documentation of ASBrS certification or verification of application at the time of survey.

An ACR Breast Imaging Centers of Excellence (BICOE) designation will meet requirements for radiology, but not surgeons, unless listed on the ACR application.

PROCESS REQUIREMENTS
The facility where breast ultrasound and/or ultrasound-guided breast biopsy is performed and the radiologists performing the breast ultrasound and/or ultrasound-guided breast biopsy are accredited through the ACR Breast Ultrasound Accreditation Program.

Surgeons performing breast diagnostic ultrasound and/or ultrasound-guided breast biopsy in a hospital, breast center, or private practice office are certified through the ASBrS Breast Ultrasound Certification Program.

DOCUMENTATION
Complete all required standard fields in the Survey Application Record (SAR).

Provide documentation of ACR breast ultrasound accreditation for the facility where breast ultrasound and/or ultrasound-guided breast biopsy is performed and the radiologists performing the breast ultrasound and/or ultrasound-guided breast biopsy.

Provide documentation of ASBrS Breast Ultrasound Certification for surgeons performing breast diagnostic ultrasound and/or ultrasound-guided breast biopsy in a hospital, breast center, or private practice office.

EVALUATION
The surveyor will review documentation confirming accreditation/certification at the time of survey.

RATING COMPLIANCE
Compliance:

1. Diagnostic ultrasound and/or ultrasound-guided needle biopsy are performed at an ACR ultrasound-accredited facility by accredited radiologists.
2. Surgeons performing diagnostic ultrasound and/or ultrasound-guided needle biopsy in hospitals, breast centers, and private practice offices are certified through the ASBrS Breast Ultrasound Certification Program.

**Noncompliance:** The center does not fulfill one or more of the compliance criteria.

**RESOURCES**
American College of Radiology, [acr.org](http://acr.org)

American Society of Breast Surgeons, [breastsurgeons.org](http://breastsurgeons.org)
STANDARD 2.11
Stereotactic Core Needle Biopsy

Stereotactic core needle biopsy is performed at an American College of Radiology (ACR)-accredited facility or by surgeons under the standards and requirements developed by the ACR and the American College of Surgeons (ACoS), or by an American Society of Breast Surgeons (ASBrS) Breast Procedure Program-certified surgeon.

DEFINITION AND REQUIREMENTS
Stereotactic core needle biopsy is most commonly used to diagnose suspicious microcalcifications and is performed with dedicated equipment. It is also used to biopsy masses and/or architectural distortions not visible on ultrasonography.

The physician performing the biopsy communicates a description of the lesion(s) to the pathologist.

The National Accreditation Program for Breast Centers (NAPBC) requires accreditation/certification by the ACR, ACR and ACoS, or ASBrS for the performance of stereotactic core needle biopsy.

The ACR designation of Breast Imaging Center of Excellence (BICOE) will meet requirements for radiology, but not surgeons, unless listed on the ACR application.

PROCESS REQUIREMENTS
Radiology facilities and physicians performing stereotactic core needle biopsy procedures in centers applying for NAPBC accreditation will be required to demonstrate that they are currently accredited/certified by one of the organizations mentioned above.

DOCUMENTATION
Complete all required standard fields in the Survey Application Record (SAR).

Provide documentation of accreditation/certification for radiology facilities and physicians performing stereotactic core needle biopsy.

EVALUATION
The surveyor will review documentation confirming stereotactic breast biopsy accreditation/certification at the time of survey.

RATING COMPLIANCE
Compliance:
1. Radiology facilities and physicians performing stereotactic core needle biopsy are accredited/certified by the ACR, ACR and ACoS, or ASBrS.

Noncompliance: The center does not fulfill one or more of the compliance criteria.

RESOURCES
American College of Radiology, acr.org

American College of Radiology and American College of Surgeons, facs.org/quality-programs/cancer/breast-biopsy

American Society of Breast Surgeons, breastsurgeons.org
STANDARD 2.12
Radiation Oncology

Radiation oncology treatment services are provided by or referred to radiation oncologists who are board certified or in the process of board certification by the American Board of Radiology (ABR). The center is accredited by the American College of Radiology Radiation Oncology Practice Accreditation (ACR-ROPA), the American Society for Radiation Oncology Accreditation Program for Excellence (ASTRO-APEX), the American College of Radiation Oncology (ACRO), or has a quality assurance program in place and the breast cancer quality measure endorsed by the National Quality Forum (NQF) for radiation.

DEFINITION AND REQUIREMENTS
Radiation therapy is a primary component of multimodality treatment, and it is administered by board-certified physicians or physicians in the process of board certification in radiation oncology from the ABR or who have specialty qualifications that are acceptable to the National Accreditation Program for Breast Centers (NAPBC) Standards and Accreditation Committee. Board certification from the ABR should be in therapeutic radiology or radiation oncology. Prior to 1969, the ABR issued certification in radiology, which covered both diagnostic radiology and radiation oncology. These certificates will also be recognized as board certified in radiation oncology.

Quality assurance practices with respect to radiation treatment are followed, as demonstrated by one of the following:
- Accreditation by ACR-ROPA, ASTRO-APEX, or ACRO
- A quality assurance program is in place, and a Radiation Quality Assurance report confirms adherence to the following minimal quality assurance practices:
  - Patient identity is verified by two independent methods prior to each encounter
  - Daily, monthly, and annual radiation treatment machine quality assurance (QA) procedures are performed that comply with the American Association of Physicist in Medicine (AAPM) guidelines (machine-specific QA)
  - There is an independent check of dose calculation for every new or changed treatment prior to starting treatment
  - Patient-specific QA is done prior to initiation of Intensity-Modulated Radiation Therapy (IMRT)

In addition, the NAPBC requires that the following standard of care, endorsed by the NQF related to radiation therapy, is tracked:
- Radiation therapy is administered within one year (365 days) of diagnosis for women under age 70 receiving breast conserving surgery for breast cancer

PROCESS REQUIREMENTS
Accession List and Data Review Requirements for Survey
The center is required to provide a de-identified accession (case) list of breast cancer cases diagnosed and/or treated at the center (class of case 10–22) prior to the survey date. Class of case is defined in the Facility Oncology Registry Data Standards (FORDS) manual.

If radiation oncologists are in the process of board certification by the ABR at the time of survey, certification should be obtained within five (5) years of completion of training. The center must send documentation confirming board certification to the NAPBC administrative office.

If the center has a locally developed quality assurance program in place, a Radiation Quality Assurance report must be submitted, confirming adherence to the minimal quality assurance practices listed above.
Compliance is reviewed annually by the Breast Program Leadership Committee (BPLC).

**DOCUMENTATION**
Complete all required standard fields in the Survey Application Record (SAR).

Provide documentation of board certification for all radiation oncologists on the Breast Care Team (BCT).

Provide documentation of radiation oncology department/facility accreditation by one of the organizations/programs listed above, or the Radiation Quality Assurance report for a locally developed quality assurance program.

Document the annual audit by the BPLC in the meeting minutes.

**EVALUATION**
The surveyor will confirm board certification at the time of survey.

The surveyor will confirm accreditation by one of the organizations/programs listed above or will review the Radiation Quality Assurance report.

The surveyor will review a random sample of breast cancer patient medical records during the medical records review portion of the survey to evaluate compliance with the NQF-endorsed radiation therapy quality measure.

**RATING COMPLIANCE**

**Compliance:**
1. Radiation oncology treatment services are provided by or referred to board-certified radiation oncologists.

2. The radiation oncology department/facility has been accredited by ACR-ROPA, ASTRO-APEX, or ACRO, or a quality assurance program is in place and the breast cancer quality measure is endorsed by the NQF for radiation.

3. The following standard of care, endorsed by the NQF related to radiation therapy, is tracked:
   a. Radiation therapy is administered within one year (365 days) of diagnosis for women under age 70 receiving breast-conserving surgery for breast cancer.

4. Compliance is reviewed annually by the BPLC and documented in the meeting minutes.

**Noncompliance:** The center does not fulfill one or more of the compliance criteria.

**RESOURCES**
American Board of Radiology, [theabr.org](http://theabr.org)

American College of Radiology Radiation Oncology Practice Accreditation, [acr.org/quality-safety/accreditation/ro](http://acr.org/quality-safety/accreditation/ro)

American Society for Radiation Oncology Accreditation Program for Excellence, [astro.org/Accreditation.aspx](http://astro.org/Accreditation.aspx)

American College of Radiation Oncology, [acro.org](http://acro.org)
STANDARD 2.13
Medical Oncology

Medical oncology treatment services are provided by or referred to medical oncologists who are board certified or in the process of board certification.

DEFINITION AND REQUIREMENTS
Medical oncology (systemic therapy) is a primary component of multimodality treatment, and it is administered by board-certified physicians or physicians in the process of board certification in medical oncology by the American Board of Medical Specialists (ABMS) or the American Board of Internal Medicine (ABIM), or who have specialty qualifications that are acceptable to the National Accreditation Program for Breast Centers (NAPBC) Standards and Accreditation Committee. Board certification for medical oncologists took effect in 1970 and is provided by the ABIM. Medical oncologists demonstrating competence and privileged by their facility prior to 1970 will also be recognized as board certified in medical oncology.

In addition, the NAPBC requires that the following standards of care endorsed by the National Quality Forum (NQF) related to medical oncology are tracked:

- Combination chemotherapy is considered or administered within four months (120 days) of diagnosis for women under the age of 70 with AJCC T1c, Stage II, or Stage III hormone-receptor-negative breast cancer
- Tamoxifen or third-generation aromatase inhibitor is considered or administered within one year (365 days) of diagnosis for women with AJCC T1c, Stage II, or Stage III hormone-receptor-positive breast cancer

PROCESS REQUIREMENTS
Accession List and Data Review Requirements for Survey
The center is required to provide a de-identified accession (case) list of breast cancer cases diagnosed and/or treated at the center (class of case 10–22) prior to the survey date. Class of case is defined in the Facility Oncology Registry Data Standards (FORDS) manual.

For those medical oncologists in the process of obtaining board certification from the ABMS or the ABIM, certification should be obtained within five (5) years of completion of training.

DOCUMENTATION
Complete all required standard fields in the Survey Application Record (SAR).

Provide documentation of board certification by the ABMS or the ABIM for all medical oncologists on the breast care team.

EVALUATION
The surveyor will confirm board certification and review a random sample of breast cancer patient medical records to evaluate compliance with the medical oncology NQF quality measures at the time of survey.

RATING COMPLIANCE
Compliance:
1. Medical oncology treatment services are provided by or referred to medical oncologists who are board certified or in the process of board certification.
2. Breast cancer quality measures endorsed by the NQF for medical oncology are tracked.

**Noncompliance:** The center does not fulfill one or more of the compliance criteria.

**RESOURCES**
American Board of Medical Specialists, [abms.org](http://abms.org)

American Board of Internal Medicine, [abim.org](http://abim.org)

National Quality Forum, [qualityforum.org/Home.aspx](http://qualityforum.org/Home.aspx)
Nursing care is provided by nurses with specialized knowledge and skills in diseases of the breast.

DEFINITION AND REQUIREMENTS
The complex needs of cancer patients and their families require specialized oncology nursing knowledge and skills to achieve optimal patient care outcomes. The oncology nurse is an integral member of the multidisciplinary Breast Care Team (BCT).

Qualifications of a nurse with specialized knowledge and skills include:
- Holding one of the following certifications from the Oncology Nursing Certification Corporation (ONCC):
  - Certified Breast Care Nurse (CBCN®)
  - Advanced Oncology Certified Nurse Practitioner (AOCNP®)
  - Advanced Oncology Certified Clinical Nurse Specialist (AOCNS®)
  - Oncology Certified Nurse (OCN®)
  - Advanced Oncology Certified Nurse (AOCN®)
- A nurse with documented knowledge and skills from previous education and experience in the care of women with breast disease

PROCESS REQUIREMENTS
Nursing care is provided by nurses certified in oncology nursing and/or with documented qualifications of specialized knowledge and skills in diseases of the breast.

DOCUMENTATION
Complete all required standard fields in the Survey Application Record (SAR).

EVALUATION
The surveyor will review and discuss the required documentation at the time of survey.

RATING COMPLIANCE
Compliance:
1. Nursing care is provided by nurses with specialized knowledge and skills in diseases of the breast.

Noncompliance: The center does not fulfill one or more of the compliance criteria.

RESOURCES
Oncology Nursing Society (ONS), ons.org

Oncology Nursing Certification Corporation, oncc.org
STANDARD 2.15
Support and Rehabilitation

Support and rehabilitation services are provided or referred.

DEFINITION AND REQUIREMENTS
Comprehensive breast cancer care is multidisciplinary and includes medical health professionals addressing patient needs identified along the breast cancer continuum from diagnosis through survivorship. Supportive services help patients and their families cope with the day-to-day details of a breast cancer diagnosis. These resources address emotional, physical, financial, and other needs of the breast cancer patient. Supportive services address the needs of the majority of patients, as well as provide for special populations or needs.

The supportive services offered on-site will vary depending upon the scope of the facility, local staff expertise, and patient population.

Oncology Social Work Certification (OSW-C)-certified oncology social workers are preferred.

Supportive services not provided on-site are provided through referral to other facilities and/or local agencies.

Supportive services include:
- Lymphedema management and risk reduction practices
- Integrative medicine (for example, yoga, tai chi, exercise)
- Psychosocial distress screening and support
- Nutritional counseling
- Palliative care
- Support groups
- Transportation services
- Other complementary services, such as music/art therapy, relaxation, and massage, used in conjunction with rehabilitation disciplines

PROCESS REQUIREMENTS
An annual report of supportive services is presented to the Breast Program Leadership Committee (BPLC).

Compliance is reviewed annually by the BPLC.

DOCUMENTATION
Complete all required standard fields in the Survey Application Record (SAR).

Document the presentation of the annual supportive services report and annual audit by the BPLC in the meeting minutes.

EVALUATION
The surveyor will discuss the support and rehabilitation services available and the annual report of supportive services presented to the BPLC at the time of survey.

RATING COMPLIANCE
Compliance:
1. Support and rehabilitation services are provided or referred.
2. An annual report of supportive services is presented to the BPLC.

3. Compliance is reviewed annually by the BPLC and documented in the meeting minutes.

**Noncompliance:** The center does not fulfill one or more of the compliance criteria.

**RESOURCES**
National Accreditation Program for Breast Centers (NAPBC) Accreditation Resources, [facs.org/quality-programs/napbc/accreditation/resources](facs.org/quality-programs/napbc/accreditation/resources)

Breast Cancer Advocacy Organizations, [facs.org/quality-programs/napbc/accreditation/resources/patient-resources/organizations](facs.org/quality-programs/napbc/accreditation/resources/patient-resources/organizations)
STANDARD 2.16
Genetic Evaluation and Management

Cancer risk assessment, genetic counseling, and genetic testing services are provided or referred.

DEFINITION AND REQUIREMENTS
Cancer risk assessment and genetic counseling is the process of identifying and counseling individuals at risk for familial or hereditary breast cancer syndromes. An initial cancer risk assessment is generally conducted by treating clinicians, in the form of a basic family history, as an important part of normal patient care. The purpose of genetic counseling is to further educate patients about their risk of developing breast cancers, help them obtain personal meaning from cancer genetic information, and to empower them to make educated and informed decisions about genetic testing, cancer screening, and cancer prevention. Identifying patients at increased risk of developing breast and other cancers due to a family history of breast and other cancers or a known hereditary cancer syndrome can have dramatic effects on early detection and cancer outcomes. For this reason, cancer risk assessment and genetic counseling is rapidly becoming a standard of care for patients with a personal and/or family history of breast cancer.

Breast cancer patients are referred to a cancer genetics professional based on national guidelines (for example, the National Comprehensive Cancer Network [NCCN], the American Society of Clinical Oncology [ASCO], or the American Society of Breast Surgeons [ASBrS]).

Genetic counseling is performed by a cancer genetics professional who has an educational background in genetics and cancer genetics, counseling, and hereditary cancer syndromes and can provide accurate risk assessment and empathetic genetic counseling to cancer patients and their families.

Pre-Test Counseling
- Collect relevant information needed to assess a patient’s personal and family medical history. A three- to four-generation pedigree, including detailed medical information about the patient’s first-, second-, and third-degree relatives should be obtained. Gathering information about both paternal and maternal family history, ancestry/ethnicity, and consanguinity is necessary.
- Evaluate the patient’s cancer risk. One aspect of risk assessment is discussing the absolute risk that the patient will develop a specific type of cancer or cancers based on the family history. The second aspect is the risk that the patient carries a heritable or germline mutation in a cancer susceptibility gene.
- Perform a psychosocial assessment.
- Educate the patient about the suspected hereditary cancer syndrome, if appropriate. The provider should review cancer risks associated with gene mutations, including basic concepts such as genes and inheritance patterns and more advanced concepts of penetrance and variability expressivity and the possibility of genetic heterogeneity.
- Obtain informed consent for genetic testing, if recommended. The purpose of informed consent should include the purpose of the test and who the ideal person is to test, possible test results, likelihood of positive results, technical aspects and accuracy of the test, the possibility of inconclusive test results and how these results affect medical management, economics and insurance considerations, laws protecting against genetic discrimination, utilization of test results, alternatives to genetic testing, and the storage and potential reuse of genetic material.

Post-Test Counseling
Disclosure of the results and posttest counseling should include a discussion of the results, significance and impact of the test results, medical management options, informing other relatives, future contact, and available resources.

PROCESS REQUIREMENTS
Genetic counseling is provided by:

- An American Board of Genetic Counseling (ABGC) board-certified/board-eligible genetic counselor or (in some states) a licensed genetic counselor.
- An American College of Medical Genetics (ACMG) physician board certified in medical genetics.
- A genetics clinical nurse (GCN), an advanced practice nurse in genetics (APNG), or a nurse who is Advanced Genetics Nursing-Board Certified (AGN-BC) credentialed through the American Nurses Credential Center (ANCC). credentialing is obtained through successful completion of a professional portfolio review process.
- An advanced practice oncology nurse (APON) who is prepared at the graduate level (master’s or doctorate) with specialized education in cancer genetics and hereditary cancer predisposition syndromes; certification by the Oncology Nursing Certification Corporation (ONCC) as AOCNP or AOCNS is preferred.
- A board-certified/board-eligible physician or other trained health care professional with expertise and experience in cancer genetics (defined as providing cancer risk assessment on a regular basis) employing a model that includes both pretest and posttest counseling.
  - Patients identified to have a variant of uncertain significance (VUS) on a hereditary cancer panel and tested by one of the above providers listed in this specific bullet point need to be referred to a genetics professional for assistance with interpretation for the patient and the patient’s family.

Specialized training in cancer genetics should be ongoing and documented with Continuing Medical Education (CME) Credit/Continuing Education Units (CEU) in the fields of cancer genetics. Two CME Credits/0.2 CEUs should be obtained annually, ideally with one related to breast cancer susceptibility gene (BRCA)1/2 and one related to genes other than BRCA1/2 that cause hereditary breast cancer.

Educational seminars should include the spectrum of services for breast cancer genetics, including genetic risk assessment, genetic counseling, indications and decision-making regarding genetic testing, and appropriate posttest counseling. Education limited to learning how to order a genetic test is not considered adequate training for risk assessment and genetic counseling.

Centers that are geographically challenged or do not have access to a board-certified or licensed genetic counselor may utilize the services of a nationwide network of genetic experts available by telephone to provide consultation and guidance.

DOCUMENTATION
Complete all required standard fields in the Survey Application Record (SAR).

Provide certification/credentialing for the cancer genetics professional(s) performing genetic counseling.

Provide documentation on annual CME Credits/CEUs obtained by cancer genetics professional(s) performing genetic counseling.

EVALUATION
The surveyor will confirm that cancer risk assessment, genetic counseling, and genetic testing services are provided or referred based on national guidelines at the time of survey.
The surveyor will confirm the certification/credentialing of the cancer genetics professional(s) at the time of survey.

The surveyor will review the annual CME Credits/CEUs obtained by cancer genetics professional(s) at the time of survey.

RATING COMPLIANCE

Compliance:
1. Cancer risk assessment, genetic counseling, and genetic testing services are provided or referred.

2. Breast cancer patients are referred to a cancer genetics professional based on national guidelines (for example, NCCN, ASCO, ASBrS).

3. Genetic counseling is performed by certified/credentialed cancer genetics professional(s) or a board-certified/board-eligible physician or other trained health care professional with expertise and experience in cancer genetics.

4. Cancer genetics professional(s) obtain two CME Credits/0.2 CEUs (ideally with one related to BRCA1/2 and one related to genes other than BRCA1/2 that cause hereditary breast cancer) annually.

Noncompliance: The center does not fulfill one or more of the compliance criteria.

RESOURCES
American Board of Genetic Counseling, abgc.net
American Board of Medical Genetics, abmg.org
American College of Medical Genetics, acmg.net
American Nurses Credentialing Center, nursecredentialing.org
American Society of Human Genetics, ashg.org
City of Hope Cancer Genetics Career Development Program, cityofhope.org
International Society of Nurses in Genetics, isong.org
National Society of Genetic Counselors, nsgc.org
Oncology Nursing Certification Corporation, oncc.org
Oncology Nursing Society, ons.org

Guidelines and recommendations for cancer risk assessment and genetic counseling for hereditary breast cancer syndromes:
Agency for Healthcare Research and Quality, ahrq.gov
American Society of Breast Surgeons' Consensus Statement, breastsurgeons.org
American Society of Clinical Oncology-Cancer Genetics Practice Guidelines, asco.com
National Comprehensive Cancer Network, nccn.org
STANDARD 2.17
Educational Resources

Culturally appropriate educational resources are available for patients along with a process to provide them. The materials provided are reviewed on an annual basis and adjusted for the patient population.

DEFINITION AND REQUIREMENTS
Centers provide patients with educational information covering the entire spectrum of evaluation and management of breast disease.

Centers with culturally diverse populations must provide educational resources in various languages.

Centers are required to provide information and resources to women who are diagnosed with Stage IV breast cancer.

Centers are required to provide information about fertility options for women of childbearing age who are diagnosed with breast cancer.

PROCESS REQUIREMENTS
Educational resources are reviewed and revised on an annual basis and adjusted based on the patient population.

Educational materials can be provided in print or as audiovisual aides and can be given directly to the patient or made available in a patient education library at the center.

DOCUMENTATION
Complete all required standard fields in the Survey Application Record (SAR).

Describe the processes for providing educational resources to patients.

Provide samples of required educational materials.

EVALUATION
The surveyor will review samples of educational resources and the process to provide the resources to patients at the time of survey.

RATING COMPLIANCE
Compliance:
1. Culturally appropriate educational resources are available for patients along with a process to provide them.

2. Educational resources/materials are provided to women diagnosed with Stage IV breast cancer.

3. Educational resources/materials on fertility options are provided to women of childbearing age who are diagnosed with breast cancer.

Noncompliance: The center does not fulfill one or more of the compliance criteria.

RESOURCES
STANDARD 2.18
Reconstructive Surgery

All appropriate patients undergoing mastectomy are offered a preoperative referral to a reconstructive/plastic surgeon. Reconstructive surgery is provided by or referred to reconstructive/plastic surgeons who are board certified or in the process of board certification.

DEFINITION AND REQUIREMENTS
As part of an informed decision-making process, every effort should be made to ensure patients undergoing mastectomy are offered a preoperative discussion with a reconstructive/plastic surgeon who is board certified or in the process of board certification by the American Board of Plastic Surgery (ABPS). Board certification should be obtained within five (5) years of completion of training.

The Breast Program Leadership Committee (BPLC) is required to evaluate and report the referral offer compliance rate annually for all appropriate referral candidates.

The type of breast reconstructive surgery is dependent on the nature of the defect and the overall health of the patient. While there is an increasing trend in immediate breast reconstruction utilizing tissue expanders, implants, or autologous tissue transfer, patients should be made aware of all of their options, including delayed reconstruction. Patients need to be aware that breast reconstruction does not interfere with surveillance or detection of local recurrence. Consideration needs to be given to the timing of reconstruction with respect to systemic adjuvant chemotherapy or radiation therapy.

The American Society of Plastic Surgeons (ASPS) developed a quality improvement program, Tracking Operations and Outcomes for Plastic Surgeons (TOPS). This program is designed to provide plastic surgeons with a mechanism to submit clinical and demographic information into multiple, confidential databases, minimize redundant data entry, and provide clinical/practice information to plastic surgeons and their specialty to measure outcomes.

PROCESS REQUIREMENTS
Accession List and Data Review Requirements for Survey
The center is required to provide a de-identified accession (case) list of breast cancer cases diagnosed and/or treated at the center (class of case 10–22) prior to the survey date. Class of case is defined in the Facility Oncology Registry Data Standards (FORDS) manual.

Breast reconstruction referrals are documented in the patient medical record. If the patient is deemed inappropriate and/or the patient declines the referral offer, it must be documented in the patient medical record.

Reconstructive surgery is provided by or referred to reconstructive/plastic surgeons who are board certified or in the process of board certification.

The BPLC evaluates and reports the referral offer compliance rate annually for all appropriate referral candidates.

Compliance is reviewed annually by the BPLC.

DOCUMENTATION
Complete all required standard fields in the Survey Application Record (SAR).

Provide documentation of board certification for all reconstructive/plastic surgeons on the Breast Care Team (BCT).
Document the annual referral offer compliance rate and annual audit by the BPLC in the meeting minutes.

EVALUATION
The surveyor will review board certification, annual compliance audit, and a random sample of breast cancer patient medical records during the medical records review portion of the survey to evaluate compliance.

RATING COMPLIANCE
Compliance:
1. All appropriate patients undergoing mastectomy are offered a preoperative referral to a reconstructive/plastic surgeon, and the referral is documented in the patient medical record.

2. Reconstructive surgery is provided by or referred to reconstructive surgeons who are board certified or in the process of board certification.

3. Compliance is reviewed annually by the BPLC and documented in the meeting minutes.

Noncompliance: The center does not fulfill one or more of the compliance criteria.

RESOURCES
American Board of Plastic Surgery, abplsurg.org
American Society of Plastic Surgeons, plasticsurgery.org
Tracking Operations and Outcomes for Plastic Surgeons, plasticsurgery.org
STANDARD 2.19
Evaluation and Management of Benign Breast Disease

Evaluation and management of benign breast disease follows nationally recognized guidelines.

DEFINITION AND REQUIREMENTS
Benign breast disease is defined as breast findings found on clinical breast examination deemed nonsuspicious by the examiner and/or a Breast Imaging Reporting and Data System (BI-RADS) category 1 or 2 on breast imaging.

If the mass is cystic and tender, needle aspiration may be done at the time or deferred until breast imaging is done. If ultrasound is available to the initial examining physician, confirmation of the cyst and complete aspiration with ultrasound guidance is preferred. Palpation-guided cyst aspiration is acceptable. The mass should completely resolve and follow-up options should be discussed. The fluid, if benign in appearance, should be discarded. Incomplete resolutions of the mass and/or bloody fluid are indications for further workup.

A clinically benign but solid mass requires additional evaluation. Mammography and ultrasound, unless recently performed, should be done to confirm the solid but benign characteristics of the palpable mass. Office-based fine-needle aspiration or core needle biopsy can be palpation and/or ultrasound guided. Ultrasound-guided needle biopsy would be expected in a radiology department setting. If a benign diagnosis, without atypia, is confirmed, the patient may be observed or excisional biopsy performed, depending on circumstances and patient/physician preferences.

Occult, asymptomatic cysts found with mammography/ultrasound require no intervention but thorough discussion with the patient. BI-RADS 3 findings are usually managed with a three to six month imaging follow-up and clinical breast exam. This rule applies to both benign masses and micro calcifications.

PROCESS REQUIREMENTS
Accession List and Data Review Requirements for Survey
The center is required to provide a de-identified accession (case) list of breast cancer cases diagnosed and/or treated at the center (class of case 10–22) prior to the survey date. Class of case is defined in the Facility Oncology Registry Data Standards (FORDS) manual.

The Breast Program Leadership Committee (BPLC) determines the nationally recognized guidelines that will be used to evaluate and manage patients with benign breast disease at the center.

Appropriate evaluation and management of benign breast disease is documented in the medical record.

DOCUMENTATION
Complete all required standard fields in the Survey Application Record (SAR).

Upload/describe your center's process for identification, evaluation, and management of patients with benign breast disease.

EVALUATION
The surveyor will review a random sample of breast patient medical records during the medical records review portion of the survey to evaluate adherence to national guidelines for the evaluation and management of benign breast disease.
RATING COMPLIANCE
Compliance:
  1. Evaluation and management of benign breast disease follows nationally recognized guidelines.

Noncompliance: The center does not fulfill one or more of the compliance criteria.

RESOURCES
National Comprehensive Cancer Network (NCCN), nccn.org
STANDARD 2.20
Breast Cancer Survivorship Care

A comprehensive process to prepare and disseminate a breast cancer survivorship care plan, with accompanying treatment summary, to all eligible patients within six (6) months of completing active treatment and no longer than one year (365 days) from date of diagnosis is developed and implemented.

DEFINITION AND REQUIREMENTS
The Institute of Medicine (IOM) report From Cancer Patient to Cancer Survivor outlines the importance of providing cancer survivors with a comprehensive treatment summary and follow-up plan (in other words, a survivorship care plan) that addresses follow-up care to improve health and quality of life. This document serves as a communication and education tool that survivors can provide to all of their health care providers of various disciplines.

The Survivorship Care Plan (SCP) is the record of a patient’s breast cancer history, what transpired during active treatment, current continued long-term treatment (in other words, hormonal and targeted therapy), recommendations for follow-up care and surveillance testing/examination, referrals for support services the patient may need going forward, and other information pertinent to the survivor’s short- and long-term survivorship care. It is to stipulate specifically what surveillance is to be performed, at what frequency, by whom, and when.

The American Society of Clinical Oncology (ASCO) has defined the minimum data elements to be included in a treatment summary and SCP. This core set of data elements and templates is available on the ASCO website. At a minimum, all SCPs must include ASCO’s recommended elements to meet compliance for this standard.

An eligible patient, for the purposes of this standard, is defined as a patient who completes initial active treatment (surgery, chemotherapy, and/or radiation therapy).

Ineligible Patients and Timeline Extension
- Patients diagnosed with Stage IV breast cancer are not required to have a SCP, as they are assumed to be under continuous treatment. However, consideration should be given to providing these patients with ongoing treatment summaries for their use and to be shared with their primary care physician (PCP), including a listing of common potential late effects and their possible timing.
- The one-year-from-diagnosis requirement to provide a SCP is extended to 18 months for patients receiving hormonal and targeted therapy.

PROCESS REQUIREMENTS
Accession List and Data Review Requirements for Survey
The center is required to provide a de-identified accession (case) list of breast cancer cases diagnosed and/or treated at the center (class of case 10–22) prior to the survey date. Class of case is defined in the Facility Oncology Registry Data Standards (FORDS) manual.

Breast centers must develop and implement processes to monitor the preparation and dissemination of a SCP for all eligible patients.
A SCP is manually or electronically prepared by the health care provider(s) who coordinate the oncology treatment for the patient with input from the patient’s other care providers. Providers who are part of the patient’s care team and appropriate under this standard to deliver the SCP:
- Physicians
- Registered nurses
- Advanced practitioner nurses
- Nurse practitioners
- Credentialed clinical navigators (does not include lay navigators)

If two different facilities are providing treatment, both facilities should work together to collaborate on providing a completed SCP. The facility providing follow-up and monitoring of the patient (medical oncology) should provide the SCP. In all cases, facilities should work together to provide the information necessary for completion of a SCP containing all required elements.

The SCP is given to and discussed with the patient within six (6) months of completing active treatment and no longer than one year (365 days) from date of diagnosis. Survivors are to be provided with multiple copies of their SCP to allow them to share it with additional care providers and retain a master copy of this living document for their records. Providing the SCP without discussion with the patient does not meet the standard.

This SCP is given to all providers involved in the survivor’s care, including the PCP and/or gynecologist and other cancer-related and non-cancer-related practitioners. The SCP includes a list of providers with whom the SCP has been shared.

Implementation of the standard and required percentage of SCPs provided must follow the schedule as outlined:
- End of 2016: Provide SCPs to ≥ 25 percent of eligible patients who have completed treatment
- End of 2017: Provide SCPs to ≥ 25 percent of eligible patients who have completed treatment
- End of 2018 and on: Provide SCPs to ≥ 25 percent of eligible patients who have completed treatment

To calculate the percentage of eligible patients, it is recommended that you begin with your number of analytic cases as the denominator and then subtract ineligible patients.

DOCUMENTATION
Complete all required standard fields in the Survey Application Record (SAR).

Provide the standard of practice (SOP)/policy and procedure for preparation and dissemination of a comprehensive breast cancer treatment summary and SCP. The documented process must include at minimum:
- Defined patient eligibility
- Identify appropriate mechanism(s) for generating the SCP
- Identify appropriate individual(s) for delivering the SCP
- The method and timing of delivery of the SCP
- Tracking and reporting the number of SCP’s provided to eligible patients

Provide a sample treatment summary and SCP.

Document the annual audit by the Breast Program Leadership Committee (BPLC) in the meeting minutes.
EVALUATION
The surveyor will review the number of SCPs provided during the medical records review portion of the survey. The surveyor will also review and discuss the SCP and the implemented survivorship care process, as well as confirm the annual audit by the BPLC.

RATING COMPLIANCE
Compliance:
1. A comprehensive process to prepare and disseminate a breast cancer survivorship care plan, with accompanying treatment summary, to all eligible patients within six (6) months of completing active treatment and no longer than one year (365 days) from date of diagnosis is developed and implemented.

2. Compliance is reviewed annually by the BPLC and documented in the meeting minutes.

Noncompliance: The center does not fulfill one or more of the compliance criteria.

RESOURCES
Patient Eligibility: The decision matrix below displays eligibility by treatment scenario and is intended to be a companion tool for use with National Accreditation Program for Breast Centers (NAPBC) Standard 2.20. The scenarios listed are not intended to be an exhaustive or definitive list.

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American Cancer Society (ACS) SCP

American Society of Clinical Oncology Cancer Treatment and SCP
STANDARD 3.1
Clinical Trial Information

Information about the availability of breast cancer-related clinical trials is provided to patients through a formal mechanism.

DEFINITION AND REQUIREMENTS
By providing information about the availability of breast cancer-related clinical trials, the facility offers patients the opportunity to participate in the advancement of evidence-based medicine.

PROCESS REQUIREMENTS
A formal process is in place for providing information about breast cancer-related clinical trials and other clinical research.

Methods of providing information include, but are not limited to:
- Access to the Internet or Intranet search services through the patient library
- Articles in facility newsletters
- Pamphlets or brochures in patient waiting rooms or patient packets
- Physician/nurse education

DOCUMENTATION
Complete all required standard fields in the Survey Application Record (SAR).

Upload/describe the process and formal mechanism in place to provide information to patients about breast cancer-related clinical trials and other clinical research.

EVALUATION
The surveyor will review the breast cancer-related clinical trial information provided to patients and discuss the process to provide the information at the time of survey.

RATING COMPLIANCE
Compliance:
1. A process and formal mechanism is in place to provide information to patients about breast cancer-related clinical trials.

Noncompliance: The center does not fulfill one or more of the compliance criteria.

RESOURCES
Coalition of Cancer Cooperative Groups, cancertrialshelp.org
National Cancer Institute, cancer.gov/clinicaltrials
STANDARD 3.2
Clinical Trial Accrual

Two percent or more of all eligible breast cancer patients are accrued to treatment-related breast cancer clinical trials and/or research protocols annually.

DEFINITION AND REQUIREMENTS
Clinical research advances science and ensures that patient care approaches the highest possible level of quality. The center must demonstrate that efforts to enroll eligible patients in clinical trials are being made and that the center meets or exceeds the two percent annual accrual rate. In an effort to increase participation in clinical trials, the National Accreditation Program for Breast Centers (NAPBC) recommends inviting the clinical trials nurse and/or other research leaders to the multidisciplinary breast cancer conference (MBCC).

Eligible patients are those patients:
- Seen at the center for diagnosis and/or treatment and placed on a clinical trial through the facility
- Seen at the center for diagnosis and/or treatment and placed on a trial through the office of a staff physician
- Seen at the center for diagnosis and/or treatment and placed on a trial through another facility
- Seen at the center for any reason and placed on a prevention or breast cancer control trial

Basic science, clinical, and prevention and control research is generally conducted in cancer centers supported by grants from the National Cancer Institute (NCI) or in academic health centers. Research in community hospitals typically involves therapeutic and nontherapeutic trials.

Treatment-related clinical trial groups include, but are not limited to:
- NCI-sponsored programs such as the Community Clinical Oncology Program (CCOP)
- Cooperative trial groups such as the Alliance for Clinical Trials in Oncology
- University-related research
- Pharmaceutical company-sponsored research
- Locally developed, peer-reviewed studies

In addition to well-established clinical trials, research conducted at the local level offers patients the opportunity to contribute to treatment, prevention, diagnostic, screening, and quality-of-life trials.

Local breast cancer research studies include, but are not limited to:
- Primary prevention
- Early detection
- Quality-of-life evaluation and recommendations
- Symptom management
- Economics of care
- Diagnostic and screening trials
- Psychosocial interventions
- Prospective cohort studies (registry)

PROCESS REQUIREMENTS
Centers must accrue eligible patients to breast cancer-related clinical research at the minimum percentage rate of two percent annually.
Centers participating in clinical research show that an independent review mechanism consistent with national standards is in place and used. Research projects involving participation by human subjects must be approved by an internal or external institutional review board (IRB). Patients participating in clinical trials must give their informed consent.

A study coordinator, data manager, or other clinical research professional is available to assist in enrolling patients, monitoring patient accrual, and identifying and providing information/education about new trials.

Patient accrual and compliance is reviewed annually by the Breast Program Leadership Committee (BPLC).

**DOCUMENTATION**
Complete all required standard fields in the Survey Application Record (SAR).

Document the center’s accrual rate and annual audit by the BPLC in the meeting minutes.

**EVALUATION**
The surveyor will review and discuss the clinical trials program and accrual rate at the time of survey.

**RATING COMPLIANCE**
Compliance:
1. Two percent or more of all eligible breast cancer patients are accrued to treatment-related breast cancer clinical trials and/or research protocols annually.
2. Compliance is reviewed annually by the BPLC and documented in the meeting minutes.

**Noncompliance:** The center does not fulfill one or more of the compliance criteria.

**RESOURCES**
ClinicalTrials.gov, clinicaltrials.gov
National Cancer Institute, cancer.gov/clinicaltrials
STANDARD 4.1
Education, Prevention, and Early Detection Programs

Each year, two or more breast disease education, prevention, and/or early detection programs are provided or coordinated with other facilities or local agencies targeted to the community. For early detection programs, follow-up is provided to patients with positive findings.

DEFINITION AND REQUIREMENTS
Education and prevention programs identify risk factors and use strategies to modify attitudes and behaviors to reduce the chance of developing breast cancer. Early detection programs apply screening guidelines to detect cancers at an early stage, which improves the likelihood of increased survival and decreased morbidity.

Education, prevention, and early detection programs are provided or coordinated with other facilities and/or local agencies (for example, the American Cancer Society) at scheduled intervals as defined by the Breast Program Leadership Committee (BPLC).

Education, prevention, and/or early detection programs include, but are not limited to:
- Risk reduction through lifestyle modification or chemoprevention
- Breast cancer awareness
- Breast care education
- Genetic counseling to high-risk population
- Screening mammography and clinical examination

PROCESS REQUIREMENTS
Each year, the center offers two or more education, prevention, and/or early detection programs, on-site or coordinated with other facilities and/or local agencies (for example, the American Cancer Society), at scheduled intervals as defined by the BPLC.

The BPLC defines and implements a process for follow-up with patients with positive findings from early detection programs.

DOCUMENTATION
Complete all required standard fields in the Survey Application Record (SAR).

Upload/describe the process used to follow up with patients found to have positive findings as a result of participation in breast cancer education, prevention, and/or early detection programs.

EVALUATION
The surveyor will review and discuss the annual breast disease education, prevention, and/or early detection programs, and the process for follow-up, at the time of survey.

RATING COMPLIANCE
Compliance:
1. Each year, two or more breast disease education, prevention, and/or early detection programs are provided or coordinated with other facilities or local agencies targeted to the community.
2. For early detection programs, follow-up is provided to patients with positive findings.

Noncompliance: The center does not fulfill one or more of the compliance criteria.
STANDARD 5.1
Breast Care Team Education

Members of the Breast Care Team (BCT) participate in a minimum of two local, state, regional, or national breast-specific Continuing Medical Education (CME) (or equivalent) educational activities annually.

DEFINITION AND REQUIREMENTS
Educational activities ensure that members of the breast care team possess current knowledge of breast cancer prevention, early detection, diagnosis, treatment, and follow-up care. Members of the BCT participate in a minimum of two local, state, regional, or national breast-specific CME or equivalent educational activities annually.

Breast disease-related CME (or equivalent) educational activities include, but are not limited to:
- A lecture
- A local, state, regional, or national meeting/conference/workshop (attendance at two independent breast disease-related educational sessions, each supported by CME or equivalent, during one convened conference will meet compliance with this standard)
- A web conference
- Journal CME or equivalent
- Online education

Industry-sponsored educational programs that promote specific products or therapy are not acceptable for meeting this standard.

CME Credit offered for attendance at the multidisciplinary breast cancer conference (Standard 1.2) does not count toward meeting this standard.

PROCESS REQUIREMENTS
Physician members of the BCT participate in a minimum of two breast-specific CME activities annually. Documentation of CME activities is required.

Non-physician members of the BCT participate in a minimum of two breast-specific Continuing Education (CE) (or equivalent) activities, appropriate to the discipline, annually. Documentation of CE (or equivalent) activities is required.

DOCUMENTATION
Complete all required standard fields in the Survey Application Record (SAR).

Complete and upload the BCT educational activity tracking template.

EVALUATION
The surveyor will review and discuss the BCT educational activities at the time of survey.

RATING COMPLIANCE
Compliance:
1. Members of the BCT participate in a minimum of two local, state, regional, or national breast-specific CME (or equivalent) educational activities annually.

Noncompliance: The center does not fulfill one or more of the compliance criteria.

RESOURCES
Continuing Medical Education for physicians is regulated by the Accreditation Council for Continuing Medical Education (ACCME) and the American Osteopathic Association (AOA).
STANDARD 6.1
Quality and Outcomes

Each year the breast center conducts or participates in three (3) or more center-specific studies that measure quality and/or outcomes, or the breast center participates in two (2) or more center-specific studies and one (1) or more of the center’s physician members participate in their specialty-specific quality improvement program. The findings are communicated and discussed with the members of the multidisciplinary Breast Care Team (BCT) and other breast center staff.

DEFINITION AND REQUIREMENTS
The annual evaluation of services and care provides specific information to measure quality and an opportunity to correct deficiencies and enhance patient outcomes. These studies of quality may include structure, process, and outcome variables and are selected by the Breast Program Leadership Committee (BPLC).

Study topics must be selected based on a problematic quality-related issue relevant to the breast center and local patient population and used as a means to identify a potential issue or understand why a problem is occurring. Quality studies can evaluate various spectrums of patient care, including diagnosis, treatment, and supportive care. Within that spectrum can be issues related to structure, process, and outcomes.

Each quality study is required to have the following components, at a minimum:

- Indicate the study topic that identifies a problematic quality-related issue within the cancer program
- Define study methodology and the criteria for evaluation, including data needed to evaluate the study topic or answer the quality-related question
- Conduct the study according to the identified measures and methodology
- Prepare a summary of the study findings
- Compare data results with national benchmarks or guidelines
- Design a corrective action plan based on evaluation of the data
- Establish follow-up steps to monitor the actions implemented

PROCESS REQUIREMENTS
Each year the breast center conducts or participates in three (3) or more center-specific studies that measure quality and/or outcomes, or the center participates in two (2) or more center-specific studies and one (1) or more of the center’s physician members participate in their specialty-specific quality improvement program.

A summary of the analysis of data and outcome of each study is discussed with the members of the BCT and other breast center staff.

The BPLC sets specific quality improvement goals for the center based on the quality studies. The goals and processes to implement changes in program activities are documented and discussed with the BCT.

Compliance is reviewed annually by the BPLC.

Note the following standard specifications:

- The BPLC is required to conduct the annual audit within the 12-month date range. It is not required that studies be completed within the 12-month period, but they must be reviewed.
- Quality studies that duplicate topics or studies from year to year do not fulfill this standard.
Quality improvement study designs and research cannot be counted/allocated to subsequent triennial accreditation cycles. Review of data presented in the National Cancer Database (NCDB) data reports or tools (including measure compliance) do not fulfill the requirement for this standard.

**DOCUMENTATION**
Complete all required standard fields in the Survey Application Record (SAR).

Complete the template documenting the types of studies conducted and the methods utilized to communicate the study results, goals, and processes to implement changes in program activities with the BCT.

Provide documentation of participation in a national quality improvement initiative related to breast care and the methods utilized to communicate the study results, goals, and processes to implement changes in program activities with the BCT.

Document the annual audit by the BPLC in the meeting minutes.

**EVALUATION**
The surveyor will review and discuss the quality studies and required documentation at the time of survey.

**RATING COMPLIANCE**
Compliance:
1. Each year the breast center conducts or participates in three (3) or more center-specific studies that measure quality and/or outcomes, or the breast center participates in two (2) or more center-specific studies and one (1) or more of the center’s physician members participate in their specialty-specific quality improvement program.

2. A summary of the analysis of data and outcome of each study is discussed with the members of the BCT and other breast center staff.

3. The BPLC sets specific quality improvement goals for the center based on the quality studies. The goals and processes to implement changes in program activities are documented and discussed with the BCT.

Noncompliance: The center does not fulfill one or more of the compliance criteria.

**RESOURCES**
Specialty-specific quality improvement programs:
- [The American Society of Breast Surgeons Mastery of Breast Surgery℠ Program](https://www.asbs.org/mastery)
- [ASCO’s Quality Oncology Practice Initiative (QOPI®)](https://www.asco.org/qopi)
- [ASPS Tracking Operations and Outcomes for Plastic Surgeons (TOPS)](https://www.asps.org/tops)