National Accreditation Program for Breast Centers
American College of Surgeons

Frequently Asked Questions

Optimal Resources for Breast Care (2024 Standards)

FAQs Addressed

General Questions

Are NAPBC-accredited programs required to be fully compliant with the 2024 Standards by January 1, 2024?
Beginning January 1, 2024, all NAPBC-accredited programs must begin implementing the accreditation requirements outlined in *Optimal Resources for Breast Care (2024 Standards)*, and must begin documenting the program's compliance with the 2024 Standards.

The development and implementation of the **protocols** required by the 2024 Standards may continue throughout 2024, however NAPBC-accredited programs are expected to complete compliance implementation at the earliest opportunity, and must complete implementation no later than **December 31, 2024,** unless otherwise noted. Programs must maintain detailed Breast Program Leadership Committee (BPLC) meeting minutes as they progress throughout implementation, including barriers to compliance with specific protocols.

Compliance against the new standards will first be evaluated during NAPBC Site Visits starting in January 2025.

Will templates be provided for tracking standards compliance?
Yes. The NAPBC templates for the 2024 standards are now available in the "Resources" section of the Quality Portal. Templates for all CoC/NAPBC aligned standards have been co-branded and may be used and submitted for both CoC and NAPBC Site Visits.

NAPBC-specific templates:

- NAPBC Breast Program Leadership Committee Template
- NAPBC Breast Care Team Template
- NAPBC MBCC Template
- NAPBC Physician Assistant Education Template
- NAPBC Education, Prevention, and Early Detection Program Template
- NAPBC Continuing Education Template

Co-branded templates:

- CoC-NAPBC Physician Certification Credentials Template
- CoC-NAPBC Oncology Nursing Credentials Template
- CoC-NAPBC Quality Improvement Initiative Template
- CoC-NAPBC Clinical Research Template

Site visits occurring in 2025 will only review one year of compliance data, correct?
Yes. Site visits conducted under the 2024 Standards will begin in 2025, and will only review compliance data for calendar year 2024 – the only year for which the new standards have been in effect. Starting in 2025, compliance with the 2018 Standards will no longer be evaluated, and calendar years during which the 2018 Standards were in effect will not be reviewed.

2025 site visits will review calendar year 2024 only.
2026 site visits will review calendar years 2024 and 2025.
2027 site visits will review calendar years 2024, 2025, and 2026.

Will there be changes to the site visit process and medical record review under the 2024 Standards?
The site visit process will remain the same, with no significant changes. Each year, the NAPBC provides an updated version of the "Site Visit Instructions and Sample Agenda" document to help programs prepare for upcoming site visits scheduled for the following calendar year. The medical record review process will be included in the updated Site Visit Instructions.

Is there more information available regarding individualized shared decision making (IDSM)?
The 2024 Standards now include extensive resources to help NAPBC-accredited programs implement ISDM concepts in their delivery of high-quality multidisciplinary breast care.

Standards that require the implementation of ISDM must be reviewed by the Breast Program Leadership Committee (BPLC) on an annual basis, with documentation in the meeting minutes. The BPLC evaluation must review and assess how individualized shared decision-making principles are utilized in the required delivery of patient care outlined in that particular standard. ISDM will not be evaluated during the medical record review portion of accreditation site visits.

Please refer to the Appendix of the 2024 Standards for the newly-added section, "Resources and Examples for Individualized Shared Decision Making (ISDM)" for more information.

Protocol Development

The following section provides summary guidance on the development of protocols required to meet compliance with *Optimal Resources for Breast Care (2024 Standards)*.

Please note: This guidance, including the "General Tips" outlined below, are only recommendations for consideration.

A protocol is a structured and consistent process crafted by the NAPBC-accredited program to help implement the required compliance criteria for specific NAPBC standards. Protocols must be written and documented in a manner that demonstrates compliance with whichever NAPBC standard the protocol is designed to address. Additionally, all protocols must be formally approved by the Breast Program Leadership Committee (BPLC). Identical protocols that apply to several affiliated NAPBC-accredited programs are acceptable. Such protocols must be specifically stylized for each affiliated program, and be formally approved by each BPLC, as applicable. Protocols do **not** need to be officially-recognized hospital or institutional policies.

Protocol Content and Required Elements

Every standard that requires a protocol includes a list of required elements that must be addressed by that protocol. Evaluating protocols for standards compliance is based on whether or not the protocol addresses how each required element is implemented by the program in the evaluation and management of patients with breast disease or breast cancer. The protocol should clearly and succinctly describe how that specific aspect of care is managed by the accredited program.

General Tips on Content

- NAPBC protocols are not intended to replicate, reproduce, or replace clinical management guidelines, such as those produced by NCCN
    - Specifying **which** patient care guidelines are utilized by the program should be included in a protocol whenever necessary, but those guidelines should not be copied or replicated in the protocol
    - For example, in the required protocol for Standard 5.1:
        - "NAPBC General Hospital follows screening guidelines for breast cancer provided by the American College of Radiology"
- Most protocols can be sufficiently addressed in 1 – 2 pages
    - Length may vary depending on the program and the protocol in question
- When developing the required protocols, it may be helpful to start by outlining patient throughput within your program
    - Focus on the aspect of care addressed by the protocol, not the entire patient journey
    - Identify the sequence of events along the patient pathway, and points of interaction where healthcare providers or staff members are involved, and necessary actions
    - Describe each step clearly and succinctly
- A qualified healthcare provider should be able to read the final protocol and have a clear understanding of the processes for patient management within the program for that specific aspect of care

- Consider asking a qualified provider within your program to review the finished protocol from the perspective of the NAPBC Site Reviewer

Protocol Format and Structure

Each program has full discretion to utilize a wide variety of formats and structures when creating the required protocols. There are no NAPBC-specific templates that must be utilized. Acceptable options include, but are not limited to:

- Narrative descriptions
- Flow charts
- Process maps
- Grid matrices

General Tips on Format and Structure

- Consider developing a blank protocol template or style guide to create consistency across all protocols
    - Consider utilizing different formats depending on the content of the protocol. Narrative description may be ideal for one protocol, while a flow chart may work best for another
- Affiliated NAPBC-accredited programs within a healthcare system may utilize the same required protocols for one or more standards, provided the protocols are accurate and applicable to each affiliated program
    - Shared protocols must identify each program using the protocol, or there must be separate copies stylized for each specific program
    - Any program-specific variations in management need to be addressed
    - The Breast Program Leadership Committee at each program must review and approve all protocols as outlined in each applicable NAPBC standard, with documentation in their BPLC meeting minutes
- Consider including reference points on each protocol. For example:
    - First date of review by the BPLC
        - Most recent date of review by the BPLC
    - First date of approval by the BPLC
        - Most recent date of approval by the BPLC
    - Year/date of the next required BPLC review
    - Reference points may assist the program and the NAPBC Site Reviewer with identifying which BPLC meeting minutes document a specific review
- Only the most recent protocols are reviewed for standards compliance
    - Previous versions of protocols that are no longer used by the program may be beneficial for internal reference, but do not need to be submitted as documentation of compliance

Chapter 2: Program Scope and Governance

Standard 2.1: Breast Program Leadership Committee

Must appointed members attend at least 75% of BPLC meetings each calendar year, even if the BPLC holds more than the four required meetings?
Yes, BPLC members must attend at least 75% of all BPLC meetings held each calendar year.

We are a large hospital system. Does each hospital within the system need to have their own BPLC meetings?
Yes. The NAPBC does not offer a network accreditation model. Each program must have its own BPLC which hosts its own meetings.

It is recommended, but not required, that a community representative and/or patient representative be a full member of the BPLC. Can you provide examples of this?
An American Cancer Society representative, a breast cancer survivor (former patient), or a cancer support team representative would all be examples.

Standard 2.1 now requires two healthcare professional members in addition to the three physician members. May the program choose any two healthcare professionals for these roles?
These members of the BPLC must be non-physician healthcare professionals who are involved in the management and care of patients with breast disease or breast cancer, and must meet the membership requirements outlined in Standard 2.1. While these two members cannot both represent the same discipline of care, there are no other limitations.

Nurses, navigation professionals, physician assistants, radiology technologists, registered dietitian nutritionists, or any other multidisciplinary provider affiliated with the management and care of patients with breast disease or breast cancer may be appointed.

Are appointed BPLC members allowed to have a designated alternate member?
Yes. The standards allow one designated alternate for each appointed member of BPLC.

If one of our physician members of the BPLC is a medical oncologist, does their appointed alternate also have to be a medical oncologist?
No. BPLC membership appointments are not tied to committee roles requiring specific disciplines or specialties. Any physician who meets the requirements for BPLC membership outlined in Standard 2.1 may serve as an alternate. The same applies for the healthcare professional members.

Standard 2.2: Breast Program Director

Can the co-BPD be a non-physician?
Yes. There must be a physician Breast Program Director (BPD), but a co-BPD is permissible, and the co-BPD may be a non-physician.

Standard 2.3: Breast Care Team

Are nurses required to be members of the BCT?
While not required, it is strongly recommended that breast oncology nurses be represented on the BCT.

"The NAPBC-accredited program must have a defined, multidisciplinary, Breast Care Team (BCT) with a minimum of one appointed physician member from each of the following specialties: surgery, pathology, radiology, medical oncology, and radiation oncology."

Does "surgery" mean a breast surgeon?
The BCT surgeon must be a surgeon who treats breast patients.

"All new physicians (including surgeons, pathologists, radiologists, medical oncologists, radiation oncologists, and reconstructive surgeons) who are regularly involved in the evaluation and management of patients with breast disease or breast cancer in the NAPBC-accredited program after January 1, 2024, must be a member of the BCT, and maintain compliance with all NAPBC Standards."

Does this apply to current physicians?
No, it does not. Only new physicians joining the program who will be regularly involved in the evaluation and management of patients with breast disease or breast cancer after January 1, 2024, are required to join the BCT.

"Physicians who are regularly involved in the management of patients with breast cancer". Can you please elaborate on what is meant by "regularly involved"?
The NAPBC accredits breast programs in their entirety. NAPBC strongly believes all patients with breast disease and breast cancer who are treated at NAPBC-accredited programs should receive high quality care. The BPLC is responsible for monitoring its practitioners who treat patients with breast disease and breast cancer, and ensuring compliance is maintained with the NAPBC Standards. It is ultimately at the program's discretion to determine who is regularly involved in the management of patients with breast disease and breast cancer. This language is structured to balance flexibility for programs overseeing their participating healthcare providers while maintaining accountability with the intent of the standard.

"Physicians involved in the evaluation and management of patients with breast disease or breast cancer at multiple NAPBC-accredited programs are only required to participate as a member of the BCT at a single NAPBC-accredited program where they provide care. Such physicians must provide a letter of attestation documenting BCT membership at the facility of participation. The letter of attestation must be issued by the Breast Program Leadership Committee (BPLC) and the Breast Program Director (BPD) at the facility of participation."

Who should issue and sign the letter if it is attesting to the BCT membership and participation of the Breast Program Director?
If the BPD is the subject of the letter of attestation, the letter must be signed by at least two additional appointed members of the BPLC, and/or a member of facility administration involved in overseeing the NAPBC-accredited program.

Standard 2.4: Multidisciplinary Breast Care Conference

Can the BPLC set different MBCC attendance rates for the same physician specialty?
For example:

- Individual surgeons performing fewer than 20 breast surgical procedures each calendar year must attend at least 20% of MBCC meetings.
- Individual surgeons performing 20 or more breast surgical procedures each calendar year must attend at least 50% of MBCC meetings.

Yes, the BPLC has discretion to establish the attendance requirements for each physician specialty, and the BPLC may set separate attendance requirements based on objective criteria. The attendance rates are approved by the BPLC and documented in the BPLC meeting minutes.

Can the BPLC change the MBCC attendance requirements for a physician specialty in the middle of the year?
Changing the BPLC attendance requirements mid-year is strongly discouraged. If a physician can no longer meet the MBCC attendance requirements established by the BPLC due to legitimate mitigating circumstances, this should be discussed with the BPLC and documented in the BPLC meeting minutes. These considerations may be discussed with the NAPBC Site Reviewer during the next site visit.

Our BPLC is a subcommittee of our cancer committee. Can the cancer committee set the attendance requirements for MBCC meetings instead of the BPLC?
Yes. This is left to the discretion of the program.

If a member of the BCT is out on leave, are they still held to the same attendance percentages?
If a member of the BCT is out on leave, their percentage of attendance is only held to the length of time they are not on leave. For example, if the BPLC sets a requirement for radiologists to attend 25% of MBCC meetings, and an individual radiologist is on leave for 3 months, that individual would only be held to 25% attendance for the meetings that occur in the 9 months they are not on leave.

If a locum physician is covering for the appointed required member or their alternate, does this meet attendance requirements?
Yes. MBCC requires representation by the 5 specialties outlined in the standard. As long as the locum represents the necessary specialty, this is acceptable.

Is the analytic case load limited to just breast cases?
The analytic case load includes only the program's patients with breast cancer (invasive and non-invasive).

"At least one surgeon, radiologist, pathologist, radiation oncologist, and medical oncologist must attend each MBCC meeting."

> **Our program has only one surgeon providing care to patients with breast cancer. If our only surgeon cannot attend a meeting of the MBCC, is there an appropriate substitute who can represent the surgical discipline so the MBCC can still meet?**

Yes, another surgical oncologist or general surgeon on the medical staff may represent the surgical discipline at the MBCC meeting.

MBCC case presentation and discussion require "visual display of clinically relevant pathology slides and imaging studies". How does NAPBC define clinical relevance?
Clinical relevance is defined as pathology slides and imaging studies which may affect diagnosis, clinical management, or treatment decisions. Determining whether pathology slides and imaging studies for a particular case warrant visual display to the MBCC is left to the discretion of the BPLC and the physician providers at the NAPBC-accredited program.

Our program has a high volume of analytic breast cancer cases each year, and we anticipate difficulty with presenting and discussing 30% of these cases at the MBCC. Are there other options for meeting compliance with Standard 2.4?
Yes. The revised 2024 Standards allow programs with more than 250 analytic breast cases per year to define their own process for prospective case presentation and discussion within the MBCC. There must be a protocol in place outlining all the parameters of the program's process, including how the program determines the number of cases that will be presented each year. The BPLC must also review their compliance with this protocol each calendar year.

If the number of cases presented and discussed by the MBCC each calendar year is fewer than 30% of the program's annual analytic case load, there must also be written justification for why fewer than 30% of cases were prospectively presented and discussed. For example, if the program establishes a multidisciplinary clinic with surgery, pathology, radiology, medical oncology, and radiation oncology, and patients are evaluated at the multidisciplinary clinic rather than being presented and discussed at the MBCC, that would meet the requirement for written justification.

Is the analytic case load based on the current calendar year or the previous calendar year?
It is based on the current calendar year. It is recommended that programs add 10% to their total analytic case load from the previous year when trying to predict an estimate for this number.

If MBCC meetings are cancelled, do the scheduled meetings still count towards our total number of annual meetings?
No. The MBCC meeting must be held in order to count toward the required meeting total.

Chapter 3 Standards: Facilities and Equipment Resources

Standard 3.2: Image Guided Biopsy Quality Assurance

Our program does not have accreditation for radiation oncology. How do we meet compliance with Standard 3.2?
NAPBC-accredited programs that do not have radiation oncology accreditation must have a Radiation Oncology Quality Assurance Program in place. The requirements are outlined in Standard 3.2.

The NAPBC Radiation Oncology Quality Assurance Plan is available in the Resources section of the Quality Portal. This document provides more detail on how NAPBC-accredited programs can develop a radiation oncology quality assurance plan that meets the requirements of Standard 3.2. This

document was also available for the 2018 NAPBC Standards, and has been updated for the new 2024 standards.

In early 2025, the NAPBC released a new Radiation Oncology Quality Assurance Template that is available in the Resources section of the Quality Portal. The template must be completed by NAPBC programs that **do not** hold radiation oncology accreditation at their facility. The template must be completed and submitted with the Pre-Review Questionnaire (PRQ).

What counts as a Radiation Oncology Peer-Review Program? Can participation in tumor boards be counted as peer review?
No, discussion at tumor boards would not meet the peer review requirement. Peer review is any peer protected discussion of radiation oncology cases, such as radiation oncology morbidity and mortality conference.

Standard 3.3: Image Guided Biopsy Quality Assurance

Can surgeons perform image guided biopsies?
Yes, they can. However, surgeons must be certified by the American Society of Breast Surgeons (ASBrS) in order to perform procedures covered under Standard 3.3. To perform stereotactic core needle biopsy, surgeons must hold ASBrS Stereotactic Breast Procedures Certification or ASBrS Stereotactic Breast Procedures Certification for Surgical Fellows. To perform ultrasound-guided needle biopsy, surgeons mut hold ASBrS Breast Ultrasound Certification or ASBrS Breast Ultrasound Certification for Surgical Fellows.

Standard 3.4: Breast Imaging Quality Assurance

American College of Radiology (ACR) Breast Imaging Center of Excellence (BICOE) is no longer included in the NAPBC Standards as a compliant imaging accreditation. Why?
The ACR uses a new name for this designation: ACR Designated Comprehensive Breast Imaging Center (CBIC). The 2024 NAPBC Standards have been updated to reflect this change.

Chapter 4 Standards: Personnel and Services Resources

Do continuing education credits earned from Multidisciplinary Breast Cancer Conference (MBCC) attendance count towards compliance with Standards 4.1, 4.2, and 4.3?
Yes. Physicians (Standard 4.1), oncology nurses (Standard 4.2) and physician assistants (Standard 4.3) may all use continuing education credits earned from MBCC attendance towards compliance with their respective standard in Chapter 4.

Standard 4.2: Oncology Nursing Credentials

The Commission on Cancer (CoC) recently announced updates to Standard 4.2: Oncology Nursing Credentials, which is an aligned standard with the NAPBC. The following is how these changes will apply in NAPBC programs.

Effective January 1, 2026, NAPBC programs also accredited by the CoC are no longer required to demonstrate compliance with NAPBC Standard 4.2. The CoC program must still demonstrate compliance with the revised CoC Standard 4.2 as outlined in the implementation timeline provided by the CoC, which includes the nurses from the NAPBC program.

Beginning January 1, 2026, NAPBC programs that are not also accredited by the CoC must begin implementing the recently revised requirements of CoC Standard 4.2. For more information, the CoC standards may be accessed here. The CoC FAQ for Standard 4.2 provides additional guidance.

How will Standard 4.2 be evaluated at 2026 site visits for NAPBC programs that are also accredited by the CoC?
The recently updated standard does not impact the site visit process for 2026 site visits, which will review Standard 4.2 compliance for 2023, 2024, and 2025. NAPBC programs will be expected to submit either a CoC Accreditation Report reflecting a compliant rating for Standard 4.2 OR the documentation required to demonstrate compliance with Standard 4.2 for the NAPBC program.

However, during 2026 site visits, programs will only be expected to demonstrate 18 hours/accreditation cycle for nurses who do not hold an oncology certification.

If we do not meet the requirements for Standard 4.2 for our 2026 site visits, can we do an action plan?
Yes. If a program due for a site visit in 2026 determines it is not currently capable of meeting compliance with Standard 4.2, the program is allowed to develop and implement an action plan to help achieve compliance.

The action plan must outline the specific issue(s) affecting compliance and the interventions that will be implemented to achieve compliance. The specifics of the action plan must be documented in the cancer committee or BPLC meeting minutes. Successful documentation of a substantive action plan may result in a “deficiency resolved” rating during the 2026 site visit.

For programs that are not accredited by the CoC, are oncology nurses required to complete a certain number of breast-specific or breast-related NCPD hours?
No. It is recommended that nurses prioritize NCPD hours that are applicable to patients with breast disease or breast cancer whenever possible, but there is no specific number of breast-specific NCPD hours that must be met in order to meet compliance with this standard.

Standard 4.3: Physician Assistant Credentials

For site visits conducted in 2025 and 2026, how many continuing education credits are required for physician assistants (PAs) to meet compliance with Standard 4.3?

Reaccreditation Site Visits in 2025

- PAs are only required to document 12 hours of continuing education to meet compliance with Standard 4.3 for site visits conducted in **2025**.

- The 12 hours of continuing education may be earned during calendar years 2022, 2023, and 2024 for site visits conducted in **2025**.

Reaccreditation Site Visits in 2026

- PAs are only required to document 24 hours of continuing education to meet compliance with Standard 4.3 for site visits conducted in **2026**.
- The 24 hours of continuing education may be earned during calendar years 2023, 2024, and 2025 for site visits conducted in **2026**.

Reaccreditation Site Visits in 2027 and beyond

- PAs must meet full compliance with Standard 4.3 as written in *Optimal Resources for Breast Care (2024 Standards)*

All Initial Site Visits

- PAs must document 12 hours of continuing education earned during the full calendar year of standards compliance prior to application

Are PAs required to complete a certain number of breast-specific or breast-related continuing education?
No. It is recommended that PAs prioritize continuing education that is applicable to patients with breast disease or breast cancer whenever possible, but there is no specific number of breast-specific continuing education hours that must be met in order to meet compliance with this standard.

Standard 4.4: Genetic Professional Credentials

If genetic testing is referred to an outside provider, do we need documentation of their qualified genetic professionals?
Yes. If genetic counseling is provided by a telegenetics company or a facility outside the NAPBC-accredited program, the referred company or facility must utilize genetic professionals who meet who meet one of the qualifications listed in Standard 4.4. Documentation of their qualifications must be obtained by the NAPBC-accredited program.

Standard 4.5: Navigation Professional Credentials

Can proof of experience be provided as qualification for a navigation professional?
No. All navigation professionals at the NAPBC-accredited program must hold either a qualifying healthcare certification that includes patient navigation training within its examination **OR** provide documentation of completed competency-based training and education in patient navigation for patients with breast disease or breast cancer from a qualifying training program. Qualifying examples for both compliance options are outlined in Standard 4.5.

Standard 4.5 is specified as a "Phase-In" Standard. What does that mean?
To accommodate navigation professionals who need to complete training or certification, compliance with this standard was phased in over two years. All navigation professionals must be compliant with Standard 4.5 no later than **December 31, 2025.**

May the program utilize lay navigators and still meet compliance with Standard 4.5?
Yes. The term "lay navigator" has been retired by the Oncology Navigation Standards of Professional Practice. The 2024 Standards refer to two different types of navigation professionals: **clinical navigators,** who hold current healthcare licensure, and **patient navigators**, who do not. Previously referenced "lay navigators" are now known as **patient navigators,** or **oncology patient navigators,** and they are still an important part of providing navigation services to patients with breast cancer. Patient Navigators must meet compliance with this standard through documented completion of competency-based training and education in patient navigation for patients with breast disease or breast cancer from a qualifying training program.

Are Clinical Navigators only allowed to meet compliance with Standard 4.5 by holding a qualifying healthcare certification?
No. Clinical Navigators may meet compliance with Standard 4.5 by either:

1. Holding a qualifying healthcare certification that includes patient navigation within its exam
   OR
2. Providing documented completion of competency-based training and education in patient navigation for patients with breast disease or breast cancer from a qualifying training program

Our hospital provides in-house navigation training. Will this be accepted for compliance with Standard 4.5?
No. All navigation professionals must have a qualifying healthcare certification which includes patient navigation training within its examination, **OR** they must document completion of competency-based training and education in patient navigation for patients with breast disease or breast cancer from a qualifying training program.

Standard 4.5 lists several different navigation training programs that meet the requirements of this standard, including the George Washington University Oncology Patient Navigator Training Program, which is free for all learners and may be completed online.

Is the National Consortium of Breast Centers (NCBC) Breast Health Clinical Navigator (BHCN™) certification acceptable to meet Standard 4.5?
Yes. BHCN™ certification is listed in Standard 4.5 as a qualifying healthcare certification. All qualifying certifications must be endorsed by an accrediting agency in healthcare credentialing to meet compliance with the NAPBC Standards in Chapter 4.

Are the retired navigation credentials from the National Consortium of Breast Centers (NCBC) acceptable to meet compliance with Standard 4.5?
Retired navigation credentials from NCBC are accepted as proof of competency-based training and education in patient navigation for patients with breast disease or breast cancer. The navigation professional must provide documentation that they currently hold the credential.

Chapter 5 Standards: Patient Care: Expectations and Protocols

Standard 5.1: Screening for Breast Cancer

Do all screening patients need to have individualized discussions regarding evidence-based risk reduction strategies for breast cancer?
No. The risk reduction strategies may be provided to patients in a multitude of ways, including brochures, pamphlets, printed reports, or patient hand-outs; posters in waiting rooms or exam rooms, QR codes directing to websites with risk reduction information, or any other manner of written or electronic sources for the required information. One-on-one patient discussion is not required.

All patients at our program are screened using 3-D mammography, specifically Digital Breast Tomosynthesis. Are patients with increased density required to undergo additional screening?
No. If the patient is screened using a more detailed imaging system revealing the increased density, Standard 5.1 does not require additional imaging or screening automatically. It is at the discretion of the NAPBC-accredited program and the attending physician to determine if there are additional indications for further screening. The required protocol for Standard 5.1 must outline the program's processes for notification and education for patients with increased density, the program's guidelines for providing supplemental screening, and which additional screening techniques are available to the program and when their use may be indicated.

Standard 5.2: Diagnostic Imaging of the Breast and Axilla

All imaging services are referred to a local imaging center. How must our program meet compliance with Standard 5.2?
If the NAPBC-accredited program does not have the capability to perform imaging services on-site, the program must establish a referral relationship with a local facility with the capacity to provide all the required imaging services outlined in Standard 3.4, and the accredited program must obtain documentation from the referred facility confirming either American College of Radiology (ACR) Breast MRI Accreditation **or** ACR Comprehensive Breast Imaging Center (CBIC) Designation. These requirements are outlined in Standard 3.4.

To demonstrate compliance with Standard 5.2, the accredited program must develop and implement the required protocol outlined in Standard 5.2. The protocol must address the following: confirmation that patients with clinical findings or abnormal mammograms have undergone risk assessment for the development of breast cancer; confirmation of access to biopsy services for patients with abnormal results on MRI or mammography; and either the performance of the recommended biopsy, or confirmation that the patient has been notified of the recommendation for biopsy.

The accredited program must also have a process for confirming concordance between imaging and pathology results through clinical follow-up or consultation recommendations. Biopsy results and follow-up recommendations must also be shared with the patient.

Standard 5.4: Management of Patients at Increased Risk for Breast Cancer

"Risk reduction strategies must be discussed with the patient and documented in the medical record."

Our program has a high annual volume of patients at increased risk. Does this requirement mandate individualized discussion and documentation for ALL high-risk patients regarding risk reduction?
No, this only applies to those patients being seen in a high-risk clinic or high-risk program. It does not apply to every high-risk patient at the institution.

Standard 5.6: Evaluation and Treatment Planning for the Newly Diagnosed Cancer Patient

How do we document review of outside imaging/pathology?
The exact process is left to the discretion of the NAPBC-accredited program. The documentation must be reviewable by a NAPBC Site Reviewer during the site visit. It is recommended that your program confer with your legal/risk management teams regarding hospital/institutional policy for such documentation.

How does NAPBC define "clinically relevant" outside pathology or outside imaging?
That is left to the discretion of the NAPBC-accredited program. The outside pathology slides and imaging studies must be reviewed before the initiation of treatment in the case of clinically relevant findings that may affect diagnosis, clinical management, or treatment decisions. NAPBC-accredited programs are expected to complete the review of outside slides and images unless there is clear evidence the review would not influence treatment decisions.

Do outside images need to be reviewed by a radiologist specifically? Or is it acceptable for any treating physician to review?
Any physician can review the outside imaging. Although this is strongly recommended, it does not need to be a radiologist.

Standard 5.9: Surgical Care

Are the CoC Operative Standards required if our program is not accredited by the CoC?
Yes. All NAPBC-accredited programs must demonstrate compliance with the Commission on Cancer (CoC) Operative Standards 5.3: Sentinel Node Biopsy for Breast Cancer, and Standard 5.4: Axillary Lymph Node Dissection for Breast Cancer. The current CoC Standards are available here on the CoC Standards website. These standards require synoptic operative reports with the required core data elements as described in the Definition and Requirements sections of each standard. For additional guidance, please see the CoC Operative Standards FAQ.

Programs that are not accredited by the CoC may contact the NAPBC via email at NAPBC@facs.org if further guidance is required for implementing the CoC Operative Standards.

Do NAPBC programs that are also accredited by the CoC have to demonstrate compliance with CoC 5.3 and 5.4 during the NAPBC site visit?
No, NAPBC-accredited programs that are also CoC-accredited do not need to demonstrate

compliance with CoC Standards 5.3 and 5.4 during the NAPBC site visit. Programs may provide their most recent Accreditation Report from their most recent CoC site visit documenting a compliant rating with both standards.

How is compliance with CoC Standards 5.3 and 5.4 determined for NAPBC-accredited programs that are not CoC accredited?
At site visits in 2026, site reviewers will determine compliance with CoC Standards 5.3 and 5.4 for non-CoC-accredited programs by reviewing medical records to confirm that applicable operative reports contain all required elements in the synoptic format.

Beginning with site visits in 2027, compliance will be determined through review of an internal audit completed by the program.

For more information, please visit the CoC Standards Implementation Timelines website.

The CoC Standards 5.3 and 5.4 have an alternative compliance pathway available in 2026. Is this also available to NAPBC-accredited programs that are not CoC accredited?
Yes. Non-CoC-accredited programs may use the alternative compliance pathway by conducting an internal audit and documenting an action plan to address any deficiencies. The site reviewer will still perform a medical record review and, if noncompliance is identified, evaluate the audit and action plan. If appropriate, the program may receive a "deficient but resolved" rating.

Are NAPBC-accredited programs that are not also CoC accredited required to perform internal audits for CoC Standards 5.3 and 5.4?
Yes, beginning in 2026 for site visits in 2027, NAPBC-accredited programs that are not also CoC-accredited are required to conduct an internal audit each year to confirm 80% compliance with the requirements of Standards 5.3 and 5.4. A separate audit must be conducted for each standard. The internal audit includes a review of 30 applicable cases (or all applicable cases, if the program has less than 30). Programs are required to use the CoC Operative Standard Audit Template available in the Resources section of QPort to document the audit. If the internal audit demonstrates less than 80% compliance with CoC Standard 5.3 and 5.4, the program must develop and implement an action plan.

Programs that are also CoC-accredited are evaluated through their internal audit for CoC accreditation. They do not need to repeat the audits or develop additional action plans for NAPBC.

Standards 5.9 – 5.12

How must individualized shared decision making (IDSM) be utilized?
The 2024 Standards Appendix provides examples from NAPBC and additional resources from the NCI, AHRQ, and the ACCC on how to get started, or further expand, ISDM implementation. The specific implementation of ISDM is at the discretion of the NAPBC-accredited program. All Chapter 5 Standards that require implementation and review of ISDM (Standard 5.6, and 5.9 – 5.12) are structured the same way: The program must review ISDM principles and how they are utilized in patient care in relation to each standard (and other aspects of patient care, optionally). The NAPBC-accredited program must complete this review for each of these standards every calendar year as part of the required BPLC Review, with documentation in the BPLC meeting minutes. That review is

an opportunity to discuss new ways to implement ISDM training with staff, utilize ISDM principles in clinical management, and introduce individualized considerations for conversations with patients, family, and other providers. The program should consider barriers to ISDM implementation, success stories, gaps in training, and any other relevant considerations.

Does assessing an Eastern Cooperative Oncology Group (ECOG) Performance Status or Karnofsky Score qualify as a functional assessment for Standards 5.9 – 5.12?
No. ECOG/Karnofsky scores do not meet the intent of the preoperative/pre-treatment functional assessment by themselves. The functional assessment protocol is intended to involve physical assessment of the patient. The protocol may utilize ECOG/Karnofsky scores as an initial screening step, but patients scored with impairment or restriction would then require an actual physical functional assessment, such as the shoulder abduction and timed “Up and Go” tests described in the Appendix of *Optimal Resources for Breast Care (2024 Standards).* NAPBC-accredited programs have full discretion to develop their own protocol for the functional assessment.

Is a functional assessment required for all patients preoperatively/pre-treatment?
No. All patients must be considered for a functional assessment. The functional assessment should be administered if it would be beneficial to the patient, or useful for establishing a baseline for physical function before surgery, or prior to medical oncology or radiation oncology treatment. The 2024 Standards Appendix provides additional resources for conducting an easily-administered functional assessment that meets the compliance requirements for Standards 5.9 – 5.12.

Is a separate functional assessment protocol required for all four standards?
No. The same protocol may be used to meet compliance with all four standards. The program has full discretion regarding utilization of the functional assessment outlined in the Appendix of the 2024 Standards, or a different functional assessment tool. The program may also choose to implement different protocols for one or more of these standards based on the needs of their program, or at the discretion of their physician providers. If one protocol is used to meet compliance with all four standards, the protocol must specify its applicability to all four standards.

Standard 5.10: Reconstructive Surgery

Do we have to perform an internal audit of patient medical records from our reconstructive surgery program for Standard 5.10, and present it to the BPLC?
No. Internal audits are not required for any NAPBC Standard requiring BPLC Evaluation and Review. Each calendar year, the BPLC must review how the program evaluates outcomes for reconstructive surgery. While an internal audit of patient medical records may be helpful for this process, it is not required. Each accreditation cycle, the availability of reconstruction options must also be evaluated. Please refer to the "Evaluation by the BPLC" section in Standard 5.10 for more information.

Standard 5.11: Medical Oncology & Standard 5.12 Radiation Oncology

Standard 5.11 requires "exercise therapy recommendations for pain control, fatigue, anxiety, depression, sleep, loss of function and improved survival". Is our program required to have an exercise program on-site?
No. A structured exercise program is not required to meet compliance with this standard. The NAPBC-accredited program is only required to have specific examples or recommendations for exercise therapy that may help address these issues.

How are Standards 5.11 and 5.12 affected if medical/radiation oncology are referred to another facility?
Patient care at the referral location(s) must be consistent with the requirements outlined in *Optimal Resources for Breast Care (2024 Standards)*. NAPBC-accredited programs are responsible for coordinating appropriate referrals to qualified facilities and/or providers. Referral relationships are reviewed by the Site Reviewer during each accreditation site visit.

Chapter 7 Standards: Quality Improvement

Standard 7.1: Quality Measures

When must this standard be implemented?
Standard 7.1 remains in active development. As Quality Measures are developed by the NAPBC, more information will be provided to NAPBC-accredited programs regarding the timeline for implementation and the Expected Compliance Rates that must be monitored by accredited programs. Standard 7.1 will be rated as "Not Applicable" during future site visits until the first Quality Measures have been implemented.

Standard 7.2: Quality Improvement Initiatives

Starting with 2026 site visits and 2026 breast program activity, NAPBC programs will only be required to complete one Quality Improvement (QI) Initiative each accreditation cycle to meet Standard 7.2 compliance.

We are due for a site visit in 2026 or 2027. How many QI projects will be required?
Only one compliant QI project will be required for compliance at a 2026 or 2027 site visit. If you have already completed a compliant QI project in your accreditation cycle, your program does not need to complete any additional projects as long as it meets the requirements in the standard.

What will be required to resolve a deficiency for Standard 7.2?
If a deficiency is given, resolution requires "planning" of the next QI project. Required steps for corrective action include: the QI Initiative Title, Performance Improvement Approach, Problem Statement, Data source used to identify the problem, and QI initiative team members. These elements must be documented in the QI template and be presented to the BPLC and documented in the minutes.

Will this change in frequency of QI requirements affect the individual standards of 5.9-5.13?
The outcome reviews in NAPBC Standards 5.9-5.13 do not require quality initiatives, so this change does not impact requirements in these standards.

If we happen to meet our QI project goal sooner than 3 years, do we need to start a new project?
No, you do not need to begin another QI project for NAPBC. If your program is also CoC accredited, you need to begin 1 QI project each year and follow the QI Standard 7.3 as written in the standards manual.

Does the QI project need to span a certain timeframe?
A QI project can span across the years within the accreditation cycle. You do not need to complete the QI project in that same year it started. The project may take 1, 2, or 3 years of the accreditation cycle. Once the project is complete (in accordance with the parameters outlined in the QI Standard) you no longer need to provide status updates. If you finish the project in year 2 of the accreditation cycle, you do not need to provide status updates in year 3.

What are the reporting requirements for compliance?
You will need to complete, at minimum, two status updates per year for each year the QI project is active. For example, if the QI project takes all three years of the accreditation cycle, you will need to complete at least two status updates to the BPLC each calendar year.

What is required for compliance with Standard 7.2 at an initial site visit?
Programs undergoing an initial site visit must "plan" its first QI project. Specifically, the following steps must be completed and documented: the QI Initiative Title, Performance Improvement Approach, Problem Statement, Data source used to identify the problem, and QI initiative team members.

If we are not yet accredited and start a QI project before receiving accreditation, do we need to begin a new project to count for the new accredited cycle?
It is only required that you complete the planning stages of the QI project for the initial site visit. Completion of that same project during your first accreditation cycle would meet the QI standard for the reaccreditation cycle as well.

Why are we being given 3 years to complete an NAPBC QI project?
Many programs report on the desire to conduct a robust, well planned, and well executed QI project but face the challenge of time and capacity. By easing the time frame requirements, it will allow programs to develop high quality QI projects. The breadth and depth of the scope of the project is up to the local QI team. The project does not need to span all three years, but the extra time does afford a program the opportunity to identify an existing problem using data, develop a robust intervention, re-evaluate data linked to the intervention, and focus on sustainability.

What if our program waits to start a project until the last year of our accreditation cycle?
You can wait to start the QI project, but you will receive a deficiency for the standard for the accreditation cycle if it is not completed or conducted in accordance with the parameters of the standard. Programs have requested more time to complete robust, meaningful, and well-planned QI projects with sound data sources. Starting early in the three-year cycle will allow for this.

We want to participate in a QI national project. Will we be awarded credit for our NAPBC program?
If the national QI project is focused on a breast specific topic, you may be able to participate in a

national QI project for credit to fulfill the QI requirements for NAPBC. National projects will explicitly state what accreditation standards and for what year, if any, are fulfilled by participation.

Commission on Cancer (CoC) Considerations

If we are using our NAPBC project for compliance with the CoC standard, what year will my NAPBC project count for CoC?
The year in which the NAPBC project is **completed** is the year in which your project is awarded credit for CoC. For example, if you begin an NAPBC focused project in 2027 but do not complete it until 2028, you will be awarded completion for NAPBC QI for the accreditation cycle, and it can count for a CoC QI for 2028.

NOTE: for CoC compliance, a new project must be started each year within the accreditation cycle if not using a NAPBC or NAPRC project for compliance. In this example, the CoC program must also start a project in 2027 and 2029.

Conversely, there is no requirement that you use an NAPBC QI project for credit for CoC QI credit. It is an option, but not mandatory.

Does an NAPBC program need to present the QI project to the CoC Cancer Committee for the CoC program to receive "credit" for that year?
No. As long as the requirements for the applicable program are met, the QI project can count for a CoC project. Programs are encouraged, but not required, to share their completed QI projects with the CoC Cancer Committee.

We are currently doing a QI project for CoC that is applicable to all cancer disease sites. Through this project, we have noticed our breast cancer program will need a different approach based on data/performance. Could we reuse this QI project for NAPBC and redirect the goals/interventions of this project to be specific for breast cancer?
Yes, if a broader QI project highlights a challenge with a specific population, disease site, within a specific clinic, etc., it is permissible to use this same problem in a future year, isolating the data of the defined problem, and using specific resources/interventions to conduct a meaningful QI project.

We are CoC and NAPBC accredited. Can we do a breast focused project in year 1 for NAPBC credit and a different, breast focused project for CoC QI credit in year 2?
Yes. CoC does not have limitations on which disease sites are addressed by the QI Initiative.

Are we allowed to use the improvement of a current or retired CoC quality measure (like surgery to RT start) for NAPBC QI initiative?
In general, QI initiatives can be based on problems identified with a CoC quality measure. However, if considering utilizing a retired CoC quality measure then it's recommended that the reason for the retirement of the measure be considered. Sometimes measures are retired because of evolutions in practice or evidence supporting the measure, so it may not be a good candidate for a QI project.